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William J. Wilson
J Bone Joint Surg Am. 1949;31:198-199.

This information is current as of July 6, 2009

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Publisher Information

The Journal of Bone and Joint Surgery
20 Pickering Street, Needham, MA 02492-3157
www.jbjs.org

A SIMPLE AND EFFECTIVE SPLINT FOR USE IN THE TREATMENT OF CLAWING OF THE TOES

BY WILLIAM J. WILSON, M.D., WILMINGTON, NORTH CAROLINA

All of us have observed clawing of the toes in patients with low cord lesions and injuries of the lumbar spine. These patients usually present some degree of pes cavus as well, but the main complaint is difficulty in obtaining properly fitting shoes, as well as corn formation over the interphalangeal joints. The author has tried many different devices, such as beach sandals with straps, to flatten out the toes, but nearly always abrasions of the skin occurred that were slow in healing. This tendency to slow healing in such cases also contra-indicates tenotomies or other surgical procedures.

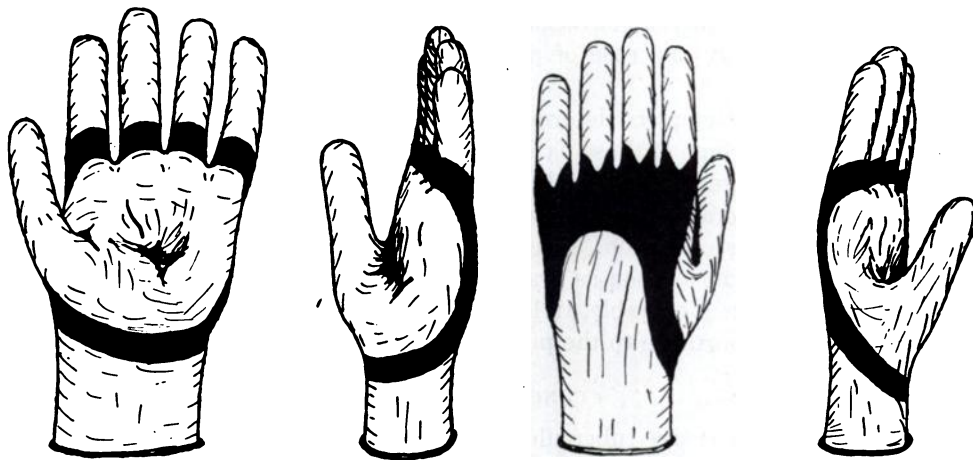


FIG. 1

Illustrates how the splint is cut from a rubber glove. The palmar, ulnar, dorsal, and radial views, respectively, are shown.



FIG. 2

Medial, dorsal, and lateral views of foot with splint applied.

A simple, efficient, and inexpensive device is presented that has proved to be of great value. Not only do the toes straighten, but the patient's walking is improved. In one case in which a tumor of the cauda equina was removed, it has been necessary for the patient to wear the device only about half the time to maintain correction. In no case has necrosis of the skin or other complication occurred.

The splint is made from household rubber gloves, which are easily obtainable from

grocery or department stores. Surgical gloves are too thin, and they tend to roll into a cord and cause constriction. This does not occur with the heavier household product. Figure 1 shows how the splint is cut from the glove. Figure 2 illustrates the splint in use. The fact that the glove has only four fingers to fit over five toes has not yet offered a problem. In one case the band from the fourth finger accommodated both the fourth and fifth toes; but usually when the first four toes are pulled down, the extensor of the fifth toe is sufficiently relaxed.

The splint offers the advantages that it can be worn comfortably under the hose in a conventional shoe, and it is not conspicuous.

DEPARTMENTAL TEACHING OF FRACTURES IN THE MEDICAL SCHOOLS OF THE UNITED STATES*

BY HERMAN F. JOHNSON, M.D., OMAHA, NEBRASKA,
AND SIDNEY L. STOVALL, M.D., SAN ANTONIO, TEXAS

Within the past decade the management of fractures has gained recognition as a definite phase in the curriculum of the undergraduate students in medical schools throughout the United States. The demand for doctors who are adequately trained in the complexities of fracture care has been greatly enhanced by the increasing number of traffic and industrial accidents, as well as by World War II. Thus, the study of fracture management is rapidly assuming an importance equal to that of general surgery and medicine.

At the meeting of The American Academy of Orthopaedic Surgeons in Chicago, in January 1947, it was suggested by several members of the Committee on Fractures and Traumatic Surgery, then headed by President-Elect Mather Cleveland, that a survey be undertaken of the teaching methods employed in the medical schools of the United States, with regard to fractures and dislocations. The Secretary of the Fracture Committee (H. F. J.) was asked by the Chairman to send letters to the medical schools of the United States to determine the number of hours being devoted to this subject, and which staff (general surgery, orthopaedic surgery, or a combination of the two) was held responsible for the teaching. Questionnaires were sent to seventy Class A medical schools, the questions asked being as follows:

- "1. How many hours are allotted to the subject of fractures and dislocations in your medical school?"
- "2. Are fractures a part of the general surgical service and taught by general surgeons?"
- "3. On either the orthopaedic or general surgical service are fractures taught by both general surgeons and orthopaedic surgeons or by orthopaedic surgeons alone?"

The response to the questionnaire was surprisingly good, as replies were received from sixty-seven (95.7 per cent.) of the schools (Table I). In addition to answering the questions, many of the deans and department heads volunteered suggestions and recommendations, some of which are quoted herein.

It is of interest to note the growing trend in the medical schools to ally fracture work with orthopaedic surgery. Several years ago fractures, in most instances, were dealt with exclusively by the general surgical service, while today more than half of the recognized schools have correlated fracture care with orthopaedic surgery. With this tremendous interest in traumatic surgery, many young men are taking residencies and fellowships in orthopaedic surgery. Into many of these same hands the teaching of this subject will ultimately fall, and hence it is to be expected that the growing demand for the placing of this borderline subject in its proper field will become even more pronounced. This refers especially to traumatic lesions of the spine and extremities. With the sharp tendency to specialization, head injuries and traumata of the chest and abdominal viscera naturally are included among the specialties covering those particular parts of the anatomy. With the extensive definitive surgery and corrective measures often necessary in the treatment of skeletal injuries, the orthopaedic surgeon, who has qualified himself for this type of work, should have the opportunity to follow these problems from the time of the emergency care through to the final end result; in many instances this requires several years of observation. Too often the early emergency treatment has been rendered by individuals lacking the opportunity to care for these patients subsequently when delayed union, non-union, or malunion develops. These patients have then, belatedly, come under the care of the orthopaedic surgeon, who must carry on until the patient has attained his maximum improvement. Thus it would appear that, often to the detriment of the patient, the final result has been obtained in many cases in a roundabout manner, rather than by the simple process of placing such cases in the hands of qualified men at the onset.

* Report of the Committee on Fractures and Traumatic Surgery, presented to The American Academy of Orthopaedic Surgeons, Chicago, Illinois, January 27, 1948. The Chairman of the Committee was Mather Cleveland, M.D., and the Secretary was Herman F. Johnson, M.D.