a good expectation of life, provided that the disease is monarticular. It is generally accepted as being the most effective procedure when the knee is seriously involved, and when deformity is developing in relation to that joint. In many cases the operation undertaken to secure bony ankylosis may fail to produce this, leaving in some cases fibrous ankylosis, and in others a false joint. This failure to secure bony union does not seriously prejudice the result in the upper extremity, and even in the lower pain will be relieved by the measure, though some deformity or contracture may develop. Failure to secure bony ankylosis results from either an incomplete operation or inadequate or insufficient fixation afterwards.

3. Formal arthroplasty, or operations designed to leave a movable joint, are naturally in favour if they are effective in curing symptoms and in giving a sufficiently stable joint. In the case of the metatarso-phalangeal joint of the great toe an operation of this character is carried out as a routine by many surgeons for conditions of hallux rigidus or valgus. The good results obtained in this operation cannot, however, be employed as an argument in favour of a similar procedure for the major weight-bearing joints, the knee and the hip. In these articulations it is clear that there is risk of the new-formed joint undergoing in course of time the same pathological changes that were responsible for the primary condition. This risk is so definite in the case of the knee that I think an arthroplasty should only be aimed at here in exceptional circumstances. In the hip-joint operations aiming at mobility appear to be coming more into vogue, being generally based on Whitman's method of reconstruction. Membrane or fascia, after the method of Baer or Putti, is often interposed to secure a movable joint. My own view is that the operation should be limited to the elderly and to those cases in which, on account of disease in the opposite hip or of other joints in the same extremity, mobility is particularly important in order to secure reasonably good function.

This survey represents a brief sketch of a complicated problem. It will be noticed that I have not referred in detail to the treatment of osteo-arthritis of the spine and sacro-iliac joints; this has not been done because the technical methods employed in these areas must still be regarded as on trial. I have not entered into the surgical technique of the different methods discussed, as a full account of these can be found in the literature. My aim has been to indicate the importance of surgical supervision from an early stage in all cases of chronic arthritis, and to demonstrate the possibilities of radical treatment of the more advanced forms.

CONGENITAL DISLOCATION OF THE HIP:

A METHOD OF CONTROLLING THE PELVIS DURING REDUCTION.

BY

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To every orthopaedic surgeon with experience of a considerable number of cases of congenital dislocation of the hip-joint in patients of varying ages it must be apparent how inadequately control of the pelvis can be carried out by an assistant during attempts at reduction. The chief reason for this is that in pressing downwards on the opposite side of the pelvis in an attempt to fix it, the assistant is converting the pelvis into a short-armed lever, the effect of which, when pressed down, is to raise up the opposite side of the pelvis from the table, carrying the vacant acetabulum with it. The manipulator is at the end of the long-armed lever—namely, the knee of the dislocated femur—and his efforts to lever the head over the posterior lip of the acetabulum are really aiding the assistant in raising the pelvis from the table, and therefore a great deal of energy is wasted as the result of their applied forces acting in the same direction.

This action of opposing levers is very evident when dealing with the older cases—patients aged 5 years and upwards.

Some time ago I was faced with the problem of reducing a case of bilateral dislocation in a child aged 6, big for her age, muscular, and with strong femora. The femoral heads were unusually high above the acetabula. An attempt to reduce the left hip failed completely and was abandoned till a future date, after a considerable range of telescopic movement had been obtained by alternate extension and relaxation. Meanwhile both hips were to be subjected to daily stretching.

A fortnight or so later a second attempt was about to be abandoned when, on considering ways and means, it occurred to me to make use of the roller towel which had been employed for

counter-extension purposes, and, passing the left limb through one loop, the two strands were crossed on themselves and continued over both anterior superior iliac spines, being well spread out so as to cover the whole pelvic front; the assistant put his foot in the other loop as it hung down towards the floor. A tri-

angular block was then placed between the pelvis and the great trochanter, against which the towel passed. This enabled me at once to apply extension at the femoral condyles with both hands, the limb being in the abducted position, and to lever the head into the acetabulum at the same time.

I have since employed this method successfully in three other cases—one a child aged 9 years—and have found that the adductors stretch easily without any kneading or hacking with the hand. The amount of force applied is under the complete control of the surgeon, the action of the towel converting the pelvis into a very efficient fixed point.

The accompanying illustration should make my meaning quite clear.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

HEMIHYPERTROPHY.

THE case recorded below is, I think, of sufficient interest to warrant publication.

The patient, a boy, was 12 years of age when first seen. The left leg, it was said, was short, and the right sometimes "pained." The father, mother, and seven other children were healthy. There had been a suspicion of inequality at the age of three weeks, and shortening of the left leg was definitely noticed when he started school at the age of five years; it was corrected by a boot. For the past five years there had been intermittent attacks of intense oedema of the right leg extending to the top of the thigh, starting with pain in the groin and accompanied by pyrexia, anorexia, and signs indicating toxæmia, but no vomiting. During the attack pain in the whole leg was extreme; the urine was scanty and dark (probably febrile), the face swelled as with toothache, and the arm throbbed and swelled. These attacks occurred irregularly and subsided with rest, lasting about ten days to a fortnight.

The right side of the body, including face, arm, and hand, was bigger than the left, but the enlargement was most marked in the lower limbs. There was oedema of the soft tissues, which increased on standing or walking, but subsided after two or three days in bed. The right leg was 2 inches longer than the left, and resulting scoliosis and limp were present. The right calf was 2 inches greater in circumference than the left, and the right thigh 1½ inches. On x-ray examination the bones were found to be normal, but the right was larger than the left. The urine was normal, and the Wassermann reaction negative.

The interest of this case centres, I think, round the intermittent attacks. It has been suggested that the enlargement might be due to a pituitary, a sympathetic, or suprarenal anomaly. I think this would be hard to reconcile with the condition, and feel that it is in all probability a diffuse unilateral lymphatic or reticulo-