below the dressing; this is to prevent the sheet wadding and stockinet from becoming soiled and hard by perspiration. The outside of the cast, behind, should be protected by a folded towel, included under the ends of the handkerchief. When wishing to defecate or urinate the patient should be placed upon a stool. The bed pan can hardly be used without soiling the dressings. The objection to operating upon young children is the utter impossibility of keeping them clean and preserving the dressings intact, holding the leg in the primary position while Nature does her work.

In this position the patient remains in the plaster-of-Paris, wearing a shoe with a cork elevation of 2½ to 3 inches, for six to nine months, the time varying with the stability of the acetabulum at the time of the reduction. As soon as the sensitiveness of the joint has subsided (a time varying from five to fifteen days) she is encouraged to walk, and the leg should be extended daily to prevent contraction at the knee. During this six to nine months Nature contracts the capsule and deepens the acetabulum, which receives the weight of the body at every step.

Upon the functional weight-bearing of the limb depends much of the prognosis. The child that walks for nine months with the limb in a stable position, stimulated by use, will have a much better chance than one who refuses to walk. This is one of the reasons why the double congenital dislocation must be retained longer in the plaster, since the child cannot walk with both limbs in the primary position.

In a bilateral dislocation, the child sits astride a low rolling chair, the height of the seat corresponding to the length of the tibia. In this position the child can push herself around, propelling the chair by means of striking the toes upon the floor. She is thus bringing the limb into activity and transmitting some weight to the acetabula.

After six to nine months, the first plaster cast is removed, and the surgeon must use his judgment as to the requirements of the limb, whether it shall be replaced in the primary position or in the secondary, or walking, position of 45° abduction and flexion 115° to 135°, or left with no diurnal support. This will depend upon the stability of the position then found, taking into consideration the stability at the time of reduction. If the capsule is contracted, the head seemingly well fixed, and you can watch your patient, you can leave off all support except, during the daytime, a strap passing from knee to knee