

of grave central lesion; in the moderate type recovery is the rule. Meningeal or medullary hemorrhage, all authorities agree, can rarely occur as a primary lesion, after trauma, except in the event of fatal destruction of the medullary elements.

Extra-dural hemorrhage is seldom a cause of inhibiting function, except when sudden, primary and of large volume. In the lumbar or sacral segments, hemostatic pressure—hematorachidian—seldom operates alone, as an inhibitory influence on the nerve-cords, as in this situation the intervertebral apertures are so large as to permit of a free sanguineous escape into the loose connective tissues along the lateral and posterior walls of the vertebra; hence in this situation concentrated and prolonged compression is quite improbable. We are justified in regarding spinal hemorrhage as devoid of grave significance, with rare exceptions. It is, there-

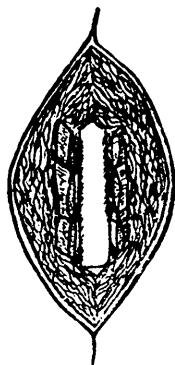


FIG. 6. Laminectomy, showing cord in position.

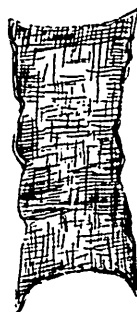


FIG. 7. Removal of posterior ligament.

fore, only when intra-rachidian hemorrhage exists as a complicating factor, that it may be a cause of serious apprehension.

*Spinal Fracture—Apophyseal and "Broken-Back."*—Spinal fracture presents so many unique and striking features that it should be always considered in a separate category. The subject becomes more simple and comprehensive if we would more critically examine into the anatomical architecture of the triple-curved, hollow, osseous tube. Its dominant characteristics are its strength and its pliancy. In virtue of the latter, its axis and angles may be altered; it may be bent within certain limits and be rotated without any marked diminution in the diameter of its canal.

Although the current works on anatomy describe the spine as made up of a chain of vertebræ, of separate independent links—something apparent enough in the skeleton—when we examine the body of the spine as a whole with the soft parts *in situ*, we will do well to note that the segments, the so-called bodies have