

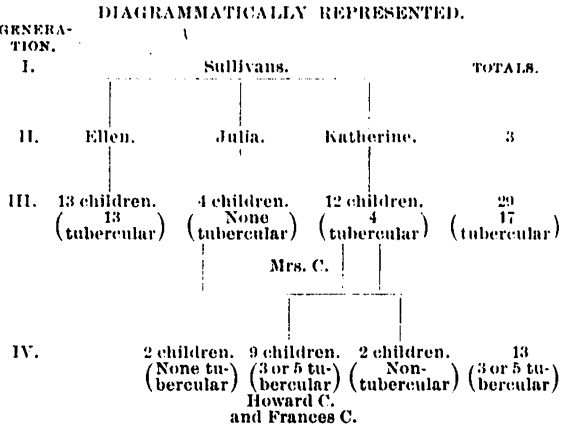
ters, Sullivan, who came to Maine from Ireland. Their parents died in Ireland: Mrs. Sullivan in childbirth, Mr. Sullivan of some unknown disease, and two Sullivan children died in Ireland of unknown diseases. Of these sisters, Ellen Sullivan died at the age of 90, her husband at 60. They had thirteen children, six of whom lived to be over 20. All thirteen died of pulmonary tuberculosis. The second sister, Julia, is living, aged 70; has had four children and two grandchildren, all non-tubercular. The third sister, Katherine, is living, over 71, her husband 73. They have had twelve children; eight are dead, five in infancy and two, at the ages of 27 and 22, of *pulmonary tuberculosis*. Of the four living, two have had pulmonary tuberculosis and recovered; one of these is Mrs. C. There are two grandchildren besides those in the C. family, and both are well.

Mrs. C. has had nine children; one has died of pulmonary tuberculosis at the age of 6, one of symptoms resembling tubercular meningitis; of her six living children, two have tubercular bone disease and a girl of fifteen is beginning to have enlarged cervical lymph nodes.

In the second generation, then, of these sisters, seventeen out of twenty-nine children were tubercular; in the third, three, or probably five, out of thirteen.

No tubercular history on any father's side can be found, except that Mr. C. has a nephew with pulmonary tuberculosis. His parents both lived to be 88.

This history is of interest because of the longevity of the survivors, and because of the distinct history of trauma in the only cases where the lesion was in the bones and not in the lungs.



The virulence of the tuberculous inheritance in this family has apparently been attenuated by the good blood brought into the family through the males who have united themselves to it by marriage.

DR. WILLIAM W. KEEN of Philadelphia has recently been elected an honorary member of the German Surgical Association at the recently held thirty-first annual session. He has also been appointed honorary president of the first Egyptian Medical Congress which will be held in Cairo, in December.—*Medical Record*.

A CASE TO ILLUSTRATE THE ADVANTAGES OF THE CORRECTION OF THE DEFORMITY OF POTTS' DISEASE.

BY H. S. WARREN, M.D., BOSTON.

J. B., 15 years of age, came to the Orthopedic Department of the Carney Hospital Aug. 23, 1901, with a history of having had Potts' disease for ten years. At entrance he was in very poor physical condition. He stood with the body deflected to the right side so that the lower ribs overlapped the crest of the ilium. A discharging sinus was present in the median line over the sacrum, and the boy complained much of pain and discomfort in going about.

An x-ray showed extensive tubercular disease of the lower lumbar vertebrae. Fig. I shows the patient at entrance.

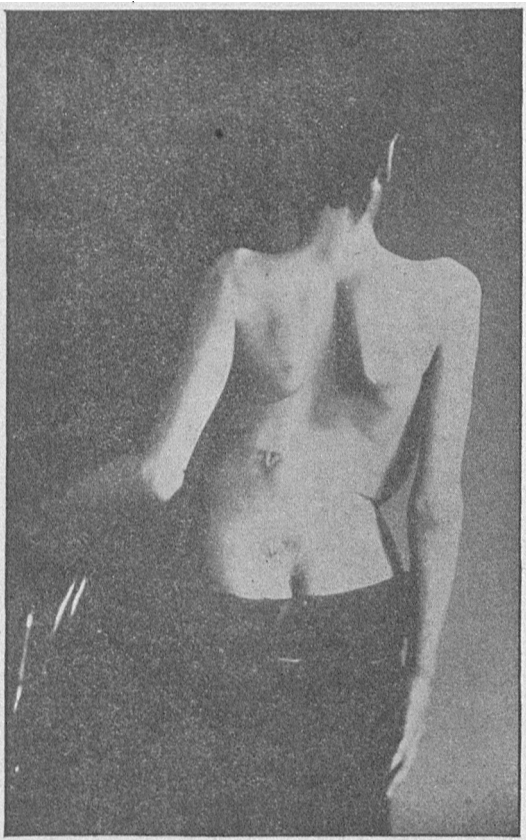


FIG. I.

He was admitted to the wards and a series of plaster jackets were applied with the patient on his back on the frame, each time correcting the position, but without the use of force, with the result that his general condition improved, discharge from the sinus became much less, and his height was increased three and one-half inches.

