From the above sketch we will readily see that the maternal mortality in properly selected cases is very slight; 401 cases collected by Korn showing a maternal mortality of only 2.9 per cent., or just a trifle more than normal labor in a normal pelvis, while the fœtal mortality ranges from 20 to 70 per cent., the average being about 33⅓ per cent. So in this operation we have a means of saving about two-thirds of the children without any risk to the mother. On reckoning by Dohrn's method, we save at least twice as many children as if we allowed the woman to go on to term and then resorted to some conservative operation. These are the prospects of the operation, but unfortunately the degree of contraction within which the operation is justifiable is very limited, and one can only think of it in moderate degrees of contraction, according to Litzmann in flattened pelves with a conjugata vera of 7.5 to 8.25 cm. (3 to 3.25 in.), and to Schroeder, 6.5 to 9.5 cm. (2.5 to 3.75 in.). As pelves with a conjugata vera above 8 cm. (3⅛ in) offer a reasonable chance to both child and mother at term, and those below 7 cm. (2¾ in.) offer no chance to the child, I think that the operation should be restricted to these limits; that is, between 7 and 8½ cm. (2¾ to 3⅜ in.) in simple flattened pelves. In the justo-minor pelvis a conjugata of 9½ cm. (3¾ in.) or less will usually be an indication for the operation. In the rare forms of obliquely narrowed pelvis, whatever its cause, we must be guided almost entirely by the history of the previous labor. We thus have the operation restricted to a very small range, 1½ cm. (⅝ in.), which should only be exceeded when the previous history tells us that the previous labors have all ended disastrously. We should not think of inducing labor in a flattened pelvis with a conjugata below 7 cm. (2¾ in.), for in that case the prospects for the child are almost *nil*, and the dangers to the mother greatly increased. Here we come to the relative indication for Cæsarean section, when it is best to allow the woman to go on to term, and attempt to save both mother and child by that operation.

With these contracted indications we readily see that an accurate idea as to the exact size and form of the pelvis is an absolute pre-requisite for the performance of the operation; and the only means by which we can accurately obtain this information is by carefully measuring the pelvis. We should not content ourselves with simply measuring the conjugata vera, but should also take the external measurements, and thereby attempt to determine with what form of pelvis we have to deal. After doing that, we must carefully examine the interior of the pelvis to determine its height; to see if it is generally contracted; and if contracted, if the contraction increases as we approach the outlet. We must look for exostoses of the pelvic bones, and carefully examine the promontory to see if it is double or not. If we think the pelvis contracted laterally, we should measure the distance between the tubera ischiorum on each side, as Breisky recommended. We should also attempt to estimate the transverse diameter of the pelvis, which is most difficult to do, and the most that can be expected is to examine alternately with each hand and try to stroke the linea innominata, and so relatively to get some idea as to the transverse diameter.

Having decided that an operation is necessary, the next question is, when shall it be done? Of course the younger the fœtus, the smaller will be its size, and consequently the easier its delivery. But, unfortunately, the smaller the fœtus, the less chance will it have of living, even if it survive the operation. Generally speaking, we say a child is viable after the twenty-eighth week, but its chances of living are almost *nil*; indeed, children thirty to thirty-two weeks old have next to no chances of living. The later the operation, the more chance has the fœtus of living after it, but unfortunately its size and consequently the difficulty of its delivery increase with its age. If possible the operation should be done about the thirty-fourth to thirty-sixth week, our object being to operate at the latest possible period consistent with safe delivery. To fulfil this object, we must attempt to gain an accurate knowledge as to the size of the child's head. Unfortunately we are unable to determine its size with mathematical precision, or even with the relative precision of pelvimetry; so we are obliged to take advantage of every possible hint on the subject. Some of the following points may be of assistance in different cases. We must consider the mother's account as to the duration of the pregnancy; notice the size of