PROCEEDINGS AND REPORTS OF UNIVERSITIES, COLLEGES, COUNCILS AND ASSOCIATIONS

GREAT BRITAIN

BRITISH ORTHOPAEDIC ASSOCIATION

ROYAL GRANT OF ARMS

The British Orthopaedic Association has had the privilege of receiving a Royal Grant of Arms with the authority of the Garter Principal King of Arms, Clarenceux King of Arms and Norroy and Ulster King of Arms. A copy of the Grant is reproduced on the opposite page. It declares "That the affairs of the Association are managed by an executive committee consisting of the President, the Vice-President and certain other elected Officers and Fellows of the Association. That the said executive committee is desirous that Armorial Bearings should be assigned for the said Association with legal authority and he, as President, hath requested the favour of His Grace's Warrant for Our granting and assigning such Arms and Crest and in the same Patent such Supporters as may be proper to be borne and used for the British Orthopaedic Association on Seals, Shields, or otherwise according to the Laws of Arms."

The transcript of the last part of the Grant reads "Know ye therefore that We the said Garter, Clarenceux and Norroy and Ulster in pursuance of His Grace's Warrant and by virtue of the Letters Patent of Our several Offices to each of Us respectively granted do by these Presents grant and assign the Arms following for the British Orthopaedic Association that is to say:—Azure a Scannum between two Cords nerved Or on a Chief paly of four Gules and Gold a Lion passant guardant counterchanged And for the Crest On a Wreath of the Colours On a Mount Vert a young Plane tree in leaf with a crooked stem bound with Cords to a straight Post on the dexter all proper as the same are in the margin hereof more plainly depicted. And by the Authority aforesaid I the said Garter do by these Presents further grant and assign the Supporters following for the British Orthopaedic Association that is to say:—On the dexter side a representation of Hippocrates habited Azure supporting with his exterior hand a Ladder from which a rung has been removed and on the sinister side a representation of Aesculapius habited Argent supporting with his exterior hand his Staff all proper as the same are also in the margin hereof more plainly depicted the whole to be borne and used for ever hereafter for the British Orthopaedic Association on Seals, Shields or otherwise according to the Laws of Arms."

There is historic tradition in the scannum which was used in the treatment of fractures and dislocations two centuries ago. Even the knots on each side of the scannum have been reproduced with accuracy from early Hippocratic illustrations. The ladder held by Hippocrates as supporter on the dexter side has one rung removed, as it usually was removed in this treatment for dislocations of the shoulder so that the patient would not break his neck. Aesculapius with rod and serpent is supporter on the sinister side. The crest is a tree with twisted trunk bound to a straight post, copied from Andry's Orthopaedia—probably the first published volume on the prevention and correction of deformity. We have made it a plane tree because it was beneath a plane that Hippocrates stood at Cos to teach his disciples. The mount below includes the English rose, the Welsh daffodil and the Scottish thistle—but we are proud to know that this emblem is now also incorporated in the Presidential badges of our fellow associations in the United States, Canada, Australia, New Zealand and South Africa, with an American eagle, a maple leaf, a spray of wattle, a kowhai flower and a giant protea respectively. The motto on the British grant of arms is the single word Recte which is to be translated not only as straightly but as uprightly—befitting, proper and good.

2 Guicci. J. A. De: Officina Aurea d.i. Guldene-Werck Statt der chirurg Oder Wundt-Arztmey (Frankfort am Meyn), 1607.
To All and Singular

In the name of God Amen, we record in these presents, that such and such a person has been elected and appointed by the British Orthopaedic Association, to be the new President of this Association, for the term of one year, commencing on such and such a date. The said person shall have the power and authority to act as the President of the Association, and to do all such things as are necessary for the proper conduct of its affairs. The said person shall also have the power to appoint such other officers and agents as may be necessary for the proper conduct of the Association, and to delegate to such officers and agents any power or authority conferred on him by the Articles of Association.

Dated this day of January, in the year of our Lord nineteen hundred and ninety-eight.

