The Operation.—A paramedial incision was made on the right side, with its centre at the umbilicus. This incision was enlarged upwards and downwards in order to deal with the intestines. The following condition was found. The caecum was very much distended and was with some difficulty lifted out of the pelvic brim. Its inner surface, with the appendix, was directed upwards and formed the doughy mass noted in the hypogastrium. The areas of the ascending colon were found about half the outer side of the ascending colon were found about half the distended coils of small intestine all congested, while on the right side, with its centre at the umbilicus. The incision flexure. The ring was now seen to consist of a part of the caecum. The small intestine had to be lifted to disappear in a tight ring at the root of the mesentery. The collapsed intestine was withdrawn through this ring and consisted of about half the coils as far as the duodeno-jejunal flexure. The ring was now seen to consist of a part of the small intestine. Eventually tightening itself and passing out of the abdominal cavity before the volvulus could be untwisted. As soon as this was accomplished, the empty harrows can be taken away and the descending colon filled out. The descending colon had been of a dead white colour. By passing a rectal tube the distension was relieved to such an extent that the intestines could be retained in the abdomen easily by a flat sponge, while the abdominal wall was to sew up.

After the operation the patient’s condition was satisfactory, although the pulse-rate had risen to 130. There was no post-operative vomiting and the patient passed a very good night, quite free from pain. The convalescence was uneventful and the patient was out of bed on the tenth day, the wound being quite healed.

My best thanks are due to Dr. O'Reilly, of Bega, for his skilful administration of the anaesthetic.

The pre-operative diagnosis made in this case was acute obstruction due to internal hernia, a Meckel's diverticulum, or even an intussusception, though the latter was considered an unlikely diagnosis. The diagnosis was the result of an abdominally movable ileo-caecal segment. In this case the caecum and colon had a complete and unusually long mesentery. The twist had incarcerated the upper half of the small intestine, eventually thickening itself and passing along the colon, it became locked at the fixed end of the small intestine, when symptoms of high obstruction occurred. The actual diagnosis was volvulus of the colon, with an associated obstruction of the small intestine. Recurrence should be prevented by sutures fixing the caecum.

THE RADIOGRAPHIC SIGNS OF PULMONARY TUBERCULOSIS.

The first volume of Dr. W. Overend's book on "Radiography of the Chest" is devoted to pulmonary tuberculosis and is well arranged and excellently illustrated. The author uses a low milliamperage technique, with exposures varying from five to seven seconds. He is evidently not conversant with the more powerful transformers with which chest skia­grams can be taken in a second or under without screens.

The method of examination follows orthodox lines; the upright position is advocated for all cases in which it can be applied.

After the discussion of the usual classifications of pulmonary tuberculosis, the author puts forward a classification, based on the radiographic appearances, which is simple and worthy of universal adoption. It is as follows:—

(i.) Tuberculosis of the bronchial glands.
(ii.) Disseminated nodular phthisis.
(iii.) Disseminated nodal phthisis.
(iv.) Broncho-pneumonic pseudo-lobar phthisis.
(v.) Chronic attenuated phthisis (minor phthisis).
(vi.) Fibroid phthisis.

1 The Radiography of the Chest—Volume I.: Pulmonary Tuberculosis, by Walker Overend, M.D., B.Sc.; 1920. London: William Heinemann (Medical Books), Ltd.; Demy 8vo., pp. 119, with 9 line diagrams and 90 radiograms. Price, 17s. 6d. net.

The classification covers all forms of tuberculosis as seen in the lungs. Glandroid tuberculosis is subdivided into three groups according to the sites involved:—(a) mediastinal, (b) hilar and (c) nodal. These glands, when enlarged, are seen as greyish shadows and are readily recognizable; when caseous, calcified or fibrous, they are still more easily detected. The recognition of intrathoracic caseating glands is of great importance, as they are so often the primary focus in such conditions as tubercular meningitis. The author claims that the glands at the bifurcation of the trachea are best studied in the oblique position.

He states that the clinical criteria are of no value in the diagnosis of this condition and that it can only be diagnosed with certainty by radiography. In later stages bronchiectasis and other changes may occur in lung fibrosis about the enlarged glands.

