Section of Surgery.

President—Sir HOLBURT WARING, C.B.E., M.S.

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Transillumination of the Breast as an Aid to Diagnosis.—Sir LENTHAL CHEATLE, K.C.B., C.V.O., F.R.C.S.—The following method of transilluminating the breast for the purposes of diagnosis was described to me by Dr. Max Cutler, of New York. All that is necessary is to take a patient into a dark room and gently impale the breast on the top of a curved Cameron light. All cysts are translucent; the subcutaneous veins on the surface of the breast are shown as branching shadows; papillomata in the breast are shown if there has been any hæmorrhage into the duct in which they exist, and solid tumours appear as diffuse shadows.

Sterilization of Surgical Drums.—Sir LENTHAL CHEATLE, K.C.B., C.V.O., F.R.C.S.—I will briefly demonstrate a new surgical drum which has been made for me. The drum consists of mono-metal and can be made in any shape. In the margin of the lid are two grooves which fix into a single groove surrounding the top edge of the drum. These grooves are filled with strands of cotton wool. The drum is filled, the lid is clamped and remains closed, during and after sterilization, and is opened only when the contents are removed. The contents of the drum, unlike all other surgical drums Dr. Creed and I examined, remain aseptic for months. It is impossible to sterilize the new drum in ordinary autoclaves. For sterilization it is necessary for three separate applications of superheated steam to be made. Dr. Creed discovered that all drums which are open when placed in the sterilizer run the risk of becoming septic while in the sterilizer for the following reason, namely, that the air which passes into the sterilizer in the last stage traverses the sterilizing medium at such a pace that it fails to become sterilized. The drums again run a risk of becoming septic when they are drawn out of the sterilizer before they are shut. The possibility of the contents becoming septic is assured by the inadequate protection from infection afforded by ordinary drums.

Chronic Thyroiditis: Early and Terminal Stages.—JULIAN TAYLOR, M.S.—M. J., aged 50, admitted to University College Hospital on August 10, 1925, with a history of swelling in the neck, especially on the right side, of seven weeks' duration, considerable increase in the swelling, huskiness and difficulty in breathing for three weeks.

A hard, nodular swelling of the whole thyroid gland was found, the enlargement on the right side being considerably greater than that on the left. There was inspiratory stridor, deviation of the trachea to the left, shown in the radiogram, and right abductor laryngeal palsy.

Wassermann reaction: Negative. *Blood-count*: Normal. No evidence of thyroid toxicity.

Operation.—Right lobe removed, after which the huskiness and the stridor disappeared.

In March, 1927, the patient was re-admitted to hospital suffering from carcinoma of the stomach (cardiac end) to which he rapidly succumbed. He showed no evidence of thyroid deficiency. The left lobe of the thyroid gland, palpable on his previous admission as a hard nodular mass, could not now be felt.

Description of Specimens.—The right and left lobes of a thyroid gland, the right removed at operation, the left at necropsy nineteen months later.

The specimens show the progress of the inflammation of the gland. The *right lobe* is considerably enlarged, is nodular, and when removed was found to be of a