Under suitable conditions immediate abdominal Caesarean section, with rapid incision of the ring internally, would be the correct treatment. The site of incision being under immediate control, the choice of immediate suture or hysterectomy would then be guided by the probability of previous septic infection.

The following is the type case, the story of the other (particulars of which I am not at liberty to publish) being almost exactly similar.

Mrs. M., 29 years, primipara, was seen in consultation in a nursing home. The doctor reported the patient twenty-four hours in labour, and that membranes ruptured early; the os was fully dilated. The head was quite above brim, marked overlapping, but held down firmly on to brim and not movable to any extent. The cord was prolapsed and pulsation absent.

The marked retraction ring was very palpable and visible above fetal head but below the shoulders. Fetal parts could not easily be made out by palpation. Tonic, slightly tender upper uterine segment. Forceps had been applied several times without result. (Blunt-hook traction under chin had been tried for some time, and the hook was still in position when I first saw the case.) The temperature was 99°, and the pulse 100. Pelvic mensuration showed: Interspinous diameter, 10 in.; intercrural, 10 in.; diagonal conjugate, 2½ in. Markedly oblique rickety flat type of pelvis.

The indications were absolute for Caesarean section, but there had been much handling before I saw the case, and considerable laceration and oedema of the soft parts were present. It appeared certain that the patient must be extensively septic.

Operation.

I therefore hesitated to do abdominal Caesarean section at once and decided to give the patient another chance of delivery *per vaginam*. The head was first thoroughly broken up. Then, under deep chloroform-morphine anaesthesia (in the hope of relaxing the ring and thus of being able to get the shoulders past it and do an extensive embryotomia) steady traction of moderate force was tried for a short time. The ring showing no sign of relaxing, and the patient being in indifferent condition, it was decided to waste no more time, and abdominal Caesarean section was performed as quickly as possible. During the operation, though the anaesthesia was deep and the patient still under morphine, the fetal neck was still closely held in the ring, and the well-broken-up head was only extracted upwards through the ring with some difficulty. The ring did not appear very dilatable. The uterine wall appeared rather thicker than usual (not markedly so) during incision. Supravaginal hysterectomy was done. Both adnexa were left *in situ*.

Infection of an acute septicaemic type began on the third day of convalescence, and the patient had a stormy passage for three weeks, when the temperature subsided.

The patient was given *Streptococcus phylacogen* during the first week, and as this appeared to have no effect on the condition, she had two injections of a heterogeneous polyvalent streptococcal vaccine at intervals of a week. Continuous breast saline was given throughout.

I do not doubt that the removal of the uterus saved the patient from a still more violent sepsis and a worse fate.

In closing, it appears appropriate to point the moral that prevention is better than cure. A careful measurement of the most important diameters of the bony pelvis should be made in all primiparae, and in pluriparae with a history of previous difficulty in labour. Of more importance still is to note the position of the fetal head and its fit in the brim from ten to seven days before the expected date of labour. These should not nowadays be regarded as counsels of perfection. The necessary investigations are neither highly technical nor difficult, and are constantly practised by some practitioners (and they not the least busy). If they were carried out by all we should see far fewer of these "regrettable" cases than we do at present.

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By an Act dated October 20th, 1919, every Frenchwoman admitted to maternity benefit under the law will receive during the twelve months following delivery a supplementary allocation of 15 francs a month at the cost of the State. The allocation will be granted as long as the law relative to indemnity for the increased cost of living continues in force, on condition that the mother suckles her infant and takes proper hygienic care of herself and her child.

RHINOPLASTY AND CHEILOPLASTY.

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An intelligent apprentice engineer, aged 16, whose nasal cartilage and the skin over it had disappeared under the ulceration of lupus, and who had a patch of lupus still remaining, was taken under my care into the Liverpool Royal Infirmary, where I scraped away the small patch of disease on May 25th, 1887.

The result is shown in Fig. 1, where the upper lip is seen to be scarred, and so deficient as to leave his mouth almost permanently open. To remedy these defects I

FIG. 1.—Taken in August, 1887. Showing defect of nose and upper lip; also the lines of incision in the plastic operation.

FIG. 2.—Taken in November, 1890. Showing final state of new nose and augmented upper lip, twenty-seven years before blindness occurred.

performed rhinoplasty and cheiloplasty on April 27th, 1888, the lines of incision being marked in the illustration, photographed on August 27th, 1887. To enlarge the upper lip the scab left between the nose and upper lip was cut out; the lip itself was freed somewhat to permit its depression to meet the lower lip, and the skin dissected off the nasal bones while remaining attached at both cheek ends to provide vascular pedicles, and stitched to the raw edge of the upper lip, thus making that lip wide and substantial, as shown in Fig. 2. A flap for the new nose was taken from the forehead over the right eye, and having a curved pedicle on the left to permit the flap to be turned down to cover the exposed nasal bones and the rest of the raw surface. Much care was taken to fashion the alae and septum, which gave quite a presentable shape to the new nose on the day of operation.

But this attempt at an approach to elegance failed, as the distant corners of the flap sloughed. All other attachments healed well, and the raw surface on the forehead granulated up quickly. Much trouble was also spent in trying to keep open the nostrils by means of rubber tubes, but this also failed, and the nostrils became permanently closed.

This, however, proved not to be inconvenient, and I found that, as no nasal mucus accumulated, there must have been little or none formed beyond what could easily escape unobserved into the pharynx, the absence of draught and attendant dust apparently keeping the mucous membrane quiescent.

Though the nose and augmented lip never became elegant they answered their purpose, and are well shown in Fig. 2, photographed in November, 1890. This young man became a skilled engineer, and volunteered for foreign service at Chatham Dockyard in 1900, serving as a marine engineer in Bermuda, Nova Scotia, and Newfoundland.

He married in 1905, and lived for a time in the south of England, coming several times to see me when visiting his father in Liverpool.

In September, 1916, he was second engineer in a tug patrolling the North Sea. In July, 1917, I met him in Liverpool, led about by his wife on account of permanent blindness due to glaucoma which had not been remedied by operation in time to save his sight. For this he has since been taken care of in St. Dunstan's, Regent's Park, by which he is enabled to make a living for himself, wife, and family. He has perseveringly served his country, which took him in hand until able to shift for himself, which he does in a country poultry farm.