Specimen of Vesico-Colic Fistula.—LIONEL E. C. NOBURY, F.R.C.S.—
Mrs. W., aged 45. History of flooding five months previously. Fibroids of uterus diagnosed. Abdominal exploration by gynaecologist. Large mass found in left iliac fossa, adherent to uterus, bladder, and pelvic colon. Diagnosed as either carcinoma of colon or diverticulitis. Abdominal wound closed. Passage of feces and gas through bladder soon afterwards, with definite cystitis. On Examination: Large mass felt through abdomen and per rectum in left iliac region. Thought to be a case of diverticulitis of the colon.

May 18, 1928.—A transverse colostomy performed, with subsequent irrigation of bladder. A few days later large abscess discharged through old abdominal incision, with disappearance of mass. Great improvement in general condition and condition of bladder. Although no feces passed per urethram, yet communication between bowel and bladder remained, as was proved by the fact that irrigation of the rectum or lower colostomy was accompanied by the return of fluid through the bladder. Radiograph after a barium enema showed a large communication between the colon and bladder.

Since the wound did not heal and the patient was much distressed by the constant flow of pus from the bladder, a further operation was decided upon.

October 13.—Examination under anaesthetic showed a hard mass, presumably growth in the pelvis, with adhesions to the abdominal wall in the region of the old scar.

October 15.—Resection of portion of pelvic colon, rectum and part of the bladder, together with a portion of the abdominal wall. Tube drainage of bladder and of pelvic cavity. Microscopy showed the growth to be a colloid carcinoma.

At the present time the bladder is closed, the patient is able to retain urine for at least from three to five hours, and she sleeps most of the night. General condition, excellent.

Specimen: Leiomyoma of Rectum.—W. S. PERRIN, M.Ch.—Removed from anterior wall of rectum of a man aged 39. The symptoms were hemorrhage from rectum on defaecation, which had extended over a period of three years. The growth was just above the anal canal and had a broad pedicle.

Two Specimens of Villous Tumour of the Rectum.—W. B. GABRIEL, M.S.—(1) Specimen of a large villous tumour in the upper-third of the rectum—an unusual position. Obtained post-mortem from a female patient aged 72, who had died fourteen days after colostomy was performed.

(2) Transverse sections of an extensive recurrent villous tumour of the rectum.

History.—The patient is a man now aged 65. Operations were performed in 1916 and again in 1917 for local removal of a villous tumour in the lower third of the rectum. The tumour recurred, and in 1923, posterior proctotomy and extensive excision were performed. The growth recurred in less than a year, but the patient carried on until 1928 when he was found to present an extensive friable growth reaching up as far as the finger could reach and involving the entire circumference
of the bowel. In parts it appeared firmer and nodular, and clinically it seemed suspiciously like malignant degeneration.

Treatment, June, 1928.—Colostomy, followed two weeks later by perineal excision, the bowel being divided well above the upper limit of the growth. The patient has made a good recovery and the wound has healed well.

Microscopical Examination.—This shows the tumour to be a simple villous tumour with no evidence of malignancy. Dr. Cuthbert Dukes has investigated this case by means of whole sections which show clearly the superficial nature of the tumour.

Specimen of Carcinoma of Ascending Colon with great Dilatation of Caecum. Removed by Resection of the Distal Half of the Colon after Preliminary Short Circuit.—Sir Charles Gordon-Watson, K.B.E., F.R.C.S.—The specimen was removed from a man aged 67, who was suffering from partial obstruction when he first came under observation. At operation, after the diagnosis was established, a lateral anastomosis was performed between the terminal ileum and the mid-portion of the transverse colon and a catheter was tied into the dilated caecum. Resection was delayed owing to a temporary faecal fistula, but was carried out about seven weeks after the short circuit. The caecostomy was allowed to close three weeks after the first operation.

In spite of the short circuit and temporary colostomy, the caecum had not recovered its tone but was almost as large at the second operation as at the first. This was due to the fact that some intestinal contents passed on through the ileo-caecal valve and did not easily pass the malignant stricture in the ascending colon. The ileo-caecal valve, functioning well, prevented regurgitation. The moral of the case is that a lateral ileo-colostomy without division of the ileum is not in itself a safeguard against perforation of the caecum in acute obstruction of the ascending colon, although this particular case fell short of this extremity. A second point is that a caecostomy acting as a safety valve, should not be allowed to close unless the second operation of resection is contemplated at an early date. Some years ago at St. Bartholomew's I lost a case through perforation of the caecum occurring after a similar short circuit, by acute obstruction arising in the same situation.

[Sir Charles Gordon-Watson demonstrated the specimen on the screen and called attention to the marked stenosis produced by the growth and the extreme dilatation of the caecum.]