

September 20, 1929.—Dr. J. P. Martin reported that the signs indicated interference with conduction at the first lumbar segment and also disturbance of the left side at the level of L5 and S1. Dr. Martin suggested that there might be a vertebral abscess secondary to tuberculosis of the spine.

September 25, 1929.—X-ray examination: Some irregularity of bodies of vertebræ D9 and L1, but no collapse or loss of substance.

October 3, 1929.—Incontinence gone. November 12, 1929.—Suspension treatment begun. December 29, 1929.—Smarting sensation in right leg. January 8, 1930.—Voluntary movement of toes. March 8, 1930.—Can now take five periods of suspension a day, each lasting an hour and a half. April 23, 1930.—Walking. Plantar sensations normal. Power in right leg increasing.

Discussion.—Mr. R. C. ELMSLIE said that he had seen six cases of paraplegia, with scoliosis. One, which he brought before the Section several years ago, was in a boy, who had severe dorsal scoliosis and complete motor and sensory paraplegia up to the level of the fifth or sixth dorsal segment. Lipiodol was injected, and was blocked above and below the level of the lesion. He (the speaker) performed laminectomy, and inspected the whole interior of the canal and saw the backs of the bodies of the vertebræ, but could not find any sign of disease or abscess, or of pressure on the cord. The cord, however, was under great tension. It was a feasible suggestion that the paraplegia, associated with scoliosis, was due to interference with the blood-supply. One of the other cases was a congenital scoliosis with wedge-shaped vertebræ in a patient whom he had first seen in St. Bartholomew's Hospital some years before. He saw him again when he was in the National Hospital, Queen Square, under the care of Dr. Collier, and he then had paraplegia. He (Mr. Elmslie) had treated four cases by suspension for as long periods each day as they could stand. The first case had begun with complete paraplegia; there was no voluntary movement, and there was complete anæsthesia to level of the fifth dorsal nerve. There was considerable improvement; the anæsthesia all disappeared and some voluntary movement became possible. At the end of a year the patient was walking about with a spastic gait.

His (the speaker's) only suggestion with regard to Mr. Todd's first case was to continue the suspension treatment.

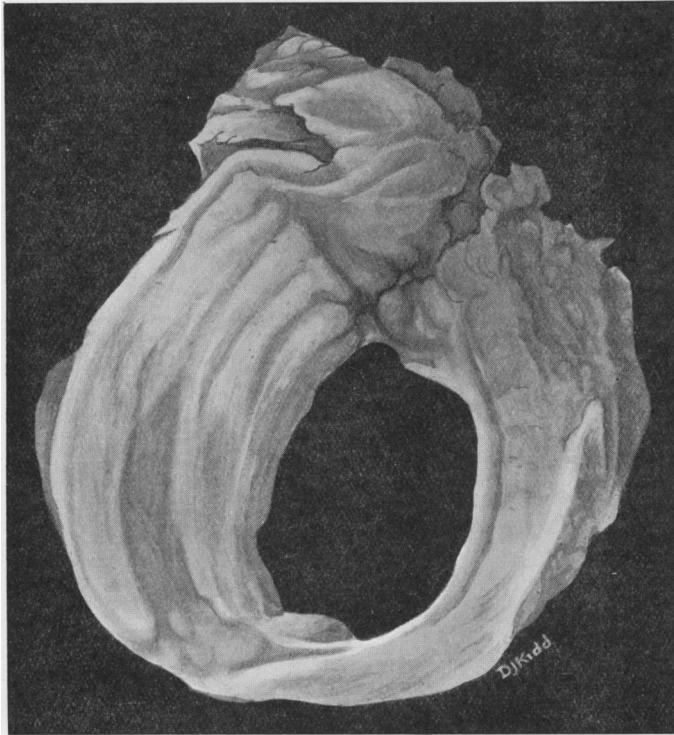
The second case was difficult to explain. The scoliosis was too low down to be a cause of paraplegia; in the cases which he had seen, the scoliosis was well up in the dorsal region. The skiagrams of the spine in this case were puzzling.

Mr. G. R. GIRDLESTONE said that he gathered that the girl did not bear suspension very well. Continuous head and limb traction could be carried out by tilting up the bed and allowing gravity to do most of the work, putting 5, 3 or 2 lb. weight on the head. That method was less severe than suspension.

The PRESIDENT said he, like Mr. Elmslie, considered that non-tuberculous scolioses were more often associated with high dorsal scoliosis. He had no experience of intermittent suspension; he put these patients on an Abbot's frame, with an improved twisted jacket used as a pad. He found that these cases did not do well afterwards, as it was difficult to support the back above the sharp angle. He agreed with Mr. Elmslie that the pressure of the back of the body was the worst factor in the pressure on the cord; hence removal of laminæ did not always give relief, and straightening out of the spinal column—if that was possible—did.

Specimen of Internal Semilunar Cartilage as a Complete Disc.— R. WATSON JONES, F.R.C.S.

A man, aged 34, for several years had noticed a clicking on the inner side of his knee. There was no clear history of injury, except a few minor strains. There was elastic resistance to the terminal 10° of extension, and the joint made a click on manipulation. The cartilage was easily removed. Is this a simple bucket-handle tear of the cartilage, sustained at some unknown period of the patient's history, which has become rounded in the course of years and hypertrophied, or is it a



Internal semilunar cartilage in the form of a complete disc. The ridge near the anterior horn is due to clamp used in removal.

congenital anomaly, a reversion to the type of cartilage which is constant in the chimpanzee? In all the three analogous cases which I have seen, it was the external cartilage which was involved, and the cartilage was a disc, not a circle with a central perforation.

Mr. R. C. ELMSLIE suggested that this was a case of old injury to the cartilage, split round the margin, which had been displaced inwards and had undergone secondary changes. In the disc cartilages which he had seen in the external cartilage, the part which came to the centre of the joint was thin and translucent.

Pathological Dislocation of the Hip-joint.—R. WATSON JONES, F.R.C.S.

Patient, a girl, aged 3 years, had a six weeks' history of pyæmic multiple arthritis of both elbows, wrists and hip-joint. Both hips were flexed and adducted, and one of them was dislocated on to the dorsum ilii and the epiphysis was displaced off the neck of the femur (fig. 1, p. 70). Whilst this hip was being manipulated under anæsthesia the other hip dislocated. Both dislocations were reduced and the hips brought into position and two plasters were applied. In the skiagram taken a week or two after coming out of the plaster, the head and neck of the right femur had completely disappeared. Now, twelve months later, the child is walking with a leather spica and both hips are freely movable (fig. 2). On the right side, despite destruction of the head and neck, there is free articulation with the acetabulum.

In these cases of destructive arthritis in infancy, it is still possible to keep a stable hip if it is reduced early, and to avoid the femur riding up on the dorsum ilii.