If the disease is acute in character, we get what is known as the second position. This is, flexion, adduction and internal rotation. Here the spasm of the muscles in their attempt to protect the painful joint comes into play, and the stronger muscles decide the attitude of the limb. It happens that the flexors, adductors and internal rotators are stronger than the extensors, abductors and external rotators, so that the resultant of the spasm of all, is the position of the second stage. Contrasting the two positions as the patient lies in bed, as I have had an excellent opportunity of doing in the case of a boy whose right leg was in the first and whose left was in the second position, we have a picture something like this:

The leg in the first position lies in an attitude of rest upon its outer side, pointing a little away from the median line of the body, and easily movable to a limited extent. The other is inverted and drawn tightly in towards the middle line and is absolutely rigid.

Resulting from these acquired positions, we have several others which try to hide the deformity. Thus, flexion is partially hidden by an increased lordosis in the lumbar vertebre, a circumstance which must be remembered in the examination of the patient. The abduction of the first stage and the adduction of the second, result in the elevation or depression, respectively, of the diseased side of the pelvis, in order that the two limbs may remain parallel. In consequence, if measurements be made from the umbilicus to the malleolus, there will be found apparent lengthening in the first stage and apparent shortening in the second. In the examination of the patient it is as important to note these masking deformities as to note the original distortion, since one is as characteristic of the disease as the other.

Of course, when the disease is very far advanced, and bony changes have taken place, within the joint, all sorts of deformities occur which follow no set rule whatever. It is not with these, however, that we, as young practitioners, have to deal when meeting a case for the first time, so that I shall pass over them without further remark.

Examination of the region of the joint itself will often, in the early stages assist in corroborating a diagnosis of hip disease. In practically all cases at the Children's Hospital, the inguinal glands are markedly swollen, and the superficial veins blue and distended. Palpation will often give the sensation of an indurated inflammatory area, although there may be no sign of abscess formation. The changes in contour about the joint are largely due to the position assumed by the limb and to the atrophy which takes place in the thigh.

As a sign of hip disease atrophy is of importance, because