apron to cover the whole front of the chest and secured to the brace by webbing and buckles to cross bars, etc., is attached to the brace, to stiffen and steady it.

Schapps provides an iron frame support to the front chest, connected by straps to the posterior bars.

Chance, of London, also has devised a good brace, and Dr. Knight, of New York, a light frame apparatus, with side uprights, not so efficient as the Taylor, but a very good canvalescent brace.

The plaster jacket provides general support for the trunk as a whole, solid at sides, front and back, but is less accurately adjustable than the brace. Again, I must impress upon you the necessity of braces being accurately fitted and their being perfectly rigid, not giving or bending with weight or wear.

The brace may be made by any blacksmith, but its construction and application must be fully understood by the surgeon. It must be measured and made for each case individually; you cannot buy it by name or ready made. Often braces are supplied which resemble this, but fit badly and are of no use. Often the uprights are of tempered steel and are too flexible, furnishing no fixation. This I found in one of my cases at the Montreal General Hospital. The brace is fitted by two wrenches or keys, and requires care and some trouble to do it properly. The brace must be daily applied with care by the parents and the patient watched that the straps are kept constantly tight. Look after the skin of the back to avoid chafing Prevent it by alcohol rubbing and Talc powdering in hot weather.

Whitman improves the Taylor brace in efficiency by attaching shoulder caps and providing backward traction; thus increasing the leverage of the brace.

The object of mechanical treatment is to free the spine from the influence of local deformity, and from the deforming tendency of the disease and its complications, and to distribute compensation. The test of an appliance is its efficiency to meet these indications. The test of the treatment is the effect upon the patient. (Whitman).

Abscess occurs in one out of five patients, as we get them late in the course of the disease, and its liability increases from the upper to the lower regions of the spine. W. R. Townsend gives statistics, cervical, 8 p.c.; dorsal, 20 p.c.; lumbar, 72 p.c., of abscess cases. In cervical disease they can be found early, as they must come forward, spread laterally or go through posteriorly. In the dorsal region they may burrow anywhere. Lumbar and iliac abscess are most dangerous from possibility of rupture internally. They sometimes rupture externally if not opened early or aspirated, and often attain great