

well padded, reaching well over the shoulder and down to the elbow, and an anterior splint from the axilla to the elbow on the outside should be applied, the forearm flexed at right angle, and a bandage applied from it to the shoulder. Extension should be kept up while splint and bandage are applied. Where there is dislocation of head of the humerus with fracture, reduction should be made even if we have to resort to McBurney's method. Delayed and non-union are more frequent in this bone than in any other. Some years ago, before the American Medical Association, I recommended letting the arm hang with the bandage on. I still think that is good treatment. To the young physicians fracture at the elbow is a bugbear. Always keep in mind that if a line is drawn from one epicondyle to the other in a horizontal direction, the top of the olecranon will be below it, so if either condyle or olecranon is fractured it may by this means be made out. We may also have the "T" fracture here, and in this or any other fracture involving the joint it is not positive that we should have undesirable results, if we remember in splinting for this fracture that the arm is used for carrying, and that the forearm and the arm form an obtuse angle when the arm is at the side and is in the normal supine position, the hand being away from the body. The right-angled splint, or when the condyles are involved, a slight flexion, is the best dressing—bandaging from hand to shoulder. It is better to have the patient keep still for a number of days and not think of moving the parts until the fractures are united.

Fractures of the olecranon process and coronoid process of the ulna, and fractures of the neck of radius, may be treated alike. First, dressing with the arm and forearm at a slight angle; second, dressing nearly at a right angle, but put on with plaster-of-Paris. If there is considerable displacement of fracture of olecranon, or if the fracture is compound, a large fenestrum may be cut out of the site, over the joint. The wound can be dressed, if compound, and if the fractured parts tilt to one side or the other, or remain apart, an adhesive plaster may be applied over the upper and posterior part, carrying one end to the right and the other to the left, around over the anterior surface of the forearm. Fractures of the shaft of the ulna and radius can be treated with the anterior and posterior splints; that the arm should be semi-pronated and the padded splints wider than the arm, are the only special things to be kept in mind. The radius comes next in frequency to the clavicle in the list of fractures. A good way to diagnose fractures of the shaft of the radius is to find out whether the head rotates with the shaft of the bone. The so-called Colles' fracture and fractures of the lower end of the radius and about one inch, or less, from the articular surface are the ones that cause us more or less trouble. First in importance is the reduction of this fracture, which can be