cervix, which, being friable, was torn in several places. Finally, two lateral cervical sutures were inserted and the clamps removed, the torn cervix was repaired with catgut sutures and the vagina firmly packed. One litre of blood was transfused during the procedure.

Postoperatively, the patient made good progress and she was finally discharged from hospital on the seventh postoperative day. She was very well when seen six weeks later and the cervix had completely healed. Histology of the curettings showed endometrium with an appreciable Arias-Stella reaction and the presence of trophoblastic tissue was confirmed in the cervical mass.

Discussion

This case history conforms to the strict criteria proposed by Duckman[2] for the diagnosis of cervical pregnancy, in that there was—"(1) a dilated, thin-walled cervical canal containing histological evidence of products of conception; (2) a patulous external os; (3) a small, firm uterine body with a normal sized internal os, resting on top of a dilated cervix."

The main difficulty in the management of a cervical pregnancy is the decision when to perform a hysterectomy, both Mortimer[3] and Dodek[4] suggesting that the procedure is indicated when the gestational age is beyond eight weeks. Nevertheless, in describing a similar case to that presented above, Flanagan[5] proposed that local excision was feasible owing to the decidual necrosis and thrombosis of the end vessels in the placenta after the previous death of the pregnancy, an event which had undoubtedly occurred.

There is insufficient evidence on the likelihood of complications developing in a subsequent pregnancy, and the risk of a further cervical pregnancy is unknown. Cervical incompetence should not occur, since by definition the internal os has not been affected.

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Inflammatory bowel disease in West Indians

Inflammatory bowel disease has not been reported in West Indians. We wish to report here five cases of "colitis" in West Indian patients presenting in the past 18 months. Failure to consider this condition because of their race led to a delay in diagnosis in two of our patients.

Patients and comment

Details of the patients are given in the table. Rectal biopsies from the three patients with Crohn's disease showed transmural inflammation and granulomata formation. In patient No 3 this was confirmed on examination of a subsequent colectomy specimen. Patient No 2 displays many interesting features other than the fact that she is a West Indian child and these are reported elsewhere.[1]

The rectal biopsies of the two remaining patients showed intense cellular infiltration of the lamina propria and they are thought to be suffering from ulcerative colitis. Because one of them (No 5) had normal appearances on barium enema examination a colonoscopy was performed. A mild total colitis was noted and biopsies from various parts of the colon displayed depletion of goblet cells and distortion of the crypts in addition to inflammatory cells.

All five patients showed normal features on barium meal follow-through examination.

Discussion

All five patients described here are West Indians of African stock. Inflammatory bowel disease has not been reported in these people, which is perhaps surprising as both ulcerative colitis and Crohn's disease are seen in the American negro, although admittedly less commonly than in corresponding white populations.[2] The American negro has of course been in the United States as long a time as his Caucasian countryman, whereas the West Indian in Britain is a relative newcomer. There are a few reports of inflammatory bowel disease in the South African Bantu.[3,4] The problem of reaching such a diagnosis in areas of high parasitic infestation has been well documented by Sobel and Schamroth.[3]

As the incidence of Crohn's disease in Britain is increasing,[5] probably we will see more of this disease in our West Indian population. It is of particular interest that the three patients with undoubted Crohn's disease are young, two being children who were born in the UK and the third a man in his twenties who had lived in Britain for 12 years before the onset of symptoms. Thus there has been adequate time for exposure to environmental factors, one of which may be a slow virus.

Failure to consider inflammatory bowel disease led to a delay in diagnosis in two of the patients reported here. Diagnosis is not usually a problem in ulcerative colitis, but it may be in Crohn's disease, which may present in various ways and sometimes without symptoms referable to the gastrointestinal tract, as shown by one of our patients (No 2). Hence, clearly the doctor must consider this disease when he is presented with patients with such symptoms as unexplained fever, arthralgia, or loss of weight, even though they are of West Indian extraction.

We thank Mr G C Brentnall and Dr A S E Fowle, who each referred a patient to us, and Mr H E Lockhart-Mummery for allowing us to report on one of his patients. We also acknowledge the financial support of the Joint Research Board of St Bartholomew's Hospital, London.

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Details of patients with inflammatory bowel disease

Patient	Sex	Birthplace	Age at onset of symptoms	Years in UK before symptoms	Symptoms	Findings of barium enema	Diagnosis
1	M	UK	10	10	Diarrhoea. Abdominal pain. Weight loss	Marked ulceration of distal transverse and descending colon	Crohn's colitis
2	F	UK	10	10	Perineal ulceration	Fissures and ulcers in rectum. Irregular mucosal pattern in sigmoid colon	Crohn's colitis
3	M	Jamaica	28	12	"Bloody" diarrhoea. Weight loss. Fever	Gross mucosal destruction with ulcers and pseudopolyps throughout colon	Crohn's colitis
4	F	Jamaica	42	6	"Bloody" diarrhoea	Fine mucosal ulceration in the rectum and sigmoid colon	Ulcerative colitis
5	M	Jamaica	34	7	"Bloody" diarrhoea	Normal	Ulcerative colitis