is expected that applications will greatly exceed the places available, and it must be understood that selection of medically suitable candidates rests finally with the N.W. Metropolitan Regional Hospital Board; the Board has, however, agreed to accept the advice of the Foundation as to academically suitable candidates as far as possible. The Foundation will be pleased to receive, at the earliest opportunity, application from any full-time student who would like to come to Pinewood and who expects to be fit to do so by the autumn, or at any time throughout the coming year. Applicants need consider themselves under no obligation to come if or when they are offered a place. It is important that application should be made early, any time up to six months ahead of the expected date of fitness, so that admission delays and empty places can be avoided. The Foundation will keep in touch with applicants so as to confirm their medical progress.

I would be grateful if any of your readers who are in touch with a tuberculous student who might wish to avail himself of these facilities would be kind enough to either give him this address or send us full details. Further information and application forms may be obtained from this office on request.—I am, etc.,

British Student Tuberculosis Foundation,
6, Gordon Square, London, W.C.1. NICOLAS MALLESON.

POINTS FROM LETTERS

Left-sided Appendicitis

Mr. C. R. STROTHER-STEWART and Dr. FRANCES MCVEY (Newcastle-upon-Tyne) write: On May 12 a man aged 44 was admitted to our wards with a typical history of acute appendicitis. On physical examination there was tenderness in the right and left iliac fossae with more tenderness on the right than on the left. He was also tender in the suprapubic region. There was no tenderness per rectum. The abdomen was opened through a muscle-splitting incision in the right iliac fossa. Free fluid escaped, but only small bowel presented; the ascending colon appeared to extend from the hepatic region to the left pelvis. The original wound was closed and a paramedian incision was made. A very acutely inflamed appendix was found lying on the left side together with the caecum. The interest in this case is fourfold, the typical history, the right-sided pain, the incomplete rotation of the mid-gut, and the acute inflammation of the organ.

Dr. A. G. NEWELL (St. Leonards-on-Sea) writes: During 56 years in the exercise of my profession (10 years purely in public health service) I have only met with two cases of complete retroversion of viscera. One (a woman) had a left femoral hernia, and at operation it was found to contain the appendix. The other case was clear enough. It does not follow that dextrocardia is necessarily part of a retroversion of viscera—i.e., it may be alone. . . . I have alway known the appendix could vary in length so that it can go behind the rectum, across to the left side, or reach up to the gall-bladder. . . . Whatever its length, however, since its base is constant to the caecum the pain will naturally be referred to the area of the caecum.

Dr. D. J. CANNON (Kildare, Eire) writes: My interest in Mr. Maurice Hershman's case of left-sided appendicitis (June 21, p. 1357) has prompted me to add the following note. A patient, aged 12, was sent to me by her doctor on account of central abdominal pain and vomiting. The pain was subsequently referred to the left iliac fossa. The patient had tenderness and rigidity in that region and left-sided rectal tenderness. Pressure on the left iliac fossa elicited pain in the right iliac fossa. A pre-operative diagnosis of left-sided appendicitis was confirmed by laparotomy. The appendix, which was on the point of perforating, was associated with transposition of the caecum. The patient made a satisfactory recovery.

Dr. C. ALLAN BIRCH (Enfield, Middlesex) writes: Transposition of the viscera may be overlooked even on an *x*-ray film of the chest, and so any clinical point, however small, may be important in a possible case of left-sided appendicitis. Some time ago I saw a young man whose left-sided appendix had been removed. I could not trace the surgeon and so do not know whether he had noted the position of the testes, but the right one was noticeably lower than the left. Possibly this obtains in some normal males, but, even so, reversal of the position of the testes may perhaps be a useful small pointer to transposition of the viscera. The point is not mentioned in Blegen's paper on "Surgery in Situs Inversus" (*Ann. Surg.*, 1949, **129**, 244).

Obituary

CHARLES READ, F.R.F.P.S., F.D.S.Ed.

Dr. Charles Read, who had a distinguished career as a specialist in Glasgow, died on July 3 at the age of 64. His main interests were in radiology and in oral and dental surgery.

Charles Read received his professional education at Glasgow, qualifying in dental surgery in 1913 and in medicine in 1915. As a student he won many medals and prizes, including the John Burns Gold Medal awarded to the best student in medicine. In 1922 he obtained the Fellowship of the Royal Faculty of Physicians and Surgeons, Glasgow, and in 1947 was elected to its council. In addition he served the Faculty as examiner for the diploma and higher qualifications, a function which he also carried out as external examiner in the University of St. Andrews. As lecturer in radiology to the Glasgow Dental School and University he gave to many generations of students the benefit of his experience and was always helpful to those who had difficulties in their studies. Last year he was honoured by the Royal College of Surgeons of Edinburgh when awarded the recently inaugurated Fellowship in Dental Surgery. He was twice elected president of the Scottish Radiographic Society, and in 1948 he was elected president of the Odonto-Chirurgical Society of Scotland, an honour which gave him much happiness and to which he lent distinction.

Read had an early interest in and fundamental knowledge of the development of radiology and radiotherapy. From 1918 to 1928 he was senior assistant radiologist in the *x*-ray department of the Glasgow Royal Infirmary, and for the last year of his appointment was acting chief of the department. He resigned to apply himself more closely to dental radiology, in which he was a pioneer and acknowledged expert, being probably the first to use radiology in dental practice in Scotland. For almost 30 years he was on the staff of the Glasgow Dental School and Hospital as visiting surgeon and radiologist. He founded and organized the *x*-ray department of the hospital—the first of its kind in Scotland—and he introduced modern methods and equipment which have established it as an outstanding department unsurpassed anywhere. He contributed many original articles on radiology and electrotherapeutics and also designed apparatus.

His surgical experience added much to the developing branch of oral surgery, and his services as consultant were in demand for the diagnosis and treatment of conditions requiring special skill and knowledge. A founder member of the Oral Surgeons' Club, he greatly enjoyed its meetings at home and abroad. At the last meeting of the club in April, 1952, in spite of ill-health he gave an interesting demonstration of the planigraph for body section radiography and stereoscopy. Illustrating the radiographic appearances of surgical diseases of the jaws before and after treatment, he revealed his unique knowledge, blending radiographic, pathological, and surgical experience.

Combined with a great enthusiasm for the advancement of knowledge were an unassuming personality and sense of humour which made him many friends. He was essentially a traditionalist with a great respect for knowledge and achievement and became increasingly