On the positions and presentations of the cactus
In some time previous to labour, the fetus is situated with the extremities folded across the trunk and the chin pressed upon the breast, thus forming an ovoid figure, the base of which is the trunk, and the apex the head of the fetus.

This ovoid is, in practice, found to present at the time of labour in three different modes.

First: in a large majority of cases the head presents, the proportion has been found to be twenty-nine of head positions to one of the other kinds of presentations.

Secondly, the breech or pelvic extremity of the ovoid presents in comparison with the head in the proportion of one of the former to thirty-two thirty-three or thirty-five of the latter. Thirdly, the transverse diameter of the
focus is occasionally presents but very rarely. Various opinions have been advanced in order to explain why the head of the infant is thus, before birth, usually placed lowest and over the os uteri, and why some special circumstances should sometimes change this law and produce malposition and malpresentations.

The opinion advanced was that gravitation was the sole cause of the attitude of the fetus. Another was that it was caused by vital or mental influences of an instinctive and voluntary character on the part of the fetus. Professor Simpson has shown that the position of the child in the uterus is owing to locomotory movements on its own part.

The theory that gravitation was the cause was founded entirely upon the greater weight of the head in comparison with the other parts of the body. They who held this theory supposed that this greater weight of the head compelled it to be lowest or nearest the os uteri, taking it for granted that the mother was always in the erect posture.

That gravitation is not the cause of the fetus being in this position is proved, first, by the fact that the
mother is not always in the correct position. Some mothers
having kept the horizontal position during many months
previous to labour.
Secondly. In hydrocephalic children the head is larger and
heavier, and ought according to this doctrine to cause
the head of the foetus to be nearest the os uteri, but
in these cases abnormal presentations of the other parts of the
body are more frequent than in cases where the head is
of its usual weight and dimensions.
Thirdly. Where the human foetus is placed in water
and allowed to fall, the part which first strikes the
bottom is not the head but the back or the scapula.
Forthly. Gravitation ought to affect the head as well as the
living, but the presentations of other parts of the body
than the head are more common in dead children
than in the living besides this argues that the life
of the child is necessary to make the head present
at the os uteri.
The other theory which was advanced, viz. that, Instinctive
and voluntary muscular movements are the cause of the
attitude of the foetus, was founded upon a misconception
of certain phenomena observable in the foetus.
Whilst in the uterus, and which will be considered in connection with the excitatory motory actions of which in reality they were instances. That they are not voluntary is proved by the fact that they occur in unacceptable children.

Reflect a excitatory motory muscular movements considered as the cause of the attitude of the fetus.

If any portion of the child is irritated before birth or after muscular movements are excited in the part and the irritated portion is moved away and takes up another position.

But the surface of the child is not equally sensitive. Some parts, as the soles of the foot, knees, elbows, and side, are more especially so, and it is these portions of the surface which in the unborn child are more exposed to irritation. If these parts be irritated in the living child, they are followed by movements of the lower extremities. To the feelings of the mother, these movements are similar to the ordinary movements of the child in uterus. They originate in excitation or impressions made upon the cutaneous surface as many other reflex movements do. They occur in unnu-
- Labyrinthine children and must consequently be dealt with the mother. The use of these occurring in uterine children is undoubtedly to cause it to take up a position where it will be more free from irritation, and which is as a general rule with the head lowest.

Both the uterus and foetus are void in shape, the void of the foetus corresponding with that of the uterus; and it is this relation in shape of the foetus with the uterus that regulates the position of the former.

The maintenance and alteration of the position, is effected by reflex movements when its continuance is from time to time the threatened by movements of the mother's body, or by other circumstances affecting the conditions of and relations of the uterus and foetus.

The reason why pelvie and transverse presentations are so common previous to the sixth month, is that previous to this time there is no adjusting correspondence of figure between the uterus and foetus; while, after the sixth month, the figure of the one comes to correspond more and more with that of the other.
This is owing to the quantity of liquor amnii becoming less and less relatively to the increasing size of the uterus and infant.

