its opposite sides. For further safety these stitches were made to cross in pairs. The clamps were released in order, first from the branches, then the distal, then the proximal, and, as the severest test, the distal clamp was tightened again. There was not the slightest oozing. In view of the exposure of the site of suture to strain, a graft of fascia lata was fixed as a collar round the vessel at this point, with its fibres transverse to the line of the artery, and with slits to allow the passage of the circumflexes. Above and below a loose stitch in the fascia near by prevented telescoping. The wound was then closed and dressed with gauze wet with 1 in 2,000 flavine. At the close of the operation the radial pulses were equal.

After-History.

Convalescence was uneventful. There was pain referred to the index and middle fingers for three days. The wound healed by first intention, and physiotherapy appropriate to the nerve condition and to the axillary scar was adopted from the twelfth day.

Three months later there was no sign of yielding; at the site of the suture was a thickening due to the presence of the graft. The brachial pulses were equal and the index showed almost complete recovery. Pulsation, though slight, indicated that thrombosis and obliteration of the artery had not occurred at the point of suture.

FRACTURE OF FEMUR: A SIMPLE METHOD OF EXTENSION.

BY

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FRACTURE of the femur in private practice is always looked upon with apprehension, and even in hospital work with some degree of anxiety.

One great reason for this attitude is the necessity for having a complicated apparatus made up of iron framework, a mast and guy-ropes, all requiring frequent adjustment and refitting, to the pain and distress of the patient. This, perhaps, may not be true of fractures below the middle of the shaft, as in these cases fair results may be obtained by use of foot extension with the limb lying straight along the bed.

The method I am about to advocate is for fractures above the middle, where the upper fragment is flexed forwards. As this fragment is too short to be maintained in any other position than that allowed by the muscles attached to it, it becomes necessary for the lower fragment to be brought into line with the upper, at the same time keeping up extension in that line. In such a case the patient is placed in bed on his back, the head and shoulders being supported by two or three pillows. The knee of the injured limb is raised until the femur is at the required angle, which is generally about 30 to 40 degrees to the horizon. It is maintained in this position with a knee pillow, or better still by a pyramid of sand-bags. A ring-shaped air-cushion is slipped over the foot, drawn up to the knee and inflated as fully as possible, the foot being allowed to fall back on the bed. A strong bandage is tied round the air-cushion exactly opposite the knee and the other end carried to a pole or mast fitted to the foot of the bed; strong traction is made in the line of the upper fragment, lower fragment, diameter of cushion, bandage and point on mast, until the ring becomes definitely oval, when the bandage is fixed to the mast. It will be seen that the extension is procured by a pneumatic pad in the flexure of the knee, and that the strain is transmitted to the femur through the head of the tibia and the ligaments of the knee-joint. These being rigid structures serve the purpose well.

Pneumatic pressure at the point indicated is justifiable, because all the great nerves and blood vessels dip deeply here under the heads of origin of the gastrocnemii, which being massive and fibrous in this situation are well adapted to support continuous pressure and protect underlying structures.

The advantages attendant on this method are:

1. Simple apparatus. A few pillows, a long piece of stick, a bandage and a ring air-cushion or inner tube of a motor tyre. Such things can be obtained almost anywhere at very short

notice, and there is no need to keep apparatus of various sizes in stock.

2. Ease of application. No skilled assistance required.

3. Once fixed adjustment is very seldom required. The bed-clothes are arranged so that the ring-cushion is uncovered and visible, a glance at its shape informs one immediately of the degree of tension and inflation.

4. The foot hanging over the pneumatic pad acts as a kind of rudder and prevents rotation of the lower fragment, or if desired it can be pushed inwards or outwards, rotating the lower fragment in any required direction.

5. There being no pulleys, guy-ropes, weights, or iron frame, there is very little necessity for disturbing the patient, which saves much anxiety and suffering. A bed slipper is easily adjusted.

6. The thigh is supported underneath by sand-bags, and others may be used at the sides if required to give a sense of security, but these are not necessary. The thigh can therefore be fully exposed, permitting easy examination, dressing or massage of suitable type, all without any disturbance of the fragments whatever.

I have treated only one case by this method:

A boy, aged 10 years, sustained a simple fracture of the right femur above the middle of the shaft. He remained in the apparatus for four weeks with the very slightest adjustments. At the end of that time, union being quite strong, the limb was removed from all restraint. At first any attempt to straighten the limb caused pain in the knee-joint, but full flexion and extension returned without assistance within forty-eight hours. The only evidence of pressure by the pneumatic pad was a very superficial blister, which no doubt would have been obviated by binding lint over the rubber before application. The shortening was under a quarter of an inch. At no time was there any numbness, tingling, or oedema of the leg or foot.

The extreme simplicity and efficiency of this method, as compared with many devices advocated, are my excuse for seeking publication.

AN UNUSUAL CASE OF MYELOCELE.

BY

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In practically all the standard textbooks myelocoele is stated to be incompatible with life, the infant being either stillborn, or dying within a day or two. Bland-Sutton holds a somewhat different view. He states:

"Many children in which this condition is present are still-born: the few that survive their birth rarely live longer than three days, the continual leakage of cerebro-spinal fluid being sufficient to explain the invariable brevity of their lives." (*Tumours: Innocent and Malignant*. 1917.)

He thus admits the possibility of survival beyond the first day or two.

In inquiries, admittedly limited, which I have made on this subject, I have been unable to trace a single case in which the duration of life exceeded a period of three days. I have therefore thought that the following case, in which life was prolonged for twenty-three days, merited publication.

I was called to see the patient, a male infant, an hour after its birth, at the Ilford Maternity Home, during the early hours of September 18th, 1920. The reason for the early call was that the infant seemed very feeble and had difficulty in breathing. On arrival I found a well-nourished, good-sized baby, which soon revived and cried lustily. He had a well-shaped head, with no evidence of hydrocephalus.

The lower limbs were held rigidly flexed to a right angle at the hips, and rigidly and completely extended at the knees. The legs resisted straightening, and were paralysed, wasted, and, as far as could be made out, anaesthetic. There was double talipes equino-varus, the varus element markedly predominating, with a well-marked crease on the soles, corresponding to the transverse tarsal joint.

Looking at the back, there was a large, raw, circular area, somewhat depressed, and corresponding to a deficiency in the neural arches and failure of closure of the neural groove, opposite the lower three lumbar and upper two sacral bodies. The open spinal cord was seen in the middle line at the upper part of the defect, while the nerves of the cauda equina could be distinguished in the lower part. The myelocoele narrowed and deepened as it was traced upwards into the funnel-shaped termination of the central canal. Cerebro-spinal fluid was constantly, though slowly, dripping out of the apical opening, bathing the raw area, and then running in drops over the buttocks. The surrounding skin was rendered as far as possible aseptic, and a dressing applied. The next day the flow of cerebro-spinal fluid was freer, and some congestion developed round the myelocoele. During the first week the child's condition remained good. The raw area gradually contracted down and became deeper, while the inflammatory redness subsided.