

prolongation through this ligament round which I might throw a ligature; but, finding that this was not the case, and that I had practically isolated the entire growth, it was as easy to remove the whole as to leave a portion. On further consideration, it would seem to me the easier and the better practice to leave a portion whether it communicates with the joint or not. It would shorten in most cases the amount of dissection, and leave the patient more nearly in his natural condition. It is scarcely necessary at the present day, when surgical wounds do so well, to argue against other forms of radical treatment of these bursæ close to large joints. The injection of iodine, for example, is more likely, in my opinion, to produce a synovitis of the knee than an aseptic wound with a partial or complete removal of the bursa.

### TORBAY HOSPITAL.

#### A CASE OF FRACTURE OF THE CORONOID PROCESS OF THE ULNA.

(Under the care of Mr. G. Y. EALES, late house surgeon.)

THE number of authentic observations of this fracture which have been published is small, but there is no doubt of its occasional occurrence. A fracture of the process without some complication is very rare. In none of the cases in which the signs during life were thought to indicate it was any actual proof forthcoming that the supposed injury had been correctly diagnosed. There remains therefore some doubt as to what the exact signs which indicate a fracture of the coronoid process really are, and it is of importance to record those injuries to the elbow in which it is considered that the process has been broken. Dr. Lediard<sup>1</sup> records a case in which he performed excision of the elbow-joint in a man aged twenty-eight for a dislocation backwards of the forearm, with almost complete inability to produce flexion, pronation, or supination. Examination of the parts excised showed that a considerable piece had been broken off the coronoid process, the fractured surface having eroded and polished the posterior surface of the trochlea. The signs which were presented by the man when the injury occurred some time earlier are not recorded, as he had been under treatment by a "bonesetter." Mr. Holmes was of opinion that the fragment removed at the operation had been still attached to the brachialis anticus; it is possible that this condition was present in Mr. Eales's patient. Few have been unaccompanied by "partial or complete displacement of the ulna, or of the radius and ulna backwards, accompanied with the usual signs of these luxations,"<sup>2</sup> and what has been considered most diagnostic, a remarkable tendency to redislocation when extension of the forearm has been discontinued. Fracture of the tip of the process is not attended with displacement, but if nearer the base the muscle would most likely draw the separated fragment upwards, and permit of its being felt. Other examples of this injury have been published in our columns, notably those described by Mr. Pennock<sup>3</sup> and Mr. J. Scott Battams.<sup>4</sup> There is also one described during recent years by Mr. Mitchell.<sup>5</sup>

About a year ago a labourer, R. T—, aged thirty-two, came to the out-patient department of the Torbay Hospital one morning and stated that the previous evening, while walking in the dark, he tripped over an object in the road and put out his right arm to save himself, thus falling with the whole weight of his body on to his right hand, his forearm being at the time fully extended. He felt something crack, as he described it, in the elbow-joint, and on flexing his forearm experienced considerable pain, together with a grating sensation in the joint.

On examination fourteen hours after the accident the following points were observed:—1. Some amount of effusion in the elbow-joint. 2. Tenderness on pressure in the bend of the elbow. 3. Inability to flex the forearm completely owing to pain. 4. Distinct bony crepitus on passive flexion of the forearm. 5. The crepitus occurring when the arm was more than half flexed. 6. On placing a finger at the bend of the elbow the crepitus seemed to be apparently immediately underneath. Careful examination showed that the lower end of the humerus and head of the radius were uninjured, while pronation

and supination of the latter bone caused no discomfort. Considering this to be an unusually interesting case it was shown to the surgical staff, who agreed with Mr. Eales that the only reasonable diagnosis was that of fracture of the coronoid process of the ulna. The arm was put up and retained in the flexed position for nearly three weeks without any apparent benefit, when the patient passed from observation, probably dissatisfied with the slow progress which was being made and to seek advice elsewhere.

*Remarks by Mr. EALES.*—The noteworthy features of this case were (1) the difficulty of retaining the fractured ends of the bone in apposition, (2) its being uncomplicated with dislocation of the forearm backwards, and (3) the fact that the head of the radius was uninjured. Bryant quotes a case in which this lesion coexisted with fracture of the head of the radius; and Holmes states in his "System of Surgery" that this injury has been said to occur in connexion with dislocation of the radius and ulna backwards; or that it may occur without any complication. There appears to be very little known about this injury, but the weight of evidence seems to show that it rarely occurs without one or other of the above-mentioned complications, and that when the radius is involved its head is usually split longitudinally. In this case there was no reason to suppose that the forearm had been dislocated backwards and had become reduced before the patient came under observation, as he distinctly stated that after the accident he could more than semiflex the forearm, and could do so completely with the passive aid of his left hand. I feel constrained, therefore, to quote this case as one of pure and simple fracture of the coronoid process of the ulna, and imagine that the force of the fall was in some unaccountable way transferred principally to the head of the ulna, and perhaps insufficient to produce any lesion to that of the radius. The treatment of this case also seems to bear out the saying of Mr. Holmes, that union is usually ligamentous, owing to the inability to bring the fragments of bone in apposition and retain them so.

## Medical Societies.

### ROYAL MEDICAL & CHIRURGICAL SOCIETY.

#### *Mechanism of Suspension in Locomotor Ataxy.—Strangulated Cecal Hernia.*

AN ordinary meeting of this Society was held on Jan. 28th, the President, Sir Edward Sieveking, in the chair.

A discussion took place on the paper read at the last meeting by Dr. JAMES CAGNEY, on the Mechanism of Suspension in Locomotor Ataxy.—Dr. GEORGE OGILVIE said that the author had shown conclusively that suspension produced relaxation of the spinal cord in the dorsal region. He had had considerable experience of this method of treatment; in many cases in which morphine had been used for several years for violent pain, the latter had been entirely cured by the suspension and the morphine abandoned. If a result such as this could be obtained by the treatment a great gain was made. He saw no advantage, but a certain amount of danger, from suspension by the neck, and was glad to see it condemned on scientific grounds.—Dr. LITTLE could not agree with the dicta laid down that suspension by the head was dangerous, and that suspension under the arms answered all purposes. Suspension by the head was not dangerous if properly conducted according to Charcot's directions, two-thirds of the weight of the body being borne by the arms, and one-third by the chin and occiput. The suspension by the head should be commenced by degrees, and Dr. De Watteville's instrument allowed this to be done gradually. If locomotor ataxy were a disease attacking the nervous system, not only in the dorsal spinal region, but also in parts higher up, suspension by the arms alone could scarcely accomplish all that was expected of it.—Mr. ROUGHTON asked on what ground the statement had been made that suspension produced a real lengthening of the cord. He was glad to hear that suspension by the head was condemned, for from personal experience he could say that the immediate results were most unpleasant.—Dr. CAGNEY, in reply, said that if the cord was benefited by relaxation in the dorsal region, the probability was that a similar lesion would not be benefited by stretching in the

<sup>1</sup> THE LANCET vol. i 1884, p. 799.

<sup>2</sup> Hamilton, Fractures and Dislocations, p. 365.

<sup>3</sup> THE LANCET, 1828. <sup>4</sup> Ibid., vol. ii. 1878, p. 207.

<sup>5</sup> Brit. Med. Jour., vol. ii. 1884, p. 1073.