sent, or only wasting. Under mercurial treatment the disease quickly improves, but where infection is known to be present the mother should be under treatment throughout pregnancy, even when no signs of the disease are present in her own person. In either congenital or acquired cases treatment should be persisted in for at least two years, and all such cases when in hospital regarded as infectious, separate linen being provided, and spoons and cups being disinfected after use; also bottles and rubber teats in the case of infants.

CLINICAL NOTES ON SOME COMMON AILMENTS.

By A. Knyvett Gordon, M.B. Cantab.

PUERPERAL SEPTIC DISEASE.

(*Continued from p.* 446.)

We have now to consider, firstly, how we should attempt to prevent the occurrence of puerperal infection, and next, the measures which we should take when we have to deal with a case in which infection has already taken place.

As I have pointed out, puerperal fever practically does not take place in women who are delivered inside the walls of a lying-in hospital, but it does occur in private practice. The reason is very simple. In hospital, delivery is regarded as a surgical operation, and in private practice, even if the doctor or midwife do so regard it, the relatives certainly do not, and it thus happens that even if they are not actually obstructive, they attach no importance to the details of asepsis, and do not do what they are told. At the next confinement they persuade the patient to engage someone else who is not so "fussy"!

Still, micro-organisms know nothing about social customs, and they can hardly be expected to refrain from the manufacture of toxins because the patient's mother-in-law did not have this kind of nurse.

Still, prejudice dies hard, and while it exists it can form an insuperable barrier to the best endeavours of the most careful midwife, so we have, in practice, to adopt a somewhat different procedure in a private house to that employed in hospital, where our word is law.

I have said that in hospital the procedure is regarded as a surgical operation, or, in other words, everything that touches the patient is sterilised, antiseptics are used for everything that cannot be boiled, and the parts are covered with an aseptic dressing until healing has taken place. Thus, the skin in the pubic region is shaved and cleansed with soap, and with whatever antiseptic application is in vogue at the particular hospital, or painted with tincture of iodine. The vagina is douched with large quantities of normal saline solution or a weak solution of biniodide of mercury, and perhaps packed with gauze also. The hands of the accoucheur are covered with boiled rubber gloves whenever a vaginal examination is made: any instrument used in delivery is boiled, and after the expression of the placenta the vulva is covered with a large pad of aseptic wool, which is changed very frequently.

But we cannot always do this in private practice, and we have then to remember that the main point is to keep organisms from invading the cavity of the uterus; if we can do this the patient is generally safe.

Now, before the head of the child has emerged from the uterus, germs cannot very easily reach its cavity, and here comes the first important point. It matters very much more what we do after the child has been born than before, because there is then an open road from the vulva to the placental site.

After the child has been born, there is usually a gush of liquor amnii which flushes the vagina and rids it of any organisms which might otherwise reach the uterus, but the vagina does not remain sterile, as it can easily be invaded by organisms from the skin and bedclothes, so we have to take care that we do nothing which can carry germs from the vagina to the uterine cavity.

Now, it is not usually necessary to make any vaginal examinations after the child has been delivered, the only exception to this being when post-partum hæmorrhage occurs or the placenta is adherent to the uterine wall, and has to be removed by hand. In both these cases the necessity is urgent, and we have to chance infection, and do just as much in the way of asepsis as we have time for.

But there is another manipulation that is not infrequently practised by midwives after delivery, and that is the use of the vaginal douche. I have no hesitation in condemning this practice absolutely in a normal case. There is not the slightest advantage to be obtained from the use of the douche, and it is open to the grave defect that it washes germs up from the vagina into the cavity of the uterus. Under no circumstances, therefore, should a midwife use the vaginal douche after delivery unless she is expressly told to do so by the doctor in attendance.

Then it is advisable to cover the vulva after delivery—and until the lochia have ceased—

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