even now when they have been in use so long, to state exactly what position they do occupy in infant feeding in the minds of those specially interested in these problems. It is probably true to say that few doctors preach or practice feeding solely on dried milks, but that the majority do use them in some way or another. Many make a practice of using half-cream milks with added sugar for the first 2 or 3 months of infancy, replacing this where advisable for the next 2 or 3 months by a full cream milk and finally aiming at changing over to fresh milk by the time the child should normally be weaned. This kind of procedure seems to me to suit as well as any other the needs of Infant Welfare work. Whether it is the conviction that fresh milk is, owing to its supposed better vital properties, the ideal always to be aimed at, whether it is the inability to discard conventional procedure, or whether it is the idea that dried milk seems unpalatable as the child gets on, which prevents dried milks being prescribed more often as late as the eighteenth month, it is difficult to say: but the fact remains that it is nearly always omitted by the ninth month.

In any case it is obvious that dried milks do and should play an important part in infant feeding to-day and it is worth the while of every doctor who has children under his care to appreciate how and why they differ from fresh milk, to know the various forms in which they are available and to work out for himself first-hand the question of what place they should fill in infant feeding and so help to form a consensus of opinion on this matter and as to how far their introduction has gone or will go to simplify the problem of a good milk supply.

MODERN IMPROVEMENTS IN OBSTETRICS.

McKIM McCULLAGH, D.S.O., M.C., F.R.C.S.,

Senior Obstetric Surgeon City of London Maternity Hospital.

There have been a great number of small and a few large advances in the practice of obstetrics in the last 20 years.

The following is an enumeration of a few of these changes.

Tears of the Perineum.

The old custom of suturing tears by deep through and through stitches of silkworm gut is disappearing and is being replaced by more efficient suturing with catgut—usually No. 3 twenty day.

It is essential to insert at least one buried suture for every superficial suture and to insert the deep suture under the skin edge so as to bite in laterally after the retracted levatores ani muscles.

The result is a more efficient union than can be got by silkworm gut, much greater comfort for the patient and the elimination of the fear of having pain when they are removed as the catgut sutures are absorbed.

The Fowlers position is then not so uncomfortable if catgut sutures are used.

Episiotomy.

Before making an episiotomy wound two or three sutures should be inserted around the end of a tongue spatula or the blades of a scissors inserted along the inner wall of the vagina.

The ends of the sutures are gripped by forceps and the incision made in the gap between the entrance and exit of the sutures.

This procedure greatly assists a uniform return of the skin and muscle edges to their natural position on tying the sutures.

Induction of labour.

This is now a not uncommon event, in comparison with former years.

Medical induction is successful in 65 per cent. of cases when adopted at or near term and is fortunately more successful in albuminuria cases than others. It is commonly adopted to avoid danger to the mother and child in cases of disproportion, postmaturity and threatened eclampsia.

The induction table I find most useful is:

8.30 p.m.	Ol ric. 3 i ss.
9.30 a.m.	Quin. Hydrochlor gr. x.
10.30 a.m.	Enema. Hot bath and tight binder.
11.30 a.m.	Quin. Hydrochlor gr. x.
2.30 p.m.	Quin. Hydrochlor gr. x.

Then at 8.30 p.m. if pains are not present or very weak three doses of pituitary extract $\frac{1}{2}$ c.c. at half-hourly intervals.

This method has been carried out for some years at the City of London Hospital without ill result to the mother or child.

Surgical Induction.

Surgical induction is employed if two attempts at medical induction fail. It was formerly done by introducing Vorhees bag or Krauses Bougies. It is now done by the œsophageal bougie or by rupturing the membranes at the os or by withdrawing 15 ounces of liquor amni by Drew Smythe's catheter.

Prevention of Sepsis.

Sepsis is the greatest single factor in the causation of maternal mortality. It has been proved in the last few years that many cases are due to droplet infection from the throats of those in attendance.

Masks are now being used frequently not only during the delivery and post-natal cleaning of the patient but also by the nurse for 5 days after delivery when dressing and cleaning the vulva and perineum. Vaginal drainage by elevating the head of the bed by blocks for 5 days and by the use of Fowlers position by day is more prevalent.

Glycerine in Midwifery.

Cases of Sapræmia and cases of Sepsis not frankly due to septicæmia are now frequently treated by the injection of sterile glycerine into the uterus once or twice daily.

The glycerine acts not only hygroscopically causing a flow of fluid by extraction but also by causing a muscular spasm of the uterine muscle thereby washing away and expelling clots and placental debris.

When the placenta is retained and cannot be expressed it is found that injection of glycerine up the umbilical vein causes the placenta to enlarge, exude glycerine from its uterine surface, separate and be easily expressable. Manual removal can thereby frequently be avoided.

Chloroform.

