to the patron. Conversely, whatsoever the personal virtues of the slave, the debasing pressure and conventions of that status must have thrown some shade upon his character; so that too often the Greek, by nature slippery and inconstant, as a freedman—and even between the *libertus* and the Roman there was still a chasm—betrayed himself as a stealthy and venomous rascal.

Of medical colleges and public medical offices I will treat hereafter; but, speaking generally, it is true that in Rome itself there was no kind of professional test or standard to discriminate sharply between such medici as the gentle and accomplished freedman Antonius Musa or the botanist Lænaeus, and villains like Vettius. As manners softened, and intelligence and skill compelled recognition, the position of these slaves and freedmen improved, especially under the enfranchisements of Julius and Augustus; but their calling could not well progress nor gain public recognition as *ars prudentiæ majoris*. Thus it was that, even under the Empire, Roman medicine remained almost wholly Greek; for the few physicians, such as Scribonius Largus, who bore Latinized names, were nearly all of them Greeks.*

How are we, then, to explain the enmity of Cato; and the malice of Pliny, who, while he endeavoured to ignore the physicians, could not refrain from signifying by his indiscriminate if not wholly unjustifiable abuse that they existed, and among the "antiqui" had existed, only too abundantly? Now, the fault of these physicians was not so much that they were crafty and rapacious as that their craft and rapacity were not of the Roman sort. As the physicians in Rome were practically all Greeks, their ideas were Greek, so Greek that no Roman could enter into them; furthermore, these Greek notions were not only mischievous in medicine, but in their more general tendency were socially subversive. The scent of a ruling class, secular or ecclesiastic, for inquisitive or esoteric opinions is amazingly keen, and its resentment ruthless. How haughty, ruthless, and unreceptive was the temper of the conquering races in Rome, how sacred were their religion and rites, how rooted their superstitions and folk medicine, how obstinately impermeable their qualities and customs to new ideas, and how incapable of elastic adaptations, we have already seen. We shall not wonder that all these conservative opinions and instincts should have incited, especially in Republican Rome, an alarm against foreign ideas. The old Roman of the type of Cato, austere and imperious as he was, was also, consciously or subconsciously, apprehensive of the instability of his State. Built as it was, not only upon slavery but also upon the quicksand of a restless, excitable *plebs*, mostly of alien blood, its security could be maintained only by the rigidity of the old iron will, consecrated tradition, military framework, and hardy strenuous habits. Thus the dominant class was clinging fiercely to creeds and rites whose validity they dare not suspect, and to intellectual conventions which, already sapped by Hellenic curiosity, were ultimately by Christianity to be overthrown. This issue the old Roman dimly but uneasily foresaw. And is it too fanciful to surmise that no less dimly, but by some community of racial instincts, the bent of the subject or plebeian Roman was apt to assimilate the notions of his distant kinsfolk of the Aegean, and to be stirred by the fickle passions, the irresponsible wit and faction of that clannish primeval race then, as before and since, intolerant of rank, though submissive to despotism? Such may have been Cato's presages; such, at any rate, was the upshot. For with spoils came luxury; with the deletion of Carthage ease and security; with intellectual curiosity the sapping of creeds and the decay of patriotism. It is scarcely true, I think, to say that Rome was unstable for lack of a middle class; the equestrians took some such place; the instability lay in the rift between the upper classes and the plebs, an unassimilated and naturally turbulent mass, mixed with the nation but not mingled or organized with it.

NOTE.—The bibliographical references are reserved for the fuller and more formal publication of these Lectures.

* Sextius Niger and Julius Bassus, in Caesar's time, are said to have been Romans, though, as the fashion was, they wrote in Greek.

THE RELATION BETWEEN THE TIME OF RUPTURE OF THE FETAL MEMBRANES AND LACERATIONS OF THE CERVIX UTERI.

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VAGINAL examination during the puerperium is a practice the value of which is not generally recognized and is very seldom followed. Were it, the experience that would have been gained would, I think, have materially influenced in certain directions some methods which are at present too common among many practitioners; in other words we should have learnt from a new quarter the disadvantages of meddlesome midwifery. In these days when midwifery is slowly but surely passing out of the hands of trained practitioners into those of partially trained midwives, it becomes most essential to discover whether our methods of conducting labour are correct, so that definite rules may be formulated for their guidance.

