Depression in skull and facial paralysis.—In the 2 following I believe that the lesions were caused by the forceps. One child was born with a depression in the left frontal bone, 1 by 1½ inches, and ½ inch deep. Within four weeks the bone had returned nearly to its normal contour. The delivery was by means of forceps and traction rods, and considerable force was required. The other child had left facial paralysis, which had so diminished by the eleventh day as to be hardly perceptible. Forceps had been applied when the head was well in the pelvis, with occiput R. A.

I am aware that in this recital of cases there is much that is commonplace, and that from your own experiences, which in obstetrics are larger than mine, you could contribute cases of equal and greater interest. If, however, any of us shall be stimulated by it to more careful observation of the lesions and symptoms of the newborn child, this paper will have a sufficient excuse for being.

OBLIQUE SUBTROCHANTERIC OSTEOTOMY, FOR THE LENGTHENING OF THE FEMUR, AND CORRECTION OF THE DEFORMITY OF FLEXION RESULTING FROM HIP JOINT DISEASE.

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OSTEOTOMY, for the correction of flexion in hip disease, has been performed in various ways on different parts of the femur, for more than a half century, and the results obtained have justified its recommendation in the majority of cases, but until recently no attempt has been made to combine lengthening of the bone with the straightening of the limb.

The earliest operators divided the bone above the trochanter major, or at least above the trochanter minor, meeting with sufficient success to warrant the continuation of experiments in this direction.

Adams' section of the neck of the femur is familiar to all, and from an anatomical standpoint it is certainly correct, but in a large percentage of cases cannot be successfully accomplished, as the neck is absent in many, while in others the pathological changes are so marked that the part is inaccessible.

Barton, Sayer, Maisonneuve and others performed the osteotomy lower down, but still above the trochanter minor, and this operation, although much less difficult than Adams' had the same disadvantage of being above the attachment of the ileopsoas muscle, which often caused a return of the flexion.

Volkman's operation, which consists of the removal of a wedge-shaped piece of bone from the trochanter major, offered no improvement over the others, and though reported successful, received but little support, soon falling into disuse.

In the year 1872, Gant devised the operation which bears his name, and the advantage gained by setting free the resistance of the contracted

ileopsoas muscle, was at once recognized, and has been almost universally used since. Although this operation removes many of the objectionable features found in the others, it still leaves much room for improvement, and while the flexion is permanently remedied, it causes a considerable shortening of the bone, necessitating the wearing of such a thick patten that it makes walking in many cases, nearly as difficult as before.

Hoffa, Lauenstein, Landeve, König, and other German savants, during the past year have successfully performed the oblique subtrochanteric osteotomy with lengthening of the femur, and strongly recommend it in preference to the so-called Gant operation. A brief outline of their procedure is as follows:

All of the contracted muscles and fasciæ are subcutaneously divided, and the patient is placed on the side, with a cushion between the thighs. The femur is laid bare by an incision some 3 inches in length, the centre of which is from 2½ to 4 inches below the trochanter major. The skin and soft tissues are held to one side by retractors, and the osteotome is placed firmly against the bone, and driven at an angle, varying from 30° to

45° upward and inward through the shaft of the femur until only a thin bridge of the inner, compact tissue remains, when the division is completed by fracture. The leg is then forcibly extended by means of a screw, drawing the smooth-cut surfaces by each other, until the desired length is obtained. The wound is dressed without closing, and a plaster of Paris spica is placed on the leg with an opening over the incision, allowing easy access to it. The leg remains in this position five weeks, after which the plaster is removed, and massage and gymnastics employed, the patient meanwhile moving around with the aid of crutches, the full weight not being borne on the fracture before the twelfth week.

