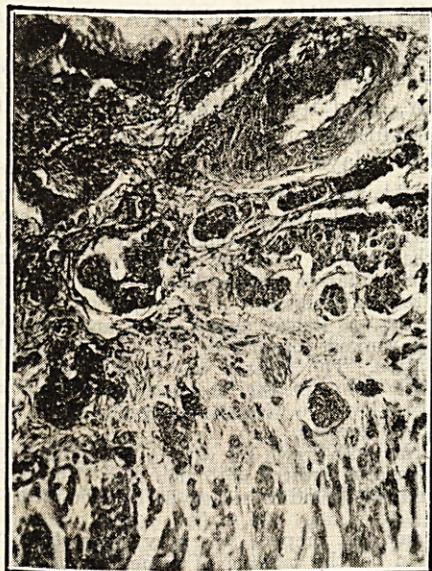


No mitotic figures are to be seen.
A section stained by silver impregnation shows the presence of argentaffine cells.

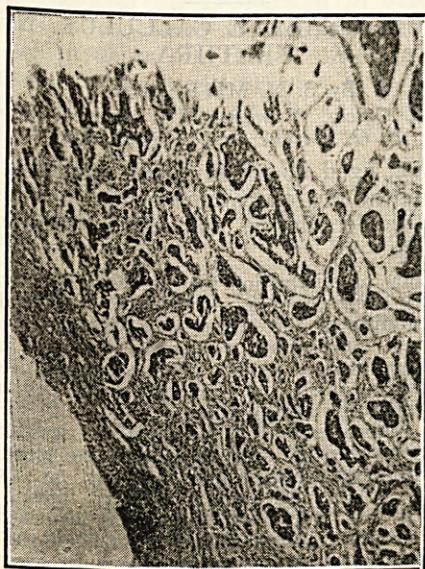
Discussion

This specimen is peculiar in (1) that the carcinoid appearance and solid alveolar arrange-



High power.

ment of spheroidal cells are absent from the mucous and submucous layers, but present in the serous layer, and (2) that the lesion is not



Low power.

confined to part of the appendix but is distributed throughout its length.

The characteristic features of a carcinoid tumour are:—

(1) The yellowish colour of the cut surface on naked-eye examination. On cross-section a

yellow ring encircles the appendix and appears to lie in the submucous coat. The yellow colour is due to a lipoid material similar to that found in the cells of the adrenal cortex and in xanthoma cells.

(2) The microscopic picture suggestive of carcinoma, *viz.* spheroidal cells arranged in solid alveolar masses usually in the mucosa and submucosa, but sometimes penetrating to the muscularis and even as far as the subserosa. The cytoplasm of the cells may be granular or may be vacuolated. That these contained granules may stain intensely with silver has raised much speculation as to the histogenesis of this type of tumour, because, while demonstrating this fact, Masson has also shown that the Kulchitzky cells in the glands of Lieberkühn in the intestine stain in a similar manner. Masson's view is that the carcinoids of the appendix and intestine arise from these Kulchitzky cells, which belong to the chromaffin system, and because of their silver-reducing property are known as argentaffine cells. These cells arise from the epithelium lining the glands of Lieberkühn and migrate as a result of some stimulus, perhaps an inflammatory process, into the nerves and become argentaffine. The age incidence of carcinoid of the appendix is early, and though invariably benign in the appendix, it is probable that all carcinoids are potentially malignant.

HÆMATOKOLPOS AND HÆMATOMETRA ✓

By R. L. SONI, M.B., B.S., F.R.H.S.

The Soni Clinic, Paungde, Burma

M. K., a Burmese girl aged 15, had some 'colicky' pains in the lower part of her abdomen towards the evening of the 3rd September, 1935, and to relieve her she was given a purgative. Next morning she purged and while straining down noticed some blood-tinged mucus coming from her rectum. The pains continued and became worse and were associated every now and then with the expression of some blood and mucus. She was given home remedies for dysentery but she made no progress and when I saw her she had suffered continuous pain for two days and three nights.

The girl was crying out with pain, sitting on the floor with her body bent forwards and her hands clenched into her abdomen. At intervals she would sit quietly for some minutes but the pain recurred. She complained of severe persistent backache, griping pain in the abdomen and at intervals a sudden severe pain below her umbilicus and in the rectal region. She had had two somewhat similar though mild attacks, each lasting for some three days—the first two months earlier and the last three weeks ago. She had not yet commenced menstruation and there was no history of urinary retention though of late she had noticed unusual frequency.

Examination.—Nothing abnormal was detected in the abdomen except in the hypogastrium where there was a hard, rounded, somewhat tender, intra-abdominal

swelling rising from below and extending some four-finger breadths above the symphysis pubis, like an enlarged uterus. The labia minora in their lower halves were fused together to form a bulging pouch which contained foul-smelling soft matter at the top and phosphatic concretions at the bottom. The pouch was cleared of its contents, irrigated with iodine lotion and cut open in the middle line between two artery forceps. No vaginal opening was evident nor did any appreciable bulge mark its site, but the place was tense and excoriated. Rectal examination revealed congested veins and a tense, large, globular swelling which occluded it from the anterior. The finger could easily be passed behind it but anteriorly it was obstructed some two inches from the anal orifice. No waves of contraction could be elicited on recto-abdominal palpation. The finger returned stained with blood and mucus.

