diately after the reception of injuries in a brutal kicking administered for some petty misdemeanour by his step-father. The child limped into the house, and ever afterwards complained of difficulty in walking, of pain in the knee joint, most severe at night, and of constantly increasing debility and fatigue. On entering the hospital, on December 6th, he was found to have an apparent lengthening of the right lower extremity, but a careful measurement showed that the increase of length was due, *not* to any actual difference between the two limbs, but to an inclination of the pelvis towards the affected side. The foot, you will remember, was slightly everted, and the thigh somewhat flexed on the pelvis. There was an ulcer about two inches below the right trochantar on the external aspect of the thigh, having that peculiar appearance which characterises sores in the neighborhood of carious or necrosed bones. In the hope that the joint might recover its tone, if relieved from constant friction and pressure to which it had been subjected, I kept the limb in extension by means of a weight attached to its extremity by adhesive plaster, the counter extension being maintained by the weight of the body. The patient was at the same time given tonics, such as iron and cod liver oil, and fed with the most nutritious articles of diet. This treatment has been pursued for two months without any other improvement in the patient's condition than that of relief from some of the pain and muscular spasm. The ulcer would at times nearly heal, but the improvement was never permanent, and it is now in about the same condition as it was when the patient entered the hospital. The boy has been gradually growing paler and thinner, and it is very evident that nothing can be hoped for from a continuance of the same treatment for an indefinite length of time.

The disease has reached a stage at which simple extension, though combined with constitutional treatment, is totally inadequate to its cure, and if nothing else be done, the patient will have before him the sad prospect of months of intense suffering, ending eventually, as is most probable, in death, or at best, in a tedious recovery, with a deformed and worse than useless limb. Under these circumstances, I have determined to make trial of an operation, which has been performed many times by different surgeons in this country and Europe, with varying success, namely, excision of the head of the femur, together with the trochanter and as much of the shaft of the bone as shall prove to be diseased. This operation was first performed by an English surgeon named White, in 1822, and has since been introduced among the legitimate operations of surgery by Ferguson and Hancock, of England, and Sayre, of New York. The ratio of mortality, as far as can be ascertained, is about one in every two and one-tenth cases; but as the operation has been reserved hitherto as a last resort, for patients worn out with long continued suppuration and pain, this ratio cannot be regarded as a fair index of the danger attending the operation in patients who have not arrived at the period of vital exhaustion. The objections which are urged against this procedure are, 1st. The hazardous nature of the operation. 2nd. The fact that the acetabulum is in most cases also involved in the disease, and that the operation would, therefore, be useless, the necrosed bone of the socket continuing to keep up the irritation and discharge, even after the removal of the opposing surface of the femur. As regards the first objection, I will merely say that the patient is *now* in a most dangerous condition; by far the greater proportion of cases, when the disease has reached this stage, ending in death. The second objection is more weighty, and I have not come to my present decision without having given it full consideration. I believe, however, that even should the acetabulum prove to be diseased, there would be more prospect of recovery after the head of the femur had been removed than under the present circumstances. The disease would, in the first place, be less extensive, the constant irritation from the friction and pressure of the femur causing the morbid action to spread to new and hitherto healthy tissues; and then, a free opening having been made, which allow would the easy exit of the detached particles of bone, there are grounds for hoping that the whole diseased mass might eventually be discharged, and the patient recover. Now that the patient is fully under the influence of chloroform, I will proceed to operate, first enlarging the orifice of the ulcer, by incising it in the direction of the trochanter, carrying the incision, as you see, up to a point a little above it, and then making a transverse incision from the anterior superior spinous process of the ilium to a point nearly over the sciatic nerve. By means of this T shaped incision, I am now enabled to open the joint, and can feel the head of the femur, necrosed and portially worn away by the attrition it has suffered for so long a time. Now, as Prof. Webber carries the thigh over the body, adducting it and rotating it inwards, the head of the bone slips from the socket. I cut away the tissues from the bone below the trochanter, and saw it through. The head of the bone, together with the trochanters, are removed, and you can see what terrible ravages the long continued disease has produced in the bony tissue. On examining the end of the shaft, I find that the saw has not removed the whole of the disease, and I will complete the work with this pair of bull-nose forceps, with which, as you see, I am able to bite into the bone, and remove the remainder of the morbid structures.

Now, examining the acetabulum, I find it, as I feared, involved in the disease, the greater part of it being denuded of cartilage, and feeling rough to the touch. As no portion of it seems to be detached, however, I will, for the present, leave it untouched, hoping that it may come away, in time, without instrumental interference.

I now close the upper portion of the wound with stitches, leaving the lower part of the transverse incision open for the better drainage of the secretions of the wound, and apply this splint, which I have made after the model given by Ferguson, and which you will find represented in an engraving in Erichsen's Surgery. You will notice that it consists of a long, straight portion, made of smooth wood, which extends from a few inches below the foot to the lower margin of the wound. The cut surface is then bridged over by means of two pieces of bent iron, fastened at the other ends to a short wooden splint, which is in turn attached to the body by means of adhesive plaster.

We will now remove the boy to his bed, and will keep him, for the first twenty-four hours, under the influence of anodynes, at the end of which time