been suffering from a high-tone deafness for many years, and the impairment of hearing was therefore not altogether related to Ménière's disease. Exactly a fortnight later I was again called out in the early hours and found him in a precisely similar attack, from which complete recovery occurred again within two days. The attacks continued at roughly two-weekly intervals, a total of six being recorded.

In January, 1947, some two months after his arrival overseas, when I had attended him in five attacks, I was faced with the problem of deciding whether this valuable officer could remain abroad or whether I should have to invalid him. He had been specially selected for this post because of his wide experience, and he was naturally most anxious to fulfil his mission. I discussed his case with several colleagues, including an E.N.T. consultant. As a result of these discussions and information obtained from current literature—e.g., Atkinson, M., *Proc. R. Soc. Med.*, 1946, **39**, 807—a skin test was carried out in order to determine whether he was histamine-positive or histamine-negative. The test is fully described in the "Any Questions?" section of the *British Medical Journal* of May 10, 1947 (p. 666), and is of course an essential preliminary to treatment if histamine desensitization is contemplated. The patient proved to be a well-marked example of the histamine-sensitive group, and I decided that he might well benefit from a desensitizing course of histamine. This treatment is also described in the section of the *B.M.J.* quoted above.

The sixth attack since his arrival developed in the early stages of treatment, which was begun in January, 1947, but was notably less severe than those from which he had previously suffered. The course was completed in April, 1947, since when (apart from mild tinnitus), he has been in excellent health and completely free from further attacks. There has also been subjective improvement in his hearing. It should be mentioned here that he has had no phenobarbitone or other medication for the past 12 months.

As more than two years has elapsed since this treatment was first given, it is reasonable to assume that a cure has probably been effected; in any case, a remarkable response has been demonstrated to histamine desensitization. Several skin tests carried out since this time have shown a consistently negative reaction.

A point of interest is that the patient's flying category, which was reduced in 1946 to non-combatant flying (passenger only), has been restored to that of an active pilot category, and he has been able to carry on with an arduous and intricate task at a highly responsible level with the utmost confidence and efficiency.

I wish to thank the Director-General of R.A.F. Medical Services and the patient for permission to publish this case.

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Congenital Cyst of the Cystic Duct Containing Calculi

I have been unable to find a report of a cyst of the cystic duct; it may be of interest, therefore, to record a case that has been under my care recently.

CASE HISTORY

A married woman aged 56 was referred to me on account of attacks of upper abdominal pain and vomiting for two years. During the attacks some tenderness had been elicited over the gall-bladder region. There had been no previous illness, but during this period she had had discomfort after eating, with flatulence, and had gained considerably in weight. There had never been any jaundice. The attacks of colic and vomiting had coincided, and the vomit was either green or brown. She had never been pregnant, and the menopause occurred at age 50.

The patient was very obese and thick-set, but otherwise quite healthy-looking. The tongue was clean, the pulse regular 108 a minute, and the blood pressure 110/65 mm. Hg. No physical signs were detected except some haemorrhoids. During chemical and radiographic investigations (during which the only

abnormality noted was a group of five ring shadows medial to and a little below the shadow of a gall-bladder which emptied normally) the patient had two further attacks of colic, and after one of these I detected a definite tenderness below the right costal margin. In view of the severity of the attacks an exploration of the biliary passages was carried out.

Operation.—A general anaesthetic consisting of hexobarbitone, gas, oxygen, and ether by intubation was administered by Dr. E. S. M. Merry. A transverse incision was employed, but owing to the patient's obesity, the flatulence, and the high gall-bladder the incision had to be extended upwards through the rectus sheath to get the necessary exposure. The gall-bladder was partially enclosed in a tunnel of liver substance. Its fundus protruded through the anterior surface of the liver. The organ was distended with bile but did not look unhealthy; but medial to its neck a hard mass could be felt deeply buried in fat which also contained the common bile duct. On dissection of the mass the common bile duct was seen to be of normal size and free of calculi.

The hard mass was in the situation of the cystic duct and consisted of a thin-walled cyst packed tightly with calculi and biliary mud. On traction on the neck of the gall-bladder it was seen to be in continuity with the cyst (see Fig.). In an attempt to bring the parts

nearer to the surface the gall-bladder was dissected from the liver, but immediately it was pulled on gently it tore away from the cyst, with which it communicated by a small aperture. This was enlarged and the contents of the cyst evacuated—the mud by suction and five black pigment calculi the size of small peas by forceps. The walls of the cyst, which was the size of a hen's egg, were extremely thin and translucent. In view of the difficulty anticipated in removing it a tube was passed into the common duct through the cyst cavity and the size of the cyst reduced by plicating sutures. The gall-bladder bed was then peritonized and the wound closed.

Examination of the gall-bladder after its removal revealed cholesterosis and three calculi similar to those in the cyst itself. As the wall of the gall-bladder was at least of normal thickness and that of the cyst was thin, translucent, and devoid of fibrous tissue and muscle, I consider that the cyst was of congenital origin and not part of an hour-glass gall-bladder. There was no inflammation, and the symptoms seemed to have arisen mechanically when its fluid contents had been replaced by the mud and calculi. These appeared to fill its cavity, but the cholecystogram showed that a passage for bile still existed between the common duct and the gall-bladder through the cyst itself. No trace of a cystic duct was seen, and the opening from the cyst into the common duct was large enough to take a No. 10 catheter easily.

COMMENT

I believe that the absence of biliary mud from the gall-bladder and common duct and its presence in the cyst was due to the flow of bile carrying into the duodenum any that escaped into the common duct during attacks of colic, and that the weight of the cyst caused valve-like actions at its junctions with the common duct and gall-bladder.

I am indebted to Professor Paterson Ross for his helpful comments in presenting this case for publication.

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The *Manchester Guardian* (June 30) has reported that the Bath Education Committee has had to close the city's school dental service because of lack of professional staff. The result of this will be that 8,000 school-children will be deprived of regular dental inspection.