myelitis and it has seemed to be of much service. I have never had a complete disposition of the paraffin such as Moorhoff himself has recorded so many cases of. Since this last operation the child has not shown any evidence of infection of the paraffin in as much as the wound looks fairly clean though there is a little suppuration from the ends. I have had no personal knowledge of recovery from so extensive a disease as the whole of the diaphysis of the tibia, and the progress of this case will be watched with interest. Dr. Elder has one case of old standing osteomyelitis of the fibula where the sequestrum has been taken away and the new bone formed, forming the typical hard eburnated tissue which usually follows this disease. I am indebted to Dr. F. Gurd, for the drawing shown.

DR. A. LAPTHORN SMITH, M.D.—I would like to know what would become of this paraffin and iodoform where the periosteum will reproduce the bone; as the bone grows will the wax be squeezed out or will it be absorbed in any way?

Dr. F. R. ENGLAND, M.D.—I would like to refer to a case presented to this Society by Dr. F. J. Hackett, where he had removed the entire clavicle for osteomyelitis. The periosteum was preserved, the part cleansed, and the wound allowed to heal by granulation. No wax was used. When the patient was brought before the Society it was evident that an excellent result had been obtained and a very serviceable clavicle had been developed.

DR. J. ALEX HUTCHISON, M.D.—In answer to Dr. Smith's question I would say that if the cavity is not thoroughly disinfected the plombage separates into small particles and is gradually washed out by the subsequent suppuration.

Where the cavity is thoroughly aseptic the plombage is gradually dissolved and gradually disappears, as Moorhoff has so well shown in his radiographs, the gradual narrowing of the shadow and its becoming smaller at different periods after the paraffin was introduced.

The fourteenth regular meeting of the Society was held Friday evening, April 24th, 1908, Dr. Wesley Mills, President, in the Chair.

FORCIBLE CORRECTION OF LATERAL CURVATURE.

J. APPLETON NUTTER, M.D.—Cases of lateral curvature suitable for forcible correction are not very common, hence I thought this of sufficient practical interest to bring before the Society. Lateral curvature may (Lovett) be divided into two large groups (1) postural, or functional, due to faulty attitude and without actual bony changes, and (2) structural, or organic, where an X-Ray would show definite changes in the spine. Postural scoliosis shows in 90 per cent of cases a curve to