

placed between the arm and the chest much discomfort will follow.

In these fractures it will generally be found that the broken ends of the fractured bone are best brought into apposition by bringing the arm well across the chest, so that the hand lies on the opposite shoulder.

In fixing the arm the use of a long strip of sticking-plaster fixing the limb to the trunk is a simple way of treating these injuries. In green-stick fracture of the clavicle, a common accident often overlooked at the time of the injury, the strip of sticking-plaster is the best method of treatment.

In the fracture of the clavicle at the coraco-clavicular ligament there is no displacement. In fracture of the clavicle external to the coraco-clavicular ligament there is no downward displacement, and the forward displacement is not observed at the time of the fracture, but becomes very evident at subsequent date. Treat all fractures by simple means; let wood, pasteboard, and lead (in cases in which the patient is confined to bed) be your mainstays, avoid all special forms of apparatus.

In *sprains*, carefully applied elastic pressure, with wadding, combined with massage and passive movement, gives the best results.

In diagnosing an injury look before you touch the limb. Remember the normal relations of the styloid processes in diagnosing injuries in the region of the wrist; the relations of the head of the radius to the external condyle, the relations of the olecranon to the internal condyle of the humerus in the elbow-joint; and let the coracoid process and its relation to the head of the humerus be the principal guiding landmark in injuries of the region of the shoulder.

Always expose the uninjured corresponding region, examine it in the first instance, and let it be your standard (having satisfied yourself that it is normal) in diagnosing the injury on the opposite side.

In *amputations of the toes*, a partial amputation may be performed in the great toe; in the other toes partial amputations are inadmissible; avoid any incision in the sole of the foot. Remember that the foot is a tripod, and that its stability rests on the integrity of three points of support—the ball of the great toe, the ball of the little toe and os calcis; interference with any one of these lessens the value of the foot as a basis of support. Any narrowing of the foot approximating the two anterior points of support also renders the foot less stable.

Utilize the plantar surface for the principal flap in amputations through the tarsus and at the ankle joint. In amputation at the tarsometatarsal joints and in amputation through the centre of the tarsus, after marking out the flaps by incision down to the bones, it is best to disarticulate and dissect the bones off the long plantar flap from behind forwards.

In all amputations in the lower extremity sacrifice length in order to obtain a stump that will

bear pressure. A painful stump is worse than useless; with it the patient has no comfort, and cannot wear an artificial support.

In amputations above the ankle the long anterior flaps give the best result. In amputation below the knee the modified circular is, as a rule, preferable to the long posterior flap. If the latter method is adopted a posterior leaden splint, curved so as to support the long posterior flap is the best means of preventing retraction. In all amputations the posterior leaden splint is the best steadier of the stump. Lead as a splint, from its weight and plasticity, makes an excellent splint in many injuries, and after operations, both in upper and lower extremities.

In sawing the bones in amputations in the leg always enter the saw upon both bones at once, so that the fibula may be divided before the tibia. In amputation below the knee it is often difficult to secure the arteries. When such difficulty arises take a curved needle, threaded with catgut, and pass it into the tissues behind the bleeding point so as to include the tissues around the vessel in the ligature.

In amputation for injury through the shaft of a long bone the periosteum may be divided at a lower level than the bone; if this is done it is best to save the periosteum on the anterior surface of the bone, and allow a flap of periosteum to hang over the divided medullary cavity. Do not stitch it for fear of deep-seated tension.

In amputation at the hip-joint amputate by the circular method below the trochanters, tie the vessels, turn the patient round so that he lies on the uninjured side, make a vertical incision over the trochanter, keeping well back where the vessels are not important and the trochanter is most superficial, and disarticulate the head of the bone.

In all amputations for injury, in which the patient has lost much blood, save any blood escaping at the time of the amputation, and mixing it with a 5 per cent. solution of phosphate of soda, as described by Mr. John Duncan (*MED. ABS.*, p. 59), inject it into the main vein before stitching together the flaps.

*Ulcers* are due to a local or constitutional cause; in most cases the local cause is the direct excitant, the constitutional cause rendering the patient more liable to evil consequences from the local irritation. Unless in the case of a burn or other distinct traumatic cause, always be suspicious of a constitutional cause if the ulcer is situated on any part of the body except the lower half of the leg, and even then be suspicious if the ulcer is on the posterior aspect of the limb. Ulcers are prevented from healing either by a congested or an injured state of the limb. Simple rest in the recumbent posture, elevation of the limb, and careful elastic pressure are the indications for treatment under which painful, fetid, and spreading ulcers will, with few exceptions, become painless, sweet, and clean. Improve the vitality of the soil, and the putrefactive organisms will die out, not finding a suitable nidus or their further growth and development. The use