away the golden moments in vague speculation; if he soothe his fears by hoping that the attack is due to malaria or milk fever; or if he cast aside the rational doctrines of to-day in favor of the idea of a general infectious and particular form of disease called by the forefathers of the French school, "*la fièvre des femmes en couche*," time will be lost which can never be regained. If, on the other hand, he is encouraged by his clinical observation to stand with many of the best pathologists and practitioners of our time in the position assumed by Hervieux—"I believe in the multiplicity of the affections classed under the head of puerperal fever; I believe in puerperal poisoning as the source of them"—he will act at once and strike at the poison before it has fairly gained a foothold. In other words, if the physician could see into the future and learn with certainty that peritonitis, cellulitis, thrombosis, lymphangitis, or true phlebitis is to be the final disorder, he should, if he reaches the case at the inception of the attack, follow, in my opinion, the course here formulated:

1. As soon as a diagnosis of septicæmia is determined upon, all pain, nervous perturbation, shock, and mental anxiety should be quieted by the hypodermic administration of ten minims of Magendie's solution of morphine, unless some special and very decided idiosyncrasy with reference to opium be ascertained to exist; and throughout the severity of the attack, whenever suffering of mind or body occurs (perhaps it will be about once in every six or eight hours), this should be repeated. In my experience, no other method of administering morphine in these particular cases compares with this, and, as it is not to be continued long, there is no fear of causing the patient to become addicted to the drug as a vice. If a small, sharp, and new needle be used, if it be thoroughly cleansed with soap and water before each time of using, and be dipped in a solution of bichloride, 1 to 1,000 of water, just before each insertion, no abscesses will occur. It is the large, rusty, unwashed and unpurified needle which the doctor's economy makes last him for many months, which so commonly results in them.

2. The physician must now decide whether, in his opinion, the septic disease which is developing has originated in the wounds situated between the os internum uteri and the vulva, or in the endometrium, above the former point. If he decide in favor of the former view, he should persist, for a time longer, in the more thorough use of vaginal injections; if of the latter, intra-uterine injections should be at once resorted to. Usually the question has to be decided by the efficacy or inefficacy of frequent germicide vaginal injections in bringing down the temperature and controlling other grave symptoms. Should the failure of these seem to prove that the origin of the disease is higher up the genital tract, more decided and radical measures must be taken.

The patient having been entirely relieved of pain and thoroughly quieted, the first injection should be practiced in this way: An Indian rubber cloth should quietly, without hurry, noise, or disturbance on the part of the nurse, be spread over the edge of the bed on which she lies, and nade to fall into a tub of warm water rendered antiseptic by the addition of 2 or 2½ per cent. of carbolic acid, or of the bichloride of mercury, 1 to 2,000, or of some other reliable germicide. Then Chamberlain's glass uterine tube, which I here show, or the very excellent and ingenious tube invented by Dr. George H. Lyman, which is here seen, thoroughly fitted to a Davidson's or Higginson's syringe, should be immersed in the tub. The nurse now aiding the patient by the shoulders, and the doctor by the hips, she should be gently laid across the bed and be made comfortable with a pillow under the head. Each foot should rest upon a chair placed at either side of the tub, and she should be entirely covered over with a couple of blankets. The doctor, now placing himself between the knees of the patient, should take the tube in his right hand while a stream of water is made to flow through it by the nurse, who squeezes the syringe bulb, and he should pass it gently up the fundus of the uterus. The stream of water, which has been steadily flowing, is now projected with gentle force againt the walls of the uterus, washing away adherent blood-clots, detaching portions of hanging membrane, and everywhere neutralizing the influence of the poison which has excited the disorder.

After the first injection the position of the patient need not be disturbed, but the injection may be given as she lies upon a bed-pan.

In some cases, in which I have had reason to suspect that portions of the placenta or membranes have been retained, I have chloroformed the patient, passed the hand, rendered thoroughly aseptic, within the cavity, and very gently scraped off adherent masses from the uterine walls, using the nails as a curette, as Wilson, of Baltimore, has advised. In some other cases I have rubbed the whole endometrium with an aseptic sponge, held in a long sponge-holder, or employed the largest of my curettes to remove clots and adherent secundines, with great apparent advantage.

That the use of antiseptic uterine injections after parturition is attended by danger is beyond question. The greatest hazard attending this plan is the entrance of air into the uterine cavity; the next, the production of hemorrhage by detaching some of the thrombi which fill the mouths of the uterine sinuses; the third, the danger of forcing the fluid used as an antiseptic directly into the general circulation, through the introduction of the tube into the mouth of a sinus; fourth, the creation of convulsions, violent pain, or nervous prostration, by a sudden and baneful influence upon the nervous system; and the fifth, the passage of the tube into a Fallopian canal, and the injection of fluid directly into the peritoneal cavity, as in a case reported by Dr. W. Gill Wylie in an interesting