THE KNEE
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THE KNEE

AND RELATED STRUCTURES

Injuries — Deformities — Diseases — Disabilities

By

Philip Lewin, M.D. F.A.C.S., F.I.C.S.

Professor and Chairman of Department of Bone and Joint Surgery; Northwestern University Medical School; Attending Orthopedic Surgeon, Cook County Hospital; Senior Attending Orthopedic Surgeon, Michael Reese Hospital; Professor of Orthopedic Surgery, Cook County Graduate School of Medicine, Chicago; Formerly Colonel, Medical Corps, A. U. S.

Illustrated With 333 Figures and 2 Colored Plates

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CONTENTS

CHAPTER 14

NONOPERATIVE TREATMENT OF KNEE DISTURBANCES

CHAPTER 15

OPERATIVE TREATMENT OF KNEE DISORDERS

CHAPTER 16

INTERNAL DERANGEMENTS OF THE KNEE

CHAPTER 17

LOOSE BODIES IN THE KNEE JOINTS—BURSÆ

CHAPTER 42

METABOLIC AND ENDOCRINE DISORDERS THAT AFFECT THE KNEE

CHAPTER 43

NEOPLASTIC TUMORS OF THE KNEE

CHAPTER 44

EQUALIZATION OF LENGTH OF LOWER EXTREMITIES

APPENDIX

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PRINTED IN AMERICA

Dedicated To

the late

SIR ROBERT JONES

The greatest authority of his time,
on the Knee*

* It was my good fortune to have served under Sir Robert at the Third Western General Hospital, Newport, Monmouthshire, England, during World War I, as Captain, M.C., A.U.S. with the Royal Army Medical Corps.

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and to the late

DR. ARTHUR DLAN BEVAN†

who kindled my interest in disorders
of the knee joint

† Professor of Surgery at Rush Medical College, Chicago

FOREWORD

By Melvin S. Henderson, M.D.

Forty-five years ago, when I was an intern in one of the larger metropolitan general hospitals in the Midwest, I was assigned to a busy general surgical service. My chief was a very able surgeon. It so happened that the most acutely ill and trying case on this service was that of a robust young woodsman from the North, who had an infected knee joint. The story was tragic. One day while clearing limbs off a fallen tree his sharp ax was deflected and cut into his knee joint. He was alarmed because, along with the bleeding, "the joint water escaped." At that time there was prevalent an evil belief among woodsmen that a good large "chew" of tobacco applied as a poultice to any wound would prevent "festering." This was done in the case here referred to, with a terrible result. The man went through weeks of terrific pain largely uncontrolled by cast, splints or traction. His fever was high and septic; he was delirious and wasted away to a mere skeleton. Finally amputation was done through the middle of the thigh just in time to save his life.

This experience so early in my professional career made a lasting and deep impression on me. As a result, I never advised or performed an operation on a clean knee joint, that the picture in this case did not lurk warningly in my mind.

In my early years in orthopedic surgery, often the advice to a patient that a damaged meniscus of the knee be removed was met by the question, "But, doctor, will that not leave my knee joint stiff if the joint water escapes?" The question was pertinent. Severe infections after an abdominal operation generally led to death. In a few days all was over. The result was accepted as unfortunate but inevitable and before long most was forgotten. Not so if the case is one of infected knee joint; after prolonged suffering the patient was likely to be left with a stiff knee. Or perhaps a lifesaving amputation was necessary and he stumped around the rest of his days, an example of a surgical tragedy. Hence arose the fear of knee joint operations in the mind of the laity.