On September 25 Sir Reginald Watson-Jones, president of the British Orthopaedic Association, and Lady Watson-Jones gave a dinner in the Library of the Royal College of Surgeons of England to mark the inauguration of a permanent collection of archives and treasures of historical interest to orthopaedic surgeons. The sixty-four guests included past presidents of the British Orthopaedic Association, present officers of the Association and members of the executive and sub-committees, with their wives. Also present were Lady Probyn Jones, daughter-in-law of Sir Robert Jones, Mrs Rowley Bristow and Mrs T. P. McMurray.

Sir Reginald, outlining the origins and purpose of the collection, paid tribute to the generosity of the relatives and descendants of pioneer orthopaedic surgeons who had presented many of their cherished possessions to the Association. Notable among the donors were Lady Probyn Jones and Mrs Hilda Watson, daughter of Sir Robert Jones. Sir Reginald told of the establishment of a new office of the British Orthopaedic Association—that of Keeper of the Archives, and he announced amid applause that Mr Rocyn Jones had that day been appointed the first holder of the office. Among the items of the collection that were of special interest Sir Reginald mentioned Hugh Owen Thomas's smoking cap and his flute, and the signet ring with which Thomas used to seal his collar-and-cuff slings to prevent interference between his visits. He read extracts from a bound set of the original letters of Evan Thomas, annotated in the handwriting of his son, Hugh Owen Thomas, which also included one precious manuscript relating to the Evan Thomas of Anglesey who was Hugh Owen Thomas's great-grandfather. Some of the letters illustrated amusingly the rivalry that existed even in those far-off days between qualified practitioners and bone-setters.

Professor Bryan McFarland, president-elect of the association, spoke of the value of cherishing mementoes of the past, the value of revering memories of our professional forefathers, the value of preserving for posterity symbols of former artists and of their art. The interest of such collections was obvious; their value lay in the power of tradition. From that power sprang the incentive to emulate and to surpass the achievements of our predecessors; from it sprang also the courage to maintain their high principles and the determination to preserve for posterity the ground that had been gained over many years by steady endeavour and sacrifice. Professor McFarland likened surgical progress to the conquest of Mount Everest. 'When Hillary and Tensing this year climbed to the top of Everest they did so on the shoulders—almost literally on the shoulders—of their comrades: and the whole expedition succeeded, standing, as it were, on the shoulders of all the previous expeditions down the years. In the same way there are amongst us to-day men of talent, of distinction, and of brilliance; but they stand on the shoulders of great men of former times.' This realisation induced collective pride but individual humility; it acknowledged the enduring force of tradition, and formed a sure and firm basis from which to hand on to the future these treasures of the past.

Sir Thomas Fairbank proposed the toast of the president and the president-elect. He recalled that they were the first among living orthopaedic surgeons to gain the degree of M.Ch.(Orth) at Liverpool University and he was proud to have been the co-examiner, with Sir Robert Jones, on that occasion. Mr William Gissane welcomed the historic collection on behalf of Dominion and other overseas surgeons.

After dinner the guests were able to examine the exhibits at leisure, and it was clear from the interest shown that the evening had been a most happy occasion for all those present. Apart from the treasures already mentioned, other items included Hugh Owen Thomas's catechism in Welsh; portrait of Robert Jones by Copnall; Robert Jones's publications, specially bound; the instrument used by Hugh Owen Thomas for percussion of bone, with his name inscribed on it; one of the only two Robert Jones Gold Medals ever presented; programme of the Joint Meeting of Orthopaedic Associations of the English-speaking World signed by Her Majesty Queen Elizabeth the Queen Mother and Her Royal Highness Princess Alice; collection of photographs of past and present
Hugh Owen Thomas's smoking cap.

Hugh Owen Thomas's signet ring.

Hugh Owen Thomas's flute and in his handwriting his own "confessions" in the form of autograph albums of that day. Note his favourite virtue, perseverance, his idea of happiness to be _always in action_, his idea of misery _everlasting rest_ and his pet aversion a _successful hypocrite_.

THE JOURNAL OF BONE AND JOINT SURGERY
presidents of the British Orthopaedic Association; the first Edward Hallaran Bennett Medal ever cast; one of the fifteen specially bound copies of the half-century number of the *Journal of Bone and Joint Surgery*; letter from His Majesty King George VI, approving the first number of the British Journal; Hugh Owen Thomas's confessions in his own handwriting; pen and ink drawings of specimens in the Musée Dupuytren, Paris, by Thomas Fairbank; sepia drawings of specimens in the Musée Dupuytren, Paris, and early editions of John Poland, Murk Jansen, Hugh Owen Thomas and Rilhon.

In addition, Mr W. E. Thompson, Clerk of the Museum of the Royal College of Surgeons of England, had prepared a display of historic instruments in the possession of the College, and Mr W. Le Fanu, Librarian, showed historic books from the College library including a first edition of Andry's *Orthopaedia*.

The collection of archives and treasures is to be housed mainly at the Royal College of Surgeons in Lincoln's Inn Fields, but it is proposed that smaller collections of treasures shall be kept at the centres whence they originated.

Hugh Owen Thomas's lathe room, at 11 Nelson Street, Liverpool, where he constructed his own splints, frames and instruments.

**TRAVELLING FELLOWSHIPS IN ORTHOPAEDIC SURGERY**

*from Great Britain and the British Commonwealth to the United States of America in 1954*

Applications are invited from Fellows, Members and Associates of the British Orthopaedic Association, whether resident in Great Britain, Ireland or elsewhere in the British Commonwealth of Nations, for election as Travelling Fellows to visit orthopaedic centres in the United States of America and Canada for an eight-week tour (including the time of transatlantic travel). Five travelling fellows will be appointed by the president of the British Orthopaedic Association on the recommendation of the Joint Committee for Postgraduate Orthopaedic Education. In the election, preference will be given to senior orthopaedic registrars, and surgeons who have gained orthopaedic consultant appointments within the last few years.

Twenty typewritten copies of the application should reach the secretary of the British Orthopaedic Association, 45 Lincoln's Inn Fields, London, W.C. 2, not later than December 31, 1953, stating name, address, telephone number, age, qualifications, medical school, and present appointments, together with an outline of previous experience and academic or literary achievements. The application must be supported by a referee who is a fellow of the Association.

If any young surgeon who is not already an associate of the British Orthopaedic Association wishes to apply, he should communicate with Miss Barbara Key at 45 Lincoln's Inn Fields who will send the necessary forms.
Clinico-Pathological Conference on Cartilaginous Tumours of Bone

Dr Henry L. Jaffe, Director of Laboratories, Hospital for Joint Diseases, New York, conducted a Clinical Conference at the Institute of Orthopaedics on June 10 in collaboration with Dr H. A. Sissons, Morbid Anatomist to the Institute and to the Royal National Orthopaedic Hospital, with Mr H. Jackson Burrows in the Chair.

Cases illustrating the various types of cartilaginous tumours of bone were presented by Messrs J. C. McNeur, M. Singer, M. F. Pilcher, J. H. Shelswell and T. L. Carr; the pathology of the cases was outlined by Dr Sissons, and a commentary on each type of tumour was given by Dr Jaffe.

