ecbolic effects had remained unimpaired. That as the strength and character of the antiseptic agent employed in the douche solution had been the only variable factor, corresponding variations in the conditions of the hospital afforded evidence of their comparative value. Such variations were shown to have taken place; for when the sublimate douche solution was reduced in strength, and again, when the sublimate douche solution was replaced by salufer, the death-rate rose and septicæmia re-asserted its influence. It was remarkable that the only three deaths which had occurred from septic poisoniug during the last five years should have taken place in the two short intervals, amounting together to less than twelve weeks, during which these solutions were used. It was pointed out that unless such an antiseptic solution was used as was capable of effectually and rapidly destroying septic material, and unless the external genitals were carefully washed beforehand with a similar solution, the routiue employment of the douche during puerpery was liable, from the danger of unavoidably introducing septic material, to be attended with positive danger to the patient, and that under such circumstances its mechanical and ecbolic advantages might be more than counterbalanced by its want of sepsis-destroying power. Unless and until the manifold sources of septic infection could be traced, and with certainty dealt with outside the body, the routine employment of the douche required no defence.

Dr. Braxton Hicks said that he had read a paper at the Dublin meeting of the British Medical Association many years ago on the Use of Antiseptic Uterine Injections. On that occasion he was opposed by the late Sir James Simpson. He considered that care should be used in injections, especially if the patient was restless, as the thoracic movements caused a tendency to the indrawing of fluids.

Dr. Hayes regretted that Dr. Boxall had not included in his report the period when he and Dr. F. Barnes were physicians to the hospital. In 1879, upon the re-opening of the hospital under an entirely new *regime*, the antiseptic rules adopted were those drawn up by Sir Joseph Lister. Absolute phenol 1 in 20 was the antiseptic used for hands and instruments, and 1 in 40 for vaginal injections. The results were highly satisfactory. He had had only one case of serious illness, and that was one of sapræmia induced by unquestionable disregard of the antiseptic rules. The patient recovered. He had adopted vaginal injections, with 1 in 40 or 1 in 80 carbolic acid in every case the for first week after labor.

Dr. F. Barnes used no vaginal injections, and his cases had done equally well. He was struck with this at the time, and he now thought that vaginal douching after labor as a general rule was unnecessary—indeed, with the ordinary run of nurses, was dangerous. They were careless about the cleanliness of the tubes, etc. He had, therefore, given it up unless the lochia became offensive, or the patient showed symptoms of illness. In suitable cases he advocated intra-uterine injections. He recomended antiseptic absorbent wool in place of diapers.

Dr. Walter Griffith thought there was greater risk in lying-in hospitals than when a patient wa confined in her own home. If doctor, nurse, and instruments were clean, all routine douching could be done away with. On the other hand, most people accustomed to habits of cleanliness preferred the douche night and morning for the first few days after labor.

Dr. Leith Napier did not think, with Dr. Grigg, that a single intra-uterine injection of one-sixteenth of a grain of perchloride of mercury would prevent or check the development of septicæmia. He asked whether the risk of routine douching was not greater than that of waiting until indications for douching arose. In inflammatory puerperal cases he thought that frequent douching was hurtful and that vaginal suppositories of iodoform were preferable. Mercuric perchloride was, on the whole, the best antiseptic for the purpose. At present creolin answered well and was non-poisonous.

Dr. Cullingworth said he was responsible for having introduced salufer in the General Lying-in Hospital as a non-poisonous substitute for perchloride of mercury. At present he considered routine douching essential in lying-in hospitals, but not in private practice, and he mentioned that in the lying-in hospitals of Boston and New York the best results were not obtained until the douche had been deliberately abandoned. He thought possibly the salufer had failed through the clogging of the valves and apertures of the apparatus by the salufer which was thrown down from the solution in cousiderable quantity. He highly recommended wood-wool pads.

Dr. Boxall, in reply, said that the intra-uterine douche was reserved for cases in which the hand or some instrument had been introduced into the uterus, or in which the fœtus was macerated or decomposed, or, again, in which clots or pieces of membrane were retained. In hospital and private practice he did it in such cases immediately after labor, but only exceptionally during puerpery, and in these he usually employed a soft rubber catheter or piece of elastic tubing. He thought much harm might be done by douching whenever the discharges were foul. The parts should be examined, beginning at the vulva and washing any part where decomposition was taking place. He thought 1 in 1000 sublimate solution far less irritating to the hands than 1 in 20 carbolic acid solution. He employed a 1 in 2000 sublimate solution during labor and immediately after delivery,