[Signature]

[Signature]

[Signature]
ROYAL SOCIETY OF MEDICINE

SECTION OF ORTHOPAEDEICS

Presidential address—Mr H. Jackson Burrows delivered his Presidential address, "An Even Keel in Orthopaedics," on March 3, 1953. He recalled that not all complaints demanded treatment, and deplored the terminology "let's do something, even if it's wrong." Many patients came to the surgeon, not in search of treatment, but for a prognosis. Such were an easy prey to the unscrupulous. Parental anxiety, especially among the better-to-do, had created a demand for treatment which the profession had eagerly met. It was no longer possible to be a really nice little man without enduring the indignities of circumcision, tonsillectomy, shoe-wedging and "remedial exercises." The practice of fitting wedges to the shoes for knock-knee often, by promoting a varus foot, delayed a recovery that was almost inevitable if nothing were done. The "remedial exercises"—so popular in schools—avoided a plantigrade foot at all costs. There was need of a S.T.O.M.B.A.*

The abstraction "rest" was now less misused than in the past, but in poliomyelitis the intemperance of the reaction against misapplied rest had led to a violence that tortured patients, provoked spasm in unparalysed muscle and even caused myositis ossificans. The speaker believed that in muscle re-education after poliomyelitis insufficient attention was given to preserving the power of active relaxation of muscles not paralysed; early attempts to contract a paralysed muscle were useful because they made the unparalysed opponents relax. There was a need to return to physiological principles in the treatment of poliomyelitis, a subject in which there had been too much unphysiological "stunting"—and not only by Miss Kenny.

The campaign against passive movements that preceded the last war had effectively diminished their misuse; but overstatement had led to many stiff joints from neglect of passive movements when paralysis made active movements impossible. A neglected agent was the ice-bag for cooling the limb after an operation or other injury likely to lead to swelling (Fig. 1). Active exercises were the basis of nearly all physiotherapy. They—and especially their elaborations (Figs. 2 and 3), such as pulley exercises, occupational therapy and remedial games—could speed or delay recovery in accordance with their wise or unwise application. All would commend industrial rehabilitation units, as at Luton and Birmingham. A beautiful application of auto-assisted movement (Fig. 4) was Denis Browne's hobble splint, in which the infant's proclivity for marking time was applied to the correction of deformity. Most would differ from its initiator, however, in his use of forced manipulation. The value of gradual correction by re-splinting had been illustrated recently by Mr A. T. Fripp with his Kite plasters for club feet; and Dr E. E. Harris at the Heritage, Chailey, was using the principle for correction of many deformities by frequently renewed plaster splints. In spastic paralysis, the extent and duration of benefit conferred by a spell of splinting—notably calipers and wrist splints—was not recognised enough. In the flaccid paralysis of poliomyelitis restraint in the use of appliances in the child had been pleaded lately, but to unfetter the boy was often to fetter the man. This was a matter in which the most careful, unemotional judgment of each patient must be combined with the greatest vigilance.

Discussing orthopaedic operations, Mr Burrows deplored unnecessary surgery. A surgeon who subjected his patient to an operation that he would not allow in his own kin was guilty of a breach of faith. Usually a diagnosis of ruptured intervertebral disc should not dismay the patient, but it often did because it suggested to him the prospect of an operation of doubtful efficacy—his friends had had it. Removal of a displaced intervertebral disc in the exceptional and properly selected case was a great surgical advance, but it had been discredited by those who had found within the disc a glittering nugget of gold.

* Society for Leaving the Poor Little Blighters Alone.

PROCEEDINGS AND REPORTS OF COUNCILS AND ASSOCIATIONS

VOL. 35 B, NO. 2, MAY 1953
Arthroplasty of the hip was another of the great advances of our time. Prosthetic femoral heads had been used successfully for only six years, still had many shortcomings, and should not be used unnecessarily in young people.

Referring to congenital dislocation of the hip, Mr Burrows thought that perhaps the dangers of radioscopic arthrography had been overlooked, reversion to operative reduction overdone, and the need for early rotation osteotomy underestimated.