Benign chondroblastoma (a case of benign chondroblastoma of the humerus. See Figures 1 and 2)—Dr Jaffe outlined the development of ideas on benign chondroblastoma, sometimes referred to as the "chondroid" or "epiphyseal giant-cell tumour" or "benign calcifying giant-cell tumour." Its clinical features were as follows. 1) Nearly all the patients were boys, usually between the ages of fourteen and eighteen years. 2) The lesion was almost always in the epiphysis of a long bone, and usually extended over the epiphyseal line. 3) Though at first believed to occur only at the upper end of the humerus, it could occur also in other bones such as the tibia, calcaneum or ilium. 4) Although histologically very cellular, and readily mistaken for a malignant tumour, it was benign. The tumour had been called benign chondroblastoma, firstly, to separate it from the giant-cell tumours, and secondly, to describe its basic cell, which resembled a chondroblast. Dr F. Campbell Golding asked if these tumours ever became malignant. Dr Jaffe considered that they did not, and that the correct treatment was curettage; they did not respond well to radiotherapy.

Central enchondroma (cases of enchondroma of a metacarpal bone and of the fibula)—Dr Jaffe said that the solitary benign tumours—usually seen in the metacarpals and phalanges—occurred less often in long bones, where they were more likely to become malignant. Histologically, the tumours showed some differences from the lesions of multiple enchondromatosis. The radiographic appearance varied with the degree of calcification. In answer to a question by Mr H. Jackson Burrows, Dr Jaffe said that there was no easy explanation for the benign character of the tumours of the bones of the hands and feet. In answer to Mr H. J. Seddon, he commented that it was not possible to state the chances that a central enchondroma of a long bone would become malignant: he thought that if such a tumour had produced symptoms through a spate of growth it should be surgically removed, even if with difficulty.

Central chondrosarcoma (a case of chondrosarcoma of the humerus and two cases of chondrosarcoma of the femur)—These cases illustrated the variation in the degree of malignancy among chondrosarcomas, and its assessment in particular cases was presented as a matter of, often, considerable difficulty. Dr Jaffe commented on the importance of clinical and radiological evidence about rate of growth. In biopsy diagnosis, much cellularity and, in particular, the presence of binucleate cells were important indications of malignancy. Such histological evidence, however, might be present only in occasional areas of a tumour that otherwise appeared benign. Biopsies should be of adequate size, and taken from the growing tissue at the periphery. The pathologist should carefully examine many fields. Adequate resection was essential, although amputation could sometimes be avoided by careful local removal. Dr Jaffe illustrated the permeation of tumour tissue into the Haversian canals of the surrounding cortical bone, a feature of some chondrosarcomas that made their local resection unlikely to succeed.

Peripheral chondrosarcoma (a case of peripheral sarcoma supervening on an exostosis of the tibia)—Dr Jaffe said that these tumours very rarely arose from a solitary exostosis, but occurred in at least 11 per cent of cases of multiple exostoses. In the former they arose from the cartilage cap of the lesion, but in the latter he believed they had a subperiosteal origin from inconspicuous foci of ectopic cartilage. The tumours were usually chondrosarcomas, in contrast to fibrosarcoma in the present case.

Chondromyxoid fibroma (a case of chondromyxoid fibroma of the tibia. See Figures 3 and 4)—Dr Jaffe described chondromyxoid fibroma as a tumour with a characteristic histological structure of "chondroid" tissue and "myxoid" fibrous tissue, occurring in adolescents or young adults, appearing radiologically as well defined radiolucent eccentrically situated tumours of the metaphysical regions of long bones. Confusion with chondrosarcoma was frequent, and Dr Jaffe himself first became aware of the lesion when studying cases of supposed chondrosarcoma showing unexpectedly long survival after local surgery.
Benign chondroblastoma—Radiograph (Fig. 1) and photomicrograph (Fig. 2) (×150) of a tumour of the left humerus of a boy aged thirteen years. Histologically, these tumours are characterised by cellular "chondroblastic" tissue, giant cells and scattered calcification.

Chondromyxoid fibroma—Radiograph (Fig. 3) and photomicrograph (Fig. 4) (×100) of a tumour of the left tibia in a woman aged twenty-one. Note the somewhat cartilaginous "myxoid" tissue of the tumour, and the elongated or stellate cells.
INSTITUTE OF ORTHOPAEDICS AND PATHOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND

Slide seminar on tumours of bones and joints—Dr Henry L. Jaffe conducted a slide seminar on tumours of bones and joints, arranged by the Institute of Orthopaedics and the Pathological Society of Great Britain and Ireland, at the Institute of Pathology, Belfast, on July 2, 1953, with Dr H. A. Sissons in the Chair.

The meeting occupied a full morning and took the form of commentaries on a series of cases which included examples of osteoid osteoma, benign chondroblastoma, chondromyxoid fibroma, giant-cell tumour of bone, fibrous dysplasia of bone, and pigmented villonodular synovitis, together with some cases in which diagnosis was uncertain. Clinical abstracts, radiographs and histological sections had been circulated beforehand. Discussion followed each group of cases, and the meeting gave British pathologists an opportunity of gaining first-hand acquaintance with some of the “entities” described in the literature by Dr Jaffe and his colleagues. Attention was particularly directed to the bone tumours occurring in Paget’s disease. Dr Jaffe put forward the view that these were often of complex histological structure. Sections of a single tumour sometimes showed in different areas the characteristic appearance of osteogenic sarcoma, fibrosarcoma, chondrosarcoma and, in addition, areas of giant-celled tissue. In some cases the giant-celled tissue predominated, but despite this Dr Jaffe did not regard these tumours as “malignant giant-celled tumours.”

UNIVERSITY OF LIVERPOOL

VISIT OF DR H. L. JAFFE

The Departments of Orthopaedic Surgery and Pathology of Liverpool University were very pleased to entertain Dr Henry L. Jaffe on June 18 and 19, and a large programme was packed into his all-too-short stay.

On the morning of June 18, he was an amused observer of that part of the Final M.B. Clinical Examination that concerned orthopaedics. In the afternoon he delighted a large audience of staff, postgraduates and undergraduates with the remark that Liverpool plainly was not the place for a set formal lecture, and that he had torn up his script and rearranged his slides. He proceeded to give a most interesting talk on fibrous dysplasia of bone, illustrated with a wealth of magnificent colour microphotographs. At the end he added a make-weight on osteoid osteoma, with fully documented and illustrated cases, which was really another lecture in itself. In the evening, the orthopaedic surgeons and pathologists dined Dr Jaffe.

On June 19, six unusual lesions of bone and joint were presented in detail to Dr Jaffe for his comment, and much interesting discussion followed.

UNIVERSITY OF GLASGOW

BONE TUMOUR CONFERENCE

Dr Henry L. Jaffe of the Hospital for Joint Diseases, New York, visited Glasgow on June 28–30, 1953, and conducted a bone tumour conference.

