

matory thickening and retraction of the ligamentous and other fibrous structures, external to the joint, the joint itself remaining in a healthy or nearly healthy condition, without any destruction of the articular cartilages, but sometimes with intra-capsular adhesions. The first is usually the result of strumous disease and to be overcome by gradual mechanical extension, with or without tenotomy. The prospect of restoring the motion of the limb in such cases, is exceedingly limited. The second class of "False Anchylosis," is the result of acute rheumatism or gonorrhœal complication. Such cases have been overcome by forcible extension under chloroform, opposing contracted tendons, having been carefully divided, a few days previously. In the incipient stage of these cases, very gradual mechanical extension, with passive motion, will occasionally succeed, but the degree of success so far, is by no means encouraging. It is of great importance to ascertain if the neck of the thigh bone, *is normal*; shortened; or obliterated, as operation is only admissible in the *first two*, providing the usual circumstances *are favorable*. The nature and character of the disease goes far, to establish the diagnosis.

There is usually no destruction of bone in rheumatic anchylosis; traumatic inflammation, in which the joint has escaped injury; or subacute pyæmic inflammation. In strumous disease, attended with necrosis and bursting abscesses, destruction of the head and neck of the thigh bone, usually take place, the only exceptions to such being, arrest of the disease in the incipient stage of developement. This whole subject is one of unusual interest, connected as it is, with arrested normal locomotion, and the recent advance made, as to a more accurate comprehension of *hip joint* pathology and treatment, is exceedingly satisfactory and encouraging as to the future benefits which may arise therefrom. It is exceedingly interesting to observe, how from time to time, the various ideas, in subcutaneous operations of bones, resulted in the development of Adams' operation. Guérin of Paris first divided bones subcutaneously in 1841. In the Schleswig-Holstein War, 1848, Langenbeck performed several resections subcutaneously, with a small straight pointed saw. According to Professor Gross, Dr. Pancoast, Sr., in 1859, perforated the femur subcutaneously,

several times through one opening, just above the knee joint and then fractured the bone. In 1860, I had the pleasure of hearing the late Dr. Brainard of Chicago, describe the operation he performed in anchylosis of the knee joint, similar in many respects to that of Pancoast, only that he used various sized long perforators, which answered admirably, the patient having recovered with a good limb.

Mr. Maunder of the London Hospital, now advocates the use of chisel and mallet in subcutaneous section of the femur, to correct angular deformity in hip joint anchylosis. So far the results of his operation have been very successful. Professor Volkman has also employed various sized chisels, instead of a saw, in this operation. Thus we observe how the usefulness of two such important joints as the hip and knee may in a great measure be restored, by a more accurate knowledge of pathological facts, and a decided advance in surgical science.

The next subject of special interest in the "Surgical Section" of the Congress, was the treatment of Aneurism, as ably reviewed by Dr. Van Buren, of New York, during which he eulogised the treatment recommended by Mr. Jolliffe Tuffnell, of Dublin, the result of *position, rest* and *restricted diet*. Mr. Tuffnell followed, and in an admirable address, explained most lucidly, the treatment of aneurism by compression, with which his name is so intimately associated. The Dublin method of treatment of aneurism has achieved considerable success, and taken firm hold in surgery, identified with which are the names of Hutton, Bellingham and Carte, as well as Tuffnell. The treatment of aneurism from remote times to the present, has been gradually progressive, but the outcome of Dublin genius carefully applied pressure on the cardiac side of the artery, cutting off the supply of blood from the aneurismal sac, or as Dr. Murray defines it, "the complete stagnation of a mass of blood in the aneurism until it coagulates," has a philosophy at its basis, with a fibrillated *blood clot*, as a *monument of greatness*. Dr. Vanburen considers that the value of Esmarch's bandage in the treatment of aneurism is not fully estimated. Mr. Favell in his address on Surgery at the British Medical Association, in August last, cited the case of Dr. Reed, successfully treated by Esmarch's apparatus, where ordinary appliance