pathological study was as follows:

1. Uterus with cervix, both adnexae and segment of rectum. Uterus 11x7x5 cms. The rectum with the anterior part is closely attached to posterior part of uterus and cervix. No ams in the submucous prostate. Length of rectum 7cms. Circumference of proximal part is 6cms of distal part 6cms, 3cms above distal resection edge, very slightly dilated in the posterior part of rectum 3cms long and 3cms in circumference. Mucosa of rectum smooth, shiny. Muscle sheath of proximal part of rectum highly hypertrophic, 0.8cms. On the anterior wall of rectum corresponding to the adhesions on posterior wall and protruding part of mucosa 3cms long 1.5cms wide. On the cut surface of protruding mass the thickness of muscle sheath 14mm and thickness of mucosa 8mm. Muscle sheath is almost transformed to whitish hard mass occupying both muscle sheaths (no border between longitudinal and circular sheaths). Two sections from rectum.

Smooth wall of uterus up to 2.5cms. Mucosa is shiny, 3mm thick. Left tube 6 x 0.5cms. Left ovary 2.5 x 1.5 x 1cm with small haemorrhagic cyst from 2 to 4mm. Right tube 7 x 0.5cms. Right ovary not present. One section from cervix, one section from uterus. One section from left ovary and tube.

2. Cystic ovary: 4 x 3 x 2.5cms with haemorrhagic cyst 2cms in diameter. Cyst with defect on surface 2 x 1cm.

3. Congestions of the left ovary 6 x 0.5cm very narrow lumen. Three sections.


Her post-operative course was uneventful. Her drains and urethral catheter were removed on 6th day. By 29-2-84 her wound had healed by primary drains and urethral catheter were removed on 6th day. By 29-2-84 her wound had healed by primary closure. Her post-operative course was uneventful. Her wound had healed by primary closure and posteriorly. Conculsion: Finding is consistent with the presence of endometriosis i.e. the presence of functional endometrial tissue separate from the uterine corpus. There was no evidence of endometriosis involving the bowel.

The patient had emigrated to Australia in his youth and had now returned for a holiday. His former occupation was as a pump-fitter. The patient smokes 20 cigarettes daily for the last 40 years and drinks a bottle of wine every day.

**Physical Examination**

On examination the patient's general condition appeared satisfactory. He was afebrile. The blood pressure was 110/70 and there were no signs of heart failure. Further examination revealed an area of dullness over the base of the right lung with decreased respiration and expiratory rhonchi. In the abdomen a smooth, firm, non-tender liver edge was felt 4 finger breaths below the costal margin. There were no splenomegaly, ascites or lymphadenopathy; signs of hepatocellular failure were absent.

**Basic Investigations**

A chest X-Ray showed increased lung markings over the right base. The ESR was 110 mm/hr.

Discussion

A review of the extensive literature on intestinal endometriosis seems to show that the condition is relatively common, essentially benign and must often go unidentified. This latter characteristic is an added reason to warrant the publication of the present case report. No cases of intestinal endometriosis have ever been reported from St Luke's Hospital, Malta. The condition is likely to present to the Gynaecologist as an unusual cause of lower abdominal pain, but may be identified by intestinal endoscopy, which is becoming more widely available. However, the condition is likely to present to the Gynaecologist as a pathological study was as follows:

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It must be ensured that tobacco products marketed in Malta do not contain higher levels of toxic substances than those marketed under the same brand designation in the country of origin.

It will be necessary to regularly revise levels of taxation on tobacco in order to discourage further cigarette consumption.

The rights of the non-smoker should be emphasised by adopting regulations to protect non-smokers from exposure without their consent. Smoke-free areas must be provided or extended in public places and special attention must be given to protect infants, children and pregnant women from contact with persons who are smoking.

An unusual cause of Liver Abscess — A Case Report

**PROF. A. PSAILA MD DCHL (Lonnd.on) MRCP (UK) FRCP (ED) FRCP**

**MEDICINE, A / DIRECTOR DEPARTMENT OF MEDICINE**

**DR. TANCRED AGiUS MD**

**HOUSE PHYSICIAN-SURGEON**

An 65-year old male presented with a three week history of weakness, dyspnoea, dry cough and right sided lower chest pain. He had spiles of temperature of 100-102°F. The patient had been prescribed various antibiotics during this period but their effect was short - lived. His past medical history was unremarkable except that hypertension was diagnosed 8 years before and was well controlled on propranolol.

