or it will become directly posterior, i.e., the occiput will rotate into the hollow of the sacrum; occasionally it will remain obliquely posterior. Only about 2 or 3 per cent. of these cases rotate with occiput into hollow of sacrum, and this is usually brought about by the large fontanelle occupying a lower level than the small one; hence anterior rotation of the sinciput; consequently posterior rotation of occiput. If such takes place the child will be born in that way, with face to the pubis. In these cases the region anterior to the large fontanelle strikes the anterior portion of the pubis; then the occiput is slowly pushed over the anterior margin of the perineum, extension takes place and occiput falls over backward and justified that the overproduction of lymphatic tissue has been a brow. nose, mouth and chin appear successively under the symphysis pubis.

Only a very small majority end in this way. We have mostly to deal with the obliquely posterior, i.e., those cases with head lying in the right oblique diameter. For sake of clearness, I will divide these cases into two classes:

1. Those with good flexion or the one with the large fontanelle high up. The one with fontanelle lying opposite the acitabulum in the right oblique line. This is the more favorable variety in which the occiput always rotates to the front or can be easily rotated to the front by the hand. This is the one which, if left alone, will have the greatest chance of rotating spontaneously, since the occiput will strike the pelvic floor first and follow the normal law of rotation.

2. The one with head not well flexed. The anterior fontanelle in this case is low down and can be easily felt; there is extension here. This is the unfavorable variety. These are the difficult cases, and, if left alone, extension will become more acute, the sinciput will strike the pelvic floor first, anterior rotation of sinciput will take place, and it will end as a case of direct posterior occipital, or occiput into hollow of sacrum. Now, many of these obliquely posterior cases, especially the ones in good flexion, will rotate spontaneously; others can be easily rotated when making your diagnosis with hand on posterior ear.

A third class: the patient would have to be placed in correct position, chloroform given, and head grasped between the thumb and four fingers of right hand ,and during the interval of a pain rotate the occiput forward.

A fourth class: The head becomes so impacted, or remains so firmly in oblique diameter that it can neither be rotated nor pushed upwards with the hand. To this class, gentlemen, I wish