

APPENDIX C.

A CASE OF CHORION EPITHELIOMA.

By L. CARRINGTON MAIL, M.B., Ch.B.

The patient was a Samoan female, aged twenty-five years. Admitted to hospital on 5/9/28.

History.—She was an in-patient one month previously for a threatened miscarriage. After a few days she left hospital apparently well. On readmission she stated that she had been losing a lot of blood for a week. She said she was six months pregnant, but that movements of the child had ceased a week before. She was having pains in the lower abdomen and back. She has had one healthy child four years ago.

On examination: Temp. 102.4 F.; pulse 98; rep. 20. The fundus of the uterus was a little below the level of the umbilicus. There was tenderness all over the lower abdomen.

Vaginal examination: The cervix was very much elongated and the os uteri was closed. No blood on examining fingers.

Progress of the case: On 10/9/28 patient was transferred to the maternity ward under my care. She was bleeding from the uterus and losing a moderate amount of red blood. She had intermittent pains in the left side and back.

P.V.: The cervix is flabby and soft and the os uteri admits the tip of the index finger. Nothing could be felt through the os. The foetal heart was not heard. Uterus enlarged to size of four months pregnancy. Breasts enlarged with pigmentation of the areolæ.

Diagnosis.—Intrauterine death of foetus at the fourth month.

Treatment.—Medicinal induction of labour by quinine and castor-oil with tight vaginal plugging was carried out on 10/9/28. This failed, and was repeated on 11/9/28 with injections of pituitrin. This second attempt failed also, and on 13/9/28 induction by bougies was carried out, a No. 13 rubber catheter being inserted into the uterus for 6 in. and the vagina packed tightly with gauze. On 14/9/28 patient had pains in the back and lower abdomen. Vaginal plugging removed and vagina repacked. On 15/9/28 pains had ceased, and the plugging and catheter were removed, and glycerine ($\frac{1}{2}$ oz.) injected into the cavity of the uterus. This had no result. On 18/9/28 a small Champetiere de Ribes bag inserted into the uterus. Good pains supervened, and the os slowly dilated, aided by the pull of a 2 lb. weight on the bag. On 20/9/28 labour had not occurred, and there was no further dilatation of the os uteri: it was therefore decided to explore the uterus. Under general anæsthesia the cervix was dilated manually and a hand passed into the uterus. No foetal parts could be felt, nor could the uterine wall be definitely defined in the region of the fundus. During the examination a piece of small intestine was grasped by the fingers, though there was no sensation that the uterine wall had ruptured. The uterus and vagina were rapidly plugged with gauze and the patient transferred back to the ward, where she died two hours later after regaining consciousness.

Post-mortem Examination.—On opening the abdomen the uterus was found enlarged to the size of a four-months pregnancy. The uterus and intestines were matted together and adherent extensively to the abdominal wall. There was pus in the pelvic cavity, which was completely shut off by adhesions from the general abdominal cavity. The uterine wall was invaded by a soft, extremely friable, cancerous growth, which in the region of the fundus had completely destroyed and replaced the uterine muscle. In the middle of the growth was a large irregular tear. The growth was the size of a large orange, and had invaded a large area of the uterine wall. No foetal parts were discovered either in the uterus or in the abdominal cavity. The nature of the growth was a chorion epithelioma.

Comment.—This is a case in which the diagnosis was not correctly established till the uterus was manually explored. The history and all the symptoms pointed to an ordinary miscarriage occurring at the fourth or fifth month.

A CASE OF PERNICIOUS ANÆMIA TREATED BY LIVER DIET.

By L. CARRINGTON MAIL, M.B., Ch.B.

The patient, an Indian named Secduck Allee, aged twenty years, was admitted to the Apia Hospital on 26/4/28.

History.—The duration of the illness was three months at the date of admission. He had been treated for hookworm disease in Suva a month previously. He complained of great weakness, shortness of breath on exertion, and progressive loss of weight.

Condition on examination: He was a miserable-looking specimen, anæmic, weak, and emaciated. The teeth were good, and there was no evidence of glossitis. The tongue was clean. Examination of chest negative. Heart not enlarged; pulse slow and weak. There was a faint blowing systolic murmur in the mitral area. Abdomen: The liver and spleen were not enlarged. His weight on 26/4/28 was 82½ lb. Fæces: The Willis method was positive for ova of *Nocator Americanus*. Urine acid, S.G. 1007. Albumin positive. Sugar nil. Centrifuged deposit nil.

Blood Examination on 26/4/28: Red cells, 2,500,000 per cubic millimetre; white cells, 5,400 per cubic millimetre; hæmoglobin, 50 per cent.; colour index, 1. Differential count: Polymorph leucocytes, 42 per cent.; small lymphocytes, 36 per cent.; large lymphocytes, 6 per cent.; eosinophile, 12 per cent.; large mononuclears, 4 per cent. The red-blood cells show marked poikilocytosis, anisocytosis, and polychromatophilia.

Diagnosis.—The blood picture was typical of pernicious anæmia.

Treatment.—The usual treatment for hookworm was first given but no worms were obtained. The patient was then treated by giving a diet of milk, rice, and vegetables to which was added liver to the amount of $\frac{1}{2}$ lb. daily. The liver was partly cooked, and eaten three times a day.