evidence not fit the conclusions? Presumably the latter, since Tow's other current report[6] on the same series concludes "in a half the cases a primary uterine growth was absent" and "hysterectomy did not improve the survival in pulmonary choriocarcinoma. This is in agreement with . . ." The virtually simultaneous presentation of totally opposite conclusions, drawn from the same data, must cast doubt on their value.

In this unit we see patients who have undergone elective hysterectomy in the hope of promoting spontaneous regression, or to confirm a diagnosis already apparent, and they sometimes die before effective chemotherapy can be given. Metastases from choriocarcinoma may have a volume-doubling time of 2 to 4 days, so that a 15- to 30-fold increase in the early postoperative phase can occur. This is not prevented by operative "cytotoxic cover," which in any case may prejudice the effectiveness of these drugs when used later. A suspicion of choriocarcinoma presents an emergency; but, unless the uterus has perforated, hysterectomy is better deferred.

Tow and Cheng's paper would seem to be the strongest possible argument for the investigation and treatment of uncommon diseases such as choriocarcinoma in specialized centres.—I am, etc.,

K. D. BAGSHAWE.

Edgar Laboratory,
Charing Cross Hospital Group,
London W.6.

REFERENCES

1 Hertz, R., Bergenstal, D. M., Lipsett, M. B., Price, E. B., and Hilbish, T. F., *J. Amer. med. Ass.*, 1958, **168**, 845.
2 Novak, E., Seah, C. S., *Amer. J. Obstet. Gynec.*, 1954, **67**, 933.
3 Park, W. W., Lees, J. C., *Arch. Pathol.*, 1950, **49**, 73.
4 Joint Project for Study of Choriocarcinoma and Hydatidiform Mole in Asia, *Ann. N.Y. Acad. Sci.*, 1959, **80**, 178.
5 Tow, S. H., personal communication.
6 Tow, S. H., *Proc. roy. Soc. Med.*, 1967, **60**, 239.

Triacetoxyanthracene

SIR,—In your issue of 18 March (p.682) under "Today's Drugs, Triacetoxyanthracene," it is stated that: "Patients known to be sensitive to dithranol are not treated with the new drug, but in one case such a patient was given triacetoxyanthracene without any adverse reaction occurring."

I have treated one known dithranol-sensitive patient with this drug and she reacted with an acute dermatitis within hours of application. One such case is hardly worth reporting, but in view of the previous statement I thought it was as well to report this.—I am, etc.,

Lincoln. ERIC RITTER.

Management of Acute Poisoning

SIR,—Your leader (4 March, p. 519) laments the lack of figures for admissions of cases of poisoning to general hospitals. It is hoped the Lincoln figures for 1966 may be of interest in this context.

Lincoln County Hospital shares with one other a largely rural catchment area of 120,000 people and is itself the Atkins Committee designated centre for poisonings in this area. Here we have no formal intensive care unit and no facilities for haemodialysis. However, we have an excellent anaesthetic service with good respirator facilities and the use of the theatre recovery ward for intensive nursing. Frusemide-induced forced diuresis is the mainstay of treatment of the more severe case.

In 1966 the total medical admissions in our area being approximately 1,800, 92 cases of poisoning were admitted to the adult medical beds of this hospital. Of these we had one death, giving a mortality on an admittedly small series of 1.1%. Drugs used included barbiturates in 23 cases and aspirin in 17. Alcohol was partly responsible in six cases. It is to be regretted that in as many as 23 cases the nature of the drug was never discovered, the patient usually having finished an unlabelled bottle of tablets either prescribed some time ago or belonging to someone else. Among the rarities, nose drops, liniment, and "aphrodisiac" tablets were each used once.

In the particular circumstances of Lincoln, with part of our catchment area 70 miles from the regional centre at Sheffield (itself the only place locally with a population sufficient to justify the appointment of a "specially interested" consultant), the district hospital must remain in the front line of treatment. It is doubtful whether the routine use of a regional centre involving a delay of at least one and a half hours in instituting treatment would improve on our results.

I am grateful to Dr. C. A. Lillicrap and Dr. E. P. Morley for permission to report on cases admitted under their care.

