sutures were not always removed. *Re* Case 2, he wished to ask how long should such a fracture be kept in plaster before resorting to more radical measures.

Dr. O'Reiley said that in this case of consultation of staff, they had decided that six weeks would be sufficient time for plaster.

Dr. Cockburn agreed with writer on continuous irrigation in separation of joints. He thought that modern surgical technic would justify cutting down, and immediately suture in simple cases.

Dr. Baugh referred to aluminium wire.

Dr. Wallace referred to use of kangaroo tendon. He also referred to the case of the Prince of Wales when the conservative methods had been adhered to, notwithstanding adverse continental criticisms, and with good results.

Paper II. Dr. White read a paper on occipito-postero presentations. Diagnosis and management important owing to danger to child and injury to mother. Diagnosis often difficult owing to compression of head in pelvis masking sutures, and often presenting large scalp tumors. In such cases position of child's ear and information gathered from abdomen, assists us in making the diagnosis. When diagnosis was made sufficiently early we divide cases into two classes: First, Roomy pelvis, flexion good, head readily engaged, strong contractions. In these cases the only treatment necessary is to maintain flexion by external pressure. Keep fœtus compact, delivery natural, but slow. Second, In other cases disproportion between head and pelvis, weak pains, projection of promontory of sacrum, small quantities of amniotic fluid, difficult labor, especially in primipara. In such cases various methods of treatment are advised:

(1) Prophylatic knee clust position. (2) Manual rotation of head forwards under anesthetic, with or without forceps, internal and external manipulation. (3) Pedalic version advised in multipara, and for inexperienced operators. (4) Temporizing and interference only when natural efforts seem to be failing. (5) High forceps delivery found to be most valuable.

B. When diagnosis is made out later, in the second stage we find two classes of cases: First, easy cases; when head is well flexed descends to pelvic floor, when rotation voluntary takes place and head is born; secondly, smaller groove, very difficult, head impacted. In these the following methods are used: (1) Flexion by manipulation. (2) Rotation with forceps. (3) Apply forceps and pull—apply to sides of pelvis, trunk or child's head.

If above methods fail afterwards resort to symphyseotomy, cecarian section or craniotomy. Some rare cases of occipito-