If you contrast the mechanism in an occipito-anterior position with an occipito-posterior one, you will see at a glance they are exactly antipodal to one another. In the former, everything is favorable for quick and easy delivery; the occiput, which must first emerge at the vulva, has but a short way to travel to reach the pubic arch, the least resistance is offered to the advancing head through friction, and the uterus is transmitting its forces in the most effective way through the spinal column and breech of the child in the axis of the entire fœtal ovoid.

In a posterior-occipital position everything is the reverse; the occiput has the longest route to travel from the sacro-iliac synchondrosis to the pubic arch—at least three times as far—the greatest amount of friction is thus necessarily produced, preventing the onward progress of the head, and the uterus is acting to a great disadvantage. In all cases when the dorsum of the child is backwards, the forces are directed posteriorly instead of anteriorly, a large amount is lost on the sacral structures, and it follows in those where rotation does not occur but the occiput is born posteriorly, that the head is only slowly and imperfectly propelled because the uterine forces, instead of passing through the head as part of the general ovoid, pass out of the ovoid at the nape of the neck. And yet these labors are called natural in our text-books, while to my mind they are dissimilar in almost every respect, and they might well be placed under the same heading as preternatural labors.

Now in regard to the treatment: Some writers, as West, recommend upward pressure on the os frontis to assist flexion; in some cases this simple plan is effective. Hodge advises traction on the occiput with the vectis or fillet so as to cause flexion. Galabin also advises the vectis; this also sometimes succeeds, but not always. There are some who do not say one word about the treatment, simply leave all to nature, and when she has failed, then apply the forceps. Smellie advises rotation to be made early by the forceps. Burns advises rotation by the fingers. Leishman advises the forceps when the head is free at the brim. Barnes admits that in the majority of cases to which he has been called to apply the forceps the delay was due to the occipito-posterior positions, and it is just with the view of preventing a long painful, tedious labor that I would like to see some definite plan adopted as regards the early rotation of these positions whenever opportunity offers of so doing. Warren Bricked once made the following statement which so exactly agrees with my notions that I am induced to copy in full his words: "Because a woman can deliver herself in occipito-posterior positions, we are not necessarily to expect her to do it—on the contrary, for the sake of both mother and child, we had better presume that she most probably cannot. If we see the case early, therefore, let us use early exertion to convert it into an anterior position. If we fail, or if we have not had the privilege of the effort, let us not, under the happy conviction that she is in natural labor, permit her to extend the extraordinary efforts which are necessary to deliver herself.

"Realize fully that before you is a patient suffering far beyond the prevailing demand in order that she may extrude her child, that the extraordinary pressure and effort to which she is subjected tell of more than possible evils to her, and that the distortions and pressure to which the child is subjected only too frequently result in death, or long, protracted, and distressing suffering. Realize these things, and help your patient."

For my own part, whenever I am fortunate enough to see my patient early in labor and before the rupture of the membranes or even after and before the head has descended very low into the pelvis, before the shoulders have engaged the brim, I give my patient chloroform sufficient to quiet all resistance, and then carefully disinfecting my hand and oiling it, cautiously introduce it wholly into the vagina, taking great care not to injure this part by undue haste, and pass it on till I reach the head, then, seizing it between the points of my fingers and thumb in the interval between a pain, I rotate the occiput forward. This is very simply done, especially before the rupture of the membranes—I then leave it to proceed as a normal case of labor.

Even after the head has engaged the brim, it is easily done, providing the shoulders are