she sat up much, keeping the right knee drawn up nearly to the chin and the hands clasped over it. Three months after her first confinement to bed, the examination revealed a dislocation of the head of the femur upon the dorsum ilii. The dislocation was easily reduced under chloroform, and kept in position by the wearing of a Thomas hip-splint. A year and a half afterwards, there is found to be anchylosis, no shortening or other deformity, and no atrophy.

A paper presented by Dr. Royal Whitman, of New York, proved to be one of great interest: "Observations on the Ultimate Deformity of Pott's Disease." Dr. Whitman showed a case in which he is employing the Taylor spinal brace with modifications. Proceeding upon the proposition that in the normal erect attitude a perpendicular line passing through the tarsus should pass through the acetabulum and the mastoid process, he aims at keeping the spine from curving forward (when disease is in the middle spinal region) in the dorso-lumbar and high dorsal and cervical regions by the employment of pads in front of the points of the shoulders, sufficiently wide to prevent the arms from being raised up in front; by two pads which keep the shoulder-blades closely in contact with the posterior part of the thorax; and by a chin piece, not intended to carry the weight of the head, but to throw it sufficiently backward to bring the mastoid processes into the perpendicular line passing through the acetabula. Several of the members had seen this case on different occasions during the last year, and claimed that Dr. Whitman was succeeding in a very unusual degree in preventing deformity.

Dr. Nicholas Grattan, of Cork, Ireland, was present, read a paper on "Osteoclasia, and demonstrated the use of his osteoclast by operating upon three cases of knock-knee and two of bow-legs. To those who admit there is a place for osteoclasia, Dr. Grattan's instrument must commend itself as the most simple, safe, and certain of those given to the profession. The general feeling, however, was that the cases must be few when osteoclasis should be preferred to osteotomy.

Two unusual cases of knee dislocation were reported: "Lateral Dislocation at the Knee-joint, Due to Local Disease or Paralysis," Dr. T. Halsted Meyers, New York; "A Case of Complete Lateral Dislocation at the Knee, Due to Traumatism," Dr. McKenzie, Toronto.

Dr. A. J. Steele, of St. Louis, presented a paper which covered much ground, and called out a lengthy discussion: "Plaster of Paris in Orthopædics." For spinal cases Dr. Steele preferred leather, wet, and applied so as to fit accurately, and then heated to a temperature of 210° Fahrenheit. Dr. Phelps claimed that there was no fixation equal to that to be obtained by the proper use of plaster of Paris. There are many who use it, but do not get the good results that might be obtained because they do not know how to employ it. As a retentive dressing in the treatment of club-foot, Drs. Steele, Phelps, McKenzie, Gilette, and others considered it superior to all other means. Drs. Ketch, Judson, Taylor, and Shaffer prefer to use the various forms of steel club-foot shoes, on the ground that they are more readily removed so as to employ massage to the foot.

Dr. Bradford, of Boston, presented a most exhaustive and lucid statement of the question of the "Treatment of Resistant Club-foot." At all ages there are those where, under an anæsthetic, the foot may be replaced in the corrected position by force alone, without any cutting, employed simply by the hand or by various forms of leverage. The next class of cases is found where there are resisting tendons or bands of fascia, which may be cut subcutaneously before torsion is applied. Next, there comes a class of cases where it is necessary to make an open incision in order to divide the resisting structures more completely, and because the skin is too short to permit correction to be made. Then, in some cases correction to be made even when all the resisting soft structures have been cut. Under these circumstances, Dr. Bradford prefers to remove a cuneiform section from the outer border of the os calcis. Various bone operations, however, have been recommended. Dr. Morton had presented some good cases operated on by removal of the astragalus, and Dr. Bradford had followed his lead, but had concluded that its removal was not justifiable except as a last resort. The cuneiform section taken from the outside of the foot should never be done until other methods have been tried, and last of all should the astragalus be removed.