method—the one advocated by Robert Barnes and followed at the Rotunda—will often fail. I would add that if this method is followed, ordinary forceps with a shallow pelvic curve or with no pelvic curve at all, are better than axis-traction forceps; for with the latter the head is apt to rotate forceps and all, and then the sharp pelvic curve becomes a disadvantage. Again the straight forceps gives a better grasp of the head when the occiput is posterior.

On August 2nd, 1904, I was asked to see a woman in consultation, who had been a long time in labor. The position was L.O.P. and had not been recognized. The vagina was dry and its tissues swollen. Forceps were applied with difficulty by one of the physicians in attendance, who exerted almost his utmost strength for about fifteen minutes, without advancing the head at all. I then introduced my right hand, freed the head from the brim by pushing it up, grasped the anterior shoulder within the uterus and rotated the back and then the occiput to the front. Keeping my fingers at the side of the head to maintain the position I slipped one blade of the forceps along the hand. The second blade was easily applied and delivery quite easy. There was a complete laceration.

On May 16th, 1904, I was asked to assist a physician at a case of delayed labor. He applied axis-traction forceps and made strong traction without advancing the head. I then made an examination and found the occiput to the left rear. I corrected this as in the previous case and delivered easily.

On September 30th, 1904, I saw another woman who had been in pretty severe labor for fifty-six hours. The uterus was so tightly contracted about the body of the child as to show its outline through the abdominal wall. Rotation in this case was difficult and extraction easy. There was an offensive odor to the discharge at the time of labor, and gonococci were found in it. Ten days later this woman died of septicemia.

In another which I saw on November 16th, 1904, the forceps had slipped several times and there was considerable laceration. The skull of the infant was fractured and there was large effusion of blood beneath the scalp, simulating hydrocephalus. Delivery was easy in this case also after rotation.

I could multiply instances, but it is not necessary, and I shall content myself with giving the history of one case in which I practiced early interference, manual rotation and extraction with forceps.

I diagnosed the position O.D.P. by abdominal palpation a week before labor set in. Labor began with the escape of the waters, and the pains rapidly became very severe and the intervals short. At the end of five hours the os was less than a shilling in size, but the cervix was taken up. I dilated under