jugate, $3\frac{3}{4}$ inches; Conjugate vera, 3 inches (estimated). By vaginal palpation the promintory could be easily reached. The sacral alæ projected forward into the brim, thus causing a sharp bend in the posterior part of the iliac bones. The lower part of the sacrum and coccyx were sharply bent and projected forward into the pelvic cavity. The pubic bone was thickened in its upper part, further tending to obstruction of the pelvic inlet.

Diagnosis.—A diagnosis of flat rachitic pelvis with marked obstruction of the inlet, was made. An attempt was made to bring the fœtal head into position over the pelvic inlet but without success, as the head seemed to be particularly large.

In view of the peculiar projection into the brim of the alæ of the sacrum and the posterior parts of the iliac bones, and the sharp forward bend of the lower part of the sacrum and coccyx, it was deemed imposible to deliver the child through the natural passages, and therefore it was thought best to recommend Cæsarean section in preference to symphysiotomy. Accordingly, that afternoon the patient was removed to the Royal Victoria Hospital and placed under the charge of Dr. William Gardner.

Report of the operation.

The case was ideally favourable for the saving of both mother and child and conservation of the uterus. The woman was pregnant to full term and had been examined only by Drs. Morphy and Evans besides myself, in each case presumably with aseptic precautions. She was admitted to the gynæcological ward of the Royal Victoria Hospital on the evening of one day. At four o'clock the next morning labour had commenced. Fœtal heart sounds could not be heard, but movements were unmistakable. At eleven o'clock of the morning of the same day when operation was commenced, the os was of the size of a silver dollar. No attempt of any kind to deliver had been made and the temperature was normal. The operation was thus, in the full sense of the word, elective. I was most ably assisted by my colleague, Dr. Garrow of the Surgical Department, and Dr. Casselman, my House-Surgeon.

The incision in the abdominal wall, six or seven inches long, was two-thirds of its length below and the other third above the navel. In doing this my experience amply bore out that of others—how easy it is to wound the uterus. One comes unexpectedly soon through the abdominal wall. Palpation before operation led to more than a suspicion of anterior implantation of the placenta. Palpation of the exposed uterus showed that this was beyond a doubt. Statistics show this position of the placenta in 50 per cent. of the cases.

Dr. Garrow making pressure on the abdominal walls around the uterus,