Following the rule which has been in force for many years at the General Lying-in Hospital, I made vaginal examinations, when advisable, upon patients before they left hospital. I noticed, among other things, in my early examinations, that the damage to the cervix varied within wide limits, and I determined, if possible, to discover the reason or reasons for these conditions.

Many different factors might be held responsible—such, for instance, as the age of the patient, the size and weight of the child, and the time of rupture of the membranes. I came to the conclusion that the size and weight of the child were relatively, if not absolutely, unimportant factors. The time of rupture of the membranes was therefore left to explain the phenomenon. During the inquiry many other relations occurred to me to study.

My conclusions are based upon a consideration of 233 primiparous cases, in 164 of which vaginal examinations were made. The notes were recorded partly by Mr. Basil Hood, who succeeded me as house physician, and partly by myself, and, as a definite systematic method was followed, the results, due allowance being made for the personal factor, are comparable.

The examinations were made on the ninth or tenth day of the puerperium, after thorough evacuation of the bowel and bladder. The points recorded were:

First, the height of the fundus uteri above the pubes.

Secondly, the lie of the corpus uteri—whether to the right of, left of, or in the midline—and also its state of version or flexion.

Thirdly, the condition of the cervix, more especially with regard to lacerations. The lacerations, if present, being recorded under three degrees: First, those reaching less than half way up the vaginal cervix; secondly, those reaching half way; thirdly, those reaching up to or beyond the reflection of the vaginal mucous membrane.

Fourthly, the condition of the bases of the broad ligaments, any thickening in them being recorded, as slight or moderate.

Fifthly, the nature and quantity of the lochia.

In addition to the important relation I hoped to establish, there were three others that I thought might possibly be shown to exist—namely:

1. A relation between the quality and quantity of the lochia and the degree of uterine involution.
2. A relation between uterine involution and lacerations of the cervix.
3. A relation between cervical lacerations and thickenings of the broad ligaments.

A careful consideration of the notes has failed to prove to me that there is a definite relation between the lochia and the degree of involution. Unfortunately two disturbing factors crept in—namely, the patient being allowed to get up for a short time the day before the examination, and being given an enema upon the same morning—both factors which often lead to an increase and an alteration in the quality of the lochia.

Although my own notes show a definite relation between the thickening of the bases of the broad ligaments and

cervical lacerations, the degree of thickening increasing with the degree of laceration of the cervix on the same side, those of Mr. Hood do not. The difference in our findings was due, I believe, to the fact that Mr. Hood examined his patients in the Sims positions whilst I examined mine in the dorsal. To my surprise, I could find no relation between involution of the uterus and cervical lacerations.

The thesis to which I now turn is that *the degree of dilatation of the os at the time of rupture of the membranes determines for the most part the degree of laceration of the cervix.*

It is generally agreed that there are three factors concerned in the mechanism of the dilatation of the cervix. There is the contraction of the longitudinal fibres of the uterus, the relaxation of the circular fibres, and the mechanical stretching by the projecting bag of membranes, or, in their absence, the presenting part of the fetus. With regard to the third factor, Galabin states:

The mechanical action of the dilating part, as it is pressed into the cervix, is that of a wedge: a fluid and uniform wedge in the case of the bag of membranes; a solid and irregular wedge in the case of the head or other part of the fetus. It follows that the effect produced by the wedge varies according to the acuteness of the angle at the points where it is in contact with the edge of the os.¹

The dilating force of the bag of membranes continues until full dilatation of the os is attained, at which point, in most naturally conducted normal cases of labour, spontaneous rupture of the membranes occurs.

The generally accepted theory as to why the membranes rupture at full dilatation is, that they have just sufficient strength to resist rupture by the increasing pains until that point is reached.² But this does not explain why the membranes should so often rupture early in cases of breech or transverse presentations, or in cases of contracted pelvis, nor does it explain why the membranes which vary so widely in density and strength should in normal cases so frequently rupture at full dilatation. The membranes rupture early in the class of cases I have mentioned because they are early subjected to direct intrauterine pressure, and probably in normal cases rupture at the end of the first stage of labour because they are not subjected until then to direct intrauterine pressure.

