CONGENITAL DISLOCATION OF THE HIP.

Dr. Royal Whitman presented a child, two and one-half years old, with a congenital dislocation of the left hip, which was reduced by Dr. Whitman ten months ago by the bloodless method. After the reduction, a plaster bandage was applied and kept on until two months ago, when an ordinary cotton bandage was substituted, which had been removed to-day. The two limbs are now absolutely equal in length, and the head of the femur can be felt in its normal position in the centre of Poupart's ligament. The child does not limp, but has a characteristic rolling walk, which is an indication of the evening up of the gait.

Dr. Whitman said he regarded one and one-half to three years as the most favorable age for operation in these cases. At such an early age there is practically no after-treatment necessary, and the speaker said a relapse had never followed in a case presenting the indications of success illustrated in the patient presented. In fact, the patient was shown for the purpose of demonstrating these indications.

Under favorable conditions, Dr. Whitman said he thought he might be able to effect an absolute cure by this method in more than 50 per cent. of the cases of congenital dislocation of the hip. One very common obstacle to the successful application of this method is an anterior twist of the neck of the bone. In such cases the dislocation can be reduced, but the head will not stay in its normal position until the deformity is remedied by an osteotomy.

In response to a question, Dr. Whitman said that in the case he had shown there was an actual reduction of the bone, not a
transposition. The latter procedure is always accompanied by slight shortening and a limp. Transpositions are often called successes when they are not such at all.

DOUBLE HALLEX VALGUS.

Dr. Robert H. M. Dawbarn presented a woman upon whom operation was done two years ago. The result has been ideal. After applying a tourniquet at the thigh, a semicircular incision, with its convexity outward, was made, and the flap turned in. The joint was then opened, and with the Gigli wire saw the head of the first metatarsal bone removed, and the flap stitched with interrupted catgut sutures. Next the toe was put into the straight position and a short splint made of a strip of cigar-box, boiled and padded with gauze, applied to the sole and this toe, being careful to maintain a gap, where the head was, to be filled by blood. Gauze dressings cover the foot, then gutta-percha tissue, and finally a plaster-of-Paris splint encases all, carried up to the knee. Only then is the tourniquet removed. The splint is left on for about four weeks, and the patient then has a painless, freely movable false joint. Healing has taken place by the Schede moist blood-clot method, the clot organizing into connective tissue with great speed.

The deformity in these cases of hallex valgus consists always in the subluxations of the first metatarsal bone and first phalanx, and practically never is there any bony hypertrophy. As to the accompanying bursitis, this is ignored and will disappear unless already suppurative; in which case the operation needs two stages. In the first the bursa is cleanly excised. After sound healing, the operation above described is performed. Dr. Dawbarn said he had done this operation in at least fifty cases, and every one had been successful; but any break in asepsis would obviously be disastrous. The operation does not necessitate the cutting of any tendons nor interference with the sesamoid bones, nor with the base of the first phalanx. The toe is shortened from one to one and one-half centimetres. The only point of originality claimed is the shape of the flap. This gives abundant room, as needed, but is so placed as not to be pressed upon by the shoe later on. The scar is semicircular, or in bad cases even horse-shoe in shape,—toe outward.
The slight shortening of the toe is of no importance, and, instead of being a deformity, it is quite the contrary, as the foot then more closely conforms to the type handed down by the Greek sculptors.

In conclusion, Dr. Dawbarn said he hoped the members of the Society would continue to use his suggestion, the term "Hallex valgus" instead of "hallux valgus." The latter term is the one universally used in the text-books, but there is absolutely no good Latin authority for it. There is no such word in the Latin language as "hallux."

Dr. Whitman thought perhaps Dr. Dawbarn was rather too enthusiastic in regard to the improvement in the appearance of the foot after the operation he had described. The result obtained in the case shown was extremely good, but he was inclined to believe that after some of these operations there would be even a greater shortening of the toe than in this instance.

CONGENITAL TALIPES EQUINOVARUS.

Dr. Hotchkiss presented an Italian, aged thirty-four years, who was operated upon, March 6, 1902, for congenital talipes of the right foot. The case was of especial interest on account of the age of the patient, the extent of the original deformity, which was extreme, as shown in the plaster cast exhibited, and on account of the excellent result, functional and cosmetic, which had been obtained.

