On the whole the results following this work in the paralysis and paresis following anterior poliomyelitis of infants have not been good, due, says Hoffa, to not treating these cases first and getting rid of contraction and other deformities before attempting the tendon suture. Further, one must pick out his muscles with care; the functional capacity is not always rendered sufficiently clear by the electric reaction, we must also depend on the appearance of the muscle at the time of operation—the normal dark red, the paralyzed white, the paretic pinkish. Asepsis and proper arrest of hæmorrhage are, of course, a necessity. Don't over shorten; don't put the plaster on too tight; don't split the tendons too finely, and follow your operative results with massage and electricity are some of the points brought forward. In the spastic diplegia of infants over shortening is very probable, the conversion of a pes equins to the still worse condition of pes calcaneus has occurred again and again. In progressive muscular atrophy surgical interference is justifiable, inasmuch as the disease is but slowly progressive, and he has seen many cases of temporary improvement after operation.

A detail of results in pes equinus, club-foot, flat foot, pes calcaneus, quadriceps and deltoid paralysis is presented.

A. S. Barker, F.R.C.S., of University College Hospital, London. "A Report on Clinical Experience with Spinal Analgesia."

"There seems but little doubt it has rendered possible life-saving operations, which would have been almost certainly fatal under general anæsthesia." Such, briefly expressed, is Barker's conclusion, though he refrains from any more definite expression as to the future of this form of anæsthesia. Barker used stovaine throughout, at first in sodium chloride solution (Chaput's), later Bier's, and finally a glucose solution of his own devising. In 11 out of the 100 he failed, but it is noteworthy that these all occurred in the first 50 cases and are, thinks Barker, due, to not introducing the solution into the canal, at least in toto. Headache, vomiting, were occasionally noticed, never severe, and it was remarkable that when patients had had experience of general anæsthesia and lumbar puncture they, with one partial exception, preferred the latter. The injection was made in the ordinary way, in 3rd or 4th lumbar space—on the average 5 c.c. of the solution were injected; in 5 to 10 minutes analgesia extending as a rule as high as ensiform cartilage occurred and lasted from 23 minutes to 2 hours, the average being 50-70 minutes. The first symptom, as a rule, was formication in feet, followed by loss of sensation in the perineum gradually extending to legs, thighs and abdomen. All operations were at a lower