Contrary to the usually accepted opinion, I believe those are correct who hold that direct uterine pressure upon the fetus forcing it downwards comes into play comparatively early in the first stage. If an examination be made, it will be found that the presenting part becomes firmly fixed over the os before the height of a pain, and by so doing acts as a ball valve which cuts off the forewaters from the backwaters, and thus from further intrauterine pressure, except such additional pressure as may be transmitted to them by any downward movement of the presenting part. Such an arrangement leads to a very gradually increasing pressure within the bulging bag of membranes. So long as the dilatation of the cervix remains less than the greatest circumference of the presenting part, so long will the ball valve action remain good; but, once the circumference becomes the least degree the longer of the two, it will cease, and the maximum intrauterine pressure will be transmitted to the forewaters suddenly and for the first time, and will as a rule be a greater strain than the membranes can resist. This, I believe, is the usual way that the maximum intrauterine pressure is transmitted to the forewaters; but it is quite possible that in many cases it is transmitted by means of descent of the presenting part, as was held by Playfair.

It follows that, when the first stage of labour is normal, the presenting part descends into a dilated cervix by which it is not tightly grasped, and hence no lacerations are likely to ensue. But should it so happen that the membranes rupture before the end of the first stage then the presenting part will descend into an incompletely dilated cervix by which it will be lightly grasped. In the latter case second stage pains will ensue and the uterus will transmit a force to the presenting part which will stretch the cervix at a rate in excess of its physiological yielding power, and, as a rule, beyond its momentarily elastic limit, and thus lead to its laceration. The nearer the os approaches to full dilatation the greater will be the force exerted upon it by the presenting part, because not

only does the angle between the two become increasingly acute, but the pains will be stronger. It is not uncommon when the membranes rupture late to find that the presenting part is driven through an incompletely dilated cervix in one or two pains, thus proving how rapidly the stretching may take place. In those cases in which the membranes rupture early we should not find lacerations of the cervix so common, for in them, as a rule, labour is slow until the cervix is sufficiently dilated to allow the presenting part to enter; and when it does enter the pains gradually change in character from those of the first stage to those of the second. In the second stage contraction and retraction of the longitudinal fibres becomes marked, and thus tends to draw up the cervix and lead to a more rapid dilatation of the os. But even with these compensations a slight rupture appears to occur in most cases.

The increase in force that a descending vertex exerts on the cervix as the cervix itself increases in circumference will be more clearly understood if we consider for a moment mathematically a somewhat similar case. The accompanying diagram illustrates graphically the increasing stretching force that a sphere grasped as far as its greatest circumference by an unyielding substance would exert in that substance, as the hole through which it was passing was increased in size. (The problem has been kindly worked out for me by Dr. Gill, of Halifax, and I append the notes which he has sent me.)

Diameter of os uteri.

Curves showing increase of dilating pressure at the edge of the os uteri as the diameter of the os increases, the pains being supposed of the same strength throughout. The lower curve gives the pressure with membranes intact, and is straight, because under these conditions the pressure varies directly as the diameter of the os. The upper curve gives the dilating pressure of the head after rupture of the membranes. $\frac{3}{4}$ in. is considered complete dilatation.

NOTE BY DR. GILL.

Assuming it to be the fact that the most extensive tearing of the cervix occurs if the membranes are ruptured when dilatation of the external os is almost complete, what explanation can be found for it?

The dilating pressure of the head will be greater than that of the bag of membranes for most degrees of dilatation, and the ratio between them increases rapidly with increase in dilatation of the os. But this is not an explanation, because when the membranes are ruptured early, the os must still pass through the stage of more complete dilatation and sustain the severer dilating pressure of the head at the stage of almost complete dilatation. Also seeing that dilatation by the membranes is usually slower than dilatation by the head, the explanation cannot be that when the membranes are ruptured early the cervix has more time to soften, and therefore yields more readily when it meets the greater pressure, rather than tearing. On the contrary, the slower the dilatation the longer time the cervix would have in which to soften, so that if the condition of the cervix were the factor determining tearing we should expect less tearing when the membranes were ruptured late than when they ruptured early, whereas the opposite appears to be the fact. The only obvious remaining explanation is that the cause of tearing of the cervix is the sudden increase in pressure which results when the membranes are ruptured and the pressure of the head is substituted for that of the membranes.

If this is the explanation, then the greater the ratio of the pressure of the head to the pressure of the membranes for any given dilatation of the os, the greater the tearing which will occur if the membranes are ruptured at that stage of dilatation.

The following is an attempt to find the above ratio for varying degrees of dilatation of the external os:

It has been necessary to neglect friction between the head or the membranes and the inner surface of the cervix, as it is difficult to say whether friction would be greater in the case of the head or the membranes.

