be felt, by both surgeon and patient, to slip about in the joint. That the diagnosis is not always easy, is instanced by two cases in which loose bodies were suspected from oft-recurring synovitis, but could not be demonstrated even after careful search. In the first case, the loose body was located by means of the X-rays, but the second was only found after the joint had been explored, by dividing the patella, when the offending body was found deeply lodged in the intercondyloid notch. Both of these cases recovered completely after operation.

The diagnosis between detached semilunar cartilages and hypertrophied synovial fringes is often difficult. The writer finds the so-called characteristic signs, viz., sudden locking of the joint and projection of the cartilage, rather uncommon, and generally had to base diagnosis on limitation of motion, with more or less clicking or snapping on motion of the joint, together with slight swelling and pain on pressure over the location of the cartilage. In several cases after operation the cartilage was found folded on itself, and thus caused the creaking or snapping sounds.

The signs of hypertrophied fringes are much the same as in displaced cartilages, except that there is never locking of the joints. There is usually slight limitation of motion, and often the fringe may be felt as a soft pad. It is necessary also to remember that there may be more than one fringe present.

The elongation of the ligamentum patellæ is less common than any of the other forms of internal derangement. It may cause sudden locking of the joint by allowing the patella to slip over the external condyle of the femur. When there is elongation of the patella ligament, the patella is found on a higher plane than normal, and looks almost directly upward when the knee is flexed, instead of forward and slightly upward.

In treatment of all these cases except the last group, it may be necessary to open the joint, and the writer states that it may be done freely and without danger, under proper precautions. He then compares the synovial cavity with the peritoneal cavity, and shows that they correspond closely in structure and physiological function, and in cases where, for any reason, a splint which limits the movements of flexion and extension, fails, or is not advisable, owing to the occupation of the patient, the joint may be explored with as little hesitation as the peritoneal cavity now is.

Mr. Walsham reports having opened the knee-joint upwards of twenty times in the last six years without any ill results.

In opening the joint, regard should be had to the following precautions:

1. Preparation of patient. It is most essential that the