

uterine cavity, I think traction on the cord, as practised by those of the Dublin school, will often afford material assistance.

After the expulsion of the placenta, we have to consider the extraction of the membranes. I say extraction, as distinguished from expulsion, advisedly; and I think the directions usually given in our text-books on this point are exceedingly defective. It is a very common practice to continue squeezing the uterus, and at once commence turning the placenta so as to twist the membranes into a cord. I believe the result of this method is frequently to tear through the membranes, while a considerable portion of the same is retained in the uterus, which is being squeezed so tightly. We are so thoroughly imbued with the *vis a tergo* idea in connection with the delivery of the child and placenta that we are apt to forget that the extraction of the membranes should be effected by an entirely different process. My advice in connection with this procedure is to take plenty of time—not less than 5 to 10 minutes. Don't drag away the membranes rapidly, but support the placenta in such a way that it will not pull forcibly on them; watch for slight relaxations or dilatations of the uterus, and during such coax them away. If you detect a slight tearing on one side, pull gently on the other. A little judicious twisting may assist sometimes, but remember the dangers connected therewith, and beware.

If no abnormal condition be present, it is quite unnecessary to introduce the fingers or hand into the vagina or uterus during the third stage of labor. In speaking to my class of students, or in giving directions for my cases in the lying-in hospital, I insist strongly that the finger shall not be introduced into the vagina after the delivery of the child if it be possible to avoid it; and, in the great majority of cases, such procedure is entirely useless. My objections, however, are not based on mere inutility, but on the fact that this is the period when there is the greatest danger of introducing septic matter into the system. The passage of the child has produced tears of greater or lesser extent in the cervix, vagina, or perineum, or perhaps in all three combined; and the open-mouthed blood vessels and lymphatics are ever ready to absorb and distribute through the body any poison that comes within their reach. If you

happen to be in doubt as to whether small portions of membranes are retained, don't investigate too carefully; leave them alone; if no septic matter be introduced, they are not likely to do any harm. If you have reason to believe that large portions of membranes or placenta are retained, it will be necessary to introduce the fingers or hand and remove them; but be careful to use the best methods of cleaning your hand and arm which science and art have placed at your disposal. Wash and disinfect them as carefully as if you were going to perform an abdominal section.

Many discussions have taken place recently with reference to the physiology of placental expulsion. I have not time to discuss this question in detail, but I will give briefly the views which prevail with the majority. Detachment of the placenta is caused by a contraction in the area of its insertion, in which contraction the placenta itself cannot share. Separation occurs in different ways, varying according to the position of the placental insertion. When inserted at the fundus it begins to separate at the centre, forming a cavity in which a certain amount of blood accumulates. When separation is completed the foetal surface of the placenta falls towards the cervical canal, and the membranes follow, being turned inside out and containing a certain amount of blood. The placenta and membranes emerge in the same order from the vulva. When the placenta is inserted in the anterior or posterior wall the separation begins either at the upper or lower edge, and, as it descends, may appear at the vulva either by its foetal or maternal surface. The lower the insertion, the more apt is the maternal surface to present at the vulva. The views herein expressed do not coincide with those of Matthews, Duncan, and others, who thought that when there was no interference the common method of separation was such that the edge of the placenta presented at the cervix. The practical point to bear in mind in this connection is that when traction on the cord is employed before the placenta is dislodged from its place of insertion, the initial separation is central; a partial vacuum is thereby produced, which sucks the blood from the large uterine vessels, or tends to invert the weak and flaccid uterine walls. This generally admitted fact