Causes of malpositions and abnormal presentations. The most common of these are: Premature labour. Death of the child. Twins. Excess of liquor amnii. Spasmodic contractions of the uterus.

Premature labour. Previous to the sixth month, the fetus does not take up the position with its head lowest, consequently if labour comes on before this time, the child is liable to abnormal position. Death of the child causes abnormal presentation by rendering it insensible to irritation, so that it does not resume its position with the head over the os when displaced from it by any cause.

Twins. The cavities which contain the two twins in multiparous pregnancies are more or less relatively different in shape from the cavity which contains the fetus in uniparous cases. And as the after irritations and movements of the fetus force it to adapt itself to the form of the cavity containing it, malpositions are more common.
Among twin cases than among single foetuses.

Excess of liquor amnii is liable to cause abnormal presentations through its giving a great amount of freedom to the foetus, and thus destroying the adaptation of the uterus to the foetus.

Spasmodic contractions in the uterine parietes may cause abnormal positions by acting in a similar manner to the preceding cause.

Organic diseases of the uterus. Placenta previa.

Distortion and distortion of the skin of the pelvis, and irregularity in the shape of the uterus, will cause abnormal presentations in the same manner as the two last mentioned causes.

Mechanical and casual displacements of the foetus may cause abnormal presentation where there is excess of liquor amnii and the foetus is small as when the mother receives some shock, but this is more likely to occur in the earlier months than during the latter months of pregnancy.

Positions of the head, its changes in each position, and the means of diagnosis.

The head of the child presents most frequently with
the right parietal bone, the posterior fontanelle being
towards the left foramen ovale, and the face turned to the
right sacroiliac synchondrosis. This position is called the
first, and occurred to Boegele in the proportion of sixty-
g-nine per cent.

Prof. Boegele describes the first position as follows: -

"Upon examination the finger which is introduced in
the direction of the center or middle line of the pelvic
cavity, and brought in contact with the head, will touch
the right parietal bone in the vicinity of its tuber;
the two fontanelles are mostly found situated at an
equal height sometimes the anterior, but more frequently
the posterior one a little lower.

The higher the head is the nearer its long diameter
corresponds to the lateral diameter of the pelvis, and
the more oblique is its direction; for which reason
the right ear can frequently be felt behind the pubis
without difficulty, which would not be the case if
the head had a perpendicular direction, or presented
at the time of labour with the occiput forwards.

In account of the oblique position of the head, the
greatest width of the cranium passes the true parietal
to the other. As well as that of its base, can never during its passage coincide with the diameter of the pelvic entrance.

It is not however the centre of the occiput that advances under the pubic arch, but the head approaches the occiput, with the posterior and inferior part of the right parietal bone, and remains in this position until it has passed through the outlet of the pelvis with the greatest circumference which it opposes to it. When it then turns itself with the face completely towards the right thigh of the mother. When the head is engaged in the external passage, and we place the sagittal suture with the point of our finger from the posterior fontanelle, it will during examination take the direction of a line drawn from the left ascending ramus of the pubis to the right ascending ramus of the ischii; it is in fact the posterior and upper part of the right parietal bone which passes first through the os occipitum.

In this position the sagittal suture will best be found directed towards the posterior or lower extremity of the os occipitum, but crossing the right ischium, in an oblique direction from left to right, at some distance.
from its posterior or lower extremity and the
uterine parietes will be distinctly felt clearing the
latex sometime before the left.

The fact that the sagittal suture runs in this di-
tection, and the situation of the tumours of
the scalp, which after delivery occupies the poste-
rior and superior quarters of the right parietal bone, and
a portion of the occipital if there has been sufficient
delay at the vaginal orifice, prove that the head
really passes from obliquely through the exter-
nal parts.