The ideal anæsthetic in midwifery is gas and oxygen but its administration requires the specialist anæsthetist.

Chloroform in actual practise is still easily the favourite. Deaths however occur from toxic jaundice and these in cases who have suffered from vomiting beforehand either because of toxæmia or because of a previous anæsthetic. I have seen two deaths due to this cause.

Chloroform should therefore only be used once during the week of delivery.

I find that the Junker Bottle with a Visick's inhaler and large tubing the most effective method of administering chloroform if conducting a delivery unassisted.

The patient herself is the best anæsthetist as she knows when the pains are coming and can give herself an effective dose in time to ease her pain. An anæsthetist is generally late in supplying the chloroform and the patient, unable to breathe at the height of her pain, is not relieved of suffering.

Antenatal Examination.

Antenatal examination is now becoming a routine with a great fall in the incidence of eclampsia and destructive operations on the fœtus.

Antenatal version has also reduced the stillbirth rate considerably. It is surprising to find that the foetal death rate is seldom under 30 per cent. for breech deliveries in our larger hospitals. The older practitioner was more expert in this delivery than the more modern practitioner.

Version has its dangers, *e.g.*, death of the fœtus due to injury to the placenta and possible rupture of the uterus due to obstructed labour from incomplete version of the child resulting in a foot and head being in the pelvis. I have seen two such cases with fatal results.

Placenta Prævia.

This abnormality is now treated with more skill and less force than formerly. If the child is likely to live a Cæsarean Section is the treatment of election.

If it is not likely to live and assistance is at hand Willett's forceps is the most scientific method of controlling the danger. Otherwise rupturing the membranes and plugging the vagina is preferable to version and pulling down a leg. The introduction of the hand and the extraction of the leg through the os is likely to tear the lower uterine segment into the placental site with a fatal result from hæmorrhage on the birth of the child. I have seen two such deaths.

Stræ Gravidarum.

The avoidance of these unsightly marks on the abdomen by the inunction of lanoline twice a week for the last eight weeks of pregnancy is much appreciated by the modern patient.

Blood transfusion.

This operation made generally known by the war has prevented many mother's deaths from hæmorrhage and subsequent sepsis.

Defibrination of a suitable blood and the use of a simple funnel and tube is on the whole the most efficient method of administration.

In cases of severe collapse I find intravenous saline safer than intravenous gum saline.

Cæsarean Section.

This operation has increased in incidence greatly in recent years. It is well to remember that its mortality is four times that of a normal delivery.

It is now but seldom if ever used in cases of eclampsia. Its increase has certainly assisted materially in lowering the still birth rate which is now forty-one per thousand.

The lower segment operation is commonly used if the patient is in labour at the time of operation as there is a lower mortality in such doubtfully septic cases.

Spinal anæsthesia is a great improvement on general anæsthesia as regards the safety of the mother and child and ease at the operation. It also lessens the risk of post anæsthetic pneumonia which is not uncommon and sometimes ends fatally.

I feel a note of warning should be sounded as regards not so much the increase in number of Cæsarean sections as the tendency to sterilise patients without adequate reason.

Resuscitation of the new born child.

Artificial respiration in all its various forms is being abandoned in favour of the application of carbon dioxide and oxygen as an inhalation to the child immediately after birth in cases of white asphyxia.

Albuminuria.

If a pregnant woman shows more than a trace of albumen in the urine, especially if the blood pressure is over 140, she is treated by complete rest in bed, saline aperients, a diet consisting of fruit and vegetables with a little milk, and by certain drugs and vitamin preparations.

Nowadays it is recognised that labour should be induced after two weeks of such treatment if no improvement occurs irrespective of the child's life as after three weeks in utero in such cases the child usually dies and the only result of delay is that the woman's health is still further permanently damaged.

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The Hospital contains 127 beds. Upwards of 2,000 maternity cases and 1,000 gynecological patients are treated during the year. Besides the Hospital, there is an external Maternity Department with over 2,000 cases. The routine for students consists of attendance at the Morning Lectures on Midwifery and Gynecology, examination of patients in the Gynecological Department, attendance at operations, and all abnormal labour in the Hospital Wards and conduction of labour cases in the intern and extern departments. Students, both qualified and unqualified, attend the Antenatal Clinics, the Infants' Ward and Dispensary. The Pathological Laboratory is also available. An X-ray Plant is used for diagnosis and treatment.

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The Hospital Courses are always going on during the year, and Students can join at any time. The Class is limited, therefore it is advisable to register in advance. Board and residence can be obtained in the Hospital; the living accommodation has been much improved lately. Extra classes in gynecological diagnosis and operative midwifery are conducted by Assistants to the Master.

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Full particulars from BETHEL SOLOMONS, M.D., Master, Rotunda Hospital.