the posterior vaginal wall. The finger could be hooked through this opening to present in the vagina alongside the rectal mass. The patient stated that the mass sometimes disappeared on lying down. Fæces were passed sometimes by the natural passage, and sometimes involuntarily by the vaginal route. The patient was admitted to hospital and the mass replaced by manipulation; she was then kept in bed for a few days to allow the congestion to subside.

Later, under anæsthesia, a further examination was made and photographs secured; these unfortunately do not give an adequate idea of the size of the mass as it was when first seen (*see* fig.). The recto-vaginal opening was found to measure about 1½ in. long by 1 in. wide. The mucosa was detached round the edge of the opening by sharp dissection, and closed by a fine catgut inverting stitch. The remainder of the opening was closed by an adaptation of the classical method of repairing vesico-vaginal fistulæ with which I have been well pleased: the edges were paired till free bleeding took place and the whole area "saucerized"; eight silver wire sutures were then used to bring the broad edges together. Finally, the anus was thoroughly stretched and a 1 in. flatus tube inserted and stitched in position; this was done as an alternative to colostomy.

The patient made a perfect recovery and was discharged after three weeks. She has remained in good health since (eleven months).

The exact mechanics of the prolapse are uncertain. It is probable that the posterior rectal wall protruded through the fistula. Alternatively, the mucosa alone protruded; it is well known that great mobility of the rectal mucosa on the submucous layer is possible.

Brief Clinical Notes on Two Cases of Retroperitoneal Schwannoma.—JOHN STALLWORTHY, F.R.C.S.

Tumours of nerve tissue origin are seldom found in either the abdomen or the pelvis. Robert Meyer in an article published in the *Archives of Pathology*, November 1943, summarized the present views on these tumours, and suggested a simplified classification of them. His article includes a good description of the nerve sheath blastoma, neurinoma or schwannoma. Stout, Laidlaw and Haagensen collected 246 cases of schwannomata and in their series found that only four occurred in the abdomen and three in the pelvis. ("Tumors of the Nervous System", Association for Research in Nervous and Mental Disease, Vol. XVI, New York, 1937.)

The clinical characteristics of these tumours are that they produce symptoms by pressure effects, by the size they sometimes reach, or by constitutional reactions secondary to degenerative changes. For the most part they are single tumours, not malignant, and if adequately removed do not recur. In this respect they should be differentiated from the neurofibroma of von Recklinghausen's disease. Common sites for their occurrence are in the nasopharynx and the skin of the upper extremities. They have not been described on the feet, in the rectum or in the urinary system.

Histologically the picture is one of capricious degeneration as a result of which the tumour tends to be divided into two zones, a dense zone in which there are aggregations of nuclei in a palisade pattern, and a loose zone with considerable intercellular œdema. The tumour is vascular and a characteristic feature is that the small vessels are surrounded by prominent collars of collagenous deposits.

CASE I.—Mrs. Y., para 4, aged 72. She was an active, alert woman who, living 5 miles from the nearest large town, used to walk in there once a week to supervise her own shopping. Over a period of two or three months she found that she was rapidly losing weight, becoming lethargic, and experiencing considerable pelvic and rectal discomfort. Examination revealed a firm, well-defined, tumour which was not tender, filling the pelvis and pressing on the rectum. There was no ascites, and there were no urinary symptoms. The diagnosis of an impacted degenerating fibroid was made and exploration advised. At operation on 8.5.43 a tumour the size of a fœtal head was found growing from the hollow of the sacrum. The rectum was displaced to the right and a small post-menopausal uterus was pushed well forwards behind the symphysis. The peritoneum over the tumour was divided and without any difficulty the mass was shelled out from a relatively non-vascular bed. On section in the theatre it was found that the central portion of the tumour was completely degenerated and cystic with xanthomatous

and hæmorrhagic areas suggesting the presence of sarcomatous degeneration. Histologically the tumour showed the characteristic features of a schwannoma. The patient made a rapid recovery, regained her health, and a year later is active and well,

CASE II.—Miss A., a nullipara of 42, complained of progressive swelling of her abdomen over a period of two years. Frequency of micturition and menstrual irregularity characterized by oligomenorrhœa and infrequent periods had been present for one year. The patient looked very well but the abdomen in contour and size resembled that of a woman who was 28 weeks' pregnant. There was a fixed abdomino-pelvic tumour, tensely cystic, with a loop of bowel running obliquely across above the umbilicus. There was no ascites. The diagnosis of an ovarian cyst was made, and at operation on 3.9.43 the tumour was removed. It was retroperitoneal and could be approached only after the transverse and descending colon had been mobilized. Removal of this tumour was most difficult. The ureter was displayed in the whole of its abdominal course, and even when this was done the tumour was still firmly fixed apparently to the vertebral column at the level of the bifurcation of the aorta. When a plane of separation was found the base from which the tumour had sprung was non-vascular. Section showed that this tumour was also degenerated with large cystic areas, and on section it presented the characteristic features already described.

This patient also made a rapid recovery and six months later was perfectly well.