

Following the history of the hip splint in this country for the past twenty-seven years, one is amazed at the great number of the so-called improvements that have been made upon it. The most important has been a perfecting of that part of the apparatus which provides for ischiatic support of the body in standing and walking. The first splint did not extend to the ground, but depended on the integrity of the plaster adhesion for keeping the weight of the body from resting on the inflamed joint. Dr. Edmund Andrews, of

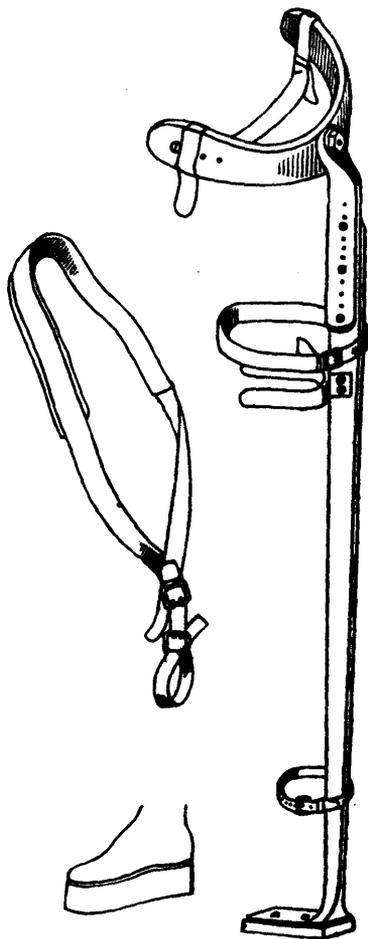


FIG. 3.

Chicago, and Dr. C. Fayette Taylor, of New York, proposed and perfected an extension of the splint to the ground, and thus left but little to be desired as an ischiatic crutch. Aside from this great improvement no essential changes have been made. Experience and increasing light have shown that certain things which it was thought that the splint

accomplished are mechanically beyond its reach, and that some things supposed to be desirable and even necessary to proper mechanical treatment are of no importance whatever. The two things which the splint does to-day, and which it has done ever since the improvement above mentioned, the two functions of the splint, so to speak, are (1) to make the effected limb a pendent member, resembling in this respect the arm, when the patient is erect, which it does as an ischiatic crutch, and (2) to apply traction to the distal member of the joint, which it does by its rack and pinion and adhesive plaster. Traction protects the joint from the traumatism of motion, muscular or otherwise, and the ischiatic support protects it from the traumatism of standing and walking, while the patient runs about and follows the ordinary pursuits of life for the months and years necessary to bring about a recovery with restoration of ability and symmetry, so far as may be.

I will close by briefly referring to two points of practical utility. The first is in regard to an early diagnosis, which is especially of great importance, inasmuch as there is reason to believe that if treatment can be begun sufficiently early the focus of osteitis in the cancellous tissue may be resolved before the other structures of the joint are involved. Reason for this belief is found in the fact that disease of the joints is comparatively rare in the upper extremity, where a focus, being in a pendent member, may undergo resolution, protected, as it is by the nature of the case, from the traumatism which assail the lower extremity in standing and walking.

Now, if the lower extremity can be made pendent, as can easily be done by the use of the hip splint, in the very incipiency of articular osteitis of the hip, before the articular contours are changed and before the circumarticular muscles are seriously involved, we may look for resolution of the osteitic focus and recovery without lameness or impairment of motion.

To assist in making an early diagnosis in a doubtful case a careful study should be made of those limitations in the motions of the joints which become apparent only when the extremes of normal motion are approached. This may be done in various ways. I have found two methods easy in practice and certain in their revelations. The first method applies to rotation, which is a