Giant-cell tumour of bone—On June 29 Dr Jaffe delivered a University Lecture on giant-cell tumour of bone. He defined this tumour and showed wherein it differed from its so-called variants, stressing the histological features of these but indicating also their sites, age and sex incidences and how these characteristics were more dependable than the radiographic appearances. Giant-cell tumours were often malignant, and radiotherapy seemed to increase the liability to malignant change; the name osteoclastoma was not justifiable. He appealed to pathologists always to prepare as many blocks as possible from resected specimens, and indicated in general that personal proficiency in bone tumour diagnosis and the general advancement of this science could come only from very thorough study of all available tissue.

Radiographic and histological demonstration—A collection of thirty rare or difficult cases from the Glasgow area was open in the pathology department, the Western Infirmary, during the period of the conference. Each case was shown as the problem it presented at the time of operation, and the follow-up data were meantime withheld. On the afternoon of June 30 Dr Jaffe, using a microprojector, dealt convincingly with the most interesting of these cases. He stressed in particular the importance of recognising chondromyxoid fibromas, and of differentiating between chondrosarcomas and those osteogenic sarcomas that showed much cartilage formation. A chondrosarcoma was a malignant tumour arising in adult cartilage and composed of anaplastic and neoplastic forms of cartilage; the prognosis after amputation was relatively good. Osteogenic sarcoma was a malignant tumour arising in primitive bone mesenchyme which might form aberrant myxoid, chondroid or cartilage, and osteoid; it had a poor prognosis even after early amputation.

At the week-end the same assiduous enquiry, eye for detail, and retentive memory were exercised on the phenomena of the Scottish countryside, and Dr and Mrs Jaffe were throughout most charming guests.
Adamantinoma—Dr R. B. Lucas said that this was an epithelial tumour bearing a structural resemblance to certain elements of the odontogenic apparatus. The tumour occurred in the jaws, more often in the lower than in the upper, and, though neoplasms of somewhat similar appearance arising in the long bones, the ovary, the pituitary and the pharynx had also been characterised as adamantinoma, it was very doubtful whether there was a true genetic relationship. The typical adamantinoma showed a follicular structure, consisting of nests or islets of epithelium in a fibrous stroma, the epithelial elements being composed of an outer layer of cubical or columnar cells enclosing an area of stellate cells resembling the stellate reticulum of the enamel organ of the developing tooth. Cyst formation within the epithelial follicles, or in the fibrous stroma, was common. Epithelial cyst formation was often accompanied by degenerative changes of the stellate cells, which produced an appearance superficially resembling squamous metaplasia and keratinisation. True squamous metaplasia in the adamantinoma was probably uncommon. Stromal cyst formation might produce an appearance not unlike that shown by the areas of proliferating but non-neoplastic epithelium which often occurred at the site of inflammation or in the walls of dental and dentigerous cysts. Solid forms of adamantinoma also occurred, which might be difficult to diagnose histologically in biopsy specimens. In all cases of difficulty, further material should be examined.

Osteolytic primary tumours of the jaws—Dr C. H. G. Price said that these accounted for only 3-7 per cent of all tumours in the Bristol Bone Tumour Register Collection 1946–53. The lesions classified as localised fibrous dysplasia and giant-cell tumour amounted to a further 6 per cent. The clinical, radiological and histological features of the tumours were described and discussed in the light of their characteristic behaviour in the general skeleton. Factual histological classification was preferred to inconclusive histogenetic considerations, these being related to atypical tissue of differentiation. The problems of histological assessment of malignancy were indicated, with special reference to estimation of growth rate by quantitative mitotic analysis. It was emphasised that prognosis was inferred from comprehensive appreciation of tumour type, site, stage, histological grading, contributory skeletal disease and possible type mutation. With the frankly malignant growths it was shown that the five-year cure rate was approximately the incidence of tumours of Grade I malignancy, and that in this grade cures could be expected from local surgery or radiotherapy only.

Fibrous dysplasia of the jaw bones—Dr P. C. Meyer had found every gradation from affection of only one bone to the comparatively rare affection of several. From a review of the literature it appeared that jaw lesions might show any of the variations of histological structure found in the skeleton in generalised fibrous dysplasia. Dr Meyer described some examples in which the jaw was involved. These included that of a middle-aged man who was cured by partial removal of the dysplastic tissue.

SOUTH-EAST METROPOLITAN REGION ORTHOPAEDIC CLUB

A meeting of the South-East Metropolitan Region Orthopaedic Club was held at the Royal Sea Bathing Hospital, Margate, on July 4, 1953. Over forty members and guests were present.

Congenital affections of the skeleton—Mr F. G. St Clair Strange (Canterbury) described a veritable museum collection of congenital affections of the skeleton.

Tuberculosis of the knee joint—Mr P. R. Wright (Margate) showed six cases of tuberculosis of the knee joint under treatment by immobilisation and systemic streptomycin. The rapid improvement in symptoms and signs was notable, but in two cases mild activity had recurred when weight bearing was resumed. The place of synovectomy in the treatment of tuberculosis of the knee joint was discussed.

Acute osteomyelitis of the cervical spine—Mr P. R. Wright also showed a case of acute osteomyelitis of the cervical spine in an elderly woman. The infection was complicated in its early stages by partial paraplegia, which had resolved completely with conservative treatment. The patient was now walking, the neck being protected by a collar. There were no residual neurological signs.

Infective arthritis of the ankle joint—Mr M. L. Mason (Margate) showed a patient with infective arthritis of the ankle joint with a focus of bony destruction in the talus. The case presented all the clinical features of tuberculous arthritis but the Mantoux reaction was repeatedly negative. The infection had settled well on conservative treatment and the patient was walking in plaster. Biopsy hardly seemed justifiable in these circumstances.
Pes calcaneo-cavus—Mr M. L. Mason showed a boy with severe pes calcaneo-cavus following poliomyelitis. There was complete paralysis of the posterior calf muscles, but all other muscles remained active. Despite his very ugly foot, this adolescent boy complained of no pain and could walk, run and play football. The danger of impeding function while improving the appearance of this foot by attempts at operative correction was emphasised in discussion, and the consensus of opinion supported Mr Cholmeley’s plea for mastery in activity unless symptoms arose to necessitate surgical treatment.

Adolescent hallux valgus—Mr Mason presented a further case for discussion: that of a hallux valgus in a girl of fourteen with metatarsus primus varus. The various forms of operative approach to this problem in the young were discussed, and though Mr T. T. Stamm’s method found some support, the suggestion was put forward by Mr W. H. Gervis that conservative treatment, and especially the correction of general faults in posture, had an important part to play in the treatment of this and other similar cases.

Surgery for deformities complicating disseminated sclerosis—Mr Mason asked the opinions of members on a case of spastic paraplegia in disseminated sclerosis in a middle-aged woman with gross fixed flexion and adduction deformities of both lower limbs. The usefulness of tenotomies and muscle slide operations in certain cases of this sort was mentioned by Mr W. D. Coltart and Mr H. L.-C. Wood. They emphasised the value of post-operative nursing in a bivalved double plaster spica to allow daily inspection of the skin.

