and delivering the child. It is rarely necessary to use any contricting ligature around the cervical end of the uterus. Excessive hæmorrhage from the placental site or the margin of the wound can very well be temporarily controlled by constricting the cervix with the hands of an assistant.

The uterine suture consists of deep sutures, embracing the peritoneum and muscularis, but not the decidua. About ten such sutures are needed. Between each of these deep sutures, half deep sutures can be passed, securing perfect coaptation of the peritoneal surfaces. The sero-serus sutures are not necessary in cases free from any suspicion of infection. In such clean cases, the uterus is dropped back into the abdomen and covered with the omentum. If there exists a slight suspicion, it is of advantage to draw the omentum down behind the uterus, thus favoring the discharge of any septic material through the lower angle of the wound.

Drainage of the pelvic cavity cannot be efficiently carried out. The abdominal wound must be concealed by a dressing made of snowy cotton dissolved in alcohol and ether, containing one part bichloride to 16,000. A little strip of gauze is laid over the wound saturated with this solution. This adheres until it is time to take the sutures out, concealing the wound, and preventing contamination from the outside much better than many layers of gauze and cotton. The baby should be allowed to nurse as soon as the mother has thoroughly recovered from the anæsthetic.

The vagina should not be douched out as a matter of routine. The vaginal outlet should be secured from the introduction of sepsis from without by separating the labia and throwing into the valvular orifice a drachm of powdered iodoform and boric acid (1 to 7). A cotton pad loosely applied to the vulva should be changed as often as soiled by the discharges. The patient thus passes through a perfectly normal puerperium.

Dr. Chas. P. Noble.—In the technique of the operation laid down by Dr. Kelly, reference has been made to typical cases. In such cases I agree entirely with what he has said. But all cases are not typical. I will report an unique case upon which I did the Cæsarean section recently.

Dr. Kelly had operated in a previous pregnancy. As a result of the first operation there remained a fistula, opening from the uterine cavity through the abdominal wall. Notwithstanding this fistula she became pregnant, and for several weeks the amniotic bag protruded into the opening, so that there was nothing between the fœtus and the outer world but the thin amniotic sac.

This sac ruptured at the thirty-third week. The woman had a generally contracted pelvis; besides having a large mass of cicatrical tissue behind the cervix, left from her previous Cæsarean labor. Had spontaneous labor been possible, the fœtus would have escaped through the fistula and not per vaginam. In view of the conditions I thought Cæsarean section preferable to delivering the mutilated fœtus *per vias naturales.*

The finger was inserted into the uterus through the fistula, and with this as a guide the incision was made through the region of utero-abdominal fistula.

Sufficient room not being afforded for delivery the peritoneal cavity was opened and the uterine incision lengthened. The living fœtus was then delivered. The placenta and membranes were firmly adherent, and were slowly peeled off. To control bleeding during this time it was necessary to insert the uterus through the abdominal incision to enable the assistant to grasp the lower segment. The patient passed through a perfectly normal puerperium and is now quite well and soundly healed. The case is entirely unique in its conditions, and in the technique of the operation.

Three cases of Cæsarean section have been observed by me, all having made good recoveries. When the operation is done at the proper time, and after the method described by Dr. Kelly, I am sure this result will be quite uniform.

The essentials of success are:

1. Operation at the proper time, before labor, or at the beginning of labor
2. Rapidity in operating.
3. Accurate suturing.
4. Asepsis.

With reference to suturing, I believe that the Lembert suture as ordinarily described, is purely theoretical. The peritoneum will not hold a suture. Operators have unconsciously included the deeper tisues in the so-called Lembert sutures. An important point, not generally recognized in this country, is, that the diagnosis should be made in the last weeks of pregnancy, and under ordinary circumstances, the operation to be decided upon and done at the close of pregnancy, before labor sets in, or immediately thereafter. I would not do the modern Cæsarean section in a case which had been tampered with by efforts to deliver with the forceps or by version; but in such cases would prefer the operation. In Philadelphia, in the last four years, twelve Cæsarean sections have been done, and ten mothers have recovered. One that died had pneumonia at the time of the operation. The other case was one in which the surgeon at the same time removed a fibroid tumor.

Dr. B. B. Browne.—I think all the procedures