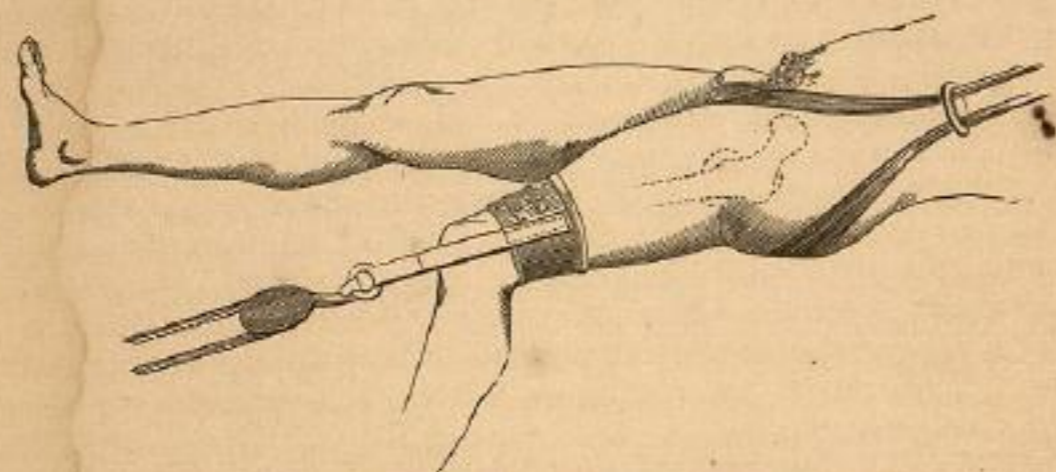


abduction and extension it was conveyed into the acetabulum. He was dismissed cured in about three months.¹

It is probable that no one method will succeed equally well in all cases; but if the head of the bone, as in the case dissected by Sir Astley Cooper, has not only actually surmounted the pubes, but pushed itself fairly into the pelvis, then the limb ought to be abducted in the manner practised by Ingalls, and forcibly rotated outwards, in order that the head may be thus lifted over the pubes; and subsequently it should be flexed upon the body, adducted and brought down. But in this manœuvre we ought to be careful not to continue the rotation outwards after the head of the femur has risen above the pubes, lest the head and neck should grasp, as it were, the psoas magnus and iliacus internus muscles, underneath which they have been thrust. On the contrary, it will be necessary at this point to rotate the thigh again gently inwards, which, by compelling the head to hug the front of the pubes, will enable it, while the flexion is being made, to slide downwards under these muscles toward the socket. If, however, the head of the bone has never risen upon the summit of the pubes, and is not actually engaged under the muscles which pass over it at this point, then the rotation outwards will not be necessary in any part of the procedure.

Barron Larrey has reported a case of dislocation "before the horizontal portion of the pubes," which he reduced "by suddenly raising with his shoulder the lower extremity of the femur, while with both hands he depressed the head of the bone."² This is the same case of which I have already spoken as being attended with the unusual phenomenon of the thigh placed at a right angle with the body.

FIG. 356.



Reduction of dislocation upon the pubes, by extension.

If reduction is attempted by extension, the patient ought to be laid on his back upon a table, with the dislocated limb falling off slightly from its side. The extending band, made fast above the knee, should then be secured to a staple in the line of the axis of the dislocated thigh,

¹ M. H. Henry, Amer. Journ. Med. Sci., Jan. 1875.

² Larrey, Lond. Med.-Chir. Rev., Dec. 1820, p. 500; vol. i., first series, from Bulletin de la Fac. de Méd., No. 1.

and of course below the table; while the counter-extending band, crossing under the perineum, should be made fast in the same line, above the level of the table, and beyond the head of the patient.

When extension is commenced, and the head of the femur has begun to move, the reduction may sometimes be facilitated by lifting the upper part of the thigh with a jack-towel or a band passed under the thigh and over the neck of the surgeon, as I have recommended in both of the backward dislocations. It may be found advantageous also to flex and rotate the limb after extension has brought the head near the socket.

§ 5. Anomalous or Irregular Dislocations, or Dislocations which do not properly belong to either of the Four Principal Divisions before Described.¹

(Bigelow regards as "irregular" only those in which there is a complete disruption of the ilio-femoral ligament.)

1. Dislocations directly Upwards above the Margin of the Acetabulum, and below the Anterior Inferior Spinous Process.

Syn.—"Sus-cotyloidiennes;" Malgaigne. "Subspinous." "Sixth dislocation;" Mütter.

