CHEILO TOMY FOR CRIPPLING TRAUMATIC ARTHRITIS OF THE HIP-JOINT.

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I WAS much interested in the communication published under the joint names of Mr. Sampson Handley and Dr. Preston Ball which appeared under the above heading in the BRITISH MEDICAL JOURNAL of May 3rd.

I have many times, in common with other surgeons, operated upon cases of chronic rheumatic arthritis to relieve pain and deformity, but as my last case is identical in all essential respects with the two cases described in the communication, and as the operation was performed on the patient's hip on October 22nd last, three months before Mr. Sampson Handley operated upon his first patient, it may be of interest to mention the outstanding features, and thus put a third case on record. The question of priority is of no great importance, but Mr. Sampson Handley and Dr. Preston Ball are in error in thinking that the operation had not been performed prior to their first case in January, 1913.

Miss H. D., aged 21, residing in London, was sent to me in September last, the subject of polyarticular chronic rheumatic arthritis from which she had suffered from childhood. The left knee-joint, the right hip and the two wrists were disorganized with the changes characteristic of the disease. The left knee could not be completely extended without intense pain, and the right hip could bear no weight whatever, the slightest pressure on the heel causing pain in the joint. Locomotion was therefore only possible with the aid of crutches, and even then was attended with much suffering. She had been dependent on the use of crutches for seven years.

X-ray photographs, taken by Dr. Hayes on September 9th, showed lipping of the tibia to the outer side of the left knee-joint, which was the site of great tenderness. A ring of osteo-arthritis bone surrounded the right hip, impeding every movement of the joint, stretching the capsule, and on pressure evidently abutting against the rim of the acetabulum and the neighbouring bone.

The first operation was performed on the knee-joint on September 12th. (It should be mentioned that the shortening produced by the enforced flexion was corrected in London by raising the boot about 2 in.) Through an incision made along the outer side of the knee-joint the lipping of the tibia was removed with a gouge and chisel through a well-marked line of cleavage such as is seen in the new bone formed in connexion with a bunion. A weight and pulley was attached to the limb for about ten days to correct the flexion, and massage was applied for a short time subsequently. All pain disappeared immediately after the operation, and on removal of the weight and pulley the joint could be fully extended and flexed.

The result of this operation encouraged me to operate upon the hip of the opposite side on October 22nd. The joint was opened through Kocher's posterior incision. There was a well-marked "cornice" of newly-formed bone encircling the junction of the head and neck of the femur, giving it the mushroom appearance commonly seen in the specimens of chronic rheumatic hips found in the surgical museums.

The capsule having been freely opened, the hip was rotated in all directions by an assistant, and the new bone was chiselled away from about two-thirds of the circumference. The result of the operation surpassed all expectations. The following day pressure on the heel caused no pain. The stitches were removed in ten days and the patient was allowed up. She could now bear her entire weight on the right limb, and the movements of the hip-joint were free and painless. Subsequent progress was uneventful. I saw the patient when in London last week, and she is walking without crutches in absolute comfort after being a cripple for seven years. I can arrange for Mr. Sampson Handley to see the patient and the x-ray photographs if he is interested in the case.

I was glad to read the result of his two cases, which convinces me that my result was no exception, and that in selected cases the operation of "cheilotomy" is destined to give instant relief, and to change completely the outlook for a certain class of crippled patients. I think the

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title of the paper would be better if the word "traumatic" were omitted; the etiology matters little if the pathological changes are the same.

I should mention that practically every form of treatment, including the use of vaccines and serums, had been tried in my case during the nine years she had suffered from the disease. The condition of the wrists has improved considerably since the patient has been able to discard the use of crutches.

THE INTERNEURONIC SYNAPSE IN DISEASE.

BY

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I HAVE long felt that the cell-exhaustion theory does not satisfactorily explain the pathology of acute delirium. Take, for instance, such a case as this: A young woman, while walking in her sleep, falls from a height, injuring herself severely, and at once becomes acutely delirious; or a girl, owing to a celluloid comb in her hair suddenly taking fire, immediately develops acute insanity; or a similar state results in an elderly widow on finding her sister dead in the same bed. Up to the occurrence of the shock, a state of mind entirely normal to the individual apparently exists, and almost immediately after we find more or less complete inco-ordination of the higher centres and mis-interpretation of stimuli. Inco-ordination of the higher centres is the outstanding result. To my mind, this suddenly developed condition, accompanied as it is by extreme motor restlessness, cannot logically be due to cell exhaustion. For purposes of comparison I have examined my records of 17 cases of insanity occurring after surgical operation in which the undoubtedly important factor producing the alienation was exhaustion—physical and mental—plus the slight shock of the operation perhaps, and contrasted them with 25 cases of insanity immediately supervening on sudden and violent mental shock, with the following results:

TABLE I.—The Types of Insanity Resulting.

Type of Insanity.	Etiological Factor.	
	Shock.	Operation.
Acute delirium	11	4
Confusional insanity	5	—
Melancholia	5	9
Mania	3	3
Stupor	1	—
Delusional insanity (systematized)	—	1
Totals	25	17

TABLE II.—Ages at Onset.

Age.	Etiological Factor.	
	Shock.	Operation.
Under 20 years	4	1
21 to 30 "	5	2
31 to 40 "	3	5
41 to 50 "	4	6
51 to 60 "	4	3
61 to 70 "	5	—
Totals	25	17

As regards predisposing causes, a family history of insanity was ascertained in 28 per cent. of the cases due to shock, and in 23.5 per cent. of those due to operation.