

ously in the field thereafter until the close of the war, at which time he was transferred to the regular service with his former rank. A short time ago, writing from his station on the Mexican frontier, he stated that he "felt no inconvenience from his old injury except the usual aches and pains from change of weather to which all wounds are subject, and, during hot weather, an occasional sense of suffocation as though there was not quite breathing room enough in the lungs." At that time "the finger could readily push before it the soft parts through the hole in the scapula, but the point of the injured rib could not be detected. The perforation in the scapula appears to be between an inch and an inch and a half in diameter and nearly round. The soft structures over the opening in the bone render it impracticable to determine with accuracy the exact condition of the osseous structures involved in the injury."

U. S. MILITARY ACADEMY, WEST POINT, NEW YORK.

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ART. VIII.—*Dislocation of the external end of the Clavicle upon the Acromion of the Scapula.* By H. F. MONTGOMERY, M.D., one of the Attending Surgeons at the Rochester City Hospital, Rochester, New York.

A REFERENCE to the works of the most recent surgical writers, as those of Gross (*System of Surgery*, 5th ed., vol. ii. p. 46), Fergusson (*System of Practical Surgery*, 4th Am. ed., p. 203), Holmes (*System of Surgery*, 2d ed., vol. ii. p. 804), and Hamilton (*Practical Treatise on Fractures and Dislocations*, 4th ed., pp. 533-5), will show how entirely unsatisfactory has been the treatment of upward dislocations of the clavicle on the acromion in the hands of the ablest surgeons. Dr. Hamilton (p. 535) says that the maintenance of the bone in its socket for a length of time sufficient to insure a firm union of the broken tissues will be found always more difficult, and, in a great majority of cases, absolutely impossible. Nearly all surgeons who have written upon this subject have made the same observation. Failure to retain the reduced bone in its socket has been the rule, and apparently with few exceptions. The successful application of a new and simple method, and at the same time one readily tolerated by the patient, one in no way endangering the circulation through the limb, and one not requiring such prolonged duration as to ankylose the joints, is, therefore, of sufficient importance to be reported.

On the 28th of June, 1875, I was called to see James R., at No. 10 Ford Street, a blacksmith, aged 42 years, who when riding home after his day's work, standing in a wagon, was, by a suddenly accelerated motion, thrown backwards to the ground, striking on his right shoulder. I found the external end of the right clavicle dislocated from the acromion and resting upon it, making a distinct tumour. I took hold of the elbow, and, pushing upward and backward, while I carried the arm anteriorly across

the chest, at the same time placing my left hand upon the projecting bone, I reduced the dislocation with an audible snap. At the same time the deformity was removed and the patient was relieved from pain. I placed the right hand upon the left shoulder and directed a hood for the elbow, or sling such as is used in Fox's apparatus for fracture of the clavicle, to be made, and this I applied to the elbow and tied to a band across the back of the neck, hoping thus to retain the bones in place, but to my disappointment I found before I left the house that the dislocation was reproduced. I then endeavoured to keep the bone in its socket by passing a bandage firmly around the external end of the clavicle and the corresponding elbow; but this was found to be impossible, as the slope of the shoulder would not permit the bandage to be retained in place. I then concluded to try Prof. E. M. Moore's dressing for *fracture* of the clavicle, which I will describe to make my case complete.<sup>1</sup> Having again reduced the dislocation, and keeping it in place by pressure upon the top of the external end of the clavicle, I carried the arm backward and forced the elbow towards the left side across the back, pressing the arm against the side of the chest. Directing a bystander to hold the arm in this position and to keep up pressure upon the end of the clavicle, I called for a common cotton sheet, which I folded cravat-shape by placing the diagonal corners together and then folding these corners over and placing them on the middle of the base-line of the triangle, and again folding the sheet till the "cravat" is about four or five inches wide. The forearm of the injured side being bent to a right angle with the arm, the olecranon is placed upon the centre of the "cravat;" (the length of the cravat being at a right angle with the line of the arm and forearm). The end of the bandage which is next to the body of the patient is carried by a half-spiral turn up along the front of the arm, in front of and over the injured shoulder, and then down across the back to the axilla of the sound side, carried forwards under the sound arm, then upwards in front of the sound shoulder, and over it to the back. The other end of the "cravat," which is away from the body of the patient, is now carried around over the front of the elbow-joint and between the arm and the body to the back of the patient, then upwards across the back to the top of the sound shoulder, there meeting the other end of the "cravat." These ends were then drawn in opposite directions so as to make the bandage as tight as could be conveniently borne by the patient, and were fastened by sewing with a strong thread the lapped ends of the "cravat" to each other and to the portion of the "cravat" which crosses them on the back. The hand of the injured side was supported by a sling fastened around the neck, or which may be fastened to the bandage where it passes over the injured shoulder. After applying this dressing my patient was comfortable, and with no apparent displacement of the end of the clavicle. I visited him the next day; everything was satisfactory. I saw him every second day for ten days, and at each call tightened the dressing and examined the injured part to see that no displacement had taken place. For the second ten days I readjusted the dressing once in three or four days. On the 18th of July, the 21st day of the treatment, all dressings were removed and treatment discontinued, except that the patient was directed to carry his forearm in a sling for a week longer, and not to go to work. There was not the least deformity, nor did the bone once move

<sup>1</sup> The original paper of Dr. Moore on Fracture of the Clavicle may be found in the published Transactions of the New York State Medical Society, 1870.

from its place after the first application of this dressing. The point of discomfort to the patient during this treatment, is under the sound shoulder by the cutting of the folds of the bandage. This must be relieved by passing the finger between the bandage and the skin to change the points of pressure, and by slipping between the bandage and the folds of the axilla some soft cotton-wool.

To show that this is not an exceptional case, and that this form of dressing is to be relied upon, I will state that since this case has been under treatment I have had a conversation with Dr. Moore, in which I informed him of my adaptation of his fractured-clavicle dressing to the treatment of a case of dislocation of that bone from the acromion, and that it was eminently successful. In that conversation he informed me that he had previous to this time heard from five different surgeons, in widely different parts of the United States, of the same successful adaptation of this apparatus to dislocation of the external end of the clavicle. We thus have reports of six cases of success in this dislocation by the use of this method of treatment. It is to be hoped that other surgeons who have tried or may try this dressing, will report them, whether success or failure follow.

This method of treating this dislocation seems to be especially appropriate, and to fill all the requirements. It makes extension by increasing the distance between the sternum and the acromion. It relaxes that portion of the trapezius muscle which is attached to the external third of the clavicle, and which in the normal position of the shoulder tends to draw the external end of the clavicle upwards, and if dislocated would tend to displace it after its reduction. It puts upon the stretch that portion of the pectoralis major muscle which is attached to the clavicle, and thus draws the clavicle downwards, and aids in holding it in place after a reduction of its dislocation upwards on the acromion, and finally the fold of the bandage, which passes over the injured shoulder, presses firmly upon the outer end of the clavicle, and assists materially in holding it down in its place after its reduction.

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ART. IX.—*Case of Chronic Laryngitis, serving to illustrate how the mucous membrane of the vocal cords may be in an objective morbid condition, though their physiological functions be restored.* By BEVERLEY ROBINSON, M.D., Surgeon to the Manhattan Eye and Ear Hospital (Department of the Throat), etc. (Read before the New York Laryngological Society.)

THE following case is given verbatim, as it was written out and handed to me by the patient himself :—

“ D. S., thirty years of age. My home is in the West. Three years ago I came to New York city, and entered Union Theological Seminary,  
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