Malgaigne affirms that the head, in this dislocation, is situated external to the anterior inferior spinous process, and about one inch below the anterior superior spinous process.

It is in this position that the head of the femur is found in a specimen deposited in the Museum of the Surgical Clinic of Bonn, by Kronlein. A new cotyloid cavity exists posterior to and on a level with the anterior inferior spinous process.²

Blasius, of Halle,³ says he has been able to reproduce this dislocation upon the cadaver by forced extension (dorsal flexion), combined with adduction and outward rotation.

The symptoms which characterize this accident are shortening of the limb, slight abduction and extension, with rotation outwards. The eversion of the toes, together with the slight amount of shortening which has in general been observed, has led several times to the supposition that it was a fracture of the neck of the femur; but the rigidity, and the position of the trochanter and head will usually render the diagnosis clear.

The following was probably an example of the subspinous dislocation: Bennett Morris, æt. 51, was thrown backwards, in wrestling, in 1851.

¹ Malgaigne, Traité des Frac. et des Lux., tom. ii. p. 869 et seq. Samuel Cooper, First Lines, vol. ii. p. 391. Pirrie's Surg., Amer. ed., 1852, p. 275. Skey's Surg., Amer. ed., 1851, p. 110 et seq. Gibson's Surg., sixth American ed., vol. i. p. 386. Guy's Hospital Reports, 1836, vol. i. pp. 79 and 97; 1838, vol. iii. p. 163. London Lancet, Lond. ed., 1848, vol. i. p. 184; 1840, vol. ii. p. 281; 1845, vol. i. p. 412; vol. ii. p. 159. London Med. Gaz., vol. xix. pp. 657 and 659; vol. x. p. 19; vol. xxxiii. p. 404. Med.-Chir. Trans., vol. xx. p. 112. Lente's paper on "Anomalous Dislocations of the Hip-joint," in New York Journ. Med. for Nov. 1850, p. 314 et seq. Philadelphia Med. Examiner, No. 51. Amer. Journ. Med. Sci., vol. xvi. p. 14. New York Med. and Phys. Journ., 1826, vol. v. p. 597. New York Journ. Med., Jan. 1860, Dr. Shady's case. Dislocation of the Hip, by Jacob J. Bigelow, M.D., 1869.

² Kronlein, Poinset, op. cit., p. 1076.

³ Blasius, Archiv für Klin. Chir., Bd. 16, Hft. 1, p. 207.

He felt a snap in the hip-joint, and found his thigh placed in a position of moderate abduction, so that he could not get his knees together. He was able to walk, but not without limping. This condition continued three years, during which time he was constantly lame, and suffered much pain when walking.

At the end of this period, when in the act of jumping from his wagon, his horses having become frightened, he felt a snap, and at once the complete functions of the joint were restored. He could walk without

FIG. 357.



Subspinous dislocation. Kronlela's specimen.

pain or halt, and he could bring his knees together. Three months later, while ascending a flight of steps, carrying a heavy weight, his foot slipped, and the dislocation was reproduced, and in this condition it remained up to the period at which he consulted me, October, 1869. I found the thigh apparently elongated, but upon measurement it was found shortened half an inch. It was moderately abducted and rotated outwards. All the motions of the joint were restricted.

Although I felt very confident that the reduction could be again accomplished, the patient left without permitting me to make the attempt.

Patrick Coleman, *æt.* 52, was admitted to Bellevue Hospital, Dec. 31, 1875, with a dislocation of the right femur upwards. He had fallen nine feet into a cellar. Dr. Erskine Mason, in whose ward the patient was received, called my attention to him a few hours after the injury was received. The limb was shortened one-fourth of an inch, as nearly as we could ascertain; strongly everted, or rotated outwards, but hanging parallel with the other when he was standing, the right foot being a

little in advance of the left. The head of the bone could be seen and felt below and to the inside of the anterior superior spinous process. The trochanter major was turned back, and there was a deep depression over it. The limb could be slightly adducted, but in all other directions it was immovable.

After several ineffectual attempts at reduction, under ether, it was finally reduced by simple extension.

March 27, 1877, Michael Munroe, *æt.* 62, was admitted into the New York City Hospital with a dislocation of the left femur upwards and forwards upon the ilium. Dr. Charles M. Allin, one of the visiting surgeons, made some efforts at reduction on the same day, but failed. On the following day, in the presence of several medical gentlemen, including myself, Dr. Allin repeated his efforts more systematically, and was successful.

