SPONTANEOUS DISAPPEARANCE OF CARCINOMA

BY

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(WITH SPECIAL PLATE)

It has long been recognized that carcinoma of the large intestine is a very slow-growing form of malignant disease, and it is being realized now that its rate of growth is probably even slower than we had previously thought. It is not until some degree of obstruction begins to make its appearance that our advice is sought, and if we go carefully into the history we may find evidence of some indefinite abdominal symptoms which may go back for as long as two or three years. Even when the disease has been present for this length of time the outlook is comparatively favourable if the acute obstructive condition is relieved and the growth subsequently removed. When we open the abdomen in these cases we usually find a comparatively small primary lesion, with some enlargement of the glands in the mesocolon. It is only in the later cases that we find involvement of the aortic glands or secondary deposits in the pelvis with free fluid. Secondary nodules in the liver are also, as a rule, a late phenomenon. The latter two forms of extension are usually regarded as contraindicating any form of radical surgery.

Case History

A man aged 41 was seen on March 29, 1927, when he gave a history of attacks of pain in the left side of the abdomen for some considerable time. These had been diagnosed as due to renal colic, and he was eventually x-rayed, with negative results, in December, 1926. Colicky abdominal pain and increasing constipation began to be felt four weeks before he came up for treatment. For ten days he had noticed his abdomen becoming fuller, and he had commenced to vomit. At the time of his admission he had absolute constipation. He was obviously suffering from acute intestinal obstruction, and as he gave no response to enemata his abdomen was opened by a right paramedian incision. A growth was found in the descending colon, and the gut above it was very much distended. His caecum was brought out through a separate incision in the right iliac fossa and a Paul's tube tied into it. Three weeks later his abdomen was reopened by a left paramedian incision and examined in more detail. The distension of the gut was considerably less. One or two of the paracolic glands were enlarged, and on sweeping the hand over the convex surface of the right lobe of the liver a nodule which was hard and about the size of a pea was felt on its surface. This was taken to be a secondary deposit and seemed to exclude any hope of resecting the growth. It was felt undesirable to leave the patient with a caecostomy on account of the difficulty of controlling a liquid discharge, and the choice lay between a short circuit and a partial colectomy. The left half of the colon was mobilized and a piece stretching from the left side of the transverse to the upper part of the sigmoid colon was removed. The two ends were closed and continuity was restored by a side-to-side anastomosis.

The pathological report on the specimen read as follows: "The growth is a typical adenocarcinoma, showing some mucoid degeneration in parts. It almost encircles the gut, causing some narrowing. Melanosis is present above the growth." Two photomicrographs are here reproduced (see Plate).

Following the operation his caecostomy opening gradually got smaller and he was discharged with it practically closed five weeks later. For about eighteen months he was seen

periodically because of some leaking from it, and it then appeared to close finally. During this time his general health improved and no sign of any further growth was seen. He went to Ireland for business reasons at this time and nothing more was seen of him until February, 1937, when he came up with a history of three weeks' constipation. His general health had been good for the ten years since his operation. He had been so well that his business affairs had prospered; but he was worried, as he knew that a growth had been removed and he was afraid of a recurrence. There was still no sign of a return of the growth, and a barium enema showed a colon, with no sign of any obstruction, in which it was practically impossible to tell that a resection had been done. He was reassured, and has now returned to his work.

Discussion

The interest in this case centres on the nature of the nodule that was felt in the liver. The obvious diagnosis was of a secondary carcinomatous nodule, but there was no verification of this with absolute certainty. Simple liver tumours occur occasionally and are usually accidental findings at a post-mortem examination, so that there is no reason why they should not be accidental findings during the course of an operation for some other condition. We are thus left with the two alternative diagnoses of a secondary deposit and a simple tumour such as a bile-duct adenoma. Except for the subsequent history the former of these would appear to be the more likely.

There is no doubt that carcinoma can and does disappear spontaneously, as instanced most strikingly in Pearce Gould's (1910) classical case. Further, we know that cancer cells which are carried to the liver and the lungs are often destroyed and that they do not always give rise to metastatic growths. Teacher (1908), in an article on the development and natural healing of secondary tumours of chorion-epithelioma malignum, brings forward evidence to show that haemorrhage and thrombosis in a tumour are able to destroy the tumour cells, and that healing is brought about by a process of encapsulation within a zone of actively growing connective tissue and blood vessels which invade the tumour nodule.

It is said that in tuberculosis when there are two foci of disease the elimination of one may allow the natural defence mechanisms to overcome the other, whereas the two together might be progressive and beyond the patient's power to deal with. May it not be that a similar state of affairs holds in cancer and that the question of dosage is an important one? It is possible that cancer cells may be left behind after radical operations, and that we may congratulate ourselves on having removed the disease in its entirety when it is really the natural resistance of the body that has made our efforts successful.

It is usually held that the presence of one growth protects its host from the development of another, probably on account of the elaboration of some antibody which makes its way into the circulating blood. Thus in the tar warts which are produced in the experimental animal only one of them becomes malignant, and in polyposis of the colon, which is well known to be pre-cancerous, only one polypus shows a malignant change. The removal of the carcinoma in such a case may be followed at a later date by the appearance of a malignant change in one of the other polypi or warts. The two cases are, however, hardly parallel. Here we are dealing with an actual growth and a potential one, whereas in the case I am reporting there were two established foci, one certain and the other probable.

