uterus relaxes. When good pains come on, I do not consider it necessary that these should be helped by the practice of expression or what is known as Crede's method. In a normal case, the risk is that the placenta, bulky as compared with the membranes, may be squeezed out too soon, and parts of the membranes left behind. When, however, the placenta remains in the uterus half an hour after the delivery of the child, expression should be tried, but only with the left hand. After some practice, one can tell whether the placenta can be expressed, or whether adhesions are present. In the former case, the accoucheur feels the uterus diminishing in bulk as the placenta is expressed; whereas, in the latter case, no impression is made on it by moderate pressure. When the placenta is in the vagina (a condition recognised by the altered shape of the uterus), but does not soon appear at the vaginal orifice, slight downward pressure in the axis of the brim will help its expulsion. If more than slight pressure is needed, the question must then arise whether the retention is not due to non-separation of part of the membranes. The cleansed fingers may be passed into the vagina, the presenting part of the placenta laid hold of, and gentle traction in the proper axis will effect delivery. When the placenta is detained in the vagina, it is sometimes convenient to place the patient in the semi-dorsal posture, to draw down and back the posterior vaginal wall with the cleansed fingers, so as to straighten it; and then by slight downward pressure, with the external hand in the axis of the brim, to effect delivery. In those cases where uterine action is feeble, expression is of the very greatest value. It then imitates the natural process, and places such a case on a level with the normal. The uterus should be grasped with the left hand as fully as possible, the thumb being in front and the fingers behind. It is then squeezed firmly in the direction of the line joining the finger and thumb, without any downward pressure. In partial adhesions of the placenta, or in adhesion of the membranes, the practice of expression is in the highest degree dangerous. The non-adherent portion is separated and forced down and out, while bits of the placenta or membranes are left behind, exposing the patient to septicæmic risks. When morbid adhesions exist, the accoucheur must separate them manually, using all antiseptic precautions. The hands must be thoroughly cleansed with corrosive sublimate solution (1-2000), and a vulvar and vaginal douche of 1-4000 given. After the separation, the douche of 1-4000 must be repeated, the amount of introduction of the tube depending on the extent of the internal manipulation. In this, as well as in a natural case, it is well to have the diapers used in the puerperium dipped in the corrosive sublimate (1-2000), and dried, or the discharge received into sublimated wood-wool wadding. *Brit. Med. Journal.*

ERYSIPELAS AND PUERPERAL FEVER.—An important paper on the relationship between these two diseases has been published by Professor Gusserow, of Berlin. He remarks that it has been believed, especially in England, that erysipelas and puerperal fever were closely allied, if not identical. This doctrine rested on the propositions which were assumed to be facts, that erysipelas and puerperal fever were found to prevail together, that puerperal fever could produce erysipelas, and erysipelas puerperal fever; and that anatomically, according to Virchow, in some forms of puerperal fever the changes in the cellular tissue of the pelvis were identical with those produced by erysipelas Dr. Gusserow thinks that our knowledge on the subject is very superficial and defective. The observations adduced in support of the propositions above mentioned, although enough to make imperative the greatest care in protecting the lying-in woman from the contagion of erysipelas, are yet far from being sufficient to prove the pathological theory which is based upon them. Dr. Gusserow is of the opinion that there is no connexion between puerperal sepsis and erysipelas. In the first place, a great number of cases of erysipelas during pregnancy, have been seen, and our author has seen erysipelas come on in pregnancy, and the patient delivered while the disease was at its height; and yet there was nothing abnormal about the lying-in; the patient suffered from ordinary erysipelas, and nothing more. He has seen erysipelas come on during pregnancy; the pyrexia lead to the death and expulsion of the child, and the mother subsequently die; when the post-mortem showed that the puerperal process was simply a complication of the erysipelas, no sign of disease of the genital organs being found, but post-mortem appearances like those usual in erysipelas. Dr. Gusserow has also seen erysipelas appear as a complication in childbed, but it ran its course just as in any other subject, the course of the lying-in being in no way influenced by it. He has seen erysipelas coming on during childbed prove fatal, and the post-mortem appearances were then simply those of fatal erysipelas, no sign of disease of the pelvic organs being present either during life or after death. Instances have moreover been recorded in which, during an epidemic of puerperal fever in a lying-in hospital, some patients have been affected with erysipelas, and other cases in which erysipelas and puerperal fever co-existed in the same patient. Both as to symptoms and post-mortem appearances the phenomena of the two diseases were quite distinct; they were combined, but did not modify one another. Lastly, Professor Gusserow urges that we have now the proof, in the existence of a special micrococcus peculiar to it, that erysipelas is a specific disease. He has failed in experimental inoculations of the erysipelas-coccus under the skin and into the peritoneal cavity, to produce phenomena anything like those of sep-