accumulations of intestinal contents above the lesion. A ring of mucous membrane is removed from the distal end, into which the proximal (with or without removal or roughening of its peritoneal coat) is passed, and there secured by suture, either looped or continuous, the whole procedure being accomplished without the aid of any mechanical support.

The principle of the method would seem to be good, for it appears to have suggested itself to at least four independent workers, who have carried it out with variations in details. Robinson of Toledo (by means of a rubber bobbin, experimentally, in the dog), published in the *Annals of Surgery*, 1891; Harris, of Chicago (making temporary use of needles for fixation until the suturing is completed), published in the *Chicago Medical Recorder*, 1892; myself, *Glasgow Medical Journal* and *Transactions of Glasgow Medico-Chirurgical Society*, 1896; and Skelly, of Pekin, U.S.A., *Annals of Surgery*, 1898; Skelly and myself making use of no mechanical aid whatever in addition to the sutures.

In cases other than those I have indicated I believe it is in no sense superior to, and in some respects not so good as, the continuous Czerny-Lembert suture which I employed in the case here detailed.

NOTE.

[1] The specimens were shown at a meeting of the Glasgow Medico-Chirurgical Society.

A METHOD FOR THE REDUCTION OF DISLOCATIONS OF THE HIP.

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Having experienced considerable difficulty in reducing the first case of dislocation of the hip-joint with which I had to deal, it occurred to me that reduction might more easily be effected if one could accurately control the movements of the head of the femur, and at the same time employ traction on the femur.

The following method fulfils those conditions, and having proved it successful in two cases, I venture to make a note of it, more especially for the benefit of country practitioners like myself, whose experience of dislocations of the hip must necessarily be limited, and who not infrequently lack any—much less skilled—assistance.

The patient being laid upon his back on the floor, is put under the influence of an anæsthetic. The surgeon, as shown in the illustrations, kneels upon his left knee when

Fig. 1.—Adduction and rotation in.

the left hip is dislocated, and on the left side of the patient. The patient's thigh is then carefully flexed to a right angle, and while this is being done the leg is also flexed to a right angle, and laid with the most prominent part of the calf on the right knee of the surgeon. The ankle is then firmly grasped with the left hand, and the condyles of the femur with the right. The thigh is then abducted for thyroid dislocations, adducted for dorsal and public, and rotated in for all, by drawing the foot away from the middle line and keeping the knee steady. Traction is now made by steadily depressing the ankle, the surgeon using his knee as the fulcrum; the patient's leg makes a most powerful lever, and the pelvis can be easily raised off the ground if necessary, the weight of the body acting as counter-traction; then finally the thigh is rotated out, and while this is being done the head of the femur slips into the acetabulum.

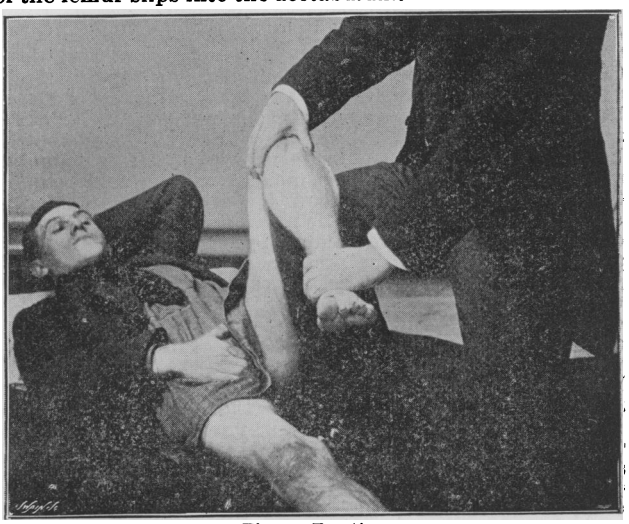

Fig. 2.—Traction.

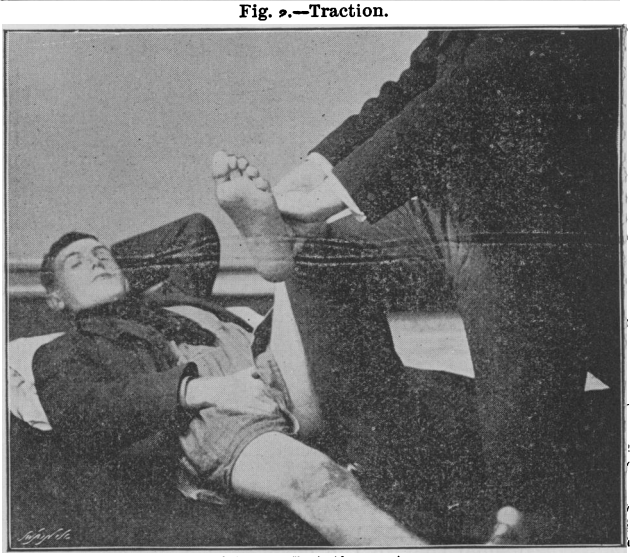

Fig. 3.—Rotation out.

I reduced my first case by this method more than two years ago, the patient being a man aged 62, and the dislocat on being a dorsal one. The operation lasted only a few seconds, and the patient regained perfect use of the limb very rapidly.

The second case I reduced some weeks ago at the request of a colleague who had unsuccessfully attempted to reduce the dislocation; the dislocation was a thyroid one when I saw it, and I succeeded in reducing it even more rapidly than my first case.

I have no doubt that those rare dislocations in which the ilio-femoral ligament is ruptured might be reduced by this method, but of these dislocations I have no practical experience.

I do not claim any originality for this method; it is merely the old method slightly altered.