

N. SILFVERSKIÖLD, STOCKHOLM:

ON OPERATIVE TREATMENT OF HABITUAL
DISLOCATION OF THE SHOULDER

(Later to be published in full).

History shows that those operative methods that aim directly at the patho-anatomical basis of the condition concerned yield the best results. Best known of these methods are *Perthes' and Eden's* operations. *S. Hybinette* (Stockholm) who has been using such a method since 1915, a method allied to *Eden's*, has the largest and best statistical collection of more than 25 cases (*Acta Chirurgica Scand.*, festival number dedicated to Prof. Key).

I have myself operated on 9 cases, all without recurrence. In 3 of these the anterior lip of the glenoid cavity was partly torn away or largely ground off, in 6 cases the damage to the bony rim was slight or none at all. All the cases were subcoracoid luxations where neither roentgen examination nor inspection at the operation revealed any damage to or near the greater tubercle. In the first location of the damage — the 3 cases — I operated with free bone grafting according to *Eden-Hybinette's* method. In the 6 other cases (without any material damage to the bony rim) free bone grafting seemed to me logically unnecessary. *Course of operation:* incision in the deltoid-pectoral groove; capsular division through the intertubercular groove, the incision passing in an arc-shaped manner and medially downwards, whereby the subscapularis tendon is divided. By chisel and raspatory the periosteum is separated, and the anterior surface of the neck of the scapula is cut through, as well as the base and lower surface of the coracoid process. This is done in order to obtain a raw bony surface to which the

subscapularis muscle can become united. Duplication of the capsule. The subscapularis is drawn forwards over this area and its tendon broadly sutured over the capsule which is thus fortified at the seat of the greatest stress. The area between the coracoid process and in front of the socket is now quite filled up. The result is a muscularfibrous-osseous stop against subcoracoid luxation. Suture in layers. Cushion in the axilla and Dessault's dressing. The patient is allowed to get up after a few days and to leave the hospital after 8—10 days. Reeducative treatment is commenced 3 weeks after the operation. Three months after the operation there is complete mobility, strength and confidence in movement.

This method can be more speedily carried out than that of *Eden* and *Perthes* and confirms the conclusion drawn from history as to the advantage of directing our attention to the patho-anatomical underlying cause of habitual luxation.

DISCUSSION:

P. Guildal, Copenhagen:

Mentions Oudard's operation, which, as we know, consists in an oblique osteotomy of the coracoid process, followed by displacement of the two fragmina in such a manner that the process is lengthened to extend down on the anterior aspect of the joint, so as to prevent the luxation. Has only performed this operation once; but it is easy technically, and according to the literature it gives excellent results.

SVEN JOHANSSON, GOTHENBURG:

A CASE OF SEPTIC COXITIS WITH STRANGE DEVELOPMENT

(abstract is not submitted).

DISCUSSION:

H. Nilsonne, Stockholm:

In connection with the instance mentioned by Dr. *Sv. Johansson*, I should like to say a few words about a case which

may be termed a most peculiar one and, as regards its issue, a surprising one too.

A girl, three years of age, was admitted to the hospital suffering from double-sided congenital dislocation of the hip-joint. Reposition was easy; the primary retention good. A few days after reposition, the temperature began to rise and, after a week, became of a septic character, although — apart from a



Fig. 1.

slight paronychia on one finger — it was impossible to discover any cause. After a fortnight, there was found an infected hematoma in the left adductor loge immediately below inguen. Incision and drainage. After another fortnight there appeared a tense fluctuation below the right adductor group in inguen. On incision, entrance was made into a highly distended pyarthrosis in the hip-joint. Counter-opening posteriorly into the joint; drainage right through the hip-joint by means of rub-

ber tubes. Caput stood exactly in the acetabulum; no degeneration of cartilage could be observed. Lorenz' position I still preserved in plaster-of-paris. After another month, identically the same process observed in the left hip-joint. Arthrotomy, counter incision, drainage. At this period, the condition of the patient was extremely bad. Severe nephrosis. For a couple of weeks, the patient was in an almost moribund condition. The



Fig. 2.

plaster-of-paris cast had, the whole time, been retained in Lorenz' position I, and all the treatment had been carried on through the window in the plaster.

Two months and a half after reposition (one week after the last arthrotomy) there was an improvement in the general condition. The hips were brought down into Lorenz' position II under narcosis. Three weeks later, the drainage was finished, and, after another month, the discharge had ended. Five months

after reposition the patient took walking exercise, and seven months after reposition she was discharged from the hospital. She walked well. The hip-joints were in their normal position; mobility was one-half the normal, i. e., the condition was the same as that in which a patient treated for an dislocation uncomplicated is discharged as cured.

A double-sided septic coxitis as complication of a reposition of double-sided dislocation is, most probably, unique. The patient's condition when it occurred was extremely unsatisfactory, and it seemed doubtful whether it was advisable to maintain the right-angled abducted position, which was kept fixed by the plaster-of-paris cast, as ankylosis was to be feared with this position. Our opinion was, however, that septic infantile coxitis allows of favourable prognosis when treated with drainage. It was found possible to carry out the treatment, and the patient was discharged from hospital within the same time as an uncomplicated dislocation would have been, and with the function as good as in the latter.

Robert Hanson, Varberg:

In a rather large percentage of the cases sent here with the diagnosis of tuberculosis of the bones or joints, it is found that the disease is not of a tuberculous nature. I beg leave to demonstrate here a case — a female patient, 19 years old, whom we have had under treatment since August 14th, 1931.

She came here under the diagnosis of tubercular coxitis, with abscess of the left hip joint. Her trouble began in April, 1931; before her entrance here she had in periods had high fever. On admission she was pale and thin. Internal organs, no special remark. Pirquet, + 15 mm. *Left hip:* Hard swelling, painful to pressure, over left hip; an abscess, the size of a child's head, on the outer side of the left thigh; considerable atrophy of left thigh and leg. The roentgenographs are particularly interesting. The first one taken (Aug. 27, 1931) shows marked atrophy in the left hip joint. The contours are muddy all through; the caput shows spotwise atrophy. This roentgenologic picture rather suggested that the case might be a

serious form of tubercular coxitis. The abscess was repeatedly punctured; the first time it yielded 580 c. c. of pus. Unfortunately no guinea-pig test was made, nor any culture. Since then, all the symptoms have receded; on Jan. 1st, 1932, the roentgenographs show normal pictures of the left hip joint. (Demonstration of the patient). The whole course of the disease, and most of all the fact that the roentgenologic picture and the function now are normal, make me conclude that we have to do here with a case of septic coxitis.

I have, before this, had occasion to treat several cases of indubitably septic coxitis, developed in conjunction with scarlet fever or other epidemic diseases, which showed a similar course. On the other hand, I have never seen an unquestionably tubercular coxitis, with roentgenographically visible destructions of the joint surfaces, heal fully and completely. The fact that Pirquet was positive in the present case is, in my opinion, by no means a valid argument for the tubercular nature of the coxitis.

In answer to Dr. *Johansson's* question regarding the precipitation reaction in the demonstrated case, I would say that on Aug. 28th, 1931, it was 84—124.