The advisability of an early recognition of the position and presentation of the fœtus is a point upon which, I am sure, we are all agreed, but there does not appear to be a very general adoption of the plan of determining this matter by abdominal palpation, before labor has commenced. With a little practice anyone can become proficient in the diagnosing of position and presentation by this method, and while one will at times make mistakes or be unable to come to a definite conclusion, the errors and failures are infinitely less than by the ordinary vaginal examination during labor, while the information is obtained before labor has started which not infrequently is a matter of great importance. It is a fact that the position and presentation found by abdominal palpation a couple of weeks before labor not infrequently changes before the beginning of labor and the value of the information obtained thereby would appear therefore not to be great.

I have watched this phase of the question somewhat closely for some time, and find that the changes which occur in the last week or two, are in the vast majority of cases from what one might term abnormal to normal positions; thus while I have not infrequently seen a posterior position change to an anterior, and in a few instances a breech turn to a vertex, I have but rarely seen the reverse take place, so that I can feel reasonably certain that an anterior position will still be an anterior at labor, and if the suspected posterior has already rotated so much the better for my patient.

On the other hand I must confess that I do not like to place much reliance on the ordinary vaginal examination *early* in labor, while in difficult cases accurate diagnosis may be much interfered with later on by the formation of a caput succedanum.

The routine use of abdominal palpation in the latter weeks of pregnancy for the recognition of positions and presentation, will demonstrate to anyone that occipito-posterior positions are far more frequent than we are usually taught, and my experience with such cases has been that failure to recognize such a position is responsible for as much difficulty during labor and invalidism afterward, as nearly all other complications put together.

I therefore feel that anything which will assist us in the early recognition of malpositions, because it is upon that that successful management depends, should be made a part of the routine management of every case.

To avoid delay at the time of the physician's first visit it is well to instruct the patient to take an enema, followed by a full warm bath as soon as she is satisfied that she is in labor; the nurse completing the preparation by disinfecting her from the umbilicus to the knees with whatever solution the attending