The operation had consisted in the removal of the astragalus, the scaphoid, a portion of the anterior end of the os calcis, and the posterior end of the cuboid, flush with the articular surface of the external cuneiform. This had been accomplished through the incision recommended by Lauenstein for the removal of the astragalus, i.e., an incision beginning at a point well up on the shaft of the fibula and extending down to and over the external malleolus, thence forward along the outer border of the foot and curving forward upon its dorsum. Through this cut the external lateral ligaments of the ankle are divided, the astragalus dislocated outward and easily removed, and the other bones were easily dealt with. The tendon Achillis, which was very small, was divided, but retracted only slightly. After the removal of the bones the foot easily fell into approximately normal position, but the
contraction of the soft tissues of the inner arch seemed still to hinder a perfect reposition, and they were divided by the open incision of Phelps. The foot was held in a somewhat over-corrected position after suture of the external wound and covered with a large dressing, over which a plaster case was applied.

The Phelps incision had healed aseptically under the blood-clot, but the external wound had discharged sloughs and had healed finally by granulation, most of the sutures being removed on account of tension due to the accumulation of fluids in the dead spaces. The final result as shown was most excellent. The patient now has a small, flat, but straight, and very useful foot. There is very slight motion at the new ankle-joint; the patient walks with scarcely a limp, wears an ordinary shoe, and is getting about better every day.

In connection with this case, Dr. Hotchkiss showed a plaster cast, which demonstrated the extent of the deformity previous to the operation. The speaker said that in these cases of extreme deformity, in adults, enough bone must be removed to allow the foot to be easily over-corrected. The removal of a wedge-shaped piece of the tarsus is not generally sufficient.

Dr. Whitman said that while the result obtained by Dr. Hotchkiss was extremely good, he would suggest the advisability, in these extreme cases, of dividing the operation into two or three sittings rather than to attempt to correct its deformity at once. If one were content, at the first sitting, to give the foot a vigorous stretching, and at the second sitting to do a Phelps operation, splitting the foot wide open, it would eventually be found necessary to remove less of the bony structure.

EXTENSIVE DIFFUSE PERITONITIS CAUSED BY A GANGRENOUS APPENDIX; PERITONEUM CLOSED WITHOUT DRAINAGE.

Dr. W. G. Le Boutillier presented a lad, sixteen years old, who was operated on October 23, 1902. He was admitted to the hospital on the fourth day of an illness that had begun suddenly with cramp-like pains in his abdomen, soon succeeded by vomiting. The pains had not been localized, vomiting had been persistent, and there had been constipation and great prostration.
When admitted, he was apathetic and suffering from general abdominal pain. The abdomen was moderately distended and tender all over, but tenderness was greatest in the lower portion, and particularly on the right side. Here the muscles were extremely tense, although there was some muscular rigidity all over the abdomen. No tumor could be felt. The leucocyte count was 14,800. Pulse, 96; temperature, 101.6° F.

The operation was done two hours after admission. A small incision was made by McBurney's method over the usual site of the appendix. On opening the peritoneal cavity turbid serum escaped, and the intestines were found deeply congested and in places slightly adherent. The wound was enlarged sufficiently by cutting across the fibres of the internal oblique, and the appendix found near the median line, dropping over the pelvic brim. The appendix was gangrenous in distal half, perforated near the tip, and surrounded by a small abscess of stinking pus, shut in by firm adhesions. The pus was sponged away after isolating the rest of the abdominal cavity by gauze, the appendix removed, and stump invaginated in the usual way. The general abdominal cavity was explored completely, and the intestines were largely exposed by evisceration. The inflammation was most acute on the right side, where the coils of gut were almost purple in color, coated with fibrin and pus. Sponges on sticks passed to the neighborhood of the loin and spleen were withdrawn coated with fibrin and charged with a thin seropurulent fluid. Much of the loose fibrin was detached from the intestines by sponging, and large quantities of saline solution were used to flush the abdominal cavity. When this returned clear, the intestines were replaced and protected, and the patient gradually raised in Trendelenburg's position. The pelvis was filled with stinking pus, which escaped through the wound, and the pelvic walls were thoroughly sponged and irrigated. The intestines were acutely inflamed wherever seen. The wound was entirely closed in layers, leaving as much salt solution as possible in the peritoneal cavity, and draining only the subcutaneous tissues with folded rubber tissue.

