cases the average time from initial surgery to resection of the tumour was over 4 months. This problem has been recognized since 1947, when Mayo noted that 15% of patients with caecal neoplasms had undergone previous appendicectomy for symptoms which in retrospect were probably attributable to the tumour.

Large neoplasms are easy to diagnose at laparotomy for appendicitis but there remain the small, early tumours. The most important aspect in management is to realize that patients are liable to have an underlying tumour. Colonic tumours are rarely found in patients under the age of 50 years and conversely, appendicitis is unusual above this age. In a random series of 329 appendicectomies reported by Miln and McLaughlin (1969) only fifteen patients were over 50 years of age. Therefore, a colonic neoplasm should be suspected in any patient over the age of 50 years presenting with signs or symptoms of appendicitis. In this group, particular note should be taken of a history suggesting anaemia, weight-loss or colonic obstruction.

On examination, the signs of acute appendicitis usually dominate the clinical picture, although a mass in the right iliac fossa should always be regarded with suspicion. Frequently, however, there will be no signs or symptoms referable to the tumour.

If the patient is over 50 years and there is any factor in the history or examination which suggests that a tumour may be present then there is a strong case for a right paramedian incision. In appendicitis, the caecum may well be thickened and oedematous as a result of local inflammatory reaction and, in this situation, even if there is a caecotomy, as in the case described, it is not always possible to exclude a tumour. Certainly palpation of the intact caecum is not an adequate means of assessment. If the caecum is abnormal in any way, an exploratory caecotomy and mucosal biopsy are strongly advocated. If possible, surgery should be undertaken where facilities for frozen section are available. In the event of an abscess being present, the pus should be examined for neoplastic cells and the abscess wall biopsied (Miller and Wooldridge, 1954).

If the presence of a tumour is confirmed, every attempt should be made to perform a right hemicolectomy at the initial operation. Ideally, continuity of bowel should be established without a defunctioning outlet, although this may be necessary in cases with fulminant abscess formation. In cases where no tumour is found at appendicectomy, development in the postoperative period of a faecal fistula or a persistent mass in the right iliac fossa should encourage early re-exploration. Unfortunately, these signs are frequently ignored, leading to an unnecessary delay in diagnosis of an underlying tumour, in a site always difficult to examine radiologically.

Finally, the authors suggest a careful follow-up of all patients over 50 years who are admitted with appendicitis. Postoperative follow-up investigations should include barium enema or colonoscopy, haemoglobin estimations and the periodic testing of stools for occult blood.

References
Collins, D.C. (1939) Aetiological factors in acute appendicitis based upon a study of 3,400 cases. Surgery, St. Louis, etc., 5, 267.
Costello, O. & Saxton, J. (1951) Appendicitis and cancer. Postgraduate Medicine, 9, 482.

Errata

Supplement 8, 1976, vol. 52. 'Infant milk powder feeds compared in a common basis' A. E. Mettler.
The author has drawn our attention to the following errors in his manuscript:

Table 6

| Values for P: for g read mg; Gold Cap SMA S26: values for Na + K mEq per litre: for 16-7 read 24-2. |

Table 7

Gold Cap SMA S26: values for Na + K mEq per litre: for 3-8 read 3-6.

Table 14

For heading 'Sweetness equivalent g of sucrose per 100 ml' read 'Sweetness equivalent g of sucrose per 100 kcal'.