as successfully as recumbency. The patient should not be placed upon an ordinary bed, but upon the Bradford frame. Fixation and joint rest can thus be easily maintained and deformity prevented, while at the same time removal of the patient from place to place is greatly simplified so as to carry him out of doors and into the sunshine.

INJURY OR DISEASE OF THE KNEE.

Very commonly ankylosis results from affections of the knee, and probably the surgeon should not be held responsible therefor; but for deformity he should be held to account. One may walk very well with an ankylosed knee if the leg be straight, or better, flexed five, ten or twelve degrees; but if the permanent flexion be greater the individual is placed at a mechanical disadvantage. During treatment the leg should be maintained at about eight or ten degrees of flexion; such a position will in no way interfere with treatment, and if ankylosis occur the leg will be found in the position of election.

Sometimes during treatment a condition of hyper-extension is permitted at the knee. Such is seen more frequently in cases of long confinement upon the back, as, for example, in the treatment of hip disease where extension is applied. Frequently the contents of the mattress become thinned about the middle and fuller toward the foot. In this way there is not sufficient support at the knee, and I have occasionally found the knee hyper-extended. This was due not to the traction, but to the support at the feet and at the buttocks while the knee was left unsupported. Such a condition of hyper-extension causes considerable disability. A comfortable pad should be kept under the knee, maintaining a moderate degree of flexion.

Case 2.—E. E., 15 years of age, had been confined to bed for a long time because of hip disease. Recovery from that affection had been satisfactory, and she had been at home for more than a year when she consulted me because of hyper-extension and disability at the knee of the limb which had been affected with disease at the hip joint. Osteotomy of the tibia was done about two inches below the joint and correction made, much as is done by the McEwan operation in knock-knee. Improvement in attitude and function promptly resulted.