Art. X.—Some Remarks on Excision of the Elbow-joint; with Two Cases. By Surgeon-Major J. H. Porter, Assistant Professor of Military Surgery, Army Medical School, Netley.

There is probably no operation in surgery in which more satisfactory results may be obtained for the patient and surgeon than that of excision of the elbow-joint, provided the cases are judiciously selected, the operation properly performed, and the after-treatment carefully carried out; and yet examples are frequently met with in which, from want of due precautions, the patients are encumbered with useless limbs. I therefore feel it is unnecessary to apologise for publishing two cases, in which, I trust, some of the circumstances connected with them will be found interesting, if not instructive.

Recently two patients came under my observation in whom the elbow had been excised with most unsatisfactory results; in one he had lost all motion in the shoulder, elbow, and wrist-joints, as well as that of the hand and fingers of the affected limb, due to want of attention in the after-treatment; and in the other there was no power of extending the forearm, and the patient was unable to flex the fingers, which had become stiff and straight. In this case the want of success was attributable to the method

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of operation, which was by the H incision, and inattention to the after-treatment.

Such unfortunate results naturally induce the surgeon to guard against and prevent similar consequences in his own practice; and, in investigating the experience of others, I was much impressed with the importance of the observations made by Mr. R. Hodges, of America, and Mr. C. T. Maunder, of London, respecting the method of operation to secure extension of the forearm. The former remarks that, in excision of the elbow, no transverse cut across the triceps should be made, and the latter (vide British Medical Journal of July, 1871) that it is essential to securing extension of the forearm, which power is not unfrequently lost, and for which he says the operation is responsible to preserve those tendinous fibres of the triceps muscle which are sent from beyond the attachment to the olecranon to blend with the fascia of the forearm, and especially with that portion of the fascia overlaying the anconeus muscle. Mr. Maunder commences the operation by a longitudinal incision at the back of the limb, in length three or four fingers' breadth both above and below, and crossing the point of the olecranon. He next sinks the knife deep into the triceps muscle, and divides it also longitudinally into two portions, the inner one of which is the more firmly attached to the ulna, while the outer portion is continuous with the anconeus muscle, and sends some tendinous fibres to blend with the fascia of the forearm. It is these latter fibres that are to be scrupulously preserved.

To these suggestions of Drs. Hodges and Maunder I paid strict attention in the two cases to be hereafter detailed, and with the happy result of obtaining most perfect power of extension, as may be seen by the accompanying illustrations. It is scarcely necessary to observe that, with ankylosis in the straight position, there may also be power of extension; but as that result is not the only one desirable, it is necessary to try and induce the power of flexion so as to produce a generally useful limb, such as one possessing the natural motions of the shoulder, wrist, forearm, hand, and fingers. To obtain these results but little has been said by authorities, except as regards the movements of the elbow, and on these points opinions differ as to the period at which motion should commence. This, of course, might be influenced by the condition of the patient and the state of the wound.

In the two following cases the limbs were first simply laid in an