spread of this tumour, there was no evidence of lymphatic or generalized disease. The prognosis in localized malignant lymphoma of the colon appears good but nearly all who die of the disease do so within a year of treatment.

Postscript (5.4.67): S T died of his disease eight months after resection. — EFD

Carcinoma in the Rectovaginal Septum

J M Davis MB FRCS
(*Whittington Hospital, London*)

Mrs R L, aged 53

Came with acute retention of urine caused by a well circumscribed mass of spheroidal cell carcinoma lying beneath the pouch of Douglas in the upper third of the rectovaginal septum. The growth apparently arose from neither the uterus nor the rectum. She died of local pelvic recurrence eleven months after a combined total hysterectomy and abdominoperineal excision of rectum (Fig 1). The tissue of origin of the growth has not been established. Without evidence of a primary lesion in ovary, lung, stomach, pancreas or breast, primary carcinoma of a pelvic embryological remnant is suggested as a possibility.

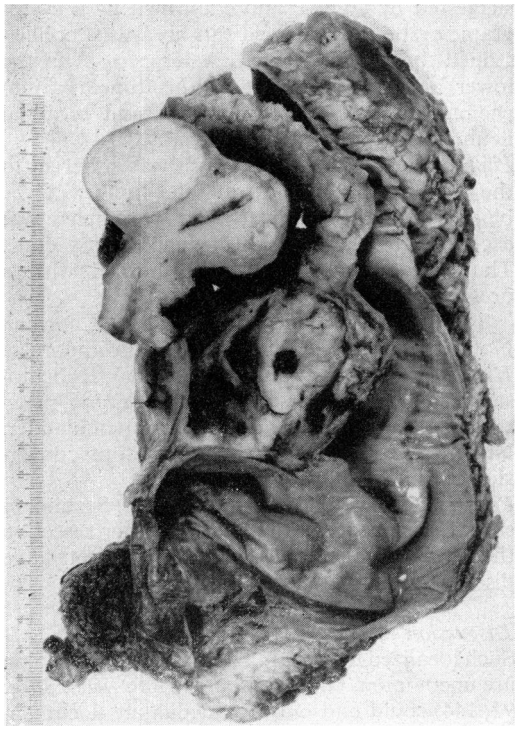

Fig 1 *Operation specimen showing a carcinomatous growth of unknown origin in the rectovaginal septum. The coincidental uterine fibroid led to an initial incorrect diagnosis of impacted cervical fibroid*

Necrotizing Colitis

W D Mackay FRCS and J L Dawson MS FRCS
(*King's College Hospital, London*)

A previously fit man, aged 57, came with a thirty-six-hour history of generalized abdominal pain and passing blood per rectum. On examination his pulse was regular and there was tenderness and guarding more marked in the lower abdomen. On rectal examination bleeding was observed. Abdominal X-ray and peritoneal tap were normal and a mesenteric infarct was diagnosed.

Laparotomy: The colon was involved in an inflammatory process involving the transverse and descending colon. No full thickness areas of gangrene were present and pulsations were easily felt in all intestinal vessels. A transverse colostomy was made and a swab taken of the mucosa which grew *Cl. welchii* (not typed), *Esch. coli* and *Strep. fæcalis.*

Two days later the patient deteriorated, complained of severe abdominal pain and became hypotensive: a peritoneal tap gave blood-stained fluid. It was considered that he had an extension of his colitic process with areas of gangrene. After energetic resuscitation a further laparotomy was performed. Sigmoidoscopy was normal to 15 cm. The large bowel now had patches of gangrene on the serosa involving the transverse and upper descending colon. Again good pulsations could be felt in the main intestinal vessels. The involved colon was removed and the rectal stump exteriorized. A decompression gastrostomy was performed. The blood pressure rose immediately after removal of the colon. The patient's postoperative course was complicated by renal failure and jaundice but he made a good recovery and is awaiting closure of his colostomies. During his convalescence an arteriogram showed no lesion of the remaining intestinal vessels.

The colon removed showed marked thickening with extensive greyish ulceration of the mucosa; the distal 13 cm of bowel appeared normal. Histologically the bowel shows areas of mucosal necrosis with ulceration; the submucosa is markedly thickened by œdema and interstitial hæmorrhage; the ulcers are covered by inflammatory exudate of polymorphs. The muscularis and serosa are less affected. There is thrombosis of the blood vessels in the necrotic area but elsewhere they appear normal. There were no significant bacteria in the lesion, no granulomatosis foci and no evidence of neoplasm.

The only feature in favour of a specific infective ætiology in this case is the finding of *Cl. welchii* in the colostomy swab but these organisms may be present in the colon of 35% of the population. No evidence of Gram-positive cocci was found in the mucosa as described by Killingback & Williams (1961), Tate *et al.* (1965) and Painter *et al.* (1966).