Pathological Report.—"The tumour has a structure superficially resembling an adenomatous polyp but in many areas showing disorderliness suggestive of adenocarcinomatous transformation. The epithelial cells in many parts are distinctly hyperchromatic and have an anaplastic appearance. In some areas the demarcation between epithelial cells and the supporting connective-tissue framework is disorderly, and there is in parts a heavy infiltration of inflammatory cells. On the whole the appearance is suggestive of a low degree of malignancy."

Case 2.—A girl aged 16, a shop-assistant and daughter of the above, was admitted to Llandough Hospital on Feb. 3, 1943, with a history of abdominal pain and vomiting for about 24 hours, the bowel action being normal. On examination the temperature was 100° and the pulse rate 126 a minute. There was marked tenderness around the umbilicus and in the right iliac fossa, but no mass was palpable. Immediate laparotomy was performed (D. B. E. F.); this revealed an ileo-ileal intussusception. Reduction by the usual technique was attempted, but the intussusciptions then split for about 4 in. In view of this, enterectomy was performed and approximately 14 in. of gut was removed and continuity re-established by end-to-end anastomosis. Post-operative progress was satisfactory, and a year later she is symptomless.

Pathological Report.—"The specimen consists of a resected portion of small intestine 14 in. in length. Ten inches of it, measuring from one end, is deeply congested and shows a condition approaching gangrene. The remaining 4 in. is only slightly engorged and thickened. At the juncture of the two parts there is a pedunculated polyp growing from the wall into the lumen. It is about 1 in. in diameter and roughly spherical, but has an uneven nodular surface and is attached by a thick pedicle. Its surface is irregularly blood-stained. In section the polyp does not show the usual clear demarcation between the glandular part which covers the surface and the fibrous part which forms the pedicle, and an appearance is produced as if there was some degree of invasion of the deeper tissues by the glandular elements. Histologically, the appearance is that of an adenocarcinoma. There is a disorderliness in the arrangement of the gland structures which is not seen in the simple adenoma of the intestine. Gland tubules are irregularly scattered through the connective tissues in the deeper layers and even in the pedicle, and the gland cells show a considerable degree of anaplasia."

It was noted that both patients presented a diffuse brownish pigmentation of the lips and face. On investigating the family history it transpired that the father's brother showed similar pigmentation, and he had been a patient in this hospital in 1935 complaining of attacks of abdominal pain, with the passage of blood and mucus per rectum. A diagnosis of mucous colitis had been made. His health is now satisfactory.

COMMENTARY

The feature of interest is the occurrence of adenocarcinoma of the small gut in father and daughter, causing intussusception. As regards the prognosis of small-gut carcinoma, it is interesting to note that of 31 cases treated at the Mayo Clinic (Rankin and Mayo, 1930) the average duration of life after operation was one year. Harries and Harrison (1935) record two cases of primary carcinoma of the small intestine. Both patients died within three months of the operation, the first with progressive debility and anaemia, the second with metastases in the chest. Mayo and Nettrour (1937) state that the prognosis of carcinoma of the small intestine is unsatisfactory, regardless of whether or not the growth can be removed.

I wish to express my thanks to Prof. J. B. Duguid for the pathological reports, and to Mr. D. J. Harries for his encouragement to report these cases.

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Congenital Deformity of the Ribs

Although clinical interest is mainly concerned with supernumerary ribs in the cervical region, a recent case of deformity of the lower ribs seems unusual enough to be worthy of record.

CASE REPORT

A young woman aged 26 was said to have swallowed a pin, and during radiological examination of the alimentary tract a curious abnormality of the eleventh and twelfth ribs on the right side was discovered. The radiograph of this region (see Fig.) shows the first part of the right eleventh rib curving almost vertically downwards to the level of the intervertebral disk between the eleventh and twelfth thoracic vertebrae, thus forming a kind of neck. The main shaft of the bone then turns away to pursue a normal outward and downward course, but at a considerably lower level than the corresponding rib on the left. At the angle between "neck" and shaft the bone is somewhat thickened, particularly below, and the inferior surface presents a straight facet which articulates with a similar facet forming the top of a short stout process arising from the upper border of the twelfth rib adjacent to the head of the bone.

All other ribs were normal in shape and number; there were no other bony processes, and, although the patient had a scoliosis, radiographs of the spine from the sixth cervical vertebra to the sacrum showed no hemivertebrae.

COMMENT

Congenital deformities are described by Brailsford (1935) as bifurcation of the anterior extremity, or fusion with an adjacent rib or ribs just beyond the tubercles, the latter deformity being associated with multiple hemivertebrae of the dorsal spine and large gaps in the bony framework of the thorax. Under the heading of developmental abnormalities, Brailsford also refers to the bands of bone attached to the ribs in myositis ossificans progressiva, and to osteomata seen in cases of multiple exostoses.

Radiograph showing congenital deformity of the eleventh and twelfth ribs on the right side

In the case reported it was at first thought that the buttress of bone arising from the twelfth rib might be an osteoma or an ossification in the soft tissues. However, the original radiographs showed no other bony processes, and when, in view of a possible myositis ossificans, the thorax was x-rayed again twelve months later no further changes were seen. Moreover, the condition of the eleventh rib is clearly an alteration of shape, presumably developed before ossification took place, and therefore being a true congenital deformity. It does not, however, conform to Brailsford's description, since the ribs are not actually fused and there are no hemivertebrae, and I can offer no suggestion to explain such an unusual development.

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Rupture of Atheromatous Abdominal Aorta

The rarity of complete rupture of an atheromatous plaque combined with the clinical picture of an acute abdomen forms a syndrome interesting enough to merit publication.

A man aged 67 was admitted to hospital with acute abdominal pain; the pain was severe and had come on suddenly at 11 o'clock the previous evening, about half an hour after a meal, since when it had persisted. There was no associated nausea, constipation, or other symptom, and it was located mainly in the right side of the abdomen. On admission his temperature was 97° and his pulse 88. The abdomen was tender and rigid, both in the right hypochondrium and in the right loin, which also contained an indefinite swelling. In the absence of any more definite signs, a non-committal diagnosis of an intra-abdominal catastrophe was made.

At operation a small amount of slightly blood-stained fluid was found in the peritoneum; all the abdominal viscera were normal, but an obvious retroperitoneal haemorrhage was found, mainly on the right side spreading downwards. Pulsation was present in both common iliac arteries, and it was decided that the haemorrhage probably arose from the rupture of an aneurysm of the right renal artery; the abdomen was therefore closed. The patient collapsed soon afterwards and died.

Post-mortem examination revealed widespread severe atheroma of the abdominal aorta, which was thin and friable and contained ulcerated and partly calcified patches. Just above the bifurcation of the aorta one of these atheromatous ulcers had ruptured and produced a large mass of retroperitoneal blood-clot, chiefly on the right side. About a pint of fluid blood was found free in the peritoneal cavity.

My thanks are due to Mr. V. Glendinning for permission to publish this case and to Dr. D. M. Vaux for performing the post-mortem examination.

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