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IS EARLY RESECTION OR CONSERVATIVE TREATMENT ADVISABLE IN COXITIS?*

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While our increased knowledge of the pathology of tuberculous joint affections has resulted, in most joints, in earlier operations in order to remove the local focus before the joint has become totally disorganized, the same cannot properly be said about tuberculous affections of the hip-joint. We still find the same disagreement between the adherents of conservative and operative treatment, and I scarcely say too much when I state that in the vast majority of cases excision is still made as *ultimum refugium* only. Yet even in these cases a better knowledge of the pathology and consequently improved operative methods have been followed by decreased mortality and improved functional results. In order to decide the question, it seems proper shortly to study the pathology of coxitis. We formerly believed that tuberculous affections of the hip, or for that matter of any other joint, commenced as diffuse inflammations, which went on to destruction of the joint. *Post-mortem* examinations were rare, except in cases which represented the later stages of coxitis. In these the synovial membrane was always found diffusely diseased, the ligaments and the perisynovial tissue changed to gelatinous, œdematous or fibrous tissue, the joint itself filled with fungus granulations, the cartilages generally ulcerated and shed, leaving the epiphyses in a state of softening and caries. But often we found the cartilages more or less intact and we therefore believed that the synovitis was the primary lesion, the disease of bones and cartilages secondary. The tuberculous bacillus was unknown and we supposed a dyscrasia present. Furthermore, all acute infectious diseases were known to be followed occasionally by inflammations of the joints, which always commenced as a synovitis, as in pyæmia, puerperal fever, typhus, scarlet fever, etc. It was acknowledged that the inflammation occasionally might commence in the bone, but it was believed that it even then commenced as diffuse inflammation of the medullary tissue in the epiphyses.

We overlooked that these diffuse processes, whether in bone or in synovial membranes, were secondary and were the result partly of an infection, partly of reactive and reparative processes.

It is the Germans, particularly the late Prof. Volkmann and Prof. Koenig, both of whom I quote extensively in this paper, to whom belongs the credit of proving that the fungous or tuberculous joint affections commence, in the majority of cases, as a local focus in the bone and that the consecutive entrance into the joints of the *materia morbi* from the local focus produces the diffuse inflammation of the synovial membranes and the epiphyses. That the disease, in a few cases, may commence as a synovitis is not denied and is occasionally proved by *post-mortem* examination.

This is by no means a generally accepted theory. Haberern, for instance, states that in 132 cases of excision a primary osseous lesion was present 80 times, 23 times a primary synovial affection, while the starting point was doubtful in 23 cases. Watson Cheyne thinks the disease more often primarily osseous, although not in the proportion Haberern states. The trouble is that only in early cases can the presence of a local focus be shown. In late cases we find exactly the same changes in bone and joint, whether the disease started as an osseous or synovial inflammation.

It is therefore probably true that the vast majority of cases commence, as Volkmann says, as an osteitis and not as an arthritis, and more particularly as a circumscribed cheesy or tuberculous osteitis or osteomyelitis.

It depends upon circumstances whether the joint later becomes attacked: viz., whether the products of the inflammation perforate into the joint, as usually, from anatomical reasons, occurs, or seek the surface. The primary focus, at least

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