Other cases—Mr P. R. Wright showed a child of seven who had a torn lateral semilunar cartilage. Mr Basil Armstrong (Margate) showed an adolescent girl with avascular necrosis affecting a sector of one femoral head, and another child with periostitis of the femoral shaft associated with tuberculosis elsewhere.

History of the Royal Sea Bathing Hospital—Mr Basil Armstrong gave a most interesting historical survey of the Royal Sea Bathing Hospital from its foundation at the end of the eighteenth century to the present day. He recalled that until about 200 years ago the health value of the summer holiday at the seaside had not been appreciated, though the waters of inland spas such as Bath and Tunbridge Wells had been used as curative for centuries. Richard Russell ("Sea-Water" Russell), son of a surgeon-apothecary practising at Lewes, while apprenticed to his father, fell in love with the daughter of a wealthy patient and married her clandestinely. Forgiven by his bride’s father who encouraged him to rise above the rank of an apothecary and qualify as a physician, Russell studied at Leyden, and on his return to England started in practice at Lewes. On the death of his father-in-law, he left Lewes to practise at Malling Deanery which he inherited through his wife.

Russell had been impressed by the virtues of sea-water which he used internally and externally in the cure of enlarged glands, and produced two books on the subject which had a wide circulation. His books made him famous and at the age of sixty-three he moved to Brighton, where he built a house and practised until his death in 1759. Brighton, or Brighthelmstone as it was then called, became much patronised by the wealthy. The Duke of Cumberland stayed there annually for his health, and probably George III would have been sent there also instead of to Weymouth for convalescence after his attacks of madness had it not been that he disliked his brother so much; and it is equally probable that it was to annoy his father that the Prince of Wales visited his uncle at Brighton and then started the memorable days of the Pavilion which established its fortune at the beginning of the nineteenth century.

John Coakley Lettsom, a well known Quaker physician of the day, a man of extraordinary energy and versatility—he was a founder member of the Medical Society of London and the Royal Humane Society, a protagonist on behalf of Jenner in the great inoculation controversy, a pioneer for prison reform, and a man of much wealth and benevolence—conceived the desire to make available to the poor what was useful to the wealthy, and he hit upon the idea of starting a hospital for them at Margate. A meeting of Lettsom and some eight others was held at the London Coffee House on July 2, 1791, when Lettsom explained his scheme and was authorised by the meeting to go to Margate with Mr Nichols and Dr Pridden to select and purchase a site for the hospital. This was done, two acres of ground at Westbrook being obtained for the sum of £300; a local committee was formed and further London meetings were held during the month of July. The hospital was opened five years later, having been built to a plan inspired by Lettsom and drawn up by the Rev. John Pridden, who was an antiquary and amateur architect. He designed the original building illustrated in Lettsom’s "Hints on the formation of a Sea Bathing Infirmary," and it is noteworthy that his design made provision for patients to live and sleep on verandas in the open air, a thing previously unheard of in hospital architecture.

The ease of access from London, either by coach or by sea, was one of the principal reasons for the selection of Margate as the site of the hospital. Stage coaches took about fourteen hours
on the journey, their fare being 16/- to 19/-. The Hoys, single-deck sailing ships which plied between Margate and the London Docks, had good accommodation for patients at 2/6 each and were consequently more widely used than the coaches.

During its early years the Sea Bathing Infirmary was open only in the autumn, from August to December. Sixteen patients were admitted during its first year, but by 1800 the number had risen to eighty-six.

Lettsom continued, until his death, to take a keen personal interest in the hospital. He visited it at least once each year, examining the patients, attending a religious service at which the collection was devoted to the hospital, and later a dinner where again a collection on behalf of the hospital was made. The Sea Bathing Infirmary increased steadily in size after his death, being enlarged in 1816, 1837, 1858, 1882 and 1919, and the original thirty patients are now augmented to 300. Its title was changed to the Royal Sea Bathing Hospital in 1898. It was the first hospital in the world in which open air treatment had been systematically practised.

EAST ANGLIAN ORTHOPAEDIC CLUB

A meeting of the East Anglian Orthopaedic Club was held on January 31, 1953, at the East Suffolk and Ipswich Hospital, Ipswich. Clinical cases were demonstrated.

**Osteomyelitis of the spine**—Mr E. Bell Jones (Ipswich) showed a case of a man of eighteen with a febrile illness, a raised sedimentation rate and pain in the back. The radiographs showed narrowing of the joint space between T.11 and 12 and of the manubrium sterni. This was presented as a case of ankylosing spondylitis, but Dr J. Phelan, who supervised the x-ray treatment, expressed some disagreement with the diagnosis on the grounds that the onset was too acute and that the radiographic changes in the sacro-iliac joints were unconvincing. He showed special oblique views of the sacro-iliac joints which showed the joint space to be present. He was of the opinion that this was a case of a low-grade osteomyelitis.

**Tuberculosis of the spine**—Mr E. Bell Jones showed a second patient who came under observation as a case of tuberculous spine with a psoas abscess but this was not substantiated by further investigation and the possibility of its being a case of ankyllosing spondylitis was discussed.

**Tuberculosis of the ankle**—Mr K. L. Marks showed a case of a tuberculous ankle in a patient with a positive Mantoux reaction and abscess formation. Out-patient treatment by daily injections of streptomycin was given; it was felt that the splintage that had been prescribed had not been carried out, for the boy developed a march fracture during the course of treatment.

**Tuberculosis of the knee**—Mr L. C. Wilkinson (Black Notley) said that no antibiotic could be expected to take the place of properly conducted general treatment and that after treatment by streptomycin the synovial membrane might produce a histological picture difficult to diagnose and needing special experience. To make antibiotics effective, operation must often be carried out, because little streptomycin might reach the bone without it. He believed in the value of a partial synovectomy in the treatment of tuberculous joints. Mr Noel Smith (Peterborough) supported the value of synovectomy with streptomycin and maintained that the removal of 70 per cent of the synovial membrane gave nature a chance to produce a normal joint.

**Osteitis of the illum**—Mr T. Denness (Ipswich) showed a case of a girl of thirteen who complained of pain over the iliac crest for three months. The pain was aggravated by running. There was some swelling at the site of the pain. Radiographs showed a layer of calcification parallel to the crest but separate from it. Later radiographs suggested that this change was probably infective, though the possibility of a neoplasm had been suggested by the earlier films.

**Osteochondritis of the radial head**—Mr T. Denness showed a boy of thirteen with pain in the elbow joint. Radiographs showed a fragmented radial head but the fragment did not unite and the possibility of its origin from an osteochondritis of the radial head was discussed. Normal function was regained but there was some cubitus valgus. There was some discussion as to whether or not the fragment of bone should be removed, and there was no general agreement whether the diagnosis should be osteochondritis or fracture.

**Ankylosis of hips**—Mr K. L. Marks (Ipswich) showed a patient with bilateral ankylosis of the hips treated by a subtrochanteric osteotomy on one side and later a Jones type of pseudarthrosis on the other. The functional result was good.

