

described nearly always causes the child to cry vigorously at the time if done without anæsthetic, yet the evidence of suffering passes away quickly, and, from the first, the child sleeps and rests as if nothing unusual had occurred, and, in at least one instance in a girl of four years, complete correction of a well marked deformity was effected, the foot, however, not being short nor very difficult to replace, without any crying of the child except at the first dressing.

It is quite unnecessary that at any stage of the treatment abrasion should occur if care is taken in manipulating the foot to bring only the soft parts of the operator's hand into contact with the foot, and if evenly distributed padding, with due attention to the prominent parts of the foot, may be used.

In the management of these cases in infants, the inversion and inward torsion of the foot should be well over-corrected sometime before the period when the child may be expected to walk, so that treatment may be adopted for the correction of the equinus, which depends largely upon the abnormal relationship which exists between the parts at the astragalo-crural joint.

In correcting the equinus the deformity which demands our attention is dependent upon the great increase in the depth of the anterior portion and the thinness of the posterior portion of the astragalus, upon the shortening of the tendo Achillis, the flexor longus digitorum, flexor longus hallucis, tibialis posticus, posterior annular ligament, fascia and skin at the back of the foot and ankle. In many instances this deformity may be satisfactorily and permanently corrected without the use of the knife, but much time is gained, and the patient is saved from suffering by subcutaneous section of the tendo Achillis. This tendon presents the chief obstruction to rectification, and when it is cut, nearly all cases may be so flexed in the direction of the dorsum of the foot as to bring the plantar surface up to an angle of 90° or less with the axis of the leg. The manipulation and dressing at this stage of the treatment are conducted as in the former part. The unexperienced, however, may easily fall into error and apply his dressings in such a manner as to cause abrasion in front of the ankle. As soon as the application of plaster of Paris is commenced, the foot must be held in the position it is intended to

remain in after the plaster has hardened. If the foot is permitted to remain extended while the bandages are being applied, and then the foot is flexed before the plaster hardens, undue pressure is thus made in front of the ankle which may cause extensive sloughing.

It is quite unnecessary to have brought the treatment to this stage until the time has come when the child may be expected to walk. The weight of the child and the action of the foot in walking constitute a most important factor in the rectification of the deformity and the restoration of normal function. There is a great difference between a child recumbent and a child walking.

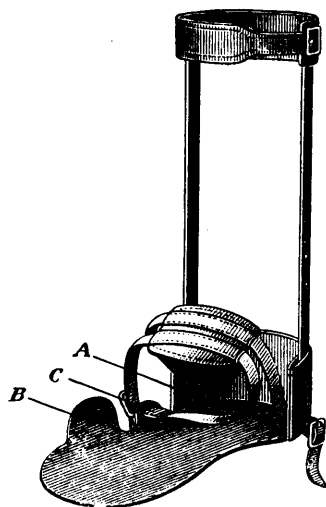


FIG. 7.—The Night Shoe.

A child in arms is yet free from the complications caused by falling of the weight of the body on the foot as it is retained in its abnormal position. If previous to this period the foot has been so changed that when the child begins to walk, the plantar surface comes into contact with the ground, then the weight of the body is changed from a deforming to a correcting agent.

During this period of treatment, *i. e.*, the period antedating the time when the child walks, various mechanical means in the way of club-foot shoes have been employed, but in the opinion of the writer there is no means of correction so effectual and satisfactory as that above described. The fixed dressings referred to, do no harm in producing atrophy or in any other way, if sufficient time is permitted between dressings for massage.

⁶When, however, correction of the varus and