

the pericardium was regarded. He thought paracentesis of the pericardium was not more dangerous in itself than the puncture of any other serous cavity, so long as there was no mistake in the diagnosis, but this difficulty in diagnosis was the reason why practitioners usually approached the operation with some degree of fear. It had fallen to his lot to tap the pericardium in two cases, in neither of which had any unpleasant symptom occurred during or after the operation which might be ascribed to it. Death resulted in both from different causes, but in neither was the fatal issue hastened by the operation. In one case the wall of the ventricle was pricked, but apparently without any harm. Aspiration in cases of hydrothorax (from cardiac disease) did not receive in the special text-books on heart disease the prominence it deserved. He had had many opportunities of judging of its value, and he gave the proceeding his unqualified adhesion, and hoped that Professor Stewart's communication would lead to its adoption by many who did not at present practise it.

Professor Grainger Stewart thanked the Society for its very kind reception of his paper. He had also to thank Dr Claud Wilson for the care he had taken in preparing the notes of the case of pericarditis, and for the pulse tracings which he had taken. He disclaimed anything novel with regard to aspiration in hydrothorax, but as he found the practice was not so common as it should be, he had ventured to bring it before the Society. He valued very much Dr Affleck's and Dr Bramwell's remarks. He thought he was not sufficiently clear on the second rule. He wanted to say that if there was a copious effusion he should tap, but if there was a considerable effusion, not in itself sufficient to cause danger, but if attended with a fading pulse, which he supposed was due to myocarditis, then he should think it his duty to try paracentesis. Given such an indication for tapping (which he had in this case, for he thought there was myocarditis present in it), he should be particularly careful not to draw off too considerable a quantity, because the muscular fibre of the heart might be too weak to admit of this. As to the point of puncture, he agreed with Dr Haddon, but preferred to go outside the nipple line, further away from the heart muscle so as not to injure it.

2. AN OPERATION FOR DISPLACED SEMILUNAR CARTILAGE. ✓

By THOMAS ANNANDALE, F.R.C.S. Ed., F.R.S.E., Regius Professor of Clinical Surgery, University of Edinburgh.

THE pathology of the condition called by that wise old surgeon Hey, of Leeds, "internal derangement of the knee-joint;" by Sir Astley Cooper, "partial luxation of the thigh-bone from the semilunar cartilages," and which is now by some authors termed

dislocation or displacement of the semilunar cartilages, has not yet been thoroughly worked out, as few opportunities occur for the dissection of a joint so affected. It is, however, a clinical fact that one of the semilunar cartilages, usually the internal one, does occasionally become loosened from its attachments; and, in consequence, this body is liable to be displaced either forwards or backwards, and so to interfere with the proper movements of the knee-joint.

Two classes of this displacement are met with: one in which the condition takes place suddenly, as a result of a twist or wrench of the knee; and the other in which the displacement is not so sudden, but appears to depend upon a gradual stretching of the attachments of the cartilage, owing to some effusion into the joints, or owing to some continued strain upon the joint, as is illustrated in connexion with certain occupations.

When the displacement has once occurred in either case, it is liable to occur again; but from my experience, I judge that in cases, the result of a sudden rupture of the ligamentous attachments, which are promptly and carefully treated, the displacement is less likely to recur than in the more chronic ones.

If the condition be not permanently relieved, the displacement of the cartilage takes place more or less frequently in different cases; and sometimes in connexion with the slightest movements of the joint.

The symptoms of this accident, as is well known, also vary in degree in different cases. The movements of the joints may be merely stiffened in one direction, or the joint itself may be firmly locked, and remain so until manipulation returns the displaced cartilage. Two patients have come to me from considerable distances suffering from this condition, and in both the knee-joint had been firmly locked in a flexed position for many hours. Manipulation easily replaced the cartilage, and the movements of the joint were at once re-established.

In all cases of this affection, some effusion into the joint follows the displacement.

The ordinary treatment of a displaced semilunar cartilage is to reduce it by flexion, extension, and manipulation; to apply a splint or elastic bandage, in order to keep the joint at rest, and prevent the displacement from recurring; and, if effusion be present, to employ the usual remedies to promote its absorption. When the accident is recent, I would strongly urge the importance of keeping the affected joint absolutely at rest for two or three weeks, so as to promote the union of the ruptured attachments.

