There is a specimen in my collection, of the lower third of a femur of a young girl not exceeding fifteen years of age. She was admitted to the Brooklyn Medical and Surgical Institute, with all the symptoms of white swelling, comprising the articulation and peri-articular structures; the swelling however likewise involved a portion of the femur. The local disturbances were as intense as were the nocturnal pains, and the spasms of the flexor muscles. The knee was of course drawn to a right angle.

From the history of the case, and the clinical character of the disease, *circumscribed osteomyelitis*, with its termination in abscess, was diagnosed and in view of her reduced constitution, and the copious discharge of matter from the neighbourhood of the joint, amputation was deemed expedient.

The condition of the specimen fully confirmed the diagnosis. There is a large pyogenic cavity at the lower end of the femur, which opens at the posterior aspect of the bone, by an irregular aperture not less than an inch and a half in diameter; in the circumference of which, the periosteum is raised up, and its internal surface covered with new bone. The epiphysis is somewhat loosened from its attachment, and in time would have become separated.

The original focus of the diesease had been obviously limited to the cancellated structure, and rather remote from the joint, but its consecutive effects had extended over the joint, and involved its soft surroundings. There may be still *other exceptions* from the anatomical prototype, but their numerical proportions scarcely affect the statistics.

The adherents of the tubercular theory, may rejoice at this pathological admission of mine, of those insular and circumscribed pathological foci, which they may claim as *bona fide* evidence of tubercular deposit.

I hold however, that pathological detritus, limited to an isolated place, cannot in the eyes of competent judges, pass as tubercle.

If the desease is permitted to spread, it eventuates in perforation of the articular cavity; the formation of external abscesses and fistulous tracts, and the more obstacles the discharge has, the more periosteum will be destroyed, and the bone corroded on its surface.

The protracted development of these phases extends over many months, and often additional injuries are required to accomplish so extensive disintegration.

A lull of all symptoms, is often observed in the like cases, to be followed by new exacerbations. A goodly number recover spontaneously, or by appropriate treatment. These recoveries happen not rarely at the period of puberty, at which time the mode of nutrition of the epiphyses becomes perfected.