The bacillus was agglutinated at once by a specific *Paratyphosus A* serum.

The bacillus completely removed the agglutinins for *Paratyphosus A* from a specific *Paratyphosus A* serum after two hours absorption at 37°C.

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Paratyphosus *A* serum before absorption with F’s bacillus, tested with stock *B. Paratyphosus A*.

Dilutions...

Paratyphosus *A* serum after absorption with F’s bacillus tested with stock *B. Paratyphosus A*.

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A CASE OF OSTEOMYELITIS OF THE TIBIA.

By Major J. W. H. HOUGHTON.

*Royal Army Medical Corps.*

Gunner S. was admitted to the Cambridge Hospital, Aldershot, at the end of June, 1910, having received a kick some days previously on his left shin.

The wound on the leg was opened and fomented, in spite of which he developed acute osteomyelitis of the left tibia, with a high temperature...
and acute toxæmia. From this he slowly recovered. On September 25, 1910, a skiagram showed sequestration of the entire shaft of the left tibia and the formation of new bone around the sequestrum.

On October 1, under spinal analgesia an incision was made along the front of the tibia and the whole of the necrosed bone was removed in three fragments.

The artilicular surfaces of the bone entering into the formation of the knee and ankle joints were alone free from the necrotic process, although the cancellous tissues at either end came away with the shaft.

The cavity left by the removal of this dead tissue was packed with gauze and the margins were approximated as far as possible by suture.

The large cavity, however, was slow in filling up, and on March 13, 1911, the upper end was scraped out and an attempt made to draw the skin over the front of the leg by undercutting the edges and stitching them together.

This led to final success, and on May 30, 1911, the patient was able to leave hospital, having perfect movement in the knee and ankle-joint, with a new and strong tibia and fit for duty.

A SEQUELA TO APPENDICITIS.
BY MAJOR J. W. H. HOUGHTON.
Royal Army Medical Corps.

PRIVATE A., age 19, was admitted to the Cambridge Hospital, Aldershot, on January 23, 1910, with symptoms of acute appendix trouble. He was placed on the operating table and an abscess in the appendix region was opened and drained. The infection from this abscess, however, had spread to his abdomen and on the third day of his admission, he developed symptoms of acute intestinal obstruction.

He was accordingly again anæsthetized and his abdomen opened in the middle line. A strong constricting band was found, around which several feet of intestine were strangulated. The condition of the strangulated intestine was such as to necessitate excision, and an end to end anastomosis of healthy bowel was made.

The patient's general condition of acute toxæmia, however, was so intense that it was not surprising when this anastomosis broke down and formed a fecal fistula, which discharged through the opening in the abdominal wall made for the drainage of the appendix abscess.

A month later an attempt was made to close this opening, but without success.

The patient came under my care in June when all his intestinal contents were passed through the fistula and no action of the bowels