Clinical and other Notes

CASE OF COMPOUND FRACTURE AND DISLOCATION OF ELBOW-JOINT.

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Boy S., aged 17, Royal Garrison Artillery, was admitted to the Royal Herbert Hospital, on September 5th, 1907, suffering from a severe injury to his elbow, caused by a fall in the gymnasium.

On removing the temporary dressings that had been applied, the whole of the articular surface of the lower end of the humerus was found to be protruding through a longitudinal wound on the inner side of the joint, the brachial artery was laid bare, as was also the ulnar nerve, to which was attached the internal condyle which had been separated intact. The external condyle had also been detached and was splintered.

FIG. 1.
To illustrate "Case of Compound Fracture and Dislocation of Elbow Joint."

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radius and ulna were dislocated forwards and pushed up on to the anterior surface of the humerus by the flexors of the forearm.

The wound was first thoroughly irrigated with a solution of hydrarg. perchlor. 1 in 3,000 and subsequently with hot normal saline, the dislocation was reduced, and the internal condyle was fixed in position with a small steel screw. Nothing could be done with the splintered external condyle. A sterilised gauze drain was introduced and the wound was stitched up with interrupted sutures, and covered with sterilised gauze. The limb was finally put up on an internal angular splint.

The wound was not touched for forty-eight hours, when the splint was taken off and the gauze plug removed. The wound looked far better than

Fig. 2.

one could have hoped for. No further drain was introduced, sterilised dressings and the splint were reapplied, and as the patient had neither pain nor rise of temperature, the arm was left alone until the fourteenth day. On removing the splint and dressings at the end of a fortnight the wound was found to have healed by primary union. Gentle massage and passive movement were commenced forthwith and continued daily by myself; the amount of movement was gradually increased as time went on and special exercises against resistance were given for the flexors and extension of the forearm and upper arm.

The accompanying photographs of the patient show the range of movement on November 1st, 1907, the day before he was discharged to sick furlough, and the X-ray photograph, showing the screw in situ, was also taken on the same day.
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He had excellent power and movement when he left the hospital, and all the muscles of the limb were in good condition. At the expiration of his furlough he returned to duty, which he has performed continuously ever since.

I confess that at the time I had grave doubts about the advisability of putting in a screw, seeing that the joint had been so exposed to sepsis, the first dressing, before he was seen by a medical officer, having been a pocket handkerchief, but in no other way could I fix the condyle in position.

ON THE ADVISABILITY OF THE OBSERVANCE OF STRICT ASEPTIC PRECAUTIONS IN DEALING WITH ABSCESES.

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There is, or at any rate used to be, a common idea that the observance of strict aseptic precautions in dealing with septic cases, or with collections of pus, is quite unnecessary. One has often heard it said, "Oh! the case is septic, a few more germs more or less will not make any difference!" Also one sometimes sees buboes opened without any previous attempt to render the skin of the part sterile, and dressings applied which are certainly not free from germs.

In the case of an abscess, the presence of the pus is an indication that the germs have temporarily obtained the upper hand, but as they have been subjected to the resistance which the natural fluids of the body provide, their vitality and virulence have been to a great extent diminished. This is well shown by the fact that it is possible to obtain healing practically by first intention in some abscesses which have been aseptically opened, wiped dry, and their walls brought into apposition by carefully applied pressure, or by deep sutures.

In a certain number of appendix abscesses, one has been surprised by the prompt healing of the wound, although it was, at the time of operation, apparently hopelessly fouled by stinking pus. Wounds, again, which have been soiled by pus in the removal of broken-down tuberculous glands, almost invariably heal by first intention, if one's aseptic precautions have been satisfactory.

When micro-organisms are admitted into a freshly made wound, suppuration usually results. When they are accidentally introduced into an already existing suppurating wound by means of unsterilised instruments or dressings, the partially devitalised organisms are reinforced by fresh and vigorous ones, and the consequence is that a wound which might otherwise have healed rapidly takes a much longer time to get well.

In abscesses which have a definite wall, it is common to find that the discharge after the first twenty-four hours is entirely serous. It is a