Probably in a moist labour friction would not be great in either case. If the friction were great enough, instead of producing a radial tear, as is usual, the head would tear off a more or less circular ring of the cervix. It has also been assumed that the head is spherical in shape. As it is more usually conical this would increase the tearing pressures above those

calculated, and in cases in which there is great moulding of the head, this will tend greatly to increase its dilating pressure on the os. The forces of the pains before and after rupture of the membranes have been taken as equal, but the pains after rupture of the membranes are usually more vigorous than those before rupture; this will further increase the ratio of the dilating pressure of the head to that of the membranes for any given degree of dilatation, so that the ratios shown on the accompanying curve probably make the dilating force of the head too small.

Before rupture of the membranes, if F is the force of a pain and r is the radius of the head, then the pressure in the forewaters will be approximately $\frac{F}{\pi r^2}$. At the edge of the os the dilating pressure will be the horizontal component of this pressure, or $\frac{F}{\pi r^2} \sin \theta$, where θ is the angle between a perpendicular through the centre of the plane of the os and a line drawn perpendicular to the tangent to the surface of the membrane at the edge of the os. Assuming that there is not much bulging of the membranes through the os and that the radius of the spherical surface formed by the bag of membranes is equal to that of the head (it could hardly be less, and is not likely to be much more), then the dilating pressure will be nearly $\frac{F}{\pi r^2} \times \frac{a}{r}$, where a is the radius of the os. After rupture of the membranes, let the force F of the pain be imagined broken up into an infinite number of very small vertical prisms of

pressure; then the pressure in each of these prisms in the direction of F will be $\frac{F}{\pi(r^2-a^2)}$ where r is the radius of the head and a that of the os. The ratio of the area of surface at the point P on the cervix at the bottom of such a prism to the cross-section of the prism is nearly $\frac{1}{\cos \alpha}$ where α is the angle between the perpendicular to the plane of the os and a perpendicular to the surface of the head at P . Hence the pressure on unit area of surface at P along the line PQ parallel to the line of action of F will be $\frac{F}{\pi(r^2-a^2)} \cos \alpha$. Then, if friction be disregarded, this pressure is the vertical component of the pressure R perpendicular to the surface at P , and the dilating pressure at P will be the horizontal component of this same pressure R —namely, $\frac{F}{\pi(r^2-a^2)} \cos \alpha \tan \alpha$, or $\frac{F}{\pi(r^2-a^2)} \sin \alpha$. At the edge of the os $\sin \alpha = \sin \theta = \frac{a}{r}$, so the dilating pressure there is $\frac{F a}{\pi r(r^2-a^2)}$. Here the elasticity of the cervix is assumed to be the same throughout its extent, and as this is probably not the case, the results can only be approximately correct. They will serve, however, to give an idea of the order of the differences in dilating pressures at the edge of the os for varying diameters of the os when the dilatation is being done by the head and the membranes respectively and the force of the pains remains constant.

It will be seen that increase of force is remarkably rapid. In the case of a vertex passing through a cervix, how much more rapid must be the increase where not only is the practically unimportant weight of the child to be considered, but a rapidly increasing *vis a tergo* brought about by increasingly strong uterine contractions. Theoretically it follows that one would expect severe lacerations in those cases in which the rupture of the membranes occurred when the os was about fully dilated—say, for example, seven-eighths dilated, clinically expressed as “almost fully dilated”—and less severe when the os was too small for the presenting part to enter.

A consideration of the accompanying statistics will show that practically these theoretical expectations are borne out. Although the figures speak clearly for themselves, one or two points may with advantage be pointed out. It is noteworthy that 5 per cent. more severe lacerations

occur in those cases in which, the cervix being clinically considered fully dilated, the membranes were ruptured, than in those cases in which the membranes ruptured spontaneously and the cervix was subsequently found on examination to be fully dilated. Most probably in both classes dilatation was not complete in some of the cases when rupture occurred, but Nature appears to have made the fewer errors. In those cases in which the os was “almost fully dilated” the percentage of deep lacerations is extremely high—namely, 45. In those in which the os was not more than a five-shilling piece in size, only 12½ per cent. show deep lacerations, but laceration of some sort occurred in every case.

