Medical Memoranda

Unusual Dislocation of the Carpal Bones

It is thought that the following case is worthy of record owing to its unusual character.

CASE REPORT

A soldier aged 21 came to hospital on the morning of December 10, 1940, complaining of pain in his right wrist. Earlier that morning a lorry, whilst backing, had compressed his right hand and forearm against a wall. The elbow was flexed at the time so that the force was an impacting one, tending to drive the carpus proximally.

On examination there was considerable radial deviation of the wrist, and the lower end of the ulna was very prominent. Any attempt to move the wrist passively caused great pain.

FIG. 1.—Radiograph showing gross dislocation of the carpal bones and fracture of the scaphoid.

A radiograph (Fig. 1) showed a gross dislocation of the carpal bones, with a fracture of the scaphoid. The only bones remaining in the correct anatomical position were the semi-lunar and the proximal third of the fractured scaphoid. The

FIG. 2.—Radiograph showing the position after reduction.

others, including the distal two-thirds of the scaphoid, were displaced upwards, backwards, and towards the radial side of the wrist. The cuneiform was occupying the normal site of the scaphoid and was overlying the proximal fragment of the latter. Thus the appearance was that of a "trans-navicular dislocation" as described by Böhler (1935).

The dislocation was reduced under general anaesthesia. A calico bandage was passed round the arm for counteraction and the elbow was flexed to a right-angle. Strong traction was then exerted on the wrist for about ten to fifteen minutes; the carpal bones were also slightly manipulated. A second radiograph (Fig. 2) showed that the position after reduction was satisfactory. A volar plaster slab was then applied with the wrist dorsiflexed, and the patient was admitted to the fracture ward. A few days later a plaster bandage was applied to complete the plaster. He was discharged in plaster on December 23, his finger and thumb movements being very good.

On January 1, 1941, the plaster was removed and the wrist radiographed. It was thought that his scaphoid showed signs of commencing union, and he seemed to be doing very well. Another plaster was applied.

I wish to thank Mr. W. Harvey Gervis, surgeon in charge of the fracture clinic, Kent and Sussex Hospital, Tunbridge Wells, for permission to publish this case and for his help and advice.

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REFERENCE

Böhler, L. (1935). *Treatment of Fractures*, Wright, Bristol.

Lobectomy for Bronchiectasis in an Infant

The following report of a case of bronchiectasis in a young child treated by lobectomy has some features of interest.

CASE REPORT

The patient, a female child aged 19 months, was a twin weighing 4 lb. 5 oz. at birth; her twin brother weighed just over 5 lb. Up to the age of 6 months she was healthy, but remained under weight. She then developed a "cold" and ever since has coughed up offensive sputum which made her sick as many as five or six times a day. She had a chronic nasal discharge, was always listless, took little interest in her surroundings, and became pigeon-chested.

On examination the left lower lobe of the lung was seen to be the seat of the trouble. There was pronounced clubbing of the fingers and the temperature was raised and very irregular. The motions were offensive, and there was constipation. Owing to the poor condition of the child no bronchogram was taken, but postural treatment was tried, with little success, for two months. On September 12, 1940, a bronchogram showed considerable bronchiectasis of the left lower lobe, with large numbers of saccular dilatations. On November 16 the child was transferred to one of my beds at the Sheffield Royal Infirmary, and, after some pre-operative treatment, an operation was performed on November 21. A preliminary attempted artificial pneumothorax revealed that the lung was adherent, so that it was possible to perform the operation of lobectomy without further treatment.

The chest was opened by the usual incision in the sixth intercostal space and the lung separated from the thoracic wall. The roof was defined and clamped with a tourniquet, and the lung removed. The cavity left was drained under "automatic suction" drainage. There were no post-operative complications, and on December 9 the child was sent back to the Children's Hospital to complete her convalescence.

Pathological examination of the excised lung showed extensive saccular bronchiectasis, the cavities for the most part being filled with pus. It is probable that the lobe was of the congenital cystic variety and became infected at the age of 6 months. As the lipiodol did not fill the upper lobe it is not possible to say whether there were saccular dilatations in it or not.

After her return to the Children's Hospital she developed chicken-pox, and shortly after recovering from this she had measles, but in spite of all her troubles she was very well when seen at the end of January, 1941. She was then quite a different child; she played with toys, was cheerful, and had a good appetite and a good colour.

I am unaware of any case in which a lobectomy has been performed at such an early age, though I expect there are some.

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