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PART I.

ORIGINAL COMMUNICATIONS.

ART. I.—*A New Method of Reduction in Dislocations at the Elbow-joint.* By J. E. KELLY, F.R.C.S.I., M.R.I.A.; Surgeon to Jervis-street Hospital; Lecturer on Surgery, Ledwich School of Medicine, Dublin, &c.

DISLOCATIONS at the elbow-joint are generally reduced without much difficulty, but the operator occasionally encounters an amount of resistance which demands the application of the pulleys or the aid of assistants. In other instances, in which a complicating fracture is suspected or recognised, considerable force may be essential to the diagnosis or the treatment, and it is expedient that, while perfectly under control, this power should be applied with great steadiness. Again, in long-standing dislocations, accompanied by extreme rigidity and consequent loss of function, authority, with the object of permitting efficacious treatment by passive motion, sometimes sanctions the fracture of the olecranon process. In any of those contingencies the following procedure permits of the necessary treatment in the most satisfactory manner.

The operator sits on the corner of a table, at the end of which the patient is placed upon a chair (Fig. 1). The injured limb is drawn under the surgeon's proximal thigh, which rests, close to the joint, on the anterior surface of the humerus, while the olecranon is accurately placed on the anterior surface of the lower third of the distal femur, and the proximal foot is

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“hitched” behind the other leg, which is flexed firmly against the frame of the table. In order to obtain the most favourable fulcrum, the surgeon fixes his proximal elbow against the antero-internal aspect of his corresponding thigh,^a and, grasping the wrist of the patient with both his hands, reduction is effected by the simultaneous and co-operative action of the muscles of the arms, back and thighs. Fixation and counter-extension are supplied by the powerful thighs of the operator, and coaptation is effected, with great nicety, by the backward pressure of the proximal femur against the anterior surface of the humerus, while the distal femur forces the olecranon forwards. Owing to the accuracy

Fig. 1.



with which it can be applied, this power, which is incalculably greater than that afforded by the pressure of the fingers and thumbs (Boyer), is sufficient, when the forearm is steadied, to reduce an ordinary dislocation without the aid of extension. Additional adjusting influence is exercised by the inner side of the proximal thigh, which by pressing against the anterior surface of the forearm, liberates the coronoid process from its position behind the lower extremity of the humerus, and allows the greater sigmoid cavity to resume its normal relation to the trochlea. Extension is supplied by the muscles of the upper extremities acting round the fixed point provided by the elbow of the surgeon, and, when his

^a This is not correctly shown in Figs. 1 and 2.

body is thrown backwards, additional force is derived from the muscles of the back, the glutæi, and the other extensors of the thighs. This power may be applied at various angles in rapid and easy succession, an advantage which the surgeon experienced in the treatment of dislocations cannot fail to appreciate.

Fig. 2.



In the lateral modifications of the posterior luxations the reduction is generally effected by the same manœuvre which is employed for the simple form of dislocation, but should special coaptation be necessary, it is at the disposal of the operator, as, when aided by the powerful constraining pressure of the thighs, the proximal hand can supply sufficient traction and stability, while the other is unoccupied and in the most advantageous position to apply any additional manipulation (Fig. 2), which may, if desirable, be afforded by an assistant. If the condition be such that the full extending force of both arms be required, the isolated rural surgeon can, with a little ingenuity, render himself independent of professional aid by fixing the bone of the arm or forearm, which is displaced inwards, by a bandage passing round his own loins, and by making lateral traction on the bone or bones displaced outwards, by another bandage attached to his foot, and passing over his knee, as over a pulley. By this simple apparatus the instinctive movements, which are essential to the reduction of the

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simpler luxations are utilised for the treatment of the more complicated forms.

Fig. 3.



For the anterior dislocation, of which the writer has had no personal experience, the following modification of the foregoing method is proposed, as being rational and obviously advantageous. The operator and patient being placed in the same relative positions (Fig. 3), the arm of the latter is passed *over* the proximal thigh of the surgeon, while his distal thigh is placed in the anticubital fossa; the distal foot is "hitched" behind the other leg, and the proximal elbow placed upon the shoulder of the patient. The arm being fixed, and the forearm pressed against by the distal thigh, the operator, grasping the wrist as in the former manœuvre, makes traction upon it in the most desirable direction, and, flexing the forearm over the thigh, he liberates the olecranon from the anticubital fossa, when the reduction is completed by the spasmodic action of the patient's triceps, aided, if necessary, by the operator, who forces the forearm backwards.

In addition to the desire to place at the disposal of the surgeon another method of dispensing with pulleys, assistants, and anæsthesia, the purpose of this paper is to direct attention to the undeveloped mechanical resources of the human body. The utility of the powerful muscles of the lower extremities in supplementing

the strength of the upper, is a topic worthy of consideration, and experience has enabled the writer to commend it most warmly to the attention of his professional brethren.

ART. II.—*A Case of Lateral Sclerosis of the Spinal Cord.* By
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THE time has almost come when it is no longer necessary to plead for a more careful study of nervous diseases even on the part of the busy general practitioner. Our knowledge, both pathological and clinical, of this department of medicine has gained in recent years so enormously, both in extent and in exactness, that it is no longer possible for anyone to neglect a branch of medical science abounding in interest and affording an unrivalled field for the exercise of those powers of observation which are the most striking characteristic of the skilled physician. Yet there are some who still deprecate the expenditure of much time and labour in the investigation of nervous diseases, and apparently on two grounds—first, that the diagnosis of such disease is often obscure and difficult; and secondly, that even if a correct diagnosis be established, treatment is of little or no avail. The first argument had better be given up by those who would shun the imputation of laziness and ignorance. The diagnosis of nervous disease, no doubt, presents very special and peculiar difficulties, but it is being pursued, both in this country and on the Continent, with extraordinary zeal and with distinguished success. Take, for example, such a disease as posterior sclerosis or locomotor ataxia. The last generation of observers scarcely recognised its existence; now our knowledge of the marvellous assemblage of symptoms presented by this malady is minute in its exactness, and far exceeds that which we possess of many familiar diseases which have been under observation from time immemorial.

The second argument—that the treatment of nervous disease is disheartening—is one of those arguments which prove too much. If our clinical studies are to be confined to those diseases in which treatment is strikingly and unquestionably efficacious, the range of our observations is likely to be somewhat limited. Granting to the fullest extent that it is in the realm of nervous disease that therapeutics exhibits its most conspicuous failures, such a fact is no sufficient excuse for the neglect of this department of study—