2. On July 21st, 1875, I attended Mrs. T., Miles Road, in her third confinement. The labor began at 4 a.m., on July 31st. The first stage was tedious, and, for four hours after the membranes were ruptured, the head remained high up in the pelvis and the os was scarcely dilated to three inches in diameter. As no progress appeared to be made, I applied the long forceps, and, after some difficulty, delivered her of a very large male child, alive and vigorous. The os was dilated to about three inches in diameter when the forceps was applied, but it did not present any difficulty, as it was soft and dilatable. She recovered well.

3. On June 28th, 1876, I attended Mrs. C., Clifton Park Road, in her first confinement. Labor began at 4 a.m. on the day previously, but the os uteri was very rigid, and, though there had been regular pains throughout the day, it was not dilated larger than a shilling at 10 p.m. I was called up to her at 1.30 a.m. The membranes had just ruptured and the pains were much stronger, but the os was not larger than a half-crown. I then felt the anterior fontanelle towards the right acetabulum, and by pressure on the right parietal eminence, succeeded in bringing the occiput round to the left acetabulum. The os uteri still continued very rigid, and by 7 a.m. was not larger than a crown-piece. I therefore used Dr. Barnes' long forceps, and, after some time and trouble, delivered her of a large male infant, alive and well, about 8.45 a.m. The pelvis was not very roomy. Some *post partum* hemorrhage followed. It was restrained by cold, pressure, and ergot. The perineum, notwithstanding careful support, was lacerated near to the sphincter. I therefore used three wire sutures. The tear healed by the first intention, and the patient made a good recovery.

4. On September 3rd, 1876, I attended Mrs. S., in Caledonia Place, in her first confinement. She was a blonde, tall, robust in make, and about 36 years of age. Labor commenced five days previously, and the pains of the first stage continued at intervals all that time. The os uteri was rigid and yielded very slowly. About 5 p.m. on Sept. 2nd, it was dilated to the size of a crown. About 9 p.m. it had dilated to the size of the bottom of a tumbler, or a little over two inches in diameter, and the membranes gave way. The pains were regular, but not very frequent. The os uteri continued in much the same state until the next morning, the head being in the pelvic cavity. I could not reach the ear, but I could feel the great fontanelle opposite the right acetabulum. The os uteri was now about two inches and a half in diameter. As the labor had become very tedious, I applied Dr. Barnes' forceps, and, after about four hours, delivered her of a large male child that had apparently been dead for some hours. I concluded that such was the case, because the liquor amnii was much colored with meconium, and the skin had peeled from a considerable part of the head. The patient made a good recovery.

The above cases, it will be observed, corroborate the testimony which Dr. Johnston has given in favor of the employment of the forceps, under certain circumstances, during the first stage of labor. In all, the result was good as regards the mothers, and also the children, with the exception of No. 4, in which the child was still-born; but, in this case, the death of the infant appeared to have occurred before the forceps was used. It will be observed also that, in one case (No. 2, a third confinement), the delay in the labor did not arise from a rigid os, but from a disproportion between the head and the pelvis, causing the head to be arrested at the pelvic brim. The diameter of the os uteri did not exceed three inches, simply because the head did not press down sufficiently upon it after the waters had escaped. This incomplete dilatation of the os uteri in cases of contracted pelvic brim has long been familiar to accoucheurs, and has not been considered to be an obstacle to the performance of craniotomy, or even to the careful employment of the long forceps. It is far different, however, in the other three cases, which were primiparæ, and in which the insufficient dilatation was the result of the rigidity. In these, the forceps would have been formerly considered to be quite inadmissible, mainly, no doubt, for two reasons: first, because the dangers and difficulties attending its use are much greater in the first than in the second stage of labor; and, secondly, because as Dr. Churchill's statistics show, a protracted first stage is not *per se* dangerous either to the mother or the child He admits, however, that a protracted first stage may, by inducing fatigue and exhaustion, act unfavorably on the second stage. I had once a well-marked instance of this kind. The patient, a primipara aged 30, had been in labor five days before the os uteri became dilated to the size of a crown. The anterior lip of the rigid os uteri then gave way, and a considerable rent took place. The second stage went on well for a time, until the pains almost ceased from sheer exhaustion. I then applied the forceps and delivered her, but the prostration which ensued was so great that the patient nearly lost her life. In this case all the usual remedies for relaxing the os uteri had been tried, but without effect. I have little doubt that, if the forceps had been applied during the first stage, the result would have been much better. One great object in using the forceps is to anticipate evil rather than to remove it when it exists. Before adopting craniotomy, the accoucheur should be satisfied that urgent symptoms exist which render prompt delivery imperative. With the forceps, however, it is far different. It is so safe