The patient had emigrated to Australia in his youth and had now returned for a holiday. His former occupation was as a pump-fitter. The patient smoked 20 cigarettes daily for the last 40 years and drank a bottle of wine every day.

Further Investigations

An ultrasound study of the upper abdomen showed a well encapsulated mass (9.4 x 7.8 cm) in the right lobe of the liver suggestive of hydatid disease. A Casorini test revealed a strongly positive immediate reaction but no delayed reaction. A C-T. Scan and hepatic angiography were interpreted by a radiologist as almost diagnostic of hydatid disease of the liver.

Tests for α-fetoprotein and Australia antigen were negative.

Progress

While these investigations were being carried out, the patient's condition varied from day to day. At times he was collapsed and with a temperature of 104°F. The patient had been prescribed atenolol 50mg a day, propranolol. The patient, after careful consideration, was advised that an operation to excise the mass in the mass in the right lobe of the liver was necessary. The patient was therefore discharged home to Australia to have the mass excised. There was no evidence of dissemination at the completion of the operation. The patient was well and able to return to Australia as an outpatient.

All health and most educational facilities should be declared smoke-free areas and mechanisms instituted to enforce these provisions.
Recto-Sigmoid Endometriosis

Colorectal endometriosis is sufficiently uncommon to warrant reporting as it is evidenced by the number of single case reports in the literature. It is, according to statistics quoted from paper to paper, common enough to present one or more times in a lifetime of surgical experience. The following is a report of a case which was treated recently at St. Luke's Hospital.

Case Report

Mrs. AJ, a 44 year old Maltese woman was referred on 2-9-83 to the Surgical Out-Patients' Department with pain in the left iliac fossa and constipation. The pain was colicky and intermittent and had been present for some two years. It was not evidently related to her periods, although her constipation, which was of long standing seemed to be worse with periods.

Her periods were regular, heavy and fairly painful. In January 1981 she had been referred to Gynaecology Out-Patients at St Luke's Hospital for vaginal discharge, pain in LIF and constipation. Vaginal examination showed a cervical erosion and a bulky uterus. The adnexae were normal. A PAP smear was taken. When seen in Surgical Out-Patients' clinic in September 1983 her general condition was good. Her abdomen was soft; there was vague tenderness in LIF. An IPM was requested and a note entered that she was to have an investigation of the colon in due course. Her IPPV was normal and she was referred to Gynae Out-Patients’ with the possibility of an ovarian cyst. On 29-10-83 she had a D & C and an examination under anaesthesia in the Gynaecological Department. The cervix was now healthy, the uterus bulky and ‘7 fixed'. Adnexae were reported as normal. The curettings were reported: Dysynchronous and hypersecretory endometrium - 2-11-83 (Dr H).

She was then referred from Gynae to the Orthopaedic Department. This was because of the severity and persistence of the pain and its tendency to radiate to the region of the left hip. Her orthopaedic assessment was negative. She was seen again in SOP on 4-11-83. She was not in pain at the time but complained of severe constipation requiring regular dosing with laxatives. P.R. was negative. A Barium enema was reported on 29-12-83 as follows: There is a narrow segment about 3” long between the sigmoid and the rectum. The outline is irregular but as the post evacuation film is not satisfactory the mucosal pattern cannot be visualized. Radiologically this is compatible with a Carcinoma but requires confirmation with a sigmoidoscope. The rest of the colon is normal. Sgd Dr S P K.

On 9-1-84 she was admitted to the Woman's Surgical Ward for sigmoidoscopy and further treatment. On 11-1-84 sigmoidoscopy was performed. (A.K.) Appearances were described as follows: Ca sigmoid colon - growth looked like cauliflower, stiff, 17cms above sphincter. Growth occupied only one side of colon.

A biopsy was taken. This histological report of 2 fragments submitted was: Two fragments of large bowel mucosa with signs of congestion. No malignancy in these samples.

On 19-1-84 she underwent a repeat sigmoidoscopy by the same Surgeon (A.K.). Again the findings were described: 15-17cms above sphincter on anterior wall of sigmoid colon CA - stiff growth with small ulceration. Biopsies were also taken. These were reported thus:

Four fragments of mucosa - Heavy colitis with severe atrophy of mucosa. No malignancy in these samples.

