duodenum bears to the mesial abdominal watershed formed by the forward projection of the vertebral bodies. Since the perforation, or, to speak more correctly, the rupture of an adhesion, usually occurs to the right of this watershed, the extravasated fluid tends to gravitate towards the right renal well (subhepatic fossa) or to invade the right subphrenic space. In those exceptional cases where the duodenum occupies a mesial position, or even lies a little to the left of the mid-line, the fluid tends to gravitate to the left, into the stomach chamber, and gives rise to an abscess under the left wing of the diaphragm.

Dr. Rolleston conjectures that adhesions may be responsible for the unusual site of the abscess in such cases, and this may well be so, but only, I submit, in so far as they may fix the duodenum in an abnormally leftward position. In other words, it is the slope at the side of the spine, and not the guiding constraint of the adhesions, which directs the infection to right or left as the case may be. In the first case recorded above the duodenal matting was rather extensive, but in the second case mentioned (Dr. Sharkey's) no adhesions were found. In this second case, too, I have a note of the position of the duodenal perforation; it lay nearly in the mid-line and was quite uncovered by the liver.

In the second case, as in the first, the contrast between the anaemic and injected portions of the pleura was evident, the line between the two being at the upper level of the sixth rib in the mid-axilla, so that in both patients the collection could have been evacuated by the lateral transpleural route on resection of portions of the sixth, or, better, seventh rib.

In justice to Dr. Jenkins and my colleague, Mr. Maynard Smith, I must repeat that the description of the most posterior part of the left subphrenic space, quoted by Dr. Rolleston from my address, is theirs and not mine.

REFERENCE.

Lancet, March 26th, 1910.

OPERATION FOR DECOMPRESSION: RECOVERY.

BY

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THE patient in the following case, a gardener aged 25, was admitted to the Cottage Hospital, Southwold, on June 25th, 1907. His family history was good and his own health had been excellent until April, when headache and dizziness had commenced; he had gradually grown worse.

When admitted his headache was constant, and vomiting, without retching, occurred at intervals. He walked somewhat unsteadily, with feet well apart, and complained of dizziness. His eyesight was unaffected and the pupil reflexes normal. Pulse 46; temperature subnormal. A diagnosis of cerebral tumour was made, and he was treated with mercury and potassium iodide. He gradually became worse. At the end of July his position was as follows:

The headache was extreme, requiring $\frac{1}{4}$ grain of morphine hypodermically, nightly. Optic neuritis was present in both eyes; he was unable to read, and even pictures looked blurred and indistinct. There was no strabismus, but nystagmus was present on lateral movements of the eyes, in particular when made towards the right. No diplopia. Co-ordination of the right arm was bad; left arm normal; right arm and leg were weaker than left. He was unable to get on his feet, but when assisted to rise his gait was very uncertain and stumbling, with tendency to fall to right side at every few steps. With feet together and eyes shut he swayed to right.

Tumour of the right cerebellum was diagnosed, and on August 5th I removed a portion of bone $2\frac{1}{2}$ in. long and $1\frac{1}{2}$ in. wide over the right cerebellar region, and, as his condition was good, I incised and removed bulging dura mater. No tumour was evident, so I closed the wound without replacing the bone. He stood the operation well and the headache at once disappeared, but there was still slight sickness, considerable inco-ordination of the right arm, and marked diplopia.

On October 4th he could walk without a stick and was much improved, and was discharged.

In August, 1908, he returned to work and obtained a post as head gardener at an hotel in Southwold, which he still holds.

At present (October, 1911) his condition is most satisfactory. His gait, sight, and co-ordination are normal. He has had no headache since the operation nor any bulging at the site of the latter. Nystagmus is still present to a very slight degree when the eyes are moved to the right, and he complains of slight dizziness when his head is dropped backwards (in a barber's chair), but he can work as hard as ever and gives complete satisfaction to his employers.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A RAPID METHOD OF DIAGNOSIS IN MALARIA.*

It has often been said to me that it is impossible to examine every case of malaria in out-patient practice, owing to the length of time required; but I feel that in order to become thoroughly acquainted with the diseases of any locality this is necessary. The following is a method which I have found useful in practice:

Thick films are made on the slide without even a cover-slip, so thick that the blood when allowed to run to one side is seen of a bright red colour. This is rapidly dried and examined directly under a drop of cedar oil and a $\frac{1}{2}$ in. immersion. The drying of this film causes the only delay. In a dry country such as Persia films will dry in the open air without any special treatment in about half a minute. In a damper climate they should be exposed to the sun turned upside down. In damp and cold weather they should be dried gently over a spirit flame. In any case one can begin the examination before the whole film is dry, and very often the information got is sufficient before the thicker edge is properly "set."

I have often proved the existence of malaria, verified, of course, by a properly stained slide, in one minute by the watch from the time of drawing blood. The thicker part of the film is best examined first, and from the character of the pigment the species of malarial parasite can, after a very little practice, be diagnosed in most cases with great ease, almost as easily as in a wet film. The diffuse and fine dots of tertian, the compact and coarser dots of quartan, and the peculiar arrangement of the pigment in the crescents in tropical malaria are very characteristic, not to mention pigmented leucocytes. They are as well seen as in a wet film, the chief point being to be sure that the pigment is on the same level as the red corpuscles, and disappears totally on focussing up or down. If no characteristic pigment is found in two minutes, the case is most likely not one of malaria; in any case of doubt, of course, the other methods are available, but probably not more than one case in ten of untreated malaria would escape detection.

I do not pretend for a moment that this is a method by which beginners can study malaria, any more than that of Sir Ronald Ross; but it is very rapid and accurate, and one, moreover, which avoids nearly all the pitfalls inseparable from those more commonly used, and, indeed, from Sir Ronald Ross's method, which I have tried. At starting, of course, a student should compare his dry slides with slides carefully stained in the usual way. This gives confidence and is a valuable check to the work.

I have no hesitation in saying that once this method is given a fair trial, it will be found of real use in out-patient work in tropical countries, where stress of work makes every minute of the greatest value.

Chepstow.

J. CROPPER, M.D.

A CASE OF HYPOGLOSSAL NUCLEI PARALYSIS.

It has been disputed by some authorities, notably Oppenheim, whether the hypoglossal nucleus gives fibres to the seventh nucleus which supplies the orbicularis oris. Oppenheim takes up a sceptical attitude and thinks that such an innervation constitutes an individual abnormality. The contrary view is held by Howard Tooth and Purves Stewart. Bruggia-Mattenci described a positive case in 1887.

In view of the rarity of such a paralysis the following

* Read at the meeting of the Society of Tropical Medicine and Hygiene, March 19th.