

surgical treatment offers a hope of increased usefulness of limb without apparatus but where patient objects to submit to operation.

J. S., aet. 23, applied to me with hope of improving function of the limb. He had an acute attack of spinal paralysis at 2½ years of age, resulting in complete paralysis of left lower extremity with final partial restoration of function of the adductors. The psoas was apparently never affected. He could get about only with the aid of a pair of crutches and the leg was more or less uncontrolled so that he thought of having it amputated.

A supporter similar to the one described above was made for him and he was able to swing it forward with the psoas and control it fairly with the adductors and he soon began to walk with two canes. Now, after one year, he can walk for several miles with comparative ease, with assistance of one cane. A second similar case was a young girl fifteen years of age with early infantile paralysis resulting finally in permanent paralysis of all muscles of right lower extremity except adductors, glutei, and hamstrings. The limb was two inches short. She could walk short distances by placing hand of affected side just above the knee thus carrying the weight of the trunk through the arm. This ungainly position had developed a marked rotary lateral curvature of the spine. A two-inch high shoe with support attached was made similar to the one described and with knee joint thus locked she was at once able to stand erect, and can now go up and down stairs and walk long distances with comparatively little limp. She is now taking gymnastic exercises to correct lateral curvature which is rapidly improving.

II. CASES WHERE MECHANICAL SUPPORT MAY BE EMPLOYED ADVANTAGEOUSLY ONLY AFTER TENOTOMY.

The tibialis anticus and posticus muscles are frequently found permanently paralyzed, and the contraction of the unopposed peronei, together with the body weight, produces a valgus deformity of the foot. The continuous rolling over of the foot tends to bring the origin and insertion of the gastrocnemius and soleus closer together, and following the well known law of nature, the tendo Achillis becomes shorter to adapt itself to the new condition. Any reposition or correction of the foot is now opposed, not only by the contracted peronei muscles, but also by the contracted tendo Achillis. The treatment as suggested by this class is division of the tendo Achillis, and possibly the peroneal tendons, and application of a fixation dressing such as plaster of Paris after reposition of the foot.

After two or three weeks the support should be applied and should consist of an outside bar attached to the sole of the boot, with a free