EXPERIENCES OF RESECTION OF THE HIP-JOINT.

Presented to the Section of Surgery at the Annual Meeting of the British Medical Association in Worcester, August 1882.

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MUCH has been written and said during the last few years about the treatment of joint-disease without excision; and, as a result, some discredit has been thrown, both intentionally and unintentionally, on that operation. In company with many other surgeons, I am confident that the excision of diseased joints is a proceeding which has preserved many lives and limbs in the past, and has very largely sustained its reputation as a measure of conservative surgery. If the excision of joints be destined ever to find its place in a museum of the surgical barbarities of the nineteenth century, it will not be because it is a proceeding unsuitable for the treatment of a certain class of cases under fairly appreciated conditions; but it will be because surgeons possess a better knowledge of the pathology of joint-disease, a fuller power of diagnosing its varieties and early stages; because there is a wider recognition by the people of the necessity of seeking surgical advice at the earliest possible moment; and, finally, because the progress of sanitary science will afford equal facilities for the hygienic and the mechanical treatment of all classes of the community. Our discussion to-day is a step in the direction of improving our knowledge in some of these respects; and it will be a happy day when we are able to cure the disease before the joint has been damaged to an extent in which excision or ankylosis, amputation or death, are the only possible terminations. I am very far from saying that the operation of the excision or resection of joints has not been misapplied. I believe that it has been performed when other modes of treatment might have sufficed; that it has been undertaken when local disease had advanced too far, or when other conditions existed in the patient which rendered such a proceeding unsuitable; and, further, that the method of performance and the subsequent treatment have not always been well calculated to ensure success. But this is only equivalent to saying that we are not all or always endowed with an equal amount of wisdom and judgment. Our very difficulties and failures have, however, had the advantage of stimulating a more extended study of the pathology, diagnosis, and treatment of joint-disease, and of suggesting our interesting discussion of to-day. But I venture to remind you that, whilst we are endeavouring to improve our knowledge in these respects, and learning to restrict the operation of resection of diseased joints, we must avoid running into the opposite error of failing to recognise its immense value in proper cases. For my own part, I desire to record my earnest protest against any sweeping general condemnation of it.

Thus far, I have spoken generally; but it must also be remembered that it is altogether impossible to form any adequate judgment or to formulate any expression of opinion on the general subject of excision which shall be of general application. The conditions of its application to different joints vary so widely, that each operation must be considered on its own merits; and I think that our knowledge of the subject will advance more steadily if we confine our attention to each joint separately.

I believe that there is no joint-disease which can be more satisfactorily treated in its early stages than ordinary hip-disease (*morbus coxae*). But, for a successful result, three conditions are essential: 1, early and correct diagnosis; 2, proper hygienic surroundings; 3, the possession and intelligent use of the necessary surgical appliances. It

because these three conditions are fulfilled, that excision of the hip is rarely required amongst our private patients. It is precisely because one or more of these conditions have been wanting in many of our hospital patients, that disease has advanced beyond the curable stage, and that excision is often required. As surgeon to a children's hospital as well as to a large general hospital, I have had to deal, during the last dozen years, with a large number of cases of *morbus coxae*; and, out of 246 cases of all stages of the disease, I have performed 65 excisions, whilst 181 cases were treated in other ways. Of the latter, I have no exact record of the number of deaths; but they were numerous, chiefly from suppuration in connection with pelvic caries and necrosis. Of the excisions I have an exact record; of these, 39 were boys and 26 girls.

Number.	Ages.	Deaths.	Per Cent.
3	18 and upwards	3	100
20	12 and under	2	10
34	6 " 12	2	5.88
8	3 " 6	0	0
65		7	10.77

The deaths were from tubercular meningitis, phthisis, or the more immediate results of prolonged suppuration. Three of the other cases subsequently required amputation, and recovered. The rest recovered with more or less useful limbs. Many of the elder children had discharging sinuses for more than twelve months, and a few for several years; but, even in them, the shortening and deformity were less, and the limbs more useful, than in the cures by ankylosis. The best cases were amongst the younger patients, many of whom recovered most perfectly, with only the line of cicatrix and one inch to one inch and a half of shortening to show that excision had been performed, the firm ligamentous union permitting complete flexion and a fair amount of rotation, and the wasting of the muscles entirely disappearing with their restored use.

The conclusions that I have formed on the subject are these.

1. Resection should be restricted to cases where there is distinct grating in the joint, accompanied by either pain or profuse suppuration, or failure of health.
2. It should be performed without loss of time, as soon as these conditions are recognised.
3. It is inadmissible in patients over eighteen years of age. All three of my older patients died with more or less prolonged suppuration, and without the slightest attempt at repair. I have never seen an adult patient recover from excision of the hip.
4. The younger the patient (my youngest patient was three and a half) the more satisfactory the result, and the more rapid the repair.

I now perform the operation antiseptically, and always remove the great trochanter with the head of the bone. By not postponing the operation, the acetabular mischief is usually slight. Both ends of the wound are closed with two silver sutures, a tube being inserted so as to keep the centre of the wound, opposite the acetabulum, open. I prefer Bryant's splint, and fix the limb operated upon about one inch shorter than the other. This extension is a matter of great importance, as I am convinced that the muscular contraction forcing the shaft of the femur against some part of the acetabulum is a frequent source of subsequent failure, and of undeserved discredit of the operation. In the last few cases, when possible, I have placed the children for the first few weeks in the prone position (face downwards), so as to avoid soaking the bandages with urine. I have tried this plan for too short a time to express any positive opinion with regard to it; but it answers its purpose exceedingly well, and is marvellously tolerated by the little patients.

NOTES ON THE TREATMENT OF ABSCESS IN BONE.

Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Worcester, August 1882.

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IN 1787, John Hunter, after stating that abscess in bone may find its way to the surface, added, "the crown of the trephine is often necessary in order to get at the seat of abscess."* It would thus appear that trephining or drilling for circumscribed abscess in bone was practised by the great master of surgery more than a century ago. It is, however, only since the publication of Sir Benjamin Brodie's paper in the *Medico-Chirurgical Transactions* (1832), just fifty years ago, that the operation has become the almost universally approved treatment of this affection.

It is indeed the only proper treatment; and probably the differences of opinion respecting it now-a-days, are confined to the rarity or frequency of the cases which require it, and to the degree of risk attending it. Possibly there are still surgeons who consider, as the late Professor Syme did, that the disease is a very rare one in surgical practice, and that the operation is attended with grave danger.† The following six cases, which have occurred in my practice during the last two and half years, point, however, to an opposite conclusion; and seem to indicate that abscess in bone occurs more frequently than is generally supposed; whilst, as regards the consequences of the operation, my personal experience, up to this period, has led me to think that good alone results therefrom in properly recognised cases.

CASE I. *Chronic Abscess and Central Necrosis in the Outer Condyle of the Humerus.*—Sigismund H., aged 44, a courier, was admitted on November 17th, 1879. Twenty-five years ago he contracted syphilis.

* Manuscript lectures of J. Hunter, quoted by Mr. Bryant in his *Practice of Surgery*, vol. ii, p. 509.
† Syme's *Principles of Surgery*, 1848 and 1863.