and properly and thoroughly repaired, without delay. It requires the union of a very small amount of tissue in front of the rectum to obtain control of the lower bowel. But this tissue must be well banked up in front of the rectum after the mucous membrane has been united, in order to approximate the separated ends of the sphincter ani muscle. These ends need not be approximated exactly, so long as they are closely united in a body of scar tissue that will close up the circle of the sphincter, or, in other words, that will repair the elastic band that has been broken. The essentials of success are that we should have a non-capillary suture that can be rendered aseptic, is non-absorbable, and is strong enough to allow the very tight constriction of the tissues. By such a strong suture, we are enabled to draw the tissues of the pelvic floor firmly together and, in this way, to prevent wound infection. We must see to it that these sutures do not penetrate the rectal wall.

The rectal wall itself must be carefully sutured with absorbable or non-absorbable sutures, according to the fancy of the operator. The tissues must be well banked, as I have already stated, in front of the rectum, if we hope to obtain control of the bowel by the torn sphincter. We must endeavor to guess where the torn and retracted fibres of the sphincter are, and to approximate these points. A pair of forceps should grasp these deep structures so that they may be raised while the suture is passed deeply into them.

The bruised and blackened tissues must be pared off and continual irrigation should be used during the operation. The amount of pain is slight and the parts may be found to bleed freely at first, but the operator must not be alarmed. Suture pressure will soon stop all hemorrhage. Irrigation plays a very important part. It gives great protection to the patient. The wound is liable to be infected from the rectum or irritated with the urine, and such infection or irritation must be much lessened by the running water. The bowels should be moved daily by enema. It is bad practice to allow fecal matter to collect from day to day, until at last we have a very large formed stool to come through the recently repaired sphincter.

Urine should be drawn by glass catheter for two or three days, after which time it may be passed with safety, provided the parts are protected with some sterilized vaseline or zinc oxide ointment, and wiped off with sterilized gauze. When the laceration is not complete, the operation for its repair should be very complete. Unfortunately, insufficient attention is paid to this fact. Every obstetrician should carry a good perineum needle and some first-class silkworm gut. Much of the gut sold is not strong enough for this work. I always use a superior quality, and when tying it always use the first part of the surgeon's knot, so that the loop will not slip when it is tightened or until the second knot is tied.