front of the right leg, and a small swelling in the right wrist and forearm. Four weeks before admission, without any history of previous illness or injury, pain and swelling developed in these two regions. Family history shows mother and one sister died of tuberculosis, (one sister had "rheumatism" two years ago), and the father was suffering from tuberculosis at the time of admission.

Patient is a delicate, emaciated boy, suffering from grave constitutional disturbance. The following day under ether anæsthesia, a free longitudinal incision over the front of the leg was made, and a large quantity of pus was set free, when it was seen that the diaphysis was devoid of periosteum, virtually separated from both the upper and lower epiphyses and was removed. Involucrum was already present. After disinfection with pure carbolic acid and alcohol, the part was packed with iodoform gauze and limb placed in a plaster cast, leaving a fenestra over the wound.

The right wrist was opened, curetted, disinfected and packed with gauze. Culture showed staphylococcus pyogenes aureus.

Eleven days later, on March 23rd, under ether anæsthesia, the cavity was disinfected, the periosteum separated from subcutaneous tissue and brought together at a few points with catgut sutures, with a view to reproducing the original circular form of the periosteum. The periosteum was then filled with Mosetig-Moorhof's plumbage. The skin being brought together over the surface, provision was made for drainage by the introduction of iodoform gauze at the upper and lower margins, carried down to the epiphysis. The limb was put in a plaster cast supplemented with a weight and pulley extension apparatus, in the hope that this might aid in retaining the normal position of the limb during the process of repair, thus preventing curving due to the fibula continuing its longitudinal growth, as well as the lack after the removal of the sequestrum.

Drainage was kept up for many months, small particles of iodoform plumbage being washed out from time to time. Patient was discharged on August 12th in good condition with his limb in a plaster cast. There is slight antero-posterior movement in the middle of the shaft on the new growth. Later he returned when it was seen that complete regeneration of the bone had taken place, although the central portion was small. Sometime later, while at play, he fractured this point of the new bone and was readmitted to the hospital on December 5th, 1908.

On December 7th, under general anæsthesia I dissected out the ends which I found to be rounded, and after freshening the surface by sawing, brought the parts together with chromic-iodine catgut. It was noted