Examining the limb while the patient was on his back, and under the influence of ether, preparatory to the operation, I found it shortened half an inch, strongly everted, and the thigh slightly flexed, but lying nearly parallel with the other. The thigh could be adducted quite freely, but in all other directions motion was more limited. With some difficulty it could be flexed to a right angle with the body. The head could be distinctly felt, but not seen, directly below the anterior superior spinous process; and from this position it was occasionally moved, while manipulating, farther forwards, but never fairly upon the pubes. The patient was a spare man, and not very muscular.

The accident was caused by stumbling while ascending a flight of steps, and falling upon his knees and face. The skin over the spine of the tibia was much bruised and scratched.

Dr. Allin made an attempt at reduction, 1st, by flexing the thigh at a right angle, and rotating outwards forcibly. This was unsuccessful. 2d. By flexion and rotation inwards. 3d. By extension in several directions by the hands, including vertical extension, with the thigh flexed upon the body. 4. Compound pulleys were attached to a lacque above the knee, and counter-extension was made by a folded sheet passed under the perineum, and secured to a staple; the direction of extension being a little back from the line of the axis of the body, as recommended by Sir Astley Cooper. A jack-towel was placed under the upper part of the thigh, by which this part of the limb was lifted upwards and outwards; a folded sheet also being carried across the pelvis to render it steady. The extension was now gradually increased, and the limb was from time to time rotated, and otherwise manipulated, so far as its condition of restraint would permit, until it seemed probable that this method was to fail also, the patient having now been under the influence of ether nearly an hour. 5th. While the extension was extreme, the cord was cut by a quick stroke of an amputating-knife; and immediately after, while the limb was lying paralyzed by the "shock," Dr. Allin seized the thigh, raised the knee a little, rotating it inwards, when the head fell easily into its socket.¹

¹ Brief report of same case, as a "suprapubic" dislocation, in *Archives of Clinical Surgery*, April 15, 1877, p. 38.

Other surgeons have met with examples of the subspinous dislocation in which the patients have been able to walk quite well immediately after the accident. Bigelow supposes that in these cases the upper portion of the capsule has been completely torn from the margin of the acetabulum, and that the head has been permitted to ascend until it was arrested by the under surface of the ilio-femoral ligament at the point where it rises from the anterior inferior spinous process of the ilium.

2. *Dislocations directly Upwards, between the Anterior Inferior and Anterior Superior Spinous Processes.*

Syn.—"Supraspinous;" more appropriately, "Intraspinous."

Cummins reports a case which occurred in the practice of Gibson, of New Lanark, where the head of the bone was believed to be situated just above the anterior inferior spinous process and below the anterior superior spinous process; and also a little inwards toward the pubes. The limb was shortened fully three inches; the toes everted; adduction and abduction were exceedingly painful and difficult, but flexion was more easily performed. The head of the bone could be felt in its new position, especially when the thigh was moved. At first it was supposed to be a fracture, but this error having been corrected, the surgeons proceeded to attempt reduction on the eleventh day. Extension was made by pulleys, and when

FIG. 358.



Supraspinous dislocation. (From Bigelow.)

the head of the bone had descended to the margin of the cavity, Mr. Gibson lifted the upper end of the femur by means of a towel, at the same moment pressing the knee toward the opposite thigh, and forcibly rotating the limb inwards; by which means the reduction was accomplished.¹

Lente has seen the head of the femur in the same position as in the

¹ Cummins, Guy's Hospital Reports, vol. iii. p. 163, 1838.

case reported by Cummins, not as a primitive dislocation, but consequent upon an attempt to reduce a dislocation into the ischiatic notch. The shortening was about two inches; the limb very much rotated outwards; the rotundity of the affected hip greater than that of the other, and the trochanter major one inch farther removed from the anterior superior spinous process. The head of the bone could be felt distinctly in its new position.

The reduction was effected finally with pulleys, by the aid of chloroform, and by rotation of the limb in various directions.¹

Morgan also reports a case in which the head of the femur was above the acetabulum, and a little to the outside of the ilio-pectineal eminence.²

Some of these dislocations have been reduced by manipulation alone, or by manipulation aided by pressure. The limb should be seized in the usual manner, at the knee and ankle, carried up toward the face, abducted, then rotated inwards, gently adducted, and finally brought down again to the bed. At the moment when the rotation and adduction commence, the head of the bone should be pressed toward the socket by the hands, and, if necessary, lifted a little over the margin of the acetabulum, by moderate extension at a right angle with the body. Others have been reduced easily by extension alone after a thorough trial of manipulation.

