

glance at the advance made during a single lifetime, we cry, Slow has been the advance of Medicine, because she went astray; but now the path that she follows is right, swift is her progress, and glorious will be her future.

## ON THE REDUCTION OF HIP-DISLOCATIONS BY MANIPULATION.

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MR. MORRIS having referred to some remarks of mine which were published in THE LANCET (1868) respecting the reduction of dislocation at the hip by manipulation, I think I ought to state that my views are in accord with those of my colleagues (now and when the late Mr. Coote was one of them) as to the manœuvre to be effected by manipulation, and to which our attention was especially directed by Professor Fabbri. Taking it for granted that his explanation as to the one primary form of hip-dislocation, and of his method of reduction, was known to the profession, Mr. Coote having then quite recently written on the subject, I sought to show, in the paper referred to, how a practical difficulty should be avoided. Looking at the manœuvres from this practical point of view it was a recognised fact that in hands having slight experience the head of the bone was liable to roll completely round the acetabulum, instead of entering the socket, if the femur was abducted when the thigh was depressed. I therefore pointed out that when the thigh was bent in extreme flexion upon the abdomen the shaft of the femur ought to be moved into a line precisely parallel with the long axis of the body, and in this precise line that it ought then to be extended until parallel with its fellow.

Probably that which leads Mr. Morris into a misapprehension is, after all, a question of the meaning attached to certain words. The femur is moved, circumducted, I believe, Professor Fabbri termed it when speaking to us on the subject, to a line parallel with the long axis of the body from the position it occupies when first flexed, when it is, of course (in dislocation on the dorsum ilii), carried up over the opposite thigh. But this circumduction is not rotation outwards. Rotation of the thigh is a movement of the femur on its axis. In moving the bone as I directed, the head of the femur is forced round the acetabulum to the lower edge of the socket; there is no rotation. Nor is there abduction; for abduction, if it means anything, is a movement outwards from the line of, or lines parallel with, the long axis of the body, of which movement in the case of the thigh the head of the femur is the centre; but in circumduction the head of the bone is forced to travel round the acetabulum, and is, therefore, in itself no centre of motion. The moment the surgeon moves the limb beyond this line of the long axis of the body he over-acts his part, and then it is, as he extends the thigh, that he runs the risk of rolling the head of the bone round the socket to the oval foramen, instead of slipping it into the acetabulum.

If Mr. Morris will be so good as to try these manœuvres on the dead subject, I think he will see the object I had in view in avoiding all reference to rotation and abduction—terms rather loosely used with reference to the manipulation—and in saying simply that the head of the bone, when flexed, was to be moved into a line parallel with the long axis of the trunk. There was no difference as to our views between Mr. Coote and myself. Writing shortly after his note had been published, I only sought to define as precisely as I could the nature of the manipulation which should be practised.

I have referred to observations on the dead subject. In his demonstrations Professor Fabbri, I well remember, asked for a knife with which to divide subcutaneously the fascia, because, he said, it saved him trouble in effecting the dislocation. But at our request he, without much difficulty, yet with a greater effort than had been required

when the section had been made, produced the primary dislocation and its secondary forms without using the tenotomy knife. His plan, however, has been fully described. I thought his method and his explanation of its success had been long before the profession. I am, with Mr. Willett, surprised to find it is not so. It is referred to (besides the few remarks by Mr. Coote and by myself) in Holmes's work on "Surgery: its Principles and Practice." In its original form Professor Fabbri's paper may be found in vol. ii. of the *Memorie della Soc. Med. Chir. de Bologna*, 1841. The treatment by this form of manipulation is given by Professor Spence in his *Lectures on Surgery*, by Chassaignac (*Opérations Chirurgicales*, 1862), by Nélaton (*Path. Chirurgicale*, 1847-48), and may be traced in Poiteau's work (*Mélanges de Chirurgie*, 1760, p. 269) to M. Maisonneuve, surgeon-major in the regiment of Maugiron Cavalry. It is, no doubt, referred to in other surgical works. Notwithstanding these notices, there is, I think, room for a note on the practical point to which I have drawn attention, and a knowledge of which will enable surgeons to manipulate a hip-dislocation with greater ease and with a certainty of ensuring reduction.

It was not my good fortune to hear Mr. Morris's paper, and, of course, I have had no opportunity of seeing it. I am informed that it was in itself excellent and exhaustive in demonstration of the manner in which the femur is dislocated from the acetabulum. I am glad he has directed attention to the subject. For myself I write simply to state that there is no difference of opinion between my colleagues and myself as to the method, or as to the explanation of the method of reducing dislocations at the hip by a plan of manipulation which has been an established practice at St. Bartholomew's for many years, and for the knowledge and exposition of which we are indebted to Professor Fabbri's demonstrations.

## CASES ILLUSTRATING THE ADVANTAGE OF THE GENU-PECTORAL POSITION.

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**CASE 1.** *Retroversion of the gravid uterus; retention of urine; redressed in the genu-pectoral position.*—R. C—, aged twenty-nine; married ten years; mother of three children. Between the third and fourth month of utero-gestation retention of urine occurred, necessitating the employment of the catheter; but no efforts were made to detect or obviate the cause of the retention. Two days afterwards she presented herself as an out-patient at Middlesex Hospital, complaining of severe bearing-down pain and inability to pass her urine. A No. 8 flexible gum-elastic catheter was introduced and two quarts of urine drawn off. The uterus was found to be enlarged to about the fourth month of utero-gestation, and retroverted, being wedged down beneath the promontory of the sacrum.

Attempts at replacement in the left lateral position failing, the patient was placed in the genu-pectoral position. Two fingers of the right hand were then inserted per vaginam and the fundus pressed to one side. On separating the fingers so as to allow pneumatic pressure to come into play, the uterus receded from the pelvis with a distinct noise as of air being sucked in. A Hodge's pessary was then inserted, and the patient directed to avoid sitting down in the ordinary posture for micturition; the genu-pectoral position to be resorted to at regular intervals. No recurrence of retention took place, and the patient progressed satisfactorily.

**CASE 2.** *Retroversion of the uterus; prolapse of the left ovary; sterility; cured by genu-pectoral position.*—A. L—, aged twenty, married four years, sterile. Suffers much from severe pain in lower back, and down the left leg on standing or walking. Has severe pain in coitus and defecation, always worse just before the catamenial period.

On examination, the uterus was found to be retroverted,