typhoid, there is not the definite history of pain and acute tenderness or pressure over some bone, nor the objection to movement of the limb.

In cerebro-spinal meningitis there may be the utmost difficulty in differential diagnosis, especially in those cases where the osteomyelitis affects the spine or cranium, as is shown in Keen's series of sixty-nine cases, where the cranium was affected in twenty-two, and the trunk in seven cases.

The pulse rate is usually slow in meningitis, the neck rigid, and Kernig's sign may be elicited. If in much doubt a lumbar puncture should be made when a turbid fluid containing diplococci is drawn off. In the bone lesion there is severe pain over the locality and in a few days swelling and redness may appear, and marked tenderness on pressure. Instead of the abscess pointing over the spine, it may form a retro-pharyngeal abscess, or burst into the posterior mediastinum, or track down the psoas muscle, and point above or below Poupart's, as seen in a case in Mr. Pierce Gould's clinic at one time. The inflammation may cause irritation of the spinal nerves, causing pain, which may aid greatly in localizing the trouble.

In erysipelas the main point in differentiation is the absence of deep-seated pain and tenderness. Tapping on the heel elicits acute pain in osteomyelitis, but not in cases where the inflammation is superficial.

A good working rule is given by Berg:

"Every child and young adult in whom there is a sudden onset of high fever, rapid pulse, etc., for which no adequate cause can be found—examine the bones, especially in those regions most frequently involved."

A radiograph may aid greatly in diagnosis. It is to be hoped that the estimation of the opsonic index for various bacteria, may assist in diagnosis.

Prognosis: The disease is always serious. The child may die in a week or ten days from general septicæmia; or if he survive this pyæmia may result, ushered in by recurring chills and irregular fever, as new abscesses form in the kidneys or lungs, or in some other bone or joint. Another fatal complication is fat-embolism. The neighboring joint is very liable to become involved either by an acute synovitis, or a septic arthritis. The former may rapidly subside after treatment of the bone lesion and leave very little or no impairment of the joint; the latter makes the prognosis grave indeed and may necessitate amputation. Should this not be called for, ankylosis is likely to occur, if the patient survive. Pathological fracture may occur from separation of the epiphysis or from fracture of the weakened shaft. In long continued cases *anæmia* is a marked feature. One of the most serious results is deficiency in growth owing to the injury to the epiphyseal cartilage. Marked shorten-