head of the femur so as to bring it opposite the acetabulum, then the preparatory steps of the treatment are completed.

Now begins the real reduction, that is, the placing the head into the acetabulum. This can be done by traction, and by bringing pressure to bear down on the trochanter. I, for my part, prefer reduction by way of forced abduction, which is kept up with a wooden pillow beneath the trochanter to act as a fulcrum, until the head can be felt to slip over the posterior border of the acetabulum. If this acetabulum were of normal shape and size all would now be accomplished, and the leg could be brought down to its normal position without any further detail. But, unfortunately, in all these cases the acetabulum is so shallow that the head would immediately slip out if the leg were brought into even an approximately normal position. In order to retain the head in its place it is necessary to put the leg in a right angle abduction. In cases of great instability of the replaced head of the femur in this position of extreme abduction, a slight over-extension is to be added. In order to still further ensure the fixation of the head in the acetabulum, it is expedient to stretch and enlarge the anterior part of the capsule by free rotary movement of the thigh.

As may be imagined, after the new position of the leg has been attained, the flexors of the kneejoint become too short and we consequently find the knee rigidly flexed. This shortness of the muscles is also overcome by careful but forced stretching of the leg, bending the knee and extending it until it is possible to have complete extension. In order to retain the desired position of the thigh and leg, I apply a plaster of Paris bandage, which I will apply in your presence so that you can see all the details better than they can be described.

In cases of unilateral dislocation, I use appliances which will permit the patient to walk as soon as the pain and uncomfortable feeling of the extreme position have disappeared. In cases of bilateral dislocation voluntary motion is practically impossible, although I have seen children walk with the aid of a cane or stick when both legs were in this extreme abduction. But the child can ride and sit astride on a little chair, pushing itself along with its feet. The child not being confined to bed all passive movements are allowed. I will further explain the various steps of the operation as I go along with our cases.

CASE I.—This little girl is only three years old and has no other trouble than this dislocation of her left hip. She is well-formed and healthy. The deformity is not very great. Watch her walk. She limps but very little. The leg is about one and a half inches shorter than the other. You see that an attempt at abduction of this leg is unsuccessful. The abduction is limited. If I do a flexion and abduction I can feel the head of