A CASE OF DUAL (KISS) CANCER OF THE STOMACH

BY

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Cases of double cancer of the stomach are rare enough to warrant publication. A review of the available literature shows that multiple malignant neoplasms of the alimentary canal are far from frequent. Benign polypi, such as those that occur in the large bowel, are, of course, fairly common. It appears, however, that multiple cancers in the digestive tract have been noticed and described for a long time. The first known observation seems to date from Carreri, who in 1779 recorded a case of "scirrhus cancer of the oesophagus coexisting with a malignant growth in the small intestine."

Multiple neoplasms are more frequent in the intestine than in the stomach. The coexistence of a gastric tumour and one or more intestinal tumours is by no means exceptional. In the stomach itself, however, neoplastic duplication is exceptional and probably a very rare occurrence. Barth in 1855 described a case of cancer of the cardia coexisting with a cancer of the pylorus, while Devic and Chatin described a similar case in the *Province Médicale* in 1892. Pellegry noted that different writers had from time to time described simultaneous cancers of the cardia and pylorus. More recently cases of double cancer of the stomach have been described in the French and Italian journals. Thus Barbier, Cavaillier, and Didierlaurent (1938) discuss a case of cardiac and prepyloric cancer of the stomach. Pellegry in 1926 wrote a thesis on multiple cancers of the stomach, covering a period of twenty-six years, and managed to unearth from medical literature six cases in which two definitely primary cancers of the alimentary canal coexisted simultaneously—namely, tongue and jejunum, pharynx and pylorus, oesophagus and ampulla of Vater, oesophagus and stomach (two cases), oesophagus and pylorus. In these cases it was easy to establish the primary nature of the tumours, as the proximal one in each instance showed a squamous-celled structure, while the distal one showed a different structure—namely, spheroidal-celled or adenocarcinoma. When double cancerous growths occur in the same segment of the digestive tract, as in the stomach, the relation between the two tumours becomes extremely difficult. It is often impossible, from histological appearances, to state whether the two tumours are independent or whether one is secondary to the other; but there is no reason why two primary cancers possessing the same histological structure should not develop simultaneously. Direct implantation by contact is a mode of spread which must be admitted

as possible. On the other hand, if this assumption be accepted, why are multiple tumours of the stomach not observed oftener?

Case Report

A labourer aged 34, the father of seven children, was admitted to the Birkenhead Municipal Hospital on October 26, 1939, complaining of epigastric discomfort of twelve months' duration, relieved by food and alkalis. There was an increasing loss of appetite and of weight, but no vomiting.

On examination the patient was seen to be of spare build. No adventitious sounds were heard in the chest, and no heart abnormality was detected. The blood pressure was 115/80. Slight epigastric tenderness was present, but no mass was palpable in the abdomen. The urine was acid, and had a specific gravity of 1020, but no abnormal constituents. The Wassermann reaction was negative. Radiographs of the chest revealed "chronic inflammatory changes only." Radiographs of the stomach after a barium meal showed: "Defect in pars media. Antrum and duodenal cap fill evenly. Trace of meal in pars media at six hours. Rest of tract normal. Appear-

ances suggest carcinoma ventriculi." Examination of the faeces for occult blood was negative. The blood picture was: red cells, 3,100,000 per c.mm.; leucocytes, 16,000 per c.mm. No abnormal cells were present. The sputum was tubercle-negative. A fractional test meal showed achlorhydria.

Operation (E. W. T.): This was performed on November 27 under high spinal anaesthesia, using 12 c.cm. hypobaric 1/1,500 percaine, and employing the ventral position for injection as advocated

by Macpherson of Hull. One-third grain of morphine and 1/100 grain of hyoscine were given one hour and 1½ grains of ephedrine fifteen minutes before operation. The abdomen was opened through a midline epigastric incision. The body of the stomach was occupied by a mass which appeared to encircle it and also to infiltrate the transverse mesocolon posteriorly. There were a few enlarged glands in the omentum and along the lesser curvature, but no metastases in the liver or pelvis. A partial gastrectomy was performed according to Finsterer's technique; the abdomen was closed, and the patient given a pint of Group O (IV) stored blood, by transfusion, immediately on return to the ward. The operation lasted two hours.

On opening up the specimen removed I discovered that two malignant ulcers were present—one on the anterior and the other on the posterior wall, immediately opposite each other. They were exactly the same size and presented similar macroscopic characters—rolled everted edges and sloughing base. (See drawing of specimen taken after fixation.)

Convalescence proved somewhat stormy in consequence of a good deal of post-operative vomiting, which continued for seven days. This, however, settled down with frequent gastric lavage. The patient was discharged from hospital two months after operation, feeling quite fit and steadily gaining weight. The eventual prognosis must of necessity be a guarded one. When seen in April, 1940, the patient had gained 1 st. in weight and was feeling fit in every way.

Discussion

The question arose as to whether these ulcers were two separate and primary cancers or a large growth ulcerating in two places. To exclude the possibility of this being a

single growth which by submucous extension across the lesser curvature had produced a saddle-shaped plaque with an area of ulceration on each side, a section was taken as shown in the drawing. It included the growing edge of each growth, at the point where the cancers approached nearest to each other, with the intervening stomach wall of the lesser curvature, and this showed unequivocally that there was no direct bridging connexion between the two growths. It was therefore established that in this case the condition was either one of two distinct primary gastric adenocarcinomata or that one of the two growths represented a contact transplantation from the other at an early stage of its development by a process analogous to the development of kissing ulcers in the duodenum.

