ther factors are the age of the patient, want of elasticity in the perineum, and disproportion between the size of the fœtal head and the maternal parts.

From the side of the child the causes are numerous, altogether aside from congenital vice and abnormalities. Regarding the head, there is a difference of opinion. Hecker and some others maintain that a small head is more liable to cause rupture, as it escapes more rapidly; whereas a large head slowly distends the parts. It seems there is frequently a difficulty in telling whether the laceration is due to the head or the shoulders, but any part may cause rupture. The *direct* causes are, of course, precipitate labor, retarded labor, injudicious use of ergot and of the forceps, etc.

With regard to the means resorted to for the prevention of rupture, the old-fashioned recommendation to supprt the perineum has, I believe, in injudicious hands, frequently been the cause of the trouble it was thought to prevent. Neither do I agree with the practice of greasing the parts. I regard those means only to be rational which are directed towards retarding too rapid labor, and securing more time in gradually dilating the introditus. I have spoken of the injudicious use of the forceps as a frequent cause of rupture; on the other hand, I have the utmost faith in their efficiency to prevent laceration, when skilfully and properly used. We have no means in our possession equal to the forceps, for controlling the course of labor, gradually dilating the soft parts, and safely guiding the head over the pelvic floor. So much so, that I am accustomed to regard the perineum as safe when I have the forceps. They should be applied in cases where rupture is threatened, before it is too late; and in no case should they be removed until the head is completely born. I pass over the subject of anæsthetics, powerful factors though they are in the prevention of perineal rupture, and merely refer to the practice (but seldom resorted to, I trust) of making incisions, only to condemn it. Of manipulating, or kneading and stretching the perineum, the best plan is that recommended by Mekerttschiantz. When the presenting part appears at the vulva and distends the frenulum, the left hand is placed over the woman's right thigh and with the palm turned towards the child, the thumb grasps the right labium and the middle finger the left, and by pulling these together, they are relaxed. The head is thus slowly allowed to distend and expand the vulva. This method I have tried in a number of cases, and believe it to be really efficient.

After the completion of the third stage of labor and the discovery of a laceration, the question of treatment must be immediately considered. This will depend in some measure upon the extent of the lesion. When complete, extending through the sphincter ani and involving more or less of the recto-vaginal septum, there are few who oppose an immediate attempt at repair and suturing the parts together in more or less perfect contact. But considerable difference of opinion exists as to the treatment of incomplete lacerations, and considerable difference of practice obtains, even among those that believe in the immediate operation.

It has been argued that these lacerations heal readily and satisfactorily when perfect cleanliness is observed, and that even when the restoration is imperfect, it does not lead to prolapse of the vagina or uterus; for, as maintained by Emmet, the uterus is swung from above, and not supported by the perineum below. It is also claimed that the symptoms usually attributed to the loss of the perineum bear no relation whatever to the extent of the injury, and that there need be no fear of immediate danger resulting from leaving the lesion unsutured. Adherents of this practice maintain that lesions occurring elsewhere in the pelvis are the sole cause of trouble, whether showing itself immediately, or at a later period; that it is a needless infliction of pain to a woman who is already worn out and exhausted, and that even when the primary operation is performed, it is far from being invariably successful.

The tendency of the times, however, is rather to the opposite extreme—to the suturing of even the slightest tear. And to the objectors we may reply, that stitching is not so severely painful, even in the absence of anæsthetics, as the condition of the parts is one of more or less analgesia. It is moreover amply proven that restoration of the perineum favors involution of the vagina—a result of prime importance. Nor should it be forgotten that the chances of septicæmia are certainly much lessened by the operation It is our duty to give the patient every chance of obtaining a perfect recovery, especially when the operation is so simple, so easily performed and so generally successful, and when