Most of us had designed gadgets that we had later regretted. A recent tendency was to show confessedly unsuccessful gadgets in the spirit that it was better to have gadjotted and lost than never to have gadjotted at all. One application that had succeeded spectacularly was Key’s compression arthrodesis of the knee, popularised by Charnley. When the knee was to be arthrodesed it should be fixed in considerable flexion, not in nearly full extension, whatever the patient’s occupation. A patient with a stiff knee must sit on the forward edge of his chair in order to get his foot near the ground; with the knee fixed in 30 degrees of flexion he could sit back in his chair and his leg projected about half as far (Fig. 7). Moreover, in normal walking, weight was never taken on an extended knee. Thus there was no case for arthrodesis of the knee in the position of full extension.
Misapplied operation was exemplified by the orthopaedic epitaph: "he died in perfect position." A person who could sit but not stand had often been converted into one who could stand but not sit. It was common knowledge that, in poliomyelitis, ill-advised lengthening of the tendo calcaneus could condemn a patient to a caliper for life; but in spastic paralysis the operation might be far more devastating. The subject of bone operations upon growing feet was more controversial. The bad late results led to the conclusion that they were rarely, if ever, justifiable. Sometimes the worst handicaps did not obtrude, and it was important always to consider the whole patient, and, still more, the patient in his own surroundings, in assessing his true disability.

Too faithful a devotion to the cult of "no-touch technique" must not promote neglect of bigger things; there were occasions for the adage "put your finger in it or you'll put your foot in it."

Mr Burrows concluded by considering the place of orthopaedics in medical education. Lambrinus had emphasised that the principles of medicine as a whole could be demonstrated perhaps better in orthopaedic patients than in almost any other. There was a strong demand among students for this teaching, which offered unparalleled opportunities for: history taking; observation of physical signs; the synthesis of these in relation to anatomical and physiological principles; the testing of the provisional diagnosis by special methods of examination; the final summing up; and finally the lucid explanation to the patient. The undergraduate schools could not for ever live in the past and ignore or suppress the so-called special departments. There was a well defined place for distinct postgraduate schools with wide facilities for special experience, pathology and research. The extensive and stereotyped training that had been planned for our future colleagues and successors was perhaps too all-embracingly technological at the expense of serious experience in the basic sciences and methods of research and of that cultivation of individuality that was rightly called education.
UNIVERSITY OF LIVERPOOL

M.CH.ORTH. EXAMINATION

Of the postgraduate students who have worked in Liverpool during the last year those who gained their M.Ch.Orth. degree in December 1952 are: Colin Conacher, Sydney, Australia; Wilfred C. Lawrence, Litchfield, England; Manuel Lunz, Johannesburg, South Africa; Robert Page, Ottawa, Canada; Abdul Rahim, Lahore, Pakistan; Eric H. Strach, Prague, Czechoslovakia; J. G. Stubbs, London, England; and Kenneth J. M. Watson, Brisbane, Australia. The two external examiners were Professor Walter Mercer and Mr Jackson Burrows, and the three internal examiners were Mr Norman Roberts, Mr Eric Wardle and Professor B. L. McFarland.

UNIVERSITY OF OXFORD

NUFFIELD ORTHOPÆDIC CENTRE

Forthcoming lectures—Lectures to be delivered at the Wingfield-Morris Orthopaedic Hospital include: ‘The Vasculature of Bone and the Healing of Fractures—an Experimental Study,” by Dr A. X. Cavadas, on May 28; and ‘Solitary Fibro-osseous Lesions of Bone and their relation to Fibrous Dysplasia,” by Dr H. L. Jaffe, on June 11. Both lectures begin at 8.30 p.m.

REGIONAL ORTHOPÆDIC CLUBS

EAST ANGLIAN ORTHOPÆDIC CLUB

A meeting of the East Anglian Orthopaedic Club was held at Addenbrooke’s Hospital, Cambridge, on November 29, 1952. Clinical cases were shown.

Atlanto-axial dislocation—Mr B. J. S. Grogono demonstrated the normal anatomy of the joints between the atlas and axis. In a dissected specimen and with radiographs he showed the variations with age and position between one patient and another. He reviewed seven cases of atlanto-axial dislocation, some caused by injury, and some associated with naso-pharyngeal infection. Treatment was by plaster or plastic collars, or by wiring and local fusion. A discussion followed in which some members spoke of the success that seemed to attend almost casual treatment of this condition. The rarity of neurological signs was commented upon and the general feeling seemed to be that operation was indicated only in cases of recurrent dislocation or when there were associated neurological signs. Mr Grogono also showed a specimen taken from the spine of a man who had died after a road accident. He had had paraplegia and the specimen showed tearing of two intervertebral discs with narrowing of the spinal column between them. A section of the cord in this area showed haemorrhage into the lateral columns.