I am indebted to Professor T. B. Davie, University of Liverpool, for his kindly help and criticism as well as for the microscopical reports and sections. My thanks are also due to Mr. R. A. Grant, medical superintendent, for permission to publish this case.

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PSYCHIATRIC CASUALTIES IN LONDON, SEPTEMBER, 1940

BY

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In the *Journal* of October 14, 1939 (p. 764) I reported cases brought to a London hospital suffering from a variety of psychiatric conditions which had occurred under the stress of the times. Then the fear which was the precipitating factor in their illness was largely of the unknown terrors of air raids which did not come. In a few cases the sirens were an actual stimulus.

September, 1940, at the same hospital forms an interesting contrast. In the latter part of August the Central London population became accustomed to sirens, and a year of war had eliminated by a process of voluntary evacuation many neurotic and potentially neurotic people. Cases of neurosis in which a large element of causation could be attributed to the war were nevertheless occurring. In particular there were relapses among the war neurotics of 1914-18. When intense air warfare broke out over London on September 7, neurotic cases began to appear among those who had been in actual danger, who had been knocked down by blast, or who had been in houses which were rocked or wrecked by high-explosive bombs. Unlike those previously seen, these had experienced actual threat of injury and death. The earlier less concrete threat claimed its victims from a more highly educated, intellectual, and responsible section of the population.

Attributability

In discussing the neuroses of war, whether in the armed Forces or in the civilian population, there has been much argument as to what cases can truly be said to have been caused by war stress; and the idea has become prevalent that if a patient has shown the least sign of neurosis in his previous history he cannot rightly be called a war neurotic. Experience of clinical material such as that described below will reveal how superficial such an argument is. If it is remembered that there exists no absolute dividing line between neurotic and non-neurotic and that probably everyone has some trace of neurotic reaction in his adjustment to reality it will become obvious that any distinction must be quantitative rather than qualitative. It must be decided not whether a patient was previously neurotic but to what extent any previous neurosis is responsible, jointly with present stress, for his condition.

In considering the first 29 cases seen since September 7, therefore, the test of estimating the state of the personality upon which the precipitating factors have been at work has been performed by asking the following questions: (1) Was the patient neurotic previous to the circumstances which are said to have caused his illness? (2) If the answer to the first question is negative: Was the patient nervous or highly strung or unduly apprehensive previously, though not to the extent of being recognized as neurotic or ill?

If the second question is answered in the affirmative the patient must be regarded as an air-raid casualty, though somewhat predisposed. If the first question is answered in the affirmative each case must be considered separately. But the additional question, Would the patient be in his present condition were it not for air raids? is almost invariably answered in the negative. There must therefore be in all these cases some element of war attributability. I have attempted to decide whether in this class of case the present stress or the previous neurosis was the more important factor. Where the present stress seemed to be more important the case was considered to be an air-raid casualty. The results of this survey are given in Table I.

TABLE I (29 Cases)

A: Cases in which there was a history of pre-existing neurotic illness	9
(4 are considered <i>mainly</i> attributable to war stress)	
B: Patients with no such history, but said to have been nervous or highly strung	10
C: Cases showing no discoverable predisposing factors	3
D: Patients showing mild psychotic or psychopathic personalities	4
E: Cases complicated by concussion	2
F: Negative—Patient refused examination	1

Categories B and C are almost entirely attributable to war stress; Category A is partially and to a variable degree attributable to war stress (4 cases, however, are considered principally to be so attributable); and Categories D and E are attributable only to a minor degree. Thus there are 17 cases which owe their causation principally to war stress.

Clinical Material

The majority of cases were brought in from the scene of a bomb explosion suffering from some degree of derangement of consciousness, varying from a completely unconscious or stuporous condition to a mildly dazed state. There was often some amnesia in those not unconscious or stuporous. Tremor, usually generalized and coarse, was common, and became much exaggerated on near gunfire. It was usually accompanied by uncontrolled emotional behaviour and weeping—in men as well as women. One case of localized hysterical paralysis was seen—in a long-standing and versatile hysteric. Only one case of hysterical exaggeration of slight injuries was seen.

Typical Cases

Case 1 (Gross hysterical symptoms in a woman not previously neurotic, but of a well-marked hysterical personality type).—A married woman aged 35 was brought in unconscious and rigid with limbs flexed, head rotated to the left, and hands tightly clenched. Her pulse rate was 130 and the volume poor. This woman had lost a sister-in-law, killed in an air raid the day before. She had been frightened in previous air raids in a badly bombed area in South London. When the mews in which she lived was hit by a bomb she was thrown off her feet. She was brought immediately to hospital, and responded well to treatment—full relaxation and movement, together with speech, being restored, within half an hour. The following night under bombardment she began to relapse into a similar state, but this was easily rectified. She slept well with adequate hypnotics, but though now showing no florid hysterical symptoms she is quite incapable of dealing reasonably with her fear, and has been strongly