CONGENITAL DISLOCATION OF TIBIA.

Dr. Lewis Marshall showed a girl, aged 19 months, who had a dislocated left tibia, the femur lying in the popliteal space. Dr. Marshall divided the rectus muscle subcutaneously just above the patella, taking care not to injure the synovial membrane. The result was most satisfactory, the child walking quite well, and the joint being perfectly restored.

GENU VALGUM AND OVERGROWTH OF THE INNER TIBIAL TUBEROSITY.

Mr. John Ewens (Surgeon to the Bristol Hospital for Women and Children), has alluded to the silence of some eminent surgical authorities on this subject, and the slight reference as regards the distinction between this affection and other forms of genu valgum made by other writers. Mr. Ewens proceeded to call attention to the various deformities of the two cases by which his observations were illustrated. The inner tuberosities of the tibia were enlarged and elongated without any corresponding change in the inner condyle of the femur. The primary cause of genu valgum was section of the tibia and condyle of the femur in a loose condition of the ligaments. Why the femur only was affected in the majority of cases, the femur and tibia in a smaller number, and the tibia alone in a third and still smaller class, was a question open to discussion. Mr. Ewens had seen the last class of cases, of which some had been under his own care, and had been operated on by him. In each variety of case it appeared probable that the condition was due to some accidental circumstance inducing increased vascular supply to one part rather than to another. The greater ease of the tibial condylar form might also be due to the normally flexed condition of the knee during sleep and when sitting, for in this position the head of the tibia was in close approximation to the posterior surface of the condyles. The common practice of allowing the child to sit on a chair without allowing them to use their feet as propellers, was added as a probable determining cause of the curvature of the tibia. Notes of the two cases having been read, the writer proceeded to discuss the treatment. It was very obvious, from an inspection of the cases and photographs, and still more evident from inspection of the living subject, that no operation on the femur, either condylar or supracondylar, could possibly bring the hip, knee, and ankle joints into relation with each other, and that the operation would be of no service to the child, either at the time of operation or during later years.

Then arose the question as to the nature of the operation, whether by removal of a wedge or wedges, or by simple section of a bone. The former method, in spite of some extra risks, appeared to be the most scientific and accurate. In Case No. 3 two wedges were removed, but on consideration Mr. Ewens thought that in future operations on a small bone a simple section of the lower part of the tibia might be sufficient. In Case No. 1 the double wedge was the only method which could possibly have remedied so serious a curve, except by such a number of sections of the bone as would have been even more dangerous. The causes of the suppuration, some unavoidable, in the cases having been pointed out and regretted, the belief was expressed that further experience would quite prevent such accidents and render the operation a comparatively safe one. The treatment of such cases by mechanical methods was then referred to, but objections to it were raised on the grounds (1) of expense; (2) impossibility amongst the class of patients in which such cases occurred of being able to secure proper attention bestowed on them; (3) the length of time required for the treatment by such methods. The last objection applied with full force to the treatment by plaster-of-paris casing. Neglect of these cases in the vain hope that the patient would grow out of the condition was strongly deprecated, even though a very small percentage of slight cases of curved tibia, genu valgum, etc., might, under especially favourable circumstances, improve without operation or instrumental aid. These cases, however, must always be treated by rule based on sound common sense principles. It was much to be regretted that early indications of curvature in bones were not attended to by suitable diet, tonic medicines, and also by splints, etc., at a period when walking was not a necessity for the child’s health.

Mr. Walsham agreed with Mr. Ewens. He said that he was more in the habit of doing osteotomies rather than osteotomy, as he obtained better results from the former operation.

Mr. Noble Smith said that he held not that deformity of the tibia was a cause, but that it existed more often than enlargement of the internal condyle of the femur, and that he had based his views not only upon examination of patients but also upon specimens in museum. With regard to the comparison of treatment by operation and with instruments, he thought that the periods of time were probably not very different, since if the joints were generally weak, instrumental support after operation would be necessary for a considerable time.

