DISLOCATION OF THE PATELLA ON ITS EDGE.*

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THE patella, though possessing great freedom of motion, is not very liable to dislocation; but, when it is displaced, it is generally to the outer or inner side of the condyles of the femur. There are, however, instances of the bone being dislocated vertically, or on its edge, described in the different treatises on surgery; but this variety is so rare, that I trust a short account of a case which came under my notice about twelve months ago will not be deemed unworthy the attention of my professional brethren.

A young gentleman aged 20, in robust health, and well formed in the limbs and joints, was wrestling with some companions in a first-class railway-carriage, and thereby caused a wrench of his right knee, which was immediately followed by excruciating pain and complete rigidity of the joint. Fortunately, the accident occurred near to the station, in the vicinity of the young man's residence. His friends found considerable difficulty in removing him from the carriage; and, as the pain increased in severity, they sent a messenger for Mr. Farr, surgeon, at Swinton, who arrived about half an hour after the accident took place. This gentleman soon discovered the nature and extent of the injury, and attempted forthwith to replace the bone, but was obliged to desist, so intense were the pain and distress occasioned by even the slightest manipulation or movement of the limb. After some deliberation, it was resolved that Mr. Farr should accompany his patient to my residence, a distance of four miles from the station. They were conveyed in a private brougham; the surgeon sitting on the seat opposite to the patient, with the foot of the latter resting on his shoulder—the only position which seemed to produce any alleviation of the pain.

I placed the patient on a couch, and administered chloroform; and, when he was completely under its influence, proceeded to examine the limb. The nature of the injury was soon apparent. The patella I found to be in a vertical position; its outer border resting on the upper and outer side of the external condyle; the inner presenting so sharp a prominence under the skin, and so tense, that it seemed as if the slightest pressure would force the bone through the integuments. As the trochlea of the femur was not encroached upon, and there was very little swelling of the surrounding parts, the two facets of the bone could be distinctly traced—the under surface, with its central projection, looking towards the internal condyle of the femur; the outer appearing almost continuous with the side of the external condyle. The extensor cruris muscle and the ligamentum patellæ were so stretched that any movement of the bone was impracticable. I therefore endeavoured, but without success, to replace the patella by pressing firmly on its outer side; Mr. Farr at the same time holding up the limb for the purpose of relaxing its muscular connections. We proceeded next to bend the knee, but with great caution, to prevent undue tension of the skin over the upper edge of the bone; and, as soon as the leg was brought to about a right angle with the thigh, the bone suddenly slipped into its place. Lint moistened with spirit-lotion, and a bandage, were then applied, and the young man was removed to his own home. Considerable swelling of the adjacent parts ensued; but this was soon reduced by evaporating lotions and complete rest. At the end of three weeks, the patient was allowed to use the limb; and, as the patella was rather more easy of motion than its opposite neighbour, an elastic knee-cap was worn until all traces of the injury had disappeared.

On referring to the few cases recorded of this variety of dislocation, I find that the details of some are so imperfect that it is difficult to determine whether they ought to be classified or not with the one now described.† All, however, show that, when the patella is twisted on its axis, or placed obliquely on one of the condyles of the femur, or fixed on its edge, the displacement is accompanied with excruciating pain, and the reduction very difficult in general to accomplish.

Most of the cases on record having, however, occurred antecedently to the discovery of chloroform, the patients had none of the advantages of that agent, which not only has a powerful influence in causing relaxation of the muscles, but seems especially adapted to relieve the severe pain, which probably formed the chief obstacle to reduction.

My own experience in this case, and the information derived from the perusal of others, lead me to suggest that no attempt be made to reduce this form of dislocation until the patient is completely under the influence of chloroform. The extensor muscles should then be well relaxed by raising the thigh towards the body, when, by bending the knee, the bone will probably, through the resistance offered by the ligamentum patellæ, be drawn into its proper place. Should this plan not succeed, the knee should be extended and bent again, and pressure applied to each side of the bone in a direction corresponding to its natural position.