Recovery from ether was prompt and satisfactory. During the night the patient vomited once, and had considerable abdominal distention, pain, and great thirst. Morphine was given in moderate quantities, and the rectal tube inserted to relieve the
distention. Salt solution eight ounces, with one-half ounce of whiskey, were given by rectum every two hours and absorbed.

During the next twenty-four hours vomiting occurred three times, but stopped after washing out the stomach. Hot water by mouth in small quantities was allowed. Pulse ranged from 108 to 90 and the temperature fell to 99.4° F. Two faecal movements resulted from enemata.

On the fifth day the temperature was rising, although the pulse was ranging from 72 to 90. The wound was reopened down to the peritoneum, as it had become infected by the pus which passed over it at the operation. The peritoneum, however, was not reopened. The subsequent progress of the case was uneventful; the patient was allowed to sit up out of bed on the thirteenth day, and to go home on November 16.

THE PRESENT STATUS OF THE TREATMENT OF MALIGNANT TUMORS WITH THE X-RAY.

A paper with the above title was read by Dr. William B. Coley.

Dr. Dowd said he had seen some of the cases to which Dr. Coley referred in his paper, and had witnessed the good results following the treatment. In some cases of his own in which the X-ray treatment had been tried, there had been a diminution in the pain, but the progress of the disease was not stopped.

Dr. Coley had called attention to the danger of the X-ray treatment in cases that should be treated by operation. Some X-ray therapeutists are so enthusiastic regarding the treatment, that they refuse to admit that any of these cases should be treated by operation; although, in fact, the curative effect of operation is much better established than that of the X-ray. Early cases of breast cancer, for instance, should not be deprived of the well established advantages of operation while the experimental use of the X-ray is being made.

Dr. Dawbarn emphasized the point that in cases of malignant growth that are clearly operable it is dangerous to wait until the X-ray treatment has been given a trial. A number of cases in which this had been done with unfortunate results have come under his observation. One patient with cancer of the lower lip upon whom he recently operated for Dr. MacCracken,
of this city, had been previously subjected to the X-ray treatment without any benefit whatever, and during that time a lymphatic node below the jaw had become involved. The removal of this added to the severity of the operation, and the fact of its occurrence greatly increased the prospects of a recurrence of the disease. While the X-ray treatment is beneficial in many of these cases, it is very unwise to depend upon it in every instance, and thus delay operative interference. It would seem, in simple cases, safer to excise, and then use the X-ray to prevent recurrence.

Dr. Willy Meyer said that while his experience with the X-ray treatment of malignant tumors was very limited as compared with that of Dr. Coley, still, he has seen some remarkable results follow its use, especially in epitheliomata. He thought the X-ray treatment was particularly indicated in cancer of the breast subsequent to removal of the tumor, because in those cases, in spite of a far-reaching excision, we know that cancerous tissue is very apt to be left behind. In all of these cases, the speaker said, X-ray applications should be given as an after-treatment.

Dr. George D. Stewart reported the case of a man, sixty the root of the nose and both eyelids, apparently a carcinoma (although the diagnosis was not confirmed by a pathological examination), which disappeared entirely under the X-ray treatment, leaving scarcely a trace behind. If this case had been operated on, it would have necessitated an extensive dissection and a subsequent plastic operation, and would no doubt have left an ugly scar.

In conclusion, the speaker emphasized the fact that in spite of the surprising cures that are occasionally reported by the use of the X-rays, and no matter how rapid the strides that are made in this method of treatment, operable cancer surely belongs to the surgeon, and the after-treatment to the X-ray therapeutist.

Dr. George D. Stewart reported the case of a man, sixty years old, who presented himself last January with a deep, ulcer-like epithelioma of the side of the neck. It was more than three inches in diameter, extending over the ramus of the jaw, the bone being apparently thickened and its periosteum extensively involved. A specimen of the growth was sent to Dr. Brooks, who pronounced it an epithelioma.

