of the child; or the cord may be ruptured; or the placenta may be torn off. In a case observed by Malgouyre the latter accident happened and the placenta was expelled simultaneously with the foetus. In a case reported by Rigby the cord was ruptured two inches from the navel. In a case occurring in the practice of a *confrere* in the country in which labor had been going on furiously for several hours without any progress, and in which he intervened with the forceps, the cord was so short that on the extraction of the child he was horrified to see it followed outside of the body by the placenta with the inverted uterus adherent. In spite of every effort and precaution he was unable to replace it, and the patient died.

In my opinion most, if not all, cases of inversion are due to tractions on the cord either owing to its being too short, or to its being wound around the child's neck, or to the tractions of the too hasty accoucheur. I cannot admit that inversion can take place from any kind of normal or abnormal uterine contractions. Not only does shortness of the cord, either absolute or by being wound around the child's neck, increase the pains of the mother and retard the delivery of the foetus, besides contributing largely towards producing inversion, but it is very hazardous for the child. According to Mayer out of 3,587 confinements the cord was wound around the child's neck in 685 cases. Of these 121 were born asphyxiated. Of these latter 72 were restored by appropriate measures while 42 died.

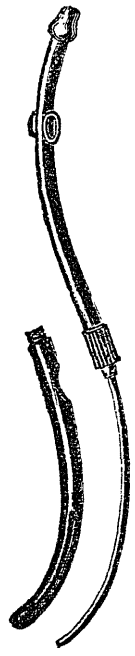
Although the two cords I have shown you are respestively much longer and shorter than the average, they are by no means the longest or shortest on record. Baudeloque has reported a case in which the cord measured nearly 59 inches in length and which was wound around the child's neck seven times. While Schneider relates a case in which the cord measured 118 inches and was wound six times round the child's neck. The shortest recorded was less than 4 inches long.

My object in presenting this brief note is to call attention to the possibility of these conditions occurring, so that the practitioner may be on the look-out for them and so govern himself accordingly.

THE FRITZ BOZEMAN RETURN FLOW CATHETER.

By A. Lapthorn Smith, B.A., M.D., Lecturer on Gynecology, Bishop's College, Montreal.

This valuable instrument is the joint production of one of the oldest and most practical gynecologists of America, Dr. Nathan Bozeman, and Professor Fritz, one of the leading teachers of gynecology in Germany. I purchased two of these instruments in Berlin, in May, two years ago, and have had them in almost constant use ever since. I have found them so useful that I could hardly do without them, and I fear that I have been guilty of culpable negligence in not having brought the instrument to the notice of the Canadian profession sooner, although I have been teaching its use to my gynecology class for the last two years.



I shall only have to task your patience for a few minutes in order to point out its advantages and uses.

First of all it is a return flow catheter. The importance of having such an instrument for irrigating the uterus after any and every manipulation performed on any part of the uterine cavity or cervical canal cannot be overestimated. At Venit's Clinic in Berlin I was surprised to see the senior students entrusted with the serious operation of dilating and curetting the uterus. But the secret of the perfect immunity from danger was the absolute antisepsis which they were able to obtain without running