

the femur very distinctly just behind the acetabulum. The dislocation is not very great and we will not have any difficulty in effecting a reduction.

It is not necessary to begin the reduction by forcibly extending the leg because the head is not very much dislocated from the centre of the acetabulum. It will suffice to make the reduction by forced abduction. By making this forced abduction the adductor muscles are made very tense, and it will be necessary to cut or tear them subcutaneously. I have given up the cutting of these muscles and I now tear them by using my hand in place of a knife. I really tear the muscles subcutaneously. You see the ridge formed by the tense adductor muscles has now disappeared completely. The muscles have been torn subcutaneously. Now, on attempting extension of the leg in this abducted position, I find that the flexors of the knee offer considerable resistance to extension. By means of forced flexion and extension of the leg I gradually overcome the resistance of these muscles. In former times I used a screw to effect this extension. For adult cases it is advisable to use it, but in children as young as this one it is wholly superfluous.

After these preparatory measures are completed I drive the head into its normal position by forced abduction, placing a block or wooden pillow under the head of the great trochanter to act as a fulcrum. This can be done without hurting the bones. You can perhaps hear the little snap as the head slides into the acetabulum over its posterior ridge. The sound can be heard very plainly in the immediate vicinity of the patient, but perhaps not at any great distance. I will grasp the head of the femur between my fingers and redislocate and replace the bone so that you can follow the reduction to better advantage. There is no doubt that the head is now in its proper position, because the head can be felt under the femoral muscles and the front of the thigh no longer shows the hollow in Scarpa's triangle. The flexion of the knee, because of the shortened flexor muscles, is still further evidence of reduction. Now the bone is in place and all the resistance of the soft parts has been overcome and we are ready to apply the plaster of Paris bandage.

A stockinet bandage is first put on, or, as I prefer, a pair of knitted drawers. Under this I run a strip of gauze about five or six inches in width, which is allowed to protrude above and below. By pulling on the ends of this strip, passing it too and fro under the bandage, the skin under the cast can be kept clean. The strip is replaced after each cleansing by a fresh strip. The leg is held in extreme right angle abduction while the cast is being applied. As I prefer to apply a very heavy and firm cast, I put on over the stockinet bandage or the drawers a very abundant supply of cotton, and over this