Kennedy McIlwraith's case. Primipara. Membranes ruptured a week before labor. After onset of labor pains went on fairly well. Child expelled normally with occiput to the front. The labor would have been quite uneventful except for the accident of a somewhat bad rupture of the perineum, which was restored by immediate operation.

I mention this case simply to show that what one might call an extreme form of dry labor may occur without any serious complication.

Primipara at Burnside. Labor forty hours. Liquor amnii discharged thirty hours before delivery. Occiput posterior. Under an anesthetic hand introduced into the vagina and unsuccessful effort made to bring the occiput to the front. Applied the forceps, delivered, occiput remaining posterior. I may say that I think the patient, in this case, was not well managed, and would not be treated in the same way to-day. Without going into full particulars I can tell you briefly that she should have been delivered about ten hours earlier instead of waiting until the soft parts were fully dilated and the head jammed down in such a way that rotation was impossible. Chloroform should have been administered sooner, the parts should have been dilated artificially, malposition corrected, and the child delivered by forceps.

Before speaking of treatment I wish to refer to a few points in connection with my last twenty-one cases. In eleven there were difficult occipito-posterior positions; in five there were occipito-posterior positions with natural rotation of occiput to the front; in five there were occipito-anterior positions. I am not certain as to the exact truth in the last two sets of cases, that is, the cases of occipito-posterior positions which rotated naturally to the front and the ordinary occipito-anterior cases. There must generally, or frequently at least, be some doubt whether an occipito-anterior position was not originally an occipito-posterior. By external examination we can nearly always discover at once whether the occiput points to the left or right, but we cannot always decide with certainty as to whether it points to the front or the rear. By internal examination we cannot get any information on this point in a fairly large proportion of cases early in labor because, we cannot reach the presenting head.

In difficult occipito-posterior cases the occiput was rotated to the front manually in seven cases and kept in such position until the forceps were applied. The occiput was manually rotated to the front, but slipped to the rear again while the forceps were being applied, in two cases. The occiput could not be rotated to the front without too much violence in two cases.