attachment to the periosteum, carrying it through the interosseous membrane, and re-attaching it to the outer surface of the radius, thus changing its action into a supinator. Vulpius, of Heidelberg, also reports some successful cases of operation on the forearm.

The following four cases are reported somewhat in detail to illustrate the methods employed in operation; but, of course, each case must necessarily be a law unto itself.

CASE 1.—A boy five years of age, acute infantile spinal paralysis at two years, with complete paralysis of right limb. There has been gradual recovery of all muscles, except peronei, which remain inactive. In spite of mechanical support the foot slowly assumed a position of marked equino-varus. At the time of operation equinus deformity was slight but varus so marked that patient walked on outer border of foot entirely.

An incision was made along the posterior margin of the subcutaneous surface of the fibula, the peronei tendons exposed, and tendon of peroneus longus isolated. A second incision was made above the ankle just internal to the crest of tibia and the tendon of the tibialis anticus exposed. This was divided subcutaneously on the dorsum of the foot, and pulled out of its sheath. Next it was pushed through subcutaneous tissue superficial to the extensor tendons into the first wound. A slit was then made in peroneal tendon and tibialis tendon drawn through it and secured by two criss-cross sutures of silk. The wounds were closed and foot put up in plaster. Wound healed perfectly and in four weeks plaster was removed and child allowed to walk. Now walks plantigrade, with very little deformity, and can voluntarily evert foot. Boy is in every way improved.

CASE 2.—Young girl, fourteen years of age, was admitted under my care at the Children's Hospital. She had complete flail condition of left lower extremity, and in right a paralysis of calf muscles, tibialis posticus and flexor longus hallucis, giving foot a position of severe calcaneo-valgus on attempting to bear any weight on the limb.

It was desirable to get a firm base of support in right leg so that a mechanical support might be made use of on the opposite side. An oblique incision was made from above outer malleolus downward and inwards, so as to expose peroneal tendons and tendo-Achillis. After freeing the tendo-Achillis the peroneus brevis was divided, carried under it and attached through a slit to the tendon of the flexor longus hallucis. The peroneus longus was then divided and attached in the same way to the tendo-Achillis. The wound was then closed and plaster applied. Passive motion was commenced in three weeks, and in six weeks patient was able to bear her weight on foot