

of the biliary tree was followed by either percutaneous transhepatic or operative cholangiography. Correct identification of the caliber of the biliary ducts was obtained by ultrasound in some 86% of cases and proved most accurate in those patients with dilated radicles (89%). The most precise indicator of obstructive jaundice was found to be dilatation of the intrahepatic biliary radicles; the common bile duct was identified in approximately 65% of cases. The authors describe and illustrate the morphology of dilated intrahepatic radicles and present the corresponding cholangiograms. The results of the study suggest that diagnostic ultrasound is a useful screening tool for obstructive jaundice and is most accurate in the presence of dilated intrahepatic radicles.

Ultrasonic Demonstration of Intrarenal Anatomy. J. H. Cook, A. T. Rosenfield, and K. J. W. Taylor. *Am J Roentgenol* 129: 831-835, 1977.

The authors present studies of cadaver, in vivo normotopic, and transplanted kidneys, as well as a fetal kidney in utero, and include discussions of intrarenal anatomy not previously reported. Since definition of the medullary portions of the kidney was possible, the cortico-medullary junction was distinguished. At relatively high-gain settings, the renal cortex was quite echogenic, compared with the sonolucent medulla, and the differentiation between the two was easier with the technique of white writing on a black background. Interlobar and arcuate arteries were defined on a barium injected specimen. Improved differentiation between cortex and medulla was observed in such entities as diabetic glomerulosclerosis in which the authors believe the increased echogenicity of the cortex was attributable to collagen deposition. When fluid was present between the kidney and the transducer (as in the case of a large ovarian cyst) the cortex and medulla are better appreciated. The authors cautioned against mistaking the medullary portions of the kidney for cystic regions and noted that the regularity of the medullary region and its separation by the surrounding cortex (the septa of Bertin) were valuable differential points.

Ultrasound-guided Drainage of Fluid-containing Masses Using Angiographic Catheterization Techniques. J. Gronvall, S. Gron-

vall, and V. Hegedus. *Am J Roentgenol* 129: 997-1002, 1977.

In 24 diagnostic punctures of intra-abdominal cavities performed over a 1-yr period, identification of the fluid-filled masses was accomplished ultrasonographically, and an aspiration transducer employed for the puncture. Standard angiographic needles were used for superficial lesions and percutaneous transhepatic cholangiography equipment for deeper ones. Upon entering the cavity, specimens were secured and a J-shaped guidewire inserted; a pig-tail angiography catheter was then placed in the cavity over the guidewire to serve as a drainage outlet. Drainage was established in such entities as pancreatic pseudocyst, intrahepatic abscess, perinephric abscess, etc. with encouraging clinical results. The authors recommend the technique particularly in patients who present high operative risks.

Gray Scale Ultrasound Evaluation of Popliteal Artery Aneurysms. T. M. Silver R. L. Washburn, J. C. Stanely, and W. S. Gross. *Am J Roentgenol* 129: 1003-1006, 1977.

Twelve aneurysms of the popliteal artery were demonstrated in eight patients with suspected aneurysms. Because of proximal occlusive disease two of these were not visualized by contrast arteriography. Bilateral aneurysms were detected in half the patients in this series, and ultrasonography proved of particular value by permitting definition of the outer walls of the aneurysm despite the presence of mural thrombus. In the performance of this study the authors caution that the scans be obtained perpendicular to the long axis of the aneurysm to avert erroneous overestimation of the diameter of the lesion.

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ERRATUM

Due to a production error, a line of type was misplaced in the article entitled "Observer Variability: What to Do until Perfect Diagnostic Tests are Invented" by David A. Turner (*J Nucl Med* 19:435-437, 1978).

The first full paragraph appearing on p 436 should begin as follows:

The appeal of this concept of observer variability is that, in actual practice, it seems to account for the lion's share of inter- and intra-observer variation, provided there is general agreement among observers with respect to which kind of findings will be considered potentially abnormal (e.g., a pulmonary nodule in a chest radiograph, or an activity void in a hepatic scintigram). Lusted made the classic observation that when the widely differing values reported for the sensitivity and specificity of chest photofluorograms in the detection of tuberculosis are plotted on an ROC graph, the data fit a single, smooth ROC curve (15). The same is true of data extracted from early reports of the sensitivity and specificity of pyrophosphate myocardial scintigraphy (Table 1) (20-23). In our laboratory we have observed a similar phenomenon in the case of three expert observers independently interpreting hepatic scintigrams*.