many a time in the future, and while the great present interest in the operation continues I dare say we shall hear of women thus delivered who have had several children before without assistance. One of the most pleasant features of the renaissance of pubeotomy is the blow it deals craniotomy upon the living child. Up to the present time we have been obliged, at term, to offer to the parents the choice of Cæsarean section and craniotomy in cases of contracted pelvis in which forceps or version was out of the question. In my experience—a large one in such cases—Cæsarean section has been refused, without exception, when the true comparison of risks was stated. In the future, with an operation at my command safer, easier, and usually quicker than craniotomy, I shall never again, I believe, do craniotomy upon a living child. The field of Cæsarean section must also be very greatly limited by our knowledge of pubeotomy. For the relative indication, at least, it will be displaced entirely.

Our next patient, who is now brought in on a stretcher, gave me yesterday a most peculiar history. She was delivered by forceps, four weeks ago, of a dead infant, after a labor of fourteen hours. She has had a number of children before, and all of her previous labors were remarkably short and easy. A day or two after the baby's birth, she noticed water escaping from the vagina, so that she was constantly kept wet. When she got out of bed and walked about, the flow became intermittent, gushing out at frequent intervals and in large quantities. Yesterday, as she walked across the ward, there was a sudden escape of water, making quite a pool on the floor, so that one of the other patients called to the nurse that the bag of waters had ruptured. On hearing this history I thought, of course, of a vesico-vaginal fistula; but the woman assured me that the water never had the odor of urine which was passed naturally, and this statement was confirmed by the head nurse. Nevertheless, I still suspected the presence of a fistula, but on a superficial examination I failed to find it. I shall now repeat my examination before you, and by care and persistence I trust we shall discover the source of this peculiar discharge. I first made a digital examination of the vagina. I find no trace of a fistula on the anterior wall; there is, however, the cicatrix of an extensive tear in the anterior and left lateral vaginal vault, that I shall test in a moment with the sound. The cervix is not much injured; the womb is in good position, well forward, of normal size, and movable.

I now pass a sound into the bladder, and sweep its tip carefully and slowly over the posterior wall and fundus, looking for an unnatural opening. As I reach the area corresponding with the cicatrix in the vagina, I am doubly careful, and follow the point of the sound in the bladder with my finger in the vagina. I discover, however, nothing like an opening. While thus engaged I notice some clear fluid trickling out of the vulva; I smell it on my fingers, but cannot detect a urinous odor. I shall now sound the uterus. I pass the uterine sound repeatedly through a cake of soap until I am sure that it is clean. In my office I should use a 50 per cent. solution of carbolic acid in glycerin. It is a matter of conscience with me to see that this instrument is clean before I employ it, which is not often. Having curved the end quite sharply, I slowly and gently pass the sound into the cervix, and then forward into the uterine cavity. It enters two and a half inches. I notice, however, a rough surface near the internal os posteriorly that needs investigation. I withdraw the sound, cleanse it again, straighten out the tip, and passing it through the cervical canal direct it posteriorly, using no force. It passes through an opening, and glides upward to a distance of four inches from the external os. At the same time there is a gush of this clear fluid. We have solved the mystery. This woman's uterus was ruptured in her last labor. The accident escaped the notice of the attending physician. The pelvic peritoneal cavity posteriorly was quickly shut off from the region above by adhesions. An encysted peritonitis or ascites developed, and hence the discharge. This condition after labor is not unheard of, but it is extremely rare. I shall trust to time to obliterate the cavity and close the opening in the womb. A more active treatment is uncalled for, as the woman has no fever and suffers no pain.*

The next patient is also a puerpera. Her

* The woman is now well. There has been no disch for several days.