the germs by frequent antiseptic douches or to wash them and their products away. But constant douching is liable to certain risks, notably the absorption of the antiseptic or the production of pelvic inflammation.

The method now in use in the University Maternity, and which, with some slight modifications, he adopts in private practice, is as follows:

1. Strict precautions are taken to scrub and disinfect the hands thoroughly before each vaginal examination.

2. Whenever possible, a preliminary vaginal douche (sublimate) is given at the beginning of the second stage of labor.

3. Great pains are taken to secure and maintain firm uterine contraction after the expulsion of the placenta; frictions to the fundus are kept up for an hour before the binder is applied.

4. After the birth of the child the vulva is kept covered with a pad of sublimated jute, and is carefully washed with a sublimate solution every time the pad is changed. Vaginal or uterine douches are not employed, except in operative cases, or where the hand has been introduced within the vagina or uterus after the expulsion of the placenta.

5. A few hours after delivery, the vulva and anterior portion of the vagina are thoroughly douched out with a strong sublimate solution, the parts carefully inspected, stitches applied if necessary, and about a drachm of boro-iodoform insufflated into the vulva and ostium vaginæ; a thick pad of sublimated jute is applied, and whenever it is changed the external parts are washed with a sublimate solution. No further dressing or douching is usually required, the uterus generally involutes rapidly, and the lochia soon fade. If the lochia become offensive, an antiseptic vaginal douche is given, boro-iodoform again applied to the vulva, and the dry dressings continued. This plan works admirably; the patients are more comfortable, elevations of temperature rare, involution more rapid and complete, and convalescence more satisfactory.

When temperature and pulse rise rapidly from the third to sixth day, and other causes can be excluded, sepsis may be generally inferred. In such cases the septic condition is most frequently due to the presence of decomposing debris in the uterine cavity; loose shreds and clots are not usually as dangerous as bits of placenta or membrane which remain adherent to the uterine wall, and are, therefore, in more intimate relations with the maternal circulation. A simple uterine douche is generally sufficient to sweep away loose debris, but is unable to dislodge those portions which adhere to the uterine wall. When a uterine douche fails to bring down the temperature in a few hours, it is good practice to follow the German method, viz., pass a blunt curette into the uterine cavity and scrape away the adherent decomposing material. He first saw this method last July in Carl Braun's wards in Vienna; it was then quite a novelty, having been in use only a few weeks, but has now become a recognized treatment. Since his return he has had occasion to use the curette in several cases. In all of them he scraped away shreds of membranes or decomposing debris firmly adherent to the uterine wall, which repeated douches had failed to dislodge.

The most important points in the antiseptic treatment may be briefly summarized as follows:

1. Great care in the disinfection of hands and clothing.

2. A preliminary vaginal douche (sublimate) when possible.

3. Careful management of the third stage of labor, and securing firm contraction of the uterus.

4. The dry method of dressing.

5. A vaginal douche, if there is rise of temperature or offensive discharge; if that fails, a uterine douche; if that fails, immediate curetting of the uterine cavity.

6. If, later on, there is evidence of peritonitis and the presence of pus in the peritoneal cavity, abdominal section with thorough cleansing and draining offer the best chance of recovery.

Discussion.—Dr. KENNEDY agreed with Dr. Cameron in his conclusions. He rarely allowed a patient to have a douche; always believes in using it in person, as he found nurses, as a rule, unreliable. He could tell by the temperature chart in the hospital which nurse had charge of a ward. He did not believe in the use of a douche, unless there had been operative procedures.

Dr. RODDICK said he was always interested in antisepsis, and had long believed antisepsis to be as important in midwifery as in surgery; but from his experience, as well as from the facts in the paper, he now regarded it of even more importance in the former. In 1877 he had been asked to give some rules for the guidance of a friend, then superintendent of the Hamilton General Hospital,