TRANSACTIONS

OF THE

PHILADELPHIA ACADEMY OF SURGERY

Stated Meeting Held January 5, 1925

The President, Dr. Edward B. Hodge, in the Chair

BILATERAL CONGENITAL EXTERNAL DISLOCATION OF PATELLA

Dr. B. Franklin Busby presented a girl, ten years of age, in whom from her first efforts at walking it had been noticed that frequently her knees would give way and she would fall forward. This condition of affairs continued until six months ago, when the child began to get fat, when the

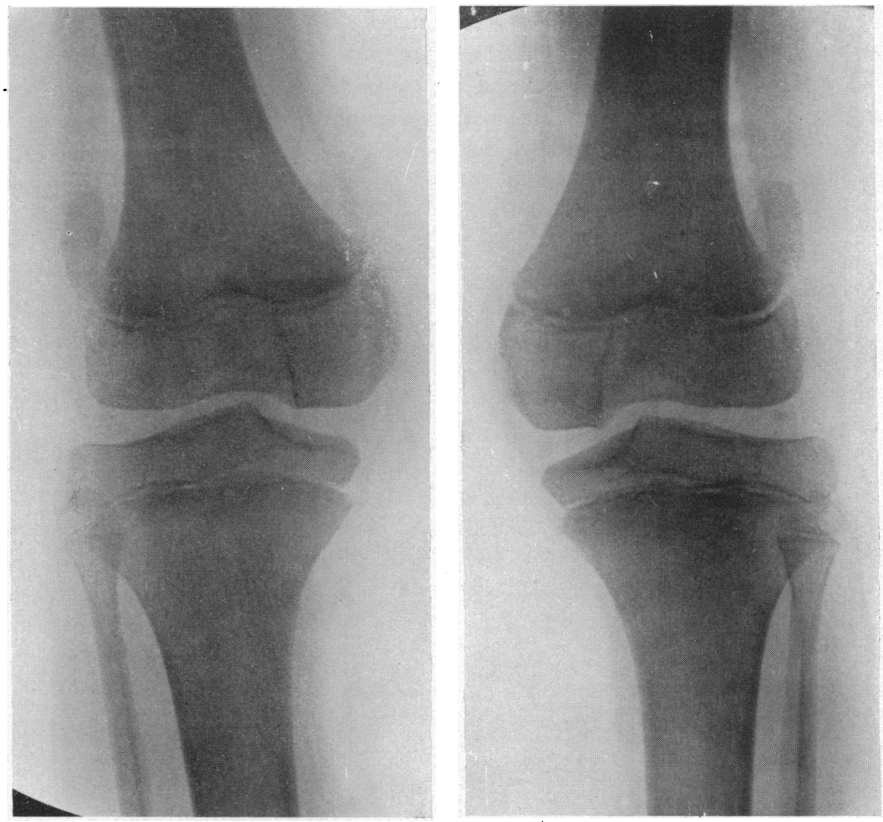

Fig. 1.—Bilateral congenital external dislocation of patella.

falls became much more frequent. For the past month the child had to be supported when walking, otherwise she would be unable to walk at all because of the collapse forward of both knees. The child was short and fat. Her general physical examination revealed nothing worthy of note except in the lower extremities. She had bilateral knock-knee of 25° on each side,

which on flexion appeared greater. She had bilateral flat feet of moderate degree. There was apparently full power in the quadriceps extensor and all other thigh muscles, but she was unable actively to extend either knee against gravity beyond 135°. Passive extension of the right knee was full, but the left could not be extended beyond 160°. Active and passive flexion was normal. When standing the knees were slightly flexed and one knee would be propped against the other for support.

The patellæ were small, about the size of a quarter dollar, and were palpable on the lateral side of each knee (Fig. 1), and in the sagittal rather than the coronal plane of the body. They were about 2 cm. above the normal position in relation to the femoral condyles. The patellar and quadriceps tendons were of normal size apparently, and the former inserted normally into the tibial spines. The femoral intercondylar notch was visible and palpable with the knee flexed. Manually the patellæ could be held nearly in the midline of the knee, but were above the normal position with relation to the femoral condyles.