Fractured femur with traumatic aneurysm—Mr R. Dee showed radiographs of the femur of an elderly woman with spiral fracture of the femur at the junction of the middle and lowest thirds. There was no palpable arterial pulsation below the level of the fracture and the thigh was very swollen. A systolic murmur was heard over the swelling. A traumatic aneurysm was diagnosed. Hunterian ligation was carried out and she slowly recovered. Although theoretically this might seem to be a likely complication of fractures at this site, no member present had had a similar experience.

Schmorl’s nodes—Mr R. W. Butler discussed the significance of Schmorl’s nodes. He said that although they were generally claimed not to be the cause of symptoms, he had encountered cases in which it was hard not to attribute the patient’s symptoms to the nodes. He pointed out that the antero-posterior diameters of the affected bones as seen in the lateral radiographs were longer than those of the adjacent bones, that the nodes were commonly seen in the upper lumbar region and were not seen in old people. An interesting discussion seemed to indicate that there was room for much further investigation.

Osteitis of pubis—Mr Murray demonstrated the films of a man who had osteitis of the pubis after appendix abscess, shown to the club in January 1950. The serial radiographs showed gradual recalcification and eventual sclerosis of the pubis and some irregular ossification round the tuberosity of the ischiun. Mr G. K. McKee showed radiographs of a similar case after prostatectomy. In the discussion members spoke of the cases they had seen after prostatectomy—especially after Millin’s operation—but only one other case of pubic osteitis complicating appendicitis was mentioned.

Osteomyelitis of fibula—Mr J. Fairbank showed a child aged seven years with uneven growth in the lower leg after osteomyelitis of the fibula. The lower end of the fibula had been removed and the ankle assumed a valgus deformity. This was corrected by osteotomy of the tibia; the stump of the fibula was fixed to the tibia. Correction was satisfactory at first but in the next year growth
continued to be uneven and the foot was assuming a valgus position again. Various suggestions were made, including stapling of the medial side of the tibial epiphysis so that continued growth would not push the talus out of the ankle mortise.

Paget's disease—Mr Dee showed a case of arthrodesis of the knee in a patient with Paget's disease of the femur. Now that the femur and tibia were continuous he wondered whether the disease would spread into the tibia. As judged from radiographs, sound bony union had taken two years to occur. Others spoke of their experience of slow bony union in Paget's disease.

Fractured femora—Mr L. W. Godfrey showed a patient who had sustained fractures of both femora treated at one operation by medullary nailing. Seven weeks after operation he was bearing weight with crutches, and had good knee movements.

Rheumatoid arthritis and gout—Mr Murray demonstrated the differences apparent radiologically in the hands of patients with rheumatoid arthritis and gout. He emphasised the difference between the small areas of osteoporosis that sometimes broke the joint line in rheumatoid arthritis and the punched-out areas of calcium biurate, deep from the joint line, that were seen in gout.

Congenital absence of upper femur—Mr Noel Smith showed a patient with congenital absence of the upper part of the femur. Radiographs showed a head of the femur and a tapering lower end. The girl had been fitted with a patten-ended caliper, but this was not very satisfactory through the lack of a greater trochanter. There was now five inches of shortening. Members were asked for suggestions and it was generally agreed that bone grafting should be delayed until growth ceased and that in the meanwhile every effort should be made to encourage the use of the limb.

SOUTH AFRICA

SOUTH AFRICAN ORTHOPAEDIC ASSOCIATION

ANNUAL MEETING

The annual meeting of the South African Orthopaedic Association was held in Johannesburg from September 23–26, 1952, under the presidency of Mr G. T. du Toit. The secretary, Mr W. T. Ross, reported that membership of the Association had increased from thirty-eight members in 1951 to forty-five in 1952.