ON A CASE OF MOLLUSCUM CONTAGIOSUM.

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As the contagious properties of the above malady are still a subject of debate, I think the following series of cases may be of interest. A clear line of distinction must of course be drawn between molluscum simplex seu contagiosum and molluscum fibrosum, to which latter contagious properties have never been assigned. The pathological conditions of these affections are quite distinct. The fibromata of molluscum fibrosum vary in size from a millet-seed to the bulk of a man's head. They are also always soft, differing in this from kindred growths. The younger nodules consist mainly of round and spindle-cell tissue. The tumours which have existed for a considerable time are fibrous in structure, but never arrive at the toughness of cicatricial tissue. In these we find a network of thick trabeculae of connective tissue with fibrous fasciculi stretching across. In the younger tumours, fissures containing fluid occupy the positions afterwards filled by the trabeculae, connective tissue being gradually formed. The morbid anatomy of molluscum contagiosum is very far apart from the above. In it the sebaceous follicle is the starting point of the malady, the connective tissue of the papillary body playing but a secondary part in the hyperplastic process. The tumour rarely is larger than a split pea, but may reach the size of a hazel-nut. It resembles a drop of wax on the skin or a soft wart. From this last it differs in having always in or about its centre the orifice of a sebaceous follicle. That the origin of the disease is an obstruction of the gland-duct is not correct, as in many of the tumours the orifice is found gaping and patulous, the contents being readily squeezed out. A section exhibits fibrous bands running between numerous cells, which vary greatly both in shape and size. In some of these cells, the contagium is supposed to reside. The following series of cases occurring in the same family lends, I think, some support to the opinion of those who believe in the communicability of the disease.

Mrs. F. presented herself at the Skin Disease Dispensary of Mercer's Hospital on December 4th, with a little girl, aged 8. She was a bright looking child, with blue eyes, fairly nourished, and had no enlarged glands or signs of struma. On her chin, right cheek, and the right side of her neck were several tumours, exhibiting all the characters of molluscum contagiosum. On inquiry, we learned that the first of these "warts," as the mother called them, appeared six months previously, and that she had "taken" them from her brother. On examining the mother, we found that she had two tumours; one on her nose, the other on her cheek. She then told us that two of her children at home (a little boy and a girl) were similarly affected. On the following Wednesday, the girl, aged 14, came to the Dispensary. She had nine spots on her face and two on her left arm. On Friday, being much interested in the cases, I went to their home. I there saw the entire family, with the exception of the father, who was only at home at night, and was said to be unaffected with the disease. There were four children, the two whom I had already seen and two others, both boys, aged respectively six years, and two years and nine months. The elder boy had no trace of the malady, whilst the younger, who first became affected thirteen months previously, and was the first of the family to exhibit the disease, had a number of shrivelled tumours on the right side of his chest and neck. The mother believed that the child had been "infected with the disorder" by a woman who then lived with them, and who, she affirms, had numbers of such spots on her face and hands.

The order in which the family exhibited the disease was—first the boy, aged now two years and nine months; then the girl, aged fourteen years; next the mother; and lastly the girl aged eight years. The family do not appear scrofulous, and are fairly cleanly. They inhabit, however, a single room, which is on the third storey in a narrow street. The children all sleep in the same bed; the father and mother do not sleep with them.

* Read before the Surgical Section at the Annual Meeting of the British Medical Association in Birmingham, August 1872.

† See H. Mayo, *Medical Gazette*, vol. ii, 1828; Wolff, *idem*, vol. iii; and Rust's *Magazin*, 1829; Welling, in Sir A. Cooper on *Dislocations and Fractures*, second edition; Curling, *Medical Times and Gazette*, February 1862; Meade, *idem*, 1862; Valentine, *idem*, 1862; Pentland, *Cyclopaedia of Anatomy*, vol. iii, p. 74; Eazzam, *Gross's System of Surgery*, vol. i, Philadelphia, 1866; Vincent, *Observations of Surgical Practice*, p. 73.