of gastrointestinal symptoms, but the manifestations could have been limited by the steroid she was taking.

Although femoral hernias usually contain omentum or small bowel, occasionally they contain appendix, caecum, testicle, ovary, a Meckel's diverticulum or a caecal diverticulum.²

Previous workers have described necrotizing fasciitis of the abdominal wall secondary to a strangulated femoral hernia containing a perforated sigmoid diverticulum in the presence of a rectosigmoid cancer, though this involved the left femoral canal.³ Necrotizing fasciitis has also been described in the abdominal wall over the right iliac fossa secondary to perforation of a sigmoid diverticulum.⁴ We have not found any previous report of a perforated sigmoid diverticulum presenting with cellulitis and abscess formation in the right thigh.

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'Aggressive keloid': a severe variant of familial keloid scarring

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Keloid scars are nodular skin lesions that in severe forms resemble neoplasms and cause much physical and mental distress. Attempts at treatment can make them worse.

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CASE HISTORIES

Case 1

A woman aged 21, of black Jamaican origin, had experienced keloid scarring from her early teens after minor trauma. Now she was much troubled by multiple large scars on the back, deltoid regions, lower legs, arms, upper buttocks and chest. Her sister and her brother also had keloid scarring. Treatments had included surgical excision, radiotherapy and steroid injections; none of these had given lasting benefit, and the recurrent lesions were worse, causing physical and psychological distress.

Case 2

A woman of 44, of black Jamaican origin, had experienced multiple keloid scarring from the age of 8. Existing scars had continued to grow and new ones had developed even after minor abrasions. When seen by us she had extensive keloid scars on her chest (Figure 1), arms, back, lower legs, pubis, and buttock. Most of the scars were sessile, in parts lobulated and of hard consistency. The scars were functionally disabling as well as emotionally distressing. In the past, unsuccessful treatments had included pressure garments, silicone gels, steroid injections, surgical excisions, and superficial radiotherapy. The only other medical history of note was recent diagnosis of a uterine fibroid. Having left Jamaica as a child she was unsure of her family history, but her father was believed to have been affected by keloid scarring. So too was her only daughter, who had multiple but less severe lesions than our patient.

Case 3

A 90-year-old man of black Jamaican origin sought advice about multiple keloid scars in his armpits and on his lower

Figure 1 Keloid scarring on chest, case 2

legs, face, feet, groin and pubic region. He had first noticed a lumpy scar after a minor shaving injury as a teenager. He had later developed bilateral axillary keloids as a result of irritation from use of deodorants. At age 55 years, after bilateral hernia repairs, keloid scars had appeared in the groin. Some of the scars, particularly on the face and neck, had become smaller in his 80s. His father had had multiple large keloid scars in several anatomical locations. Three out of his four sons had keloid scars; three out of four daughters were also affected and one granddaughter had a keloid.

COMMENT

The pathogenesis of keloid scarring remains an enigma.¹ The three cases reported here illustrate the association of severe scarring with a positive family history and black African ethnic origin^{2–5} (though a similar condition can arise in Europeans).

The special feature of the cases reported here is their unusual extent and severity, reminiscent of neoplastic disease. In such cases even an experienced clinician may have difficulty ruling out malignancy. However, in the present series and in a previous case from Kingston, Jamaica,⁶ the histology was typical of a keloid scar—i.e. nodular fibroblastic proliferation of the dermis. Several familial syndromes have been associated with keloid scars including Rubinstein–Taybi⁷ and Goeminne syndrome⁸ and conjunctivo-corneal dystrophy⁹ but none of these conditions was found in any of our cases. Patient 2 had a uterine fibroid, a benign fibrous growth which like keloids seems most common in dark-skinned individuals and tends to recur after treatment.

As regards treatment, all three patients had been unresponsive to conventional strategies, with the recurrent lesions sometimes worse than the original. Two patients (1 and 2) had experienced psychosocial difficulties requiring counselling and are being considered for novel treatments such as local or systemic chemotherapeutic agents. 5-fluorouracil and bleomycin have been previously used with variable success.¹⁰

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Haemopneumothorax after fine needle aspiration of the breast

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Fine needle aspiration (FNA) of the breast is commonly performed without image guidance. Complications are rare but can be serious.

CASE HISTORY

A woman of 54 was referred to the breast unit with a recurrent tender left upper outer quadrant mass. Mammography showed an asymmetrical density with no features of carcinoma. 'Blind' (non-image-guided) FNA yielded insufficient cells for diagnosis. Six weeks later she returned for a further blind FNA, subsequently reported as showing red blood cells and normal epithelial cells. 32 hours after the second FNA she was seen in the emergency department with left-sided pleuritic chest pain and dyspnoea. She was cyanosed, with a respiratory rate of 22 per minute and oxygen saturation 88% on air. Her trachea was deviated to the right. There was reduced expansion and air entry on the

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