Medical Memoranda

Paradoxical Haematemesis in Oesophageal Atresia

An essential prerequisite for the diagnosis of oesophageal atresia is to have the condition in mind. From the variations in its reported incidence it seems probable that in some areas the diagnosis is less frequently considered than in others. However, it may happen that because of the co-existence of an additional condition the diagnosis may be delayed or even missed altogether. As the subsequent case report shows, the occurrence of haematemesis in a case of oesophageal atresia might well obscure the diagnosis, and so lead to undesirable delay in operative treatment.

CASE REPORT

A primipara aged 35 was delivered of an apparently normal male child in her own home on the evening of October 9, 1953. The birth weight was 8¼ lb. (3.7 kg.). The baby was not put to the breast. Next morning the midwife noticed that the baby's colour was poor, that the respirations sounded moist, and that there was some white frothy mucus in the mouth. The patient's own doctor was called; he examined the chest and found no abnormality. The foot of the cot was raised to drain the chest. No feeds were given that day. On the second day the baby was put to the breast, and he sucked well. The colour was good and meconium was passed. Later he brought up some thick mucus from the nose and mouth. In the evening he would not suck the breast.

Early the following morning (third day) the baby brought up some red blood. His colour was poor and he appeared to be shocked. The doctor was called again, and he immediately sent the patient to the Bradford Children's Hospital. Here a diagnosis of haemorrhagic disease of the newborn was made and 10 mg. of vitamin K was given intramuscularly. Feeds of glucose water were returned together with some bright-red blood and, on one occasion, clots. Later he passed a melaena stool. On the fourth day there was no change and no feeds were retained; it was at this time that the diagnosis was made. An attempt was made to pass a catheter into the stomach, but without success. A little lipiodol was therefore instilled into the catheter in the back of the throat and a radiograph taken. This showed the typical upper blind pouch of oesophageal atresia together with gas in the stomach, indicating the presence of an oesophago-tracheal fistula.

Soon after this the child was transferred to the Bradford Royal Infirmary, where an operation was performed a few hours later. Through an intrapleural approach the fistula between the lower stump of the oesophagus and trachea was divided, and continuity of the oesophagus was effected by an end-to-end anastomosis, using interrupted catgut sutures. For the next seven days no feeds were given, and fluid requirements were supplied by the subcutaneous route. On the eighth day a glucose–water feed was taken well. On the ninth day, however, he vomited after feeding. A lipiodol swallow was given; the radiograph showed lipiodol to be present in the stomach and was not suggestive of a leakage from the anastomosis. The child, however, did not look well, and as a precautionary measure a gastrostomy was performed under local analgesia. The gastrostomy feeds, however, made him vomit just as much as feeds by mouth, so after twenty-four hours feeding by mouth was restarted, and this time no further vomiting occurred. He made a gradual but uninterrupted recovery.

COMMENT

The occurrence of haematemesis in the presence of oesophageal atresia is, of course, rare, but the route from the stomach up the lower segment of the oesophagus through the oesophago-tracheal fistula, up the trachea, and into the mouth has been known for a long time as an explanation for the occurrence of acid saliva in these cases. The term "paradoxical haematemesis" would seem to be a reasonable one, and serves as a reminder that vomiting can occur in oesophageal atresia with a fistula from the lower segment if there is anything in the stomach to vomit.

The delay in diagnosis in the case described was about twenty-four hours, and, as subsequent events show, was of no importance; but it takes little imagination to realize that the symptom of haematemesis might appear to exclude the diagnosis of atresia of the oesophagus in the mind of a person unfamiliar with the anatomy of the condition.

My thanks are due to Mr. J. S. Davidson, who performed the operation, for permission to publish this case, and to Dr. Elizabeth Rosenblum, of the Bradford Children's Hospital, who made the diagnosis.

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A Case of Malignant Melanoma and Pregnancy

The association of malignant melanoma and pregnancy is not commonly reported. Cases have been described of malignant melanoma giving rise to secondary deposits in the placenta or foetus, but no reference is found to the effect of pregnancy on the growth of a melanoma. The following case illustrates this relationship.

CASE HISTORY

A woman aged 39 was first seen in July, 1949. She was expecting her first child, and was eight weeks pregnant. In August she noticed that a deeply pigmented mole on her left calf was enlarging and weeping a little. There were no signs of any secondaries and she was referred to hospital for surgical opinion. A biopsy of the tumour was performed and the histological report was of a "non-malignant cellular naevus." In February, 1950, the baby was delivered, but it died six weeks later of bronchopneumonia. In May the tumour was excised and a histological report confirmed that it was a "simple non-malignant cellular naevus."

In June she was once again eight weeks pregnant. The antenatal period and delivery in January, 1951, was normal, but three weeks later she noticed a rapidly enlarging lump developing in the left groin. This was clinically a mass of glands and she was referred for further surgical opinion. A biopsy of a gland was taken and fresh sections were cut off the original naevus. The histological report stated that "the naevus is almost certainly malignant and the glands in the groin are secondaries." The glands were excised in May, 1951, and a course of *x*-ray therapy to the groin was given.

All was well for the next two years, and mother and baby flourished. In September, 1953, she was once again 20 weeks pregnant. The antenatal period and delivery in January, 1954, were again quite normal, but after delivery a large tender mass was felt in the left iliac fossa displacing the involuting uterus to the right. She was referred to hospital and the diagnosis of further metastases made. A further course of *x*-ray therapy was given and the mass of glands disappeared. The patient is at the time of writing quite well, showing no other secondaries. Unfortunately the baby is a mongol.

COMMENT

The case appears to show that pregnancy has stimulated the growth of a melanoma. It is difficult to think such an appearance could be mere coincidence, since it happened on three different occasions. Presumably the stimulus is hormonal in character, and the query arises whether pregnancy should be terminated in such cases. Since this is but a solitary case the query must remain unanswered.

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