Orthopaedic aspects of chronic arthritis—Mr S. Sacks dealt comprehensively with the means of treatment at our disposal, such as rest, traction, splintage, manipulation, intra-articular injections and the various types of surgical operations. In discussion, Mr Hamilton Bell pleaded for more co-operation with the physicians, especially in the early stages when much deformity could be prevented. Mr C. Morris suggested that when hydrocortone was injected into joints, a radio-opaque substance should be injected with it to show whether it really was in the joint. This applied especially to the hip joint. Mr H. I. Maister recommended correction of knee deformities in rheumatoid arthritis by the application of a light Thomas splint, to which the limb was bandaged. The splint was bent a little each day until the desired correction was obtained. He also stated that the pain in arthritic knee joints could often be relieved by simple joint lavage with normal saline to wash out fibrinous deposits.

Cervico-brachial neuritis—Mr R. N. Houlding of Rhodesia described his findings in sixty-five cases. Symptoms included pain in the neck, headaches, torticollis and cutaneous hyperaesthesia in the arm or hand, and weakness of grip. He thought the symptoms were due to disc protrusion from relaxation of the posterior common ligament when the neck was forcibly extended from a flexed position. The slowly progressive cases might be due to disc oedema. Relief of symptoms was obtained in sixty-two of the sixty-five cases by manipulation under anaesthesia followed by head traction (five pounds) for one to seven days. Operation was required in three cases. It was stressed that accurate localisation of the level by clinical and radiographic examination was essential. A small bone graft was placed under mild compression between the two spinous processes contiguous with the affected disc space so as to open up the disc space posteriorly. Behind this graft two longer grafts were placed on each side of the spinous processes and fixed together with a single screw. Good results were claimed.

British and continental orthopaedic surgery—A report was given by Messrs J. M. Edelstein, G. T. du Toit, C. J. Kaplan, G. Dommisse and W. T. Ross, all of whom had recently returned from overseas. This proved to be one of the high-lights of the meeting, and the audience was fascinated by a description and demonstration of recent trends in orthopaedics, including many new operative tricks and gadgets. It is noteworthy that the field to be covered included so much that none of the speakers overlapped on any of the subjects seen in their travels, which ranged from Edinburgh to Florence!
**Clinical Meeting**

A clinical meeting was held in the Medical School of the Witwatersrand University.

**Ewing's tumour**—Mr B. Polonsky showed a case of Ewing's tumour in the upper end of the femur of a girl aged nine years, first diagnosed in 1948. It had been treated by deep x-ray therapy, but recently spontaneous fracture had occurred. No other deposits had been found elsewhere in the body. Unfortunately the parents' consent could not be obtained for any operation except a biopsy. It was felt that amputation at an early stage might have proved effective.

**Ischio-femoral arthrodesis**—Mr Polonsky also showed a successful ischio-femoral arthrodesis for tuberculous arthritis of the hip in which a massive strut of bone had formed along the line of the graft. Mr G. T. du Toit, while complimenting the surgeon on the good result obtained, stressed that this was not hypertrophy of the graft in the true sense of the term, but ossification around the graft.

**Osteoclastoma of radius**—Mr W. T. Ross showed a woman of thirty-five years, the distal four inches of whose radius had been excised for osteoclastoma and replaced by the upper end of the fibula. Fourteen months after operation the result was excellent; she had a strong painless wrist, with fifty-five degrees of movement. Mr Ross thought this was the method of choice in this condition, although degeneration of the articular cartilage on the graft seemed inevitable in the absence of a nerve supply. He was not satisfied with the results of deep x-ray therapy or curettement plus bone chips.

**Rupture of extensor pollicis longus**—Mr W. T. Ross showed a middle-aged woman who had ruptured the long extensor tendon of her thumb fourteen years before, after a Colles fracture. Inability to "let go" when shaking hands, and diminished rotation of the forearm, had been embarrassing and disabling. At operation the extensor indicis tendon was transplanted into the distal end of the extensor pollicis longus, and the lower end of the ulna was excised. Six months later she had full function of the thumb and wrist. Mr Ross thought extensor indicis was a more suitable tendon to use than extensor carpi radialis longus or brevis, or extensor pollicis brevis.

