was known as "drainage," and when the fragments were kept in the vise-like grip of rigid, unyielding adjustments, and thereby the vascular system nearly palsied, surely enough tardy or imperfect union was the rule.

Compound fracture wounds were formerly quite invariably drained.

Prophylactic drainage had indeed been regarded as a surgical dogma in open fractures, as in open wounds of nearly every description, whether they involved cavities or not. But we have now been convinced that indiscriminate drainage is a bad practice, and that in an aseptic or a recent wound, in healthy tissues, "drainage" is worse than useless.

It therefore follows that in recent compound fractures not attended with extensive laceration or contusion of the soft parts and an absence of shattering of bone, the overlying tissues may be closed in, with or without suture, and prompt primary union may follow of the fleshy and bony tissues.

Incision through the overlying tissues for purposes of diagnosis in fractures is certainly not justifiable, except in those involving the skull. By the use of the X-ray and other expedients a therapeutic diagnosis is practicable in all fractures.

Free incision, therefore, in many fractures is permissible for purposes of treatment—osteoplasty, for diagnosis only, never, except in skull fractures.

The Scope of Secondary Osteoplasty in Defective Joints or Deformed Limbs after Fracture.

Secondary osteoplasty, judiciously utilized, will often yield remarkable results, and may be regarded as one of its most salutary achievements in traumatic surgery. It deals with bones after their fragments have united, when the nerves are caught or compressed; in a hyperostosis, when the shafts are greatly deflected—in fact, when the limb is crooked and deformed—when a joint has been involved and its motions are either greatly impeded or entirely lost. It is an invaluable resource in the pseudarthroses. With the joints its great fort is at the hip, the shoulder, or, above all, at the elbow. Stimpson has utilized it with advantage after union and deformity at the ankle in Pott's fracture.

Secondary osteoplasty, however, may be employed with great latitude on the bony shafts of the extremities; with the greatest advantage on the leg. The sooner after union and the younger the patient the better. It is almost marvellous what we may accomplish by osteoplasty in the bones of growing children, as was recently demonstrated by Heuter (*Wiener klinische Rundschau*, März 12th, 1899). In a fracture of the humerus (patient five years old) attended with considerable loss of bone and a flail joint, he turned to the skeleton of the thorax and resected ten centimetres of the fifth rib, imbedded it in the hiatus in the arm and