to nine and ten daily, and when the dose of boric acid was increased to ten grains the improvement was still more marked; the fits ceased on the fifth day, and the child subsequently left the hospital completely cured. Since that time I have repeatedly prescribed boracic acid and borax, both for ordinary epilepsy and for the convulsions associated with the spastic hemiplegia of infancy, and, as a rule, with good results.

As regards the mode of administration, it may be observed: (1) that both borax and boric acid are very soluble in glycerine; (2) that if we wish to prescribe borax alone, much glycerine should be excluded, for a mixture of pure neutral glycerine and pure borax is acid, owing to the presence of free boric acid; (3) that borax increases the solubility of boric acid to a considerable extent, so that it is often advantageous to give them in combination.

In conclusion, perhaps you will permit me to draw attention to the occasional value of borax or of boric acid in the treatment of coughs. A few grains of either drug will sometimes remove an obstinate cough in a young child, and especially if this be associated with an irritable condition of the fauces or pharynx. Boric acid is also highly spoken of by Atkinson* as a remedy for puerperal fever; Bukhaloff† considers it a very effective substitute for quinine in the treatment of malarial fevers; aud Peyrusson‡ recommends large doses in cholera.—Judson S. Bury, in *Lancet.*

## PREGNANCY CYSTITIS.

An eighteen-year-old primipara was delivered ten months ago. In the third month of pregnancy she suffered from frequent dysuria. She had to empty the bladder at least ten times daily, and several times at night. The dysuria has continued ever since. The urine is cloudy and alkaline; sp. gr. 1,016. It contains bladder epithelium and pus.

Cystitis in pregnancy, while not frequent, is not rare. Pregnancy nephritis has been described and so there is a pregnancy cystitis, but the latter is more frequent than the former. Monod found that 26 out of 124 pregnant women suffer from cystitis; 16 of the 26 were primigravidæ. In his opinion pregnancy cystitis is chiefly due to vesical hyperæmia, caused by the close vascular connection between the bladder and the uterus; the blood supply of the latter being naturally much increased. The frequent excessive intercourse of the newly married contributes in no small degree to vesical inflammation. Under the title pregnancy cystitis are not included those cystites due to retroversion or retroflexion of the gravid uterus, after it has become incarcerated; spontaneous evacuation of the bladder being impossible, it becomes enormously distended and sloughing with fatal consequences may result, or at least permanent vesical disease.

In the treatment of cystitis, medicine given by the mouth which must be eliminated by the kidneys, to affect the vesical mucous membrane, can be dispensed with. Washing out the bladder by means of suitable solutions or mixtures gives the best results. The irrigation should be done with Hager's funnel, to which a rubber tube and the catcher have been attached. The funnel tube and catcher are filled with the preparation to be used. The funnel is held so low down that the fluid cannot escape through the catcher previous to the introduction of the latter. The catcher is introduced, then the funnel is raised, and the fluid passes gently into the bladder. After the quantity judged necessary has entered, the funnel is lowered and the bladder is at once emptied. The fluids used vary. Braxton Hicks advises the use of slightly acidulated warm water; one or two drops of hydrochloric acid to the ounce of water. I have used a mixture of creolin and water with good results. I used at first a two per cent. solution, but found that this caused discomfort to many patients. It is better to begin with a solution one-half as strong, or even weaker. The fluid used should be warm. —Parvin, in *Med. Standard.*

* Practitioner, 1880. † Vrach, 1888. ‡ Lyon Med., 1884.

Laceration of the Cervix, Immediate Repair of.—Recent experience with this operation has been so favorable that I deem it worth while to lay the method briefly before you.

The operation may be done in Sim's position. I prefer the dorsal decubitus, with the patient's hips at the edge of the bed and the legs held well flexed by the sheet-sling, which is a simple substitute for the various clutches (*N. Y. Med. Jour.*, April) (a drawing was shown). The lower corners of the tear are seized in the grip of a single pair of double tenaculum forceps. The extent of the tear is thus seen and the rent steadied for stitching. This is the one point on which I wish to lay stress. A needle-holder and straight needles, or this modified Peaslee needle bent at right angles and curved like a Hagedon, serve well. Trustworthy gut is best, but I have been using ordinary No. 8 cotton thread, soaked in biniodide solution, 1-4000. No assistant is required beside the nurse.

*Objections.*—Several theoretical reasons will occur to you at once why this little operation may be difficult in ordinary cases.

1. The flabby vaginal wall may fall in and hamper all manipulations.
2. The bell shape of the cervix after labor might fog any working ideas of the normal relations.
3. The "reach" is too long.