or covers it, there exists the grave danger of a hemorrhage which may cause death before the doctor can reach the bedside. The safest procedure for the mother is, therefore, the immediate induction of labor. There is, however, a serious objection to such an action when the fœtus is alive, but not viable. While I would not sacrifice the life of a mother for such a consideration, I would be willing to assume certain risks in the interests of the unborn babe. I would say in a general way: Keep your patient quiet; if possible, have with her a trained nurse capable of acting promptly in case of alarming hemorrhage; as to yourself, keep as close as possible to the handle of your patient's front door, armed with your best-filled obstetric satchel. When the fœtus is dead our rule should be to induce labor at once.

When pregnancy has advanced to the end of the seventh month, we have to consider the safety of both mother and child—the welfare of the mother being the more important consideration with most of us. Fortunately, in the majority of cases the induction of premature labor is safer for both mother and babe. At this stage the child is viable, and under a policy of non-interference its chances in utero are somewhat precarious. The partial detachments of the placenta, which are apt to occur, and which cause the hemorrhages, tend to produce asphyxia in the child. If, on the contrary, no hemorrhages occur up to the time of labor, and only slight ones then, the mother is comparatively safe, and the newborn babe is likely to be strong and vigorous. Such happy but exceptional histories should not influence us in the direction of a do-nothing policy, or what is called the expectant plan of treatment. Under such circumstances it is decidedly better for the mother, and certainly as well if not better for the child, that premature labor should be induced.

Barnes' hydrostatic dilators are considered by the majority of authors the best means of dilating the cervix and producing labor pains. I am not a great admirer of these dilators. Rubber is a most unreliable material in this changeable climate of ours. After having kept the bags for a few months, we are apt to find them utterly useless when we want them. They are not easy to use in all cases, as they are prone to slip in too far, or suddenly pop out of the cervical canal as we are filling them. In injecting them with water it is hard to know when they are properly filled. If we inject too little they are not of much use, and if we inject too much they may burst. However, they are sometimes very useful, and it is well to have them at hand.

There is another dilator, somewhat old-fashioned, in disgrace in certain quarters, viz., the clean finger-tip, or a combination of two or three fingers. Put intelligent eyes into your finger ends, proceed cautiously and carefully in stretching the cervical canal with them, and you can frequently, if not generally, do good work. In a large proportion of these cases the cervix is soft and easily dilatable and, under such conditions a judicious use of the fingers can accomplish much. The finger dilation may, however, do much harm if accompanied by undue force, in consequence of the development of large blood vessels in the cervical region through the faulty position of the placenta.

Another method, rather old, and vigorously condemned by some of our ablest obstetrical authorities, is the vaginal tampon. Braxton Hicks, in the discussion on placenta prævia at the British Medical Association, August, 1889, speaking of the stoppage of hemorrhage, says: "With regard to the pressure by the tampon, I believe that the general consensus in British midwifery is against its use, and with this I am in accord—partly because, unless perfectly done, and this is difficult, it is of no use; and if perfectly done, it is very distressing to the patient, especially if it be necessary, which it often is, to renew it to avoid septic generation. Still it has some advantages, because, by distending the roof of the vagina, we also dilate the os, and provoke uterine action. But its action is tedious, and lacks the precision afforded us by the more recent methods." On the other hand, so high an authority as Dr. More Madden stated that after trying various plans he had found nothing superior to the tampon, "the introduction of which is followed by labor, and then effecting delivery by version."

In considering so vital a question as the treatment of placenta prævia, I am anxious to choose a method not only efficient, but always available. Barnes' bags are excellent things in their way, but very unreliable. Any practitioner, though he own a dozen of them, may be caught in an emergency when the bags are not at hand. The materials for a plug are always easy to get. You can get clean cotton, hot water, and soap in any house. You will probably have some antiseptic with you; if not, your soap and hot water will clean the fingers, with the aid of a penknife, and your hot water will render aseptic anything like ordinarily clean cotton. If you are attending a case of placenta prævia, with a dead fœtus or viable child, where there is hemorrhage with an undilated os, your aim should be to stop the hemorrhage and at the same time dilate the os and bring on labor as soon as possible, and for that purpose I contend that one of the most easily available and most efficacious procedures is the introduction of a vaginal tampon. Dr. Hicks thinks that unless it is perfectly done it is of no use. Certainly! I agree with him, but it ought to be perfectly done. He also objects because it is very distressing to the patient "if perfectly done." My opinion is that if it is perfectly done it is not, as a rule, very distressing. Dr. Hicks admits that it has some advantages in distending the roof of the vagina and thus dilating the os and provoking uterine contractions.

This leads to the question: What may we expect from the tampon? (1) It helps to prevent hemorrhage in two ways; first, by direct pressure; second, by irritating the nerve ganglia in the upper portion of vagina and thereby causing uterine contractions. These uterine contractions tend to close the bleeding vessels by the direct pressure, and also by forcing the fœtus against them. (2) It helps to dilate the os in the majority of cases. (3) It excites the uterine contractions, and thus, together with the dilatation of the os, precipitates labor.

For material I prefer old soft cotton torn into strips not more than an inch and a half wide. I generally have these strips stitched together so as to have one continuous piece, which is very easy to remove. I saw this plan carried out by the late Dr. Taylor, of New York, about twenty years ago, and I have seen no improvement on it since, excepting the additional antiseptic precautions. Dr. Taylor used the cotton in the form of an ordinary