The second position. In this position the posterior
posterior fontanelle of the child corresponds to the right
occiitae synchondrosis, the anterior fontanelle to
the right acetabulum. This position occurs in
practice next in frequency to the first and occurred
twenty-nine times in one hundred cases which
were attended by Professor Mageli. It also occurred
twenty-six times out of three hundred and
thirty-five cases observed accurately by Professor
Symonson.

The fontanelles in this position are generally
at a level until the pressure compels one or other but generally the posterior to ascend. The caput succedaneum in this position is pressed on the left parietal bone at its upper edge, usually at an equal distance from its angles, and the finger introduced in the middle line comes in contact with it.

As soon as the head is engaged in the cavity of the pelvis, Maggei observes, the great fontanelle turns towards the ascending ramus of the left ischium, and both can be felt at an equal height as to each other. As soon as the head experiences the resistance which the inferior part of the pelvic cavity opposes to it, or in other words the oblique surface which is formed by the lower end of the os pubis, by the crura coccygis, the ischiatic ligaments, &c. by which it is compelled to move from its position backwards, it turns by degrees with its great diameter into the left oblique diameter of the pelvic cavity; that is, the posterior fontanelle is directed to the right foramen ovale, and as the head approaches nearer and nearer to the inferior aperture, it is the
posterior and inferior quarter of the left parietal bone which is felt in the cavity of the pelvis, opposite to the pubic arch; so that when the point of the finger is introduced under and almost perpendicular to the symphysis pubis it touches nearly the middle of the inferior and posterior quarter of the left parietal bone: and this is precisely the part, as the head advances further, which first distends the cavity, with which the head first enters the external passages, and the spot upon which the swelling of the integument forms itself. Thus the head according to Kregel, is changed from the second position into the left oblique diameter of the pelvis.

The two positions which have been described above are the most usual, and are the normal positions, the others occur so rarely in comparison with them as scarcely to merit that name.

The position in which the head of the child presents in point of frequency after the above, is usually described and named the second, but ought to be termed the third.
In this position the head is in the left oblique anterio of the pelvis, viz. with the posterior fontanelle towards the right front of the bowl, and the anterior towards the left sacroiliac synchondrosis. It passes through the pelvis much in the same way as the first position, only the left parietal bone is in the front part upon which the cephal sacroiliacum forms as well as the first part to present. Hægelb and with this position once in 1290 cases and Dr. Sympson once in 256 cases.

Many cases which were at the commencement of labour in the second position, have on account of imperfect examination been classed by many with the second, as is shown by Hægelb, Sympson, and others.

The last posterior position is the most unusual of these presentations and occurred to Hægelb in the ratio of .03 per cent, and to Prof. Sympson two cases occurred out of 335 head presentations. In the fourth position, the posterior fontanelle corresponds to the left sacroiliac synchondrosis, and the anterior fontanelle to the right
foveum ovale, and as the head is pressed through the cavity of the pelvis, changes analogous to those in the second position take place, but in the opposite direction, that is, the long diameter of the head is turned from left to right, so as to bring the posterior fontanelle towards the left fornix ovale and the anterior to the right. Succoideus, etc., etc., or it may be described by saying, that as the second position changed into the third, this the fourth changes into the fourth first, and afterwards passes out in the same manner as the first.

In some flexures, owing to excessive width of the passages in comparison with the head of the child, the changes above described do not take place, but the head passes directly out of the same diameter in which it entered the pelvis. Thus in the second or fourth position, the head would not change from these positions into the third and first but would pass out, viz. on account of the pelvis not affording sufficient opposition to it.
Some pelvis are found to present the greatest measurement in the conjugate diameter, in those cases the head of the child presents in that diameter, but these cases are very rare: it was however thought to be the most frequent position.

