on admission. Urine sp. gr. 1002, contained albumin and sugar, no oxybutyric acid and no acetone. The temperature rose steadily after admission to between 101° and 102° F., and he became drowsy. He was diagnosed as a case of diabetes. He became steadily worse, and on the eighth day after admission his temperature suddenly rose to 107.8° F. and he died two hours afterwards. Post-mortem examination.—Brain—pus on base. Ventricles filled with turbid fluid. No organisms in pus or fluid. Heart and kidneys normal. The lungs showed hypostatic congestion of the left base. Pancreas, large and firm.

Compound Dislocation of Elbow-joint. Shown by Captain Matthews, R.A.M.C.—Boy C., admitted with a compound dislocation of the left elbow due to a fall from a horizontal bar in the gymnasium. Both bones of forearm were protruding through skin behind, and both condyles of humerus were fractured. The dislocation was reduced under anaesthetic, and the internal condyle was screwed into position. The external condyle was too splintered to do anything with. A gauze drain was put into the wound and left there for two days. The arm was put on an angular splint for fourteen days, when passive movements were begun. The wound healed without suppuration, and the patient has now practically perfect movement in the joint.

Heart Disease. Shown by Lieutenant-Colonel Sutton, D.S.O., R.A.M.C.—Serjeant M. came to the hospital for a bottle of medicine, as he was not feeling well. He was examined and found to have mitral and aortic regurgitation and a hemic presystolic murmur, which afterwards cleared up. This case was brought forward as pointing to the necessity of a careful examination in a man reporting sick.

True Rupia in Syphilis. Shown by Major French, R.A.M.C.—Gunner F., admitted with severe rupia. He contracted malignant syphilis in 1906, in England, and was treated in London by injection of insoluble grey oil, with no effect on the disease. Major French said that true rupia was extremely rare in syphilis contracted in England, but more frequent in the severe cases met with abroad. The man was treated with mercury inunctions and potassium iodide. The rash has practically cleared up. From some of the healed scars on the face a relapsing nodular syphilide later developed.

X-RAYS AS AN AID TO THE DIAGNOSIS AND LOCALISATION OF HEPATIC ABSCESS.

By Major C. B. Lawson.
Royal Army Medical Corps.

During the year 1907 three cases of abscess of the liver were admitted to the Military Hospital, Valletta, Malta, and in each case the localisation of the collection of pus was greatly assisted by the use of X-rays, the abscess in every case being struck at the first puncture. The method
of X-ray examination employed was fluoroscopy with a medium tube (4 or 5 inch spark gap), 24 volts from accumulators, and a Mackenzie-Davidson mercury-break. The patient was placed either in the recumbent or sitting posture, and the area of hepatic dulness was screened both in the antero-posterior direction and obliquely. The cases were:

(1) No. 7498, Private W. E. L., 2nd Royal West Kent Regiment, who was landed from H.M. Transport "Sicilia" on January 20th, 1907. The patient was being invalided from Pekin for debility. He gave a history of dysentery, pyrexia and sweating. His blood showed a leucocytosis of 20,000 per cmm., and his liver was greatly enlarged. Screening showed a shadow about the size of the fetal-head in the centre of the region of the right lobe, the lower part of the shadow appearing on a level with the eighth rib in the mammary line. The patient had to be examined in the recumbent position as he was too ill to sit up. His diaphragm was motionless on the right side. An aspirator needle was inserted in the seventh space in the anterior axillary line, 2 inches of the seventh rib were resected, and 1½ pints of characteristic tropical liver abscess pus evacuated.

(2) No. 11,933 Sapper R. L., Royal Engineers, diagnosis hepatitis (?), abscess. Screening showed small shadow near the upper limit of hepatic dulness on the right side. The aspirator needle was inserted in the mid-axillary line in the ninth space, and directed towards the position of the shadow. Four ounces of reddish-brown pus were evacuated.

(3) No. 729 Staff-Sergeant E. J. B., Army Pay Corps, admitted with hepatitis (?), right sided pleurisy (?), liver abscess. The first screening showed fluid in the pleural sac. This became absorbed, and on screening again a dome-shaped shadow encroaching on the right chest was visible. The diaphragm on this side had an excursion of about ½ inch. This dome-shaped swelling could not be made out by the ordinary methods of clinical examination. The patient had a tender spot 1½ inches below and external to the right nipple. The aspirator needle was inserted here and directed towards the dome-shaped shadow, pus being struck at a depth of 3 inches. A portion of the eighth rib between the nipple and the anterior axillary lines was removed and a large drainage tube inserted. Five ounces of thick curdy pus were drawn off.

The seeing of a single shadow gave at the outset a hopeful prognosis, which, I am happy to state, has been quite realised, as all the cases have recovered.