We know, further, that cancer cells may remain latent, presumably encapsulated by a fibrous tissue reaction. This is the only possible explanation of the late recurrences sometimes seen. I would instance a patient whom I saw recently who had a radical removal of the breast done for carcinoma, and who came up twenty years later for a recurrence in the lumbar spine. In this particular case it is certain that the deposit was there at the time of the operation. I am suggesting that operation, by cutting down the amount of cancer present, allows it to be successfully dealt with and shut off. Then at a later stage some other factor comes into play, possibly trauma, possibly a lowering of the general health of the patient, and the cancer cells resume their interrupted activity.

I do not wish to imply that partial operations should be undertaken, or that radical removals of a primary source should be done in the presence of gross secondary deposits. I am only placing this case on record to show that a patient who might have been regarded as hopelessly inoperable is still alive and well after an interval of ten years.

Summary

A case of carcinoma of the descending colon associated with a nodule in the liver is reported in which the patient is alive and well ten years after a partial colectomy.

REFERENCES

- Gould, A. Pearce (1910). *Lancet*, 2, 1665.
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THE PLANTAR WART

VERRUCA PLANTARIS: VERRUCA PEDIS: PLANTAR PAPILLOMA

BY

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(WITH SPECIAL PLATE)

At the present time there is a widespread epidemic of plantar warts among school children. So far as my experience goes the epidemic is most severe among adolescent girls, although I have seen several boys whose ages ranged from 8 to 17 years suffering from the complaint. In South-West Lancashire the epidemic scarcely affects the so-called hospital classes, and the majority of cases are in children who attend boarding-schools; it would seem to be unduly optimistic to believe that all classes of the community will not be soon infected. Until recent years this type of wart has not been prevalent, and it is difficult to discover why the present epidemic has developed.

Plantar warts (or "verrucae," as they are called by many patients and some chiropodists) are a minor malady, but when they have reached an average size they considerably curtail the activities of the person affected, owing to the pain caused by pressure on the warts whenever he attempts to walk or run. The warts develop insidiously. The first sign is the formation of a small semi-translucent macule, 1 to 2 mm. in diameter. There are no signs of inflammation. The macule is slightly painful on pressure, but is usually disregarded by the patient, who, if he considers the matter at all, believes that he has a tiny piece of grit embedded in the sole of his foot. The lesion, as a rule, develops on the heel or the ball of the foot, but may appear on any part of the plantar surface,

including the toes. The macule increases slowly in size until it reaches a diameter of approximately 0.5 cm., when the wart may be regarded as being fully formed. On examination one finds a roughened, hyperkeratotic type of lesion, greyish yellow in colour, and its papillomatous nature is usually not apparent until the wart is pared with a knife. Satellite warts develop, and it is not uncommon to find as many as ten warts on one foot. The subjective symptoms vary with the site of the warts and the stoicism of the patient. One can generally obtain a history of throbbing pain, which is most severe when the patient gets out of bed in the morning or when he puts on his boots and starts to walk. The pain usually diminishes after he has been standing for some little time. He may complain that the warts throb when he has a hot bath.

Plantar warts have to be differentiated from callosities due to pressure; but medical men are so accustomed to recognizing callosities due, for example, to dropping of the anterior arch of the foot or to faulty shoes that the differential diagnosis is not often a matter of difficulty. In a doubtful case one should remember that whereas little or no pain is experienced when a callosity is pressed, the patient always complains of severe pain if a plantar wart is treated similarly; further, if the lesion is pared down the papillomatous nature of the wart becomes apparent.

Aetiology and Pathology

There is little doubt that plantar warts are caused by a filter-passing virus. It is probable that individual susceptibility to this virus varies considerably, but the virus is virulent and appears to be able to obtain a secure foothold on skin which to the naked eye reveals no sign of abrasion. Whilst the virus probably cannot develop or multiply except on a medium of living cells, it is reasonable to presume that it can remain alive for some minutes, if not for a few hours, on areas where an affected foot has pressed. If the superficial layers of a wart are shaved off the closely packed papillae are revealed. The papillae are in most cases yellowish white in colour, but may be stippled with red or brownish stains where haemorrhage has occurred. They are encircled by a tough horny collar. The lesion is broader at its base than at the opening on the surface of the skin.

The histology has been described by MacLeod (1933) in the following terms: "Microscopical sections show hyperkeratosis at the periphery, and marked acanthosis and elongation of the interpapillary processes in the centre. Towards the centre of the processes the prickle cells tend to be vacuolated." Inclusion bodies may be found in these vacuolated prickle cells.

Treatment

Treatment must be divided into two categories, preventive and active. In my opinion preventive treatment is of the utmost importance at the present time, and I would urge that all doctors who are in charge of schools should institute regular inspection of their pupils' feet, at least until the present epidemic has passed. School children suffering from plantar warts should be segregated so far as dormitory accommodation is concerned. They should have their own bathrooms and changing-rooms, and should not be permitted to use the school swimming-bath. Special care should be taken that their boot lockers are far removed from their colleagues', whilst the bootblack should have instructions always to clean the patients' boots in a batch after he has finished with those belonging to the rest of the school.

DIGBY CHAMBERLAIN: SPONTANEOUS DISAPPEARANCE OF CARCINOMA

FIG. I.—Showing the proliferative character of the growth. ($\times 45$.)

FIG. II.—Showing how the growth is invading the muscle. ($\times 45$.)

R. M. B. MacKENNA: THE PLANTAR WART

Plantar warts.

PHYLLIS F. L. DAPLYN: BLOCK ANAESTHESIA FOR
INSERTION OF RADIUM TO EPITHELIOMA OF LIP

Condition of lower lip at operation.