The diagnosis of head positions is generally admitted to be a matter of some difficulty, especially before the rupture of the membranes. Some of the means of overcoming this difficulty have been mentioned in the descriptions given above, as the different situations of the foetamders and the direction of the sagittal suture in each of the head presentations. Précéla puts great faith in the observed fact, that the movements of the child are felt more on one side than on the other in the first and second presentations. When these movements have been felt more on the right side, we may presume that the head is in the first position, and when on the left side in the second. But this affords no means of judging between the first and fourth and...
For between the second and third positions, even if it can be relied upon for the others.

By means of the stethoscope we are enabled to distinguish the probable position of the fetus thus: if the fetal heart be heard in the left inferior abdominal region, diminishing in intensity from that locality, it is most likely in the first position. If the heart be heard beating most loudly on the right side, the head of the fetus is probably in the second; and if the heart be heard high up in the abdomen we may suspect that the child is presenting with the breech.

In ordinary cases we possess an infallible test of the correctness of our diagnosis in the tumour of the scalp. It is formed by the pressure of the head against the margins of the openings through which it has to pass—first against the os iliri, and lastly against the labia of the vagina. It always forms on the lowest or presenting part, so that the primary tumour indicates the part which presented at the os iliri, the secondary and primary together that which presented
at the opening of the vagina.

In the first position the primary tumour occupies the uterus of the right parietal bone, and the secondary tumour in addition to those the posterior and superior part of the same bone with a part of the os pubis. In the second position it occupies the left uterine parietale, and the posterior angle of the same bone secondarily. In the third the primary tumour is somewhat anterior to the left uterine parietale, but by the change to the second position the uterus and posterior part of the bone become the seat of the secondary tumour. In the fourth the primary tumour is anterior to the right uterine parietale, but the secondary includes it and the posterior part of the bone.

It is of the utmost importance both as regards the life of the mother, and child, that we should be able to discriminate between the different head positions. In cases where we require to use either the long or short forces the greatest injury may be inflicted if the attendant is ignorant of
The position which he has in hand.

The exact presentation to that of the head in point of similarity is the face. This presentation (from statistics of British practice) occurred 404 times in 113,101 cases. According to the statistics both of British, French and German practice 1077 face presentations occurred out of 232,859 cases.

There are four presentations of the face, as of the vertex. In the first, the forehead is towards the left acetabulum; in the second towards the right acetabulum; in the third towards the perineum, and in the fourth towards the left acetabulum. These positions are analogous to the presentations of the head, and may be looked upon as vertex cases in which the head has become accidentally extended. The first and second are the most frequent, the third and fourth occur so very rarely as not to need description. Of the first and second, the former is the most frequent, as being to the second according to Dr. Kraegele as 2 to 1 is to 17.

In the first position, if the finger be introduced
in to the or where is the commencement of labour
it will touch the bridge of the nose of the finger
be carried forwards and to the left, it comes upon
the forehead where the frontal sinus may be felt.
The anterior fontanelle can seldom be reached
and the brow it is out of reach the letter. Tracing
the face in the opposite direction the finger will
come upon the mouth, and the alveolar ridge may
be felt for it. Lastly the chin may be felt in relation
with the eight second incisor dentition. The nose known
which is analogous to the sagittal section in vertex
presentations, and occupies the same place and
relations nose post fixed the os uteri equally but
is more posterior than anterior and consequently
the right side of the face occupies the anterior
and greater segment of the os uteri. The primary
caput succedaneum will in this presentation
be found upon the upper half of the right side
of the face, and will include a surface corresponding
to the right eye, nasal bone, and adjoining parts.
When the head ascends into the pelvis it gradually
turns so as to bring the chin forwards from the
right. Accoedly on this side, to the right of the putamen, and in doing this the chin is brought down in the pelvis. The spine of the ischium is the directing agent as in vertex cases, and the left side of the chin is the part acted on. At the chin altitudes and turns forwards the arch of the cranium is arched backwards towards the hollow of the sacrum. As this part of the process the right clavicle and angle of the mouth are the presenting parts, and the chin is just on the point of coming from under the pubes. The first step is the emergence of the chin not exactly in the middle line but somewhat to the right. By the liberation of the chin room is given gained, and now a process of fusion takes place analogous to the extraction of vertex presentations, the chin becomes temporarily almost fixed, and the head rotates upon its transverse axis, so as to bring the cranium out with a swing over the perineum, the uterus being the last part expelled. During the fusion there is an advance of the head. If the face remains long pressed against the opening of the vagina a second torsion is
formed on the lower half of the right clavicle.

