were caused by previous ventrofixation; 3 of these cases followed operation by one man, who was accustomed to suture the fundus and posterior wall of the uterus firmly to the fascia, muscle, and the peritoneum just above the pubes. The other 2 cases were those of accidental fixation, where the operator intended to practise suspension. In 2 cases sterilization was accomplished by the removal of the tubes; and hysterectomy was done in 1 case because the vagina was so occluded that proper drainage could not be obtained. The operation was performed as rapidly as possible, and this was thought a valuable point in the technique. Two of the patients were operated upon a second time. A tendency to acute dilatation of the stomach was the most troublesome complication after operation, but was readily controlled by lavage. Three-fifths of the mothers nursed their children; the remainder were unable to do so. This series illustrates the extension of the operation in conditions other than contracted pelvis, and also the success of the operation when patients are taken in good condition.

Eclampsia and Anaphylactic Phenomena.—FELLANDER (*Zeitschrift f. Geburtshülfe und Gynäkologie*, 1911, Band lxxviii, Heft 1) in a considerable number of experiments upon guinea-pigs found no reason to believe that eclampsia is an anaphylactic process. In his experiments he employed albuminoid material from the fetus, from the placenta, and from the amniotic liquid.

The Treatment of Children Apparently Stillborn.—AHLFELD (*Zeitschrift f. Geburtshülfe und Gynäkologie*, 1911, Band lxxviii, Heft 1) considers the old division of cases of apparent failure in respiration, into livid and pallid asphyxia, to be illogical and misleading. After trying various forms of treatment, he believes that when a child does not show signs of life promptly after delivery, the umbilical cord should be immediately tied and cut. The child should be placed in a warm bath and the surface of the body cleansed as quickly as possible, fresh warm water being added to the bath at a temperature of 38° to 40° C. An effort should be made to determine what the exact condition present is, and whether the respiratory passages are occluded. One must remember that the heart may not beat at short intervals, and the child still be revived; and again that a child may be practically dead although the heart continues to beat. After the circulation of the skin has been stimulated by the warm bath, and the air passages have been cleansed from mucus and meconium, the child is suspended by the feet, the chest is compressed gently, and an effort made to force out the mucus which may have been inspired. If respiration does not occur, the child is wrapped in a warm towel, a catheter passed into the trachea, and suction exercised to remove the mucus. If the heart is beating the child will usually make a deep inspiration and the heartbeat become stronger and more rapid. The physician can usually determine by the presence or absence of reflexes in the mouth and throat whether or not the child is actually living. Ahlfeld lays great stress upon gentle but persistent counterirritation of the skin in stimulating respiration. He would have the child rubbed with warm towels, or again placed in a warm bath and then thoroughly dried. Schultze's method of swinging the child should not be used