small and weak. This was immediately followed by a considerable increase in the quantity of urine, which rose to 130 ounces on the 13th and 20th. The codeia was resumed on the 21st, in doses of four grains and a half, and on the 30th was increased to nine grains daily, with the same result as before—an immediate fall in the urine from 130 to 90 ounces.

On July 5th, morphia (half a grain three times a day) was substituted for the codeia, and a few days later in grain doses, whereupon he was made an out-patient, and ordered to continue the morphia and cod-liver oil steadily for a month.

These three cases all exhibited marked improvement whilst taking codeia, which improvement ceased when the codeia was withheld, and was renewed on its repetition. Morphia had a good effect in two of the cases; but the improvement was much less marked with it than with the other alkaloids.

NOTE ON UTERINE HÆMOSTATICS.

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As a small contribution to the practical portion of the subject of uterine hæmostatics, I venture to make a few remarks on the mechanical kinds, which we know by the name of plugs or tents. In doing so I must be understood to refer only to those cases where the cavity of the uterus is not sufficiently large to contain blood in quantity, the loss of which from the circulation is likely to produce anything of serious detriment.

If we go back to former practice and to text-books, we find it recommended that, in case of threatened abortion with much hæmorrhage, a vaginal plug should be used.

The vaginal plugs recommended are the tampon, cotton or wool, silk or cambric handkerchief, rags, or sponges passed in till the vagina is filled up. An India-rubber ball also has been suggested, covered with felt or such like material. Now, even with the best management, there is much of distress to the patient in the use of the vaginal plug; and with regard to its hæmostatic effect very much of uncertainty, and generally partial failure; and in the hands of the unskilful and careless there is positively no restraint of bleeding worth the mention. If at any time any good results be produced, it is rather by the reflex irritation that it causes, whereby the uterus expels its contents. It is not so very rare an occurrence that one finds, on removal of the plug, the ovum on the uppermost part of it.

But besides its palpable inefficiency, a vaginal plug, being of a porous texture, absorbs a large quantity of blood and thus conceals it from our sight; it also favours decomposition, and this, as is well known, occurs within a few hours; and thus we have a new element of danger.

Again, in many cases, when called to such a case, we have no speculum at hand; and although we may extemporise one out of card-board, book-covers, or such like material, yet, before we have thoroughly and firmly filled the vagina, we must have given the patient considerable pain and distress, besides having occasion to put such pressure on the urethra as may necessitate subsequent catheterism. For these reasons, namely, the imperfection of action, pain in introduction, and danger if left in long—in other words, its general crudity, it seems to me that as a general rule the vaginal plug should, in the cases I have supposed, be discarded.

And as a substitute I would urge the employment of the cervical plug as being more precise in action, as well as being capable, if we use a dilating kind, of expanding the canal for the purpose of exploration, or for the expulsion or removal of its contents.

If, then, in any case of uterine hæmorrhage, where we have the conditions above alluded to, we desire, besides immediately checking the bleeding, to dilate, we can use the compressed sponge-tent; the best form of which I have found to be those made, after Sir James Simpson's plan, by Duncan, Flockhart, and Co., of Edinburgh. These can be introduced by a long pair of forceps, and retained *in situ* by placing a piece of sponge, with tape attached, in the upper vagina. Of course, even these materials retain some secretions, etc., and tend to facilitate decomposition; but their removal and cleansing can be effected much more readily than the vaginal plug, because it requires but a small portion. The sea-tangle tent, by reason of its slipperiness, is unreliable as a plug in hæmorrhage. If we desire, however, only to plug the cervix, we can very easily extemporise a plug from materials to be found in every house.

For instance: take a stick (say a flower stick) about a foot long, and taper it at one end to about the size of an uterine sound, or rather larger; wind round this end, for about three inches down, strips of cambric

rag, lint, or sponge to the required thickness, judging from the size of the os. Strips of sponge can be readily obtained from cup-shaped sponges of compact texture, and they can be tied on by thread, layer after layer, till the requisite conical form is obtained. The strips of the other materials can be laid on similarly. After the covered end has been well greased, it is passed into the canal, and the stick retained *in situ*, after the manner in which we tie in a catheter; an elastic tape, if obtainable, is to be preferred.

A catheter or bougie, or the end of the long injection-tube, can be treated in the same way. If we require great precision of application, then it is best that the hand should hold the external end till the hæmorrhage has ceased. If the catheter and stilet be used, then I have found it convenient to bend the external portion backwards, between the buttocks, tying the tape round the ring of the stilet—the ends of the tape being carried, as usual, to back and front of the waist-band.

These more homely adaptations I have recommended, rather than the especially made kinds, because they are often wanted at times when we cannot send home for a more showy sort. In any case, a cervical plug, expanding or not, is more precise, less crude and painful in application, than the vaginal, and, in my experience, nearly always successful. In all cases of abortion, where a plug is necessary, I would lay it down as a rule, that the expanding tent should be employed. In cases of flexion with abortion (and it is this complication which so frequently increases the hæmorrhage) it will be found that the covered stick or stemmed plug, above described, is very useful: for, if the fundus be elevated during its introduction, the uterine cavity is straightened, and evacuation of the contents thereby facilitated.

ON STERILITY.

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It is somewhat surprising that more notice has not been taken, in our modern works on gynæcology, of the frequency with which married women miscarry during the first few months of their matrimonial existence, or become mothers within the first twelve months, and yet never afterwards conceive.

The mere fact of conception occurring once, shows that the reproductive organs are in a normal physiological condition to start with. Some new factor must, therefore, have been introduced to explain this sudden cessation of fertility. Can it be that the effort is too great, and the capacity for further child-bearing exhausted? Is it not rather from some of the numerous complications likely to follow the act of parturition? That these latter will explain the occurrence of sterility in many cases, may be readily admitted; but there are a large number of cases where parturition is safely accomplished at full term, where there is no history of subsequent inflammatory mischief, and where, beyond a somewhat tedious convalescence, with possibly prolonged or profuse vaginal discharge, no active symptoms are present, such as to necessitate a local investigation.

A history by no means unfrequently met with is, that the patient was perfectly well up to the time of marriage, menstruation being normal, and unattended by pain or any serious discomfort. The first few periods may be somewhat painful and profuse, and followed by more or less mucous discharge. Cessation of the catamenia and other well recognised symptoms soon warn the patient that pregnancy has commenced. Increased leucorrhœal discharge, pain in the back, inability to stand or walk far, are naturally attributed to her condition, and no steps are taken to relieve them. Miscarriage occurs before the first half of pregnancy has been reached, due really to gradually extending inflammatory mischief of the cervix uteri, aggravated, it may be, by some imprudence in the way of over-fatigue or undue excitement, such as dancing, riding on horseback, travelling, etc. The miscarriage being attributed solely to some apparently preventable cause, no steps are taken to ascertain the exact condition of the uterus. After resting up for a longer or shorter interval, generally the latter, the patient begins again to take her place in society and attend to her domestic duties. Although warned by her own sensations in the form of backache, leucorrhœa, menorrhagia, and other distressing symptoms, that all is not as it should be, the patient imagines that these are but the sequelæ of her miscarriage; and, beyond resting up a little more than usual, simply because she cannot endure fatigue as heretofore, nothing is done to improve the state of the uterus, which meanwhile is in a very unhealthy condition.

Now, what is the interpretation of this? In many of these cases, the patient has become infected with latent gonorrhœa, as pointed out