

made by fixing the arm, grasping the prone hand, palm to palm, and making firm extension, then manipulate upon the palmar and dorsal surface until fragments are in position. A well-padded splint from the elbow to the end of fingers, the fingers and hand slightly flexed, cotton for a posterior splint, the arm in a semi-prone position and bandaged—that is the treatment. There are cases of transverse or slightly oblique fracture where Dr. Moore's dressing will do. At the end of the first week's dressing the distal joints of the fingers may be freed; at the end of the second week the next joint; at the end of the third week the next joint, etc., about five weeks being required to get firm union. We should not forget greenstick fractures of the radius and ulna, which are frequent with children. I would advise, when having a history as of injury of the forearm in a child, to apply splint. In fractures of the carpal bones any splint that gives rest will do; the metacarpal bones can be treated with a ball in palm of hand, the hand and fingers bandaged over that. Fractures of the phalanges—extend fingers on a padded splint and bandage.

*Pelvis.*—Fractures of the pelvis are divided into those of the so-called extremities or prominences, crest of the ilium, ischium and coccyx, all of which, except the latter, may be treated with circular bandage. The coccyx may be replaced by finger in rectum and retained by gauze packed around a tube in rectum. Where we have fractures involving the ring of the pelvis it is a serious condition, as the urethra, bladder, blood vessels, and even intestines may be involved in the injury and should receive first attention. Outside of the complications the fractures of the ring of pelvis or acetabulum require extension applied to leg, fixation of pelvis by circular bandage and rest in bed. The femur is implicated in about one-eighth of the fractures of the lower extremity. Intracapsular, extracapsular and fracture of the neck of the femur are frequent in the aged, and we wonder at times how slight violence could produce this fracture. In making the diagnosis we should not forget that in the intracapsular fracture the patient may be able to walk a little at a time without a great deal of discomfort. In the extra capsular variety this is hardly possible. In fractures of the neck of femur the pain and displacement is so great that the patient is unable to walk, and this is a diagnostic point. In intracapsular and extracapsular fractures there may not be any suggestive position of the limb, but in fracture of the neck of femur the picture is typical; the limb lies helpless, is everted, the muscles and fascia being quite relaxed yet the limb may be flexed and raised. So I would say that pain, crepitus, eversion, shortening and spasm of the muscles, all being in the affirmative, the crepitus would make the diagnosis of fracture of neck of femur quite easy and positive. Personally I have come across more undiagnosed cases involving the head of