intravisceral drainage is a manœuvre almost as rapid of execution as external drainage. The anastomosis commends itself, therefore, in selected cases, as a valuable alternative to cholecystostomy, with its manifest disadvantages. In this connexion, it would seem especially worthy of trial in pancreatitis of varying grades, in view of the theory of its pathogenesis, which is founded on the work of Opie and of Archibald, and on the convincing researches of Bruce Dick.

Suitably modified to the occasion, the principle might well be applied in the case of biliary disorder with peptic ulcer in "an indifferent surgical risk." In such a case the inspiration to apply it came to one of us just too late to obviate the trauma of cholecystectomy followed by gastro-jejunostomy in a patient none too well equipped. The ulcer could easily have been excised and the gall-bladder joined to the margins of the stomach wound.

The operation is more readily performed through a Kocher approach, and is further facilitated by the use of Wilkie's duodeno-jejunostomy clamps.

The anastomosis operation has the merit of revocability, and might well become that of election when there is doubt of the viability of the common duct, or certainty of its occlusion, when measures for the relief of the obstruction are impracticable, or fraught with grave hazard.

UNUSUAL DISTRIBUTION AND MORPHOLOGICAL MODIFICATION OF COMEDO

BY

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Topographical and morphological variation in quite common skin diseases occasionally introduces an element of confusion in diagnoses which otherwise would present no difficulty. Until quite recently I little suspected that a condition so common and obvious as comedo might roughly simulate in distribution and colour the lesion of xanthoma palpebrarum.

A retired journeyman engineer, aged 72, sought relief, in October, 1930, at the skin department of the Western Infirmary, for an affection of the eyelids. He appeared to be well preserved for his years, exhibited a mild degree of acne rosacea, and was bald save for a fringe of hair, approximately three inches deep, laterally and posteriorly. He had been in the habit of occasionally taking a little alcohol, of smoking three ounces of tobacco a week, and of eating a fair amount of sugar. On taking his seat he gave the impression of being the subject of xanthoma palpebrarum, more particularly of the left upper eyelid. This impression, however, on closer inspection, was soon dispelled, the lesions proving to be comedones of atypical distribution and, in my experience, of unique shape.

He said that he had been accustomed to work in a very hot atmosphere—subject, however, to some temperature variation—and with a great deal of oil. He had perspired very freely, and blackheads had developed, especially round the lower eyelids. The blackheads had been removed from time to time. Later, about ten to twelve years ago, blackheads had appeared on the upper lids some of which had slowly increased in size, gradually become flattened and pale yellow in colour, but had caused no difficulty in the closing or opening of the eyes, and had never been treated.

On inspection the left upper eyelid, mainly anteriorly, showed flat, approximately circular plaques, raised slightly above the skin level, pale yellow in colour, with

a more or less central black spot, and resistant to the touch. They were distributed mainly anteriorly, and some tended to project beyond the palpebral margin. The largest was about a quarter of an inch in diameter. The right upper eyelid was affected, but did not exhibit

Left upper eyelid shows modified flattened disc-like comedones, in one of which, near inner canthus, a central dark point is visible. Some project beyond the palpebral margin.

the same degree of modification. Comedones were present on both lower lids.

While I have seen comedo on the lower eyelid in more than one patient, I have never noticed it, save in this particular case, on the upper one, nor has one of my colleagues, an ophthalmologist of careful observation and long experience.

The morphological modification is of particular interest. Although working a good deal with oil, he had habitually washed his face with cold water. This ablution is practised by many in a careless, half-hearted manner, as may be demonstrated in the case of some town dwellers in large smoky industrial centres during foggy weather, where a "high-water mark" may sometimes be left in the orbital region. Assuming that the patient had washed in this perfunctory manner, and especially so with cold water, the follicles would tend to remain plugged with oil and particulate matter. Two factors would probably largely account for the peripheral increase and resulting disc-like shape of the lesions—namely, the underlying dense fibrous tissue of the tarsal plates, and the diurnal palpebral movements.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

SARCOMA OF THE LUNG

In view of the difficulties of diagnosis involved, the following case may be of interest.

G. B. A., of fair physical development and with a chest expansion of three inches, enlisted in the Army in 1916, at the age of 32. In 1917 he was accidentally burnt on the face and hands while on service. Three months later, while still in hospital, he had a "haemoptysis—right apex crepitations"; two months later, "bronchitis—feeling faint on exertion"; no other symptoms or signs. In 1919 he was pensioned on account of bronchitis—"coughing up blood-streaked phlegm; V.F. and V.R. plus at right apex." These conditions remained much the same until September 29th, 1925, when pulmonary tuberculosis was diagnosed, and there was "active infiltration of the upper lobes of both lungs." His expansion had become "poor," and "a few crepitations were heard at the apex." On March 11th, 1926, pulmonary tuberculosis was admitted by the Ministry. He continued to show very