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NECROSIS OF THE FEMUR.

[Read before the Boston Society for Medical Improvement, Feb. 22d, 1864, and communicated for the Boston Medical and Surgical Journal.]

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MR. F., 28 years of age, applied to me in February, 1864, on account of a necrosis of the femur, for which he requested to have an amputation performed. When he was 15 years old, he received a shock in the limb by jumping from a wall, which was followed by severe inflammation ending in abscess, which opened at the lower and inner part of the thigh, just above the knee. In the course of a year, abscesses formed along the whole length of the limb, communicating with the bone, some in front and some on the outer side, as high as the trochanter major; through these apertures small bits of bone were occasionally discharged. In the course of the first year, while bearing some weight on the leg, the femur gave way in its lower third, but united again, with shortening of three or four inches, and with a decided bend outwards. During the last eight years he has suffered much at the original site of the disease, the inflammation extending to the knee-joint, which is now nearly stiff. During nearly half of this period of thirteen years he has been confined by successive attacks of inflammation, and he finally decided to submit to an operation by seeing that his future usefulness and comfort were likely to be altogether destroyed. A consultation was held upon the case at the Hospital, which resulted in the decision to remove the limb at the level of the highest fistulous opening, which was at the commencement of the upper third of the femur, and, in case the sequestrum should be found to extend higher, to attempt its forcible extraction by means of forceps, as I had before successfully accomplished in a similar case, where it was important to preserve as long a stump as possible. The exact amount of bone diseased could not be accurately determined, owing to the severe pain and protracted con-

stitutional disturbance which had several times followed the attempt to probe the lower openings in the popliteal region, and which was explained on dissection by the proximity of the sequestrum to the popliteal nerve.

The operation was performed Feb. 27th. A flap was first cut out on the front and outer side of the thigh, having its base at the upper aperture already described, which was placed rather on its inner aspect. An inner and posterior flap was then made, and the bone sawed off just above the point of junction of the flaps, which proved to be in the sound bone, three quarters of an inch above the upper extremity of the sequestrum. This was about four inches long, and lay loosely encased in a cavity in the back and lower portion of the femur, which was open for the most part, but was crossed at about the middle of its length by a bridge of new bone of about half an inch in breadth. The nerve, as above stated, lay directly on it. The sequestrum was so loose that it could have been entirely removed if it had been possible to reach it by any justifiable operation. The knee-joint had been partially disorganized by inflammation, two small surfaces, however, remaining on the condyles still covered by cartilage, each about half an inch in diameter, and corresponding to the articulating surfaces of the tibia, which were concerned in the slight motion remaining. On the curved portion of the bone, in front and opposite to the sequestrum, were marks of the very oblique fracture which had taken place during the first year of the disease. The specimen is now in the Warren Anatomical Museum.

In connection with this case, I have been led to the remark that I have seen very few cases of extensive necrosis of the femur which have been relieved by operation. The records of the Massachusetts General Hospital show the same fact. In one case, a young man, I removed half of the shaft, near its lower extremity, with perfect relief; in another case, of twenty years' duration, which was one of necrosis of the whole length of the shaft of the bone, the operation was followed by so long and exhausting suppuration as to compel the amputation of the limb just below the trochanters, to save the patient's life. Curious to relate, this man afterwards died of an extensive cancer of the stump. In the present case, even if the removal of the dead bone had been practicable, the patient would have been left with a deformed limb, three or four inches shorter than its fellow, and with little or no useful motion of the knee-joint.

It may be interesting to mention that in this case, as is usual where there has been much previous inflammation in the amputated limb, the hæmorrhage from the smaller vessels was very abundant.

The convalescence was slow, and interrupted by a series of abscesses in the stump. Although no exfoliation of bone took place, it was several months before the patient was well enough to return to his home in the country, but with his stump only partially healed. In October, 1864, I saw him in fine health and high spirits, his

stump entirely healed, and having gained thirty or forty pounds of flesh. This increase in weight, as is well known, is not unusual in persons who have submitted to amputation after having gone through with a long suppuration from a diseased limb.

BIRTH OF A CHILD THROUGH A LACERATED PERINÆUM. SPONTANEOUS RECOVERY.

[Communicated for the Boston Medical and Surgical Journal.]

On the 17th of September, 1864, I was called in, on my way to visit another patient, to attend a Mrs. W., who was in labor with her first child. The family were new-comers in the neighborhood, and, being strangers, the messenger despatched for a physician had failed to procure one in season. The pains were quite strong when I arrived, and had been for several hours. These subsided partially as I entered the room. On examination, I found the perinæum very much distended, and through the *thin* integuments I could trace completely the crown of the head. The vertex presented, as usual, externally, although the vulvæ were not as much distended as is customary at this stage of labor. The sphincter ani muscles were also quite lax, and presented a patulous opening to the rectum.

I have noted these conditions in detail, although at the time there was scarcely delay enough in the pains to prepare to support the perinæum, or assist the head in passing through the natural channel, before a strong pain came on, with a simultaneous giving way of the parts—commencing at the anterior border of the anus and extending nearly to the fourchette of the vagina; and through this fissure a child weighing about ten pounds was immediately expelled. The placenta very soon followed, through the same opening. The laceration took place at the first pain after I sat down to the patient, and the delivery was completed in ten minutes after I entered the room.

The mother and child were now cared for, as usual, and I left without informing any one of what had occurred, as nothing could then be done, and I wished to avoid any unnecessary anxiety on the part of the patient. I considered, too, that no particular treatment could be resorted to during the lochial discharge. In two days after, I directed the external application of cloths wet in warm water. These were continued, with injections of warm water, and warm soap and water to keep the parts cleansed. This was the main treatment. I saw the woman occasionally, until the 20th of January last, when the parts were healed, the fæcal and urinal discharges, which had before all passed through the same fissure, then following the natural passages.

The above case being of unusual occurrence, in country practice at least, and in Ramsbotham a lengthy note being made of a similar one, I send it to you for publication if you deem it worthy a place