**Other cases**—Mr C. Morris showed a Bantu male child aged two years with swelling of the right foot and wasting of the right thigh and leg. A limp was present. Radiographs showed changes in the metatarsals, talus, tibia, fibula, femur and pelvis. These changes were compatible with a diagnosis of multiple cystic tuberculosis, which was confirmed by biopsy. Mr J. M. Edelstein showed a patient in whom an ilio-femoral arthrodesis had been performed nearly twenty years ago by Mr Seddon in London for tuberculous arthritis. The result was excellent. Recently the patient had developed tuberculous infection of the elbow, and excision of the elbow had been performed by the Kirkaldy-Willis technique with a good result. Mr G. T. du Toit showed a case of paralytic scoliosis, in a boy aged fourteen years, with marked pelvic tilt. The mechanics of the deformity and the possible methods of treatment were discussed at length.

**Officers for 1953**—Mr F. P. Fouché was elected emeritus president and Mr G. T. du Toit president. Other officers are: secretary, Mr W. T. Ross; executive members—Messrs J. M. Edelstein, C. T. Moller and J. G. du Toit.

**ITALY**

**ITALIAN SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY**

**Annual meeting**—The thirty-seventh annual meeting of the Italian Society of Orthopaedic and Traumatic Surgery was held in Genova from October 6–8, 1952, at the Simon Boccanegra’s Castle, in St Martin’s Hospital, under the presidency of Professor R. Zanoli. The principal subject discussed was paralytic shoulder. An official report on this subject was presented by Drs F. Rosende and A. Strata. On this same subject forty-one papers were presented. The second subject discussed was periarthritis of the shoulder. An official report on this subject was presented by Professor A. Bonola. The meeting was attended by many eminent orthopaedic surgeons from other countries, including Professor H. Platt (Great Britain), Professor M. Lange, Professor L. Böhler, Professor C. Mau, Professor G. Hohman, Professor S. Weil, Professor K. Niederecker, Professor Kreisel, Professor Hackenbrock (Germany), Professor Etienne, Professor Perrot, Professor Perea, Professor J. Creyssel, Professor J. Herbert, Professor J. Forestier (France), Professor V. Sanchis-Olmos (Spain), Professor Contargyris (Greece).

**Programme for 1953 meeting**—The thirty-eighth meeting of the Italian Society of Orthopaedic Surgery and Traumatology will be held in Rome in October 1953 under the presidency of Professor Carlo Marino-Zuco. The principal subject for discussion will be post-traumatic joint stiffness. Papers and discussions on this subject are invited and should be submitted before July 10. Papers on other subjects will also be considered. Headsets for the reception of simultaneous translations in English, French and German will be available.
AUSTRIA

ORTHOPAEDIC AND TRAUMATOLOGICAL ASSOCIATION OF AUSTRIA

1952 meetings—In March 1952 a clinical demonstration was held. The use of ultra-sonic waves in orthopaedic surgery was discussed. In May 1952 an international meeting was held in Sonnenheilstatte Stolzalpe; the main subject for discussion was bone and joint tuberculosis. At a further meeting in December 1952 the main subjects discussed were surgical appliances and the use of plastic endoprostheses.

Officers for 1953—Professor Erfacher was re-elected president of the Association for 1953.

New rehabilitation centre—On May 24, 1952, the Sonderstation Tobelbad, a rehabilitation centre near Graz, financed by a leading insurance company, was opened by Korner, the President of Austria. The centre caters for the rehabilitation and resettlement of injured patients and has special facilities for the treatment of paraplegics and amputees. The clinical directors are Dr W. Ehalt and Dr Neubauer.

ECUADOR

ECUADORIAN SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY

In September 1952 the Ecuadorian Society of Orthopaedic Surgery and Traumatology was founded in Guayaquil with Dr Eduardo Alcivar as president. The vice-president is Dr Galo Ballesteros and the secretary Dr Jaime Barredo.

BRAZIL

CONGRESS OF ORTHOPAEDIC AND TRAUMATIC SURGERY

The congress of orthopaedic and traumatic surgery for 1953 will be held in Rio de Janeiro from July 19–26. Communications should be addressed to the secretary at Praça Florianó, 31-3o andar-sala 303, Rio de Janeiro.