**Osteochondritis dissecans**—Mr K. L. Marks demonstrated a case of osteochondritis dissecans in the right ankle. Mr T. J. Fairbank (Cambridge) suggested that these cases began as fractures into the ankle joint and that a fragment of articular cartilage became detached in that way.
Monteggia fracture—Mr E. Bell Jones showed a case of dislocation of head of the radius with fracture of the ulna. Attempts at reduction failed. A medullary nail was inserted and this proved an expeditious method of treatment.

Fractured femur—Mr D. M. Keir (Ely) showed a case of medullary nailing for a fracture of the mid-shaft of the femur. Fracture of the nail occurred six months after the original injury. Six months later he fell again and fractured the neck of his femur. The medullary nail was removed and a Smith-Petersen nail inserted.

Osteoclastoma—Mr R. C. Howard (Norwich) showed the radiographs of a bone tumour for diagnosis. These were the films of a boy who, at the age of fourteen, received a blow on the shin from a cricket ball. The appearance of the tibial lesion gave the impression of a simple cyst, but a second radiograph showed periosteal new bone. At biopsy a brownish fluid was removed which contained several giant cells, and the diagnosis of osteoclastoma was suggested. Six weeks later he sustained a fracture into the cyst. While the limb was in plaster the biopsy scar broke down and a fungating mass developed. A second biopsy showed nothing more than blood clot in the mass, with a few scattered giant cells. The opinion was expressed by members that this condition had probably been malignant from the beginning.

Dr J. Phelan (Ipswich) spoke of his experience with the changes in some of these cysts after trauma which gave appearances resembling a sarcoma and reported that there was difference of opinion as to whether they were malignant or not. He was of the opinion that they were a form of giant-cell tumour whose behaviour was altered by the increased vascularity after injury.

A further meeting of the Club was held at the West Suffolk General Hospital, Bury St Edmunds, on March 28, 1953. Clinical cases were shown.

Osteomyelitis—Mr D. J. Martin (Bury St Edmunds) showed radiographs of two boys with osteomyelitis of the femur and tibia respectively which had not responded to antibiotics. He discussed the place of surgery and how extensive it should be. The failure of antibiotics to be an effective means of treatment alone could be due to delay in beginning treatment, to inadequate dosage, to to insensitivity of the organism. Operation was sometimes delayed too long, so that bone was already dead, and it was often not sufficiently extensive. A discussion followed in which other members agreed that when antibiotics were used it was not so easy to decide on the right time to operate. It was agreed that it was better to operate too soon than too late; that if pus was found under the periosteum the cortex should be drilled; that if pus escaped from the drill holes the medullary cavity should be channelled; and that the wound should be closed by primary suture.

Unusual cases—Mr Martin then showed a series of curiosities. Toxoplasmosis—The girl attended with injuries from falling in a fit. The radiograph of the skull showed the characteristic crescentic calcifications in the brain. One eye also showed old choroïditis-retinitis. Eosinophilic granuloma—A small child with a soft swelling in the skull which showed radiographically a clear and localised osteolysis. The blood chemistry and sternal puncture were normal and the blood picture showed a slight excess of eosinophils. While under observation over six months the swelling disappeared, as did the area of transradiancy in the skull. Radiographs of the rest of the skeleton showed no other abnormality. No biopsy was made. Infantile cortical hyperostosis—The baby was first thought to have osteomyelitis of the jaw, but the condition subsided spontaneously, only to come up again. Radiographs taken on the second admission showed the additional layer of bone on the cortex of the mandible, and possibly also of the clavicle. Other bones were not affected. Members spoke of cases they had seen affecting the scapula, ribs and pelvis. Osteochondral dystrophy—This man had had a grossly enlarged left arm since birth. The thumb was seven inches long, deformed and useless. He carried it hidden in a linen bag and was unwilling for it to be seen, nor would he allow anything to be done to it. He had come into hospital for some other unconnected reason.

Radiotherapy for orthopaedic affections—Dr M. Bennett (Cambridge) showed a number of cases referred from the orthopaedic department for radiotherapy. The first was a case of a secondary deposit in the pelvis from a carcinoma of the breast removed five years before. This had eroded the ilium to such an extent that a fracture had occurred through the acetabulum into it. Treated with x-radiation and testosterone, the bone re-formed and the growth disappeared, leaving a large gap in the ilium. The second case shown was one of osteoclastoma of the sacrum. The patient had sought advice for sciatic symptoms. The nature of the growth was established by biopsy. Treatment was by x-radiation, but the ureters became involved and she died from pyonephrosis. Some difference of opinion was expressed about the value of x-rays in treating these cases, but Dr Bennett believed that good results could be obtained in many cases with efficient treatment. He would prefer to treat the tumour from the beginning rather than after it had been "scraped out" by a surgeon.
Osteoporosis of the spine—Dr M. Bennett showed a case. At first the patient had been thought to have secondary carcinomatous deposits in the vertebrae, but this diagnosis was given up as the patient was observed, for extension of the disease did not occur and the osteoporosis of the vertebrae was generalised. Mr D. J. Martin showed radiographs of two other cases of senile osteoporosis and Mr R. W. Butler (Cambridge) showed the films of a boy with pulmonary tuberculosis whose spine had assumed an appearance exactly similar. The use of butazolidine for the relief of pain and the use of dicalcium phosphate was recommended by other speakers.

Perthes disease—Mr D. J. Martin showed radiographs of children with Perthes disease. He disagreed with the statement made by Legg: "While a process suggesting weakness of bone structure is going on, it is theoretically sound to allow no weight bearing, but in practice relief from weight bearing in no way affects the end results." He believed that the occurrence of osteoarthritis of the hip after Perthes disease in childhood would be evidence against this contention. He made a plea for treatment with bed rest and light traction for many months—perhaps a year—until some regeneration was seen to be taking place, followed by the use of a patten-ended caliper on the affected side and a patten on the other.

A further meeting of the Club was held at the Thorpe Hall Rehabilitation Centre, Peterborough, on June 6, 1953. Clinical cases were demonstrated.

Myelography for prolapsed disc and spinal tumours—Mr K. L. Cleminson (Peterborough) demonstrated, with a series of radiographs, the value of myelography in the diagnosis of protrusion of intervertebral discs. It enabled the site of the lesion to be determined and helped to differentiate a displaced disc from spinal tumour.

Infantile cortical hyperostosis—Mr Noel Smith (Peterborough) showed films of two cases of this condition and discussed the differential diagnosis. Mr Bell Jones made the comment that since the previous meeting of the Club he had seen a child with this condition and thought it remarkable that four cases of this rare condition should have been reported in the region in so short a time.

Metaphysial aclasis—Mr Noel Smith showed a case of metaphysial aclasis in which the predominant symptom was pain in the shoulder. Radiographs showed an exostosis on the scapula and further studies revealed similar exostoses on many other bones. It was proposed to remove the exostosis on the scapula.

