of Morgagni, and is preserved in the Pathological Museum of the University of Oxford. The patient made an uninterrupted recovery.

This case has seemed worthy of record rather on account of the rarity of the condition than of its clinical significance. I have failed to find any allusion to this lesion in the literature of the subject, nor do any cases appear to have been published recently, at least in this country, America, or on the Continent. It would be interesting to know whether previous cases have been observed but not published.

The description of the original colicky pain was suggestive of a uterine origin, and was attributed to the incipient abortion, but the severe right-sided pain which induced vomiting did not begin until the abortion was almost complete—that is, three weeks later—when the uterus contained nothing but a few necrotic fragments. It seems not improbable that this pain was due to the stretching of the covering peritoneum produced by the engorgement of the strangulated hydatid. No cause was found for the torsion. The ovarian cysts were both simple follicular cysts following an old perioöphoritis, which had produced on the right side a few inconsiderable adhesions; the appendix presumably could have had nothing to do with the condition.

TORSION OF THE APPENDIX OF THE TESTIS (HYDATID OF MORGAGNI).

BY

L. R. BROSTER, D.M., M.Ch.Oxon., F.R.C.S.,

ASSISTANT SURGEON, CHARING CROSS HOSPITAL; SURGEON, QUEEN'S HOSPITAL FOR CHILDREN;

AND

RALPH COYTE, M.B., B.S.Lond., F.R.C.S.,

ASSISTANT SURGEON, ALL SAINTS' HOSPITAL, QUEEN'S HOSPITAL FOR CHILDREN, AND PRINCE OF WALES'S GENERAL HOSPITAL, TOTTENHAM.

THIS condition appears to be one of rare occurrence, in view of the fact that we can find no reference to it in standard textbooks or recent English literature. It is therefore of interest that during the year 1928 we have each operated on two such cases at the Queen's Hospital for Children. All four cases we were able to diagnose before operation.

In each case the patient was a boy aged 12 years, and had not attained puberty. The cases demonstrated a marked similarity of onset and subsequent history, and the following case may be taken as typical.

The patient, five days before admission, complained of sudden pain in the right testis, without history of trauma. There was no vomiting or constitutional disturbance. Pain continued in spite of rest in bed, and on attendance at hospital the following condition was observed. There was swelling and tenderness of the whole testis, the skin of the scrotum was reddened and oedematous, and the spermatic cord was thickened throughout its length. On palpation a small body, about the size of a pea, was felt lying between the upper pole of the testis and the globus major. This small swelling was exquisitely tender, and not freely movable.

At operation the tumour was found to be of a deep plum colour, and obviously full of blood clot. There was marked oedema of the spermatic cord. The tumour was in the position of the hydatid of Morgagni, and had a pedicle, which had obviously undergone torsion. The pedicle was ligatured and the hydatid removed. On microscopic examination the following report was obtained: Section shows organizing blood clot undergoing degeneration; here and there are cystic spaces lined with flat unciliated epithelium.

The patient was immediately relieved after operation, and made an uninterrupted recovery.

In one case of five days' duration the hydatid showed signs of commencing sloughing. Another case was brought to the hospital six hours after onset, and already demonstrated oedema and reddening of the scrotal skin. Two cases occurred on the right side, and two on the left.

In conclusion, we wonder if this condition is really of rare occurrence, or whether these cases are frequently treated as orchitis of unknown origin, and left until the twisted hydatid sloughs, and resolution eventually occurs; presumably a painful and protracted process.

VARICOSE VEINS: THEIR MODERN TREATMENT BY SCLEROSING INJECTIONS.

METHODS AND TECHNIQUE OF "SICARD AND GAUGIER"
AS PRACTISED AT THE HÔPITAL NECKER, PARIS.

BY

P. KENNEDY MURPHY, M.A., M.D., B.Ch.,

LATE TEMPORARY ASSISTANT SURGEON TO ST. MARK'S HOSPITAL
FOR DISEASES OF THE RECTUM.

SCLEROSING injections for the treatment of varicose conditions have emerged successfully from the trial stage and are now almost universally regarded as being safe, effective, and the treatment of choice for varix.

The object of treatment is to obliterate the whole or part of the veins concerned in the superficial circulation of the limb—namely, the internal and external saphenous veins and their branches. These veins run in the subcutaneous tissue and have no support except their own walls; when the superficial circulation is occluded the blood returns by the deep veins, which are well supported by the muscles of the leg.

The principal points of interest to the doctor who intends taking up this work are: (1) methods of selecting cases suitable for treatment; (2) technique of injection; (3) choice of sclerosing fluid and strength of dosage; (4) number of injections necessary and interval between each; (5) the pathological effects of injection on the vein; (6) after-effects and possible complications. The advantages of this method are that when properly administered injections are safe and certain in their results, cause little pain or discomfort, and the patient need not lie up.

A bewilderingly large literature on injection treatment is being added to daily; most of it is interesting and helpful, but a lack of agreement on the essential points just mentioned is unfortunately a frequent and salient feature. In the confusion thus caused many who wish to take up this work find it difficult to decide what procedure to follow. Ill results of a serious character following treatment are being reported with increasing frequency, and are mainly due to defective technique and lack of authoritative knowledge on the subject. As it is universally conceded that it is to Professor Sicard of Paris we are indebted for establishing, in 1916, the treatment of varicose veins of the limbs by injection as a safe and effective procedure (the idea had been experimented with unsatisfactorily for seventy years), those who are about to adopt this method of treatment for the first time will be wise to follow the methods of this, the greatest authority, or at least adopt those methods as a sound basis on which to found their own experience. (The principle of employing sclerosing fluids for treatment of varix was, however, first successfully put into practice by British doctors, but only for the treatment of haemorrhoids. Morgan and Colles of Dublin were the pioneers seventy years ago, and Mr. Swinford Edwards, whose house-surgeon at St. Mark's Hospital it was my privilege to be, first introduced the method to this country, his article in the *British Medical Journal* of October 13th, 1888, being still one of the most instructive.)

Sicard's opinions and advice on this subject are as authoritative as Ehrlich's on the treatment of syphilis by arsenical injections. His special clinic at the Hôpital Necker, Paris, is of world-wide reputation, and here he and his colleagues, Gaugier, Paraf, Forestier, Haguénau, and Lermoyez, have treated many thousands of cases, necessitating hundreds of thousands of injections, with excellent results and without a single serious mishap.

Sodium salicylate is the sclerosing injection they recommend, and since the publication of their results many other workers, acknowledging their indebtedness to Sicard's work, have endeavoured to find, if possible, an even more effective chemical for injection; quinine (Génévrier), mercury biniodide (Montpellier and Lacroix of Algiers), glucose (Nobl), the citrate (Troisier), chloride (Linsler), and carbonate of sodium, and other solutions, all have now their own advocates. Every new sclerosing fluid recommended by any authoritative worker is given an