Medical Memoranda

Gummatous Infiltration of Oesophagus Masquerading as Carcinoma

The operation of transthoracic partial oesophago-gastrectomy has passed the experimental stage and is now regarded rightly as the routine procedure in the operable case of cancer of the lower oesophagus. This extensive operation, performed as it is on patients often debilitated by slow starvation, carries with it a mortality above that of most standardized procedures for the resection of carcinoma elsewhere. It therefore behoves the surgeon to be very certain of his diagnosis before embarking on the operation, and the report of the following case may serve as a reminder that other pathological conditions may mimic malignant disease.

CASE REPORT

The patient, a man aged 77, first attended hospital in May, 1948, with a five-months history of increasing difficulty in swallowing solid food. He felt as if the food stuck at the lower end of the sternum, and on frequent occasions he had regurgitated his meal almost as soon as he had taken it. At the time when he was first seen he had reduced his diet to semi-solids and fluids only. He did not complain of pain, and he denied marked loss of weight. There was no relevant past history. The patient was an intelligent but frail old man showing signs of loss of weight. Except for obvious anaemia there were no abnormal physical signs. Blood examination showed: Hb. 38%; R.B.C., 2,830,000; C.I., 0.68; W.B.C., 5,600; and W.R., ++. A barium swallow was reported as showing "undoubted carcinoma of lower third of the oesophagus," and comparison with a film taken three months previously showed considerable extension of the disease. The patient was admitted for oesophagoscopy and biopsy. At the time of the instrumentation there was a technical failure and the procedure was abandoned. It was considered that, as radical resection would not be possible in view of the frail condition of the patient, further instrumentation was not desirable. He was referred to St. Bartholomew's Hospital with a view to treatment by irradiation, but it was considered that he was unlikely to benefit by this form of therapy.

Over the next few months, contrary to all expectation, the patient's condition did not deteriorate and it became obvious that doubt must be cast on the diagnosis. He was readmitted for oesophagoscopy, and a granular area at the lower end of the oesophagus was observed. Biopsy from this area revealed no carcinoma. In view of the very strongly positive W.R. the patient was put on iodides, and within a short time his swallowing had improved dramatically. He now eats any food without discomfort or difficulty, and at nearly 79 years of age is in very good health.

COMMENT

In view of the strongly positive W.R. and the marked improvement on iodides, it can be assumed reasonably that the patient was suffering from a gummatous infiltration of the oesophageal wall. Such cases, although rare, are well recognized, and Guyot (1931) was able to collect 55 cases from the literature when reporting two from his own practice. The symptoms produced by this lesion are indistinguishable from those associated with a carcinoma, and the resulting stenosis may be as complete. Even with antisyphilitic treatment subsequent dilatation of the resulting stricture may be necessary. Perforation of a gummatous lesion has also been reported (Rodrigo Sabalette and Garcia Martinez, 1945).

A positive W.R. is not always present to help the diagnosis, and of course such a finding is a common accompaniment of carcinoma. Oesophagoscopy may leave the surgeon quite sure that he is dealing with a malignant lesion, and Abel (1929) reports a case in which the lesion appeared so typical of carcinoma that, in spite of a negative biopsy, the condition was treated with radium applicators. Subsequent progress of the disease and further repeated biopsies left no doubt that the condition was due to a gummatous lesion. Leucoplakic patches may sometimes be seen in the oesophageal mucosa above the site of a gummatous infiltration, but ultimately the diagnosis must depend on repeated biopsies, persistently negative for carcinoma, and the response of the symptoms to antisyphilitic treatment.

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Oedema of Glottis Treated by Tracheotomy

A generation ago emergency tracheotomy was largely performed in cases of laryngeal diphtheria, but, fortunately, since the widespread use of immunization in this country it is now rarely necessary. That it may still be required occasionally is shown by the following case.