Obliteration of brachial artery by crutch pressure—Mr K. L. Cleminson described obliteration of the brachial artery by crutch pressure in a man who had suffered from extensive paralysis from anterior poliomyelitis at the age of two years. He had used T-shaped crutches all his life, but recently he had noticed coldness and cyanosis of his hand. There was a contracture of the fingers similar to that of Volkman's ischaemic contracture. An arteriogram showed a block in the first part of the axillary artery. At operation the artery was found to be blocked as far down as the elbow. Treatment was discussed. Stellate ganglionectomy and division of the scalenus anterior were suggested.

Fibrosarcoma of tibia—Mr Noel Smith showed an operation specimen of a fibrosarcoma of the tibia. The patient was first seen in 1946, when the growth was removed locally and the gap bridged by a cadaveric graft and bone chips from the ilium. Healing progressed for ten months, when it was found that the growth had recurred; amputation above the knee was therefore carried out. Some discussion on the value of x-ray treatment followed.

Senile gangrene—Mr Cleminson discussed the use of intra-arterial vasodilators in the case of incipient or established senile gangrene and described his technique and the preparation used.

Multiple fractures—Mr Noel Smith demonstrated the value of medullary nailing in a case of refraction of the mid-shaft of femur and another of refraction at the site of a bone graft for subtrochanteric fracture. Two further cases of multiple fractures were shown: one followed electric convulsive therapy; the other was in a child of three years without blue sclerotics and in whom the question of maitreatment was considered. He then showed a case of massive loss of bone from a humerus after an industrial accident. The fracture had been treated with a tibial graft to bridge the gap; eight months after the operation the arm was stable but the elbow was rather stiff.

Fracture through cyst of tibia—Mr G. K. McKee (Norwich) showed radiographs of a girl with a fracture through a cyst in the tibia. Three years later this had developed into a fibrocystic area. The diagnosis was discussed and the suggestion that it was an example of Albright's syndrome was considered.

Paraesthesia of arm and paraplegia—Mr R. C. Howard (Norwich) showed the radiographs of a man of fifty-one with pain and paraesthesia in the arm and paraplegia. He had been operated upon by a neurosurgeon who had carried out an extensive laminectomy, which led to cervical
subluxation. Skull traction produced some improvement, but when the traction was removed the paraplegia returned. There were hardly any spinous processes remaining and the possibility of grafting from the skull to cervical vertebra 7 was considered. The general opinion was that skull traction should be continued in the hope that fibrosis would eventually afford adequate stability.

JOINT MEETING OF THE MANCHESTER AND LEEDS REGIONS ORTHOPAEDIC CLUBS

A joint meeting of the Manchester Orthopaedic Club and the Leeds Orthopaedic Club was held in Harrogate on June 26 and 27, 1953, at the Royal Bath Hospital.

Surgical treatment of rheumatoid arthritis—Mr H. Petty (Harrogate) claimed that better results would be obtained by closer co-operation between physicians and surgeons from the very beginning and throughout the whole process of the disease. He advocated earlier surgical intervention, and believed that clinical and laboratory signs of disease activity were not any contra-indications; advantage ought to be taken of the healthy state of the patient’s tissues in the early stages of the disease. For the hip joint, arthroplasty was recommended early in the disease; a posterior atraumatic approach was used and an acrylic prosthesis was fitted after resection of part of the femoral head; early activity was encouraged. In the late chronic stage arthroplasty was of no value and resection of the femoral head and neck was the only operation worth considering. In the knee joint, activity of the disease despite conservative measures could be reduced either by arthrotomy and lavage or by synovectomy. Bilateral arthroplasty of the knee could give excellent results but it was better, when both knees were stiff, to have one painless stiff knee and one knee rendered mobile by arthroplasty. In the ankle joint, pain and disorganisation made early fusion imperative. In the foot much could be done for the later deformities to improve function by resection of the second, third, fourth and fifth metatarsal heads, Keller’s operation, moulding and plaster fixation. Disease of the shoulder and elbow was usually controlled adequately with conservative care and seldom required operative treatment. In the early stages, if the elbow joint was almost or entirely stiff arthroplasty ought to be seriously considered because at least half the normal range of movement with good stability could easily be obtained. Arthroplasty of both elbows was not recommended because the patients found difficulty in using sticks for walking; it was better if one elbow was stiff in semi-extension to give more stability. In the wrist joint pain necessitated early fusion and the results were satisfactory. In the hand, though there might be marked deformity, function was often quite good. A judicious combination of physiotherapy and occupational therapy was often very efficacious and manipulation was frequently of value. At a clinical demonstration Mr Petty illustrated the following orthopaedic conditions occurring among “rheumatic” patients: arthritis mutilans, Sjögren’s syndrome, osteoporosis and subluxation of both shoulder joints, acrylic and cup arthroplasties, cervical spondylitis with cord compression, gout, psoriatic arthropathy, gross synovial swelling of the knee, Still’s disease and Klippel-Feil syndrome, gargoylism, and syringomyelia with neuropathic arthropathy of wrists.

Films—Mr R. Broomhead (Leeds) showed two colour films—one on the technique of the Smith-Petersen arthroplasty of the hip and one on rehabilitation after arthroplasty of the hip.

Arthroplasty of the hip—Mr R. Broomhead referred to arthroplasty of the hip both by vitallium mould and by the acrylic prosthesis. The following were some of his observations. 1) Many moderate results from vitallium mould arthroplasties are caused by failure to perform the operation thoroughly. 2) When the acetabulum is irregular and has to be gouged out the mould is preferable to an acrylic prosthesis. 3) Evident deafness is almost a contra-indication to operation because of the patient’s inability to appreciate the post-operative instructions. 4) Post-operative progress when an acrylic head prosthesis is used is much quicker than after a mould. 5) A number of patients who have a mould in one hip and a prosthesis in the other prefer the mould because they feel it is more secure.

Development of the Leeds Region Rheumatic Centre—Mr H. Petty gave a short account of the history, the present position and contemplated future developments of the Leeds Region Rheumatism Centre at Harrogate. He indicated how an orthopaedic unit had been developed and what part it played in the rheumatic service. Members of the Clubs were shown round the Harrogate Rheumatism Centre at the Royal Bath Hospital, the White Hart Hospital and the Royal Bath Treatment Centre.

CANADA

CANADIAN ORTHOPAEDIC ASSOCIATION

At the Ninth Annual Meeting of the Canadian Orthopaedic Association, which was held in Winnipeg and Minaki Lodge, Ontario, from June 20–24, 1953, members were honoured by the presence as guest speaker of the president-elect of the British Orthopaedic Association, Professor
Bryan McFarland. His presence, with Mrs McFarland, added tremendously to the inspiration of both our social and scientific programmes. The members of the Canadian Orthopaedic Association, in an effort to express their appreciation in a tangible way, elected Professor McFarland an honorary member of the Association.

ITALY

ITALIAN-FRENCH ORTHOPAEDIC DAYS

The meeting known as "Italian-French Orthopaedic Days" was held in Venice on May 14 and 15, in Bologna on May 16 and in Turin on May 18, 1953. It was attended by many orthopaedic surgeons of the two countries; among them were Drs G. Huc, M. Fevre, M. Guilleminet, Ducroquet, J. Judet, E. Calandra, U. Camera, F. Delitala, E. De Marchi, C. Marino-Zuko, O. Scaglìetti, R. Zanoli, some Belgian guests and others.

