senting foot and delivered it with a good portion of the breech. After some difficulty the second foot was brought down. As the child was presenting with its abdomen anteriorly—a threatening position for the child—I seized both feet and rotated the body of the child on its long axis, so as to get the dorsum anteriorly. The chair was now removed and the patient dropped to the level of the bed, so as to facilitate further manipulations. The shoulders and arms gave rise to considerable difficulty in their delivery, and the right humerus was fractured in the forcible efforts used. The head—using the Prague method—was readily extracted. After being born the child was found to be cyanotic and in a condition of suspended animation, although the pulsations of the cord were quite strong. Muscle tonus being distinctly present, the cord was quickly cut, allowing a little blood to escape from the fœtal end. A little shaking up, after clearing the throat of mucus with the finger, was sufficient to start respiration, and shortly afterward the child began to cry. The mother, in the meantime, was losing considerable blood from a partially detached placenta. Efforts at expression failing, I was obliged to resort to the manual removal of the placenta. After an intrauterine douche and a dose of ergot the mother was turned over to the midwife. The baby was found to weigh ten pounds. A plaster-of-Paris splint was applied to the broken humerus. Mother and child made an uneventful recovery.

There is no doubt in my mind but that the elevation of the pelvis in this case was entirely successful in keeping the prolapsed cord out of harm's way until delivery was completed, and was chiefly instrumental in saving the child's life. At least six inches of cord presented in advance of the child's foot. If left to nature the cord would have come down more and more as the child's body advanced. Compression would have taken place to such an extent as to have cost the child its life.

CASE II.—Mrs. F., æt. 28, third confinement. Previous labors fairly easy. The midwife after being in attendance the entire day, went off for an hour. On her return she found the membranes ruptured and a large loop of the umbilical cord in the bed. On my arrival, about an hour later, I found about twelve inches of prolapsed cord in bed and a complete absence of labor pains; the cord pulsated one hundred and fifty times to the minute. On internal examination the os was found fully dilated; the right hand presented, and above this could be readily felt the face with the chin posterior. A hopeless prognosis as to the child was given. Immediate action was indicated in the interests of the child, so that anæsthetics and assistants were dispensed with. The foot-piece of the bed being about eighteen inches above the place of the bed proper, an incline was quickly made with a washboard and an ordinary piece of board. These were covered with a pillow and the woman drawn up the incline so that the pelvis was elevated. Seizing the cord with the hand, it was pushed back into the uterine cavity. The presenting hand and face were now pushed to one side and the foot drawn down. The cord again presented to a small extent and remained prolapsed during the remainder of the manipulations. The opposite foot was next delivered, then the shoulders, and finally the head. The entire manipulation did not exceed five minutes in duration. The child was born asphyxiated to the first degree, but the escape of a little blood from the divided fœtal end was sufficient to resuscitate it. Both mother and child were doing nicely on the following day.

The second case was not as perfectly successful as the first in the complete reduction of the cord. This I attribute to the long duration of the prolapsus (probably an hour and a-half), the considerable length of the cord prolapsed, the absence of a sponge to keep it in the background, and the absence of anæsthesia and assistants. The fact that the child was notwithstanding born alive is all the more marvellous. I was very much impressed in this case with the ease with which the prolapsed hand and face were turned to one side and the podalic version performed. I cannot help thinking that the elevation of the pelvis proved of great value in bringing about the happy result.

Since the above was written another case was met and treated in a similar manner. The history in brief is as follows: A woman in her second confinement was taken with a slow labor on the morning of November 7th. The midwife who was in attendance all day, noted very little progress. Toward evening, with the os dilated to the size of a fifty cent piece, the membranes ruptured and a loop of the umbilical cord presented in advance of the vertex. An hour and a-half later, when I arrived, I found a highly hysterical woman with feeble labor pains. An examination revealed a somewhat contracted pelvis, a cervix not fully dilated, a vertex presentation with head movable, above the brim, and, in the vagina, about six or eight inches of pulsating umbilical cord. Under chloroform anæsthesia, given by Dr. M. Cisin, the patient was drawn up an improvised incline at the foot of the bed, so that the pelvis was elevated to a height of eighteen inches, and the legs and thighs kept extended (Walcher's method). After a little difficulty the cord was pushed back into the uterine cavity and kept back with the aid of a sponge which had previously been boiled. Forceps was applied, but the movable condition of the head and the somewhat diminished conjugate diameter decided me, in the interests of the child, to relinquish them and resort to version. There was no especial difficulty in pushing up the head and getting down a foot, but during the manœuvres