ribs the liver dullness seems to extend upwards into the axilla and the resistance to the fingers is increased. No definite change in the breath sounds beyond some lessening over the dull area. X-ray evidence showed a large cyst, about 4 to 5 inches in diameter, present in the axillary line, just above the diaphragm on the right side. A beautifully clear outline was shown and there was no possible doubt as to the nature of the disease. No blood cell changes. There was a shadow at the root of the lung of small size. The radiologist reported that this was due to inflammatory thickening around a bronchus. Operation revealed a degenerated cyst full of odourless pus and cyst debris. The patient has since developed phthisis.

2. F. F., aged 38, sailor, admitted May, 1914, with pleural effusion. He had a history of left-sided pneumonia and pleurisy for the last eighteen months. Complained of cough and increasing weakness. After aspiration there remained some dullness below third rib in front. The pleural fluid contained polynuclear cells. He was discharged at the end of three weeks relieved. Readmitted May, 1915. He had lost flesh, and had an irritating cough, relieved by lying on the left side. Movement on left side restricted. The heart was displaced to the right, 3 in. from mid-sternal line. There was fluid in the left pleura. There was evidence of consolidation of the lung in front, from the clavicle to the nipple line. Crepitations could be heard at the base of the left lung. The right lung was clear. The radiologist reported that the right lung was healthy throughout. The heart was displaced to right; the left lung was dense all over, lessening a little at apex and base and most dense in lower lobe. Later he reported a rounded deeper shadow, the maximum depth being in the position of the left nipple. June 2nd, lung still clear. Later in June it was found that the fluid in the pleura was purulent. A rib was resected and the pleura opened and a large quantity of hydatid material was discovered. When first admitted his temperature fluctuated between 101.8° and normal; later it remained normal till just before the operation, but was never so high as on admission. From time to time the sputum was blood-stained during a period of eighteen months or more. He had a positive Wassermann reaction, and the general opinion of the staff was that the lung was syphilitic. No eosinophilia was found in repeated examinations, and in spite of a normal temperature the physical signs did not improve. At the time he first came under my care I made a diagnosis of cyst, but I was unable to induce a surgeon to make a thorough exploration of his chest. It was only the subsequent occurrence of an empyema that led to an operation.

3. J. L., labourer, aged 42, admitted October 22nd, 1918, complaining of pain in lower right anterior chest, worse on taking a deep breath; he sought advice on this account. Temperature normal, lungs slightly emphysematous, heart normal as to position and sounds; general health always good—he was at work up to the day of admission. Cough very little. On examination no pleuritic rub was found. There was a circumscribed area of dullness in the lower right chest, with a slightly more resonant area between the lung and liver dullness in the anterior axillary line margin and extending upwards about four inches. The transition from dullness to resonance was sharp. Breath sounds over dull area weak, no adventitious sounds heard, and no bronchial breathing. X rays showed a clearly defined cyst occupying a large part of the lung, the radiologist estimating this as half the lung. No eosinophilia. Refused operation, as he did not consider it necessary; he is not inconvenienced at all.

Conclusions.

It will be apparent that hydatid cyst may simulate many lung diseases, and to discuss differential diagnosis in detail would be to discuss the character of almost every known disease of the thorax. Moreover, it is clear that a cyst so rarely gives rise to pressure symptoms that the diagnosis must depend on the history and x-ray evidence.

VOLVULUS OF THE SMALL INTESTINE FOLLOWING ILEO-COLOSTOMY.

BY

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THE following case seems worthy of record, owing to the comparative rarity of the condition, and the successful result of operation.

Mrs. G., aged 62, had for three years suffered from progressive loss of weight, increasing constipation, and frequent attacks of severe indigestion and abdominal pain. When first seen, in the autumn of 1919, she was leading a semi-invalid life, and looked very thin and ill. There were no definite signs of abdominal disease, but operation was advised in view of the possibility of cancer.

First Operation: Ileo-colostomy.

