# PROCEEDINGS AND REPORTS OF UNIVERSITIES COLLEGES, COUNCILS AND ASSOCIATIONS

## GREAT BRITAIN

### BRITISH ORTHOPAEDIC ASSOCIATION

#### SPRING MEETING, 1962

The spring meeting of the British Orthopaedic Association was held in Margate from May 3 to 5, 1962. The President, Mr F. W. Holdsworth, was in the chair.

**Pes cavus**—*Dr D. Brewerton, Dr P. Sandifer* and *Mr R. Sweetnam* (London) said that information about the cause of pes cavus was scanty. The most commonly held belief was that it was the result of muscular imbalance associated with some neurological abnormality. Investigation of 629 patients seen between 1949 and 1958 at the Royal National Orthopaedic Hospital showed that in only 26 per cent was there any recorded evidence of neurological involvement. Since 1959 seventy-seven new patients suffering from this condition had been subjected to full neurological investigation, including electromyography and muscle biopsy. In two-thirds of these patients there was evidence of neurological abnormality. Thirty-three per cent suffered from peroneal muscular dystrophy and 44 per cent had spina bifida. The authors had not found a consistent pattern of muscle imbalance, but they had no doubt that the deformity did result from some muscular incoordination. *Mr W. Sayle-Creer* (Salford) asked if microscopy showed any damage to the plantar fascia, and whether the contraction of it was primary or secondary. *Mr W. J. W. Sharrard* (Sheffield) asked what was the definition of pes cavus. He had seen a patient with pes cavus, without demonstrable neurological change, who at necropsy was found to have considerable cord damage. *Professor J. I. P. James* (Edinburgh) asked what was the mechanism of deformity, and if biopsy of the intrinsic muscles had been done. Mr Sweetnam said in reply that the plantar fascia was not examined because it was considered that the changes in it were secondary. He did not think there was any scientific definition of pes cavus. Clawing of the toes was not always present, and sometimes it was late in developing. Biopsy of the intrinsic muscles had been inconclusive, and the absence of any pattern of muscular weakness made it difficult to determine the actual mechanism of the deformity.

**Tarsal movements**—*Mr E. Shephard* (Maidstone) presented a film demonstrating the movements that took place in the mid-tarsal and subtalar joints. The peritalar movements were of the ball-and-socket type, about an oblique axis at 42 degrees to the sole of the foot, and inclined 16 degrees medial to the vertical plane, passing through the long axis of the foot between the first and second toes. A considerable range of movement was possible. The mid-tarsal joint was divided into a ball-and-socket joint and a saddle-shaped joint. Movement was restricted to a small range by the ligaments. The axis of movement made an angle of 52 degrees with the sole and 57 degrees with the bony axis of the foot passing between the first and second toes.

**Osteomyelitis of the patella**—*Mr D. K. Evans* (Sheffield) reported five cases of osteomyelitis of the patella. They were acute, subacute or chronic. The two acute lesions occurred in children, and one presented with an abscess subcutaneously. Without radiographs the bony origin might be overlooked. They were treated with splintage and antibiotics. Two subacute infections presented with an effusion in the knee and intermittent pyrexia. Patchy decalcification was present, and ultimately superficial sequestration. Healing followed sequestrectomy. In one case the disease was chronic: the patient was twenty-eight years of age, and the lesion was brought to light by an injury. Patellectomy gave a good result. The condition was not found before the age of five years because ossification was not sufficient. In children the knee joint was not involved because of the thick layer of cartilage. *Mr I. S. Smillie* (Dundee) said that other differential diagnoses to be remembered were abnormalities of ossification and Sinding-Larsen-Johannson's disease.

**Charnley compression arthrodesis of the hip**—*Mr J. B. Morris* (New Zealand) pointed out that this type of arthrodesis was developed to overcome the difficulty of obtaining bony ankylosis. He had