

My own opinion is, that our text-books are too lax in dealing with cases of this nature. We have general principles instead of fixed data to work upon, the result being sometimes detrimental to the best interests of the sufferers.

During childhood, not only are the tissues soft and yielding, and the bone textures merely in a process of consolidation, but the little patient is restless, nervous, irritable, and not easily controlled. It is often a difficult matter to so bandage the arm in a flexed position, that the various segments constituting the joint may continue *in situ* as when the splints were first applied; as the swelling in the arm abates, the bandages slacken, thus favoring displacement; this untoward result much to the doctor's annoyance, being aided also by the irrepressible activity characteristic of the early years of life. This is bad enough when the latter is not absolutely certain in his diagnosis; but infinitely more so when he is certain, and when he knows that a proper reduction has been effected.

Of late years I have as a rule pursued a line of treatment, somewhat at variance with the orthodox methods, and in nearly all cases have used straight splints of pasteboard held in position by starch bandages as the first dressing. One of our chief difficulties in many of these cases is, first to find, and then to insure for the future, the position of the head of the radius. We are told that full extension will reduce a dislocated head. If that is the case, then continued extension will insure continued reduction; and a week in that position would in a great measure restore the orbicular ligament to its original attachment.

In separation of the epiphyses of the humerus, well padded anterior and posterior splints would give perfect immobility, a thing so essential in juvenile cases; while it would limit to a minimum the retractive force of the triceps. In dislocation of the ulna backwards, when there is any reason to suppose that the head of the radius may have been displaced, the straight position after reduction, if continued for a week or so, would effectually guard against all peradventures; and so with nearly all complicated cases. I think from my own personal experience, as well as from the anatomical construction of the joint itself, that there are few injuries at the elbow in juvenile life, in which, for the first dressing, the long well padded

splints are not preferable to angular ones. Hamilton recommends that passive motion in elbow injuries be commenced at the end of one or two weeks. If that be allowable, then the long splints could be safely removed after the like interval, and angular splints adjusted, if the nature of injury demanded it.

I was very much pleased to see, in the October issue of the *Canadian Practitioner* for 1886, that Dr. White, the esteemed Secretary of our Association, had advanced views very similar to my own, in an able address delivered before the Huron Medical Association. In that article, however, there was no citation of cases; and probably I cannot do better than conclude, by briefly relating my own experience in this matter for the past few years.

CASE I. On May 9th, 1881, D. B., a boy aged thirteen, fell off a branch of a tree, alighting on his elbow upon the stone-bed of Mill Creek, producing a compound fracture of the olecranon process. The wound was ragged, oblique, directly over the process, and nearly two inches long. The olecranon was severed and retracted slightly by the triceps muscle; the forearm flexed and the joint laid open, venous hemorrhage being quite profuse. The clothing being removed, I flexed the arm still more, and douched it freely with tepid water, thus checking the hemorrhage and cleansing it from foreign matter. The arm was then fully extended, parallel with the body, bringing the segments of bone almost in juxtaposition. A long, well padded splint was applied in front of arm, from shoulder to wrist, and the bandages so arranged as to draw down somewhat upon the upper fragment. The wound was dressed with carbolic oil, one to eight, on lint, oil-silk protective, light bandages, and patient put to bed. The olecranon was separated from the ulna about the eighth of an inch. Patient improved very nicely. There was slight rise of temperature. The wound filled with granulations, and by the tenth of June was entirely healed. There was bony union, but the olecranon process seemed slightly elongated. This was one month after the accident and marked the commencement of passive motion; this was gently but persistently carried out, and when, after another month's interval, I again examined the lad, the adhesions at the joint had become pretty firm; for although passive motion had been