Operation.—After emptying the bladder and cleaning the parts with acriflavine, under local infiltration anæsthesia the site corresponding to the vaginal opening was incised and the dissection carried up in the median line. A prominent bulge made its appearance at a depth of about an inch. Under spinal anæsthesia the bulging mass was separated all round to some depth, and this dissection was considerably helped by a finger in the rectum and a catheter in the bladder. As the dissection proceeded the mass itself protruded more and more till it almost reached the skin surface. It was desired to reinforce the recto-vaginal space, which had thinned down, but this could not be done for lack of working space, which was at this stage wholly occupied by the bulging sac. The sac was loosely stitched to the sides and punctured, and tarry odourless fluid flowed out in a stream. The flow was regulated by an artery forceps in the puncture, to avoid the danger of collapse from sudden decompression. About two pints escaped in about 1½ hours when she sweated profusely, complained of giddiness and her pulse was found to be thready. Half a c.cm. of pituitrin relieved her. The forceps were now withdrawn and the fluid allowed to ooze out unchecked.

A loose diaper was kept on and she was advised to change it frequently. Also an ergot-quinine mixture was prescribed.

Subsequent course:—

The tarry fluid continued to come out for about 20 hours and then there was a reddish flow lasting for another two days.

On the fourth day the uterus was not palpable abdominally. The vaginal wound was inflamed, the stitches had given way, and the temperature was 100°F. The lower part of the vagina was packed with gauze soaked in B. I. P. P. and the pack changed every morning for a week. Examined later the wound was found to have healed and the vagina appeared normal except for a copious white discharge. The cervix was normal and the uterus firm and in its proper place. The tubal regions were also found normal on bi-manual palpation and the bulge into the rectum was absent.

The next menses occurred after 27 days and lasted for two days. It was scanty and associated with backache. She was given freshly-prepared calcium lactate in mixture and liquor asoka and advised to take plenty of fresh vegetables, milk and fruits. The three menses that followed were somewhat irregular but for the last six periods she has been quite regular and normal.

Comment.—Cases where hæmatometra is superimposed on hæmatokolpos are comparatively rare and may be taken to be due to failure of early recognition of the condition. In this case it appears that the lower part of the Mullerian duct had failed in canalization though the remaining parts of the genital tract above it appear to have developed normally. The pouch formed by the lower parts of the labia minora is of interest, but it cannot be

definitely stated whether it was a congenital malformation or the result of an acquired adhesion, though the appearances were suggestive of the former. The phosphatic concretions were most probably derived from the ammoniacal decomposition of urine.

STONE IN THE URETHRA OF A BABY

By RAMENDRA K. BASU

Civil Assistant Surgeon, Kishanganj, District Purnea

A BOY, aged ten months, was brought to me with the history that he had not passed urine for several days.

The child was in obvious distress and the bladder greatly distended and tender. The penis was erect and on palpation a hard mass could be felt near the anterior end of the urethra. Urethral obstruction was confirmed by failure to pass a fine rubber catheter further than the obstructing mass.

The child was lightly anæsthesized and the obstructing body worked forward to the meatus by external manipulation. The meatus was incised sufficiently to expose the point of the obstruction which was then removed by leverage with the single blade of a Spencer-Wells artery forceps.

The urine was drawn off with a fine rubber catheter and the meatus sutured with fine silk. The urine was turbid and was found to be heavily charged with oxalate crystals.

Next day the prepuce was very œdematous causing obstruction to the passage of urine, so the child was circumcised after which he made a complete recovery.

The foreign body proved to be a calculus the size of a black pepper, of dark brown colour, and nearly round.

I am reporting this case as it must be very rare for so young a child to develop a stone.

CALCIUM OXALATE CALCULUS IN THE URETHRA

By S. N. MITRA, L.M.F.

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A MALE, aged about 40 years, employed as a 'line' chowkidar, was admitted into the hospital on the 7th September, 1936, with the following symptoms:—

Frequency of micturition for one year, the quantity passed on each occasion being very small and pain and irritability of the glans penis. These symptoms had become much worse during the past four or five days. There was a slight muco-purulent discharge from the meatus and microscopical examination revealed intracellular diplococci.

A soft rubber catheter was passed and was arrested just three-quarters of an inch behind the glans penis by a hard mass which could be felt on external palpation. It was extracted by artery forceps after breaking it into four pieces and it was identified as a calcium oxalate calculus. The total size of the stone was three-quarters by half an inch, irregular, very hard, and dark brown in colour. The patient was relieved of his symptoms and no further stone could be detected either in the bladder or in the urethra.

The man has lived in the garden for over 20 years. There is no previous history of any continuous fever nor any family history of calculus. He is much addicted to drinking country liquor and chews a great deal of betelnut.