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FRACTURE OF NECK OF FEMUR

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The treatment of fractures of the neck of the femur must necessarily vary with the character of the fracture and the age and condition of the patient.

Impacted Fractures.—Impacted fractures are not uncommon, and since the introduction of the *x*-ray the surgeon should be satisfied with a few diagnostic indications. Slight shortening with moderate eversion, diminished arc rotation, and relaxation of fascia lata are sufficient. After the *x*-ray shadow has been secured, the sooner such a fracture is dressed with plaster-of-Paris casing, extending from the thorax to the knee (or in restless cases to the leg), the more rapidly and certainly will union take place.

In fractures of the neck with mobility; complete eversion, moderate shortening, lessened arc rotation, and relaxed fascia lata will be sufficient for diagnosis even though a skiagraph cannot be secured. In any case of doubt an anesthetic will greatly assist in diagnosis. Treatment must vary in accordance with the age and condition of the patient. As a general rule (though subject to slight exceptions) union need not be expected in an individual over sixty-five; under that age

measures to secure union should always be instituted with expectation of good result. With the patient under sixty, in good health, and where the skiagraph shows that the outer fragment can be brought down into good line with the caput, a steel nail or screw driven through the trochanter into the head will assist markedly in maintaining accurate apposition. The latter is best, as it can be buried and primary wound union obtained. The screw can be readily removed also after union has been secured and its presence is no longer needed.

In old and debilitated patients I make no attempt to secure union, simply making them comfortable, placing them upon a gas-pipe frame or tray with canvas support for trunk and legs, leaving a vacancy from the sacrum to below the anus. This allows them to be raised from the bed without disturbance, and the ends of the stretcher being supported, they can be kept clean and bed-sores avoided. Extension by pulley and weight and large sand-bags may be used intermittently, depending upon the amount of comfort or discomfort derived from their employment, but they are not essential. The patient should be allowed to sit up as soon as possible, the chief attention being given to the condition of health.

The intermediate cases—those that bear confinement well—can be treated by a moderate amount of extension with pulley and weight, the gas-pipe frame already alluded to being of great benefit in

securing comfort and cleanliness. When confinement is not well borne, plaster-of-Paris from thorax to knee is of great benefit and allows the patient out of bed at an early date. This dressing is also of great service in mania a potu and delirious cases.

In many cases early release from bed may also be secured by adapting to the patient a Thomas posterior bar hip-splint with one band around the thorax, another at the pelvis, two at the thigh, and one about the leg. With crutches and a high shoe, locomotion is readily secured; its use should be continued for many months. I have never tested the Ruth lateral double traction method, but it seems practical.

In cases that present themselves a year after the injury the problem is a difficult one. If the *x*-ray shows marked absorption of the neck, the best treatment will be to permit the patient slowly to form a false joint by voluntary movements. If, however, the head, trochanter, and neck are in fair line with the joint, the fragments may be screwed or nailed together. An open operation with fixation of the fragments requires so much manipulation that it is a serious matter and is not advisable, provided the patient has already secured a fair amount of fixation and is able to move about without serious pain.

In cases in which it is decided to secure a false joint, an apparatus with leather encasement of pelvis and body, with an-

other stiff leather band encircling the thigh, will be very helpful. These broad bands may be connected by a joint which can be unlocked for the sitting posture and locked when the patient is erect.