ed to 34.4 per cent. He is in favour of hebosteotomy taking its place in obstetrics, as he believes it is a safe procedure for both mother and child. The operation does not interfere in any way with walking or working, and in many there is a permanent increase in the size of the pelvis.

Scheib reported a case that had died from atonia uteri twenty-seven hours after hebosteotomy. The woman was a primipara, aged 39, with a slightly assymetrical flat rachitic pelvis (conjuguta vera 6.9 cm.). He made casts, and gives the following as his conclusions: (1) That it is important that the expulsive forces act in the same way as in the complete pelvis; (2) That the increase in the obstetric conjugate is greater than in the transverse diameter when the expulsive force acts vertically; (3) That the increase in the transverse diameter of the pelvic inlet is due to the pelvic bones opening like the halves of a door, the axes being at the sacro-iliac synthondroses; (4) That when the bones were apart, there was no increase in the length of the oblique diameters.

Menge's treatment for the commoner forms of contracted pelvis is as follows: (1) When the conjugate is between 5.5 and 6.5 cm., and the child of medium size and alive, cæsarean section; (2) With a conjugate between 6.5 and 7.5 cm., at times labour can finish naturally. This is possible in head presentations. In breech and transverse presentations, prolapse of the cord or small parts, and when in the interest of the mother or child delivery must take place without delay, cæsarean section; (3) With a conjugate between 6.5 and 7.5 cm. hebosteotomy may be done before it is possible to know the proportional relation between the fœtal head and the pelvis, *i.e.*, before rupture of the membranes, as natural delivery can scarcely be expected. It is, however, advisable to wait till the os is fully dilated. When the membranes have ruptured, the operation should be done as soon as possible; (4) With a conjugate over 7.5 cm., spontaneous delivery of a full-term child may occur. When, however, some considerable time after the membranes have ruptured, it is clear that the disproportion between the fœtal head and the pelvis will not allow of a normal delivery, and the child is still alive, hebosteotomy should be done; (5) With a conjugate between 7.5 and 8.5 cm., hebosteotomy is preferable to version and extraction when the presentation is transverse and cephalic version impossible, when there is prolapse of the cord or small parts, or when the presentation is a breech; (6) Immediate delivery after hebosteotomy is only proper when the mother or child are in danger.

Reifferscheid reported 27 hebosteotomies. One died five days after operation from emboli. Bladder lesions occurred in three instances.