The head being thus impelled, the rest of the body behaves as in vertex cases. The right shoulder being thrust in the pelvis is propelled against the anterior surface of the right ischium and rotated from right to left so as to place the shoulder fully in the conjugate diameter of the outlet of the pelvis. The right shoulder is thus born first, and the left meconium over the perineum. In the second position the head is directed towards the right acetabulum, and the chin towards the right for the occipitopatelvic, and all the rotations are reversed.

The diagnosis of face presentations like those of vertex cases is difficult prior to the rupture of the membranes, and the full dilatation of the os uteri. In the advanced stages of labour it is not so difficult if continued pressure has not modified the face by causing swelling as to make it like the breach. In this case the malar bones may be mistaken for the buttocks, the mount for the arms, and the eye...
for the value of a female child. But in ordinary cases the frontal bone is wider than the anterior fontanelle, - the ridge of the nose with the orbits on each side, - and beyond the nose the mouth with the alveolar margins ought to enable the attendant to recognize the case. If there is any difficulty reference to the abdomen may aid in solving the difficulty; question, thus in thin women the head may sometimes be felt through the abdominal parietes provided there is not a large quantity of liquor amnii. The meconium may also be diagnostic, for although met with both in breech and cephalic presentations yet in the latter it is not diluted as it is in the former.

There is an intermediate presentation, in which the head is not completely flexed as in earlier cases, nor completely extended as in face cases. This goes by the name of the brow presentation. On examining these cases at the commencement of labour, the frontal protuberance of the right or left side will be found to be as nearly as possible the presenting part. The diameter of the
fetal head which enters the right or left oblique diameters of the pelvis is that between the chin and the great fontanelle. In the later stages of labor this presentation may be recognized by means of the anterior fontanelle which is touched more easily felt than in face presentations. The anterior fontanelle and chin are higher in the pelvis than the forehead. The kind of presentation of the fetus which is usually described with respect to the face is that in which it presents with the left pelvis or breech.

Bagele reduced all pelvic presentations into two orders: in the first, the back of the child is towards the abdomen of the mother; in the second, the abdomen of the child is towards the abdomen of the mother. These may be called dorsosanterior and abdominoposterior positions. The back of the fetus is more situated directly anteriorly or posteriorly, but usually so that one hip is always anterior to the other. The dorsosanterior is according to Bagele the more frequent than the other in the proportion of three to one.

