and three silver wire sutures, the former lying within the vagina, the latter being secured by perforated shot, which lay close together on the perineal surface. This patient lived in town, and was under the care of a moderately well-qualified nurse, so that although affected with atony of bladder and requiring catheterization every eight hours, she progressed favorably to recovery. Bowels were kept regular by aid of pulv. glycyrrh. co. and enemata. The result was all that could be desired, although convalescence was retarded by hasty removal of patient to another room during great excitement caused by a fire in the building.

Case E.—Had a previous miscarriage at third month, and had reached term in second pregnancy. She resided ten miles from town; and when I arrived the liquor amnii had escaped, while the pains had been strong and frequent for a period of about seven hours. Occiput was almost directly in the hollow of the sacrum, and I barely succeeded after placing patient in genu-pectoral posture, in rotating head to first position. Patient was extremely nervous and unmanageable; the attendants fearful of chloroform, allowed her to inhale just sufficient to make her restless; the consequence of which was that with the final expulsive pain, until which all had gone well, she drew up the thighs, abducted them strongly and induced a slight tear of perineum. After delivery I introduced three sutures of ordinary linen thread, previously soaked in a sublimate solution; removed them the 6th day and found union complete. In this case also, bowels were kept relaxed and the urine evacuated while patient knelt over the vessel on the bed.

Case F.—A primipara, æt. 40, labor powerless, head presenting in fourth position. Short forceps were applied by consulting practitioner and direct efforts at traction used. I advised patience and at the same time suggested that the operator pay attention to the arc described by the handles at each pain. In the course of a few minutes, the head assumed the second position and delivery was effected. My attention was drawn to the laceration subsequently, and an operation was performed six weeks after delivery, two catgut sutures being used in the vagina, and two wire sutures being employed on the perineal surface.

Whether owing to imperfect asepticism of catgut sutures or some other cause, considerable irritation was set up by them subsequently. A shallow pocket was left just within the introitus, and a slight tendency to rectocele still exists in this case.

Case G.—Resided at a distance of seven or eight miles from town, and was attended during a season when roads were almost impassable, owing to drifts, in consequence of which the subsequent watchfulness, which is so necessary especially when the patient is under the care of an unskilled nurse, could not be exercised in her behalf. She had been afflicted for two or three days prior to accouchment, with a severe diarrhœa, making it impossible to preserve even an appearance of asepticism during delivery. Pains had been severe during the passage of the head through the brim and into the cavity of the pelvis. Head presented in the l. o. p. or fifth position. Uterine contractions were very strong, and after making several efforts at rotation by aid of right or posterior blade of long forceps over left parietal bone of child as a fulcrum, with first and second fingers of right hand pressing right aspect of forehead in the opposite direction. I concluded to administer chloroform and try rotation with the short forceps. I withdrew the blade which I had been using as a vectis, and had hardly given the patient half a dozen whiffs when a violent and prolonged pain occurred, accompanied by retching, and suddenly before I could resume my position at the bedside, the head was expelled. On examination I found a complete laceration (involving sphincter ani) extending upwards in the septum about $\frac{7}{8}$ of an inch. One or two hæmorrhoids were hanging in the rent while, the hæmorrhage and intestinal contents obscured all the parts involved.

I was unprepared for the emergency, and at all events the septic material, butting the wound would probably have prevented union.

After washing vagina and rectum out with a carbolated solution, I introduced two deep and two superficial sutures, tying them on the perineal surface. Nothing but a double cotton thread and ordinary sewing needle were available.

In company with a young surgeon, I visited the patient on the third day, and operated after the manner advised by Tait, turning one pair of flaps made by splitting into the rectum, the other into the vagina. Catgut sutures were used for the