a tendency to collapse on the part of the patient herself, we deemed it best to attempt reduction. We did so, but much to our surprise, we utterly failed to reduce the protruding shaft of the femur. Dr. Minshall and I called Dr. Douglass to our aid, and we made another attempt at reduction, but with no better result. As the patient now began to show signs of suffering from the continued anæsthetic (one hour), I advised amputation of the protruding end of bone to facilitate reduction, and my confrères concurring, I removed three-quarters of an inch, which allowed us easily to reduce the remainder.

Beyond the impossibility of reduction, I had other reasons for the course I pursued, viz. (1), the danger of pinching some important vessel or nerve between the diaphysis and epiphysis; (2) the probability of necrosis following the denudation of periosteum; (3) the greater probability of bony union between the fragments if the smooth end were sawed off.

The wound was then thoroughly douched out with bichloride solution, and the external wound closed by ten silk sutures. Iodoform was dusted over the parts, antiseptic dressings applied, and the limb left in a flexed condition at both hip and knee. The only antipyretic ordered was quin. sulph. gr. i, 4tâ horâ. Next day we put up the leg on Smith's anterior wire splint, and suspended the limb from the ceiling. The temperature was then 101$\frac{1}{5}$°, but gradually subsided to normal on Sept. 3rd, patient having suffered very little in the meantime. But next day (probably owing to want of drainage) temperature went up a little, and wound showed signs of sloughing. We removed sutures and gave vent to some bloody serum, and by Sept. 8th temperature was normal again, and we removed all sutures and held the edges together by adhesive strips. The wound then healed rapidly, and on Oct. 25th I removed the splint and found no articular effusion and some motion. Put leg up again on anterior copper splint and starch bandage, and left it until Nov. 14th, when I substituted a short knee splint, and found more motion and evidently good bony union. Ordered patient up on crutches, and from that on her improvement was rapid. On Dec. 1st she walked with only a slight limp, had a good moveable knee-joint, with one inch shortening of the affected leg."