A CASE OF DISLOCATION OF PROXIMAL PHALANX
OF GREAT TOE

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P. W., male, white, laborer, aged 56, reported at the surgical outpatient department of the University Hospital, service of Dr. B. A. Thomas, May 28, 1913, with the history of having been kicked by a horse nine weeks previously, and of having been treated at another hospital for an injury to the left knee. He now complains of pain in great toe. Examination

Fig. 1.—Base of proximal phalanx of great toe resting on dorsum of head of first metatarsal. Note plane occupied by sesamoid. Lateral view.

tion reveals fixation of great toe in extreme extension and crepitation at metatarsophalangeal joint. The roentgenogram (Fig. 1) shows displacement of proximal phalanx of hallux onto the dorsum of the head of its metatarsal. The anteroposterior view (Fig. 2) is of interest in showing concomitant displacement of the sesamoids from the plantar aspect to each side of the joint. Under nitrous oxid reduction was attempted by means of Levis' apparatus, but owing to lacerations of the skin this method was abandoned. A trial was next made of the method proposed by Dr. Crosby of New Hampshire in 1826, for reducing dislocations of the thumb, which was so well spoken of by the elder Gross. The toe was raised perpendicularly and strong pressure applied against the base of the phalanx, so as to push it from behind forward

Fig. 2.—Note shortening of hallux and diastasis of sesamoids so as to embrace the joint. Anteroposterior view.

and from above downward. Reduction was maintained by strapping the hallux down on a plantar splint, which was applied after the method described by Cotton.

This injury was evidently overlooked at the other hospital, and the deformity must have been greatly increased during the intervening nine weeks by contraction of the extensor hallucis proprius.

That the injury is rare is attested by the statement of Dr. Henry K. Pancoast, who took the roentgenogram, and also

by the fact that Gross' had seen but two cases. Of twenty-two cases of luxation of the proximal phalanges of the toes Malgaigne states that nineteen were of the great toe. In Holmes' "System of Surgery," the analogy between this luxation and that of the corresponding phalanx of the thumb is pointed out, as well as a similar difficulty in reduction. In four out of ten cases noted by Malgaigne³ the reduction could not be accomplished. In accounting for this difficulty of reduction it is of interest in connection with our case to note the statement of Gross' that "it depends probably on the manner in which the adductor muscle and the sesamoid bones are dragged by the displaced phalanx backward over the extremity of the metatarsal." The roentgenograms, especially Figure 2, show clearly the relative positions of the sesamoids, and that they in no way interfere with reduction, not in my case at least.

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CASE OF FOREIGN BODY IN THE RECTUM

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On the morning of Aug. 11, 1913, I was called by the proprietor of a hotel to see one of his employees, a dishwasher, who, he said, had been sick since the day before. The patient, a Dane, aged 68, stated that he had fallen on a cup about two weeks before and cut himself. He complained of severe pain in the left iliac and hypogastric region. He gave no history of vomiting, but stated that his bowels had moved the day before and that he had urinated that morning. His temperature was 99 and his pulse 80. There was blood on the bed. Examination showed a mass in the left iliac region.

I took him to the hospital, and on further examination found blood coming from the rectum, and a deep laceration through the mucous membrane and the sphincter muscle in its posterior aspect. Examination under anesthesia disclosed a china cup in two pieces, the smaller piece being about one-third of the side of the cup.

The cup, being firmly held with a pair of pliers, was broken into eight pieces with short quick raps of the hammer on a cold-chisel, and the pieces removed.

I irrigated the area with normal salt solution and could find no perforations. Examination of the cut surface of the sphincter showed an old wound covered with granulations, the bottom made up of fibrous tissue. The sphincter muscle and mucous membrane were sewed later. The man made an uneventful recovery, leaving the hospital in nine days, seemingly with good control of the sphincter. I am convinced that the patient had been accustomed to putting foreign bodies in the rectum for some time to satisfy an abnormal sexual appetite, and that at this time he inserted the cup, when, on account of the spasm of the sphincter at the time of the orgasm, the cup was forced up inside. He evidently had made an attempt to remove it afterward, which would account for its being broken.

The cup, a thick one without handles, measured 82.5 mm. ($3\frac{1}{4}$ inches) in height, 90.5 mm. ($3\frac{9}{16}$ inches) in diameter across the top, 51 mm. (2 inches) across the bottom and 1 cm. ($\frac{6}{16}$ inch) thick.

Kelsey mentions a specimen in the Museum of Anatomy and Pathology in Copenhagen, which was introduced by a patient in an attempt to prevent a prolapsus. It is a long, oval, flat stone about $6\frac{1}{4}$ inches long, $2\frac{1}{2}$ inches wide, $1\frac{1}{2}$ inches thick and weighs nearly 2 pounds. The stone was extracted by a surgeon, Frantz Dyhr, in 1756.

In the Surgical History of the War of the Rebellion, II, p. 322, there is mentioned an operation performed on a sailor who had introduced into the rectum a stone $5\frac{1}{2}$ inches long by 3 inches wide. The colon was perforated, and the stone was removed from the peritoneal cavity by an incision near the umbilicus.

1. Gross: System of Surgery, 1882, I, 1162.
2. Holmes: System of Surgery, 1881, I, 989.
3. Malgaigne: Agnew's Surgery, 1881, II, 126.