the nurse all necessary information without being asked, so much the better.

The patient's diet will be prescribed by the doctor, but the nurse should see that it is daintily served, and as varied as possible. The appetite is even more capricious than is usual with an invalid, and a very slight thing may cause the patient to enjoy, or refuse, a meal. All food should be light, nourishing, and extremely digestible.

Fresh air—if only through an open window—sunlight, and cheerfulness, are all necessary to the patient's recovery. People who are dull, or pay lengthy visits, or are exceedingly emotional, should be excluded from the sick room.

Some colourings in wall papers are more soothing than others: green and blue are the best shades. Unfortunately, it is rarely in the nurse's power to choose.

An over-crowded room is never restful, and it is always possible to remedy this matter.

OUR PRIZE COMPETITION.

WHAT ARE THE SIGNS BEFORE DELIVERY THAT THE CHILD'S LIFE IS IN DANGER? WHAT WOULD YOU DO IN SUCH A CASE?

We have pleasure in awarding the prize this week to Miss Nellie Chopping, Sittingbourne, Kent.

PRIZE PAPER.

Auscultation.—The condition of the fœtus before delivery can be determined by auscultation, that is, listening to the fœtal heart sounds and finding out whether they are regular, and their frequency. The normal rate is from 130—150 beats per minute, care being taken to count between the uterine contractions.

Should the beats rise to or above 160 or fall below 120 beats per minute, it is very sure that the fœtus is in danger of its life. This is one of the signs of prolonged labour, and the patient must not continue longer without medical aid, which should be sent for at once.

Palpation.—Tumultuous movements on the part of the fœtus show that all is not well with it and also indicate prolonged labour.

If on palpation the presentation is found to be abnormal, such as transverse, brow, &c.; these conditions will prove more dangerous for the child during delivery, as version will have to be performed. In breech presentation the prognosis is not so bad as in the former case, but great care should be taken to have a warm sterile towel in readiness, to cover the buttocks when born, as the colder air coming in contact with them causes the child to make premature attempts at breathing, and doing so sucks in the mucous and other discharges from the vagina, and would result in asphyxia.

A loop of the cord should be gently pulled down as soon as the umbilicus is born, as this not only relieves pressure and traction on the cord, but by feeling the pulsations the condition of the fœtus is ascertained, and if the pulsations are weak not a moment should be lost in delivering the rest of the child.

Vaginal Examination.—Presentation and prolapse of the cord, especially the latter, are very serious conditions for the child, owing to the length of time the cord is exposed to pressure during delivery.

The patient should immediately be placed in the knee-chest position, that is, with the head lowered and the buttocks raised. This will relieve pressure on the cord and it may eventually slip back to the fundus.

If assistance has not arrived, and the patient tires of her position, she may be placed in Trendelenberg's position: this is done by placing an inverted chair on the bed, covering its back with pillows, so as to protect the patient, who is placed with her head and shoulders on the bed, her body on the back of the chair and her legs flexed at the knee at the highest point of the chair. This is more comfortable than the knee-chest position, and can be maintained any length of time.

Hæmorrhage on the part of the patient, whether accidental or unavoidable, early in pregnancy or during delivery, cannot fail to be a source of danger to mother and child.

Treatment.—In each of the above cases, the following should be prepared in addition to the things necessary for the patient, in case the baby should be born asphyxiated:—

Hot and cold bath, a mucus catheter, or failing one, a gum elastic catheter, some brandy or whisky, some clean linen for wiping catheter, some square pieces of gauze in case mouth to mouth respiration is performed, some bath towels, and a warm receiver.

If the child is born in white asphyxia (*asphyxia pallida*) the cord is severed at once and the child held head downwards to allow the mucus to run out of the mouth. It should then be placed in a bath of water of a temperature of 100° F., and while in the water the mucus should be sucked out of the trachea and larynx with the catheter. The child should then be taken out of the bath and dried with a warm towel. Sylvester's method of artificial respiration should be persisted in until it passes into blue asphyxia (*asphyxia livida*), when, after

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