

lina Hospital, which is largely used by Jews. He tells me that few children are there admitted for hip disease, and that most of those so received belong, not to the Jewish, but to the Christian community. I have appended also the second part of the table—that which divides the cases into ages—although I think in certain ways the division is not very reliable; for finding it impossible to ascertain from the accounts given by parents the exact period of commencement, the age at which I saw the child or admitted him into hospital has been recorded. Children of course came under my notice in all stages of the disease; hence the table shows nothing as to the time at which the malady commenced.

The important fact, however, is simply coincidence of phimosis and hip disease—a coincidence which I should never have dreamed of or imagined had it not been forced on my observation. Upon the mode in which the one influences the other I would rather not speculate further than to point out that phimosed children have facile, frequent, and often long-continued priapism; that this condition, unnatural in the infant, must produce after a time a certain irritability or irritation of the lumbar spinal cord; that from this part the various nerves of the pelvis and lower limb are given off; that the influence of spinal irritation on the trophic nerves is well known, and that just at this particular period large trophic changes are in progress about the hip-joint.

Of course, I have not overlooked the fact that hip disease also occurs in female children, though I believe less frequently than in the male.¹ I regret exceedingly that I did not simultaneously tabulate such cases, as I am now engaged in doing; but this I can say with certainty, that in a large proportion of girls afflicted with hip disease will be found vulvitis, even vaginitis with or without discharge, and generally, I believe, produced in the first instance by thread-worms creeping from the rectum to the vagina. In a certain proportion will be found protruding nymphæ or nymphæ covered by a cuticular surface. Further than this, as my numbers are incomplete, I am disinclined to go. The inference as to treatment of male cases in the earlier stages is obvious.

The Disturbance in the Growth of the Long Bones after Necrosis of the Diaphysis.

In this paper Prof. HELFERICH gives (*Deutsch Zeit. f. Chir.*, Bd. x.) careful measurements of the affected region in 141 instances in which necrosis had attacked some part of one of the long bones. He shows that the relation between liability to disease and the rate of growth in a bone, and also in the upper and lower ends of a bone, has been already noted by other observers, and on the whole is correct. The chief exception is the tibia, which is more liable to necrosis than the femur, though its rate of growth is less. This is explained by the greater liability of the tibia to injury, which also causes its shaft to be more frequently affected than that of other bones. With this exception, necrosis is most frequent near the ends of the diaphyses, and in each case near that end at which the growth is the greater.

The numerous careful measurements which the author has made show that interference with the growth of the part affected is frequent, and he suggests that it is often overlooked in consequence of its being, in some instances, slight, and in others masked by a compensatory greater natural growth in the bone or bones of another segment of the limb. In the femur he found 13 instances of shortening to 3 of lengthening; in the tibia, 12 of shortening to 14 of lengthening; in the humerus, 4 of shortening to 1 of lengthening; in the radius, 2 of shortening. These interferences with the length do not take place after the growth of the bone has ceased and after the epiphyses are ankylosed to the shafts. They

¹ During the time that I was noting 100 male cases I saw only 73 female cases.

depend upon some influences exerted on the epiphysal cartilages by the disease. The lengthening is due to the prolonged hyperæmia attendant upon necrosis extending to the epiphysal cartilage, and giving an impetus to the cell formation there; and it is most frequent in the tibia, because the necrosis in that bone frequently affects the shaft; whereas in other bones the disease, in consequence of its being nearer to epiphysal cartilage, is more likely to cause destruction of the cartilage and consequent arrest of growth. Examples are quoted in which disease of the epiphyses, occurring in affections of joints, was attended with elongation of the bones, but that is rare in comparison with shortening from this cause. He alludes to the possibility of necrosis causing impairment and destruction of the nearest epiphysal cartilage and arrest of growth at that, the proximal, end, and merely inducing hyperæmia and increase of growth at the other and more distal end. Thus there would be diminution and increase of growth in the same bone, and produced by the same disease, affecting the two ends in an unequal degree.

The lengthening of the adjacent bones, which, though rare, may be associated either with lengthening or shortening of the diseased bone, is in either case to be attributed to the accession of blood-supply to the limb, which is in some way brought about by the disease, and like the similar change in diseased bone, it must be limited to the growing period of life.

The associated shortening of the adjacent bones may be attributed, as indeed may sometimes in part be that of the diseased bone, to inactivity of the limb. It is most frequently observed when the disease is in the proximity of a joint, the use of the limb being in such cases interfered with most.

The associated elongation of the adjacent bone, as in the case of the fibula when the tibia is elongated, may depend upon the accession of blood extending to the fibula, or, upon tension exerted upon it by the growing tibia, or by both causes. The resistance of the fibula may, however, limit the elongation of the tibia, or may cause it to assume a curve, as has been observed by Paget and Stanley. In some instances, however, the fibula has not been thus elongated, but has undergone luxation from the upper part of the tibia, its lower end remaining fixed to the tibia, and the upper end being drawn away from it. Two cases of shortening of the tibia were observed by Humphry, in one of which the upper end of the fibula was luxated, and projected above its articular surface in the tibia, and in the other the lower end projected downwards and touched the ground. Other deformities resulting from the unequal length of the two bones of one segment of the limb are mentioned.—*London Med. Record*, July 15, 1879.

Reproduction of the Tibia after Osteomyelitis.

At a recent meeting of the Gesellschaft der Aerzte in Vienna (*Allg. Wien. Med. Zeit.*, No. 24, 1879), Professor WEINLECHNER presented a lad, aged 17, who in October last had been taken ill with a severe inflammation of the left leg, from the knee downwards. When admitted into the hospital he was in a very precarious condition, a complication with pneumonia had set in, the temperature was permanently high, and he was much reduced in strength by the constant suppuration. When the patient had recovered from the pneumonia, Weinlechner proposed amputation of the leg, as osteomyelitis had manifestly set in; however, as this was objected to, Weinlechner removed the whole diaphysis of the tibia, which had in the mean time become necrotic. The extremity did not present a very slightly appearance after this operation, as the soft parts of the leg hung loosely about the remaining bone. The suppuration, however, decreased rapidly, and three weeks later the whole empty space was filled by osseous neoformation, which had developed within that short time. Five months have elapsed since,