removal will be followed by cutting-off of the original poison without which there would have been no trouble.

If the dose of toxine already introduced into the woman's circulation is so great as to preclude the possibility of recovery, or if the effects of that toxine upon her liver and kidneys has been so pernicious as to irreparably damage them and introduce into the case perhaps new toxines arising from faulty matabolism or retained by deficient excretion, recovery must not be expected from the removal of the possibility of further supply. On the other hand, without cutting off the supply of toxine it is not reasonable to suppose that in such a case, medical means, by depleting the blood of toxine and diluting what is left, would accomplish any more than surgical. But because surgical measures are taken it is not necessary to neglect the benefits to be derived from elimination and dilution.

The second point which suggests itself is, that if termination be the best procedure, what is the best means of effecting it? The following methods are open to us:—

1. Induction of labor.
2. Accouchement forcé.
3. Dührssen's incisions.
4. Abdominal Caesarean section.
5. Vaginal Caesarean section.

Induction of labor. The objection to this method is that it is too slow and uncertain, often requiring many hours to bring on uterine contractions, which time together with that consumed by labor itself, may be so great as to let pass the patient's only chance for safety.

Accouchement forcé has a mortality itself as great as that of eclampsia so that in adopting this measure one is only substituting one danger for another of equal magnitude. It cannot therefore be considered at all.

Dührssen's incisions might be used where there is a rigid or partially dilated os, the cervical canal having been already taken up and labor under way.

Unless the cervical canal has been obliterated these incisions can be of no service, and attempts at delivery may result in extensive and dangerous tearing.

This method should be reserved for cases in which labor has advanced somewhat, and more room is wanted to admit of immediate delivery.

Abdominal Caesarean section has a field in the management of these cases, but should, I think, be reserved for cases at or near to term, with a fair-sized child in which it is possible to have careful preparation made before and ample assistance at the time of operation.

For the ordinary case which one meets in the seventh or eighth month, with an undilated os and unobliterated cervical canal, with little