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**DEERING J. ROBERTS**

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# THE SOUTHERN PRACTITIONER

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## *Original Communications.*

TREATMENT OF COLLES' FRACTURE WITH REPORT  
OF A CASE OF DOUBLE FRACTURE OF THE  
LOWER ENDS OF THE RADIUS.\*

BY DUNCAN EVE, A. M., M. D., OF NASHVILLE, TENN.

Colles' fracture has been the cause of more suits for malpractice than perhaps all other fractures combined. We should therefore strive to minimize deformity, which is the rule. It is the most frequent fracture except perhaps the one of the clavicle, at its outer and middle third juncture. The injuries sustained by the soft parts are extensive. The ligaments are strained and

\*Read at regular meeting of Nashville Academy of Medicine, Tuesday, March 24, 1908.

lacerated, the tendons and sheaths contused and the synovial sac often filled with blood.

Like in all fractures, reduction is all important, which too often is not thoroughly accomplished. Imperfect replacement means deformity, stiffness of tendons and wrist and often an almost useless hand.

Helferich, suggests if the backward displacement of the lower fragment is very pronounced, the middle of the fore-arm of the patient should be grasped with the left hand of the surgeon and his thumb used to control the fragments, while the patient's hand is grasped at the metacarpus with the right hand of the surgeon, and quick and increasing traction should be exerted in the axis of the fore-arm. By this plan he claims most displacements can be reduced.

It will sometimes require simultaneous traction, forced flexion and pronation, for the lower fragment is often pushed back in supination at the time of the injury, while the rest of the radius is forcibly pronated. Bergmann, approves of combined flexion and pronation, as the hand is brought into the best position for maintaining reduction.

For fractures caused by falls upon the dorsum of the flexed hand, the steps of manipulation should be in the reverse order. Extension is facilitated over a fulcrum such as your knee, or a sand bag. In an oblique fracture, there is great tendency for the displacement to return if the surfaces of the upper and lower fragments are not entirely apposed. After reduction the line of continuity of the radius should be unbroken.

Pilcher, has demonstrated the fact that in Colles' fracture a portion of the dorsal periosteum is untorn, and this untorn portion acts as a binding band to hold the fragments in deformity. For this reason, we think it is best to employ Levis' plan of reduction, which is first, to make hyper-extension to unlock the fragments, by relaxing the dorsal periosteum; secondly, to make longitudinal traction to separate the fragments; and finally, to make forced flexion to get them into position.

"The practice and custom of the individual will determine the choice of this and that method. With the proper selection there

are many roads to success, for the time has passed when every new observation should lead to a new splint." If the tendency to displacement is slight, the splint may stop at the elbow, but where it is desirable to immobilize the entire radius, some authorities claim the elbow should be included. The splint should be adapted to the individual case, and if possible, leave one side of the fore-arm free for inspection. The renewal of the support depends upon circumstances, but ordinarily it is well to change the dressing every two or three days for gentle massage.

A great many devices are in use, among them can be mentioned Bond's splint, used by surgeons to a great extent in the East. This splint is so arranged as to allow the fingers to be left free, so that passive motion can be made early. The splint should be removed in three weeks and a bandage worn for a week or two more, because of the resulting swelling. In applying Bond's splint, it is advised not to pull the hand too much up on the block, for fear the fracture will unite with a projection upon the flexor surface of the extremity, as the tendons of the wrist are apt to be caught in the callus. Roberts, of Philadelphia, claims the most satisfactory dressing is a straight dorsal splint. He claims it prevents the recurrence of deformity and is mechanically the proper mode of treatment. He advises it to be worn three or four weeks. Moore, of Rochester, advised a cylindrical compress over the ulna, held in place for six hours with adhesive strips, then cut the plaster, placing the fore-arm in a sling, and let the hand hang over the edge of the sling. Pilcher, also uses a band of adhesive plaster around the wrist and supports the wrist in a sling. "Koenig, recommends the employment of Roser's splint which is about the width of the fore-arm, begins at the external condyle and extends at least to the first phalanges of the fingers." Naturally it is well padded. It is so applied to the back of the fore-arm and hand that the hand is allowed to hang down in flexion. The splint is thus in contact with the arm only to the wrist, the free space beyond to the fingers is filled in best with a firm graduated linen compress, so applied as to form a wedge. The tapered end lies directly upon the lower backwardly displaced fragment.

The fingers are left free in order that they may be moved

while the splint is in place. Schede's anterior strip, as it is called, is a device popular with many German surgeons.

The treatment of this fracture without splints has recently found several advocates. Helferich recommends Storp's suspension cuff, which is applied as follows—"After reduction is accomplished, the hand is brought into extreme adduction and flexion; a strip of adhesive plaster about four inches wide is wound several times around the lower end of the fore-arm down to the styloid processes; a second strip forms a loop over it on the posterior surface, to which a sling is fastened. This strip or loop is attached over the middle of the radius on its dorsal surface, so that when the hand is suspended from the neck by the sling, it will be in ulna-volar flexion."