CASE REPORT

A road-sweeper aged 34, of good physique and in good health, reported sick at 1.30 p.m. on September 26, 1949, complaining of difficulty in swallowing of recent onset. Examination showed an apparently normal throat. An anodyne was prescribed and he was sent home to rest. At 4.30 p.m., on an urgent call, he was seen at home and was obviously very ill; a respiratory stridor was audible throughout the house. The patient was pacing the room, occasionally grasping a bed rail in an effort to draw breath. Unable to speak, he made signs that he was choking. It was obvious, in view of his wild behaviour and "bad" colour, that there was a need for tracheotomy.

At 4.35 p.m. a vertical midline incision was made from the cricoid level downwards for 1½ in. (3.75 cm.), without anaesthetic. Much dark blood oozed from the purplish tissues. The trachea was identified by touch. After displacing the pretracheal muscles to either side and extending the incision downwards better exposure was gained. The point of a pair of aural forceps penetrated the trachea below the first ring, acting as a guide to the scalpel, which was used to divide three rings below this point. A blast of air indicated restoration of an airway. There was improvement in the general condition, and bleeding ceased with oxygenation of the tissues. A temporary tracheotomy tube was fashioned from a wide-bore male rubber catheter in which air-holes were cut; it was secured by a safety-pin before introduction. The patient was noticeably shocked, and the initial cyanosis had given way to a greyish tinge; there was extensive sweating.

To ease respiration he was kept upright during conveyance to hospital, and the edges of the trachea had to be kept apart with aural forceps. In the operating theatre a metal tracheotomy tube was inserted without difficulty. No anaesthetic was required. He was then transferred to a warm bed and given an injection of morphine, ¼ gr. (16 mg.), later repeated. Penicillin was injected to prevent respiratory complications. On the following day continuous glucose-saline to a total of 2 litres was given intravenously because of the inability to swallow.

Recovery was gradual. On September 27 he was still unable to breathe through mouth or nose. The fauces were swollen

symmetrically as in bilateral quinsy, but differed in that the tonsils were healthy and the tissues pale and watery; his temperature was 98.4° F. (36.9° C.). A diagnosis of oedema of the glottis seemed to be indicated. On September 28 he breathed through his nose. Extension of the oedema below the mandible caused a "double chin." Next day he started a light diet. Oedema of the fauces was subsiding, and on September 30 the tube was removed. Subsequent progress was satisfactory, and the patient returned to work three weeks later.

The crigin of the oedema of the glottis was investigated, but no definite conclusions were reached. Questioning on September 27 did not elicit a history of the patient having been stung by a wasp or bee on the previous day. He had not felt a pain in the throat whilst eating his lunch. It seems likely that local trauma to the throat was responsible, and that this occurred during the lunch meal. In spite of the lack of positive evidence the possibility that he swallowed a wasp without noticing cannot be excluded.

COMMENT

The treatment of allergic oedema of the glottis may be said to depend upon the stage at which the condition is recognized. Many, perhaps most, cases may be seen at an early stage before any considerable swelling has occurred, as when a patient can report with certainty that he has been stung in the throat. Here treatment by an immediate subcutaneous injection of adrenaline, followed by full doses of antihistamine drugs, may be completely successful. Other cases are, for various reasons, seen at a later stage. These include patients in remote country districts where distance obviates early consultation. The absence of a clear-cut history, as in this case, may lead to a late diagnosis. Here the need for tracheotomy, as shown by severe and increasing asphyxia, may arise.

My thanks are due to Dr. H. O. Lync and the staff of the Whitby War Memorial Hospital for their valuable help in the management of this case.

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Oesophageal Foreign Body Precipitating Dissecting Aortic Aneurysm

In the case reported below it is probable that the disturbance incident on a realization by the patient that she had swallowed a fish-bone precipitated commencing aneurysm of the aorta in a predisposed subject. The eventual cause of death was rupture into the pericardium. The double pathology must be extremely rare, and for this reason the case is recorded.

