

improper use the anterior portion of the head may be enabled to lead, and the normal mechanism is disturbed. If the pressure be exerted at the side of the head, as it will be if directed immediately behind the pubes, dilatation does not take place, and the head is really held back. The pressure must be exerted only during a pain, and the patient be directed to bear well down. The efficiency of the uterine action is thereby greatly increased.

This method of aiding labour need not be confined to protracted cases; gentle and properly directed support is of advantage in all. The force employed need not be more than is represented by the word support. A due amount of chin-flexion is secured, and upon this depends the facility of the subsequent rotation of the occiput. More especially is this of importance in the occipito-posterior positions; if attention be paid to secure early and full flexion of the chin, no difficulty will be experienced in the rotation. Before it is possible in the latter cases to slip the cervix over the occiput an initial degree of chin-flexion is necessary. If the forepart of the head is on a level the occiput is beyond the range of the fingers, and the manœuvre is impossible. Aid may then be extended by pushing the forehead upwards during the interval of the pains and retaining it as far as possible in that position by pressure during the contraction of the uterine walls, and repeating this manœuvre until the posterior fontanelle can be felt.

Greater precision may be given to our opinions regarding the use of digital dilatation by the more recent advances of our knowledge regarding the changes which occur in the body and cervix of the uterus during the first stage of labour through the researches of Litzmann, Bandi, Braune, and Luschka. The lower uterine segment of the body of the uterus and the tissues of the cervix both undergo dilatation; but in the former the transverse expansion is associated with marked shrinking or shortening of its longitudinal diameter, whilst the latter is greatly stretched or lengthened. The division between uterine segment and the cervix, is what is known as the internal os, whilst the external os is what we recognize as the os of ordinary obstetric language. The distance between these, as shown by Braune's frozen section, may be as much as four inches. In normal labour the dilatation of the internal and external os go on simultaneously, the former slightly in advance of the latter. This relation, however, may be deranged. The internal os may be fully dilated whilst the external is very small. We cannot, however, get any degree of dilatation of the external os without the previous opening of the internal. The opinion I would advance is this, that digital dilatation can exert a beneficial action only upon the cervical tissue, we cannot by this means aid the

expansion of the lower segment of the uterine walls. So long, therefore, as delay is associated with incomplete dilatation of the external os, digital interference should not be employed; but when delay is due to want of dilatation of the external os whilst the expansion and retraction of the internal has well advanced, we may expect benefit from artificial means. The degree of dilatation of the internal os I believe we can estimate by the condition of the upper portion of the vagina. When the former is complete the latter also is fully expanded and drawn upwards. If the external os has not been simultaneously dilated, the cervical tissue will be felt stretching across like a diaphragm, with a varying degree of thickness and resistance. If, however, the internal os be not fully dilated the upper portion of the vagina will be found lax and attached near the os, or curving in towards it. Digital dilatation will then have no beneficial effect unless it be by stimulating the uterine contraction. But when the diaphragm is developed it will yield to judicious gentle manipulation; if the os be small by a rotatory action of the fingers; when once half-way dilated, and the head in actual contact, by support and gentle pressure of the lip in the direction of the occiput. A clear conviction should also be established that the cause of delay is in the cervical tissue only, and not due to want of rupture of the membranes, or to malposition of the head, to abnormal direction of the uterine axis, or to narrowing of the pelvic brim. Many cases of tardy dilatation are due to these causes, and of course cannot be aided by artificial dilatation.

By care in diagnosis the time when digital dilatation may be employed with advantage can be readily determined, and if practiced as I have indicated, with due regard to the mechanism of labour it may be employed with precision and safety. It affords material aid, increases the effective character of the pains, insures and facilitates the normal movements of the head, and if properly employed, is free from all danger to the patient. It is a proceeding, therefore, which merits recognition at the hands of obstetricians, more than it has hitherto received. By extending our aid in the first of labour by watching and furthering the normal mechanism, I am confident that we may very materially lessen the frequency with which in recent times instrumental interference is deemed necessary.—*Obstet. Journal.*

MANAGEMENT OF BREECH PRESENTATIONS.

BY PROF. THOMAS, NEW YORK.

Now comes the important point which I wish to make in connection with the case; and that is, that if you treat your breech presentations properly, you will seldom lose the child. If you will examine