PRIMARY CARCINOMAS OF THE STOMACH AND SIGMOID COLON OCCURRING SIMULTANEOUSLY

BY

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Dr. Pemberton and Dr. Waugh of the Mayo Clinic, in the August, 1937, issue of *Surgery*, describe a case of a male physician, aged 57, who was admitted to their clinic suffering from a cancer of the sigmoid flexure of the colon. At operation primary growths were found to be present both in the colon and in the stomach. The tumour in the colon was excised after the manner described by Paul and Mikulicz, a subtotal resection of the stomach being undertaken some weeks later. Microscopically both growths were adenocarcinomas, and both were Grade 2. They write:

"Multiple primary carcinomas which affect the same individual have aroused the interest of the profession since the first reports of such lesions in 1869 by Billroth, although the frequency with which present-day pathologists report this finding is tending to make it almost commonplace. However, the finding clinically of two separate and distinct carcinomas appearing simultaneously in the sigmoid flexure and stomach is rare, and this, coupled with the fact that both lesions were amenable to surgical treatment, makes the report of the . . . case unique. . . . The case . . . cited is, so far as we are aware, the only recorded instance of successful surgical removal of simultaneous independent carcinomas of the stomach and sigmoid flexure."

In view of these statements and also because I have had in my own practice recently a similar case, in which, however, it proved possible to excise at one single operation (partial colectomy and subtotal gastrectomy) both the primary growth in the sigmoid colon and the cancer of the stomach, I have considered it worth while to submit a record of the details of this case.

Case Report

A married woman aged 55 was admitted under my care at the Southend General Hospital on June 26, 1937, complaining of intermittent bouts of abdominal pain, loss of weight, and severe constipation. Some three months before her admission she stated that she had had several recurrent attacks of abdominal pain situated mainly centrally, but occasionally referred to the left side rather low down. The pain lasted only a few minutes, but was cramp-like and intractable. The attacks had no relation to food and did not appear to be relieved by medicines.

Approximately one month before admission she was seized with severe subumbilical colic and vomiting, which lasted for over six hours and then cleared up spontaneously. She had always been constipated, but this was becoming progressively worse, there being no history of attacks of alternating diarrhoea and constipation or of blood and slime in the motions. She had been gradually losing weight, and estimated that she had lost about two stone in three or four months. Her appetite was good and there were no symptoms of indigestion or other gastric disorder.

On examination she was thin and pale, the tongue was clean and moist, the abdomen was scaphoid rather than distended, and there was a palpable movable lump about two inches below and to the left of the umbilicus. A digital rectal examination as well as a sigmoidoscopic examination proved negative. A complete blood count showed that there was a

slight degree of secondary anaemia, and the barium enema revealed a small annular stricture at the beginning of the sigmoid colon.

On July 3, after a week's pre-operative preparation, the abdomen was explored (under spinal anaesthesia) through a left oblique Kocher incision which started at the tip of the tenth costal cartilage and proceeded vertically downwards towards the pubis, all the layers of the abdominal wall being divided in a line with the incision. A small freely movable growth was located in the gut at the point indicated by the barium enema. The abdomen was further explored to ascertain whether there were any metastases in the mesocolon, along the aorta, in the omentum, or in the liver. No enlarged glands could be detected in the mesocolon or elsewhere, but while a hand was being swept upwards into the epigastrium to palpate the right lobe of the liver an indurated mass was felt on the lesser curvature of the stomach; this was thought to be in all probability an early cancer of the stomach and not a secondary implant from the original growth in the colon. The descending and sigmoid colon was freely mobilized, and some twelve inches of gut (including the growth) exteriorized and resected by Paul's method.

The abdominal wound was closed as snugly as possible around the two short projecting portions of colon, and the clamps were left *in situ*, occluding the proximal and distal ends. This area of the operation was isolated with sterile towels, and as the resection of the colon had proved a simple matter and the patient's condition was highly satisfactory, after fresh sterile gowns, gloves, etc., had been donned, the epigastrium was immediately prepared for exploration.

Through a median vertical epigastric incision the stomach was examined and was found to contain an ulcerated area in the middle of the lesser curvature about one and a half inches long by two inches wide. On invaginating the stomach in the region of the greater curvature the ulcer could be felt to have a raised indurated edge, which was of stony-hard consistency. There were a few shotty glands along the lesser curvature, but these did not appear to be malignant, nor was there any involvement of the visceral peritoneum of the stomach.

A subtotal gastrectomy, with removal of the great omentum, half of the first portion of the duodenum, practically the whole of the lesser curvature, and two-thirds of the greater curvature with all the adjacent lymph glands, was performed. The jejunum was brought over the transverse colon and its proximal portion anastomosed to the cut end of the stomach after its top half had been closed, the proximal loop of the jejunum being applied to the reconstructed lesser curvature and the distal loop to the greater curvature, after the manner suggested by Hoffmeister.

At the completion of this anastomosis it was found that the proximal jejunum took a rather short and graceful curve to the point of anastomosis, and it was therefore not considered necessary to perform an entero-anastomosis between the proximal and distal loops, a procedure which is much favoured by Balfour. The abdominal wound was closed in the usual way without drainage.

The patient made a splendid recovery, and was discharged on August 13 with the colostomy working well. She was readmitted on September 18, and a clamp was applied to the colonic spur on the Paul-Mikulicz stoma, while on September 29 the colostomy was closed under spinal anaesthesia. Shortly after this the bowels functioned naturally, and the patient's condition to-day leaves nothing to be desired.

The pathologist's report was adenocarcinoma of the sigmoid flexure without any involvement of the lymph nodes in the mesocolon which had been excised, and the microscopical section of the ulcer in the stomach likewise showed adenocarcinoma undergoing colloid degeneration. Several glands which were adherent to the stomach, and particularly those adjacent to the ulcerated region of the lesser curvature, were examined microscopically, and all were found to be normal in appearance.