Sims's position and an incision was made from the base of the coccyx to about one inch behind the anus. The coccyx was freed and removed entirely. The rectum was then freed in all directions so as to allow that part of it in which the growth was situated to be brought well up into the wound. The wound itself was next packed with gauze and gauze was placed around that portion of the rectum which was to be opened. An incision was made into the posterior wall of the rectum to one side of the growth and that portion of the bowel from which the tumour was growing was excised together with half an inch of healthy tissue around it. The portion of the posterior rectal wall removed measured three square inches. The wound in the mucous membrane was closed by a continuous suture and another line of suture was used to close the muscular coats. A small drainage tube was inserted in the upper part of the wound and the skin wound was then sewn up.

The patient made a practically uninterrupted recovery. A slight rise of temperature occurred on the third day and continued till the fifth day after operation, disappearing after the bowels were opened. He was discharged from the hospital a fortnight later. The last time that he reported himself he was perfectly well and only a slight narrowing of the bowel could be felt in the rectum at the original site of the tumour. Microscopically the growth presented the ordinary appearance of a papilloma; there was, however, some small-celled infiltration of its base and a slight ingrowth of the epithelium suggestive of commencing malignant degeneration.

As I have already mentioned, papillomata of the rectum are by no means common, rather less than 40 cases in all having been recorded. The form of rectal papilloma most usually described is of the nature of a villous tumour, similar to the villous tumours which are found in the bladder. The growth in this case was sessile and its surface was nodular rather than villous. An interesting point is the fact that so large a portion of the posterior wall of the rectum can be removed (in this case three square inches) without causing any serious narrowing of the lumen of the bowel. As far as the patient was concerned the restoration of function was complete, the loss of the coccyx causing him no inconvenience.

Cavendish-place, W.

A CASE OF BLACKWATER FEVER TREATED WITHOUT QUININE.

BY DAVID DONALD, L.R.C.P. & S. EDIN., L.F.P.S. GLASG.

THE article by Dr. R. Mowbray in THE LANCET of August 26th (p. 599) is interesting as showing the difference of opinion as to whether quinine ought to be prescribed in the treatment of blackwater fever or not. Without doubt quinine is a specific in the treatment of malaria and on the presumption that blackwater fever is closely allied to that disease is considered necessary. But that such connexion exists has not yet been clearly proved.

A few weeks ago I was called to see a young man who had just returned from Nigeria. He had served there as an engineer for two years and a few months before coming home had a severe attack of blackwater fever. The condition of matters when I saw him was as follows. He lay in bed almost collapsed, his expression was anxious, his lips were bloodless, and he could only talk in a whisper. His temperature was 102° F. and his pulse was almost imperceptible. He complained of intense frontal headache and sickness, with pain referred to the region of the kidneys. Beside his bed was a vessel filled with urine deeply stained with blood. The danger of absolute collapse was so great that I had hot water bottles put into his bed, and fomentations over the kidneys and small quantities of champagne and hot milk alternately every hour were ordered. The following morning he had rallied considerably. His pulse was better, his temperature was 101°, the sickness was less, and the headache was not quite so severe. I gave him ten grains of phenacetin and caffeine (eight of the former and two of the latter) and prescribed iron and strychnine, continuing the champagne and milk with an occasional spoonful of Brand's essence of beef. On the following day the headache had gone, there was no sickness, the temperature was 100°, there was still slight pain over the kidneys, and the urine was still

bloody. The champagne was now stopped and milk puddings, light soup, and barley water were ordered. On the next day the temperature was almost normal and the urine was much more clear. The patient asked to have some beef-tea and this I allowed. On the next morning I was sent for early as the patient was worse. I found on arrival that he had a rigor; the temperature was 103°, the pulse was over 100, he had slight delirium, and the urine was again loaded with blood. I gave phenacetin and caffeine, ordered champagne and milk, and had extra blankets put over him. In the evening he was rather better, the temperature having fallen to 100°.

For the next four days the patient was fed on milk, eggs, white fish, Brand's essence of meat, and twice daily four ounces of champagne. At the end of this period his temperature had come down to normal, his urine had almost cleared, and he had no pain anywhere. He had slight discomfort from the constipated condition of his bowels but this was relieved by a good dose of effervescing sulphate of soda. On the fourteenth day from the commencement of the illness he was allowed out of bed, his urine having become quite clear, and he was given a little carefully cooked meat. I prescribed a mixture of cascara, podophyllum, nuxvomica, and spirit of chloroform. On the seventeenth day he had a drive for two hours and on the twentieth day he was able to walk to my house to report. His colour was better, the lips being quite red; he had no pain anywhere and his urine was clear.

Such is the case, and from first to last no quinine was prescribed. The idea of a stimulant treatment was suggested to me by the state of collapse I found the patient in and apparently it suited the case.

Aldershot.

ENDOTHELIOMA OF THE VERMIFORM APPENDIX.

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THE following case appears to me worthy of record for two reasons, firstly, the association of a neoplasm with a suppurative attack of appendicitis; and, secondly, the nature of the neoplasm, which proved to be an endothelioma. The clinical details present no feature of special interest. The patient was a girl, 12 years of age, in her first attack, who had been ill for three weeks. A small mass was present in the right iliac fossa. The abdomen was opened by the incision recommended by Mr. Battle through the sheath of the right rectus muscle, the general peritoneal cavity was packed off with gauze, and the abscess was opened by the finger. The appendix was readily found and removed, and the girl made an uninterrupted recovery. The appendix was three inches in length and was acutely inflamed; its mucosa was deeply ulcerated but the wall was not perforated. These changes were most marked in the distal portion, beyond a point half an inch from the cæcum where the lumen was obstructed. The obstruction was found to be due to a spheroidal mass of tissue of the size of a small pea, which projected into the lumen, and appeared to be a tumour. It was examined microscopically by Mr. L. S. Dudgeon, who reported it to be an endothelioma. The child was seen five months later, when the wound was found to be perfectly sound and no evidence of recurrence of the growth could be discovered.

The exact position of the endotheliomata with respect both to their classification and their malignancy must at present be regarded as undetermined. Howard Kelly,¹ however, not only regards them as malignant, but classifies them as carcinomata, for, he says, "there are now on record 49 cases of carcinoma of the appendix, including two designated endothelioma." Arguing from the analogy of the well-known association of carcinoma with chronic inflammation in other situations and commenting upon the rarity of tumours of the appendix compared with the frequency of its inflammatory affections, it is evident that Kelly regards neoplasms of the appendix as secondary to other forms of disease of that organ. This may be true in the milder forms of

¹ Kelly: The Vermiform Appendix and its Diseases, 1905.