In dorsanterior pelvic positions the relation of the
fetus to the maternal pelvis is as follows. The transverse
diameter of the child's hips occupies the left thigh
diameter of the pelvis, its sacrum is directed towards
the left acetabulum, its left trochanter towards
the right acetabulum, and its right trochanter
towards the left sacro-iliac articulation. Upon
examination at the commencement of labour, it
will be found that the os uteri is occupied by a
double tumour soft but elastic having a sulcus
between the tumours which is situated more posteriorly
than anteriorly, that is one buttock, the left,
occupies the anterior part of the os uteri. It will be
observed that this part is the lowest in the pelvis
and is the presenting part. As labour advances
and the hips descend, the left hip is still the
lowest in the pelvis and steadily directed somewhat
to the right side. A slight rotation is generally held
to take place at this part of the process, the left
thigh moves forwards whilst it comes directly under
the pubes, but this rotation is not so well marked
as the rotation which takes place in cephalic cases.
There is not the same difference between the diameters
of the breech so there is of the head, and consequently
not the same necessity for adaptation. Supposing the
breech to have become entirely engaged in the
avity of the pelvis the left hip will be situated
just within the vault, and the right hip beginning
to press down the perineum behind and to the
left. The left hip then becomes nearly fixed under
the pubic arch and a movement of flexion takes
place analogous to the flexion throat of face and
dextusion of vertex presentations. The right hip sweeps
over the perineum. The pelvis of the fetus rotating
as it were upon its antero-posterior diameter. As
soon as the right hip has escaped a movement
forwards of the whole part takes place, the feet
slip out the knees become disengaged and the
inferior part of the child is thus born. The front
or abdomen of the child is at first turned towards
the right thigh of the mother. The rest of the
child follows in the same manner, the shoulders
entering the left oblique diameter of the pelvis.
The arms generally slip out during the labour, but
they may become extended and obstruct the
passage of the head. The head enters and passes through the pelvis, the right oblique diameter, thus, the forehead is towards the right sacroiliac synchondrosis and the occiput towards the right acetabulum. It is not the upper part of the occiput which enters this diameter with the frontal bone for the chin is depressed and the occiput is the highest point.

By this means sufficient room is gained to enable the head to be engaged in the pelvis and to permit the face to be rotated into the bottom of the parum. The under surface of the occiput now rests against the inner surface of the symphysis pubis and the face occupies the pelvic cavity. The face finally turns over the perineum.

In the second variety of retroanterior positions the hips of the child occupy the right oblique diameter of the form of the pelvis, the right buttock presents and the left loins over the perineum. The right side of the foetus is directed slightly somewhat to the left acetabulum and the abdomen turns towards the left thigh. The head enters in the left oblique diameter, the forehead being towards
the left sacroiliac synchondrosis; the face turns into
the perineum as in the first.

Anterio-posterior positions of the foetus are like
the former of two kinds. In the first and most
frequent variety the hips of the child occupy the
right oblique diameter of the inlet, the left trochanter
is towards the left acetabulum of the mother.

The left hip presents and the whole body is expelled
as far as the shoulder looking towards the right.
The head enters the left oblique diameter of the
pelvis the occiput being towards the left sacroiliac synchondrosis.
As the head ascends in the pelvis, the occiput rotates
forwards from left to right until the face is lodged
in the hollow of the perineum just as it rotates in the
fourth vertex position. The parts of the child which
are already born may be observed to turn with
the head which is still in the pelvis.

The second variety of abdominal anterior positions is
where the hips of the foetus lie in the left oblique
diameter of the inlet, the right trochanter being towards
the right acetabulum. The right buttock is here the
presenting part. The head enters in the right oblique
Diameter of the inlet, with the occiput towards the right, postero-symphysoidal, and undergoes the same kind of rotation as the first variety. The anterior surface of the child which was at first turned forwards and to the left is at the same time rotated so as to look backwards and to the left.

Keegele gives a description of two unusual terminations to pelvic labour.

It sometimes happens, he says, where the infant is premature, small, or where there are reasons that the abdomen which was directed forwards and to the left, or forwards and to the right, is suddenly and during a single pain turned so completely round that the abdomen looks backwards and to the right, or backwards and to the left.

The other anomaly which Kuegele has described is where the head, instead of being forced upon the chest is extended, the occiput being pressed down upon the nape of the neck. In such cases the vertex rotates backwards into the hollow of the sacrum, the under surface of the lower jaw is brought into relation with the symphysis pubis.
and the head emerges in such a manner that
the occiput sways over the perineum, and lastly
the face.

It does not make any serious difference as regards
the mechanism of birth cases whether the feet enter
in breach present, but still there are some differences
as regards the duration of the case in the different
stages. Thus when the breech presents the birth
of the body is slower but the head follows more readily;
when the knees descend they sometimes catch upon
some part of the pelvis as against the sacrum.

and when the feet present the birth of the lower
half is comparatively rapid, but the upper parts
are much slower.

