Osteoarthritis of Shoulder-Joint with Pressure on Inner Cord of Tracheal Plexus.

History.—Mrs. W. G., aged 32. For over ten years suffered from recurrent dislocation of the right shoulder-joint, associated with epileptic fits. Two years ago the usual reduction was not performed. In spite of limitation of movement of the shoulder-joint the arm has been adequate in function. During the past six months she has complained of pain in the joint, and for three months she has noticed tingling and pain along the inner border of the forearm and hand.

Examination.—On inspection the right-angled contour of the shoulder is evident together with fullness beneath the coracoid process. Palpation confirms the absence of the head of the humerus from the glenoid cavity, and its presence underneath the coracoid process. There are no objective signs in the arm or hand.

Errors.—The condition should be diagnosed on inspection, but many candidates missed the fullness beneath the coracoid process indicative of the misplaced humeral head. Consequently such conditions as injury to the circumflex head, and caries sicca were suggested, the altered contour of the shoulder being ascribed to wasting of the deltoid muscle.

Diagnosis.—Osteoarthritis of the newly formed joint causing the local pain. Commencing pressure on the inner cord of the brachial plexus resulting in referred pain along the inner side of the arm and hand.

Treatment.—Excision of the head of the humerus through the surgical neck, which is sufficient to relieve pressure. Removal through the anatomical neck is unnecessary and interferes with the attachments of four muscles.

Case presented by R. J. McNeill Love, M.S.

Syphilis of Bone.

I have a little daughter, aged 2½ years. She has been given a number of dolls which she has undressed and dismembered. These dolls are kept stored in a big drawer. When a visitor enters the nursery and asks to see one of the dolls—for instance, Sam the Sailor—my daughter will go to the big drawer and open it. She will then produce Sam's trousers, then possibly his leg, followed by the abdomen and trunk. The whole of Sam may be in the drawer but he, as a composite doll, takes a lot of piercing together. Often it is only with the help of someone else that Sam's head and arms can be found in the drawer. Even then considerable help may be necessary to put the dismembered parts together.

If you substitute a fellowship candidate for my daughter, the drawer for his brain and the dismembered dolls for the surgical facts stored therein, Sam the doll, a long case and the visitor the examiner, the analogy will often be a true one.

Let me quote an example.

When A, a candidate, was recently asked what he thought about the patient he had just examined, this is what he said:—

"The man has osteitis deformans. He is taking a larger size in hats. There is swelling and bowing of the tibia and of the ulnar. He has a certain amount of pain and I should give him aspirin for it if he fails to sleep at night. If it becomes worse I should do an osteotomy. I should tell his wife that the condition is progressive and that he will never recover. By the way, I should do a Wassermann reaction. (The candidate
was informed that the Wassermann reaction was positive. I should like to see the X-ray. (This was shown to him.) Oh, it cannot be osteitis deformans, it must be syphilis periostitis."

When this candidate was presented with a patient for diagnosis he reacted as the baby reacted to the request for a doll, and produced some thoughts from his disordered surgical knowledge in a way similar to that in which my daughter produces the limbs from her dolls.

In the first instance the man failed to obtain a history from the patient. Had he questioned him carefully he would have elicited the fact that there was a history of a primary syphilitic lesion followed by an inadequate course of treatment some fifteen years ago. The painful swelling of the right arm and left leg had occurred six years previously. The man has had a recent course of N.A.B. and bismuth. He still has scars of needle punctures over the basilic vein of his left arm and on his buttocks. There is a scar of an old sore on the penis. The left tibia is enlarged, but the enlargement is confined to the shaft of the bone, it is a gradual enlargement whose maximum height is reached near the middle of the shaft of the bone. The swelling is quite unlike the enlargement of an osteitis deformans, for in osteitis deformans the whole bone is usually involved, and not the shaft only. The swelling, of course, might have been mistaken for a growth in the bone, but the length of history, the shelving edge, the even consistence, ruled this latter suggestion out.

The fusiform swelling on the ulna which was situated near the middle of the shaft and also had shelving edges gradually tapering off to the normal bone presented similar characteristics to the swelling of the tibia.

The next bad mistake the candidate made was to give an opinion on a bone lesion without at least having asked to see the X-ray plates. A candidate should not ask to see X-ray plates as soon as he is confronted with a patient suffering from a bone lesion, but he should always ask for them after he has made a systematic examination of the patient. The X-ray plates in the patient just described presented the typical appearance of a periostitis of the tibia. The shaft of the bone was enlarged in a fusiform manner, and the new bone had been laid down under the periosteum.

Most candidates can interpret X-ray plates quite readily, but they are unable to fit this knowledge into the picture they are attempting to present to the examiner.

Lastly, the blood-test clinches the diagnosis of a syphilitic lesion of the bone.

Such a diagnosis is based upon the sound foundation of a history, the examination of the patient, the X-ray examination of the bone, and the blood-test.

If a routine method of examination is adhered to, it is unlikely that a serious lesion will be overlooked, or that a bad mistake will be made. Tidy your own mind, card index the knowledge you already have, store it in some form of order so that when produced it will appear in a logical connected manner.

Case presented by D. Levi, M.S., F.R.C.S.

CASES DEMONSTRATED AT THE M.R.C.P. CLASS.

Encysted Pleural Effusion.

History.—Male, aged 13 years. Eighteen months ago complained of cough and pain in the left chest. After a few days in bed the pain ceased, but the unproductive cough has persisted to date.