After an extended trial, we have come to look with favor upon Levis's and Gordon's pistol-shaped splints. This latter is not Nelaton's full-angled pistol-shaped splint, but one that accomplishes moderate ulna deflection of the hand and fingers. In a case with only moderate deformity and without grave complications we use the Levis splint, applying it on the anterior surface of the fore-arm and leave the fingers free for passive motion which is begun within the second week of treatment. It places the hand in a natural position of rest (semiflexion of the fingers, semi-extension of the wrist and deviation of the hand towards the ulna side). Upon the other hand, in well defined cases, especially where there is impaction, which should always be pulled apart, we employ a Gordon splint on the dorsal surface of the fore-arm and hand, which extends from the elbow down past the fingers; with it we use a shorter anterior splint extending from the junction of the middle with the upper third of the fore-arm, just past the wrist. These latter supports are to be worn with suitable compresses, one, the larger posteriorly over the lower fragment, and the other, the smaller, anteriorly over the lower end of the upper fragment. The dressing should be worn for three weeks but removed and re-applied every few days. At the end of three weeks, it has been our custom to remove the Levis or Gordon splint and apply for an additional week or ten days, a strait dorsal splint. In old persons the splints should be worn longer. Massage



and passive motion, should as a rule, be commenced not later than the second week.

If a stiff joint and limited tendon-motion eventuate we use sorbefacient ointments, tincture of Iodine, electric massage, hot-air apparatus, or give ether and manipulate the member. The prolonged use of hot water and the constant squeezing of a soft rubber ball, will ordinarily accomplish normal functional results. It is always well never to dismiss a patient until it is known the member has been made useful as possible.

In general, the statement is correct, that typical fractures of the lower end of the radius, by satisfactory treatment and in the absence of functional disturbances resulting from callus, recover in from three to four weeks. In young subjects this is almost without exception, but in middle life it requires five to six weeks, and in the aged even a longer time.

We take great pleasure in presenting a patient we are just about concluding the treatment of. The following is the history, etc. :—

Mr. R. H. Thrall, aged 30, of this city, fell off the top of a box-car to the ground on Feb. 17th, last, receiving his weight on both out-stretched and pronated hands, causing by a cross-strain a transverse fracture of his left radius three quarters of an inch above the wrist, and an oblique fracture of his right radius an inch above the wrist. In each fracture the usual dorsal mounting up of the lower fragments took place. A complication presented itself in the fracture of the right wrist, which our experience leads us to believe is not unusual, viz. : the tearing off the internal lateral ligament from the ulna styloid. Both hands were abducted, the lower ends of the upper fragments could be felt anteriorly beneath the flexor tendons ; voluntary pronation and supination were lost ; crepitation could be felt in each on manipulation, and in every way the fractures presented the characteristic "silver fork deformity."

Attempt was made to anesthetize the patient with ether, but showing an embarrassment in breathing, we discontinued the anesthetic and with the assistance of my son, we simultaneously reduced the fractures by Levis' plan.

Levis splints were employed to maintain reduction. Finding, however, on the third day, the right radius was not assuming as good a position as liked, we concluded to substitute a Gordon splint for the Levis. These splints were employed for three weeks, when both the Levis splint on the left and the Gordon splint on the right were finally removed to give place to straight dorsal supports which were used ten days longer.

We attribute the promising good results, both in the relief of deformity and seeming restoration of function, to having thoroughly reduced the fractures, immobilizing the same in proper supports and having the patient apply early and sufficiently often for the accomplishment of passive manipulation and massage.

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#### THE DIAGNOSIS OF CYSTITIS CYSTICA BY MEANS OF THE CYSTOSCOPE.

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BY HERMAN L. KRETSCHMER, M. D., CHICAGO, ILL.

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In the diagnosis of surgical diseases of the urinary bladder, the cystoscope stands first and foremost as the single factor giving us the most accurate findings which enable us to make an exact diagnosis, without which, a rational therapy is out of the question.

With the cystoscope practically in a state of perfection, and a resort to its use in all cases presenting symptoms of an intravesical lesion, or a lesion higher up in the urinary tract, combined with a careful microscopic study of small pieces of tissue removed from the bladder during a supra pubic cystotomy, has not only resulted in clearing up many obscure vesical conditions, but they have also proven that many conditions of the bladder that were formerly regarded as extremely rare are in reality of rather frequent occurrence.

Just as the examination of a patient complaining of cough, dyspnoea, and haemoptysis would be incomplete without the examination of the chest with the stethoscope, and a careful micro-

scopic examination of the sputum, just as incomplete is the examination of a patient complaining of symptoms relative to the urinary tract, (Hematuria, Dysuria, etc.) without a cystoscopic examination, and a careful microscopic examination of the urinary sediment. Especially if we will remember that such an examination can be carried out practically without pain, being free from danger, and consuming but a few minutes' time.

While it is very true that the urinary examination is a big aid toward establishing a probable diagnosis, it can not give us enough information upon which to make a positive diagnosis, such as can be made by the use of the cystoscope.

The presence, for example, of blood or pus in the urine, is simply evidence of disease in the urinary tract. The origin of the blood or pus can accurately be determined by the use of the cystoscope, which on the one hand may demonstrate the nature of the intravesical lesion producing the blood or pus, such as a stone, tumor, etc., while on the other hand, if the blood or pus be of renal origin it excludes the bladder and at the same time establishes the fact whether the bleeding or the pyuria is bilateral or unilateral, and if the latter whether it be right or left sided. As an additional aid with a view to being accurate beyond all doubt the ureteral catheter should be resorted to.

In view of these facts too strong a plea cannot be made for a more universal use of the cystoscope and ureteral catheter, in all cases of obscure urinary symptoms, for without them it is impossible to carry out a rational surgical therapy.

Oftentimes in cases which come to operation without a cystoscopic examination having been made before operation, there may be noted during the course of the operation, changes of various kinds in the bladder mucosa. The operator should never hesitate in these cases to remove a small piece of tissue from such a bladder for microscopic study, since this procedure can under no consideration do the patient any harm whatsoever, while on the other hand many pathologic changes in the bladder are easily and positively cleared up in this manner.

This can easily be carried out in cases for example of cystitis cystica, and should always be done as a routine procedure in