We were expecting to do a Cesarean section. So certain were we of operating that we invited a number of our professional confreres, who had expressed a desire to witness the operation. Much to our chagrin at the time and since, because we have been twitted about the matter by certain physicians, after being in labor for some hours, the head engaged in the pelvic brim, and my assistant, Dr. Calder, was able to deliver a small, but healthy, living child with the high-forceps operation. Practically all modern authorities agree that craniotomy is a brutal operation, causing not only the death of the child, but frequently that of the mother as well. In the only case in which I have resorted to craniotomy, I lost both mother and child.

Craniotomy is unjustifiable, except:

First.—Where the mother is exhausted by long labor, and undoubtedly septic from many vaginal examinations and futile attempts at forceps delivery.

Second.—Where the fetus is dead, or so feeble that it is not likely to live under any condition.

Third.—Where the fetus is a monster.

Fourth.—Where, from necessities of the case, either craniotomy or Cesarean section must be performed by unskilled hands, craniotomy is probably the safest operation for the mother.

And now, in conclusion, a few words on the technique of the operation. After the usual preparation of the abdomen with benzine and iodine, I have used a six-inch incision, three inches above and three inches below the umbilicus, through the right rectus muscle. Some of the authorities are advising that the incision be made wholly above the umbilicus to avoid adhesions between the abdomen and uterine wounds. In my cases I have been able to draw the omentum down over the uterine wound, so that there has been small chance of adhesions. I think, too, that my using a continuous Lembert for the uterine wound would obviate any danger of this complication. After opening the abdomen, a long gauze roll, wrung out of hot salt solution, is packed around the uterus to wall off the intestines, and prevent the amniotic fluid from gaining entrance to the abdominal cavity. My second assistant then presses the abdominal wall firmly against the uterus while I make a longitudinal incision into the uterus, to be enlarged either with a knife or scissors. The placenta, if presenting, is pushed aside, or may be cut through, a leg grasped and the child extracted. In my last case, as it was a breech presentation, I grasped the shoulder and extracted the head first. While handing the child to a sterile nurse, and clamping and cutting the cord, my first assist-