—I am, etc.,

Lincoln. C. R. H. PENN.

Gastrocolic Fistula Complicating Benign Peptic Ulceration

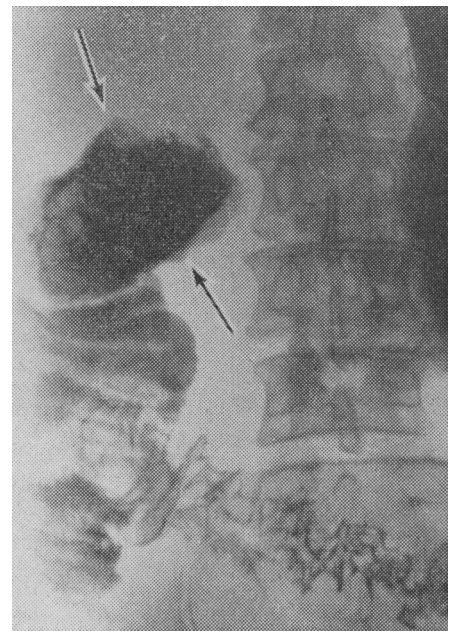
SIR,—Although fistulae between the stomach and colon are relatively common following surgery, or secondary to malignant disease, they are exceedingly rare as sequelae of benign peptic ulceration. Smith and Clagett in 1965 were able to trace only six cases since 1920,[1] when the condition was first described by Firth.[2] There follows a further description of a patient with this complication.

A male aged 59 was admitted to hospital with a history of epigastric pain of several years' duration. This pain was relieved for three hours following a meal. There was no history of vomiting. A barium meal three months previously showed duodenal scarring. During the two weeks prior to his admission the patient developed diarrhoea and had been losing weight for about two months. There had been no previous surgery. Examination showed the patient to be emaciated, but, apart from the presence of epigastric tenderness, there were no other clinical abnormalities to be detected. Barium enema was carried out and this showed a fistula between the stomach and colon (see Fig.) The appearances suggested that the condition was due to a carcinoma of the colon which had invaded the stomach. He was given a preoperative course of neomycin by mouth.

At operation, the gastrocolic fistula was found to be secondary to a large duodenal ulcer. The gall bladder was adherent at the site of the fistula but there was no communication from it to the bowel. A conservative resection of the stomach was carried out and the duodenum divided distal to the ulcer. The scar tissue around the fistula in the colon was excised and the colon closed. The stomach was then anastomosed to the jejunum in the conventional fashion following gastrectomy.

Histological examination of the specimen showed no evidence of malignancy. There was chronic simple ulceration of the duodenal mucosa and chronic inflammatory change in the gastric mucosa.

The patient's initial postoperative progress was satisfactory, but he collapsed suddenly five days after the operation with intense gastroenteritis, subsequently found to be due to *Clostridium welchii*. All attempts to revive him failed and he died after a few hours of illness.



Barium enema showing filling of the stomach with arrows at the site of the fistula.

The interest in this case rests principally on the rarity of the condition. Also of importance was the fact that, despite careful preoperative preparation with a bowel antiseptic, the patient still developed *Clostridium welchii* infection in the bowel postoperatively. This emphasizes the advice of Smith and Clagett that these patients need extreme care in pre-operative preparation to avoid such a hazard.

I wish to thank Mr. G. T. Watts, of the General Hospital, Birmingham, for permission to publish this case.

—I am, etc.,

Warwick Hospital,
Warwick. D. N. GLASS.

REFERENCES

1 Smith, D. L., and Clagett, O. T., *Surgery*, 1965, **58**, 634.
2 Firth, D., *Lancet*, 1920, **1**, 1061.

Acute Abdomen in Childhood

SIR,—In your leading article (18 March, p. 648) referring to an article by Dr. H. S. Winsey and Dr. P. F. Jones (same issue, p. 653), you comment on the importance of early diagnosis in children with acute appendicitis. In a review of 118 cases reported in the *British Medical Journal* in 1954[1] it was pointed out that if a diagnosis of acute appendicitis is to be made before peritonitis has developed the importance of localized tenderness without rigidity must be stressed. It was further shown that such a point of tenderness is not necessarily in the right iliac