of continuous retropubic discomfort, and 20 minutes later the pains ceased completely. I saw her 10 minutes later, when her pulse rate was 86 and blood pressure 126/76. There was no clinical evidence of any deterioration in her general condition. There was marked tenderness on pressure above the pubis, the foetal head could not be felt at the pelvic brim, and rectal examination showed the presenting part to be no longer in the pelvis. There was a moderate bright-red vaginal loss. A diagnosis of rupture of the lower segment was made, and the patient was taken immediately to the theatre, where laparotomy was begun 35 minutes after cessation of the pains, a blood transfusion having been started meanwhile. By the time the operation was begun the blood pressure had fallen to 76/38, the pulse was 126, and the patient was showing evidence of severe blood loss. The peritoneal cavity contained 4 pints (2.2 litres) of blood. There was a ragged tear across the anterior surface of the lower segment extending round the right border of the uterus and down into the cervix on that side. The right uterine vein was completely torn across and was bleeding profusely.

The foetus (weight 9 lb. 3 oz.—4.2 kg.) and placenta lay free in the abdominal cavity, and the body of the uterus was firmly contracted.

Bleeding was controlled, foetus, placenta, and blood were removed, and a subtotal hysterectomy was carried out. At the termination of the operation the blood pressure was 84/40, 2 pints (1.1 litres) of blood having been given. Subsequent progress was uneventful, and the patient was discharged on the 14th day.

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Acute Phlegmonous Colitis

As this condition has not, so far as I can find, been described in this country, the following case is of interest. Two cases of acute phlegmonous caecitis were described by Nardell (1949) and a third by Shove (1950). The lesion in the present case lay in the medial wall of the ascending colon adjacent to the ileo-caecal valve. Eleven similar cases were reviewed by Spivack and Busch in 1943.

CASE REPORT

A man aged 22 was sent to hospital by his own doctor in the early hours of January 28, 1949, with a diagnosis of acute appendicitis. Abdominal pain had begun the previous night. During the previous day he had eaten his breakfast and lunch but not his evening meal, and his bowels had been opened once normally. On the night of admission the pain became very acute and he vomited several times. He had been feeling unwell for several weeks, and had been attending his doctor for a boil on his left forearm and an ulcer on his tongue. In March, 1948, he had been in hospital with left lobar pneumonia, and in 1946 he had had a mastoid operation for left-sided acute otitis media. He had been demobilized from the Army in February, 1948, after serving with the Army of Occupation in Germany.

On examination his temperature was 100° F. (37.8° C.), pulse 136, and respirations 32. He appeared pale and shocked. The whole abdomen was acutely tender, with muscle guarding in the right iliac fossa. This prevented any mass from being felt. Rectal examination revealed nothing abnormal. There was a healing boil on the left forearm and a small circular midline ulcer on the dorsum of the tongue near the tip.

An intravenous infusion of glucose 5% and normal saline was begun immediately. An hour later operation was per-

formed under general anaesthesia. When the abdomen relaxed a distinct mass could be felt high up in the right iliac fossa. A gridiron incision was made and only a small amount of serous fluid was found in the peritoneal cavity. The appendix was hanging free from its mesentery and showed no macroscopic abnormality. A solid mass about the size of a golf ball was felt in the ascending colon, and was exteriorized for inspection; it was situated in the medial wall of the ascending colon immediately adjacent to the ileo-caecal valve. The peritoneal surface was pink and grossly oedematous and there were two small areas where the surface was grey and rough. The lesion was well localized, though affecting the ileo-caecal valve and caecum at its periphery. The ileo-caecal valve was not obviously obstructed. The oedema extended into the mesentery, in which several greatly enlarged soft lymph nodes could be felt. The appendix was not removed and the mass was returned to the abdomen. The abdomen was closed without drainage.

The intravenous drip was continued post-operatively, and sulphadimidine, 1 g., and penicillin, 100,000 units, were given by injection four-hourly. The patient's condition, however, rapidly deteriorated: the pulse rate and temperature rose and the blood pressure fell. He died 20 hours after operation.

At necropsy, which was performed by Dr. Richard Pearce, it was noticed that the right thigh was larger than the left. On tapping it with the flat of a knife blade it gave a resonant note compared with the left. Extensive gas gangrene was discovered in the abdominal musculature round the operation wound, in the right ilio-psoas muscle, and in the muscles of the anterior compartment of the right thigh. There was no general peritonitis. The intestinal lesion consisted of an area of acute cellulitis, involving the whole thickness of the intestinal wall, measuring 2 to 3 in. (5–7.5 cm.) across. Except for this area the whole gastro-intestinal tract appeared normal. No trace of ileitis or diverticulitis was found, and there was no obvious ulcer or injury to the mucosa covering the inner aspect of the lesion. The ileo-caecal valve, though involved, was not completely obstructed. There was haemorrhage into the right suprarenal gland and signs of active chronic inflammation in the cells of the left mastoid. Both lungs showed some terminal basal pneumonia and old pleural adhesions. A section of the lesion examined under the microscope showed "spreading anaerobic infection of the whole thickness of the bowel wall." A section of the ulcer of the tongue was reported as "granulomatous ulcer non-specific."

COMMENT

The pathology of this lesion corresponded with that described as the circumscribed type of acute phlegmonous caecitis by Nardell (1949), Bulmer (1947), and Spivack and Busch (1943). It seems likely that the lesion began as a haematogenous focus from the mastoid or the boil on the forearm. The gas-forming organisms then traversed the lesion from the lumen to the adjacent abdominal muscles. In the cases described in the literature there is no record of gas gangrene as a sequel to this lesion. A case of gas gangrene complicating carcinoma of the colon was reported by Wyman (1949), who briefly reviewed other cases of endogenous gas gangrene. Although Spivack and Busch came to the conclusion that removal of the lesion when circumscribed is unjustifiable, it is conceivable that in the present case resection might have prevented the onset of gas gangrene.

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