emphysema in addition to decreased perfusion, and a number of physiological studies have confirmed these features. The explanation of this abnormal development has been the subject of much conjecture and little evidence. Macleod originally warned that the lung was irreparably damaged during the growing period, resulting in distended dwarf-like lobes. He commented on the evidence of severe past primary tuberculous infection in similar cases but excluded these from his main series. He also noted the resemblance between this select group and those with unilateral bronchiectasis and associated emphysema. There is now growing confirmation of these postulates that the damage originates in childhood infections, usually pneumatic but occasionally following primary tuberculous infection. G. R. Cumming and his colleagues record the development of this emphysema in five children after pneumonia, in three of whom viral studies suggested adenovirus as the possible agent.

The basic lesions are multiple peripheral obstructions at bronchiolar level, an obliterative bronchiolitis. It is no longer reasonable to distinguish this from the same process developing in the lobular bronchi, obliterative bronchiolitis. Why then is the disease unilateral? Firstly, unilaterality was one of the criteria used in the original selection of material. Secondly, pneumonia, if it is the precursor, often is unilateral. Thirdly, if the disease is truly bilateral, such severe damage is incompatible with life. Fourthly, the same disease process has been recognized as affecting some lobes or segments of both lungs. Finally, obliterative bronchiolitis may present in a scattered lobular form throughout both lungs, appearing as generalized obstructive Airways disease in childhood or later life and masquerading superficially as resistant chronic asthma. The unilaterality is a false distinction, and terms such as “Macleod’s syndrome” should now be abandoned and replaced by lobar bronchiolar obstruction with emphysema.

While the accumulating evidence strongly favours the view that the lobar disease follows early childhood infection, some investigators suggest that the predisposing factor is a congenital hypoplasia of the pulmonary artery. While this may explain the transradiancy with decreased perfusion, it overlooks the obstructed ventilation, unless it is assumed that such defective perfusion leads to unilateral airways obstruction. Pulmonary embolic occlusion may temporarily result in acute asthmatic bronchoconstriction, but there is no evidence that such decreased pulmonary perfusion leads permanently to irreversible bronchiolar obstruction. In patients with congenital absence of one pulmonary artery the lung may be abnormally transradiant, but the ventilation is little affected.

The damaged lung, once recognized, generally shows little change over the years of recorded observation. It is a poor organ for respiration, but it rarely if ever interferes with the function of the opposite lung, though the originating disease may well have damaged it also at the same time. The diseased lung has, however, a useful space-filling function and therefore should be left alone. There is no place for surgical resection unless, as rarely occurs, the lung is the site of a lung cancer. Once the diagnosis has been reasonably established, too much attention, as with any uncorrectable deformity, may cause the patient needless worry.

Retrorectal Tumors

In conducting a digital examination of the rectum the clinician is so accustomed to feeling primarily for something in the bowel itself or lying anterior to it—for example, in the prostate, uterus, or pelvic peritoneum—that it almost requires a conscious effort of will to palpate with the same thoroughness in a posterior direction. The conditions that may be encountered as retrorectal “tumors” are rare, so that it is good for the average surgeon to be reminded of their varied nature and characteristic features by periodical reviews of large collective series of cases. The present review, being the most recent being a report by D. T. Freier and his colleagues.

Retrorectal swellings may be inflammatory, due to inadequately draining anorectal abscesses and fistulas, to barium that has escaped through a tear in the rectal wall during a barium enema examination, or even to entrance of phenol and oil into the perirectal tissues during a badly given injection for haemorrhoids. Another group comprises ordinary soft tissue tumours, such as lipomas, liposarcomas, fibromas, fibrosarcomas, haemangiomas, neurofibromas, and neurolemmomas. A third group consists of bony tumours affecting the sacrum and coccyx; these include primary osteosarcomas and chondrosarcomas, giant cell tumours and bone cysts, and bony metastases from visceral carcinomas. But unequivocally the commonest retrorectal tumours are congenital lesions—teratomas, dermoid cysts, and chordomas.

Teratomas are initially encapsulated cystic or solid tumours containing a mixture of tissues. Though largely confined to infants, a few have been recorded in adults, 12% of them being malignant. Superadded infection is common and may mask the underlying condition. Moreover, the tumour may burst into the rectum. X-ray examination may be helpful in diagnosis by showing bone formation or teeth. Because of their tendency to become infected and to rupture, teratomas should be excised if possible. Usually this can be done through a sacral incision, but occasionally an abdominal or abdomino-perineal approach is required. If the lesion is benign and is removed intact the prognosis is excellent. Incomplete removal results in recurrence. The outlook with malignant teratomas is also poor.

