A. BERNTSEN, COPENHAGEN:

OSTEOPLASTIC OPERATION IN RELUXATIO COXÆ

After *introductory remarks* on probable causes of reluxation and considerations as to the best position of the limb in the bandage after the reposition (*Lorenz'* primary position, *Lange's* position, or modified *Lorenz* position), in connection with a brief historical review, report is given of the *present results of osteoplastic operation on 7 patients,* 4—15 years of age.

Technique: Smith-Petersen incision; under the operation, the limb is fixed in *Lange's* position, under extension, which is kept up till the plaster cast is finished.

In the operation, a »lid« is formed right over the caput. The lid is flapped down and in the resulting hollow is fixed the bridge, which in some cases is taken from the tibia, in others from the iliac crest.

The plaster cast is left on for 2 months, and the patient keeps his bed 1 month more.

X-ray plates, taken at least 1 year after the operation, show plainly the transplant in 5 cases, in which there had been subluxation of the caput in an enlarged acetabulum. No bridge could be made out in 2 cases where there had been uncomplicated luxation — perhaps because the caput had pushed it to a side.

Indications: Preventive operation against further dislocation of the caput through reluxation or subluxation of the hip, in cases where reposition and plaster cast for 6—7 months had been tried 2 times before.

Contraindications: Caput luxated too high up or too far back.

Result: Absence of pain and probable prevention of further

dislocation; but, unfortunately, the patients are still limping more or less.

Cause of the limp: This is partly to be found in the temporary division of the glutæus medius; and it has to be reckoned that there will go some time before this muscle recovers its function. Abduction exercises are to be recommended. It may be that the limp is partly due to an inefficiency of the stopper function of the transplant; perhaps the great trochanter should be transplanted a little downward.

DISKUSSION:

Bülow-Hansen, Oslo:

To claim that osteoplastic operation ought to be performed as early as after the 2' reluxation is rather too hasty, I think.

In my opinion, one should not give up unless one has tried out the plaster cast in pronation and abduction (Codivilla), as stability may be obtained in this way.

Even though stability is obtained by osteoplastic operation, this does not do away with the *Trendelenburg* sign: shortening and slight limping.

I prefer, therefore, to perform the *Lorenz* bifurcation which gives excellent results in this condition as well as in inveterated luxation. Here, too, the old master's operation is superior to others.

Nilsonne, Stockholm:

I wish to thank Dr. *Berntsen* for taking up this subject which is most actual just now. For the present, it is a question of great interest. In the treatment of luxations, I think, we have all met with cases where reluxation or high position of the caput with subluxation have given us a great deal of trouble. The flat acetabulum which in most instances is the cause of this trouble, is a complication one may not master very well with any reposition or fixation method. The value of the *Lorenz* luxation treatment is not lowered in any way by our recognition of the fact that this standard method is not adequate in every case.

At the German orthopedic congress in Munich, last autumn; *Spitzy* demonstrated his material of osteoplastic operation for luxation of the hip. This material covered 16 cases, and the results of the after-examination were rather convincing. It has been interesting here to learn of *Berntsen*'s findings which, I think, invite to adoption of the method.

Berntsen:

Points out that it is desirable at the next congress further to discuss the primary position of the limb after reposition. He emphasizes that *this operation is to be considered a prophylactic measure* against further dislocation of the caput. Finally he mentions that the operation should be aimed also to do away with the limp of the patient; and he repeats that it may be necessary to extend the operation by moving the great trochander downwards.