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FREE INCISION OF ABSCESS OF OSTITIS OF HIP; AND CLOSURE WITHOUT DRAINIGE.

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I will in this paper refer only to cases in my private practice in preference to my hospital experience, because these cases were in a more favorable condition for operation, and because it was possible to keep them under control in a more satisfactory manner, and I was less likely to lose sight of them. My hospital experience in similar cases is far less satisfactory, and I regret that I cannot at this time give the statistics in addition to those contained in this paper.

I am convinced that the occurrence of an abscess of any considerable size is generally evidence of neglect, and that its growth to a size to raise the question of the advisability of its evacuation is a still further error. The neglect of early recognition of the malady and the enforced postponement of rigid immobilization render necessary the consideration of the question now under discussion.

In view of the well-recognized facts that spontaneous resolution by absorption does take place in favorable cases, and that even after spontaneous rupture of an abscess the resultant sinus sometimes does ultimately close, it might appear to be adding an unwarranted risk to operate at all. But on the other hand, the occurrence of the abscess being often caused by neglect, and the doubt that must exist as to the possibility of obtaining a final favorable result, even with the employment of the desirable forms of mechanical rigidity of the joint, favors the application of remedial measures of an operative nature which are based upon sound surgical principles. The great diversity of opinions, even among orthopedic surgeons, as to the expediency of operative interference in hip abscess is evidence, first, that operative procedures alone never cure in this condition, and, secondly, that the scientific use of mechanical principles alone frequently accomplishes that which can be obtained in no other way. Until the recent introduction of asepsis and antisepsis the evacuation of hip abscess was followed by no better results, and not infrequently by not as good results as those obtained by spontaneous rupture. In those cases that did not succumb by amyloid degeneration or fatal tubercular disease elsewhere, there was almost invariably a sinus of nearly a lifetime's duration. At the present day the successful accomplishment of a cure of hip abscess, by free incision, depends upon the thoroughness with which aseptic precautions are observed. I am convinced that where failure has occurred it has been largely due to incompleteness in antiseptic precautions, and I believe that it would be far better not to open such an abscess when for any reason the most strict asepsis and antisepsis could not be obtained and maintained. I can see no good reason for waiting for an abscess of the hip to reach the point of rupture before resorting to surgical interference, because at that time there is not only a natural increase in the size of the abscess accumulation, but the original site of the osseous origin has had everything to favor an increased destruction. The abscess wall has become thin, and tends to a non-union at that point, leaving the much-to-be-dreaded sinus; the constitution will have become depraved from the presence and attempt at absorption of so great a quantity of deleterious material and it is not at all unlikely that bone excision is so frequently indicated because of the great extent of erosion produced by the delay in evacuation. The proportion of cases of hip disease that have abscesses is variously stated as being from 50 to 75 per cent.

The London Clinical Society's committee in 1880 reported 401 cases of hip disease, of which 69 per cent. developed abscesses in the course of a few years.

Cazin* reports 80 suppurative cases treated in a hospital at Berck. Fifty-five per cent. were cured; 12½ per cent. died; 25 per cent. were not cured; 7½ per cent. were improved. In Alexandra

*Bradford and Lovett: Orthopedic Surgery, p. 294.