

This results from two causes, 1st, the atrophy and yielding of the abdominal and thoracic structures under this abnormal pressure; 2nd, the softening and relaxation of the plaster itself from the absorption of bodily moisture. It follows of necessity, that the support having yielded, the upper portion of the body telescopes down upon the lower, the diseased structures are grinding in contact, and *the benefit obtained by extension is lost by the collapse which follows.* Hence arises the necessity of removing the apparatus and reapplying it, in itself at times painful and annoying. So I have found it, notwithstanding, I have been able to finish the dressing in ten minutes of suspension. Again, pressure upon the protruding spine often excoriates or prevents the healing of a pre-existing sore, and although a *fenestra* is cut, it is objectionable, since the discharge from the ulcer gets beneath the dressing, causing an offensive odor and removal of the jacket. Or a fragment of plaster, or foreign body dropping between the dressing and its re-application.

The method to which I now ask your attention, obviates these various difficulties. Without suspending my patient, the arms being held out of the way by an assistant; outside of the tightly-fitting knit undershirt, I apply *two* jackets of the required thickness. The lower edge of the upper jacket is just above the diseased points and extends upward to the arms. The upper edge of the inferior jacket is just below the seat of disease, and extends down over the hips. As the plaster bandages are "setting," I place three zinc plates about 2 by 4 inches perforated by numerous holes from opposite surfaces so as to prevent them slipping, in each section of the jacket. To the center of the plate is securely riveted a flattened staple of iron. One of these is fastened over the spinal column above and below, one under each arm and one directly underneath these over the hips. These are held securely in position by several turns of the plaster bandages, passed over them alternately above and below the *staples* which are left exposed. As soon as the jackets are firmly "set" the *extension* bars can be applied. Each bar consists of a shoulder at each end, and a solid section cut with cogs and grooves which telescopes into a hollow section, with a key for lengthening or shortening, and a "spring-catch" to hold it fixed at any point. It is the same mechanism that is used in Prof. Sayre's knee-joint splint.

The shoulders are caught in the staples riveted to the imovable plates, and the requisite extension is secured by means of the key.

Mr. Harz, of Reynders & Co., has, with creditable ingenuity, devised for me a lighter *extension-bar*, consisting simply of a male screw, which works into a movable female screw, which secures the same extension. The principle, the application and the mechanism of this method is so simple

that I deem any detailed explanation unnecessary. The amount of extension is under the perfect control of the surgeon, and can be graduated to suit the comfort of the patient and the necessities of the disease. As the jackets yield, as they will under all circumstances to a greater or lesser extent, the extension is increased to meet the exigency and the same jackets will last throughout the treatment. At night, or at any time while the patient is reclining, when there is not a demand for much support, the middle bar is removed, allowing the patient to rest comfortably on the back. It will be seen that by my method the upper portion of the body rests upon the tripod of bars which are anchored, one over the sacrum and one over each hip, and that the diseased spinal column is relieved from all pressure from above or laterally. If there exists a lateral curvature one of the lateral bars can be extended more than the other and the curvature corrected. If the curvature is antero-posterior with the concavity backward (lordosis) the posterior bar will demand extra extension, and if the convexity of the curve is backward, the two lateral bars will require extension at the expense of the posterior. Around the portion of the body between the two jackets, a dry unplastered roller is carried moderately tight in order to retain any dressing on the sore (if this exist) and to equalize the pressure. Dr. Wyeth gave the history of a case which was in every respect a critical test of the value of this method, since it was successfully tried under the worst possible conditions and after all other methods had been faithfully tried under conditions which should have insured a better chance of success.

SYME'S AMPUTATION AT THE ANKLE JOINT FOR CLUB FOOT IN THE ADULT.

By Stephen Smith, M.D., Bellevue Hospital.

The following clinic on the above subject is from the *Hospital Gazette*. You will remember this patient, whose left foot was amputated at the ankle joint in the early days of the session. She has now perfectly recovered and is supplied with excellent artificial feet on which she walks with ease and grace. The occasion is opportune for calling your attention to the class of cases which she represents, and deducing from her case some useful practical conclusions.

Her disability was congenital talipes-equinovarus of both feet, she has never been able to walk about with any freedom. When she first came under observation about one year ago, the foot was dwarfed to the size of the foot of a child 10 years of age; the tarsal bones were firmly united at their articulation, and the whole foot was very painful after every considerable effort to walk. It was re-

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