in this way. By moving the bowels early and often there is no trouble with flatus. No rectal tube is necessary, and therefore no dilating of the sphincter, and the pushing of a hard, unyielding foreign body by the line of union. No enemas are necessary. The less the operation field is handled the safer I feel as to the result. Should there be a great amount of soreness about the wound I have two small pieces of linen or gauze soaked in Pond's Extract and water, equal parts, placed one on each side of the sutured sutures and kept wet. As a routine, one corrosive douche of two quarts (1-5,000) is given twenty-four hours after the operation, to cleanse the vagina of any blood that may have collected there. No further vaginal douche is given until the stitches are removed.

The patient sits up on the tenth day, and is about in two weeks.

Emmet gave utterance to most of the ideas advocated in this paper at least ten years ago. Six years ago I was first impressed by the results obtained by stretching the sphincter before operation and moving the bowels soon after, and found them far better than by any other method. Since then I have operated by that method, and have had uniformly successful results; and it is because of these favorable results, and because I believe the correct principles of repair are shown in the technique, that I have ventured to call your attention to the subject anew.

The points that seem to me to be of especial importance are the preliminary stretching of the sphincter; thorough attention to the bowels, both before and after the operation; and in operating in the simplest manner possible, that is, by using only one set of interrupted sutures passed straight across.

Clinical Department.

TWO ILLUSTRATIVE CASES OF POSTERIOR POSITION OF THE OCCIPUT.¹

BY CHARLES W. TOWNSEND, M.D.

ALTHOUGH the simple expedient used in these cases is well known to the members of this Society, cases of posterior position are so often mismanaged that it seems worth while to allude occasionally to the subject.

This has been brought to mind recently by a case where I was called by two consultants to do craniotomy. I found the head presenting at the pelvic brim, occiput right posterior, and slightly extended. Numerous attempts had been made to drag the head through the pelvis, which naturally resulted in failure. Besides this the forceps had slipped and the child's scalp was torn in one place down to the bone.

It was a simple matter under ether to make an accurate diagnosis of the position, and thus determine the cause of the trouble. Many physicians seem to be satisfied with the diagnosis of head presenting, without an accurate diagnosis of position. Even if the sutures and fontanelles are obscured by a caput succedaneum, it is always easy, at least under ether, to feel an ear which determines the exact position.

With one hand in the vagina the head was easily turned from O. D. P. to O. D. A., the shoulders and body of the child being turned at the same time with

the other hand placed externally. Keeping the head in this position by an assistant's hand placed externally, the forceps (with Reynolds' traction-rods) were applied, followed by an easy delivery of a living child weighing eight pounds.

Another case, seen a few weeks ago, was a primipara with the child presenting in the rare O. L. P. position. This position is not so very exceptional as some suppose, for I have seen six or eight examples of it.

Here I kept the head well flexed but it refused to rotate, owing to inefficient pains. After a second stage of two hours, the head and body were easily rotated as described before. The head was held in place by the hand in the vagina while the blades of the forceps were applied. This is perhaps the easiest method and the one I usually employ. A living child weighing nine and one-half pounds was brought into the world with some difficulty over an intact perineum.

If the forceps had been applied without rotating the head, or if version had been done, it is evident that the child's chances and those of the perineum would have been small.

A CASE OF APPARENT HERMAPHRODITISM.¹

BY FRANCIS MINOT, M.D.,

THE patient is dressed as a woman, is twenty-five years old, tall, muscular and of dark complexion. There is no beard, the breasts are masculine, the voice base. Has never menstruated.

The clitoris is of the shape and appearance of an ordinary glans penis, with a prepuce which partially covers it, but is cleft below, presenting exactly the appearance of a circumcised organ. In the place of the meatus is a simple depression. Below the clitoris is the urethra, and below the urethra is the entrance to the vagina with a hymen. The finger easily penetrates into the cavity for about an inch, no cervix or other organ being felt. Both the labia are normally developed, but nothing can be felt within either, but she says that something is apt to come down into the left labium when she strains much; and on her making a "bearing down" effort, a hernia is seen to protrude into it.

She says she has no sexual desire, and has no voluptuous sensations in the clitoris, and her mother says her daughter does not seek the society of men.

Medical Progress.

RECENT PROGRESS IN OBSTETRICS.

BY EDWARD REYNOLDS, M.D.

CELIOTOMY FOR ECTOPIC GESTATION.

WERDER¹ writes on celiotomy for ectopic gestation at or about term, and reports an interesting case in which he made the diagnosis at six months and operated about two weeks before the expected time of term, keeping the patient under observation in the mean time. After opening the abdomen, the case proved to be a tubal pregnancy ruptured primarily into the cavity of the broad ligament, and secondarily,

¹ Medical Record, 1894, No. 21, vol. xlv.

¹ Read before the Obstetrical Society of Boston, May 11, 1895.