Dr. Braidwood said that as a rule operation was not required till after the tenth year, and in his experience division of the femur gave the best results.

NERVOUS DISORDERS FOLLOWING SECONDARILY CERTAIN ACUTE INFECTIOUS DISEASES OF CHILDREN.

Dr. P. Murray Braidwood (London) in this paper considered the pathology and treatment of nervous disorders following group (including diphtheria), influenza, measles, mumps, whooping-cough, röthen, scarlatina, and chicken-pox. He stated his belief that convulsive and epileptiform disorders following secondary infectious diseases in children are generally due to some accidental cause, such as a fright or the overpressure of schoolwork. Paroxysms of eclampsia infantilis closely resembled in their symptoms those of epilepsy in the adult. The convulsions might be repeated three or four times, without any injury, or the convulsive condition and complete loss of consciousness and sensation might continue. The persistence of the reflex sensitiveness in such circumstances might easily mislead, for touching the conjunctiva produced contraction of the orbicularis, and sprinkling with cold water excited reflex contraction. Mr. Braidwood, in the course of his paper, also considered the causes and treatment of chorea, Jacksonian epilepsy, unilateral spasms, and tetanus occurring in children. Massage had, he said, yielded him excellent results in cases of infantile paralysis, especially when it was combined with electricity. The paper was illustrated by a table indicating the chief nervous diseases met with in children after the various infectious diseases.

TREATMENT OF PERICARDITIS BY THE ICEBAG.

By D. B. Lees, M.A., M.D., F.R.C.P.,
Physician to St. Mary’s Hospital and to the Hospital for Sick Children, Great Ormond Street

[Dr. Lees began his paper by drawing attention to the serious consequences, in damage to the cardiac muscle and the formation of adhesions, which too often resulted from a pericarditis after apparent recovery. He pointed out that the present treatment of pericarditis was not merely practically useless, but that it was seldom actually a minus quantity, for the occurrence of this complication often induced the physician to give up the use of salicylates on account of the supposed danger of their employment in this condition. After a considerable experience in the use of ice in the treatment of pneumonia, he had ventured to try it for pericarditis, and with very satisfactory results. It is clear that if the local application of ice has any influence in checking the subjacent inflammation, insofar it will tend to relieve the heart from depression, and thus act as a true cardiac tonic. Whether it does this or not can only be discovered by cautious employment of the icebag, and careful observation of the result.]

CASE I. Acute Rheumatic Pericarditis.

Transcribed by Miss Clow and by Scobin and the icebag: Immediate Relief.—A girl, E. H., aged 18, admitted into St. Mary’s Hospital, January 21st, 1890, for her first attack of rheumatism on which the joints were affected, but into pericarditis on admission. Temperature 100.8° F., pulse 120, respiration 44. The house physician applied three heat packs, and directed the use of her 20-grain digitalis every four hours, afterwards every four hours. I saw her on January 22nd; she was then in much distress: the pulse had then fallen to 120; a number of heat packs had been applied. I found a double rub over the heart, a systolic murmur at the apex, also tenderness and loud pleuritic cracks in the left axilla. I directed that a large
The Icebag in Pericarditis.

Far down; the cardiac dulness reached the third rib, with slight impairment in the second space. On the 2nd she was quite lively, and the rub was distinctly heard, but there was no other evidence of effusion, and the respiration was nearly as rapid as before. The icebag was applied. On the 3rd the rub became entirely a disappears without any evidence of effusion. It cannot be doubted that if such effusion had been retained over for three days and a half. Two days after the application of the ice, pustular eruptions on the face and neck appeared. The right side, but there was now absolute dulness in the left second space, dulness over the second rib, a good tone in the first space. The right pleural dulness had also subsided, but the right upper second space was still clear. The dulness in the second space vanished in a day or two, and on July 1st she felt well.

The following cases were all in children, and were under my care at the Hospital for Sick Children, Great Ormond Street. The fourth case is interesting as showing the action of the icebag in arresting pericarditis without any assistance by salicylates, and also in demonstrating the influence of the icebag on the pleuritic friction.