INTERNATIONAL SOCIETIES

INTERNATIONAL SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY

The Sixth Congress of the International Society of Orthopaedic Surgery and Traumatology will be held in Berne, Switzerland, from August 30 to September 3, 1954, under the presidency of Sir Harry Platt.

Officers—The honorary president of the congress will be Professor R. Scherb, of Zurich, and the president of the congress will be Professor E. Sorrel, of Paris. All correspondence regarding the participation as well as the scientific part of the congress (reports, discussions and personal communications) should be addressed to the secretary-general of the Society, Dr J. Delchel, M.D., 34 Rue Montoyer, Brussels, Belgium.

Provisional programme—The provisional programme is as follows: First day (Monday, August 30, 1954)—08.30, Meeting of the International Committee; 11.00, official opening of the Congress; 14.00, scientific meeting; presentation of the first subject: treatment of scoliosis; 17.00, departure for dinner in the Bernese Countryside. Second day (Tuesday, August 31, 1954)—09.00–11.00, Scientific session; discussions and individual communications; 11.00, general meeting; 15.00–18.00, Scientific session. Third day (Wednesday, September 1, 1954)—Visits to different Swiss Hospitals and Institutions in groups: Berne—Isle-Hospita and Macolin—Federal School of Athletics (clinical demonstrations, communications, symposium on physiology of movement). Zurich Hospitals (clinical demonstrations; symposium on joint pathology). Basle Hospitals
(clinical demonstrations; symposium on chemical aspects in orthopaedic surgery). Lausanne Hospitals and Leysin Sanatoria (clinical demonstrations; symposium on joint and bone tuberculosis). Geneva Hospitals (clinical demonstrations; symposium on bone pathology). Jungfraujoch: Alpine research centre. Return to Berne in the evening. Fourth day (Thursday, September 2, 1954)—09.00–12.00, Scientific session; presentation of the second subject: surgery of the hand; 15.00–18.00, Scientific session; 20.00, official banquet. Fifth day (Friday, September 3, 1954)—09.00–13.00, Scientific session; individual communications. In the afternoon: closing of the Congress.

**Participation at the Congress**—Members of the Society: free of charge. Other participants: Swiss Francs 40.

**Excursions**—Further excursions will be arranged at the end of the Congress. Apply to the Congress Office, Kursaal-Berne, during the Congress.

**Local organising officers**—Vice-president of the Congress and responsible for the co-ordination of the organisation: Professor M. Dubois, Inselspital, Berne. Collaborator: Dr Hausammann, M.D., Inselspital, Berne. Treasurer of the Congress: Professor H. Debrunner, Burgerspital, Basle. Secretaries of the Congress: Professor M. R. Francillon, Balgrist, Zurich, Professor Ch. Scholder, Hospice orthopedique, Lausanne, and Mr A. Perrot, M.D., Hopital Gourgas, Geneva.

**CORRESPONDENCE**

**DEAD BONE GRAFTS IN ORTHOPAEDIC SURGERY**

*From Professor H. L. Rocher, Bordeaux, France*

To the Editor of the Journal of Bone and Joint Surgery.

Sir,

In 1946 I presented at the French Congress of Surgery my experiences with the use of dead bone in orthopaedic surgery, prepared according to the method of my son, Dr Christian Rocher. The technique was first described by my pupil, Leon Dorriotz (Utilisation de L’Os Mort Humain Conservé en Chirurgie Orthopédique de Reconstruction, 1939. Bordeaux: Imprimerie Bière), who referred to sixteen cases, the earliest being in 1937. I thought it would be interesting to your readers

![Fig. 1](image1)

![Fig. 2](image2)

![Fig. 3](image3)

Use of cadaveric bone grafts for shelf operation, formation of a bone block, and filling of bone cavity.


The bone is removed from amputated limbs. The soft tissues and the periosteum are cleaned off and the articular cartilage is removed. The bone is then boiled for three hours to clear thoroughly all the soft tissue from the marrow cavities. After this preliminary boiling the bone is cut into blocks of suitable size and shape for use as grafts, some being of compact bone and some