May 12, 1924, under gas and ether anæsthesia, the following procedure was carried out on the left side: Under tourniquet hæmostasis a longitudinal incision was made over the middle of the knee and lower half of the thigh. The patella, quadriceps tendon and patellar tendon were mobilized. A strip of fascia lata 10 cm. long and 2.5 cm. wide was removed and folded longitudinally. This was laced subperiosteally through transverse slits, four in number, on the anterior surface of the patella and the upper inner aspect of the tibia, after the method described by Soutter in the *Journal of the A. M. A.*, in April, 1924. A supracondylar osteotomy was then done through the same incision and the knock-knee was overcorrected, and at the same time the lower fragment of the femur was rotated so that the external condyle was rendered more prominent and the patient's toes pointed inward about 45°. The fascial transplant was then made taut, which brought the patella almost in the midline of the knee. The transplant was then sutured at both insertions and lapped and resutured. The defect in the fascia was obliterated, the skin wound closed without drainage, and a plaster case applied.

Two weeks later, May 26, 1924, the same procedure was carried out on the right leg. However, at the site of the application of the tourniquet on this side a hæmatoma developed which became infected a week after operation. This as well as the upper 7 cm. of the wound was opened and a large amount of sanguino-purulent material was evacuated. Drainage was inserted and Dakin treatment instituted. The infection cleared up within two weeks and fortunately the process did not extend to nor involve the structures about the knee.

New cases were applied July 3, 1924. The wounds were in good condition and union was firm in the femora. The patellæ were on the anterior surface of the knees but slightly external and above the normal position. Considerable atrophy of both quadriceps muscles was present at this time.

New cases were applied August 20, 1924, and the patient was instructed to walk in these cases with the aid of crutches, which she did very well. Both cases were removed September 17, 1924, after which walking was continued with crutches and physiotherapy begun. X-ray at this time shows firm union of the femora with the patellæ displaced upward and slightly laterally.

On October 15, 1924, full flexion of both knees was present and painless and the patient could extend, and hold fully extended, the right leg against gravity but not the left one. She could walk well without crutch support but with moderate intoeing.

Within the past month the left knee has slightly collapsed on three occasions and at the present time passive extension is possible, on the left side, to only 165° and a lateral view X-ray taken on December 17, 1924, shows an exaggerated forward convexity of the lower femur. This deformity he proposed to correct later by a supracondylar osteotomy, after which he hoped that the tendency to collapse of this knee will be overcome. At the present time the intoeing which resulted from the rotation of the lower fragments of the femora has practically disappeared and the child gets around in comfort and without falling.

The mother says that the father of this child had the same kind of deformity of the knees and the same weakness, but that he never had any attempt made to relieve the condition.

DR. HUBLEY R. OWEN mentioned a case operated upon by him at the Orthopædic Hospital some years ago. The difference was that this case was not one of habitual dislocation as was Doctor Busby's, but was a recurring dislocation which could be reduced. He did not do an extensive operation but simply fastened half of the ligamentum patellæ to the tibia. His patient was seen one year ago when the result was still good.

RELATIVE USES OF CHOLECYSTECTOMY AND CHOLECYSTOSTOMY

DR. JOHN B. DEAVER read a paper with the above title, for which see page 761.

DR. JOSHUA E. SWEET said that he believed he was responsible for the statement which Doctor Deaver quoted only in part in his paper, *i.e.*, that whatever under normal conditions goes into the gall-bladder through the cystic duct never passes out through the cystic duct; he was still of that opinion. Otherwise he agreed with what Doctor Deaver has said. It seemed to him that there is no question but that the removal of the infected focus is indicated. The only problem existing now is not cholecystectomy *vs.* cholecystostomy, but how is the surgeon to recognize whether the physician has waited too long so that when the patient comes to the surgeon he is suffering from a condition Doctor Deaver has termed as "what not?"

DR. A. P. C. ASHHURST said that in one matter he did not agree with Doctor Deaver, a matter in which he seems to be scarcely consistent. The speaker much preferred the operation of cholecysto-gastrostomy to that of cholecysto-duodenostomy, because it is much easier to do and therefore much safer. Moreover, it gives quite as good results. Doctor Deaver's objection to it is that the Almighty made the duodenum and not the stomach the natural drainage place of the bile. Yet it is well known that for many years Doctor Deaver preferred gastrojejunostomy to Finney's method of pyloroplasty. Has he utterly and permanently abandoned the former operation?

