Traumatic dislocations have been considered very rare in children. It is quite certain, however, that they do occur. The history should afford help. Mobility in this case is sure to be much less than in congenital dislocation.

If attention be given to the history, this affection should not be confounded with hip disease, nor with its results; yet, this has often been done. It is only in the very late stage of hip disease when the femoral head has been absorbed or removed, that gliding of the femur upon the pelvis can be observed.

The amount of resulting disability varies greatly in different subjects. As a rule, children are not much inconvenienced thereby. The limp is, of course, always strongly marked. The child generally tires easily, and long walks or violence applied through accident, sometimes causes pain. Persons of great weight, and those of weak muscles suffer most.

Treatment by purely mechanical means may be dismissed with a very few words. Though many attempts have been made, it may safely be said that none have succeeded.

Hoffa, of Würtzburg and Lorenz, of Vienna, are justly entitled to more credit than any other surgeons for placing the treatment of this affection upon a scientific and successful basis. Operative measures were resorted to at an earlier date by Poggi and Marjory, and by Paci at a later date; but the many cases treated by Hoffa and Lorenz, and by Delanglade, in France, enabled them to elucidate the obscurity of the pathological anatomy, thus laying the only secure foundation upon which to erect surgical success.

The first successful cases were reduced after incision, the cutting of shortened muscles, the opening of the capsule and deepening of the acetabulum. At this time many fatalities resulted, and there was not a little prejudice against operative interference; but increased knowledge of technique brought about, not only better results, but safety also.

In cases treated by operation, the incision is made to extend from the anterior superior spine downward and backward, crossing just below the tip of the trochanter, running along the outer border of tensor fasciæ femoris downward to the level of the trochanter minor. Muscles are retracted, and fascia incised till the capsule is reached. The capsular ligament is now freely incised and the femoral head and trochanteric line freely exposed. If now the attachment of the ligaments to the femur be completely severed, the head may be pulled outward and the acetabulum, covered by the capsule stretched across it, may be deepened with the curette. After the acetabulum has been prepared for its reception, the head is brought into position. It is important to see that the soft structures are sufficiently divided to enable the head to stay easily in the cup prepared for it, and that the latter is deep enough to present a good rim which may serve to retain the replaced head in position.

In dressing, the utmost care is required; and, in fact, throughout the whole procedure, the aseptic precautions must be most rigid. As the wound is a deep one, and may easily be shut in in its deeper parts by muscular contraction or the closure of layers of fascia, drainage is important.