This affection may become so troublesome, owing to the constant recurrence of the displacement, that a patient's occupation and comfort are seriously interfered with; and I relate the following example of such a condition in order to illustrate a new method of procedure which I successfully adopted in connexion with it.

The excellent result obtained in this case encourages me to express the opinion that this, or some similar proceeding, may now become an established means of treatment, when the more simple methods fail to give relief, and to obtain for the patient an useful limb.

CASE.—Thomas M., aged 30, miner, was sent to me from the north of England, on November 1st, 1883, with the following history. About ten months before his admission, he was working in a kneeling position, when he felt something give way in his right knee. He suffered sharp pain, but continued at his work for a few hours. Great swelling of the joint followed, and the pain became much aggravated, so that he could not return to his work, and he had not since worked at his occupation. The condition was treated by rest, blistering, the application of iodine, and various liniments, with the result of reducing the swelling; but the pain still continued, and the movements of the joint were interfered with by something "slipping" in the knee.

On admission, the joint was slightly swollen, and there was a small amount of effusion into its cavity. The patient complained of acute pain in certain movements of the joint, which frequently became locked in the flexed position. He was able, by a little manipulation, to unlock the joint, but the frequency of this symptom made him quite unfit to follow his employment as a miner. On careful examination of the joint, there was a well-marked hollow over the anterior border and position of the internal semilunar cartilage. This hollow was most marked when the knee was flexed. Having decided that the case was one of displaced semilunar cartilage, and one not likely to be cured by any ordinary treatment, I, on November 16th, performed this operation. An incision was made along the upper and inner border of the tibia, parallel with the anterior margin of the internal semilunar cartilage; and, the few superficial vessels having been secured, the joint was opened. It was then seen that this semilunar cartilage was completely separated from its anterior attachments, and was displaced backwards about half an inch. The anterior edge of this cartilage was now seized by a pair of artery catch forceps, and it was drawn forwards into its natural position, and held there until three stitches of chromic catgut were passed through it and through the fascia and periosteum covering the margin of the tibia. The forceps were then withdrawn, the cartilage remaining securely stitched in position. The wound in the synovial membrane and soft textures having been closed with catgut stitches, a splint and plaster-of-Paris bandage were applied, so as to keep the joint at rest. The progress of the patient, after the operation, was perfect, the temperature never rising above 99° Fahr. Seven weeks after the operation, the splint and bandages were removed, and gentle movements of the joint practised.

On January 25th, 1884, the patient was dismissed cured, the

movements of the joint being good, and the limb steadily gaining strength. In April of the same year the patient returned to show the result. He was then seen and examined by many of our distinguished guests at the tercentenary, who all expressed the opinion that the result was everything that could be desired. He had perfect movement in the joint, and had never had the slightest stiffness or locking of the joint since he commenced to go about after the operation.

Meeting V.—March 4, 1885.

Dr H. D. LITTLEJOHN, *President, in the Chair.*

I. ELECTION OF ORDINARY MEMBERS.

The following gentlemen were elected Ordinary Members of the Society:—Allan Thomson Sloan, M.B., C.M.; John William Ballantyne, M.B., C.M.

II. EXHIBITION OF PATIENTS.

1. *Dr J. M. Cotterill* showed a CASE OF TALIPES EQUINO-VARUS CURED BY OSTEOTOMY. The patient, a young woman, suffered so much pain from the deformity that she was unable to follow her occupation. The sole of foot could not be put to the ground, and the tendo Achillis was very much contracted. The tibialis anticus and posticus tendons, the plantar fascia and the tendon of the adductor pollicis were first divided, and splints were put on to bring the foot into the same straight line with the leg, but no attempt was made to bend it at the ankle. A fortnight later the cuboid and external cuneiform bones were removed, along with the thickened bursa lying over the cuboid, and the tendo Achillis was divided. This allowed the foot to be brought into very fair position. The subsequent treatment, consisting in the application of the weight and pulley, effected a complete cure. The pressure made in this way was lighter than it would have been by splints and bandage, and the traction more efficient. This was a mode of treatment which had not received the attention it deserved. It could not be applied so easily in the cases of young children as in the adult, but it might be more often tried than it was. The patient could wear an ordinary boot and walk any moderate distance without trouble.

2. *Dr C. W. MacGillivray* showed a case on whom he had operated for TALIPES EQUINO-VARUS OF THE LEFT FOOT. The patient, a boy æt. 6, had come under his care about six months previously.