Case IV.—M. L., aged 7, was admitted, September 22nd, 1891, suffering from rheumatism, mitral regurgitation, and pericarditis. She had previously been an in-patient for rheumatism, chorea, and endocarditis. On admission she had many erythematous patches of various sizes on her skin, one of which was distinctly urticarial. She had to be propped up by the icebag, especially on the head. A physician (pro.) applied two icebags on the 24th, but did not order salicylates, on the 25th the friction had much diminished, and the rub had become quite soft; but the rub was about the same. An icebag was applied at 19 noon; she did not dislike it, and preferred it to hot applications. On the 26th, the right pleural dulness had also subsided, but she remained, and the apex was two fingers' breadth outside the nipple line. There was no pain, and she left well, but the pulse was still rapid (120). I kept her in bed for some weeks, but the rapidity of the pulse did not diminish.

In the fifth case we had the opportunity of attacking a pericarditis at its very commencement, and the result was as good as could possibly be wished.

Case V.—M. H., aged 1, was admitted on October 9th, 1891, for her first attack of rheumatism, with a temperature of 102°, and a systolic apex murmur; the cardiac dulness reaching from the right margin of the sternum to one finger's breadth inside the left nipple line; sounds at the base normal. Six grains of salicylate of soda every three hours were ordered. On October 11th at 10 A.M. she began to sweat all over the upper part of the body, and at 12 noon the house-physician found a soft rub over the sternum at the level of the right nipple, and dulness had also subsided, (right pleural dulness from salicylate from 9 grains to 3.) An hour after the application of the ice the child was free from pain. She liked the bag. At 10 P.M. he applied the icebag for seven hours, the rub was softer, and the child felt better, free from dyspnea, and lying on her side, although on the 12th and 13th there was a slight dulness heard all over the heart. The icebag was kept in position for sixty-two hours continuously. On the 15th, after it had been applied for two days, I noted that it did not matter whether a new bag or an old bag was applied. There was some increase of the precordial dulness; it now extended from one finger's breadth outside the right edge of the sternum to half a finger's breadth inside the left nipple line; above, not higher than the third cartilage; a systolic rub, with a sort of canting rhythm, could be heard over the right ventricle, and even as far as the second cartilage. There was also a blowing systolic murmur at the apex, not conducted far. On the 16th the icebag was removed, the temperature having fallen to 97°, but she had had some fever, when it had again reached 100°. The next day the icebag was reapplied. Similarly, on the 18th, it was omitted for a few hours. On the 16th the child was much better, quite easy, and free from pain. The rub was barely audible, only at one spot, and there very faintly. The right side of dulness had now returned to the normal. The treatment was continued with icebags. On the 23rd no rub at all could be heard, the dulness was normal, and I thought the apex murmur less loud. But it was finally removed, twelve days after its first application. From noon on the 11th to 10 A.M. on the 23rd there were 286 hours, during 100 of which the bag was removed, so that it was over the heart for 186 hours with a continuous application of 62 hours. The child was now practically well, but I placed her in bed for another month, in order to give the heart a long rest. On November 4th I noted that the cardiac dulness was quite normal, that the apex was in the normal position, that a systolic murmur could be heard behind, and that the line of the murmur went straight, being quite regular. The child was now practically well, and had no murmur heard at the base. Evidently to claim this result as extremely satisfactory.

In this case, that of G. M., aged 12, admitted October 26th, 1891, a pericardial rub vanished in two days, and a pleuritic rub at the base of each lung in about a week, under the application of icebags. He was a very sensitive child, and had been attacked by scarlet fever, strongly under the latter, being taken to bed a grant, strongly under the latter, being taken to bed a

February 18, 1893.

The Icebag in Pericarditis.
The peculiar erythematous rash something like German measles, then deafness and tinnitus, and lastly slight irregularity of the pulse. This last symptom was observed on the 29th, just after the abscess had been opened, and two days after the icebag had been removed from his heart. It is a symptom which I have once previously observed as a result of salicylate treatment.

