vent abrasion. The most eligible of the fixed dressings thus employed is plaster of Paris.

The success and satisfaction attendant upon treatment will depend much upon the quality and preparation of the dressing employed. The plaster of Paris should be of the highest grade, that which is used by dental surgeons (sold as F. F. F. plaster). It should be so preserved that it will not be exposed to the air or to moisture. The bandages are made by tearing into strips of a necessary width some light, open meshed material. For this purpose the writer has found what is sold in Canada as book-muslin the most satisfactory form of web as foundation for the plaster. In the United States, surgeons employ what is purchased in the shops as crinoline. This should be torn into strips varying from two to five inches in width and from three to six yards in length, the smaller being used in the treatment of infants and children while the larger are found more satisfactory in dressing the feet of the adult.

Various machines are used for rolling the bandages, embodying the plaster as the rolling is done. The work, however, may be quickly and satisfactorily accomplished by rolling with the hands, spreading the plaster on the web, and rubbing in evenly with the edge of a table knife or druggist's spatula. The bandage should then be wrapped in paper and kept in a tin box ready for use.

In manipulation of the foot of a child, with a view to making correction, it is well to bring only the softer portions of the surgeon's hand into forcible contact with the parts that are to endure most pressure, *e. g.*, the head of the first metatarsal bone and the prominence over the cuboid and astragalus. If some minutes are occupied in moulding the foot into shape, and if the correction be carried during manipulation, further than it is intended to retain the foot in the dressing, the likelihood of causing abrasions or sloughing is rendered much less. Pressure with the tips of the fingers or with one or two fingers upon the plaster, while it is setting may be productive of unpleasant results, causing ulceration of the parts beneath. Constant watchfulness is necessary, but, when due care is exercised, the utmost confidence may be felt that no harm will result from pressure.

The dressing applied should be left on for a period varying from one to several weeks, and having been removed the foot should be left without dressing for several days, massage to be employed and the foot frequently manipulated so as to stretch the shortened structures at the inner side. This may be accomplished by an intelligent nurse or mother without creating any alarm in the child, thus favoring the development and healthful condition of the foot.

A second dressing is applied in the same manner as the first, the foot having been so everted as to carry the correction further than was done on the first occasion. After a week or more this dressing is removed and the case treated as before. These dressings are repeated from time to time until the varus is quite over-corrected and the distal portion of the foot is strongly everted.

If the child has been walking, and for this or any other reason the speedy correction of the deformity is desired, more forcible manipulation may be employed while using an anæsthetic from time to time and the over-correction of the varus be more speedily effected. Time, however, is an important element in the satisfactory correction of this deformity, as relative atrophy and shortening must result in the tissues of the outer side of the foot, while lengthening and growth must occur in those of the inner side, if the remedial measures are to be followed by an ideally successful and permanent result. In his earlier experience the writer frequently performed tenotomy especially of the tibiales at the commencement of his treatment, but now finds it quite unnecessary in most children under three or four years old.

Though the manipulation and dressing as above

FIG. 6.—The Day Shoe.