after labor. This was necessitated in many instances by the fact that the women were not admitted till after labor. Late suturing proved so satisfactory in these cases that it was adopted for practically all extensive lacerations. Granulating wounds were found to unite perfectly when closed without vivifying at any time before they began to cicatrize. In patients becoming septic union very rarely occurs, even under immediate suturing. The advantages of late repair in severe injuries are several. The character of the injury is better defined, the work is not obscured by the bloody flow from the uterus, a good light, plenty of help, and ample preparation are possible. Thus the work is more exact and complete, and restoration of the parts to their primal condition in nearly all cases results. When the wounds are repaired at the close of labor, often in insufficient light, at the time when the structures are more or less disturbed from their normal relations and the preparation inadequate, perfect restoration fails in a considerable proportion of cases.

The objections to late repair are that the patient is, perhaps, subjected to a second anesthesia, and that she is kept somewhat longer in bed. But these considerations are of minor importance.

The technique is substantially the same as that adopted by Emmet in the secondary operation, and in injuries not involving the sphincter is as follows:

Normally the posterior rests against the anterior vaginal wall. The centre point of its lower end falls just below the meatus. Catching the posterior wall with a volsella at its centre point close to the wound-surface, its lower extremity is held up against the anterior wall immediately behind the meatus. Thus a trough-shaped tear is developed, running up one or each sulcus as the case may be. The gutter-shaped wound is closed with interrupted sutures, introduced from the vaginal surface. Beginning at the upper angle of the tear they are applied in succession from above downward nearly to the skin surface. The other sulcus if torn is treated in like manner. The sutures are so laid that the loop or bight of each is nearer to the operator than the points of entrance and emergence. The plane of each is oblique to the suture line. This has the effect, as the sutures are tied, to draw upward the sagging pelvic floor. The sutures are tied as fast as placed. A shallow wound of little more than skin depth now remains on the perineal surface. This is best closed with interrupted sutures introduced from the skin side. The entire length of the suture-line is carefully examined, and at every gaping point, on skin or mucous membrane, a superficial suture is applied. The skin-sutures are subject to very little strain. The vaginal sutures