ANTERIOR OBLIQUE DISLOCATIONS.

3. *Dislocations Upwards upon the Dorsum Ilii, and near its Anterior Margin.*

Syn.—"Anterior oblique;" Bigelow.

Bigelow, who, as has already been stated, regards as irregular only those which are accompanied with a complete rupture of the ilio-femoral ligament; but whose classification in that regard I am not fully prepared to adopt; has nevertheless given us the most intelligible and most prob-

FIG. 359.



"Anterior oblique dislocation." (From Bigelow.)

able explanation of the mechanism of these irregular upward dislocations, and of several other forms of irregular dislocations. According to this writer, the "anterior oblique dislocation," in which the limb is found greatly

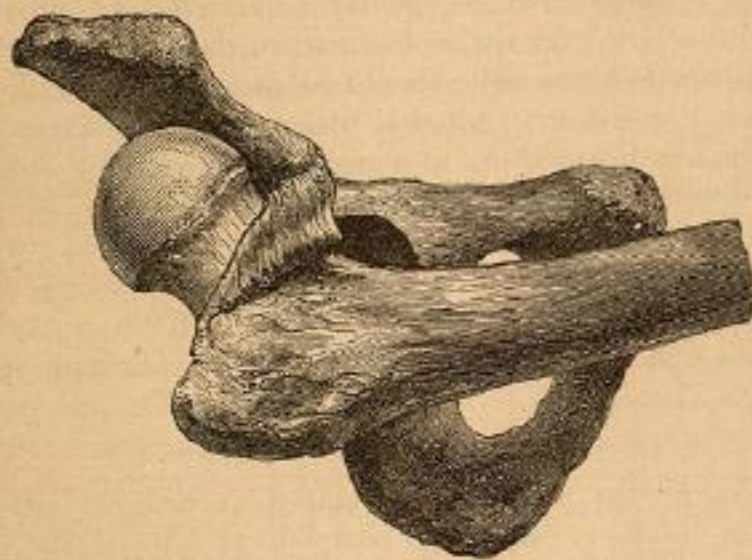
¹ Lente, New York Journ. of Med., Nov. 1850, p. 314.

² Pirrie's Surgery, p. 276. See also Phil. Med. Exam., No. 51, Mütter's paper.

adducted, and at the same time strongly everted, is a regular dorsal dislocation, the head being advanced upon the dorsum to a point near the anterior margin of the ilium. If now the limb be brought down, the neck of the femur will be made to bear against the outer fibres of the ilio-femoral ligament, and as these gradually give way the head will become more and more hooked over the remaining fibres of the ligament, and above the inferior spinous process ("supraspinous"); or, continued efforts being made to straighten the limb, the ligament will give way entirely, and the femur will assume the position indicated by the dotted lines (Fig. 358).

Bigelow recommends a plan of treatment essentially the same as that hitherto recommended by myself. "The anterior oblique dislocation

FIG. 360.



Mechanism of "anterior oblique dislocation." (From Bigelow.)

may be reduced by inward circumduction of the extended limb across the symphysis, with a little eversion, if necessary, to disengage the head of the bone. Inward rotation then converts this into the common luxation upon the dorsum."

4. Dislocations Downwards and Backwards upon the Posterior Part of the Body of the Ischium, between its Tuberosity and its Spine.

James C., æt. 35, was admitted to the Pennsylvania Hospital, on the 23d of January, 1835, under the care of Dr. Hewson. The patient, a muscular man, had been crushed under a falling roof, and, as he thought, with his right thigh separated from his body. When received into the hospital, one hour after the accident, the right thigh was flexed upon the pelvis, and rested upon the left; the right leg was also flexed upon the thigh; the knee was below its fellow, the toes turned inwards, and the whole limb shortened at least one inch. The head of the bone could be distinctly resting upon that portion of the ischium which lies between the acetabulum, the tuberosity of the ischium, and the spine.

