

ing from infantile paralysis is found in the lower extremities. It is extremely rare to find this disability symmetrically distributed



FIG. 3.
Plaster cast of foot showing
calcaneo-cavus.

in the two lower limbs. Very commonly one extremity so far recovers as to present finally but little evidence of previous disease, while the other remains variously disabled. A marked characteristic of the affection is that the muscles are apt to recover, or remain paralysed, in groups. For example, a deformity very frequently met with is talipes equinus, or equino-cavus, resulting from a paralysis from which the muscles on the back of the leg have more or less fully recovered, while the anterior tibial group of muscles have made little or no progress from the condition in which they were left by the primary attack of poliomyelitis. (Fig. 1.) If the anterior tibial group have made greater advance toward recovery, then

there results a condition of calcaneus or calcaneo-cavus. (Fig. 3.) There is no variety of club-foot which may not be due to this disease, while flat-foot and "weak ankles" may often be traced to the same source. (Fig. 4.)

The mechanics of the various trunk deformities arising from infantile paralysis is a subject of much interest. If one limb has been paralysed in early life and has failed to recover or has recovered imperfectly, it does not grow equally with its fellow, and if the extremities are of unequal length the pelvis droops more or less on the side corresponding to the short leg, and the sacrum leans in the same direction. Built upon this slanting base, the lumbar vertebræ start upward, not perpendicularly, but inclined to the weaker side, producing a lumbar scoliosis followed by the development of secondary compensatory curvatures. Careful examination of our cases of lateral curvature has convinced us



FIG. 4.
Extreme flat-foot caused by infantile paralysis.