From Fig. II, taken four months after treatment was begun, it is seen that he stands with only a very slight deviation of the spine at the seat of the disease.

He now wears a leather jacket, and his general health continues to improve.

A study of the x-ray in this case shows that the maximum yielding of the spine is somewhat above the seat of the disease, and is not dependent upon the loss of the substance in the bodies of the vertebrae.

In the forcible correction of deformity at the point of disease, as practised by Calot and others, it has been shown pathologically that the material thrown out in the process of repair does not contain enough calcium salts and other bone-producing material to give it a consistency anywhere near that of the bone which it replaces. As a result relapses are very common, which, together with the danger of dissemination of the disease, outweigh the advantages to be gained.

Under these conditions one must look to the gradual correction of faulty compensatory curves, as in the above case, in order to reduce the de-

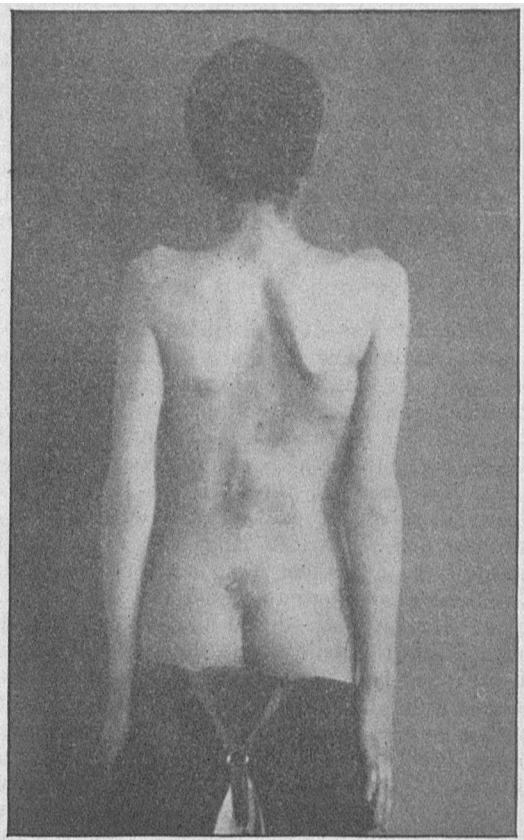


FIG. II.

formity to a minimum. A second and no less important advantage to be gained by correction of position in these cases is the effect of the improved position upon the mental and physical condition of the individual; a feeling of hopefulness is inspired, and a marked improvement in the general health is commonly noted.

THE Royal Infirmary at Aberdeen is the recipient of a gift of \$150,000 from Lord Mount-Stephen, who previously cleared the institution from a debt of \$125,000.—*American Medicine*.

## EXCISION OF THE HIP FOR CONGENITAL DISLOCATION.

BY W. E. BLODGETT, M.D., BOSTON.

GENEVA H., age 12, entered Out-Patient Department Sept. 27, 1901. Deformity and disability of right hip noticed as long as the family can remember.

Healthy girl. Characteristic lunging gait. Head of right femur felt dislocated upwards and backwards on the dorsum. Trochanter much above Nélaton's line; cannot be pulled down. Actual shortening of leg, two inches. Atrophy of thigh, two inches; of calf, one-half inch. Permanent flexion, 25°; permanent adduction, 15°; permanent internal rotation, 40°. Correction of the permanent deformity appears not to be resisted by muscle or fascia. Motion in flexion and in adduction, normal; in internal rotation, abnormally free.

Oct. 16. Admitted into house.

Oct. 18. Bloodless reduction under ether was tried, but the full strength of six men, variously applied for half an hour, forced the trochanter downwards only half an inch. The child was put to bed, and 15 lbs. traction applied. This application of traction was continued until the open operation.

Nov. 11. Oblique incision over trochanter. To expose the neck of the femur freely, the gluteus medius had to be divided in the direction of its fibres at its trochanteric insertion. The neck was not over three-fourths of an inch long, and extended inwards, backwards and downwards (extreme coxa vara). There was no head. The neck was chiseled off, and the capsule and gluteus medius were sutured with silk, leaving a small wick. Light extension and sand-bags, with limb in corrected position. Healing was by first intention, and Dec. 1 patient was discharged with crutches, and plaster spica holding the limb extended, 15° to 20° abducted, and somewhat externally rotated.

Dec. 20. Out-Patient Department. Plaster removed. Motion in flexion free; in abduction, to 20°; in external rotation, slight; in internal rotation, abnormally free. No permanent flexion. Great improvement in the gait. Plaster not re-applied. To continue crutches and to use the limb a little.

Jan. 3. High sole ordered, but the sole is to compensate for only a part of the shortening, in order to encourage abduction.

Jan. 13. Gait has become worse than immediately after removal of plaster—marked return of the former lunging. Shortening, two inches; trochanter can be pulled down one-half inch. Motion in flexion, adduction and internal rotation, as before. Permanent flexion, 10°; permanent adduction, 5°; permanent internal rotation, 5°. By continued pressure, the permanent adduction can be overcome, and the leg forced into a slightly abducted position; further abduction is resisted by marked tenseness of the adductors. Directions given for massage and for active and pas-