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GLEANINGS FROM MY NOTE-BOOK.

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Having been present at the meeting of the American Medical Association at Detroit, from the 2nd to the 5th of June, inclusive, with, *ex officio*, the most free access to such matter as was deemed worthy a place in the forthcoming volume of Annual Transactions, it occurs to me that a few points may interest your readers, few of whom will have access to the Transactions.

EPIPHYSEAL FRACTURE OF HUMERUS.

I had the pleasure of being present last September, when, Dr. E. M. MOORE of Rochester, Professor in the University of Buffalo, read, before the Academy of Medicine in New York, a paper on "Epiphyseal Fracture of the Superior Extremity of the Humerus," which had been described first by Dr. Robert W. Smith. In the last edition of *Gloss* it is not treated as a distinct fracture. Frank H. Hamilton has recently done so, after Smith. Moore then insisted on its being distinct from fracture of either the surgical or anatomical neck; illustrated it by a humerus with separated epiphysis; explained a method of reduction original with himself, namely; raising the arm to a perpendicular position, locking the shaft of the humerus into the separated epiphysis and bringing it down to the side, making slight extension and advised retention by a method already given to the profession by Dr. Swinburne, of Albany. Dr. M. now returned to the combat with a decision and precision there was no gainsaying, showing himself master of the situation. From its nature, the fracture occurs only in youth and adolescence.

Frank Hamilton had a case last fall, aged 19, believed to be the oldest on record, patients rarely exceeding 16. The *symptoms* are striking and uniform. The head of the bone can be distinctly felt in the glenoid cavity; a slight depression is felt beneath it, the head remaining motionless when the shaft is rotated. A striking and abrupt projection is observed beneath the coracoid process, caused by the upper extremity of the shaft being drawn inward by muscular action. The shaft seldom clears the head, and hence the small amount of shortening. This projection is smooth and slightly convex, in contrast to the irregular margin of ordinary fracture. The elbow projects but little from the side, and can be readily brought in contact with it. Pressing the upper end outwards while holding the elbow to the side and making extension and counter extension, the deformity disappears, to recur as soon as left to unopposed muscular action. The diagnostic points are; first, the projection beneath the coracoid; and second, the immediate recurrence of the deformity when the means for reduction cease retaining the shaft in place, there being no fracture of the superior end of the humerus in which retention is so difficult. In general the nature of the injury is unrecognized although the symptoms have been clearly stated by Sir A. Cooper, Professor R. W. Smith, and Frank H. Hamilton. The surgeon does not know what to do when a case occurs. It should not be mistaken for dislocation, because dislocation lacks the mobility here present. Again the projection of the lower fragment does not occur in fracture at either neck, and indeed cannot occur in fracture of the surgical, because the muscles causing the projection (*supra-spinatus*, *infra-spinatus* and *teres minor*) are inserted *above* the surgical neck.

ENCEPHALIC CIRCULATION.

Dr. R. A. VANCE, of New York, had a paper read on "The Mechanism of the Encephalic Circulation" of which the following is a brief summary:

1. Atmospheric pressure operates in such a manner as to keep the fluid contents of the skull of constant bulk.

2. The heart can, under certain circumstances, exert a compressing influence upon the encephalic centres.