A third sigmoidoscopy was performed this time by another Surgeon (A.S.) The findings were described thus:

At 15cms rigid stenosis especially anterior wall of rectum but without cauliflower formation. Biopsies were taken. The biopsies were histologically examined and reported by Prof. B thus:

Heavy colitis with severe atrophy of mucosa. Nest of 7 microuncinoid adenocarcinomatous formation in lamina propria. Malignancy must be taken into consideration. The sample is superficially taken.

An ultrasound scan of liver (7-1-84) showed no evidence of 5th deposits. The liver texture is normal. (Dr A S W).

The patient underwent operation on 12-2-84 under G.A. (J.A.M.) Through a left paramedian incision the abdomen was explored. A right ovarian ‘chocolate cyst' was present. The uterus was bulky and densely adherent to rectum above posterior fornix. The anterior rectal wall in this region felt thickened and hardened. No tumours or other pathology were evident in rest of rectum and colon. Rectal endometriosis was considered to be the diagnosis. An anterior resection of the rectum was performed together with a total hysterectomy and bilateral salpingo-oophorectomy with removal of (R) ovarian cyst. An axial colorectal anastomosis was performed using the EEA stapler gun. This was protected by a caesareostomy after appendicectomy. The patient made an untruncated recovery. The histological report of specimen submitted for...
working at the microscopic coagulation of the Bruce Micrococcus attentions of the military authorities. The microbe causing the disease was discovered by Surgeon Major (later Sir) David Bruce while he was working at the Station Hospital in Valletta in December 1886. He found the microcococcus in the spleen of 5 fatal cases of Undulant Fever. A few months later, in collaboration with the Maltese Dr. Caruana Siciliana, he cultivated the organism on Agar-Agar.

Recognition of the disease was made easier in May 1909 when another Maltese, Dr. (later Sir) Themistocles Zammit applied Widal’s Method to the serum diagnosis of the fever and demonstrated the microscopic coagulation of the Bruce Microcococcus when treated by the blood serum taken from a patient suffering from the disease.

The prevention of the illness, however, still remained a grave problem for, as long as the source of the microcococcus was unknown, no prophylactic measures could be devised.

In June 18, 1905, Zammit discovered the organism in the blood of the goat. The work of the commission set up by the Royal Society, at the request of the Armed Forces worked very hard from 1904 to 1906.

Zammit’s discovery was soon confirmed by an unpremeditated experiment on human beings. In the summer of 1904, Mr. Thompson of the Animal Industry obtained a herd of 65 goats from Malta and shipped them to America via Antwerp on the S.S. Andrew. During the voyage many of the ship company drank freely of the goats’ milk. On arrival at Antwerp the goats were re-embarked on the S.S. St. Andrew and again, during the passage to New York, a larger quantity of milk was consumed by the crew. Bacteriological examination of deep samples of several of the goats that reached America resulted in the recovery of the micrococci.

Exceedingly satisfactory results were obtained by pasteurisation. In the following months the Garrison also changed over from goat’s milk to condensed milk. Someone, very unwittingly, remarked that those who opened the goats saved the British Army from extinction.

During the two World Wars, Malta was the Nurse of the Mediterranean, although during the last War the Island was a battered Nurse taking a very active part in the battle against the enemies of Democracy, and paying heavily for so doing.

In the medical field we are doing our best to carry on the good work at St. Luke’s Hospital as did the Knights at the Holy Infirmary, because, like Osler, we have loved no darkness

Sovereign Abscesses: The rate of infection in these cases is usually either from a bile duct infection with ascending cholangitis or from a pyelephilitis resulting from any infectious process in the urinary tract. In the latter situation, bile duct complications are less common sites for these cysts but they may occur practically anywhere in the body. The causative organism is a tapeworm Echinococcus, the most common species being E. granulosus. The natural life cycle of this parasite involves sheep and dogs. Man is a secondary host and becomes infected by ingesting vegetables or water fouled by dogs or by handling parasite-infested dogs. After ingestion the shell of the egg is destroyed by gastric acid and hatching occurs within the duodenum. The liberated embryos migrate through the gut wall, into the mesenteric circulation and lodge within the liver where each embryo is converted into a small vesicle which as it grows establishes a germinative epithelium eventually evolving brood cysts. As with amoebic abscesses secondary bacterial infection may occur in these cysts.

An interesting point about this patient is that the root of his evil was the matchstick found in one of the diverticula. This appeared to have provoked the diverticular complication which spread to the liver and eventually caused the liver abscess. This matchstick must have been swallowed inadvertently with food, possibly even months before. It was a whole, used matchstick found anchored in a diverticulum. The patient did not have the habit of chewing matchsticks.

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