grammes of pilocarpine was followed by the usual good effect.

Friday 8th—The child had slept perfectly. There was no fever. Expectoration was purely mucus, a little thick but very easy. A last injection was given as a precaution. In the afternoon the canula removed as a trial, was entirely removed in the evening. The next day and the following days the larynx became freed at the same time that the tracheal wound closed. From this time on the case proceded without interruption.

We are convinced (Dr. Duliscouet and myself) that tracheotomy alone would not have saved our little patient, and that the honor of the cure was due to the repeated injections of pilocarpine. It seemed to us from every evidence presented, that the beneficial action of pilocarpine is due to the bronchial hypersecretion that it induces and the expulsion of false membrane which obstructs the respiratory tract.—*Journal de Medicine et de Chirurgie.—Nashville Journal of Medicine.*

PERITONEAL SURGERY.—The New York *Medical Record* of October 22nd, gives an interesting report of a discussion on the recent progress of peritoneal surgery in the New York Academy of Medicine. The discussion was opened with a paper by Dr. Marion Sims. Dr. Sims reviewed the progress of peritoneal surgery, and specially directed his mind to this question: "Does it lead to a better treatment of gunshot and other wounds of the abdominal cavity?" Dr. Sims claimed for ovariotomy that it was the parent of peritoneal surgery, and that the governing principles of the one must govern all operations affecting the other. Dr. Sims arrived at the following conclusions:—1st. Wounds of the peritoneal cavity have a common course to run. 2nd. They have a common termination, and that is death by septicæmia. 3rd. That is the general law in death after ovariotomy. 4th. It is the general law in death after gunshot and other wounds of the abdominal cavity. 5th. Septicæmia is the result of absorption of bloody serum found in the peritoneal cavity after wounds or operation. 6th. Gunshot wounds of the pelvic cavity are recoved from because of the natural drainage afforded by the track of the ball. 7th. Patients with gunshot wounds of the abdomen die of septicæmia because there is no natural drainage, and the bloody serum falls into the peritoneal cavity, and is there absorbed. 8th. The effect of bloody fluid upon the abdominal cavity is such as to demand abdominal incision, the suturing of wounded intestines, the tying of bleeding vessels, the cleansing of the cavity, and the use of the drainage-tube or not, according to circumstances. 9th. If this operation be well done there is hardly any need of a drainage-tube. Dr. Sayre expressed practically the same views as Dr. Sims. One of the chief features of the discussion was a speech by Dr. James R. Wood. He allowed much, but "not all the glory," to gynæcologists for the advance in peritoneal surgery. He cautioned the Academy against too quickly reasoning from the case of ovariotomy to cases of abodominal wound. He was especially cogent when he showed the difficulty of diagnosing the seat or the nature of the injury in gunshot cases, saying "with reference to reaching into the cavity of the peritoneum in search for bullets, or injured parts, it is a very serious matter"; also in pointing out the difference between a patient about to undergo ovariotomy and one recently the subject of gunshot injury. The one was not in a state of shock, and was well prepared for the operation. The general surgeon has the state of shock to deal with in gunshot wounds of the peritoneum. Such a note of caution from a surgeon of Dr. Wood's boldness and experience will not be misconstrued. It is obviously premature to apply the facts of ovariotomy to gunshot and other wounds of the peritoneum.—*The Lancet.*

MANAGEMENT OF LABOUR IN THE VIENNA LYING-IN-HOSPITAL.—In *Le Medicin* for March 12, is given the following as the *modus operandi* in this Hospital. As soon as the head appears at the vulva, the woman is made to lie on her left side, her right leg being raised and held by an assistant. The accoucheur, standing on the right of the parturient woman, passes his left hand between the woman's thighs, carrying it forward and applying it against the child's head, He supports the perineum with his right hand; but the resistance thus afforded must not be a passive one. He must on the contrary, during each labour pain press energetically over the sacro-coccygeal region, and pull as much integument as he can over the child's head. Meanwhile, his left hand steadies the head at the vulva and prevents its coming out under the *influence of uterine contractions.* In the interval between the pains, the head goes back, soon to return again. The forced alternate motion which the head undergoes has for its result the gradual distension and a greater elasticity of the vulva. At last, the head comes out and extension takes place. One must carefully prevent this expulsion from taking place during a uterine contraction, and let the head come out when the pain is nearly over. The perineum must be supported to the end, for the passage of the shoulders is ordinarily more dangerous than that of the head itself.—*Le Medecin Practicien*, March 12.

A MALPRACTICE suit in Belgium, brought against a physician for the alleged improper prescription of morphia, resulted in acquittal not only, but the plaintiff was adjudged to pay the defendant one thousand francs damages. It is reported that the action was instigated by a rival doctor.