It is unfortunate that in the last two classes the number of cases is so small, but I think the results, taken in conjunction with the rest, are sufficiently striking to arrest attention. As I have before mentioned, I believe that the premature rupture of the membranes is by far the most important factor in the causation of cervical lacerations; but belief, however firm, cannot in itself be considered proof. I have, therefore, considered the average weight of the infants, their suboccipito-bregmatic diameter, and their suboccipito-bregmatic circumference in relation to rupture of the cervix, and I find, as the second table will show, that they are quite negligible. I may add in this connexion that with two of the lightest fetuses deep lacerations occurred.

TABLE I.

	Number of Cases.	Average Age.	Percentage of Cervical Lacerations.		
			Extent of Laceration.	Right Side.	Left Side.
All cases	164	23.17	Slight	49.39	46.93
			Moderate	15.24	17.07
			Deep	6.09	12.18
Spontaneous rupture:			Slight	48.48	48.48
Os fully dilated ...	33	21.16	Moderate	3.03	21.21
			Deep	6.06	9.09
Artificial rupture:			Slight	54.34	41.32
Os fully dilated ...	46	22.8	Moderate	19.56	36.95
			Deep	6.52	15.21
Spontaneous and artificial rupture:			Slight	36.36	27.27
Os “almost fully dilated”	11	23.52	Moderate	36.36	18.18
			Deep	9.09	45.45
Os not more than five-shilling piece	8	21.5	Slight	50	75
			Moderate	25	12.5
			Deep	0	12.5

TABLE II.

	No. of Cases.	Weight of Child in Ounces.	Suboccipito-bregmatic Diameter.	Suboccipito-bregmatic Circumference.
Rupture of membranes—spontaneous:			In.	In.
Os fully dilated	33	105.24	3.77	12.14
Rupture of membranes—artificial:				
Os fully dilated	45	110.51	3.81	12.2
Rupture—artificial or spontaneous:				
Os not more than five-shilling piece	8	113.56	3.81	12.28
Os almost fully dilated	10	116.9	3.75	12.22
Average for all cases	96	111.5	3.78	12.21
Deep lacerations all cases	33	111.75	3.76	12.07

The practical results to be drawn from this inquiry are, I think, obvious. If the ideal to be aimed at in the conduct of labour be to bring the process to a conclusion with the least harm both to the mother and child, then that ideal will be best attained by leaving the patient to deliver

herself, whenever possible, until towards the end of the second stage. It is curious to note how much attention is given to the preservation of the perineum, the principle borne in mind being to deliver gradually, and to contrast this with the frequent treatment—namely, hurrying—adopted when the presenting part is passing through an incompletely dilated cervix—an almost analogous condition. It follows that the membranes should only be ruptured artificially when the indications are definite, and as a routine method of hastening labour should not be practised. In those cases in which such treatment becomes necessary, the best time to rupture appears to be when the os is about half dilated, and on no account should they be ruptured towards the end of the first stage. Moreover, when the os is nearly fully dilated, the character of the pains gradually merges into that of the second; hence, the best chance will be given to the membranes to rupture at the critical time if the woman be advised neither to strain or bear down.

In conclusion, let me say that I in no way consider the results in my paper as finally settling this most important point. My original wish was to base them upon a thousand cases, but the opportunities for doing so having passed, I publish this paper rather in the nature of a preliminary communication, and in the belief that it opens up a neglected field for research in obstetrics.

Much labour has been expended in its production, the greater proportion of which has been borne by others rather than myself. Upon Miss Olive Haydon, the head midwife at the General Lying-in Hospital, has fallen by far the greater share; and to her my thanks are chiefly due, for without her patient help in many directions the paper must have remained unwritten.

REFERENCES.

¹ *A Manual of Midwifery*, by A. L. Galabin, 1904, p. 165. ² *Ibid.*, p. 167.

A SHORT CRITICISM OF THE SO-CALLED
"RATIONAL PUERPERIUM."

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I THINK Dr. Haultain's paper entitled "A Plea for a Rational Puerperium" should receive more criticism than it has. For some time past many German surgeons and obstetricians have been recommending early rising on the second or third day following abdominal operations and labour. Professor Kroenig has practised this early rising during the puerperium for more than two years. I admit that many of us keep our abdominal section cases in bed for too long a period, but I feel convinced that the ten to fourteen days' rest in bed during the puerperium is not only right but rational. I think Dr. Haultain's arguments in favour of early rising are far from convincing. He first mentions a few social reasons in favour of early rising, and says that multiparous patients spoke in eulogistic terms of it in comparison with their former experience. This may well be, because to them such treatment was a novelty, and the public, as a rule, likes something which they imagine to be new. On the other hand, one finds that women of the poorer classes complain commonly of having been forced to get up on the third or fourth day on account of domestic affairs, and they frequently date their uterine trouble from this period.