The programme in Venice (Ospedale Civile)—Many interesting problems were discussed. They included fractures of the femur in childhood (Dr J. Judet); Küntscher's nailing in arthrodesis of the knee joint (Dr R. Ducroquet); recurrence of solitary bone cysts after operation (Dr J. Creysseil); the treatment of the paralytic elbow (Dr P. Lecoeur); can infantile paralysis benefit from tissural therapy? (Dr E. Calandra); functional stabilisation of the flail lower limb (Dr A. Albanese); bone synthesis with tridimensional plates (Dr C. Marino-Zuco). Ciné films were shown of arthroplasty in hallux valgus by Dr R. Ducroquet, and herniae of cervical intervertebral disc (Professor O. Scaglìetti).

The programme in Bologna (Istituto Ortopedico Rizzoli)—Professor M. Guilleminet discussed the treatment of congenital pseudarthrosis of the tibia. Ciné films were shown of arthrodesis by compression by Dr R. Zanoli and metallic endoprosthesis in resection for tumours by Dr F. Delitala.

The programme in Turin (Clinica Ortopedica)—Professor U. Camera discussed the problems of tuberculous coxalgia, the biological treatment of skeletal tuberculosis and the surgical treatment of osteoarthritis of the hip joint. Patients were shown to illustrate the late results. The demonstration was followed by an operating session.

SOUTH AMERICA

JOINT MEETING OF THE LATIN-AMERICAN SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY AND THE BRAZILIAN SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY

The second congress of the Latin-American Society of Orthopaedic Surgery and Traumatology was held in Rio de Janeiro and in São Paulo from July 18 to August 1, 1953. The conference was attended by more than five hundred orthopaedic surgeons from all the Latin-American countries and by many others from the United States of America and European countries. The guests of honour who had received special invitations included Drs Alan De-Forest Smith, Francis W. Glenn, Harold Boyd, Harry Winkler, John R. Cobb, John R. Moore and Stirling Bunnell from the United States of America; Professor R. Merle d'Aubigné and Dr Jean Judet from France; Professor F. Delitala from Italy; Dr M. Bastos Ansart from Spain; Professors G. Küntscher and Max Lange from Germany; Professor Lorenz Böhl er from Austria; Professor Sten Friberg from Sweden; and Sir Reginald Watson-Jones and Professor J. Trueta from Great Britain.

The first part of the congress was held in the magnificent Quitandinha Hotel at Peropolis, a town situated in the mountains forty miles from Rio de Janeiro at 2,000 feet above sea level. The whole hotel had been booked by the organisers. Its many halls, lecture rooms and large theatre together with ballrooms, restaurants and cabarets allowed the many scientific discussions and exhibits to be combined happily with reunions and social occasions. The annual meeting of the Brazilian Society of Orthopaedic Surgery and Traumatology at the same time gave all the visitors the opportunity to appreciate the maturity which orthopaedics has reached in Brazil.

The congress demonstrated clearly the merit of organising a scientific and clinical meeting in the same premises as members were residing, many with their wives. There was a unique opportunity for all those attending the meetings to become acquainted with each other and to discuss problems of interest informally while sitting in the lounge of the hotel.

The subjects of discussion included fractures of the wrist; reticulo-endothelial and Ewing's tumour; fractures of the os calcis and scoliosis; and there were about twenty special lectures given by the guests of honour.

Apart from the value of scientific discussions aided by the excellent system of simultaneous translation, so that those attending the meeting could stay in any part of the hall and with
earphones hear a translation into his own language at the same time that the speaker was delivering his lecture in French, English, Spanish, Portuguese or German, there was tremendous success in the social activities. Visitors to Brazil must have been impressed by the facility with which the Latin-Americans and Brazilians could switch from serious scientific discussion to light-hearted entertainment and dancing.

The second part of the congress was held in the city of São Paulo which by some is known as the "New York of South America" and by others as the "Soul of Brazil." There were discussions on the treatment of skeletal tuberculosis, fractures of the upper limb in infants, recurrent dislocation of the shoulder, and fractures of the humerus. The new Orthopaedic and Accident Hospital of the Medical Faculty of São Paulo under the directorship of Professor Godoy Moreira was officially opened by the Governor of the State, Dr Lucas Nogueira Garcez. This magnificent building with its extensive accommodation and efficient organisation of services would honour any city in the world.

There was one happy evening when those attending the congress entertained each other, and the two visitors from Britain displayed "The Harley Street Surgeon in Brazil" removing large masses of metal, consisting mainly of spoons, knives and forks, from a fractured thigh, and then rehabilitating the patient with sambas and rhumbas. The occasion has passed into the orthopaedic history of South America. It was a very enjoyable meeting and visitors carried away with them a memory of high scientific endeavour, skilfully organised surgical programmes, magnificent hotels and wonderful mountain scenery, firework displays over the lake, folk-singing over camp fires, and a general sense of the gaiety of life in Brazil.

Tribute must be paid for their tremendous effort to Dr Juan Farrill of Mexico and Dr José Bado of Uruguay who are presidents of the Latin-American Society, and to Dr Pinheiro Campos, president of the Brazilian Society, together with all those others who organised the meeting, including Professor José Valls, the honorary president of the congress and Dr Luthero Vargas, son of the president of Brazil.

INTERNATIONAL SOCIETIES

BRUSSELS TREATY ORGANISATION: PROSTHETIC SUB-COMMITTEE

AMPUTATION STUMP LENGTHS

Before the 1914–18 war there was much diversity of opinion about the best length of amputation stumps, and the old adage that most leg stumps should be end-bearing died hard. The impact of approximately 45,000 amputees in Great Britain alone, from the 1914–18 war, enabled a prolonged study of the problem to be carried out and there now appears to be a general consensus the world over, with perhaps a few exceptions, that certain lengths of stumps give better results than others both functionally and prosthetically and that what came to be termed the "ideal" stump is least liable to complications from the prolonged wear and tear of limb wearing.

At the meeting of the Prosthetic Working Party Sub-Committee of the Brussels Treaty Organisation in Utrecht from February 23-25, 1953, attended by prosthetic experts from Belgium, Britain, France, Luxembourg and the Netherlands, the following lengths of stumps were agreed as "ideal" in adult males of average height. The above-knee stump should measure 10–12 inches from the tip of the greater trochanter, and the below-knee stump 5½ inches from the medial articular surface of the head of the tibia. The Stokes-Gritt amputation was not favoured by any country, and France alone favoured the trans-metatarsal foot amputations. Foot amputations were not generally recommended; Britain was alone in favouring the modified Syme's amputation in selected cases. The Priogoff, Chopart and Lisfranc amputations were not recommended, but the Netherlands thought that the Priogoff and Lisfranc amputations might be considered exceptionally. No country favoured disarticulation at the hip, and Britain was alone in advocating disarticulation at the knee in selected elderly patients and in children and adolescents. The ideal upper arm stump was considered to be one measuring 8 inches from the tip of the acromion, and the forearm stump 7 inches from the tip of the olecranon. Disarticulation at the shoulder and at the elbow were not favoured by any of the countries concerned, and only the Netherlands favoured disarticulation at the wrist in special circumstances. All the countries agreed that as much sensitive and scar-free tissue as possible should be conserved in attempting to retain a functionally useful hand or part of a hand.

