The author advises, I think wisely, not too rapid an emptying of the uterus, keeping the bladder and rectum empty, and seeing that the uterus itself is completely emptied of the placenta and membranes. Half an hour is long enough to wait for the expulsion of the placenta. The writer states an interesting point when he declares that a previous curettement may influence the mode of attachment of the placenta—and so where that operation has been done manual removal is more likely to be required. The writer doesn't state his reasons for such a statement, and I can hardly agree with him.

Infection—Thirteen cases died. The method advised to avoid sepsis is thorough cleansing of the vulva. Never give an ante-postum douche, even when gonorrheal vaginitis is present, and as few vaginal examinations as possible, substituting the rectal examination and external palpation.

Toxemia.—This includes nephritis, pernicious vomiting, and eclampsia. No case of eclampsia that was delivered immediately after the *first* convulsion died. Hence early interference is advised for eclampsia, and also for nephritis.

For vomiting, plenty of fluids and purgatives are advised, but a milk diet is contra-indicated on account of the high calcium content.

When in doubt in these cases induce labor by Krause's method or some modification, after having held a consultation.

Of the disabilities following labor, two rules need to be followed:

1. Forceps must not be applied till the cervix is fully dilated.
2. Extensive laceration of the cervix or perineum should be at once repaired.

As regards tight bandaging of the patient and keeping her on her back: these two factors prevent the spontaneous involution of the round ligaments, keep the uterus tilted backwards, and so keeps a laceration of the cervix gaping, and, lastly, prevent the bladder spontaneously emptying itself, and so compels catheterization. Hence the abdominal binder serves no useful purpose.