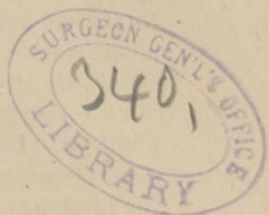


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The therapeutic and
operative treatment of hip-
disease ~~~~~





THE
THERAPEUTIC AND OPERATIVE
TREATMENT OF HIP DISEASE.

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In this Journal, for December, 1884, the writer discussed the Mechanical Treatment of Hip Disease. The conclusion arrived at being, that, of all apparatuses, the one invented and used by Mr. Thomas, of Liverpool, was best adapted to meet the indications for treatment and the theory of its use was in accordance with physiological investigations. The cases upon which this and the preceding article are based, were about sixty in number and were under observation in 1880 and '81, being under competent supervision. In these cases all the leading types of apparatus were employed, and, as far as was possible, in accordance with the views of the inventor. The conclusion that seemed to be the only one possible, after careful comparison of results, is the one given above. There yet remains, to complete the sub-

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ject, the two divisions of treatment indicated in the title of this article.

In the minds of many practitioners, apparently, the terms therapeutic and expectant treatment are very similar. Yet, in fact, this is by no means the case. The writer has seen cases in which good results were obtained with continuous rest in bed with simple drug treatment, even, indeed, where the history of the case left no reasonable doubt but that the bone had been thoroughly involved. In fact this plan, by some termed expectant, seems far preferable to any in which apparatus, permitting motion at the hip joint, is used. But the term expectant has a wider signification, in that the attendant is supposed to meet new conditions as they arise, indeed circumstances might even render it necessary for him to perform the operation of excision. Taking the term in its broadest sense one can understand it to mean the rational treatment of the disease in question. But there is, after all, a purely drug treatment that deserves attention. In placing the patient under the best possible hygienic conditions, much good can be accomplished and, indeed, to this cause alone may be attributed much of the success attained in hospitals. Of the articles in the *Materia Medica*, cod-liver oil holds by far the first rank and is the sheet anchor of treatment, next, the syrup of the iodide of iron has its reputation based on clinical experience, no matter what views we may entertain in regard to the relation of hip disease to scrofula. To add another preparation to the list, the bichloride of mercury, as it is usually administered with the compound tincture of cinchona, has an apparently well grounded reputation. Relief of pain is important, which can usually be adduced by fixation, so that opiates are seldom necessary. Counter-irritation, although but few physiological facts seem to warrant its employment, has always been a resource frequently employed. The more violent forms, as friction with liniments, issues, setons and the actual cautery, about which so much is contained in the earlier literature, increased observation has justly placed among the obsolete practices. But in the early exacerbations, blisters, and at other times counter-irritation produced by the strong tincture of iodine, have held their place and seems, from the clinical point of view, to be useful.

Among the operative procedures the treatment of abscesses has always received much attention. In the past, many and varied opinions have prevailed. All methods will fall into more

or less deserved disrepute unless it is always considered that before any treatment is instituted the joint must be absolutely fixed. Thorough examination of old recovered cases of hip joint disease will usually show extensive and often multiple scarring from abscesses, in fact some high authorities contend that better joints, and less pain and tenderness, are found where the suppuration has been great and the abscess left without particular treatment. This opinion seems to be based upon the former disinclination to interfere with cold abscesses. However, of late better results are claimed from antiseptic aspiration or if the pus be too curdy, free incision, careful removal of all pus secreting surfaces. If this is done with thorough cleanliness and perfect fixation, certainly one element of danger, to the life of the patient, is removed. The dressings should be those always remaining porous.

Anchylolysis in an unfavorable position, where the treatment has been fixation, can hardly occur but, in such a case, if it be fibrous, the proper position can be obtained by fitting the Thomas splint and gradually reducing the deformity. ~~En~~otomy or myotomy may be, in rare cases, necessary. In bony anchylolysis we have the choice of several operations, for each particular case, the best will be that one which permits section to be made nearest to the joint. If possible it should be made above the insertion of the psoas and iliacus muscles. No one is credulous enough to believe that a fully equipped artificial joint will ever be produced by surgery.

Excision of the hip joint is an operation in which those who have been unfortunate in receiving badly treated cases and those whose methods have been faulty, have had the largest experience. This operation is far too formidable and produces results hardly satisfactory enough to be considered in the early stage of the disease. Drilling of the head of the femur can never be substituted for it, as the seat of the disease is by no means always in the head of the femur or even accessible in that method. Excision is indicated when all other forms of treatment have failed and the disease is rapidly exhausting the patient; since in this way the surgeon may extend to him every possible chance for life. Yet extensive statistics show that about thirty *per cent.* of cases in which this operation has been performed, die from exhaustion, while of those that survive about thirty-five *per cent.* obtain useful limbs. Usually, however, the cure without operation affords better chances for limbs sufficiently strong for sup-

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port. How much shortening will result can never be determined, for of the published cases, many have been found in after years where it was far in excess of the amount stated in the tables. Unfortunately the number of cases operated upon has been very large, so that the best method of operating is now well understood. The curved incision, posterior to the greater trochanter, the periosteum being, so far as is possible, saved, all diseased products removed, thorough fixation and cleanliness in after-care are all that need be insisted upon.

Amputation may be considered, when excision has failed to arrest lardaceous disease, or if there be such shortening and deformity, or such extensive necrosis of the femur that excision, if performed, would result in an entirely useless limb.

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