The patient, although having some febrile disturbances, was a man of excellent physique. He had no organic disease, but he was a rheumatic, and it was while suffering from an arthritis in right ankle that he fell down a flight of stairs and was injured.

After a careful study of the case, it occurred to me that we should make further effort to save the limb before condemning it to amputation. Our first attention was directed toward endeavoring to place the wound in a healthy condition; then, ten days later, radical osteoplasty was undertaken. Here we found about three inches of the tibia necrotic, but the fibula was not fractured.

Operation was begun by denuding and pressing the free ends of the fragments well out through the wound, then thoroughly clearing away all necrotic or infected tissues. The saw was now sent through that part of the shaft known to preserve its vitality. After this a segment of the fibula was removed equal in length to that lost in the tibia. Now the foot was pressed up, when both the tibial and fibular ends were solidly wired together. Heavy wire girders, with a gypsum cast, were laid on over antiseptic dressings.

The case pursued an uneventful course. The fragments solidly united with free ankle action. Following January was able to walk on street with aid of cane. In a year used no support of any kind.

This case was a remarkable one, for its time, a period when surgeons scarcely allowed their patients time to collect their senses before an amputation was pressed for.

To the inexperienced it might seem that there was no hope for this bloated limb, with a gangrenous sore and large fragments of dead bone in evidence. But the limb was saved, and two years after operation, he walked, on a wager, from Harlem to Coney Island and back, a distance of thirty-six miles, without crutch or stick, in ten hours.

It is remarkable to note here that since the accident patient has never had any more rheumatism in the injured limb.

In a younger subject, in a youth under fifteen years, we might have spared the fibula and hoped for osseous regeneration if the periosteum were preserved without shortening. There can be no question but in the adult, healthy patient left with a pseudarthrosis, the so-called flail or cushion joint, after loss of part of the central segment of the tibial shaft from fracture and disorganization of bone, osteoplastic section and splicing, offers us greater prospects of restoration of function than any variety of heterogeneous grafting.

CASE 3.—Compound fracture of the tibia and fibula in upper third, with extensive shattering. Autoplastic grafting and solid union without shortening. Primary osteoplasty.

Patient, a man aged 26, was injured by slipping while dis-