logically deducted. Another object will be fulfilled if the foregoing thoughts of a clinical observer will induce further inquiry into the interesting and practically important field of mixed parasitic infection.

INJURIES RELATING TO THE ELBOW-JOINT.*

BY J. P. BROWN M.B., L.R.C.P., GALT, ONT.

Among the most common and at the same time most troublesome accidents to which young boys are liable, are those relating to the elbow-joint. While Erichsen, Wilson, Miller, and a number of other authorities in surgery say nothing in regard to the comparative frequency in the sexes of accidents in this region, Holmes tells us very pointedly that fractures and dislocations at the elbow are much more common among boys and young men than among persons of the opposite sex. My own experience is in strict accord with this dictum, for while I have had a goodly number of boys pass through my hands suffering from elbow accidents, yet I never saw a girl suffering from a similar injury. In speaking to my medical *confrères*, I find that their experience in this matter agrees pretty generally with my own. This almost total one-sidedness seems to be a peculiar circumstance, as our Canadian girls are almost as fond of out-door pastimes as our boys; witness as we may our ice-ponds, skating rinks, and toboggan slides in winter, and our croquet and tennis lawns in summer.

There is one field, however, supplying probably one-half the cases, which the boys have about entirely to themselves—the very extensive one of free rides on wagons and sleighs; and if our municipal councils and magistrates were sufficiently active in rooting out the evil, this class of injuries would materially weaken in regard to severity as well as frequency. During infancy and boyhood—fractures at the elbow or perhaps more correctly, separations at the epiphyses—are more common than dislocations; and while fractures often occur by themselves, dislocations rarely do. All authors dwell on the frequent difficulty in diagnosis, arising from several features incidental to injuries in this locality. In early life the muscular and areolar tissues of the arm are soft and pliable, and so susceptible to rapid distention by serous effusion, that it is often, when the surgeon is summoned, impossible to tell the exact nature of the injury. How frequently, when he arrives several hours after the accident, there is so much tenderness and swelling, that although he can discover deformity and produce soft crepitus between the segments of the severed cartilage, yet fails to diagnose with absolute certainty, whether the head of the radius is *in situ* or not, whether the condyles have been separated from each other or the shaft, and whether the olecranon itself has entirely escaped injury or displacement. The surgeon is almost forced to treat cases of this nature on general principles.

The text-books tell us that when serious doubt presents itself, we should for a time abstain from active treatment, place the injured arm on a pillow, apply evaporating lotions, and when the swelling abates, reduce the parts to position and put on our splints.

It appears to me that there are one or two serious objections to this line of treatment. In the first place, the evaporating lotions do not reduce the swelling to any appreciable extent, for the very obvious pathological reason, that the displaced fragments, whether fractured or dislocated, are of themselves a source of constant irritation to the tissues, and must be until reduction is effected; and in the second place any physician, whose reputation is not thoroughly established, would be sure to lose what little he possessed by any such protracted waiting. Hence, if not productive of direct good, such procedure would scarcely be justifiable. I have often also doubted whether the orthodox active treatment as usually laid down by our works on surgery, is altogether to be relied on. For almost all the multitudinous injuries in the vicinity of the elbow, flexing the arm to the right angle, the application of splints, the arm being kept in a position midway between pronation and supination, and supported by a sling, appear to be the *sine qua non*. Erichsen makes some exception in the case of head of the radius being displaced forwards. He favours the straight splint, but leaves the question open; while all authorities enjoin the straight splint in fractures of the olecranon. These I believe are about the only exceptions to the general rule.

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