hemorrhage may result from direct puncture of a vessel by an ingested object. However, long-delayed hemorrhage as reported by Lascano and Senonan is more compatible with their conclusion that the mechanism is erosion of the esophageal mucosa with subsequent abscess formation and finally aortic perforation following evacuation of the abscess.

Krause (quoted by Barrie and Townrow) thought the formation of a perivascular clot arrested the initial hemorrhage but that progressive sepsis ruptured this clot, leading to further hemorrhage.

Probably any one or all of the mentioned mechanisms may apply in cases of this type. Since in cases of swallowed bone the offending foreign body is seldom found, it cannot be stated how much of the aortic lesion is due to continued trauma and how much is due to the secondary septic process with no initial direct trauma to the aorta. In the present case the process was probably one of acute localized esophagitis leading to acute mediastinitis and finally periarteritis and arteritis of the thoracic aorta with final weakening of the aortic wall to the point of rupture. No foreign body was recovered and probably the entire course of events was initiated by a superficial wound of the esophageal mucosa without the actual participation of the offending foreign body in the subsequent events. If the perforating object remained in the involved area, it might well be washed out by the gush of blood attendant upon aortic rupture.

Banks, in discussing a similar case, stressed the importance of early esophagoscopy, a view with which the authors are in accord. However, since in several cases esophagoscopy revealed neither the foreign body nor the perforation, and since localized mediastinitis appears to be a major factor in producing aortic perforation with or without aortic-esophageal communication, vigorous chemotherapy is indicated, regardless of the endoscopic findings. Following the swallowing of a foreign body, sequential appearance of initial pain, symptom-free interval, and "signal" hemorrhage should call to mind this syndrome. Probably thoracotomy must be performed if the final fatal hemorrhage is to be prevented.

**SUMMARY**

A case of aortic-esophageal fistula with fatal hemorrhage secondary to swallowing a fishbone is presented, with clinical and pathological findings. A review of the pertinent literature suggests that localized mediastinitis following esophageal perforation is responsible for the establishment of the aortic-esophageal fistula. Vigorous chemotherapy is imperative even in the face of negative esophagoscopy findings. The sequential appearance of pain, symptom-free interval, and "signal" hemorrhage indicates aortic esophageal hemorrhage and heralds a fatal hemorrhage which may be prevented only by thoracotomy.

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The patient was on the medical service of Lewis Gunther, M.D., College of Medical Evangelists, Los Angeles.

**REFERENCES**

5. Krause, quoted by Chiari and Barrie and Townrow.

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**Term Pregnancy Following Removal of Right Ovary and Left Corpus Luteum Cyst**

**VIRGINIA A.Singleton, M.D., San Luis Obispo**

The patient, a 29-year-old white gravida IV, para II, first observed January 10, 1949, reported irregular "spotting" since the last normal menses on September 5, 1948. She also had noted nausea, menstrual-like cramping, low backache, and a pain in the lower left quadrant of the abdomen.

In the three previous pregnancies there had been two normal deliveries at term (1942, 1944) and one spontaneous miscarriage at four months' gestation (1945). In 1945 an appendectomy and a right salpingo-oophorectomy had been done because of an "infection."

Physical findings were within normal limits. Blood pressure was 110 mm. of mercury systolic and 70 mm. diastolic. The uterus was gravid; gestation had progressed approximately two and a half months. There were no palpable adnexal masses. The cervix was bluish and intact. The
Hepatitis and long-continued a when white pine sinusitis history of antimony and aware was by ounces. in the literature.

On August cramping and nausea, but at the diagnosis of that unruptured cyst. The patient was compliance of some left-side pain. A pyelogram was made; no evidence of disease in the kidneys or ureters was noted.

This case brings up the question of the actual necessity of the corpus luteum hormone in the first trimester of pregnancy. Bonn reported a case in which bilateral oophorectomy was carried out on the 35th day of gestation and pregnancy proceeded uneventfully to term. Hartman stated that, in the monkey, the corpus luteum of pregnancy may be removed as early as the 25th day of gestation without interrupting the pregnancy. Certainly, the answer is not yet known. In the case here reported, stilbestrol was given on the theory that stimulating the secretion of progesterone would reduce the risk of miscarriage. Whether or not the pregnancy would have proceeded to term without it is uncertain.

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REFERENCES

Hepatitis and Nephrosis Due to Cough Syrup Containing Chloroform
CHARLES J. WALLACE, M.D., Sacramento

It has been known for over 50 years that chloroform causes damage to the liver, kidneys, heart and nervous system. Instances of poisoning due to chloroform inhalation have been common in years past but clinical reports of chloroform poisoning by ingestion are rare and none have appeared in the literature since 1933. Recently an extraordinary case of long-continued daily ingestion of chloroform was observed.

CASE REPORT
A 47-year-old salesman complained of anorexia, loss of libido and generalized weakness of one year's duration. The family history was non-contributory. There had been no major illnesses in the past and the only operation was for repair of a traumatically ruptured testicle during childhood. Chronic sinusitis and bronchitis had been present for 12 years, and several physicians had prescribed Cheracol.

In traveling about the state the patient visited many physicians and requested prescription for Cheracol. Only the patient was aware of the amount of medicine he used. With some embarrassment, he admitted to an average daily ration of 12 ounces of Cheracol for the past ten years. On occasion, when a particularly bothersome upper respiratory infection occurred, he even increased the daily dose to about 20 ounces. With the 0.8 to 1.3 gm. of codeine thus ingested, the patient also took 1.6 to 2.6 gm. of chloroform daily. Other medication consisted of "One a Day" vitamin pills and occasional use of a penicillin spray. A diet survey revealed an average daily consumption of protein 50 gm., carbohydrate 80 gm., and fat 65 gm. In former years, the patient took one to two whiskey highballs before dinner, but during the past year he had discontinued this altogether because of feeling so "run down."

Upon physical examination the patient was noted to be well developed and well nourished. The weight was 171 pounds, the height 69 1/4 inches. The patient looked tired. The skin was pale and swollen. The tongue appeared normal. Blood pressure, heart and lungs were normal. The abdomen was soft; a single spider angiomia on the upper back. The odor of the breath was not remarkable. The eyes and ears were normal. The nasal and pharyngeal mucosa were slightly injected and swollen. The tongue appeared normal. Blood pressure, heart and lungs were normal. The abdomen was soft; a smooth, hard, non-tender liver edge extended 9.5 cm. below the xiphoid process and 5 cm. below the mid-clavicular line. The spleen could not be felt. The right testicle was about twice normal size. No abnormalities were noted in a rectal examination. There was no edema in the extremities. The reflexes were normal. Sensation was intact.

Laboratory data: Erythrocytes numbered 3,490,000 with hemoglobin (Dare) 11.0 gm. or 68.8 per cent, giving a color index of 1.0. There was moderate variation of size of red cells, with a moderate number of macrocytic cells. Reticulocytes made up 2.5 per cent of the total. Leukocytes numbered 8,950, with 69 per cent segmented neutrophils, 4 per cent non-segmented neutrophils, 3 per cent eosinophils, 1 per cent basophils, 25 per cent lymphocytes and 3 per cent monocytes. The pH of the urine was 4.0 and the specific gravity 1.018. There was a trace of albumin, no glucose. Many hyaline and granular casts were noted. A very few erythrocytes and leukocytes were observed. A second urine analysis confirmed the trace of albumin and casts. Results of a Kahn test of the blood and of stool examination were