DISLOCATION OF THE HIP IN A BOY EIGHT YEARS OLD—REDUCTION ON THIRTY-SECOND DAY.

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L. G., age and sex *ut supra*, was brought to my office with an injured hip, on the 25th of March 1877. From his father I learned that 30 days previously, *i.e.*, on the twenty-third of February, he had when running and looking backwards, slipped and fallen with his right leg in a hole in some crusted snow. Being unable to raise himself from the ground, he was carried to the house, and his right hip was then noticed to be out of shape. No marked pain or swelling followed the accident. The limb was helpless, but in a week he began to lift himself round on crutches. His treatment was eminently expectant; his friends expecting that the hip would "come all right," contented themselves by rubbing it with "Pain Killer," &c.,

Examined standing, the right hip was found to be flattened while the right thigh was flexed slightly, rotated inwards and adducted, so that the knee of this side was in front of and slightly above the inner margin of the left patella. The thigh could be freely flexed, slightly adducted but abducted not at all. The right foot could be placed upon the ground with its great toe approximating that of the left foot, but no weight could be borne upon it. Shortening of the limb did not quite reach half an inch. Nelaton's line drawn from the ant. sup. sp. process of the ilium to the most prominent part of the tuberosity of the ischium fell across the lower part of the great trochanter, leaving the major part of this process with the head and neck of the femur above it. The great trochanter approached the ant. sup. iliac spine and the gluteo-femoral crease was less sharp, while more elevated than that upon the left side. The head of the femur could be plainly felt to roll under the fingers when the thigh was rotated, and to move upwards and downwards when it was flexed and extended. With the patient on his back and the pelvis secured, the thigh could be rotated so far inwards that the popliteal space looked directly outwards, and the leg when flexed on the thigh pointed in the same direction. This point I have not seen mentioned, but I believe the position would be impossible to an ordinary mortal whose femoral heads were in their normal sockets.

So long as the right thigh was well flexed upon the pelvis, the patient's lumbar spine lay flat upon the table, but as soon as the thigh was extended this part of the back became arched.

Recognizing that I had to deal with an ancient sciatic dislocation, and meeting with marked muscular antagonism in the manipulations necessary for a diagnosis, I asked for a consultant to administer chloroform. Two days later my friend Dr. Wells met me, and agreeing with the diagnosis, took charge of the anæsthetic. The manipulations popularized by Dr. Reid, of Rochester, were then put in practice. The right hand grasping the ankle, and the left being placed under the knee, the leg was flexed to a right angle with the thigh and the knee carried upwards over the sound thigh toward the umbilicus and opposite side of the body. Next the thigh was abducted, and using the leg as a lever rotated outwards. In doing this the right ankle was carried over the left, and the right toes became everted instead of inverted. Lastly a slight rocking motion was given to the limb, (Nathan Smith's manœuvre), and the thigh was slowly brought downward toward the table. Mindfull of the enormous power given by the disproportion between the long and short arms of the femoral lever and of the danger of epiphysal separation at this age these movements were made and repeated with the utmost gentleness. Nevertheless, a constant crackling and snapping was heard and felt each time the head of the bone was made to mount toward the rim of the acetabulum. Whether this was due to laceration of the capsule, or to the rupture of new adhesions, or both, could not be determined. The first attempt failing, it was repeated five times without bringing the limb completely down. On the sixth trial the head slipped into its socket with the well-known "click." Perfect mobility was at once restored. Up to this present time (April 16th) there has not been the least tenderness or pain in the limb since the reduction. Although, as a precaution necessary with an unruly youngster a long splint is still applied, he can bear the whole weight upon the right side, and the motion in one leg is as good as in the other.

This case has seemed worthy of record on account of the age of the patient and the duration of his dislocation. Occuring under 8 years Dr. Hamilton* has collated 11 cases of luxation at this

* Fractures & Dislocations, 5th Edition.