The seventh case is of special interest, because in it we witnessed the rapid absorption of a pericardial effusion under the local influence of ice.

Case VII.—A. B., aged 9, was admitted on November 26th, 1891, having been ill about ten days with feverishness and pain in the chest. She had been taken to the infirmary with the diagnosis of chronic pleural effusion, but it had remitted, and on the 29th she had her temperature down to 97° F., and the pulse regular. The heart was palpable over the left fourth intercostal space, and the cubital pulse was weaker on the right than on the left. She was otherwise quite healthy. The chief complaint, but it is to feature carditis tissue of necessarily confined that very early the nipple line.

The precordial effusion was first observed on the 29th, when the left cardiac dulness was not quite 3 inches. On the 30th, carditis was already quite intense, and the heart was palpable on the left side only, with a Apex digitata. Physical examination gives negative results so far as intrathoracic signs are concerned, but it will be observed that perspiration is productive of great pain, especially in certain areas. Occasionally much suffering is complained of on one occasion she was in so much pain that she was given a gramine of citrate of potash with 3 minims of tincture of opium every six hours. She had an icebag applied over the precordial region, but it was taken up at 10 A.M. on the 7th, and found that she had, in addition to a double rub in the third left space and over the fourth rub, evidence of considerable effusion to the left. Pericardial disease was confirmed in one and a half fingers' breadth to the right of the right edge of the sternum, and three fingers' breadth outside the left nipple line, and upwards the second left space was dull, and even the first left space much impaired in resonance. There was also a blowing systolic murmur at the apex outside the nipple line. On account of the effusion the house-physician had refrained from giving salicylates, and had ordered for her 10 grains of citrate of potash and 10 grains of bicarbonate of potash with 3 minims of tincture of opium every six hours. 

On account of the effusion the house-physician had refrained from giving salicylates, and had ordered for her 10 grains of citrate of potash and 10 grains of bicarbonate of potash with 3 minims of tincture of opium every six hours. 

Twenty-two hours later, at 6 P.M. on the 29th, there was still further admission of a pericardial effusion. The carditis was intense. The double rub was much less loud, but it was heard over rather a large area. The ice had been applied for periods of two or three hours at a time during the 28th and 29th, and it was used for several more periods. On the 30th I found that the dulness did not extend beyond the mid-sternum, and there was not the left lung bowing away from the nipple to the sterno-clavicular articulation. Thus after only three days' treatment with ice the effusion had practically vanished. The rub could still be felt, but it was applied for a much longer period.

The effusion on the 29th it was used for two hours, and for a like time on December 1st and 2nd. After this it was given up. On the 4th there was a slight left and right space, and even in the third. Cardiac dulness to the right reached the mid-sternum, to the left two fingers' breadths outside the nipple line. The rub had quite vanished. The apex had a long systolic murmur and no second sound. A little friction sound was heard on the 5th, and on the 7th, but not sufficiently to extend barebly to two fingers' breadths to the left of the nipple line, and not quite up to the mid-sternum; above to the third space. The impulse was in the nipple line in the fifth space, and just outside. There was a blowing systolic and a short blowing post-systolic murmur. The systolic murmur could be heard very distinctly at the sagues of the scapula. I was not able and research of the scapula, and probably early stenosis, but the result as regards the pericardium must be promptly very satisfactory.

It so happens that during the last six months I have not had the opportunity of treating any other cases. But what I have narrated is sufficient, I think, to prove that the icebag, when used with reasonable caution, is a safe application in pericarditis, that it is usually liked by the patient, that it tends to check the violence of the local inflammation and to hinder effusion, and that it may even help to cause absorption of effusion which is already present. It acts cito, tuto, et jucundam.

ABSTRACT OF A PAPER ON PERICARDITIS.

By P. BLAIKIE SMITH, M.D.,
Physician and Lecturer on Clinical Medicine, Aberdeen Royal Infirmary; Late Examiner for Degrees in Medicine, University of Aberdeen.

