

becomes enlarged and the cortex becomes thinner as age advances. Constitutional trouble, as syphilis, rickets, scurvy, struma and trophic lesions, due to diseases of the nervous system, are factors; also caries and local inflammation, as osteitis, and atrophic changes in the aged. The nature of the force, the weak points and the contour of the bones will help determine the diagnosis and the seat of fracture; for instance, in fracture of radius, clavical and neck of femur, etc. The complications of fractures, like other injuries, may be immediate or remote. The immediate complications are shock, followed by delirium, injury to soft tissue, arteries (causing free hemorrhage), veins and nerves. Secondary complications may be delayed union, false joint or an ankylosed joint, sepsis, thrombosis, embolism, tetanus and trophic changes due to pressure or involvement of nerve in callus.

*Diagnosis.*—Differential diagnosis ranges from the cases that can be made out by the eye alone, to those cases where every point in the history, subjective and objective symptoms, pain, deformity, redisplacement, loss of function, mobility, crepitus, ecchymosis, shortening and other means have been reviewed without positive results. The comparison of the two sides is the means that few of us use to the advantage we should. The landmarks of the two sides should be almost identical, as well as the symmetry and measurements. Ecchymosis over or near superficial bones, and at the nape of neck will point to fractures near the side of the ecchymosis and at the base of the skull respectively. In distinguishing fractures from dislocations we should remember that when a dislocation is once reduced the function of the limb is normal. This is not so of a fracture. The fracture once set, and the parts allowed to take rest the deformity is re-established. There are fractures which, under certain conditions, it is impossible to diagnose. Some of these are: fractures at the base of brain, impacted fractures (especially near joints), greenstick fractures, epiphyseal separations, intracapsular fractures, fractures of the malar bone, fractures of the vertebra and of the carpa, metacarpal, tarsal and metatarsal bones.

*Treatment.*—In compound comminuted fracture of an extremity it is always good surgery to make an attempt to save the limb, especially if the arterial circulation appears to warrant it. These cases of compound fracture should first be put locally in good surgical condition, the patient, if necessary, being placed under general anesthesia to carry out the details of making a complete diagnosis. These cases need the gentlest of traction, and the least amount of lateral support requisite to keep the parts in place to prevent muscular spasm, etc. To prevent absorption of septic material, drainage must be allowed with an abundance of gauze protection. The swelling may be kept in check by the judicious