although it was recognized that the clinical features were not altogether indicative of that condition.

Operation.

The abdomen was opened by a right paramedian incision, the rectus muscle being displaced outwards. The appendix was normal. A dark red mass, measuring $3\frac{1}{2}$ by $1\frac{1}{2}$ inches, was found adhering by its lower extremity to the middle of the ascending colon. This was easily separated, and proved to be an isolated (or accessory) portion of omentum attached by a twisted pedicle directly to the transverse colon, and well to the right of the main organ. It was found impossible to untwist the pedicle owing to an elastic recoil which at once reproduced the original torsion, thus demonstrating that the anchoring of the mass by its lower end to the ascending colon was not essential to maintain the torsion. The twist, of two complete turns, commenced about half an inch distal to the colic attachment, so that it was a simple matter to ligature the pedicle close to the transverse colon and remove the mass. Appendicectomy was performed, and the abdomen closed. The patient made an uneventful recovery, and was discharged on December 8th.

In the eighteen cases collected by Cowell the ages ranged from 14 to 55; this case is therefore the oldest on record.

In considering such an apparently rare condition as abdominal torsion of the great omentum one wonders whether any (or many) such cases have been missed through the use of a gridiron incision to open the abdomen.

For the accompanying illustration my thanks are due to Dr. W. O. Reid, Dundee.

REFERENCE

¹ *British Journal of Surgery*, 1925, vol. 12, No. 48, p. 738.

A METHOD OF ESTIMATING THE SIZE OF AN ENLARGED PROSTATE.

BY

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It is always difficult to estimate the size of an enlarged prostate, and the usual method of recording this by comparison with the size of a tennis ball, apple, or other object is unsatisfactory. To note that the prostate is enlarged to the size of a large apple does not help one at a subsequent examination, and if the case is referred to another surgeon this note is of no value, depending as it does on the personal opinion of the first examiner, whose idea of a large apple may differ from that of the next person to examine the patient. In order to make some sort of accurate measurement I have been using the following device, which, if not scientifically exact, at least gives definite figures which can be checked at any future examination.

The three measurements I wish to obtain are: (1) the width—that is, the distance from side to side; (2) the vertical—the distance between the upper and lower edges;

(3) the thickness—that is, the distance between the floor of the prostatic urethra and the rectal wall.

To measure the width of the gland I use a metal probe 30 cm. long. The patient bends over a couch; the left forefinger is passed into the rectum and maps out the prostate, noting any hardness, inequality, or tenderness. The probe is then introduced along the palmar surface of the finger, and carried

FIG. 1.

by the finger to the left lateral limit of the gland, as represented by the line b—c (Fig. 1). An assistant holds a sheet of cardboard resting against the back of the patient's thighs, and marks with a pencil the position of the end of the probe (c). The finger then moves the probe across the gland to the right lateral limit of the swelling, and the new position of the end of the probe is marked on the cardboard (d—e). With the nail of my right forefinger I mark the point where the probe enters

the anus, and withdraw the probe. Laying the probe on the cardboard, and measuring the distance between the points e and c, I can obtain the distance between the points b and d, which I record as the width of the prostate.

To measure the vertical length a piece of drainage tube 20 cm. long is slipped over the probe and pushed up to the point (Fig. 2). The left forefinger is passed into the rectum, and the probe with its rubber cover introduced along the palmar surface, and pushed up until the finger reaches the upper limit of the gland. Keeping the probe in this position, the rubber cover is gently pulled down by the right hand until the lower margin of the gland is reached. The rubber and probe are then pinched together and removed. The uncovered end of the probe is measured, and this gives the vertical length of the gland.

FIG. 2.

To measure the distance between the floor of the prostatic urethra and the rectal wall I use a rigid rubber-covered probe (Fig. 3, A) soldered at right angles to a 10 cm. rule (B). A brass block (C) 2 cm. square and 4 cm. long is slotted to slide along the rule, and is drilled at the upper end to form a sleeve fit for a catheter (X). A circular window (Y) is drilled in the centre of the block to serve as a window through which the scale can be read.

The catheter is passed gently into the bladder until urine flows. The rectal tube is passed into the rectum and pressed against the prostate. An assistant then very gently slips the end of the catheter into the hole in the brass block and slides the block backward towards the rectal probe until the tissues prevent further movement. As the catheter and probe are rigid and parallel the thickness of the gland is shown by the point on the scale that is seen through the window. An x-ray photograph taken with the patient lying on his side with the instrument in position showed the lines of the rectal probe and catheter to be quite parallel.

FIG. 3.

The three measurements are recorded in my notes. I take some dental wax and mould it into the shape given by the measurements, adding any irregularity or abnormality discovered by the examining finger. The model is labelled with the patient's name, and serves as a record of the examination.

While not suggesting that this method is ideal, I may claim that it is painless and gives some fixed figures to record.

OPERATIVE TREATMENT OF ACUTE PERFORATED ULCER OF THE STOMACH AND DUODENUM:

OBSERVATIONS ON SIXTY-SEVEN CASES.

BY

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It is generally admitted that duodenal ulcer, like appendicitis, is markedly on the increase, and that the complication of perforation is now common. In patients suffering from duodenal or gastric ulcer perforation is said to occur in 23 per cent. of male patients and in 9 per cent. of female.¹ Spontaneous recovery occurs only occasionally; I have seen only one such case, upon whom it was necessary, some months later, to operate for pelvic abscess and a recrudescence of the symptoms of ulcer. Perforation is often a "seasonal" complication: it occurs with greater frequency during the