The diagnosis of pelvic presentations is not very much
aided by external examination. Neither is it rendered
certain by auscultation, nor by any other means
except the recognition of the parts presenting
during labour. When the finger is introduced
the os uteri is found occupied by two elastic tumours,
[the breech presentations] leaving a slit between
them, in the track of which is the anus which
may be distinguished from the mouth by the absence of the tongue and alveolar margins and by its widening around the finger when it is introduced.

The knee may be recognized by its having two tubercles and a depression between them, and a flexure of the leg and thigh which may be reached. It may be distinguished from the elbow by its two tubercles from the elbow by having a depression instead of the sharp point of the olecranon between its tubercles and from the shoulder in having two tubercles instead of one from which the scapular spine and clavicle may be traced. The foot may be distinguished from the hand joint by the line of the toes being even, secondly, by the great toe lies near the other toes thirdly, the foot is much thicker than the hand and its inner border is rounder than its outer fourthly.

The heel projects and the foot is at a certain angle with the leg whilst the hand is in the same line the anterior surface of the foot is in touch cases corresponds with the direction of the feet.

Yoursense presentations from the last group of the positions of the foetus. They include the presentation
of the shoulder or some other part of the superior extremity. And the presentation of the dorsal or abdominal surface of the child. The most important and at the same time the most frequent are those in which the shoulder arm or hand presents.

In arm presentations, two principal positions are recognized depending on the relations which exist between the abdomen of the fetus and the back and abdomen of the mother. In the greater number of transverse births the back of the child is towards the abdomen of the mother: In a smaller proportion the back of the fetus is towards the maternal spine. These may be termed dorso-anterior and abdomen-anterior positions. They occur in the proportion of two to one of the latter. Besides these there are minor varieties in the position of the child in arm cases depending on the situation of the fetal head on the right or left side of the mother. In dorso-anterior position the head may be on the left side of the mother, in which case the right shoulder or arm is the presenting part, or it may be
toward the right iliac fossa when the left upper extremity is the presenting part. In the abdomeno-
acrania positions the head may be directed to the right or left side of the mother. When it is to the left the
left arm, and when it is to the right the right arm of the fetus presents.
There are numerous complications but with in
transverse presentations. Besides the presentation
of any part of the body, the arm and head, both arms, the feet and arm, or an arm and
foot may adhere together. If these cases are left
to mature spontaneous expulsion may take place.
This is caused by the excessive contractions of the
uterus overcoming all difficulties. The body of the
child is as it were bent upon itself. The arm
which first presented with remains down.
The head and inferior extremities swing over
the perineum, and the other arm then comes
down. The head is born as in such cases.
The diagnosis of these cases is as in all cases
difficult before the rupture of the membranes
and yet it is desirable that the position should
be recognized previous to this event. The external configuration of the abdomen may in some cases assist us but it can never afford us certain information on this point. The diagnosis between the birth and shoulder, the knee and elbow, and the hand and foot has been given in the description of pelvic presentations. The chief difficulty is the diagnosis of between the elbow and knee when both the leg and forearm are bent upon the thigh and arm. In cases of doubt it is better to bring the hand or foot gently down when the question will be at once solved.

The three great divisions of positions above described, viz. Vertex, Pelvic and Transverse comprise all the well-known positions of the fetus. There is however one position which, when it occurs obstructs labour and which is described by Professor Simpson. This position depends upon accidental displacement of the arm. The arm of the child instead of being folded across the thorax is turned
round the back of the neck, and the elbow is the point which causes the obstruction.
Excellent well-timed summary. Continued with

Aims - Little Pointe-

Lead - Park interior & above.

Are - 4 acres.

The transverse

Mechanism of transverse
does not mention cephalic start. Could be

Symptoms - Sickness