was more rapid. However, as her health continued satisfactory I was in no hurry to make an incision. At last febrile symptoms having appeared, an opening was made on the 25th Oct. The pus of this abscess was found to be healthy and free of smell. A poultice was at once applied, and the matter allowed to escape by degrees, no pressure being made. The febrile symptoms soon disappeared, and the general condition was satisfactory. I now noticed that she had greater use of the limb, and that moving it gave little pain. The limited movements of the limb seemed due to contractions of the muscles and adhesions in the vicinity of the abscesses of the thigh and groin. I could flex and rotate the thigh with no pain to the patient. There was little or no tenderness from pressure over the trochanter. Flexing the leg, the knee could be rapped sharply without causing pain in the hip joint. This was a state of affairs I had not anticipated. Taking it for granted that the primary trouble was in the joint, the disease had evidently not only departed from it, but had left the joint in a functionally very good condition. Finding this I instructed the patient to move about more and try to use the limb. Since that time she has acquired more use of the limb, and, I believe, could walk upon it if it were not shortened. Her health has improved and is now fully re-established. At the present time the discharge at the groin is very limited, and, from the contraction around the mouth of the sinus, seems likely soon to close. The discharge from the back shows no sign of ceasing, but it is never great. It is sometimes watery; but otherwise laudable pus. It does not irritate the integument around the opening.

The question naturally arises, What is the cause of the continued suppuration? What is its source? In a word, what is, and has been the pathological state of the structures involved.

A few days ago I made a careful examination of the patient. Directed to stand as erect as possible, it is observed, looking at the back, that the spinal column is seemingly almost in a line with the axis of the right or sound leg. A closer observation shows that the pelvis is oblique, the left crest being nearly four inches higher than the right. The lumbar portion of the spine is curved. The left buttock stands out with marked prominence. The left leg is slightly flexed at the knee, and the limb slightly inclines across the opposite leg, but can be brought by the patient on a line with its fellow. The heel can be brought to about four inches from the floor, the toes about three. The limbs measured, while the patient is lying down, from the anterior superior spinous process to the ankle, shows the left leg to be one inch and a half shorter than the right one. From the summit of the crest to the heel of the left side, it is nearly four inches less than in the right. The thickened and indurated condition of the part prevents a satisfactory examination of the trochanter. The outlines are indistinct. But the distance from the pubes to the trochanter is pretty much the same. From the left superior spinous process to the trochanter, the distance is about an inch less than on the opposite side.

From the history of the case and the present symptoms, it will be seen that it is in several respects very singular. We have not the ordinary features characteristic of morbus coxarius; or rather, we have with many of the usual features, others of an exceptional character. To these I will now refer in the order in which they appear in the history of the case.

The first peculiarity was the paroxysmal pains, occuring twice a day at regular hours and the absence of any other symptoms. She was quite well between the attacks, and at the end of three weeks, without any treatment, the attacks ceased. After this she was seemingly quite well for about eight months. Now I must confess my inability to account for these very distressing paroxysms of pain. We may take it for