into bed, covered the intestines with an old night shirt, and sent for the doctor. The woman reached the hospital in a critical condition. Temperature sub-normal, pulse 128, very thready, face anxious, extremities cold, showing considerable shock. She was immediately put under an anæsthetic. On the binder and dressing being removed, she presented an appalling sight. A full term pregnant uterus, a ruptured abdominal wall, a huge mass of black, lymph-covered, intestine, larger than a common pail, which covered the left lower abdomen and thigh, hanging down to the table, made a picture not pleasant to look at. The intestine was flushed off with hot water, and covered with hot towels. The abdomen was then rapidly opened in the middle line and Cæsarean section made. A child was delivered alive, and the incision closed as rapidly as possible after sponging out the abdomen. Thanks to good assistance this was finished in fourteen minutes, and then the inguinal ring was incised, the intestines separated, cleaned and returned to the abdominal cavity, which was flushed out and left full of hot saline. The inguinal ring was closed with kangaroo tendon, and the patient returned to bed. She was rather badly collapsed, but picked up rapidly after an intravenous injection of hot normal salt solution. She made an uneventful recovery, except for a broncho-pneunomia, which she developed on the fifth day. However, she left the hospital with her baby at the end of the fifth week.

CONCLUSIONS.

1. Cæsarean section is a much less dangerous procedure than we considered it a few years ago.
2. Rapid operation is a great factor in these cases.
3. Early operation, if possible, before exhaustion of patient or rupture of uterus.
4. Advisability of careful examination of all obstetrical cases by the family physician, especially with cases where there is a possible rickety history.
5. Cæsarean section is a much safer procedure for mother and child than a high forceps operation.