Broncho-pneumonic "phthisis" (caseating broncho-pneumonia) is described as existing in three forms, viz.: (a) nodular, (b) nodal, and (c) pseudo-lobar. In the first the pulmonary forms of lesions are large and multilobular; in the second they are formed by fusion of nodal deposits and exist as larger diseased areas.

It appears to us that the term "phthisis" in this connexion is undesirable. It should be abandoned. The condition is said to be secondary to caseating foci at the hilum and the infection is scattered throughout the lung by res­piratory effort. The nodules are recognizable as shadows situated at the branchings of the bronchioles.

In the nodal and pseudo-lobar forms of disease the shadows are larger and scattered through one or both lungs.

The physical signs are of little value and tubercle bacilli may be absent. Dyspnoea may be a prominent symptom, even when there is little visible change in the skigram. Perilar forms of pseudo-lobar tuberculosis sometimes occur as primary lesions, but usually they are secondary to apical foci. Cavitation may occur with any of these forms.

Chronic "attenuated phthisis" is described as a slowly progressive process, which is often arrested. It generally occurs as a localized deposit, which may, undergo caseous or calcareous degeneration. Smooth-walled cavities and bronchiectasis often occur. In these cases more or less localized shadows are seen, while the cavities give the usual appearance of a light area surrounded by more dense shadow. This form of lesion gives rise to the healed areas so often seen on post mortem.

The various complications are dealt with and the radio­graphic appearances described. In the description of "fibroid phthisis," the author calls attention to the importance of Darwin's sign, viz., the displacement of the mediastinum to the affected side on deep inspiration. The fibroid pro­cess often becomes more or less arrested and is classed as a chronic bronchitis or asthma. It is generally bilateral, but is more advanced on one side. The author points out that it may be recognised by the wavy shadows in the skigram caused by the fibrous bands distributed along the bronchi.

Pneumonic and miliary tuberculosis are said to be secondary to apical infections, as a rule, but they may follow hiliar or perilar disease. In miliary tuberculosis the lung areas are seen to be studded with small foci, uniformly distributed.

The book should be of great value to the clinician, as well as to the radiographer. It contains a record of the clinical signs, as will as of the radiographic findings, in all these conditions. The skigrams reproduced give a good idea of the actual intra-pulmonary changes which give rise to the various signs.

THE COOLIDGE TUBE.

We have received for review a small book1 by H. Pilon on the Coolidge tube. It contains no new matter; the material has all been previously published in the radiographic journals either by the author or by Coolidge & Moore.

1 The Coolidge Tube: Its Scientific Applications, Medical and Industrial, by H. Pilon; Authorized Translation; 1920. London: Bellière, Tindall & Cox. Crown 8vo., pp. 96, with 56 figures in the text. Price, 7s. 6d. net.
the General Electric Company. But the information conveyed in its pages is nevertheless of value. The general construction of electron tubes is described and the two forms in which it is procurable and their use are fully described. The author quotes freely from the work of Coolidge and Moore in the description of radiations from points other than the focal spot. The stability of the tube under various conditions is discussed and the author's experience has borne out the experience of the inventor, viz., that instability is found only in induction coil outfits and is not met with in transformer apparatus. This instability can be traced to the inherent defects associated with induction coil construction.

Tungsten as a target is quite equal to platinum and its higher melting point is a very valuable property. The tube gives as clear definition as the ordinary gas tube and Pilon can distinguish no difference in akiagrams taken under similar electrical conditions by the two types of tube.

Radio-metallurgy is but lightly handled. It is somewhat disappointing that there should be so little from one of the pioneers in this branch of radiography. Protection is discussed, but the methods described would be found too cumbersome for inclusion in a busy radiographic department. The book can be confidently recommended to those who desire a theoretical knowledge of the modern Röntgen ray tube.

Naval and Military.

APPOINTMENTS.

The following appointments, etc., have been notified in the Commonwealth of Australia Gazette, No. 72, of September 2, 1920—

Australiyan Imperial Forces.

Second Military District.

Lieutenant-Colonel C. L. Chapman, D.S.O., Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 26th May, 1920 but to take effect from 25th July, 1920.

Major G. A. M. Heydon, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 26th June, 1920, but to take effect from 24th August, 1920.

Major G. C. Wilcock, O.B.E., M.C., Australian Army Medical Corps, relinquished appointment as Assistant Director, Medical Services, Administrative Headquarters, Australian Imperial Force, 23rd April, 1919.

