bicipital groove, having in mind a case somewhat similar where the surgeon on cutting down discovered an osteochondromatous enlargement of the humerus at that site. But the radiographs show quite another condition. Just below the acromion is a distinct shadow, probably due to bone, with quite a clear space between it and the regular contour of the head of the humerus. The question naturally arises as to the cause of this deposit of bone at this site and seemingly free from the humerus. Is it due to bone salts being deposited in a hæmatoma or is it due to a strip of periosteum being partially stripped off? The disability appears to be due to this bony mass, either in the capsule or in the joint, becoming impacted against the acromion in abducting the arm. Naturally there has been some arthritis associated, and one would expect adhesions in such a joint. There is no mass palpable, only the general thickening over the joint and marked atrophy of the deltoid.

II.—DOUBLE CLUB HAND AND DOUBLE CLUB FOOT.

This case was referred to me by Dr. Garrow. Such symmetrical deformities of the four extremities are comparatively rare. Following the method of Lorenz "modellirende redressement"—the right foot and left hand were completely corrected, and the left foot partially corrected. the deformity of the feet was marked equino-varus position; of the hands the right angled flexor deformity—no radial or ulnar deviation. The flexor tendons were markedly shortened; those of wrist, fingers and thumb. The correction of the hand was very gradual taking about half an hour and was then splinted; the feet being at once put up in plaster after correction.

C. B. KEENAN, M.D.—These cases present certain difficulties in prognosis and in treatment. Since at the first examination the usual signs of fracture are absent a good prognosis is given which is not justified in the result. The skiagraph alone can show the lesion in these cases. At times there is a partial fracture of the anatomical neck with impaction, again a crushing of the great tuberosity while at other times there is merely a tearing away of the periosteum. I judge the latter to be the lesion in the present case.

The treatment must be directed towards preventing limitation of movement which is almost wholly mechanical and due to the new bone formation (the callus) hindering the movements.

Whether to employ rest to prevent excessive callus formation or to use passive motion early to avoid its results is yet a debatable question.

F. R. ENGLAND, M.D.—In correcting the club foot case I would like to ask if an anæsthetic was used and if any apparatus was applied or whether continued passive motion in the treatment is relied upon.