surfaces of the metacarpal bases; and at the same time to leave the trapezium, the pisiform and the hook of the unciform, such preservation may be accomplished. Before the actual operation is commenced an attempt should be made to freely flex and extend the fingers, special attention being given to the metacarpo-phalangeal joints, and during the operation the tendon sheaths, if undiseased, should as far as possible be preserved intact. As a rule an attempt has been made to preserve all undiseased periosteum. Such a step is strongly advocated by Ollier, who claims that the subperiosteal method brings about a stronger connection between the forearm and metacarpus and decreases the tendency to the establishment of a flail-joint. On the other hand, it should be remembered, that the periosteum is frequently much involved by the disease, and as the diseased parts must be removed it will be at best a tedious task to select and separate off the healthy parts from the bones: and what remains in scattered areas is likely to retard rather than hasten, and to interfere with the accurate approximation of the bones of the forearm and of the metacarpus which is brought about by the contraction of the surrounding soft parts and by the adaptation of the muscles and tendons to the decreased length of the limb segment.

The preliminary application of an Esmarch's bandage facilitates the operation, but when it is removed, free oozing of blood is likely to occur from small injured vessels and from any cut surfaces of bone. On this account adequate gauze drainage should be provided for at least twenty-four hours.

After the application of a copious absorbent dressing a retentive splint is applied to the part with the hand very slightly extended and the forearm flexed and in a semi-pronated position. Lister and Ollier devised special forms of splints for use in such cases, but an improvised, straight, and carefully padded anterior splint will answer very well. When first applied it may extend from just below the elbow to the finger tips, but after the first two days have passed, at which time movements of the fingers should be begun, it should be shortened so as to terminate just above the metacarpo-phalangeal joints, thus allowing the patient to move the fingers at will. Caution should be given to have this done frequently, not neglecting the thumb, and making the movement active in the metacarpo-phalangeal joints. To allow of the proper approximation of the ends of the bones the splint should be removed and readjusted every second day, the wrist being kept steady until the end of a week, when its passive movement should be undertaken and subsequently repeated with at least second day frequency until the chance of bony ankylosis ensuing is obviated, the ultimate aim being fibrous union and a movable joint. As