rounded ball, leaving a triangular orifice on either side. The texture of the pouch was identical with that of the remainder of the valve cusp.

The liver showed advanced nutmeg change, the peritoneal sac contained 5 pints (2.8 litres) of clear fluid, and there was a cluster of tiny cysts in the head of the pancreas, forming a mass 1 in. (2.5 cm.) in diameter. No other abnormality was found in the abdomen.

COMMENT

Various diverticula have been reported in the left ventricle. Skapinker (1951) describes a congenital diverticulum arising from the apex of the heart and presenting as a pulsating swelling above the umbilicus. A successful excision was carried out. He cites 12 other cases in the literature.

The acquired diverticulum of the muscle wall, the so-called "aneurysm of the ventricle," is due to the progressive expansion of a fibrotic patch derived from obstruction of a branch of the left coronary artery. These lesions may be 4 in. (10 cm.) in diameter, and the condition is termed "bag heart." A full description is given by Friedburg (1950).

The described diverticula of the mitral valve seem to be limited to the pouches occasionally resulting from the destructive inflammation in acute bacterial endocarditis. These are usually mentioned in the formal descriptions given in textbooks of medicine and pathology.

In this case it is clear that the pouch was acquired and not congenital. It can hardly be thought that a woman could pursue an active life for 63 years and only then present symptoms. It is equally clear that she was not suffering from an ulcerative endocarditis. Her illness was protracted and afebrile, and at necropsy the valves were free from vegetations.

There may be an association between the eye condition and the diverticulum. The first symptoms of cardiac disorder appeared during the first days of the iridocyclitis, and it is possible, though it cannot be proved, that the weakening of the valve cusp and the iridocyclitis had a common origin, perhaps infective.

We are indebted to H.M. Coroner for the Craven District, Mr. Stephen E. Brown, for permission to publish this case.

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REFERENCES

- Friedburg, C. K. (1950). *Diseases of the Heart*, p. 458. Saunders, Philadelphia and London.
Skapinker, S. (1951). *A.M.A. Arch. Surg.*, 63, 629.

Unilateral Haematocolpos Haematometra

Imperfect canalization of the lower end of the Müllerian duct is the commonest cause of haematogynaecolpos. The latter designation, derived from the Greek forms meaning blood, female, and tube, has been suggested by Alders (1953) as a collective term for the accumulation of blood in a portion or in portions of the Müllerian ducts.

The combination of failure of fusion of the Müllerian ducts resulting in a double uterus and vagina, and unilateral atresia with haematocolpos, haematotrachelos, and haematometra, must be very rare. Few such cases have been described (Purslow, 1922; Wilson, 1925; Simon, 1928; Brown and Brews, 1930; Martindale, 1935; Embrey, 1950). A further case is recorded here.

CASE REPORT

A girl of 12 was referred to the out-patient department of Swanage Hospital because of increasingly severe dysmenorrhoea. Her periods had started six months previously, and for the first three months had occurred at two-weekly intervals, and the loss, which lasted five days, was described

as heavy. For the last three months they had occurred at monthly intervals and were associated with pain, chiefly referred to the back, which was increasingly severe with each period.

She was an intelligent well-developed girl. General examination revealed no abnormality of significance. Nothing abnormal was discovered on abdominal palpation, but on rectal examination a tense cystic swelling was found to fill the pelvis. No attempt was made to examine her vaginally. A tentative diagnosis of ovarian cyst was made and a laparotomy advised.

A few days before the planned date of admission she developed difficulty in starting micturition, which was relieved on lying down. She was therefore admitted as an emergency case to the Royal Victoria Hospital, Bournemouth.

Under general anaesthesia the abdomen was opened through a median subumbilical incision. A symmetrical, tense cystic swelling was seen to be rising out of the pelvis. On its top were perched two uteri of approximately normal size, though the left was somewhat larger than the right. Both Fallopian tubes and ovaries were normal. The vesico-uterine fold of peritoneum was incised and the bladder was dissected off this swelling. The latter was incised transversely; about 10 oz. (284 ml.) of viscid dark fluid was evacuated, and it was seen that there were two separate vaginae. The left vagina ended blindly below and was grossly distended. The left cervical canal was gaping, and similar tarry fluid was seen emerging from it. The slightly larger size of the left uterus was obviously due to haematometra. The right vagina was quite narrow, and ended below at a normal hymen. The right cervix was small and admitted a probe. The septum between the two vaginae was resected throughout its length, and the incision in the now single vagina was closed with catgut sutures. The incision in the vesico-vaginal fold was sutured and the wound closed in layers. Vaginal examination whilst the patient was still anaesthetized revealed the presence of a wide single vagina into which two cervixes dipped.

The patient made an uneventful recovery apart from a transient pyrexia (which was thought to be due to the presence of some of the contents of the haematocolpos in the pelvis).

In view of the frequent association of renal with genital malformations an intravenous pyelogram was taken while she was still in hospital. This showed complete absence of excretion on the left side and a slightly enlarged right kidney. The right renal pelvis, ureter, and the bladder appeared normal.

The patient was seen six weeks after the operation, when she had had a painless period of five days' duration.

COMMENT

The diagnosis of haematocolpos was missed because of the absence of the leading symptom of cryptomenorrhoea, the two uteri were not felt on rectal examination because of the presence of the large cystic tumour, and the imperforate hymen on the left side was not seen as no attempt at vaginal examination was made because of her youth.

I should like to express my thanks to Mr. N. Alders, under whose care the patient was admitted and who performed the operation, for permission to publish this report.

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REFERENCES

- Alders, N. (1953). *J. Int. Coll. Surg.*, 19, 286.
Brown, R. C., and Brews, A. (1930). *J. Obstet. Gynaec. Brit. Emp.*, 37, 233.
Embrey, M. (1950). *British Medical Journal*, 1, 820.
Martindale, L. (1935). *Lancet*, 1, 1389.
Purslow, C. E. (1922). *J. Obstet. Gynaec. Brit. Emp.*, 29, 643.
Simon, H. E. (1928). *Surg. Gynec. Obstet.*, 47, 356.
Wilson, J. St. G. (1925). *J. Obstet. Gynaec. Brit. Emp.*, 32, 127.