peroneal type, (b) the contracted muscular type, (c) the fibrous adhesive type, (d) the bony adhesive type.

(a) *The Peroneal Type.*—Here the foot is rigid through spasm of the muscles, and especially of the peronei. These, on attempted inversion of the foot, stand out in a position of extreme tension. The arch is often quite high. There is less likely to be disturbance of the circulation in this than in the other forms of rigid valgus. There is usually marked pronation. The scaphoid is rarely unduly prominent. The peroneal spasm is, as has already been inferred, probably of reflex origin. Under an anaesthetic it disappears, although the peronei may be congenitally or relatively normally shortened, this condition being demonstrated by muscular spasm. In this class probably belong most of those patients who have in the past resisted all forms of treatment. All surgeons who have been interested in valgus have experienced failures in the treatment of certain patients. Perhaps a brace has been used with results detrimental to the surgeon's reputation. Possibly the deformity has been corrected under an anaesthetic and placed in plaster of Paris in a position most satisfactory to the operator, and yet a recurrence has followed.

The treatment of this condition is peroneal resection, although this, to my mind, cannot be defended on theoretical grounds, practically it seems to be the only efficacious measure in some cases. This type has been studied principally by Mr. Robert Jones, of Liverpool, and in his hands the resection of three-quarters to one inch of the tendons of both peroneals with the destruction of their sheath at the place of resection, has been followed by most satisfactory results.

(b) *The Contracted Muscle Type* and (c) *the Fibrous Adhesive Forms* may be considered together except as to treatment. In the first type tenotomies are necessitated. Division even of the tendo-achilles being performed in some cases to assure proper correction, whereas in the second type wrenching is usually all that is required primarily.

In these there is inability to invert at the mediotarsal joint. The arch is usually low. There are usually signs of passive congestion, and there may be oedema. Flexion and extension are free. Attempts to passively invert are followed by pain and resistance. The latter may usually be overcome and the foot over-corrected by tiring out the muscles which are spasmodically contracted. If this is impossible, even under an anaesthetic, the adhesions must be more forcibly broken down by manual manipulations or by the use of the Thomas wrench, and the patient's foot put up in a position of extreme inversion in plaster of Paris. Osgood has suggested that the plaster is best removed in twenty-four to forty-eight hours. The foot at first gently, and later vigorously, manipulated,