Greatest and least lengths of stumps were also discussed in relation to the possibility of fitting the average type of limb, and it was agreed that a femur should not be less than 6 inches or over 12 inches in length, except that Great Britain felt that the average type of limb could sometimes be fitted to stumps shorter than 6 inches. It was generally agreed that the below-knee stump
should not be shorter than 2 inches or longer than 6 inches. It was agreed that the length of a stump above the elbow should range between 1 inch below the pectoralis major tendon and 3½ inches above the elbow if the most useful type of articular arm were to be fitted and adequately controlled, and that a forearm stump should not be shorter than 3½ inches or longer than 8 inches from the tip of the olecranon—the Netherlands again advocating the retention of the through-wrist amputation exceptionally.

INTERNATIONAL SOCIETY OF ORTHOPAEDIC SURGERY AND TRAUMATOLOGY

PROVISIONAL ARRANGEMENTS FOR THE 1954 MEETING IN BERNE, SWITZERLAND

The Sixth congress of the International Society of Orthopaedic Surgery and Traumatology will be held in Berne from August 30 to September 3, 1954, as briefly announced in the May number of the Journal. To facilitate the task of the organisers, those who intend to be present are requested to notify the secretary general (Dr Jean Delchef, Rue Montoyer 34, Brussels, Belgium) before May 31, 1954, at the latest. Active and retired members of the Society are admitted without charge to the scientific sessions. Those who are not members of the Society may participate as associate members on payment of a registration fee of 40 Swiss francs. Members of the Society will receive the reports to be presented to the congress on or before February 28, 1954. Those who wish to take part in the discussion of the reports should inform the secretary general before May 31, 1954, and should forward a summary of 250 words, preferably in English and French. Members of the Society who wish to read papers at the meeting should send to the secretary general, through their own national committee, a summary of 250 words, in English or French, before May 31, 1954. They should certify that the communication has not already been published either in substance or in form.

In due course those registered as taking part in the congress will receive a personal card (of different colour to distinguish active members, associate medical members, and associate non-medical members). Each card will have a number which will enable the holder to exchange it readily, on arrival in Berne, for his congressis's folder. This folder will contain: a congress badge; the final programme of the congress; the text of the reports; the summaries of papers and discussions; a summary of the lectures to be delivered during visits outside Berne on September 1; and a card of admission to the outside visits and to the social functions of the congress.

Those who intend to take part in the scientific programme are reminded that reports are limited to twenty minutes each, and discussions and papers to ten minutes each. This rule will be strictly enforced.

Provisional Programme

Monday, August 30—9.00: Meeting of International committee. 11.00: Official opening of congress. 14.00: First scientific meeting. The treatment of scoliosis—Reports by Professor Bryan McFarland and Mr J. I. P. James (Great Britain). 14.45: Discussion. 17.15: Departure for dinner in the Bernese countryside.

Tuesday, August 31—9.00: Further discussion on the first subject. Papers. 11.00: General assembly. 14.30 to 17.30: Papers.

Wednesday, September 1—Visits, in groups, to various Swiss medical centres. Group 1: Basle. Departure from Berne at 8.30. Visit to hospitals, with clinical demonstrations arranged by Drs Hans Debrunner and E. Birkhardt (Basle). Symposium on orthopaedic and traumatological problems in gerontology (openers Drs A. L. Vischer, R. Nissen and Hans Debrunner (Basle)).

Group 2: Berne-Macolin (in the Bernese Jura). Departure from Berne at 9.00. Visit to hospitals, with clinical demonstrations, arranged by Dr Marcel Dubois (Berne). Symposium on the physiological background of maximal performances in sport (openers Dr E. Howüh-Christensen (Stockholm), Dr Alex von Muralt (Berne) and Dr E. Grandjean (Zurich)). Visit to the Federal School for Gymnastics and Sports at Macolin. Group 3: Geneva. Departure from Berne at 8.45. Visit to hospitals, with clinical demonstrations by Drs A. Jentzer and A. Perrot (Geneva). Statement on the physiopathology of fractures by Dr R. Patry (Geneva). Symposium on osteoarthritis of the hip (openers Drs E. Rutishauser, P. Bardet and A. Perrot (Geneva)).


Group 5: Zurich. Departure from Berne at 8.25. Visits to hospitals, with clinical demonstrations arranged by Dr M. R. Francillon (Zurich). Statement on the legal basis of accident surgery in Switzerland by Dr F. Lang. Symposium on the physiology and pathology of locomotion (openers Drs O. Wyss (Zurich), M. R. Francillon (Zurich) and Z. Senn (St Gallen)).

Thursday, September 2—9.00: Presentation of the second subject: Surgery of the hand—Report
CORRESPONDENCE

Radiological interpretation of Jüngling's disease and chondroma of bone—Although quarterly journals do not readily lend themselves to the vigour of correspondence columns, so that after one or two trials the British Editorial Board has discouraged such correspondence, we would like to record the comments of Dr Campbell Golding of London on two articles published in the May issue of the British volume of the Journal of Bone and Joint Surgery in criticism of the radiological interpretation. In reference to the paper by William Girdwood of Johannesburg* in which a case of tuberculosis of the hand and foot was described as Jüngling's disease he writes: "This was in fact tuberculous dactylitis in an adult showing trabeculated and expanded bone, from which the bacillus was identified; it is an uncommon manifestation of tuberculosis but it is not Jüngling's disease. Jüngling described osteitis tuberculosa multiplex cystoides, which bears no resemblance to this condition; he never isolated the bacilli from the lesions. I understand Jüngling's disease to be one of the synonyms for sarcoid, and similar to lupus pernio, Schaumann's lymphogranuloma, Besnier-Boeck sarcoid, or, as it is now called Boeck's sarcoid. Without correction, this article may help to perpetuate a fallacy."

Dr Golding refers also to the article by W. Laurence and E. L. Franklin† in which five cases were described as chondroma in long bones and he writes: "The case in which a biopsy was performed looks like a chondroma but the others do not. There are many cases in the literature with identical appearances which were in fact infarcts of bone. Of the cases published in this article one patient was aged fifty-three years and the other four were all over sixty years—an age when infarction may easily occur. The pathological evidence which is presented, based on degenerated cartilage, is not enough to establish the diagnosis of chondroma. I would not have quarrelled so much with the report if there had been reference to infarct of bone in the differential diagnosis; but it was not even mentioned, whereas chondroblastoma and Brodie's abscess were put forward as possibilities, both of which are slightly ridiculous—the first by reason of the age of the patients, and the second because the lesions bear no resemblance to chronic abscess."