On the following day, the muscles of the patient having been sufficiently relaxed by suitable means, the pulleys were applied; but, after

a second attempt, some of the bands having given way suddenly, the pulleys were removed, when it was found that the reduction had been accomplished, although neither the patient nor his attendants had noticed the return of the bone to its socket. For several days there was entire loss of sensibility and motion in the leg, owing probably to the pressure which had been made upon the sciatic nerve; but these symptoms gradually disappeared, and at the time when the case was reported, about two months after the accident, he was walking with crutches.

Dr. Kirkbride, who reported this unusual case of dislocation, doubted whether the extension was necessary to the reduction, as the head of the bone was brought very near the margin of the acetabulum by lifting the thigh with a towel, and it probably afterwards entered the socket as soon as the extension was relaxed.¹

Malgaigne has referred to several similar examples.

5. Dislocations Downwards and Backwards into the lesser or lower Ischiatic Notch.

Syn.—"Behind tuber ischii;" Gibson, S. Cooper. "Fifth dislocation;" Gibson.

September 7, 1821, Charles Lowell, of Lubec, Mass., was riding a spirited horse, when the animal, being restive, suddenly reared and fell back on his rider, in such a manner that the weight of the horse was received on the inside of the left thigh; Mr. Lowell having fallen on his back, a little inclined to the left side. The surgeon who was immediately called, recognized it as a dislocation, and thought he had succeeded in reducing it; but a day or two later it was seen by a second surgeon, who declared that it was still out of place, and repeated the attempt at reduction, but without success, as the result proved.

In December of the same year Mr. Lowell called upon Dr. John C. Warren, of Boston, who was now able to determine, easily, as he affirms, the precise character of the accident. The limb was elongated, contracted, and the head could be felt in its unnatural position. By advice of Dr. Warren, he was taken to the Massachusetts General Hospital, and a persevering attempt was there made to reduce the bone, but with no better success than had attended the efforts previously made.²

Mr. Keate has reported a case produced in a very similar way by a horse having fallen backwards with the rider into a deep and narrow ditch; but the position of the limb was somewhat extraordinary, considering that it was a dislocation backwards, the whole limb being very much abducted and the toes being turned outwards, as if the head of the bone was in front of the tuber ischii, rather than behind it. The thigh and leg were much flexed, and the whole limb was shortened from three to three and a half inches. The head of the femur could be distinctly felt "inferior to the ischiatic notch, and on a level with the tuberosity of the ischium." In the first attempt at reduction the head of the bone was thrown into the foramen thyroideum, from which

¹ Kirkbride, Amer. Journ. Med. Sci., vol. xvi. p. 13.

² New York Med. and Phys. Journ., vol. v. p. 597, 1826. Letter to the Hon. Isaac Parker, etc., by John C. Warren, 1826. North Amer. Med. Journ., vol. iii. p. 169.

it was, however, after one or two more attempts by extension, and by lifting with a jack-towel, restored to the socket. Mr. Keate believes that the dislocation was originally into the foramen ovale, but that in the struggles made by the patient to extricate himself, it was thrown backwards into the position in which he found it.¹

Mr. Wormald has reported a primitive accident of the same kind, occasioned by jumping from a third-story window. The patient died soon after, and at the autopsy the head of the femur was found under the outer edge of the glutæus maximus, projecting through the torn capsule opposite the upper part of the tuber ischii. The shaft of the femur lay across the pubes, and the limb was considerably shortened and turned inwards.²

6. Dislocations directly Downwards.

Syn.—"Sous-cotyloïdiennes;" Malgaigne.

The following is one of several similar examples now upon record:

A man, æt. 50, was admitted into the London Hospital under the care of Mr. Luke. A dislocation of the left femur was easily diagnosed, but the symptoms were peculiar, inasmuch as the limb was lengthened one inch, without either inversion or eversion; yet the head of the bone could be easily felt, and was thought to be in the ischiatic notch. By manipular movements reduction was easily effected about an hour after the accident. The man subsequently died from the effects of broken ribs. At the autopsy, Mr. Forbes, the house-surgeon, before dissecting the parts, again dislocated the bone. This was done with ease, and it was clear that the original form of dislocation had been reproduced, as the bone could not be made to assume any other position. The head of the bone proved to be displaced neither into the ischiatic notch nor the thyroid hole, but midway between the two, immediately beneath the lower border of the acetabulum. The gemellus inferior and the quadratus femoris had been torn, the ligamentum teres had been wholly detached, and there was a laceration in the lower part of the capsular ligament.³

Dr. Blackman, of Cincinnati, informs me that, in January, 1859, he reduced a subcotyloid, incomplete dislocation, in a man æt. 70, by manipulation, Dr. Judkins lifting the thigh upwards and outwards by means of a towel, while Dr. Blackman first flexed and then abducted the limb.