CASE REPORT

The patient, a woman aged 44, was admitted to hospital as an emergency case at 10.30 p.m. on January 29, 1950. Two hours before admission she swallowed a fish-bone (plaice) and immediately coughed and had a severe substernal pain; the severity was such that she broke into a sweat. She vomited twice on her way to hospital; on the second occasion the vomit consisted of some frothy blood-stained fluid containing two small fish-bones. The substernal pain did not change in character or position after the vomiting.

Examination showed her to be a pale woman who, although in pain, was stoical, cheerful, and in full possession of her faculties. The temperature and pulse were normal. Examination of the heart and lungs revealed no abnormality. The blood pressure was 140/80. Indirect laryngoscopy showed a healthy larynx and clear pyriform fossae.

Oesophagoscopy was performed under general anaesthesia about half an hour after admission. The oesophagoscope was passed easily. As it went through the cricopharyngeus a little blood-stained froth came into view. A vertical superficial

laceration about 1 cm. in length was present on the right postero-lateral wall of the oesophagus at 37 cm. from the incisor teeth. No foreign body was found.

Soluble sulphadimidine 1 g. was ordered to be injected four-hourly, and it was decided to give nothing by mouth for eight hours.

Recovery from the anaesthetic was normal. The substernal pain persisted and omnopon $\frac{1}{2}$ gr. (22 mg.) was given for its relief at 3 a.m. on January 30. At 7.15 a.m. the patient became cyanosed over the face, neck, and chest, and the neck veins were congested. The pain shifted from the substernal region to the epigastrium. It is not known if the onset of this cyanosis was sudden, because she was not under continuous observation and it might have been gradual over about half an hour. On examination she was found to have a pulse of 120, with a poor volume. The blood pressure was 90/60. The lungs were normal to percussion and auscultation, and the heart sounds were normal. There was a slight epigastric fullness and a little guarding over the right upper rectus.

She was given continuous oxygen with a B.L.B. mask, and radiographs of the chest taken with a portable machine were normal.

At about 10 a.m. she was examined by Mr. R. G. Macbeth and Dr. E. M. Buzzard. By then her blood pressure had improved a little and was 110/80. It was decided that she was suffering from a cardiac failure. There was no evidence of an acute abdominal condition or of respiratory disease. Nikethamide 1 ml. hourly was ordered, and she was given hourly drinks of glucose and lemon-water. The oxygen was continued.

A physician under whose care she had been previously was consulted by telephone during the day. He stated that she was a hypertensive, though this was apparently not known to the patient or to the doctor who had sent her into hospital. A diagnosis of coronary thrombosis was suggested.

Her condition improved during that day, and the following night the epigastric pain slowly disappeared, but cyanosis always returned when the oxygen was withheld.

The next day an electrocardiogram was done, but the typical appearances of coronary thrombosis were not seen. Throughout this day her condition was unchanged. The next morning, February 1, the pulse rate was 80 and the blood pressure 190/120, but the cyanosis and engorgement of the neck veins persisted. At 9.30 a.m. she suddenly died just as an examination was about to be made of her heart.

Post-mortem Summary.—Spontaneous rupture of aorta with dissection and eventual rupture into the pericardium causing haemopericardium and death. Ante-mortem superficial laceration of the posterior wall of the oesophagus. Early nephrosclerosis.

Histological examination of the aorta showed an increase in sudanophil material in the media but no unequivocal findings of cystic medionecrosis. It is possible that the findings indicate an early stage in the development of this condition. Evidence of hypertensive changes was also found.

I would like to thank Mr. R. G. Macbeth, into whose ward the patient was admitted, and Dr. E. M. Buzzard. My thanks are also due to Dr. R. A. Sladden, who performed the post-mortem examination.

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The Ministry of Health announces that enrolments in the National Hospital Service Reserve in England and Wales at the end of September reached 4,573, an increase of 1,350 since last June. Membership consists of 372 trained nurses and 4,201 auxiliaries. The immediate target for the Reserve is 30,000. Wales has recruited a total of 840 members. In England the South-west Metropolitan Hospital Region has enrolled the highest number of recruits, the total reaching 627; the New-castle Hospital Region came next with 387; and Sheffield R.H.B. a close third with 386.