Analysis of the causes of deformity is necessary in order to arrive at a scientific method of correction.

The hand is abducted not only by the supinator longus and extensor proprius pollicis, but also, owing to the fact that, excepting in young subjects where the epiphysis is often separated, a certain degree of radial shortening ordinarily occurs through impaction.

The continuance of that force, which drives the inferior fragment upwards and backwards and lacerates the triangular cartilage, drives the ulnar portion of the carpus away from the ulna, whose styloid process finds its way forwards and inwards amongst the meshes of the annular ligament.

This is easily accounted for: the fibro-cartilage, the direct bond between radius and ulna, is already severed, and both anterior and posterior radio-ulnar ligaments passing downwards and inwards do not offer the same opposition to separation of the bones as though they were transverse; therefore the ulna has nothing to encounter in the way of luxation excepting the superficial structures.

In a recent instance with which I met there existed an additional deformity. The patient was a child and the radius was fractured at the epiphyseal line; therefore the opposing surfaces, being comparatively smooth, considerable flat pressure was required over the muscles to prevent the upper fragment from approaching the ulna. This tendency is caused in part no doubt by the pronator quadratus, but chiefly by the elastic stringency of the surrounding fasciæ.

Considering the difficulties attending perfect reduction, I do not think that any but the most simple cases should be attempted without an anæsthetic, and under its influence, while extreme adduction with extension are made, the most delicate manipulation should be observed in order that the operator may fairly conclude that the fragments are so accurately adjusted as to bring compact tissue in contact with its kind, otherwise it will enhance the difficulty of obviating radial shortening and consequent deflection of the hand to that side.

Subsequent circumduction of the hand with firm pressure will often restore the ulna to its proper position; but, should the dislocation be extreme and irreducible, although I cannot speak from experience, I imagine it an open question as to whether or not subcutaneous section of the offending fibres of the annular ligament would be less objectionable than a badly-deformed wrist.

A thousand and one splints have been devised and christened. I am well aware that in offering suggestions I run the gauntlet of being set down as another crank; and, in the way of excuse, express the conviction that the plan of treatment meets as far as possible every