necessity for the more severe operations may often be avoided. I should also like to hear the opinion of the members as to the tendency to relapse. In my limited experience this tendency is great, if the after treatment by manipulation and splint is not for a long period continued.

Mr. Davy, of London, advocates in severe cases with tendency to relapse after tenotomy, that a wedge-shaped block of the tarsal arch should be removed by a fine saw or chisel; the base of the wedge is outwards, inwards, or upwards, according to where there is the greatest deformity.

Dr. Phelps, of Chateauguay, N.Y., has lately introduced a new operation for club-foot. He makes an incision across the sole of the foot, and divides all the resisting structures down to the bones. The foot is then brought into position on a special splint, and the wound left open. By brushing a stick of nitrate of silver through the bottom of the wound the granulations are prevented from springing up too rapidly, and the wound is induced to heal from the sides, and so contraction is avoided. I am afraid that I have already almost exhausted your patience, and so shall conclude this report by touching lightly on the *Surgery of the Joints*. Now-a-days, joints are opened fearlessly, and often recklessly and unnecessarily. This, no doubt, is due to the success of antisepticism. At the International Congress this subject was very fully discussed, and the feeling among English surgeons, at any rate, was that most cases of joint disease could be cured by rest. They deprecated the early excision which was advised by Continental surgeons, and thought excision should only be resorted to in extreme cases, and that in private practice it was rarely necessary. Since the Congress, a method of treating diseased joints by *Erasion* has come into vogue. Where the disease is confined to the synovial membrane, an incision is made in the side of the joint, an instrument introduced, and the diseased parts of the synovial membrane scraped away. The wound is then stitched up and a drainage tube inserted. Cases are reported where, after healing of the wound, passive movement was commenced, and the patients recovered, with easily-movable and almost perfect joints. Where the disease commences in the bone, trephining and scraping out the diseased bone has been successfully accomplished, the patients recovering with perfect joints.

König, of Göttingen, in a paper on the tuberculosis of bone and joints, says the synovial membrane is rarely the primary seat of disease in tuberculous cases, and that not even in the most favourable cases can any cure be expected from any therapeutical measure short of a surgical operation. The surgeon should aim at removing the primary morbid deposit in the bone, and then extirpate the diseased parts of the synovial membrane. In his after treatment he finds Iodoform of the greatest service. In cases where it is used the discharge is usually scanty, and the first antiseptic dressing may remain on for many days. He lays great stress on the point that the disease in the articular ends of bones should be removed before the joint is affected, and where it has already reached the joint, if the joint is opened early, the disease may be removed before the synovial membrane is affected.

I know that our worthy President is rather sceptical about these cases, and so great has been his success with excision, of the knee especially, that he prefers to adhere to the practice for which he is so well known. I merely present these methods of treatment to you for discussion, trusting that some new light may be thrown on the subject.

And now, Mr. President and gentlemen, I have come to the end of the subjects I proposed in the beginning of the report to touch upon. I feel that I have but poorly accomplished the task I set myself to do; still, I shall feel amply satisfied if you, with your matured wisdom and experience, will add your quota to the knowledge we already have of these subjects.