in various places around the joint, some seven or eight incisions were made for the purpose of evacuating pus.

On examination the patient's general condition was considered good. The right hand was firmly ankylosed in a flexed position at an angle of about 135° with the forearm, the fingers being extended and only allowing of a minimum amount of movement. Scars were present all around the joint, and on the palmar surface there was a large sinus out of which the semilunar bone, much necrosed, had made its way on the previous day. The opening, which was about three eighths of an inch in diameter, presented excessive, unhealthy granulations and emerging from it was a purulent discharge. Pronation and supination could not be performed. From the history and the condition on

examination, the diagnosis was made of infective necrosis of the wrist.

Amputation seemed inevitable but as the general condition was good and there were no signs of acute disease, one suggested a stay of six weeks in hospital and decided to spend the first two or three in seeing what could be accomplished by excision, and, if neccessary, to amputate later.

On September 20th, I had him admitted to St. Michael's Hospital and performed the operation on the following day, Dr. Hodgins assisting, and Dr. Chambers administering the anæsthetic.

After an attempt to move the thumb and fingers, which was not very successful, and an Esmarch's bandage had been applied, the sinus was cleared out by curetting and disinfected with a solution of alphozone (1 in 1,000). A single metacarpo-dorso-