on the following day from weakness. The broad ligaments were ligated, the cervical arteries tied, the uterus amputated, and the stump stitched over. Two strands of iodoform gauze were passed down to the stump for drainage. The patient made a good recovery and the result of the operation was very satisfactory.

[We do not find it necessary to employ drainage in these cases, as under ordinary circumstances the patient is not septic and recovers promptly without a drain.—Ed.]

Facial Paralysis in the Child Following its Spontaneous Birth.—At a recent meeting of the Obstetrical Society of Vienna (*Centralblatt f. Gynäkologie*, 1898, No. 19), SCHUTZE reported the case of a child born in spontaneous labor who had facial paralysis, which was found upon autopsy to depend upon hemorrhage at the base of the cranium and pressure on the cortex. A depression was found on the left parietal bone, and the scalp showed the effects of severe pressure.

Incomplete Rupture of the Uterus in Placenta Prævia.—At a meeting of the Obstetrical Society of Vienna SCHUTZE also reported (*Centralblatt f. Gynäkologie*, 1898, No. 19) a case of placenta prævia in which it was necessary to immediately make version to stop a severe and prolonged bleeding. The os and cervix would admit but three fingers, but the cervix was very soft and the version was readily made. A half hour afterward the child was easily born. Very severe hemorrhage followed the expulsion of the child and placenta which could not be checked sufficiently early to rescue the patient.

On examination, an incomplete rupture of the uterus was found, and also a partial separation of the pubic joint and increased mobility of the left sacroiliac joint. The tear in the uterus began at the cervix.

In discussion it was brought out that special danger exists in placenta prævia of uterine rupture, because the cervix and lower uterine segment are always very greatly softened.

Posterior Positions of the Occiput and Presentation of the Parietal Bone.—In the *Monatschrift f. Geburtshülfe und Gynäkologie*, 1898, Band vii. Heft 5, MUELLER concludes an extensive paper on this subject as follows: He distinguishes three posterior positions of the occiput, right, left, and sacral. The two former in most cases end in spontaneous rotation to the front. Occasionally some other presentation develops. It is possible for birth to occur by the forehead pivoting under the pubes and the occiput being forced out over the perineum. It is important to recognize the difference between a presentation of the parietal bone and a posterior rotation of the occiput. Sacral rotation of the occiput is rare. Labor is prolonged in these cases, and laceration of the pelvic floor is inevitable. It is possible, however, in most cases to deliver the patient with forceps, although mother and child will undergo severe pressure during labor. Fortunately over 96 per cent. of all cases terminate in spontaneous anterior rotation.

Pregnancy in Fibroid Uterus, with Double Uterus in Addition.—In the last report of the Rotunda Hospital, *Dublin Journal of Medical Sciences*, May,