The rack for the railway van is of the same construction, but has another tier made in the same manner.

**Note by Lieutenant-Colonel T. B. Nicholls, R.A.M.C.**

This stretcher rack was demonstrated during an inspection of the Hereford Voluntary Aid Detachment, and proved to be most suitable for its purpose. It is easily made, rapidly fitted and is stable and comfortable. As applied to railway vans it appears to be the most suitable apparatus yet devised for the preparation of improvised ambulance trains, as it is strong, rigid and very economical of space.

The Quartermaster who devised this useful rack was persuaded to prepare this article, as it was considered to be of general interest.

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**A case of departure from the normal in the rotation of the gut.**

**By Major F. J. O'Meara,**

*Royal Army Medical Corps.*

The following note is written to place on record an example of transposition of the stomach during development. The mid and hind gut were also involved, to a lesser degree, in the mal-position of the bowel in the abdomen. There was no transposition of other viscera. A radiogram of the chest showed the normal position of the heart, with the apex beat to the left, as indicated by clinical examination. The radiograms of the abdomen showed the liver in its normal position.

Rifleman R. was admitted to the British Military Hospital, Meerut, in January, 1938, for investigation for dyspepsia. The stool was negative for occult blood and a fractional test meal was within normal limits. Radiograms of the abdomen after a barium meal showed the disposition of the stomach, small and large intestine as described below. The meal had passed out in twenty-four hours, leaving no residue. A barium enema was subsequently given, but as the patient was not screened during its entry into the bowel, I am still uncertain of the exact position of the anatomical divisions of the large bowel. The following sketch is a composite picture from the radiograms demonstrating, as far as I have been able to ascertain, the component parts of the alimentary canal in the abdomen. The stomach was to the right. The small intestine occupied the left side of the abdomen above a line passing through the 9th right costal cartilage, umbilicus and anterior superior spine of the left ilium. The large intestine occupied the right side of the abdomen and the pelvis below this line.

The position of the alimentary canal in the abdomen was as follows:
Name | Extent | Position in Rifleman R.'s abdomen
---|---|---
Fore-gut | Stomach and duodenum to ampulla of Vater | Stomach in the epigastrium rotated to the right. Duodenum to the left of the vertebral column
Mid-gut | Ampulla of Vater to the junction of the middle with the left third of the transverse colon | The small intestine filled the upper part of the left side of the abdomen. The ileum opened into the cecum on the right side of the abdomen beneath the right lobe of the liver. The cecum and ascending colon descended into the pelvis and looped back along the right flank. The deeply haustrated bowel is considered to be transverse colon. This ascended to form a second loop below the right lobe of the liver and then passed diagonally across the abdomen to the left iliac fossa.
Hind-gut | Left third of the transverse colon, descending, iliac and pelvic colon and rectum | The colic angle had remained in relation to the superior mesenteric artery and had not ascended to form the splenic flexure. A loop of large bowel lay in the left iliac fossa. The remainder of the large bowel being in the pelvis.
Clinical and other Notes

To those inspired "to seek out the secrets of nature" the excellent description of the complicated mechanism of the rotation of the gut in the "Synopsis of Surgical Anatomy," by A. L. McGregor (John Wright and Sons, Ltd., Bristol), is recommended. Without the assistance of Mr. McGregor's book this case could not have been recorded.

My thanks are due to Colonel K. Comyn, Officer Commanding, British Military Hospital, Meerut, for permission to submit this record for publication.

URINARY GLUCOSE IN PREGNANCY.

By MAJOR C. R. CHRISTIAN,
Royal Army Medical Corps.

The renal threshold for glucose, or leak-point of the kidney, is that level of blood-sugar above which glucose appears in the urine. The normal threshold is about 180 mgm. glucose per 100 c.c. blood. The amount of blood-sugar in the normal individual does not rise above this level; hence the urine is sugar-free.

The threshold for glucose, however, may vary in different individuals in health and disease. Thus certain people who have a low threshold may exhibit glycosuria although the blood-sugar is normal and such people are apparently healthy. This is termed renal glycosuria, the cause of which is uncertain.

Although a temporary lowering of the renal threshold in pregnancy is not a fresh discovery, most textbooks say little or nothing of this matter. It is not of uncommon occurrence and its true nature is not always recognized by medical officers occasionally in charge of families. It is hoped, therefore, that the following notes of cases which were dealt with at the Military Hospital, Colchester, may be of interest.

Case 1.—Mrs. Fr., aged 24: Primigravida 7 months.

Previous health very good. The patient looks and feels well and is well nourished. On further questioning she complains of slightly increased thirst and micturition and a mild pruritus vulvae, but has not reported these symptoms which have only lasted for a few weeks. There are no signs or symptoms of thyroid, pituitary or adrenal disease. Glucose is present in considerable quantity in the urine, as shown by the fermentation of yeast. The history of the case is as follows:—

The urine had been examined during the fifth and sixth months of pregnancy and no sugar found. In the seventh month the urine contained considerable glucose; no ketone bodies, albumin or casts were found; specific gravity 1030. A few days later the glucose tolerance test was