An operation was undertaken, not with the idea of com-
pletely eradicating the disease, but simply for the purpose of improving the condition. As much as possible of the growth was excised. It was found to involve the external carotid artery and the deep jugular vein, and, as the operation had already been somewhat prolonged, it was decided to stop and perhaps do a subsequent operation. Instead of this, he was subjected to the X-ray treatment for about a month. During this interval the cavity left by the operation, which was very deep and over three inches in diameter, gradually became filled with granulations. These were subsequently covered by skin-grafts, cut according to Thiersch’s method, some of which took and others did not. At any rate, the patient felt so well that he soon left for his home.

When he presented himself again, a few days ago, he was apparently cured. The cavity had entirely filled, and was covered with fair integument which was slightly eczematous about the margin of the wound.

Dr. W. B. Coley asked that Dr. F. S. Mandlebaum, Pathologist to the Mt. Sinai Hospital, be permitted to show a microscopic specimen from the sarcoma of the femur which had been presented by Dr. Rogers at a meeting of the Society a month ago, and who was well more than four years after toxin treatment. In the history of the case which was given by Dr. Rogers at the time, some doubt had been raised as to the accuracy of the diagnosis of sarcoma on account of the subsequent development by the patient of a condition in the nose which had been regarded by one observer as specific.

The specimen shown by Dr. Coley was a typical giant-celled sarcoma, and had been so pronounced by Dr. T. Mitchell Prudden, Professor of Pathology at Columbia University.

Dr. F. S. Mandlebaum, the pathologist of Mt. Sinai Hospital, who had made the microscopic examination in the case shown by Dr. Rogers, stated that when the patient was first admitted to the hospital, on May 24, 1898, she had a fracture of the neck of the femur, caused by slipping on the floor four days previously. The limb was kept in Buck’s extension for nine weeks, and the patient left the hospital on July 24, before union had occurred. In November of the same year she fell, and felt a sudden snap in the region of the original fracture. This was followed by pain, and when the patient returned to the hospital,
on December 20, she was apparently suffering from an ununited fracture of the neck of the femur. There were two and one-half centimetres shortening on the affected side, and false motion in all directions, but no crepitus. A tumor was made out over the outer aspect of the thigh. On January 5, 1899, Dr. Gerster incised this growth and removed a specimen for microscopic examination. It proved to be a giant-celled sarcoma. Suppuration followed, the patient developed considerable temperature, and broken-down masses of the tumor were discharged. From January 25 to February 19, 1899, the patient received daily from one to three minimis of the erysipelas toxins, after the Coley method. In spite of this treatment, the tumor continued to grow, enlarging towards the femoral region. The retroperitoneal glands were much enlarged. From July 27 to August 8, 1899, injections of arsenic were made, and on August 14 she was transferred to the Montefiore Home.

In August, 1901, the patient was operated on by Dr. Rogers, who curetted a large bone cavity, and in February, 1902, by Dr. Elsberg, who cleaned out the cavity and filled it with iodoform paraffin. It was during the latter's service that the patient finally recovered, the sinus in the femur closing up, and all evidences of a malignant growth disappearing. A portion of the material removed by Dr. Elsberg was examined by Dr. Mandlebaum, and this showed only inflammatory fibrous and myxomatous tissue; the former evidences of giant-celled sarcoma had entirely disappeared.

In commenting on this case, Dr. Mandlebaum said that the pathologist is extremely cautious in making a diagnosis of round-celled sarcoma, as a number of instances are on record where sarcoma has been mistaken for syphilis, and vice versa. In the case under discussion, however, the diagnosis of giant-celled sarcoma was very clear, and there was no suspicion of syphilis.

As far as the recovery of this patient is concerned, we all know that this occasionally happens in sarcoma. Such a recovery has frequently followed the occurrence of some infectious process, and we know that giant-celled sarcoma is less malignant than other types of the disease.

Slides and photomicrographs of the tumor were then exhibited. (See figure.)
Photomicrograph of section of sarcoma of thigh operated upon by Dr. Rogers.