the circumstances, to say the least of it. The doctor has obtained as good a result as was seen in the case which I showed you—the one that was operated upon years after the injury. I have, however, perhaps a little more perineum in my case. I do not believe that either of us obtained perfect union of the ends of the sphincter muscles, but we secured the next best thing—union through the medium of considerable scar tissue, so that the sphincter can perform its function by contracting toward the perineum as the fixed point. So you see that the anus is drawn forward because of this fixed point of scar tissue; she, however, has perfect control of the rectum. This is proved by the testimony of the patient and the fact that, as I introduce my finger into the anus, the muscle contracts toward the fixed point firmly enough for all practical purposes, and the patient will be able to get along well enough.

These cases are called perfect results; they are, perhaps, good enough, and we are glad to get them, but yet they are not the most perfect results attainable. This case gives us the opportunity to call attention to the importance of the primary operation, as it is called, in laceration of the perineum. There has been some discussion about that of late years, some claiming that, if you simply bring the parts together without sutures, you may secure union, and that you are not more likely to obtain it if you introduce sutures; for this reason some have advocated this mode of treatment. Others, again, and I think that the great majority of gynæcologists of the present day, favor the primary operation. By that I mean the immediate operation, which is performed as soon as you have removed the placenta, and the uterus has contracted. Do not leave your case and go home, and then return the next day to perform the operation, because then the parts are not in a condition to unite by first intention; if you disturb them by manipulation, you then, also, utterly spoil the possibility of union without sutures. If you are careful to remove all bloodclots and bring the parts together, and bandaging the limbs to secure perfect rest, you may get union if there is not much subsequent hæmorrhage. Union has frequently occurred under those circumstances. So, if you propose to trust to nature, you had better adopt this plan; but do not change your mind and use sutures the following day, because that would almost insure failure.

I am a great advocate for the primary operation, and in all cases of any importance I believe that it is always well to introduce sutures, if you do it properly, putting in your stitches just tight enough to keep the parts in apposition.

I remember a case which made a profound impression upon me. I was sent for by a medical gentleman in the case of a primipara, and, on examination, I found a breech presention, with the os partially dilated. I suggested that he might wait a while. The patient had a masculine pelvis, and I thought it would be advisable to secure perfect dilatation before attempting delivery. I heard no more of the case until the following morning at about the same hour, when her physician again sent for me. I then found, upon examination, the os fully dilated, the labia œdematous, and the nates of the child presenting at the vulva, and extremely dark in color. The physician told me that the os dilated soon after I left on the day previous, the breech at once settling down in the pelvis, where it remained. We proceeded at once to remove the child, and succeeded in extracting the feet and bringing down one arm, and, while I was bringing down the other arm, the doctor wispered to me that they were very anxious for the life of the child. At this moment the little fellow moved one of his feet, much to my surprise. I then extracted rapidly, and succeeded in obtaining a living child. I, however, tore the perineum through to the rectum, the parts being in that extremely œdematous condition they had lost their elasticity.

This patient began the process of parturition late in life, and this long-continued pressure (in all three days) rendered the parts so œdematous that they gave way, and I made the biggest perineal laceration I have ever made in my life. I immediately brought the parts together with sutures, though I had very little hopes of their union in such a condition, as they were so enormously swollen. However, we brought them together, and I heard no more of the patient for twenty-four hours, when I was again sent for by her physician, he informing me that he had failed to pass the catheter. I separated the labia, and found a dark, sloughing mass, which rendered it quite difficult to tell where the meatus was. I however, made gentle pressure at the point where I supposed it should be, and, without further difficulty, passed the catheter and evacuated the bladder. The doctor pased the catheter once or twice afterward, when all at once the patient urinated of her own accord, he thinking it was all right; but, upon a careful examination, it was discovered she had a vesicle fistula.

I saw her a week after, when the labia and thighs were covered with an ill-conditioned-looking diphtheritic exudate. It was a horrible condition to be in, the lochial discharge flowing over these surfaces, and the urine dribbling away. She, however, recovered from this, and you will hardly believe me when I tell you that the vesicle fistula closed of its own accord—a thing which does sometimes occur. When we removed the stitches from the perineum, it was found that she had a perfectly good perineum and a good sphincter; I have never yet seen a better.

The case made a profound impression upon me, for, if we can get union occasionally in such cases, we can have good hope for success in simpler ones. I would say, always perform the primary operation when the condition of the patient will permit, for, if you do not get union, you can operate subsequently. If you get just a little union, it is some