

the ankle swollen and reddened for two or three days and the child had been feverish and very fretful. On examination we found considerable swelling over the lower tibial epiphysis and ankle joint. It did not extend up the shaft. The part was hot, red and œdematus and fluctuation was easily obtained. On operation the whole lower epiphysis was found separated from the diaphysis and almost surrounded by pus, which also filled the ankle joint. The child died two days after the operation.

The diagnosis may be easy, as in several of the preceding cases, where there was redness, swelling, pain and tenderness over the region of the epiphyseal cartilage, when first seen. Other cases are much more difficult and may be mistaken for typhoid fever, or show signs of peritonitis, as in case 1, or of tubercular infection as seen in the case of the errand boy. Some cases may be mistaken for rheumatism, or acute septic inflammation of a joint, and others again may be confounded with erysipelas.

Rheumatism usually affects several joints, shifts from one to another and is accompanied with acid sweats. The tenderness is in the joint, whereas in osteomyelitis the pain and tenderness do not shift from one place to another, but continue where they first originated, though in some cases foci exist in more than one bone; on careful palpation tenderness is most marked above or below the joint, over the epiphyseal cartilage, not in the joint. Those cases where the joint is also involved as well as the bone, are not likely to even suggest rheumatism, as the symptoms are so pronounced and severe.

In typhoid fever there are usually prodromal symptoms for several days before very severe constitutional disturbances are set up, and the temperature usually rises gradually for a few days after the first visit, whereas in the bone affection there may be no preceding symptoms, the disease setting in abruptly with a *chill* followed by a rapid rise of temperature which *continues high* until the pus is evacuated or death occurs. The *pain and tenderness over a bone* are the two most important available guides, and the latter may usually be elicited even though the patient be comatose. In difficult cases a leucocyte count should be made. We have always found a well marked increase of leucocytes in osteomyelitis, which is not present in uncomplicated cases of typhoid. The pulse rate is usually slower in typhoid. The Diazo reaction of the urine may be present in both. The Widal reaction is not obtained in the bone disease unless the patient be suffering or recovering from typhoid at the time.

In miliary tuberculosis the onset is not usually as sudden, the temperature is more irregular and the breathing more rapid. Foci may be found in the lungs or glands, and the leucocyte count is not high. As in