of the body, but in these extreme cases of prematurity the head is cold from the birth, and becomes colder and colder till life ceases; hence the head must be kept warm. With respect to nourishment, of food in its ordinary sense but little is required, and the object we have in view in giving that little is to support combustion—*i.e.*, maintain the respiration; and I find *cream* with the addition of a little castor sugar, better than anything I know of—half cream and half hot water, one teaspoonful of each given drop by drop at frequent intervals every hour. In past years fluids were given through a quill, better than a spoon; but I prefer the reversed long-tubed nipple shield—it is very easy to shorten the india-rubber tubing—and the teat should be *soft and small.* Place this between the lips, and when the food reaches the mouth an act of suction may be induced, and some of it swallowed.

It is very unlikely that our poor little patient will live, do what we may; but to my mind the apparent hopelessness of the issue should never lead us to neglect any or every measure that may tend to give us a chance of success, for there is a possibility that even these frail little lives may be preserved, as occurred within my own experience a few years ago, the infant of that date being now a small, but healthy and active little lad, popularly known as the "little wonder." Remember in these cases of extreme prematurity the temperature of the body must always be maintained by *artificial heat.* The navel cord is longer exfoliating than in full-term infants, and it should *not* be interfered with until the fifth day from birth. The napkins must be changed when necessary, as there is often a good deal of meconium passed, and the buttocks washed, *but no other part of the body*, until the cord is off. There is a peculiar shrill but feeble cry emitted from the hour of birth, apparently the result of a painful inspiratory effort, and these cries continue until the pulmonary circulation is more fully established or the infant dies from debility.

Still-births are matters of more interest in Midwifery practice than in Midwifery Nursing, but as Obstetric Nurses you should have some knowledge on a subject that will often be brought before you in the course of your duty.

The death of the fœtus before birth may take place either *in utero* or *in parturo.* In the former case, it is due to causes quite unconnected with delivery, such as putrefaction; in the latter, some untoward accident of birth may occasion the death of a full-term and healthy infant—within reach of life, as it were—the most frequent cause being malposition, requiring interference to complete the delivery of the infant; and, as a rule, the more skilful the manipulator, the greater the chance of his or her success, and intelligent aid from a Nurse is often a very important factor in the result. For instance, suppose the accoucheur is delivering a breech, nothing will help him better than for the Nurse to know how *to take the fundus* and make firm, equable, and downwards pressure upon it, which will aid the expulsion of the head, the crucial part of the delivery. I have pointed out this matter to you in one of my papers in the maternal division of my subject, and refer you to it. Every Obstetric Nurse should receive this technical instruction; but we know that a vast number do *not*, and one might as well ask *them* to find the North Pole as to define the *fundus.* I speak from acute experience in this matter, and hence draw my Nursing readers' attention to the point. With respect to premature still-birth, there is so little difficulty in attending delivery from the extreme smallness of the fœtus, that the matter need not be dwelt upon, a tedious dilation being the usual result of the small soft head. The patient is often a long time in labour, and requires careful nursing attendance the while. The strength should always be maintained by suitable fluid nourishment.

Twin infants are generally small, and more often than not premature. An interesting point in these cases is the varying sizes of the infants, due to a difference in intra-uterine age, or one infant may be small and still-born, and the other live-born and small, but both full-term; or one infant may be full-term and the other half-term; and I have often noticed that the youngest is born first—that is the smaller of the two. In typical cases, the infants are so identical in size and weight, that where the sexes are the same we have to put a distinguishing mark upon the firstborn, or we should never know one from the other. In twin cases, and both infants living, poor Nurse has double duty on her hands, and as there is a deep-rooted tradition that when *one* cries the other invariably follows suit, things are *rather* lively for her. (*To be continued.*)

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