Laparotomy on December 7th, 1919, revealed no growth, but there was marked visceroptosis, and the colon was thin and atrophic. Ileo-colostomy was performed by lateral anastomosis of the closed and divided lower end of the ileum to the pelvic

colon. The patient made a good recovery from the operation; the bowels acted freely, pain and indigestion were relieved, and in the spring of this year she was walking up to eight miles a day. A post-operative hernia was controlled efficiently by a Salt's corset-belt.

Second Operation (for Volvulus).

She remained in improved health till June 26th, 1920; on this day she was seized with sudden acute abdominal pain, which gradually became worse. When seen next day, the abdomen was slightly distended and tender, but not rigid; the tongue dry and furred, and the pulse feeble and irregular. She had passed some flatus, but no faeces. She was evidently suffering from obstruction, but her general condition was so bad that palliative measures were tried first. No result followed a large turpentine enema, and on the third day from the onset vomiting set in. Operation was then undertaken as a last resort, though her condition was desperate. Under open ether anaesthesia (given by my partner Dr. W. E. Moore Ede), preceded by morphine and atropine, two pints of saline were given intravenously, and the abdomen opened by a median incision below the umbilicus. A twisted mass of intestine, black and gangrenous, the size of a fetal head, was found in the pelvis. The peritoneal cavity contained a quantity of turbid fluid with a strong faecal odour.

The mass proved to be a volvulus of the lower end of the ileum caused by a short cord-like adhesion between two folds of mesentery. As the gut involved was already gangrenous, the intestine above and below was divided between clamps, and a wedge of mesentery resected, the whole specimen being thus removed without attempting to untwist the volvulus. Even so the gangrenous portion burst in the necessary handling and distributed its contents in the wound. The length of gut removed was two feet, and the volvulus had two complete revolutions on its axis. The cut ends of intestine were united by an end-to-end anastomosis, two layers of catgut sutures being used; the peritoneum was cleaned by dry swabbing, and the wound closed by through-and-through silkworm sutures.

Recovery.

The patient made an excellent recovery, shock being combated by the intravenous saline given before the operation, and by frequent rectal saline injections during the twenty-four hours after. In the second week some troublesome diarrhoea, with undigested food in the faeces, was arrested by the use of a mixture containing hydrochloric acid and malt extract. The wound suppurated slightly, but not so much as might have been expected after the gross soiling of the wound at the operation. There was never any sign of peritoneal infection.

The patient was up in a month, and able to walk two miles in six weeks from the date of operation. Since then her progress has been steady; she looks and feels well, is gaining weight, and the bowels act regularly without pain.

Strangulation of a coil of intestine, which, following an ileo-colostomy, has slipped through the gap between the mesentery of the ileum and that of the pelvic colon, is a well recognized accident; and all authorities therefore recommend that the gap be closed by a suture to prevent the occurrence of this form of internal hernia. This had been done at the first operation in the case now recorded, but when the acute obstruction occurred, it was thought that the suture had possibly given way.

Operation, however, showed that the gap remained closed, and that the condition was due to a volvulus. The adhesion giving rise to the volvulus was no doubt a sequel of the first operation—ileo-colostomy.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TRANSPPOSITION OF VISCERA IN TWO MEMBERS OF ONE FAMILY.

TRANSPPOSITION of viscera is a condition not often met with, and two cases of transposed viscera occurring in members of one family must be so rare that I think the following notes are worthy of publication.

When I was carrying out a medical inspection at a school in Somerset in November, 1919, a girl, aged 12, was presented for routine examination. Upon inspection of her chest, the cardiac impulse was visible just inside the right nipple line; percussion and auscultation showed that the heart was transposed. The abdomen was then examined, and it was found that the stomach, liver, and spleen were transposed also. The mother of the girl, who was present at the examination, then informed me that the girl's brother, aged 10, "had his heart on the wrong side." I examined this boy the next day, and found that in his case, too, the heart, stomach, liver, and spleen were transposed. Both children appeared to be quite healthy.