

of the glenoid cavity—especially when the dislocation is forward, by a combination of pressure, locomotion and torsion—in many cases so damages the neural structures as to thereafter dangerously compromise the vitality, nutrition and contractile power of the muscles which this plexus animates. Hence, with many dislocations at the shoulder, we will find the full functional strength of the joint permanently impaired. And when active myositis spreads, and the thoracic muscles with the advance of sclerogenic changes within the muscle sheaths with adhesions binding more or less the various muscles together, the range of articulation is greatly restricted. In others, although reduction is readily effected, a more serious phase of contracture may follow. Progressive parenchymatous inflammation may occupy one or more muscles and wholly destroy their striated corpuscular elements. When this change occurs, degeneration, atrophy and immobility follow, and the full functional use of the joints is forever lost. In another class, though not so very rare, we will observe that from the time of accident, as all muscular contractile power at the shoulder is destroyed, the bone cannot be retained in the socket, but continually falls out as often as returned. When, however, none of the muscles, except those which fix the bone in its articulation, are injured, the limb may possess a fair share of usefulness. Similar myopathic states are met with in other articulations, but in none so commonly and so well accentuated as at the shoulder. The primary, initial and predominant lesion here is neural; the muscular, arthritic, vascular and osseous are chiefly, if not solely, consecutive.

Among injuries which occupy the front rank in frequency and importance in inducing circumscribed or extensive atrophies or motorpalsy, are the different varieties of fracture. These lesions entail damage to the neural trunks, the muscular and other tissues—first, by extreme tension, contusion or laceration; secondly, by the extremely active inflammatory reaction, which may follow, when the extent of bone disorganization is extensive; and thirdly, by inclusion or pressure, or by an over-riding or angular deformity of the reunited bone shaft.

In certain phases of fracture which involve different bones, temporary or permanent atrophic phenomena, with or without motor paralysis, are unavoidable and inevitable, during early childhood particularly. Hence, in consequence of this, unless a critical and discriminating examination is made, with a full knowledge of