pictures and specimens prove that under favorable conditions the progressive development of the pelvic bone will still further add to the security of the new position of the head. It seems to me that in a certain number of cases even a bony wall is formed around the head of the femur so that the acetabulum, which was originally flat and very shallow, now becomes enlarged and gives the head a suitable socket.

These considerations will justify my routine of leaving the first cast undisturbed for six months at least, sometimes even longer. Of course, I take all necessary precautions to keep the skin clean under the cast. My principal treatment in the future, after the cast has been removed, is to keep the head of the femur pressed against the acetabulum as much as possible. I do not try to correct the position of the leg in any way. I permit only so much reduction of the extreme abduction as is absolutely necessary for letting the child walk with spread legs during the day. At night the primary extreme abduction is reinstituted. I accomplish this with a cushion which is placed between the legs and fastened there. I might add that the ease with which the legs can be reduced from the slightly diminished abduction into the primary extreme abduction is a characteristic prognostic symptom. If any difficulty is met with in performing this manœuvre, it can safely be assumed that the head shows a tendency to slip out of the acetabulum and to glide under the superior anterior spine of the ilium.

CASE II.—The next child on which I will operate is already five years old and has, so far as I know, a double dislocation. I am sure that we will have some difficulty in reducing the dislocation, because it is a matter of experience with me that in all cases of bilateral dislocation reduction is rendered impossible at a much earlier age than in cases of unilateral dislocation.

The prominences of the great trochanter are visible on both sides and the head of the femur can be felt very distinctly. There is considerable shortening of the legs. The highest point of the trochanter is now four centimeters above Nelaton's line. The degree of abduction is diminished considerably. You can see the prominent line formed by the adductor muscles when the leg is abducted. The soft parts are very resistant. Although the child is only five years old, I do not believe that the reduction will be effected very rapidly.

I will begin by making a little extension of the adducted leg, and then forced rotation of the leg. Next I will attempt to overcome the contraction of all the soft parts, beginning with the adductors. The wooden pillow is placed under the trochanter and I institute forced abduction with massage of the adductor muscles until I have torn these muscles subcutaneously.