puberty. The lymphatic glands, lungs, bones, joints, and intestines, are never affected. Nothing is less common than to see a lupus-patient develop phthisis. The most typical forms are often co-incident with good general health, and with the absence of any family history of tuberculosis. He believes that lupus is as closely related to cancer as to tuberculosis, and that an unbiased statistical investigation would show that the latter association is not so frequent as is commonly assumed.

Reminding his hearers that syphilitic symptoms could imitate lupus, he said that since syphilis in its tertiary stage is only a chronic infective inflammation, deriving its peculiarities from the antecedents of the patient, and having nothing whatever to do with tuberculosis or bacilli, it is reasonable to suppose that lupus, which so exactly resembles it, might also be a process of chronic inflammation made peculiar by the vital proclivities of the patient. If lupus were of bacillary origin he thought it remarkable that in gland struma the skin does not assume a lupus-state and that the glands never become involved in lupus. Of primary tubercular ulceration of the skin he has had no personal experience but tubercular ulceration of mucous membranes presents characters quite distinct from those of lupus in that situation.

In conclusion he said, "I may own that the sum of the evidence seems to me much in favor of the belief that lupus is a specialized form of chronic inflammation rather than the result of infection. In suggesting this I am well aware that it is merely a negative conclusion, which is liable to be overthrown at any time by the accumulation of positive evidence. It may be that in the future the presence of bacilli in lupus-products may be demonstrated in earlier stages, and much more constantly than has yet been the case. The results of Koch's injection-treatment may possible force us to believe that there is something about lupus which connects it far more closely with tuberculosis than I have admitted."—*Correspondence Med. News.*

MANAGEMENT OF LINGERING LABOR.

A discussion on the modern methods of managing lingering labor, before the British Medical Association, was opened by Dr. W. S. Playfair. After referring to the dread of meddlesome midwifery, on the part of leading obstetricians, of thirty-five years ago, and the readiness with which these men resorted to bleeding and debilitating medication, the speaker proceeded to review the methods of the present day. The mere wear and tear of a labor lasting more than twenty-four hours seemed to him to be a very serious thing, and he did not think it right that we should sit with hands folded waiting until serious symptoms should arise before taking action. He first considered the frequently-met-with difficulty arising from non-dilatation caused by inertia, or by irregular and cramp-like pains, premature rupture of the membranes, and over-distension of the uterus from excessive liquor amnii. For the relief of rigid os uteri prolonging the first stage of labor, Dr. Playfair advocated most strongly the internal administration of chloral hydrate. Under the use of this agent the pains become longer, steadier and more efficient. The patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled as when chloroform is used. The wild state of excitement is calmed and soothed. Fifteen grains should be given at the first dose, repeated in twenty minutes. Possibly a third dose may be required, but never more.

As an oxytocic Dr. Playfair recommended quinine. In a labor with feeble, ineffective pains, one or two doses of quinine of fifteen grains each will have a beneficial effect in altering the character of the pains. This drug does not possess any of the dangerous properties of ergot.

Speaking of mechanical means for producing dilatation of the os, the speaker referred to a suggestion first made by Trenholme, of Montreal, that the finger be swept around the inner surface of the os, separating it from the membranes. Why it is so Dr. Playfair did not know, but he was satisfied that this simple procedure did excite marked dilatation of the os.

When the head is pushed down low in the pelvis, the os being soft and relaxed, and the membrane ruptured, it was his belief that gentle manual dilatation, pushing, as it were, the os over the head, is frequently extremely useful. Pushing up the swollen anterior lip when impacted between the head and the pubes is not only legitimate, but essential to save injury to the os.

In prolonged second stage, Dr. Playfair referred to ergot and condemns its use at this time in the strongest terms. The only oxytocic he would recommend at this period of labor was manual pressure applied over the uterus to increase the pains when they are feeble, or to take place when they are absent. The best way of using it is for the practitioner to stand by the side of the patient, and to spread his left hand over the fundus. When the pain comes on, strong downward pressure is made in the direction of the axis of the brim. If the finger of the right hand be placed simultaneously on the head, *per vaginam*, it will be felt to be pushed down in a very marked way. One may often push a head through the brim where it has been delayed for hours and on to the perineum in two or three pains. One may often avoid the use of forceps.