

the tibia down to the ankle joint. The tissue was exceedingly thin, a little more than parchment-like in thickness. This was followed by a gush of thick, yellow, creamy-looking pus with some small blood clots.

When this was mopped out it was seen that the whole diaphysis of the tibia was free from periosteum in its entire length and circumference. It could be seen on examining the edges that the periosteum had retracted. The bone was completely bared. At the upper and lower portions near the upper and lower epiphyses there were evidences of regeneration of bone in a number of isolated patches. The bone was quite loose below but fairly firmly attached above. On closer inspection of the upper epiphysis it was seen that the whole of the front and sides and part of the posterior wall of the tibia were separated from the upper portion. With my fingers I simply lifted away the diaphysis from the lower epiphysis. The epiphyseal margins were covered with necrotic tissue and exudation. The periosteum was bright red and there were already evidences of granulation tissue over its entire surface. The part was cleansed out with a disinfecting solution and then packed with iodoform gauze. The ankle joint was not involved. The wrist was opened and the bones were found to be quite loose, in fact, the small bones slipped out when the examining finger was inserted in the incision. The second metacarpal was broken in its centre and practically disorganized so that it had to be removed largely with the curette.

A culture taken from the wound showed the staphylococcus aureus. This is the common infective medium in such cases. The removed bone was perfectly dry, showing a polished surface. The child was very ill for a few days but eventually improved, and about a week or ten days ago I made the attempt to close in the periosteum on the front of the wound, hoping that by so doing we might get new bone formation. To do this I used the method of Moorhoff. Unfortunately we have not in Montreal Moorhoff's complete apparatus for cleansing out such cavities. However, we attempted to thoroughly disinfect and dry out the membrane, and by bringing the parts together with a few interrupted sutures we made a channel or canal, and into this was poured the Moorhoff plombage, which consists largely of iodoform and paraffin, sterilized previous to being used and poured in in a heated condition, where it quickly solidifies. The success in its use depends entirely on the degree of disinfection of the space before its use; if this is successful the paraffin remains as a solid medium in which the periosteum will lie and is gradually disposed of during the next few weeks. Moorhoff's article refers to radiographs taken at intervals during convalescence, showing at first the cloudy area of the preparation, later its narrowing shadow, until it is practically disposed of. I have used it also in other cases of