may be introduced deeper than the tendon so as to cut toward the surface or may be introduced between the skin and the tendon so as to cut inward. The internal lateral ligament and also the calcaneo-scaphoid may be cut through the opening made in reaching the tibialis posticus. In cutting the plantar fascia it is well to introduce the tenotome at its inner margin as close to the tubercle of the oscalcis as possible. By so doing the knife is made to pass behind the plantar arteries and cutting may be done freely without any fear of hæmorrhage. The same precautions should be taken to secure an aseptic condition of the foot before making these subcutaneous sections as if an open wound were being made.

The next class of cases is such that rectification cannot be made even when tendons and fasciæ are cut subcutaneously. Here the simplest and most satisfactory method is that which is known as "Phelps' Open Section.", Phelps himself begins the operation always by cutting the tendo Achillis and then rectifying the deformity as much as possible. Personally I much prefer to commence by making an incision as he describes a little in front of the internal malleolus, extending downward and forward in the concavity at the inner margin of the deformed foot as far into the plantar surface as may be necessary. Through this incision are cut all the structures which will stand in the way of rectification. There may be especially enumerated the tibialis posticus, the tibialis anticus, the fascia at the inner border, the internal lateral ligament, the abductor hallucis, the short flexor, the plantar fascia, the long flexor of the toes and the calcaneo-scaphoid ligament. It must not be assumed that all of these structures are to be cut as soon as the incision is made. In many instances the deformity may be corrected when only the skin and the superficial structures have been cut. At each stage of the operation when any obstructing band has been incised an effort should be made with the hand to place the foot in a correct position. If this can be done no further cutting is required. However, if the foot cannot be placed in a corrected or rather an overcorrected position then further section is needed. It is claimed that some cases cannot be corrected even in this manner. If so, the next step is to make a linear section through the neck of the astragalus. Should it still be impossible to fully correct the foot then a wedge-shaped piece should be removed from the outer aspect of the oscalcis. Personally I have not found it necessary in more than one case to make a section of bone to correct any deformity of the foot.

The dressing of this wound is an important matter. In my first case I packed the wound from the bottom so as to control hæmorrhage. In this case healing occurred leaving a deep hollow at the inner margin of the foot, and other cases I have seen where a deep scar remained extending to the bone. I now dress over the wound leaving it without any filling. I find it quite possible to leave the dressings on for a period of two weeks or more without having any considerable elevation of temperature and on removing the dressings, frequently find the wound healed and the surface even. Hæmorrhage in this operation is very seldom troublesome. The vessels and nerves may be seen and avoided. After the dressing of the wound a plentiful layer of absorbent cotton is placed about the foot and limb as high as the knee and the limb incased in plaster of Paris.

When it is thought that the wound made at the inner border and plantar surface of the foot has sufficiently healed, then section of the tendo Achillis should be made, and the equinus corrected. In my experience there are few feet that may not have this portion of the deformity well corrected when complete section of the tendo Achillis has been effected. The foot must now be forced into a fully corrected position, *i. e.*, to say into one in which the plantar surface will make an angle of 80° or less, with the axis of the leg, and must then be retained in the fixed dressing for some weeks.

After section of any of the tendons or structures above named, there need be no hesitation in drawing the segments of the cut tissue as far apart as the circumstances require. It is not uncommon, for example, to draw the segments of the tendo Achillis an inch and a-quarter away from each other. If asepticism has been carefully secured union will be good, and the gap will be thoroughly filled in.

There remains still another class of cases. That in which the equinus cannot be fully corrected after section of the tendo Achillis. When the anterior portion of the articulating surface of the astragalus is so broad that it cannot be wedged in between the malleoli it may act as a fulcrum,