patient left hospital on September 29 and resumed work a few weeks later, but the bronchocutaneous fistula still persists.

DISCUSSION

This seems to have been a fairly typical but severe case of Friedländer pneumonia, except that repeated sputum examinations were negative. Necrosis of lung tissue is a common feature on microscopical examination, with the production of multiple thin-walled abscesses which often rupture into a bronchus, but occasionally result in empyema. Belk (1926) reports this as occurring as early as the fourth day. Solomon (1937) mentions six cases with sloughing between the fifth and eleventh days. In our case it was visible on the tenth day. Massive sequestration of a whole lobe or part of one, as described in cases reported by Taylor (1944), Humphreys (1945), and Brock (1946), and in our case, is distinctly unusual other than as a post-mortem finding. A double pneumonic process, such as occurred in our case in which there was a patchy consolidation in the base of the right upper lobe in addition to the main lesion in the left upper lobe, is said to occur in 56% of cases. Mortality is high—Solomon (1937) gave 97% of 32 cases; Perlman and Bullowa (1941) 84% of 37 cases; and Hyde and Hyde (1943) 51% of 51 cases—and 80% of the deaths occur in the first five days from toxæmia and intense pulmonary oedema. Peripheral failure is rare.

The appearances of serial radiography have been classified by Kornblum (1928) and Collins and Kornblum (1929) as follows: (1) primary bronchopneumonia; (2) pseudolobar pneumonia; (3) multiple abscess formation and cavitation; and (4) fibrosis simulating tuberculosis. This progressive nature of the lesion was well exemplified in our case, except that stage 4 did not occur.

Streptomycin seems to be the most effective antibiotic. Nataro *et al.* (1950) give a summary of 10 successfully treated cases from the literature and add two of their own. They quote the case of a patient, described by Rosenthal, who made a successful recovery, although streptomycin therapy was not begun until the fortieth day of the illness. In our case this treatment was begun 30 days after the onset, and 69 g. was given. Aureomycin had no obvious effect, although the patient received 15 g. in all over 13 days. Nataro *et al.* report a dramatic improvement within 24 hours in their patient treated with 1 g. six-hourly for five days. This patient had been ill 11 days and cavitation was not present. In our case the antibiotic was not given until the seventeenth day of the illness, at which time cavitation was radiologically apparent.

Surgery seems to have been life-saving in our patient, although he still has a minimal amount of discharge from a small fistula. Solomon (1940) states that in this condition the fistulae resulting from surgery drain interminably. He believes that most abscesses will drain through a bronchus, if aided by posture and repeated bronchoscopy.

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Antiperistaltic Movement of a Foreign Body in the Colon

Foreign bodies introduced into the rectum are not rare. Most pathological museums contain several specimens. Often such foreign bodies are small glass bottles, though other objects have been removed from this situation. A foreign body, however, which has been introduced into the rectum and subsequently ascended the bowel, producing perforation of the descending colon, is very rare.

CASE REPORT

A man aged about 50 was admitted to hospital on January 2, 1951. He stated that he had pushed a bradawl into his rectum two days before admission. He was obviously very

ashamed of the whole incident and did not wish it to become known why it was introduced. An abdominal x-ray picture showed the foreign body well up in the descending colon (Fig. 1). Examination of the abdomen revealed some tenderness and some guarding over the line of the descending colon, and a diagnosis of perforation of the colon was made.

At operation the descending colon was explored through a muscle-cutting incision in the left iliac fossa. The bradawl (Fig. 2) was palpated, the handle being wedged in the splenic flexure, and the point had perforated the descending colon. There was early peritonitis in the vicinity. The point of the instrument was grasped in a strong clamp and pulled downwards. The bowel was then incised in its longitudinal axis on to the handle of the bradawl. The foreign body was removed and the incision in the colon stitched in two layers transversely. A small drain was left in down to the site of the suture.

The patient made an uninterrupted recovery from his operation, and was discharged to a convalescent home seven days after admission.

COMMENT

An interesting feature of this case is the mechanism by which this foreign body ascended the colon from the rectum. It would seem probable that peristaltic waves forced their way over the handle of the bradawl while the point was fixed in the mucosal folds of the intestine. Relaxation of the peristalsis produced ascension of the instrument. A similar mechanism is seen in threading a cord through the top of a pair of pyjama trousers. It was not until the handle became fixed at the splenic flexure that peristaltic waves produced enough thrust to drive the point of the bradawl through the wall of the bowel. No reference to a similar case has been traced in the literature.

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FIG. 1.—Radiograph showing bradawl with handle almost up to the splenic flexure.

FIG. 2.—The bradawl after removal.