

Another question relates to the permanency of the disease. I have now examined sixty-eight urines in forty-one cases of bilharziosis. Two of these cases I would consider certainly cured, on the ground that their urines were free of ova in 1905 and 1906, *i.e.*, 4·8 per cent. of the cases. Eight others may be cured, as no ova were present in their urines when last examined, but no definite opinion can be formed from one examination. In three cases I examined in 1905 ova were absent, but were present when the men were examined again in 1906. All these eight cases must therefore remain *sub judice* for another twelve months. How long the patients who have recovered had been suffering from the disease I am unable to state, as specimens of the urine only were supplied without information about the patients. A large mass of statistical information must, however, be accumulating at headquarters with regard to the pensioners discharged the Service for bilharziosis, which, we may hope, will be in time published, and authoritatively settle the question.

I should not venture to offer these few remarks on the subject, but that departure on foreign service prevents further observations at present, and possibly these notes may be of use to some worker.

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ACUTE APPENDICITIS. PERFORATION. REMOVAL.  
RECOVERY.

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PRIVATE C. was admitted to hospital on June 12th, 1906, for double middle ear disease, for which he had passed his invaliding board on September 3rd, and was awaiting departure.

On the morning of September 23rd he was seized with acute abdominal pain, associated with some tenderness in the right iliac fossa, and some rigidity of the abdominal muscles.

September 24th.—Abdomen rigid, almost motionless, and distinct swelling in the right iliac fossa, over which there is extreme tenderness; pain paroxysmal; pulse 80.

September 25th.—Abdomen quite motionless; considerable general distension; percussion over swelling in iliac fossa dull; liver dullness normal; pulse 120. Oil and turpentine enema given with no result. At 4.30 p.m. no change in condition, save for slightly increased distension of abdomen. The patient said he had no pain, but was unable to pass urine. Pulse 135, small, running. This rapidly rising pulse-rate was considered an absolute indication for operative interference, in spite of the absence of pain or high temperature, a useful "tip" which I recently acquired at St. Bartholomew's Hospital.

Chloroform was administered, the urine drawn off, and the skin

prepared in the usual way. An incision was made two inches long in the usual position over the swelling. About two ounces of sero-pus escaped when the peritoneal cavity was opened. A large, acutely-inflamed mass of omentum presented in the wound; it was almost gangrenous in appearance, and covered with thick flakes of lymph. This mass was drawn through the wound until healthy omentum appeared, when the pedicle was ligatured in small sections and the whole mass removed. The cæcum, which was attached to the under surface of the omental mass by recent adhesions, was carefully separated. After the removal of the inflamed omentum the appendix was discovered fairly easily. It was perforated about three-quarters of an inch from its free extremity. In the free extremity was a faecal concretion, exactly the size and shape of an ordinary cherry-stone. The appendix was amputated in the usual manner, a sleeve of peritoneum being drawn over the end of the stump, and a large tube inserted through the wound, which was closed with silk sutures.

For the first three days after the operation his condition was very grave, and he had extensive peritonitis, retention of urine, and marked intestinal distension. He has now completely recovered.

The above case is considered worthy of record and of interest on account of the condition of the omentum described.

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#### A SIMPLE METHOD OF RECOLOURING THE DIVISIONS OF THE MERCURIAL INTRAMUSCULAR - INJECTION SYRINGE.

BY LIEUTENANT-COLONEL W. J. BAKER.  
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To any one who is not gifted with hyper-acuteness of vision, it will be found extremely difficult to see with perfect exactitude the divisions on the barrel of the injection syringe when the red enamel wears off, which it very quickly does, and especially if turpentine in any form is used for cleaning purposes. To remedy this, the following simple procedure will be found useful. Thoroughly heat the barrel of the syringe in the flame of a spirit lamp, then rub the markings with a stick of sealing-wax, allow the wax to cool to the consistence of dough and scrape off with a knife. The wax will remain in the engraved divisions.

The marking will remain for quite a long time and can be easily renewed when required.

It will be found that white sealing-wax is the best colour to use for this purpose, the white colour showing up far better against the grey mercurial cream than either red or black.

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