The term pericarditis is applied to an affection whose chief feature is suppuration cellulitis of the thoracic wall. It is not necessarily confined to the neighbourhood of the pleura, but it may extend downwards and involve the connective tissue of the loins and abdomen. The disease was first described by Delafond, and to the salicylate it had been given by his countrymen we are indebted for almost all the information we possess on the subject. English writers, with the exception of Wilson Fox, are practically silent concerning it, and to this circumstance, as well as to the undoubted rarity of thecomplainant, it is ascribed the slight attention which it has received in this country.

With reference to the etiology of the disease, it would appear from an examination of the cases published abroad that a close relationship exists between pericarditis and pleurisy. Sometimes the former is an affection producing an

secondary results either pleurisy or pleuropneumonia, while in other instances the inflammation of the cellular tissue is the consequence of the disease in the pleural membrane. Occasionally it may arise from mechanical injury to the thorax, as in the case presently to be narrated, or it may be the solitary suppuration signifying a chronic pulmonary disease.

Clinical History.—The complaint is one of great rarity. It is commonest in the male sex. When uncomplicated, it generally begins suddenly with a rigor, accompanied, or soon follows, with decided perspiration. It is attended with a feeling to lie on the affected side. At this stage it is indistinguishable from pleurisy, and the resemblance is still further strengthened by the presence, in some cases, of slight dry cough. Accompanying these symptoms are the usual disturbances attendant on a fluid in the thoracic cavity elevated.

The following case is a good example of uncomplicated pericarditis, the result of muscular overstrain:

Early in June, 1891, a sailor, aged 45, was sent to the Aberdeen Royal Infirmary, supposed to be suffering from pleurisy. His previous history was of no importance, but the account which he gave of his recent illness was highly significant. Towards the end of May he was at sea, and on one occasion he was thrown into the sea, every cough was ascribed to the cold. But he could not bear his post and go below, and very soon afterwards he was seized with a rigor; the rigors were severe, and the skin was excessively sensitive that they had quickly to be discontinued. On arriving at port he was examined, and on that day he complained mainly of catching pain in his right side and right loin. He breathed 24 times a minute, and, through the respirations were shallow, he was from breathing through which, which, grave agitated the pain; he could lie perfectly comfortably on the left side, and he lay on his left side and turn him to lie on his pain in his hip. Upon examination the lower two-thirds of the right thoracic wall—anteriorty, laterally, and posteriorly—were uniformly swollen, and in several places there was a hardness. The arm was extremely hyperesthetic. Both sides moved equally well on respiration, and the intercostal spaces, though somewhat prominent, were not unduly separated. On percussion the axillary areas gave a dull note; auscultation discovered faint vesicular breathing, unattended by adventitious sounds; an empyema was absent, and the patient was well developed. Percussion produced much pain. The circumference of the right chest at the level of the nipple was 2 inches greater than that of the opposite side. The axillary glands were enlarged, painful, and tender, and the arm could not be moved owing to the pain in the thoracic wall. There were nothing abnormal, and to the appetite was poor, and thirst was urgently complained of. The skin was covered with perspiration. The thermometer registered 101° F. Sleep was much disturbed, chiefly by pain in the sides and chest, which was observed at night. The urine was of the usual febrile type.

During the next two days the swelling decreased in superficial extent, and gradually became concentrated in three regions: in the flank, near the nipple, and posteriorly from the angle of the scapula as far as the two-thirds of the arm. The skin in these areas was red and exquisitely tender, and palpation detected obscure fluctuation. Over the base of the neck, anteriorly and laterally, over the right scapula (and especially diminished) percussion and auscultation gave more satisfactory results than before. Next day there was no longer any doubt as to the presence. Accordingly, the patient was confined. With the discharge of matter the symptoms rapidly improved. The swelling of the right side subsided, the pulse was better, and the physical signs became normal in every particular. Soon afterwards the patient was discharged.