The opening at the internal ring was very small. Herniotomy was performed and the pillars were sewn up. The child had a normal action the same evening. There was no vomiting and he made a good recovery, being discharged on Sept. 9th.

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EVAGINATION OF MECKEL'S DIVERTICULUM.

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MECKEL'S diverticulum, the remains of the omphalomesenteric or vitelline duct which connects the yolk sac to the convexity of the U-shaped primitive intestine, should have disappeared by the sixth month of fetal life. It springs from the ileum about 100 cm. in adults and 30 cm. in newborn children above the ileo-cæcal junction, but it may be found as high as the duodenum or jejunum, or even in the cæcum or colon, according to which limb of the primitive intestine undergoes development. Kelly describes four types of Meckel's diverticulum. In the first the canal is short; there is a broad fissure at the umbilicus through which faecal matter is discharged. The distal part of the ileum is insufficiently developed and the anus is constricted or occluded. In the second type the umbilical opening is smaller, the canal is longer, and there is no constriction or occlusion of the anus, and faeces pass in the normal way. This type may be produced at birth if the diverticulum still extends into the cord and becomes tied off with it. The case described below was originally an example of this variety. In the third type the distal portion of the vitelline duct has become obliterated, forming a fibrous cord, the filum terminale or terminal ligament. The fourth type is the variety of Meckel's diverticulum usually met with.

Meckel's diverticulum is the cause of intestinal obstruction in 5 or 6 per cent. of such cases in the ileo-cæcal region, and numerous are the ways in which it may bring about this condition, varying with the stage at which the obliterative process has been arrested. The obstruction may depend on the vagaries of attachment of the terminal ligament or the formation—knot or otherwise—which it may assume when unattached. The part it plays in intussusception is well known, while as a result of inflammation of the diverticulum paralytic ileus may be caused, or stenosis of the intestine may occur from adhesions, or from the pressure of an abscess. Ileus from evagination, partial or complete, of Meckel's diverticulum must be a very rare occurrence.

The patient was a baby, 13 months old, and was admitted to hospital on Jan. 7th, 1910. After separation of the cord an opening was noticed at the umbilicus from which, if the child had diarrhoea, faecal matter was passed, but from which there was a constant slight discharge of a sticky, watery fluid. There was always a pouting of the mucous membrane when the child cried or otherwise strained, the degree of prolapse varying with the straining effort. Some hours previous to admission the child was straining and the diverticulum was completely everted. The everted diverticulum presented rather a puzzling appearance. At first sight it looked like a knuckle of deeply congested distended intestine about two inches long lying on the abdominal wall. On closer inspection it was noted that an aperture existed at the distal end and that the outer covering was of mucous membrane. The child could retain nothing. The abdomen was large, but not much distended, and I think the possibility exists that gas might find an outlet through the diverticulum. Reduction at this stage was out of the question and operation afforded the only hope of recovery. Following therefore somewhat the umbilical method of Mayo, a circular incision through the skin round the diverticulum was made and the abdomen opened. The everted diverticulum, lined internally with serous membrane, with its contained loop of afferent and efferent intestine was lifted out, clamps were applied, the intestine was divided, and end-to-end anastomosis performed. The child's condition rapidly improved, and it was fed from the bottle from time to time and seemed to be making favourable progress, but died suddenly ten hours afterwards in a convulsion.

With regard to the treatment of this rare condition it

appears to me that, if the case is seen early and the child is in poor condition, reduction might succeed with or without an anæsthetic, aided, perhaps, by incision of the umbilical opening, recurrence being prevented by an appropriate dressing supported by strapping or an umbilical truss. Operation might then be resorted to under more favourable circumstances. Failing reduction, or as an alternative method, the diverticulum might be excised and the possibility considered of suturing the aperture in the intestine. As the structure of the diverticulum is similar to that of the intestine, part of the former might be used to close the opening or to strengthen the line of suture. Another method that the surgeon might be compelled to adopt would be to remove the diverticulum and suture temporarily the aperture in the intestine to the umbilical opening. If the child were in good condition the operation performed in the above case would seem to be eminently satisfactory.

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Reviews and Notices of Books.

A Clinical Atlas of Sectional and Topographical Anatomy. By RICHARD J. A. BERRY, M.D. Edin., M.D. Melb., F.R.C.S. Edin., F.R.S. Edin., Professor of Anatomy in the University of Melbourne. With 60 plates in colours. London and Edinburgh: William Green and Sons. 1911. Price 42s. net.

BOTH author and publisher are to be congratulated on the production of this volume, for the Clinical Atlas is a very attractively got up publication upon which a great deal of care has been lavished by all concerned in its making.

It is to the wealth of material available at the University of Melbourne that Professor Berry owes his opportunities for carrying out a large number of carefully planned sections of formalin-hardened and frozen bodies. He has been fortunate in his opportunities and wise in the use he has made of them. Great efforts have been made to ensure the accuracy of the reproductions of the actual sections, and to this end photography has been employed. We may miss, perhaps, the delicate detail of the beautiful plates of Braune and of Symington, but at least we are compensated by the knowledge that no craftsman's personal factor has been introduced, and that what we study in the plates is the actual condition in the body under observation. The methods employed are thoroughly up-to-date, and a band-saw driven by electricity has replaced the more laborious contrivances used by former workers in the field of sectional anatomy. In these details of technique Professor Berry's work marks a great advance upon that of his forerunners; but the innovation which most distinguishes this atlas is the cutting of the sections in planes recognised by the clinician, rather than in some arbitrary series of lines which have no meaning in the ordinary examination of the living body. The planes advocated by Dr. Christopher Addison have been chosen by the author, in order that the clinician may study the sectional anatomy of the body along lines whose surface markings are familiar to him. Sections taken between these well-recognised planes are indicated by their distance in centimetres from the planes. To assist the student in locating in the actual body the structures which he studies in the sections, the cadaver has been photographed while still intact with the plane of each individual section marked clearly upon it. It is therefore only necessary to turn to these plates to see exactly where the slice under examination came from, and so to build up a reconstruction of the organs as they lie beneath the surface of the body. Two such reconstructions are given by the author, and others could readily be made from the plates.

For the study of cranial topography the head has been cut in the transverse plane into ten slices at measured intervals