

has left me with the conviction that the results obtained by the accredited methods of treatment are far from satisfactory.

Every general surgeon has upon his list one or more cases illustrative of this point. Too often pain, deformity and limited function cripple the patient and humiliate the attendant. It matters little that the patient has been forewarned as to what have been regarded as inevitably disastrous consequences of his injury, nor does the approval of able counsel as to the line of treatment adopted free his mind from the impression that the result ought to have been more satisfactory. With the facilities now at hand is it possible to establish and maintain a higher standard of excellence in the treatment of elbow-joint fractures? The time has come when surgeons should answer this question definitely. From our large hospitals, wherein the pace is set so far as surgical achievement is concerned, there should issue an edict setting forth the rules of practise governing these cases, thereby approving or condemning methods which now prevail.

Fractures in this locality suggest a multiplicity of lesions, whose pathology and individual peculiarities have been adequately described, demonstrated and illustrated. Their limitation is between the supra-condylar line and any imaginable communication of the lower end of humerus. Their thorough understanding depends upon an accurate determination of three points: 1. The number, relation and direction of fracture lines. 2. The extent and character of displacement or dislodgement of fragments. 3. The relation of the fragments to the ulna and radius.

It is absolutely essential in considering these points, that appeal be had to the radiograph for a satisfactory interpretation of existing symptoms. No longer can the visual and tactile senses be implicitly relied upon for every link in the chain of evidence. It is true that the determination of the existence of a fracture, together with its general features, is a comparatively easy task. To predicate its exact limitations, to draw an accurate clinical picture, to identify each individual fragment, and give to it its true value in relation to prospective deformity or impairment of function, is most difficult of accomplishment. Surgeons will continue to inspect and palpate, to compare and manipulate. The three bony prominences of the elbow will be appealed to for such evidence as they may afford. The condyles will be scrutinized for mobility, crepitation, or faulty relations, but in most cases the evi-