cavity. Although the subsequent efforts to completely reduce failed, the patient has received much benefit. When admitted, she had no use of the arm, but now she can bring the hand to the top of the head. Passive motion was kept up, and she has been instructed to use the limb, with this result The obstacle to the reduction which has not been overcome, may not be fully determined. The adhesions seemed to be entirely broken up at the time of operation, the action of the muscles was overcome by the chloroform and the extension. Probably the capsular ligament had been ruptured, so as to permit the head to slip through, which was then caught as a button in a button-hole

TWO CASES OF DISLOCATION IN THE AXILLA—EXTERNE PATIENTS

Both men of middle age. The first, who was brought by Dr. Fisher, of Toronto, was a strong muscular man, and he had to be fully etherized before the reduction was effected, which was done by placing the heel in the axilla, and extension being made by assistants. The second case was easily reduced, without chloroform, in the same manner as the first.

FRACTURE OF THE SHAFT OF THE RIGHT FEMUR AND LEFT FIBULA.

Thomas H., aged 28, Canada, admitted June 21, 1871. While engaged in superintending the razing of an old brick building, the chimney fell upon him, almost burying him beneath the bricks. But fortunately a ladder had fallen upon him in such a way as to protect his body from fatal injury. He received several bruises and a fracture of the fibula, but the main injury was the fracture of the femur a little below the middle The fracture was slightly oblique from before backward. He was conveyed to the hospital, and a few hours later the limb was put up. A long splint from the axilla would have been preferred, but one so long not being immediately available, a shorter one, extending, however, from about five inches above the crest of the ilium was employed. A great object secured by the long splint is the fixture, so to speak, of the body and the fractured limb, thereby preventing motion. Extension was made by means of adhesive straps applied to either side of the leg from the knee, and sufficiently long to be passed through a foot board attached to the straight splint, and tied. The counter extension was effected by a perineal bandage fastened to the upper end of