time must be lost in sending for medical aid; if, on the contrary, it is pulseless and cold, the case is not so urgent, though in either case the Doctor must be sent for.

Reposition may be attempted in three ways: 1st, by the so-called postural treatment, *i.e.*, placing the patient on the bed in the knee-elbow position, that is to say, resting on her knees and elbows; by this means the pelvis is raised up, and the cord descends back into the uterus by gravitation, but this manœuvre can only succeed when the membranes are intact, still there is no harm done in trying it; 2nd, by manual reposition of the cord *after* the rupture of the fœtal sac, but as far as a necessarily limited acquaintance with a rare complication goes I consider these aforesaid measures come out a great deal better in *print than practice*; 3rd, reposition may be effected by attaching the blind end of a gum elastic male catheter to the cord by means of two strands of thread passed through it in the form of a loop with the stilette and cut afterwards. Keep the latter in the catheter and then pass it well into the uterus right above the head (it is only in *head first* labours that the measures we have discussed are of any use) and leave it there until after the birth of the child. I cut the open end of the catheter off—the bone is not compressible. I just mention this plan as I have *known* it to succeed on *one* occasion in my own practice, and we had a live baby for our reward. I used a No. 12 catheter (which is a size too large), but it was a case of Hobson's choice!

In my judgment these temporising measures for *reposition* are *not* to be relied on, and the child's best chance of safety lies in *prompt delivery*. Forceps if the head present, version in transverse positions, and traction on one foot, in footlings; and in these cases artificial respiration is almost always necessary. These cases are always anxious, for do what we may the infant mortality is extremely high, and for this reason they are of much interest in Obstetric Nursing. A Nurse may render valuable aid by giving timely intimation of the trouble to the Accoucheur, and comforting assurances to the Patient as to her safety.

Convulsions may occur before the advent of labour, and under three forms:—(1.) Hysteria; (2.) Epilepsy; (3.) Puerperal eclampsia. The first is the least serious, due to nervous irritability excited by some strong emotional cause such as fear, grief or passion, accompanied by uncontrollable fits of weeping or laughter. During the paroxysm, the hands are *raised above the head* and become entangled in the hair. I regard this symptom as almost diagnostic of hysteria, and have not noticed it in either epilepsy or apoplexy. The usual treatment is douching the head and face with cold water, loosening the dress, and exposing the face and chest to the air. When the fit is passing off, a dose of *sal. volatile* (one drachm), or half a drachm of spirits of lavender in half a tumbler of lukewarm camphor water, is usually given in two doses at an interval of one or two hours, the patient must be undressed and put to bed as soon as possible, for after the wild tumult of the storm, a profound calm may succeed, and the repose should *not* be broken night or day. Epilepsy.—This is due to causes unconnected with pregnancy, and in many cases the fits are less frequent during that period than under ordinary circumstances. I have pointed out to you in a previous paper how to treat these attacks. In neither of these forms of convulsions is the infant's life jeopardized. There is one point I have observed in epileptic patients, great placental adhesions, and it would almost seem as though the "fits" affected the placental structure; in one case that came under my notice, the adhesions were so numerous and intricate, if I may use the word, and difficult to follow, that a large portion of the placenta had to be broken down into portions so small that the attending surgeon compared them to bits of fur. The patient did well.

Puerperal Convulsions.—These place the lives of mother and infant in the gravest peril. The disease is peculiar to pregnancy, and may almost be called a temporary dyscrasia, arising in a measure from intense renal congestion caused by the pressure of gravid uterus upon the kidneys, thus interfering with their natural functions—urea being retained in the blood, and albumen passing into the urine, and the convulsions due to blood poisoning are sometimes described as uræmic puerperal eclampsia. Young primipara are more liable to the disease than multipara. The attack may come on quite suddenly and generally when in labour; the seizures recur at frequent intervals, there is a peculiar sibilant noise during the paroxysm that resembles air rushing through the clenched teeth—total loss of consciousness—deepening into coma—ending in death. I have told you in a former paper what to do *ad interim*, but of course at the first outset of the attack medical aid must be at once summoned. Under skilful treatment patients can be rescued from this desperate strait, and never have any return of the disease in subsequent labours.

(To be continued.)

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