terference is necessary in the first stage the best moment is when the os is half-dilated. The pains at the end of the first stage are often somewhat bearing down in character; if the midwife gives the patient the pulley and encourages her to strain, the membranes may rupture when it is least desirable, *i.e.*, when the os is almost fully dilated. It should not only be the aim of the midwife to prevent laceration of the perineum, but she should, wherever possible, prevent by non-interference lacerations of the cervix. It is not always easy to decide if the os is fully dilated; it is therefore wiser, according to Dr. Colyer, failing contra-indications, to wait till the membranes rupture spontaneously, although it may prolong labour.

This is an important point, and worthy of careful consideration; midwives would do well in primiparous cases in which the membranes rupture when the os is almost fully dilated to ascertain by a vaginal examination on the tenth day if the cervix is deeply torn. A patient with a badly torn cervix is more liable to sepsis, thrombosis, and white leg; indeed, it is impossible to say how far-reaching in effect such lacerations may be; cancer may have some relation to them, and it is certain that chronic inflammation of the cervix often follows in their train.

The writer had the pleasure of assisting Dr. Colyer with the investigations of these results of the tenth-day examinations.

M. O. H.

Eclampsia.

An interesting paper on the above subject was read recently before the London Hospital Medical Society by Dr. R. D. Maxwell, and published as a Clinical Supplement to the *London Hospital Gazette*.

In treating this condition the indications, Dr. Maxwell points out, have been for the last ten years:—(1) To control the convulsions. (2) To empty the uterus as expeditiously as possible with the minimum injury to the patient. (3) To eliminate the toxins. He thinks that eliminative treatment has given the best results, especially since the diuretic effect of saline infusions (either alimentary or intra-venous) has been better known.

Eliminative Treatment.

Under the head of eliminative treatment, Dr. Maxwell says, first and foremost we consider venesection. This is no panacea. The case must be judiciously selected. Most accoucheurs are familiar with two types of eclamptic patients—the one bulky, plethoric and cyanotic, with a bounding pulse of good volume, moderate rate, and considerably raised tension. This is the ideal patient to bleed. To begin with, the prognosis is much better in this type, and they frequently react very quickly to this treatment; 15 to 20 ounces of blood should be drawn off.

The opposite type is a collapsed, cold, white patient, with a rapid running, thready, irregular pulse, with all the signs of cardiac dilatation, an acute organic heart lesion, due, I imagine, to the eclamptic toxin. This class of patient stands venesection very badly; as it is, her prognosis is well nigh hopeless, and venesection is quite sufficient to render it absolutely so.

Next in order of importance stands diaphoretic treatment. We can dismiss the hot air bath at once. . . The hot pack—a linen bed sheet wrung out of boiling water, cooled down a little, and applied to the patient's body, which is then swathed in several blankets—gives admirable results. I am bound to admit this treatment is, however, of greatest service in impending eclampsia. It is a most soothing treatment, and will do much to relieve headache and restlessness. It obviously has a minor *rôle* with the patient in labour and demanding obstetric attentions and treatment.

Pilocarpine. I mention this merely to condemn. Anyone who has seen the end stages of an eclamptic patient treated vigorously by this drug has a most unpleasant recollection of its action on the bronchial mucosa.

Purgation by a hydragogue drug is best carried out by one drachm of pulv. jalapæ co., reinforced by two minims ol crotonii. The purge is mixed with three or four ounces of milk and introduced to the stomach by a nasal tube.

On the whole the best eliminative effect will be secured by purgatives and venesection, followed by the introduction of salts, both to combat the acidosis and produce diuresis (sodium citrate and sodium acetate), always provided that the cases have the clinical characters warranting venesection.

The Central Midwives' Board.

An interesting episode in the proceedings of the recent Penal Cases Session of the Central Midwives' Board was the appearance before the Board of Mr. Longmore, Clerk to the Hertfordshire County Council, who appeared to ask the Board to alter their regulation in regard to the procedure adopted at its Penal meetings. The present procedure is for the Secretary of the Board to conduct the case against the defendants, but Mr. Longmore urged on behalf of the Hertfordshire County Council that the Local Supervising Authority if it so desired should have the right to conduct its own cases. It had already investigated such cases locally, and found a *prima-facie* case, and was in possession of the pertinent facts.

Mr. Longmore pointed out that it was the general practice of other bodies, including the General Medical Council to hear an advocate on behalf of the person making the complaint as well as on behalf of the defendant. He asked the Board to consider whether it would not be more convenient, and in accordance with justice, if a representative of the authority making the charge

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