I do not believe that many women will agree with Dr. Haultain's patients that the ten days of rest is irksome to a degree, nor is it the rule for women to look upon their puerperal rest as either "invalidism or penal servitude." In my experience the majority of puerperal patients lie in bed after the birth of the child in a contented and happy frame of mind, while the uterus and surrounding structures undergo involution, and the process of lactation becomes established. It is true that labour and the puerperium are physiological processes, but this statement requires qualification. It would be more accurate to describe the puerperium as an extraordinary physiological process which, on account of the profound alterations in the local and general condition of the patient, may become immediately or remotely pathological. If this be not so, what is the use of the presence of the doctor? Now, con-

sidering that these profound changes are taking place during the puerperium, we have to place our patient in the best position to help Nature, and to avoid the many pathological incidents that may arise.

Dr. Haultain and some of the German authorities would have us believe that the upright position will not only help a normal puerperium, but will also prevent displacements and even benefit septic uterine conditions by affording better drainage. I am quite convinced that there is no real evidence that the lying-in period during the puerperium should be curtailed or altered in any way; and, further, that the position of rest for ten or fourteen days is the best means of aiding the natural physiological processes at work during this time, and that it also lessens the likelihood of incidental pathological complications. Dr. Haultain has given several specific examples in support of early rising. First, he says that by getting the patient up the active movements of the abdominal wall quickly increase the tone of the muscles, and therefore increase the intra-abdominal pressure, which he thinks of great importance in relieving venous engorgement and preventing constipation. In opposition to this theory I maintain that the abdominal walls will undergo involution just as well while the patient is lying in bed, for in spite of all theories to the contrary, the one great method of relieving congestion and venous engorgement of the lower abdominal viscera is to place the patient in the natural position of rest—namely, recumbent. Moreover, if the patient is allowed to be in the upright position on the second or third day, the abdominal muscles will have to bear the weight of a large uterus together with all the mobile abdominal viscera while they are yet in a slack and softened condition. This pressure must cause permanent stretching and pendulosity, and it seems to me that the useless obstetric abdominal binder would in this case be of some small use. In the recumbent position the abdominal muscles undergo a quiet and passive involution, unmolested by the weight of the viscera above, and aided to a small degree by active respiratory movements. I believe that rest, good food, and a happy state of mind will do more to prevent pendulosity and visceral proptosis during the involution changes of the puerperium than any small amount of tone that can be acquired in six or seven days of indifferent active muscular movements in the upright position. In ten to fourteen days profound physiological changes take place which render the abdominal walls able to withstand the visceral pressure of the upright position, let alone the fact that the uterus at the end of this period has sunk below the level of the pubes, and therefore no longer throws its weight upon the abdominal walls.

SEPSIS.

Dr. Haultain says rightly that the position of the patient has no influence as a primary cause of sepsis, and I suppose no one would allow a bad case of sepsis to be wandering about even if she could do so. So I will confine myself to the less virulent forms. Dr. Haultain quotes an ancient authority in connexion with this point (Rueff, 1634), and then goes on to say that several of his cases during their first day's exercise passed large clots which, had the woman rested in the recumbent position, would probably have remained in the genital passages for an indefinite period as a medium of septic incubation. He further states that the upright position affords better drainage of septic lochia. Now, if a puerperium is normal and the uterus is undergoing involution as it should, the passage of large clots is of rare occurrence. Again, if the lochia is septic, our duty is to clear out the uterine cavity and keep the patient all the more at rest in order that the circulation should be as quiet as possible, and thus prevent a local condition becoming a general infection. Further, I cannot see any reason for supposing that the uterus, which, after all, is the most important organ concerned, drains one whit more satisfactorily in the upright than in the recumbent position. No doubt if clots form they may remain in the upper part of the vagina for a short while, but some excessive respiratory movement or active straining at once dislodges them. Moreover, the upper part of the vagina should be sterile, and infection by this means extremely rare.

The last point which I wish to touch upon is the question of uterine displacements. For the sake of