DR. JOHN H. JOPSON said that in going over his own statistics for the last few years, he finds that he is leaving unremoved an exceedingly small percentage of gall-bladders. He believed also that statistics from the various clinics all over the world show that the number of cases of recurrence of symptoms after cholecystostomy is much greater than after cholecystectomy.

The last series he went over was the report from the Johns Hopkins Hospital which showed that the recurrence of symptoms was found oftener in cases of drainage than after cholecystectomy. If the surgeon can satisfy himself that his own case mortality is not increased by cholecystectomy, then he believed he will be doing best by the patient in the long run to remove the gall-bladder.

As to internal drainage of which he spoke, as far as any function of the gall-bladder as an absorbing or concentrating organ is concerned, it is done away with by the establishment of a large stoma between it and the gastro-intestinal tract.

As to the injury of the common duct, it seems that everybody has it happen occasionally—even the most expert. In a case operated upon recently in which a stricture of the common duct followed accidental wounding of the duct during cholecystectomy at the hands of another surgeon, he practised the method of anastomosis recommended by Doctor McArthur and the result promises to be satisfactory. He believed that in most of these cases McArthur's method is the best.

DR. CHARLES NASSAU did not know how a condition which is suitable for internal drainage can be diagnosed accurately. One would have to be on his guard, for instance, not to make an internal drainage in a primary carcinoma of the gall-bladder. He remembered a case in which he removed the gall-bladder for an apparently mild gall-stone condition, where the laboratory report showed a primary carcinoma of the gall-bladder. The patient recovered from the operation, but two years later she began to die of cancer. Recently he had a second case in which there was not the slightest suspicion of anything but a cholecystitis where the laboratory showed carcinoma of the gall-bladder. Whether this patient is going to escape a recurrence is problematical. He had had no experience with so-called internal drainage cases except in malignant disease which involved the common duct. In malignant obstruction of the terminal portion of the common duct, the last months of the patient's life can be rendered so comfortable by a cholecystoduodenostomy that the risk is more than justified. In the cases where the patient is badly jaundiced, the mortality will be higher than it is in ordinary gall-bladder surgery. A cholecystectomy is the operation of choice except in those patients who suffer from a very acute empyema of the gall-bladder, where the walls of the gall-bladder are very thick, friable and hemorrhagic; these gall-bladders should never be removed at first operation. It is far better to do a second operation on these patients and have them live than expose them to unjustifiable risk by doing a cholecystectomy.

DR. HARRY C. DEAVER said that in long-standing gall-bladder disease, with disturbed liver function, it has been his rule not to operate too soon after the patient enters the hospital, for in advanced gall-bladder disease the liver, kidneys and myocardium suffer as well. Pre-operative treatment is most essential, which means rest in bed, a mild diet, with plenty of water.

In the border-line cases, it is a difficult question sometimes to decide

whether to remove or drain the gall-bladder. In his opinion, one must rely upon the clinical symptoms, especially where they overshadow the condition of the gall-bladder. Under these conditions he always removes the gall-bladder. In his own cases he has had fewer recurrences of diseases of the biliary tract after cholecystectomy than after cholecystostomy.

ENTERO-MESENTERIC CYSTS

DR. THOMAS A. SHALLOW read a paper with the above title, for which see page 795.

DR. HARRY C. DEAVER said that he reported a case of mesenteric cyst in 1902. This is the only case he had ever seen. It sprang from the wall of the small intestine and extended between the layers of the mesentery. It was diagnosed as a case of intestinal obstruction. The patient was ill only a few hours. He operated immediately before any damage was done to the bowel, doing a resection and an end-to-end anastomosis, with recovery of the patient. These cases are extremely rare and their symptoms usually point to some form of obstruction.

KIENBÖCH'S DISEASE OF THE SEMILUNAR BONE

DR. RALPH GOLDSMITH (by invitation) reported three cases of this condition, illustrated by lantern slides. For his remarks in this presentation, see page 857.