Clinical and other Notes

But, as a rule, when the sticky stage of the "morning drop" does not disappear under irrigations, it is best to give tonics.

Like others, I have known some few chronic cases which claimed to have been completely cured after a debauch following an abstinence of months.

With regard to irrigation, a late colleague of mine, Dr. Plasz, told me that this method was practised in Hungary many years before the procedure generally known as that of Janet's was described.

At the first attempt at intravesical irrigation it is difficult to overcome the constrictor urethrae in a nervous patient unless the douche tin is held sometimes as high as six feet. However, this pressure of water is too great, and if one cannot overcome the constrictor with an elevation of four and a half feet it is generally advisable to use a catheter. But, as a rule, once the patient has experienced the benefit and comfort of anterior irrigation it is quite easy to irrigate him intravesically. Orderlies with some aptitude can easily be trained to use the irrigation apparatus. The best craftsman at the Lock Hospital in my time was an ex-private of the Royal Army Medical Corps.

Although well aware that it is only with the younger generation of urogenitary surgeons in England that the bugbear of "driving back the gonococci" has lost its terrors, I have never seen any complications which are alleged against this method of treating gonorrhoea.

A CASE OF RECURRENT DISLOCATION OF THE LEFT HUMERUS.

By Captain E. W. Bliss.

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E. D., a private in the 1st Royal Fusiliers, was admitted to the Portsmouth Military Hospital with a view to having some operation performed for the relief of the above condition. His statement was that the shoulder was first put out three years before, and since that time it has been repeatedly dislocated; latterly, a very slight cause has been sufficient to produce the condition. He thought that in all the shoulder must have been out about fifty times. The patient had gone in a good deal for boxing, and this had on several occasions been the cause of the dislocation. On examination he was found to be a well-built powerful man of exceptionally good muscular development. No difference could be noted in the appearance of the two shoulders, and from his description the dislocation appears to have always been of the sub-coracoid variety. There seems to be unusually free movement in the affected shoulder joint. As the disability was causing him a great deal of inconvenience and pain at times, and he was extremely anxious to have something done, I
decided to operate with a view to closing a rent in the capsule, if such should be found, or, failing that, tightening up the capsule if it should prove to be abnormally loose.

On May 31st, under chloroform, I made an incision about six inches long commencing just below the coracoid process and passing downwards in the interval between the pectoralis major and deltoid muscles. The cephalic vein came into view at once and was cleared and drawn outwards with the deltoid, and the upper third of the fibres of the pectoralis major were divided to give more room. The coraco-brachialis and biceps were next defined, cleared and drawn inwards. The fibres of the subscapularis muscle were then seen, and some of them divided and separated from the capsule. A careful search was then made for any rent in the capsule, the humerus being meanwhile moved in various directions. No tear in the capsule could be found anywhere, but it appeared to be extremely lax, allowing of abnormally free movement of the head of the humerus. I therefore decided to endeavour to tighten it up by means of including an illiptical portion in sutures.

In the only literature on the subject to which I had had access I could only find two cases recorded that had been operated upon, and in each of these the joint had been opened and an illiptical portion of the capsule having been caught up with forceps was removed, the opening afterwards sutured up. I did not see why as good a result should not be obtained without opening the joint; I therefore took up with vulsellum forceps a portion of the inner and anterior portion of the capsule, and with a mounted needle threaded with No. 4 plaited silk passed four sutures through, the two centre ones being much the deeper. On tying these up it was found that a considerable difference had been made in the laxity of the capsule, but not to such an extent as to in any way interfere with the mobility of the joint. All haemorrhage having been stopped, the divided fibres of the pectoralis major were sutured with catgut, and the pectoralis and deltoid muscles were allowed to fall back into their normal positions. The skin incision was closed with silk-worm gut; no drainage was used.

After treatment.—The patient was kept in bed for five days with the arm bandaged to the side. The wound was dressed and sutures removed on the ninth day, and passive movements were commenced. At the present time the patient has perfect movement in the joint, but has been warned against making any excessive movements likely to reproduce the disability.
To illustrate paper by Captain H. J. McGrigor, R.A.M.C.,

"A Case of Erythema Multiform of the Iris Type."