the Press. The case was a bogus one and seems to have been for the purpose of entrapping Dr. Garratt. The Star of 16th May, in reporting the case as tried before Mr. Justice Latchford, makes Mr. J. W. Curry, K.C., say, "what I had in my mind was the obtaining of evidence sufficient to bring Dr. Garratt before the discipline committee of the council, and not to bring the court into contempt in any way whatsoever."

The Grand Jury threw out the charge against Dr. Garratt for perjury and obstructing the work of a court of law. We now congratulate Dr. Garratt. We had much sympathy for him in this whole affair. Dr. Garratt is a member of the profession of undoubted ability. That he was, to some extent, imposed upon in this case does not reflect on either his skill or his honesty. We feel satisfied that the medical profession will still accord to Dr. Garratt the same confidence as he enjoyed before this fake suit.

OPERATIVE TREATMENT OF CHRONIC OSTEOMYELITIS.

Beck states that bones differ only from other tissues in the process of repair, the scar formation of the soft tissues being replaced in bone by the formation of new bone on top of an old inflammation, the repair often outgrowing the damage. The lower third of the femer and the upper third, lower third, or whole tibia are the usual sites of osteomyelitis. Pain and abscess formation are the two principal indications for surgical interference. They are concomitant, the pain ceasing when the pus can flow freely. The old treatment of making a big enough opening to curette out all the necrosed bone you can find it condemned by Beck as changing a partial necrosis of bone into a chronic suppurative cavity of bone which will constantly discharge from one or more fistulæ. This is because the edges of the bone are separated and cannot heal, just as any other wound with separated lips cannot heal. Bone chips, skin grafts, waves, and pastes have been used to overcome this, but Beck affirms that pastes are of use only in narrow channel-like cavities and that the following three rules are paramount for good results: 1. Open broadly, leaving periosteum intact as much as possible. 2. Remove all diseased tissue. 3. Leave no cavity behind. The bone is chiselled away till perhaps half its circumference is gone. The periosteum, which has been carefully separated and conserved, is sutured and allowed to fall against the flat surface of chiselled bone, obviating any cavity. The periosteal cavity may in some cases be packed with gauze and later with paste for a number of days. The external wound is closed with sutures or adhesive plaster and readily heals. Results are still better in the tibia, for here the whole tibia has been removed, leaving the periostum only, from which a new tibia has formed.