ticæmia. The erysipelas coccus produces erysipelas, and nothing else. Redness and swelling of the skin, which undoubtedly are sometimes present in septicæmia, ought not to be called erysipelas unless the erysipelas coccus is present —(*Achiv f. Gynakologie.*)

MANAGEMENT OF THE SECUNDINES.—So long as retained placenta is in the uterus or vagina the life of the woman is in jeopardy, and she may at any time be attacked with profuse hemorrhage, septicæmia, and pelvic cellular or peritoneal inflammation. When she has apparently recovered, a placental or fibrinous polypus may form in the uterus, or she may suffer from subinvolution, hyperplasia, etc. Several women in Louisville have died within a few years from septicæmia, with pelvic peritoneal and cellular inflammation, or hemorrhage, caused by a retained placenta.

It may be urged that puerperal septicæmia is always exogenetic in its origin, but we know that a decomposed retained placenta is a prolific cause of the disease, and that its removal or disinfection is the only rational treatment. In abortions before the end of the second month, if hemorrhage ceases, no effort should be made to remove the membranes, unless they protrude into the vagina and can be taken away without introducing the fingers or instruments into the uterus. These little membranes are generally innocuous, and will be separated and expelled without causing dangerous complications. But if pregnancy has continued until a placenta has formed, expectation should not be practiced. If in abortions after the second month the placenta is not expelled in twenty or thirty minutes, it should be removed, unless the woman is threatened with collapse or syncope from hemorrhage, and when, from the absence of arterial pressure, hemorrhage has stopped. We may then wait until she has recovered from shock, or until there is decomposition of the membranes, or a recurrence of hemorrhage.

If the operation is done without delay the os will usually be dilated or dilatable, and a finger or fingers may be easily introduced into the uterus. There is no instrument that can be substituted for the fingers, though it may sometimes be necessary to use other means to dilate the os. Tents should, if possible, be avoided, and if the os cannot be dilated with the fingers, Ellinger's dilator, or my modification of Leonard's dilator, or Molesworth's dilator, may be used. The operation is seldom difficult, and with the patient anæsthetized, any part of, or the entire hand, may be introduced into the vagina, enabling us to examine all the uterine cavity with the fingers and to remove every part of the placenta and membrane. Hemorrhage will then stop, and there will probably be no other untoward symptom. Of course our hands should be thoroughly disinfected, but this should be done in every case of delivery. In premature labor and in labor at term, the placenta is more easily separated than in the earlier months, and is less frequently retained. I fail to recognize a single fact to justify expectation in the management of the third stage of labor in the latter months of pregnancy, and while I do not believe it usually necessary to supplement or supplant nature in an effort to remove the membranes immediately after the child is born, I do not think the placenta should be left in the uterus more than twenty to thirty minutes, and it should be removed from the vagina immediately.

The membrane can generally be removed by judicious expression during labor pains, but if this fail we may assist expression by introducing some fingers into the vagina and gently drawing upon the end of the folded placenta. With a reasonable degree of care this treatment would neither cause septicæmia nor invert the uterus, and such accidents could only result from criminal ignorance or carelessness in the physician. Unless uterine inertia follows the birth of the child there is no necessity for attempting expression until the uterus contracts in an effort to expel the placenta. We should then follow the Credè method, being careful to express only during a contraction. But it is always safe treatment to keep a hand over the uterus to see that it does not relax, and to encourage it to contract by kneading, massage, or expression, if it fail to do so otherwise.— DR. WATKEN, *Jour. Am. Med. Assoc.*

THE ORIGIN OF SCARLET FEVER.—There is good reason to believe that we may be on the brink of making one of the most startling discoveries ever chronicled in the history of medicine, that, namely, of the source and origin of scarlet fever, a disease that is accountable for one out of every thirty deaths that occur in the United Kingdom. It has long been familiar to those engaged in sanitary investigations that many epidemics of scarlet fever have followed a particular milk supply; but in most of these instances the disease has first appeared among persons concerned in the work of collection or of distribution, and it was therefore assumed that its subsequent extension to consumers was a result of its infectiousness, and was brought about through the ordinary channels of human intercourse. When the boy who carried the milk had himself scarcely finished peeling after the malady, it seemed superfluous to look beyond him for the means of its communication to others. Last December, however, outbreaks occurred in South Marylebone, in St. Pancras, in Hampstead, and at Hendon, which were evidently related to a common source of milk supply, but in which it was impossible to trace any source of human infection. The dairy from which the milk was derived was shown to be in excellent sanitary condition, and the medical man