Dermoid cysts are presumably due to a faulty inclusion of ectoderm when the embryo coalesces. Usually they do not appear till adult life and are much more common in women than men. They may be unilocular or multilocular and vary in size from an average diameter of 2-5 cm up to 10 cm. They are prone to be complicated by infection and may thus be confused with ordinary anorectal abscesses and fistulas. The prognosis as to life is excellent, but recurrence after operation is not infrequent because of incomplete removal owing to the size of the lesion or its adherence to surround-

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lings parts. Excision can often be effected from below after
disarticulating the coccyx, but for bigger cysts situated
higher up an abdominal or abdomino-perineal approach is
necessary.3 4

Chordomas arise from remnants of the fetal notochord.
They may occur in either sex at any age but are most often
seen in men past middle life. They slowly enlarge over the
years, causing sacral or sciatic pain and later interfering with
the sphincters or sexual function. In 10% of cases distant
metastases are found. On rectal palpation the tumour is
felt as an elastic, sometimes lobulated, swelling. X-ray
examination shows circular or oval areas of translucency in
the sacrum corresponding to the lesion; there may also be
trabeculation or calcification. Biopsy discloses characteristic
vacuolated mucus-containing cells. Chordomas have usually
been treated by excision through a sacral approach, but are
often found to be beyond the scope of surgical removal, or
they may subsequently recur, so that most patients eventually
die of the condition.1 3 7 In resecting chordomas surgeons
have usually been careful to preserve the uppermost two
pieces of sacrum together with the third sacral nerve on at
least one side to safeguard sphincter function.7 But recently
S. A. Locatilo9 has employed an abdomino-perineal technique
and removed all but the first sacral segment without detriment.
These tumours are generally considered to be radio-
inensitive, but Sir Brian Windley has reported excellent
long-term results with supervoltage irradiation.9

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Cholera in Spain

The arrival of cholera in Spain is not unexpected, for the
disease has been edging into the Mediterranean littoral for
some time. Sporadic cases also appeared last year in Great
Britain1 and in Czechoslovakia.2 The Briton who brought
the disease back to this country had been on holiday in
Tunisia.

Though cholera is unlikely to become established in epide-
mic form in Britain on the Continent of Europe, the possi-
bility of outbreaks must be taken seriously. This is especial-
ly so in some popular holiday lands where the incidence of
endemic typhoid already shows the standards of sanitation to
be below those enforced in Britain. The question of who
should be vaccinated must be settled quickly, and the public
also needs to be clearly informed that the protection
obtained is poorer than with most other types of immuni-
zation. Travellers have become accustomed to believing
that a jab in the arm gives virtually complete protection
against a disease, but this is not true of cholera. In
one study the protection was reported to be only 85% effective
three months after two injections and practically nil after
six months.3 They must therefore be told plainly how to
weigh the risk of infection against the benefit of a holiday
or whatever the purpose of their journey may be. Some

3 New Chairman of Council

At the Council Meeting after the Annual Representative
Meeting at Leicester Mr. Walpew Lewin was elected Chair-
man of Council for a period of three years in succession to
Dr. Ronald Gibson. Mr. Lewin, who is 55, is consultant
neurosurgeon at Addenbrooke's Hospital, Cambridge. Since
1968 he has been chairman of the Central Committee for
Hospital Medical Services and deputy chairman of the Joint
Consultants Committee. He is on the council of the Royal
College of Surgeons of England, a member of the G.M.C.,
and on the Central Health Services Council. He is a Fellow
of Darwin College, Cambridge, and of University College,
London.

Dr. Gibson retires from the chair with the good wishes and
grateful recognition of all his colleagues. He has rendered outstanding service to the Association and the profession it represents.
Elected Chairman of Council in 1966 in succession to Mr. J. R. Nicholson-Lailey, his term of office spanned five exceptionally busy years. Hardly was he in the chair when the Prime Minister of the day announced the Government's intention to freeze wages and salaries. This was the prelude to recurrent economic crises which culminated so far as the profession was concerned in last year's resignation of the
Review Body. Parliament passed the Abortion Act, with provisions contrary to advice given by the B.M.A. and the Royal
College of Obstetricians and Gynaecologists. The Seebohm report appeared, followed quickly by legislation. The Medical Acts were amended, giving the G.M.C. new powers, a step which led to the crisis of confidence with that council. Successive Governments' changing views on the future of the Health Service were made known in the two Green Papers and the Consultative Document, and now there is the Industrial Relations Bill, which will affect all who work in the Service. In addition to actions of Government this quinquennium saw the publication of the Todd report on medical education, as well as constitutional reform within the Association designed to improve the balance of representation by craft. In all these events doctors were vitally concerned, and the Association, led by its Chairman of Council, put forward the profession's views. Dr. Gibson will be remembered specially for his firm and courageous leadership, his accessibility and success as roving ambassador for the Association, and for a breadth of vision which put equal value on the promotion of the medical and allied sciences and the maintenance of the profession's honour and interests.