Fourth Military District.

Lieutenant-Colonel H. C. Nott, Australian Army Medical Corps, relinquished appointment as Senior Medical Officer, Australian Base Depots and Senior Medical Officer, 1st Australian Convalescent Depot, 1st July, 1919.

APPOINTMENTS TERMINATED.

Third Military District.

Major T. Cherry, 22nd July, 1920.

Captain F. A. Bouvier, 12th July, 1920.

Fourth Military District.

Captain G. S. Shipway, 8th August, 1920.

Australian Naval and Military Expeditionary Force.

To be Major, Army Medical Corps—

Captain H. St. J. Mitchell, 1st August, 1920.

URINARY DISEASES.

In the annual report for the year 1919 of the Committee of Management of St. Peter's Hospital for Stone and Other Urinary Diseases in Melbourne, the following note is recorded:—Dr. R. J. Silverton held the position of House Surgeon during a portion of the year. The work carried out at St. Peter's Hospital has for many years commanded the respect and attention of surgeons interested in urology. The statistics published in the annual report are of considerable interest. It appears that suprapubic prostatectomy is performed for benign hypertrophy of the prostate rather more than 100 times every year. In 1916 10 patients were subjected to this operation and eight of them died; in 1917 there were 122 with eight deaths; 1918 105 with five deaths and in 1919 110 with ten deaths. The total number of patients admitted during 1919 for prostate enlargement static was 116. In addition there were 11 patients with malignant disease of the prostate. Of these, seven were subjected to operation, six by the suprapubic method and one by the perineal method. Five of the six patients died.

Of 38 patients suffering from vesical tumours, all but five were dealt with surgically. There were 23 instances of benign tumours. In 18 of these cases excision was carried out successfully. Radium treatment was instituted in another case and the result was satisfactory. In four patients the treatment consisted in the establishment of permanent drainage. Resection of the bladder was performed 15 times for malignant disease. One of the patients died.

A good record has been established in regard to the treatment of vesical calculi. For some reason not immediately evident the number of cases dealt with in 1919 was appreciably smaller than in the preceding years. In all, 38 patients were subjected to treatment for bladder stones. Of these, 32 were subjected to litholapaxy and six to suprapubic lithotomy. One patient of the 32 died. During the decade 1864-1873 the death-rate of operations for stone of the bladder was 15.35%. No improvement followed in the next decade, but from 1884 onwards there has been a gradual lowering of the mortality. In 1919 it reached its lowest ebb at 2.6%.

In regard to diseases of the kidney the record is also good. Nephrectomy was performed 16 times for renal tuberculosis, with recovery in each case. Two patients with malignant disease of the kidney were treated by nephrectomy. One of them died. A third patient suffering from the same condition was too far advanced a stage to admit of the removal of the organ. Nephrectomy was also performed twice for pyonephrosis, with happy results. Success also attended all the nephro-lithotomy, pyelo-lithotomy and uretero-lithotomy operations performed. Only five cases of movable kidney were dealt with; of these, two were treated nephroexy with satisfactory end results.

INTRA-CEREBRAL PRESSURE IN EPILEPSY.

Dr. T. J. Brooke-Kelly, of Brisbane, writes that he has had three patients suffering from epilepsy under operation. In each a trephining operation had been performed, but no improvement had resulted. Dr. Brooke-Kelly has noted that during every epileptic seizure the tissues were sucked into the trephine apertures. He presumes that the intracranial contents decrease in capacity during the fit. These observations are suggestive. It has frequently been noted that the blood pressure in some, but not all, cases is lowered immediately before the fit. On the other hand, every surgeon with experience of trephining for idiopathic epilepsy is familiar with the bulging of the dura mater and cranial contents when the skull is opened. Our knowledge of the conditions governing intra-cranial pressure in its relations with blood pressure and with disturbances of the cerebral circulation is lamentably meagre.

The following appointments, etc., have been notified in the Commonwealth of Australia Gazette, No. 72, of September 2, 1920—

Australian Army Medical Reserve Corps.

Third Military District.

Australian Army Medical Corps Reserve—

To be Honorary Captain—

Frank Longstaff Apperley, 1st July, 1920.