

the parent in the implicated area to enter the circulation. This shows the importance of protecting the filaria and the danger of injuring it. If in these fourteen Cochinese the filaria had remained healthy, never aborted, never obstructed the lymphatics, there would have been no elephantiasis. And so I hold that once established in the human body the filaria should be left alone, protected rather than persecuted. Pathology indicates that the proper treatment of chyluria is in principle the same as the treatment of acquired varix in any inaccessible region. This should be rest, elevation, lowering of the tension in the lymphatic vessels by the use of saline purgatives, limited and appropriate food, abstinence from fluids as much as possible. Certain drugs have been vaunted as specifics for chyluria; I have tried several of them, but never with success of a permanent character. Temporary recovery from time to time is the rule in chyluria, and the drug which was being used at the time the urine cleared spontaneously from healing of the rupture in the varix in the bladder is often credited with the cure. I cannot understand how a drug introduced by the mouth can possibly cause the closure of a gaping varix in the bladder.

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HIPPOCRATES AND ELBOW FRACTURE.

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IN view of recent papers, notably those of Nunn before the Clinical Society of London and of Stimson and Lane before the American Surgical Association, I think it may not be out of place to draw attention to what Hippocrates says on this important subject. Reference to Adams's translation for the Sydenham Society will show that Hippocrates did not simply put the arm up at right angles; on the contrary, he gives very explicit instructions, which seem to have been entirely disregarded, and which Adams himself appears to have misunderstood. Hippocrates shows that it is bad to bind the arm in the extended and semiprone (Archer's) position, or the extended and supine position, because when the arm thus bandaged is bent to a right angle the bones at the elbow assume a different attitude from that assumed when they were bound up. He then says: "But if one will extend a broken arm as I direct, he will turn the bone situated at the extremity of the little finger into the straight line and also the one at the elbow, and when the arm is suspended in a sling it will be in the same attitude as that in which it was bound up" &c. Adams in a note says it is the straight position that Hippocrates deprecates. But Hippocrates distinctly tells us to extend the arm and to place the forearm in the only remaining position—viz., in pronation. But what is the difference between flexing a supine or semiprone arm on the one hand and a pronated arm on the other? I am greatly indebted to Sir William Turner, before whom I placed this problem, for having investigated this matter for me, and through his kindness I am enabled to give my own conclusions as facts founded on actual experiment. Morris tells us that "the hand in flexion is carried towards the middle third of the clavicle, and any greater inclination of the forearm towards the median line of the body.....is caused by rotation of the humerus at the shoulder."¹ Associating this fact with what Hippocrates says I came to the following conclusions:—1. On flexing to a right angle a supine or semiprone arm there is rotation of the humerus at the shoulder. 2. On flexing to a right angle a pronated arm there is no rotation of the humerus. In this last the necessary rotation of the humerus takes place on pronating the forearm and while the limb is still in extension. Hence, with the arm bound, extended and prone, it is quite ready to be bent to a right angle without any movement other than flexion. The bones at the elbow may thus be said to be in the same attitude as that in which they were bound up. Now to apply this to elbow fracture, if the fragments be adjusted with the limb extended and supine or semiprone, when the arm is bent to a right angle the necessary rotation of the humerus will tend to occur, not at the shoulder, but *at the seat of fracture*. Thus, however perfect the setting in the first instance, there is likely to be displacement as soon as we bend to a right

angle. On the other hand, if the fracture be set with the arm extended and prone, there is not the same danger of displacement when bending to a right angle, though, in my opinion, the mere act of flexion may be sufficient to cause displacement. We thus see that there is a very good reason why Hippocrates should say that fracture of the elbow is best set in the extended and prone position. It is only in the straight position of the arm that we can be sure of accurate coaptation of the fragments; however great the displacement it will never be detected so long as the arm is bent. It is not enough simply to put the arm up at right angles and rest satisfied because we have placed the limb in the orthodox position. I do not think this is what Hippocrates meant us to do, and unless we follow the careful instructions he gives us I think the rectangular position is the worst that could be adopted. If I am correct in my interpretation of Hippocrates' words, would it not be better, in all injuries of the elbow, to dress the limb in the straight position with the forearm prone? Those who have employed this method find that they obtain a much earlier return to usefulness and, above all, *obviate the deformity* so frequently seen after treatment in the rectangular position. With the arm extended and prone the outward configuration of the limb becomes practically straight, so that instead of a complicated angular splint a simple straight one can be applied, thus enabling the surgeon to see that all is right. The normal outward obtuse angle at the elbow is formed by the humerus and ulna; it is still present, therefore, whether the forearm be prone or supine. Whilst, therefore, we are keeping up the normal relation of bone to bone we have a limb that is much more easily dealt with if the forearm be prone than when it is supine, and the latter position becomes extremely tedious after a time. The prone position is a natural one, and most comfortable to the patient; and since it is associated with slight flexion we avoid the danger of over-extension—an important point in treatment of fractured olecranon.

In elbow fracture the injured tissues on the flexor aspect require to be kept at their normal physiological length in order that they may not heal with shortening; the opposite holds good for the extensor surface. The straight position is certainly indicated for injuries of the elbow-joint, more especially as with the arm extended there is no impediment to the flow of the blood or lymph. Absorption can therefore proceed and healing can in this position be greatly aided by means of massage. The most important point in these cases is to obtain accurate coaptation of the fragments. The better the setting the sooner the fragments will unite. The sooner union takes place the sooner will passive motion be permissible. When the joint is first moved I hold that it should be through its natural path. If movement be painful it is very apt to be harmful. Fracture of the elbow is often overlooked; but if the straight position were to become the rule instead of the exception, then the treatment of dislocation would not be detrimental to possible fracture. Those who use the bent position seem to be the most anxious to begin passive motion early. Those who use the straight position find early motion unnecessary. It is only a question of accurate coaptation of the fragments. In the bent position we can only hope that all is well; we cannot be sure that reduction is being kept up. In the straight position we can be sure of good position, and there will therefore be less tendency to stiffness and an earlier return to usefulness, and, further, less likelihood of exuberant callus; and we entirely avoid deformity.²

² Those interested in the subject will be glad of the following references:—Provincial Medical Journal, Jan., March, and April, 1892: Transactions of the American Surgical Association, vol. ix., 1891.

THE members of the Metropolitan Asylums Board will inspect the new fever hospital now in course of erection at St. Ann's-road, Stamford-hill, N., to-day, Friday.

NEW RECREATION GROUND FOR ST. ALBANS.—Sir J. Blundell Maple, M.P., has sent a letter to the Corporation of St. Albans in which he gives particulars of the gift which he intimated some time ago he was about to bestow on this town. The hon. gentleman will also erect a lodge and cricket pavilion and bear all expenses connected with the laying out of the grounds, which cover about 24 acres. The isolation hospital, which was lately presented to this corporation at a cost of some £4000, has just been completed.

¹ See also Cathcart, Journal of Anatomy and Physiology, vol. xix., 1835.