7. Dislocations Forwards into the Perineum.

Syn.—"Périnéales;" Malgaigne. "Luxation sur la branche ascendante de l'ischion;" D'Amblard. "Inwards on the ramus of the os pubis;" Skey.

D'Amblard published an example of this accident in 1821, occasioned by a violent muscular exertion made by the patient in an effort to spring into his carriage, the symptoms attending which did not differ materially

¹ Amer. Journ. Med. Sci., vol. xvi. p. 226, 1835; from Lond. Med. Gaz., vol. x. p. 19.

² Wormald, London Med. Gaz., 1836.

³ Luke, Med. News and Library, vol. xvi. p. 34, March, 1858; from Med. Times and Gaz., Jan. 2, 1858.

from those which were found to be present in the three following examples, except that in the first case the toes were turned slightly inwards, while in each of the other cases they were turned outwards.¹

Mr. E. æt. 35, a calker by occupation. The injury was received while at work under the bottom of a canal-boat, July 20, 1831, the boat being raised upon props three and a half feet long. The patient was standing very much bent forwards, with his feet far apart, between which lay a piece of round timber one foot in diameter, when the props gave way, letting the whole weight of the boat upon himself and his companions. One of the workmen was killed outright. On extricating Mr. E. from his situation, the left leg and thigh were found extended at a right angle with the body, the toes turned slightly inwards, the natural form of the nates was lost, and the head of the femur could be felt distinctly moving, when the limb was rotated, in the perineum, behind the scrotum, and near the bulb of the urethra.

For the purpose of reduction, the patient was laid on his back upon a table, and the pelvis made fast by a muslin band. Extension, accompanied with moderate rotation, was then made in a direction outwards and downwards, bringing the head of the bone over the ascending ramus of the ischium, beyond which it was lying, into the foramen thyroideum; and from this position the bone was replaced in the acetabulum, by carrying the dislocated limb forcibly across the opposite one. The patient soon recovered the use of the joint.²

J. B., an Irishman, æt. 40, on entering the St. Louis Hospital, gave the following account of his accident, which had occurred six hours previously: He was engaged in excavating earth, and having undermined a bank, it unexpectedly fell upon his back while he was standing in a bent position, with his thighs stretched widely apart. The weight crushed him to the earth, breaking both bones of his right leg, the radius of the same side, and dislocating the left hip into the perineum. The thigh presented a peculiar appearance, being placed quite at a right angle with the body, but somewhat inclined forwards. The part of the hip naturally occupied by the trochanter major presented a depression deep enough to receive the clenched fist; while the head of the bone could be both seen and felt projecting beneath the skin of the raphe in the perineum. Rotation of the limb, which was difficult and excessively painful, rendered the position of the head still more manifest. The patient had also retention of urine, occasioned probably by the pressure of the femur upon the urethra. Having dressed the fractures, Dr. Pope placed the patient under the full influence of chloroform, and then proceeded to reduce the dislocated thigh; for which purpose "two loops were applied, interlocking each other in the groin, and using the leg as a lever, extension, by means of the pulleys, was made transversely to the axis of the body. A steady force was kept up for a short time, and the thigh-bone glided into its socket with a snap that was heard by every attendant and patient in the large ward."³

¹ Malgaigne, op. cit., tom. ii. p. 876.

² W. Parker, New York Med. Gaz., 1841; N. Y. Journ. Med., March, 1852, p. 188.

³ Pope, St. Louis Med. and Surg. Journ., July, 1850; N. Y. Journ. Med., March, 1852, p. 198.

A man, æt. 22, was admitted to the Toronto Hospital, under the care of Dr. E. W. Hodder, January 15, 1855, having been injured by the fall of a bank of earth an hour before. The head of the right femur was found under the arch of the pubes, the neck resting upon the ascending ramus. The thigh formed nearly a right angle with the body; being strongly abducted, and the toes were slightly everted. On the following day, the patient being placed under the influence of chloroform, extension and counter-extension were employed in the direction of the axis of the femur, that is, nearly at right angles with the body, while, at the same moment, the upper portion of the femur was lifted by a round towel. By this manœuvre the head of the bone was carried into the foramen thyroideum. The force was now applied in a direction "more upwards and outwards; the ankle held by the assistant was drawn under the other and at the same time rotated." In a few minutes the complete reduction was accomplished. His recovery was steady, and three weeks later he was discharged, being able to walk very well with the aid of a cane.¹

§ 6. Ancient Dislocations of the Femur.

