deformity, then apparatus, so employed as to afford the needed support, with only so much constriction and pressure as are unavoidable, may supply the lack and should be early employed, that the functionating of the affected part may not be unnecessarily delayed.

While it is true that a large proportion of the deformities resulting from infantile paralysis require nothing further than training, combined if necessary with the use of mechanical appliances, to secure for them the greatest attainable degree of benefit, yet a considerable number of cases, especially those of older children and adults, require operative procedures. The fact should never be lost sight of, however, by those who have to do with the early treatment of poliomyelitis that many of the deformities that result from this disease, and which if neglected may eventually require operation, can be entirely prevented by the intelligent use of mechanical means. When operation is called for there should be no hesitation in making all necessary tenotomies, fasciotomies, etc., required to effect correction of the deformity. After operation the parts should at once be put into a normal position, or perhaps even super-corrected, and so maintained by fixed dressings till healing occurs. Afterward, mechanical treatment of some kind is nearly always needed, and neglect to use it is almost certain to be followed by a return to the condition present before operation. Cases are constantly coming under notice which have been operated upon in the hope of correcting deformity, in whom much of the expected advantage has been missed, largely because the mechanical after-treatment essential to success has not been followed up. If a foot which has long been in a position of equinus be corrected by section of the endo Achillis and forcible manipulation, it tends to return to its old position of deformity as soon as the incised tissues are healed. The new tissue tends to contract, and the anterior tibial group of muscles not being effective to produce dorsal flexion, relapse speedily occurs. Especially does this occur at night while the bed-clothes drag the foot back to its old position, unless prevented by appliances. (Fig. 5.) While walking about the weight of the body is a corrective agency and may prove sufficient in some instances, while in others some form of mechanical apparatus attached to the boot, or some modification of the boot itself, or both, may be essential to the maintenance of the gain secured by operation. No routine treatment of these cases can be recommended. Each case must be dealt with according to its own requirements, and the varying nature of the disabilities and deformities resulting from the disease under consideration make necessary a very wide range of therapeutic

FIG 6.

Plaster cast of left foot seen from behind, showing extreme pronation of the foot from infantile paralysis.