require opening it should be done by trochar with the exclusion of air The knife should only then be employed when air has entered the pyogenic cavity, and decomposed its contents. In this way septicæmia with its fatal consequences can be averted.

With a view of bringing about a more decided detachment and diminution of the structural detritus, various means have been recommended. John Gay insists upon free incisions into the affected joint; others allege they have successfully employed the seton, and Kirkpatrick favours an opening with his escharotic into the joint and uses it freely upon the osteoporotic substance; and finally exsection. The two former apply only to superficial and accessible joints, and all four are necessarily followed by copious suppuration. They are therefore but available in well preserved constitutions, and in superficial caries of the articular faces.

It is obvious that no debilitated patient can pass unharmed through so consuming an ordeal. As to exsection I beg to submit:

I. That if a thick slice is removed from the epiphyses, we approximate the cartilaginous disks fastening them to the shaft, which may thus become involved, protract and even prevent the reunion.

II. That if we comprise the cartilaginous disks in the operation, the extremities become so much shortened as to render the result nugatory, and the artificial leg preferable.

III. That the exsection of single tarsal and carpal bones is but very exceptionally attended with good results on account of the existing intercommunication of the tarsal and carpal joints.

The arrest in the growth of extremities operated upon by exsection, as observed by Kœnig of Hanau,* is probably founded on error and should not prevent us from resorting to so legitimate an operation in its proper place. The growth is impeded by the previous disease, a fact most probably ignored by that author.

From these remarks it appears that exsection, as well as amputation, has its defined therapeutic value, and one cannot well be substituted for the other without risk and injury to the patient. I have nothing to do with the technicalities of either operation at this juncture.

Permit me, however, to tender my advice in reference to two points in exsection.

I. Before proceeding with the operation, overcome, if possible, the existing malposition by dividing the contracted muscles. I have mostly taken these preparatory steps and thereby secured perfect control of the subsequent position of the extremity. I owe, perhaps, to the observance

* Archive of Clinical Surgery, Berlin, 1867.