POSTERIOR POSITIONS OF THE OCCIPUT.

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In spite of the forces which tend to bring about the O. L. A. position at the brim, the occiput, in a certain proportion of cases, is directed posteriorly; and in a great majority of these cases the back is to the right. The head descends into the cavity in this position, and when the occiput reaches the pelvic floor it is rotated to the front in accordance with the law of internal rotation that "that part of the fetus which touches the pelvic floor first is rotated to the front." Rotation thus occurs late in labor, and, as it is through three-eighths of a circle instead of through one-eighth, as in anterior positions of the occiput, labor in this position is always tedious. In order that rotation may take place at all good flexion is necessary (unless the pelvis is very large or the head very small), because, as the occiput rotates from the rear to the front it is obvious that at some time during the process the long diameter of the head must be in the transverse diameter of the cavity. This diameter is about 4½ inches in the dried pelvis, and with the soft parts in place is rather less. With good flexion the diameter of the fetal head engaging in it would be the sub-occipito bregmatic—3¾ inches. With poor flexion it would be the occipito-frontal—4½ inches, which could not pass the transverse. Under these circumstances the occiput is rotated still further to the rear under the influence of the inclined planes of the bony pelvis, and the head has to be delivered in the occipito-posterior position. It is of these cases in particular that I wish to speak. Many minor measures have been recommended in treatment, most of them useless. There are two main lines of treatment to-day: (1) Leaving the case to nature as long as we can, and delivering with the forceps if rotation does not take place; (2) Manual rotation of the occiput to the front. Hitherto I have pursued the former of these courses, but further experience leads me to prefer the latter, because (1) labor is nearly always long and exhausting; (2) a much greater degree of force is required to deliver with the forceps in this than in anterior positions of the occiput; (3) the forceps are very apt to slip—all three of which factors tend to kill the child and injure the mother. I think a large part of the danger to the child is due to the pressing of the forehead against the symphysis, a danger which is increased by the fact that in this position the forceps tends to undue flexion. If they must be used they should be of the axis-traction pattern, and one should draw slightly posterior to the ordinary axis of traction.