jury, is a good illustration of non-union. It was a transverse fracture at the junction of the head and neck of the bone. Specimen No 1130[8]0, from the same Museum, on the other hand, is here shown you; it is described in the Museum catalogue as an intracapsular fracture firmly united; and by longitudinal section shows bony union. The specimen belongs to Dr. T. G. Morton, and was removed from a patient, aged 67 years, twelve years after the accident that caused the injury. There is some evidence of impaction near the base of the neck; and it is perhaps *possible* that part of the line of fracture extended without the capsule. Of this we have no definite evidence, as the ligaments were removed in preparing the specimen. This cast of a specimen is from the Mütter Museum of the College of Physicians, and represents an impacted fracture of the femoral neck in which there was *inversion* of the leg. The patient was under the care of Dr. Conklin, of Ohio.

I have made these prefatory remarks to introduce the clinical history of a patient who has now good use of her limb subsequent to an intracapsular fracture, although treatment was abandoned shortly after the receipt of the injury. She has probably a short fibrous union; possibly a true bony one. In either event, however, the result is gratifying; and teaches that such cases should not be looked upon as necessarily hopeless in respect to union.

She is a German, 78 years old, and was admitted to my ward in St. Mary's Hospital, on August 30th, 1884, after falling from a street car. The resident surgeon believed there was no fracture at the hip; but on my visit I considered that the position of the limb and the patient's age pointed to intracapsular fracture of the neck of the femur. On taking hold of the leg and making rotation without violence I felt indistinct crepitation. At once desisting from further manipulation, I ordered permanent extension by weights and lateral support by sand bags to be the treatment. Within four days incontinence of urine, the development of a superficial bed-sore and the debilitated condition of the patient showed me that there was danger of the aged woman dying. I accordingly ordered the resident surgeon to discontinue the fracture dressing, so that the patient's buttocks and back could be kept clean and the bed-sore properly dressed; telling him that no union of the fracture was likely to occur, and that we must endeavor to save life by tonics, stimulants and food, and the prevention of further bed-sores. I gave a similar prognosis to to my Polyclinic pupils who saw the case. Ten days later, that is two-weeks from the time of injury, another incipient bed-sore was noticed on the buttocks. The hospital notes of this date say that I ordered change of posture to be frequently made, and that she sit up as soon as possible. Six days subsequently she was sitting up in a chair. I am unable to say whether she got out of bed previous to this date or not. The bladder symptoms gradually improved, she soon sat up all day, and on October 4th, five weeks after admission, it is recorded that she was walking on crutches. On October 26th she was able to walk a little *without* crutches, though she did not do so much. She continued to gain in activity until her discharge, on November 2nd.

The result was so unexpected to me, for no restraint of motion at the hip was attempted after four days, that I almost mistrusted my diagnosis, and concluded that possibly the resident surgeon's original diagnosis was correct. I had made no investigation of the condition of the limb since she began sitting up. A few days before her discharge, however, I put her in bed, and with my colleague, Dr. Keen, examined her. The leg was strongly everted, as in intracapsular fracture, immediately after the injury, and she was able to invert it only so far as to make the toes nearly vertical. She could raise the leg, however, and lay it across the other or carry it outward, and, indeed, appeared to have every motion of the joint, except full inversion, though she stated it was a little stiff when walking. She had no pain. The everted leg, therefore, made the correctness of my diagnosis an established fact. Here, then, in a woman of seventy-eight years, was obtained union and a useful limb, despite the absence of treatment. In the face of such result, treatment should always be attempted, and not abandoned unless circumstances, such as arose here, demand its discontinuance. Well directed treatment will certainly be expected to make many good cures, if no treatment will occasionally give so excellent a limb.

TREATMENT OF TUMORS.

Dr. McNaughton Jones (*Med. Press and Circular*) gives the following advice in regard to the treatment of tumors:

The larger our experience of tumors of the mammary gland becomes, the more do we see the uselessness of trusting to external applications of any kind to dissipate them. Iodide of potassium, iodide of lead, iodine, the oleates of lead and mercury, discutient lotions of chloride of ammonia with camphor, combined with compression, are at times of use in the case of small nodosities, chronic induration after inflammation, and small cystic growths, but they more frequently fail, and unless growth is otherwise arrested, the use of the knife is sooner or later called for.

Lipomatous tumors, small cystic tumors, galactocele, adenomatous nodules, may remain for years if not permanently, without growing or giving rise to any pain or even uneasiness, and all such growths cause great uneasiness in the mind of the woman, and make her apprehensive and unhappy. I am not so certain that if the rule to completely