

pectoralis major causes abduction. The unopposed subscapular causes internal rotation, which, however, is also due to the action of both the latissimus dorsi and the teres major. Paralysis of the supinator brevis and biceps allows of pronation. The extension of the forearm is due to weakness or paralysis of the flexors, such as the biceps and brachialis anticus.

Treatment is altogether unsatisfactory. Certain of the milder cases seem to improve greatly themselves. Some improvement can be hoped for in nearly every case during at least the first twelve months of life, even without treatment.

Active treatment may be divided into (1) Treatment by electricity and massage. (2) Muscle shortening, as suggested by Mr. Robert Jones, and (3) Operative procedures.

Palliative treatment, as suggested (numbers 1 and 2), may be persisted in for some time, but the study of these paralyses by Doctors Clark, Taylor, and Prout, suggests that a period of one year is sufficient to test the permanency of the lesion, after which time the question of operative interference suggests itself. Operation here is theoretically advisable. The excision of the permanently injured parts of the brachial plexus, with the suturing of the cut ends, is rational, but I have not been able to convince myself, either by an examination of the cases presented by Dr. Taylor, or by the results reported, of the practical advantage to be derived from interference, although strong measures would seem to be justifiable in dealing with so grave a lesion.

*Cerebral or Spastic Paralyses* may be considered under three headings—Hemiplegia, Paraplegia, and Diplegia.

Hemiplegia, *i.e.*, a paralysis of one leg and one arm, is usually an acquired deformity, although in childhood it is usually acquired before the first year. Rupture of a cerebral vessel during a convulsion is, probably, the most frequent cause. Paraplegia, *i.e.*, the paralysis of both lower extremities, and diplegia, where we see a paralysis of both legs and arms, are usually congenital conditions, and are most frequently due to the use of instruments or to a difficult labour. These deformities are most frequently accompanied by disordered cerebration.

Treatment.—Much can be done in the milder forms, and, indeed, in some of the gravest, by tenotomies of contracted tendons and myotomies. I know of few classes of patients where the surgeon can get more satisfactory results in even bad cases when the patient may have extreme equinus, scissor gait through adductor spasm, flexion at the knees, even accompanied by defective cerebration. The majority of these patients can, by operative procedures and by tenotomies, be enabled to walk, and the ability to walk seems to give new confidence to the little patient, and the chance