In undertaking this operation the writer felt that it might be much simplified by obviating the use of such powerful force in the separation of the bone, and the destruction of so much of the soft tissues subcutaneously, thereby reducing the liability of infection and injury to the blood vessels and nerves. A description of the method employed by him on a patient where flexion of 45° and actual shortening of the bone amounting to 3½ inches were present, is given below:

The site of the operation was prepared in the usual manner, and the patient placed on the side with a large sand bag between the thighs against the perineum. The osteotome, which was of the same width as the bone, was entered through the skin, and underlying tissues, upon the femur about 4 inches below the upper border of the trochanter major, where it was firmly held at an angle of 30°. It was then driven through the bone as far as the inner compact tissue, when it was exchanged for a narrow one, and the division continued well into this, after which, it was withdrawn and the section completed by fracture. The leg was placed in the corrected position, and dressing applied. A temporary splint was bandaged to the side to prevent accident during transportation from the operating room to the ward. After the patient was in bed a Buck's extension was applied to the leg, with side plasters reaching to the fracture. A side splint which extended from the axilla to the foot was loosely bandaged to the body, and weights were placed on the end of the extension, and

gradually increased. The muscles relaxed in thirty-six hours, when the length and position were regulated and the splint firmly applied, retaining the leg in the corrected position. Measurements were frequently made in order to ascertain if the length remained unchanged, and at the end of the eighth week all apparatus was removed, and the patient allowed to move around in bed. At the commencement of the tenth week he was given crutches and exercised freely. The femur was lengthened $1\frac{1}{2}$ inches, by actual measurement, and the flexion was completely corrected, as the adhesions were broken up by the operation, allowing movement of 15°. Recovery was uninterrupted, union being firm at end of eighth week, and the patient now walks easily with the heel of the shoe raised $\frac{3}{4}$ of an inch on inside. There are several steps in the operation which the writer considers of importance, and which should be brought to the notice of the surgeon:

Too much stress cannot be laid upon the advan-

tage of making a radeograph, which will enable him to determine the size of the femur, and the exact location at which the osteotome should be entered in order to free the attachment of the ileopsoas muscle to the trochanter minor.

Another point to be considered is the width of the osteotome, which must be regulated by the size of the bone, so as to obtain a clean cut surface by one passage of the instrument. The angle at which it is to be held must also be governed by the size of the femur.

It will be found necessary to use judgment rather than any hard and fast rule in regard to the amount of weight necessary, as it varies with different patients, and must be gradually increased until results are obtained when it can be lessened and held by the side splints.

Clinical Department.

A CASE OF CHIN LEFT POSTERIOR.¹

BY H. T. SWAIN, M.D., BOSTON,

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MRS. A. P., an Italian, thirty-two years old, in her third pregnancy. Previous history negative. Previous labors normal.

When I first saw the patient in the Out-Patient Department of the Lying-in Hospital, November 15, 1900, at 8.30 P.M., she had been in labor about six hours, the membranes having ruptured three hours previously. She did not send for a doctor until she had been in labor for some time, and when first seen by the externe the head was so low that he easily made a diagnosis of face, sending at once for assistance. When seen by Dr. Cary, the out-patient house physician, the presenting part was only a little higher than the position in which I shall describe it.

Abdominal examination showed the back to be to the left, fetal heart loudest in the lower left quadrant, rate 130. During each pain the uterus contracted firmly, and the abdominal muscles were rigidly set, the patient straining violently. The intervals of the contractions were about two minutes, and they lasted a good minute. Visual examination showed considerable bulging of the external genitals during each pain.

Vaginal examination showed the os fully dilatable, membranes ruptured, and a face presenting about one and a half inches from the introitus, with the chin left and posterior. During a pain the head descended very little. There was not the least rotation. What little was gained during the pain was lost in the interval, for the head receded immediately. I tried during two or three pains to rotate the head by pressure with the hand against the posterior ramus of the lower jaw, but was unable to accomplish anything, the head being firmly wedged into the excavation. Dr. Cary's attempts

¹ Read before the Obstetrical Society of Boston, January 15, 1901.