CLINICAL MEDICINE

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1 **Necrosis of Third Metacarpal Bone.** On Sept. 8, 1952, a three-year-old mare of mixed breeding was admitted to Stange Memorial Clinic. The history was recorded as follows: In June of 1952, the mare had received a deep laceration on the dorsal surface of the right fore leg in the middle of the third metacarpal bone. The wound was treated at this time and healing apparently took place; however, in about three weeks a purulent discharge occurred at the site of the original wound. Treatment was repeated with similar results. There were two recurrences of the condition before the patient was presented at the clinic.

Examination of the mare prior to treatment revealed evidence of bone necrosis. A purulent exudate was noted at the fistulous opening. Following examination, a bichloride of mercury pack was applied to the wound area for presurgical disinfection. It is of importance to note that wounds in this area are often complicated by sequestra formation. Satisfactory healing cannot occur until all the necrotic bone has been removed.

On Sept. 9, the patient was given 30 Gm. of chloral hydrate via stomach tube and restrained on the operating table. The wound was enlarged and the necrotic tissue, including a 5 by 1 by ¼ inch sequestrum, was removed surgically. The surface of the third metacarpal was curetted of necrotic bone tissue. Sulfanilamide powder and a sterile gauze pack was applied to the wound surface. Fifteen hundred units of tetanus antitoxin were given subcutaneously.

Postoperative treatment consisted of changing the bandage daily with the application of sulfanilamide powder. On Sept. 15, sulfa-urea powder was substituted for sulfanilamide powder to stimulate the growth of granulation tissue.

On Sept. 17, due to the delay in healing of the wound and the presence of an exudate, further bone necrosis was suspected. On Sept. 18, a radiograph was taken which revealed a small irregular sequestrum about ⅛ by ¼ by¼ inch in size.

On Sept. 22, the mare received 30 Gm. of chloral hydrate and was restrained on the operating table for further surgery. The sequestrum was removed and the bone area again curetted. Sulfa-urea powder was applied and the wound was dressed with a sterile gauze pack.

The wound was rebandaged daily through Oct. 1, during which time the drainage ceased and granulation tissue gradually filled in the wound area. On Oct. 2, the bandage was discontinued and boric acid and air-slaked lime powder in equal parts was applied to the surface of the wound.

The patient, apparently making a satisfactory recovery, was discharged Oct. 4.

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