Says Sir Astley Cooper: "I am of opinion that three months after the accident for the shoulder, and eight weeks from the hip, may be fixed as the period at which it would be imprudent to attempt to make the reduction, except in persons of extremely relaxed fibre or of advanced age. At the same time, I am fully aware that dislocations have been reduced at a more distant period than that which I have mentioned; but in many instances the reduction has been attended with the evil results which I have just been deprecating." A remark which later surgeons do not seem always to have correctly understood, or which, if they have understood, they have not correctly represented; since it has many times been affirmed of this distinguished surgeon, that he regarded reduction of the hip as impossible after eight weeks, and they have proceeded to cite examples which would prove that he was in error. But long before Sir Astley's day, Gockelius mentioned a case of reduction of the femur after six months, and Giulio Saliceto declared that he had reduced a similar dislocation after one year,² and Sir Astley says that he is "fully aware" of the existence of such facts or statements; yet with a knowledge of what has so frequently followed these attempts, he would not recommend the trial after eight weeks, except under the circumstances by him stated; and notwithstanding the number of these reported successes has been considerably increased in our day, I suspect that Sir Astley's rule will continue to govern experienced and discreet surgeons. Certain examples which have recently been published of successful reduction after six months by manipulation, if sufficiently verified, would encourage a hope that the period might be greatly extended, were it not that manipulation also has already failed many times in the case of

¹ Hodder, *British Amer. Journ.*, March, 1861.

² Malgaigne, *op. cit.*, tom. ii. p. 185; from *Gallieinium Medico-practicum*, Ulm, 1703, p. 288.

ancient dislocations, and that the attempt has sometimes been followed with disastrous results, even in recent cases.

The following case was published in the first edition of this treatise, but I regret that I am now unable to say from what source my information was then obtained, and communications addressed by me to gentlemen in Havana have failed to trace the case to its original source. It will be observed, however, that there is no history of the accident which caused the dislocation, and its existence was not suspected until the patient arose after an illness which had confined him to his bed for a month or more. It was reduced without anæsthesia; it was three or four times redislocated, notwithstanding the employment of judicious means to keep it in place, and while the patient was in bed; that it was reduced with a snap, "deeper than is ordinarily observed in the reduction of recent dislocations;" and, finally, when the patient was dismissed it is only said, he was able to walk without crutches. In short, a careful reading of the report must convey to the experienced surgeon a suspicion that it may not have been correctly diagnosed, and that, if it was, its reduction may not have been thoroughly accomplished and permanently maintained.

A Chinese boy, named Ah-sin, aged about sixteen years, arrived at Havana on the 4th of June, 1856, suffering from a severe illness, which confined him for a month or more to his bed, and the existence of the dislocation was not discovered until he had sufficiently recovered to rise upon his feet. It was then ascertained that he had a dislocation of the left femur upon the dorsum ilii. Upon inquiry, Dr. Martial Dupierris, of Havana, learned that the accident had occurred before leaving China, a period of more than six months. The boy was still feeble, the limb somewhat emaciated, and instead of being rigid from muscular contraction, all the muscles "were in a flaccid condition, except the great gluteal, which was painful to the touch." Deeming the use of anæsthetics improper, on account of the boy's feeble condition, these agents were not employed. Dr. Dupierris describes the method of reduction as follows: "The body being held by two assistants by means of two bands, one of which passed beneath the perineum, and the other under the axillæ. traction was made upon the limb by two strong and intelligent assistants, The movement of the head of the bone, resulting from this manœuvre, was very limited, even when the force was much increased; and the excruciating pain, which the patient referred to the iliac region, compelled us for a moment to desist.

"The following day, the patient having obtained a tolerable night's rest by means of a narcotic potion, I concluded to attempt the reduction by flexion, believing that I could thus better prevent any accident which the necessary force might produce; the operator, in adopting this method, having it in his power to follow the head of the bone by pressure upon it with the hand, aiding its movement in the proper direction, or correcting any deviation that may occur. The emaciated condition of the boy was eminently favorable for such a procedure.

"The patient being placed upon his back, and the trunk of the body made steady by assistants, with the left hand I grasped the upper part of the leg, placed the right hand upon the head of the bone in the iliac