Remarks ON EXTERNAL POLYPOID TUMOURS OF THE STOMACH.

By JAMES SHERREN, F.R.C.S.,
SURGEON TO THE LONDON HOSPITAL, ETC.

AMONG the rarer abdominal tumours requiring surgical intervention are the pedunculated growths springing from the stomach. Usually originating from its posterior surface near the greater curvature they grow into and often become intimately adherent to the lesser peritoneal sac. In a few instances they have sprung from the lesser curvature and grown between the layers of the gastro-hepatic omentum. Erlach¹ has reported an example of this, in which he successfully removed a large myoma from this situation. While the clinical features of the tumours are identical, microscopic examination shows several types.

These tumours are met with most often between the ages of 35 and 55, and are more common in women. I have been able to collect 18 cases in which the sex was mentioned; 13 were women. The characteristic feature of a case of this nature is the discovery of a tumour in the upper or mid abdomen in a patient whose chief or only complaint is abdominal discomfort. Occasionally the presence of an abdominal swelling is the only thing noticed. The tumours are smooth and rounded, often cystic and movable from side to side. In a woman the diagnosis of an ovarian tumour is almost inevitable if the tumour is large and fills the mid and lower abdomen. Operations were undertaken with this diagnosis in several cases (Herman,² Cantwell,³ Maylard,⁴ v. Eiselsberg⁵).

The following case, in which the diagnosis was made before operation, illustrates some of these points:

J. M., a man of 57, was under my care at the London Hospital in February, 1911. He had suffered from "indigestion" for twenty years. This consisted of epigastric pain immediately after meals with much flatulence. He had always been constipated, and in addition had had two attacks of colicky abdominal pain at intervals of a year. He was a healthy-looking man. The appearance of his abdomen was such that had the condition occurred in a woman the diagnosis of an ovarian tumour would almost certainly have been made. Just below the umbilicus an irregular rounded mass was visible; it did not move on respiration, but was freely movable laterally. It gave the impression of a tense cyst. His liver was not enlarged, urine was normal, and examination of the gastric contents after a test meal revealed normal acidity.

At operation I found a large, rounded, nodular tumour covered by transverse colon and omentum. After separating adhesions I found it was springing from the posterior surface of the stomach close to the middle of the greater curvature by an attachment measuring about an inch (*vide figure*). This I clamped, and then removed the tumour and closed the opening in the stomach. After removal of the tumour I discovered several small nodules of growth in the liver on its under surface.

He left hospital fourteen days later and I heard in May that a large mass had developed in the liver, and he had taken to his bed.

The tumour weighed 6½ lb. The large rounded mass was cystic, and contained altered blood. The smaller nodules were solid. Microscopic examination showed masses of elongated cells, apparently grouped around capillaries, such as is seen in endotheliomata. Myxomatous degeneration was present in many places. On examining a section of the stomach wall the growth was found to be continuous with its serous coat, but was not involving the muscular or mucous coats.

Tumours of this type have certain features in common; they are mesoblastic in origin, and usually form polypoid masses hanging from the greater curvature of the stomach into the lesser sac, to which they become adherent. Their exact nature is only discovered on microscopic examination. They are usually malignant, and may start in the submucous, muscular, or serous coats, but do not involve the mucous membrane. When originating in the first and last situations they are always malignant, but tumours described as myomata may grow from the muscular coat and present no sign of malignancy. In other cases with similar microscopic characters secondary deposits have been found—leiomyoma malignum. Thus in 14 recorded cases of operation for gastric myoma 4 were of this nature.

Although rarely met with, myomata are the most common benign tumours of the stomach. Deaver and Ashurst⁶ have been able to collect over 40 cases of gastric myoma. Of these about half were external. Most of the tumours, however, have proved to be malignant, either myo- or fibro-sarcomata, a few endotheliomata. All are liable to myxomatous change, which may lead to cystic formation; this may also occur as the result of haemorrhage. The rarest type appears to be that to which the tumour in my case belongs, first

The label is attached to the portion of stomach removed with the tumour.

described by von Bergmann⁷ as endothelioma carcinosum and considered by him to have its origin in the omentum. Borrmann, in an excellent paper "Ueber Netz und Pseudo-Netz tumoren nebst Bemerkungen über die Myome des Magens," is of opinion that it belongs to this group, and from the account which he quotes it is highly probable. Nichols⁸ and later Maylard⁹ have described similar cases. Salaman,¹⁰ writing of sarcoma of the stomach, grouped these cases under the term "polypoid sarcomata." It is a useful clinical term to distinguish this form of tumour.

Diagnosis of their exact nature is impossible before operation. Treatment should be by removal with wide resection of the gastric wall from which the tumour springs.

REFERENCES.

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- ⁴ Maylard, *Annals of Surgery*, 1910, vol. lli, p. 506.
- ⁵ v. Eiselsberg, *Archiv klin. Chir.*, Bd. 40, 1897, p. 599.
- ⁶ Deaver and Ashurst, *Surgery of the Upper Abdomen*, 1909, vol. i, p. 214 et seq.
- ⁷ Von Bergmann, quoted Borrmann, *Mitt. aus den Grenzgeb. der Med. und Chir.*, 1900, Bd. 6, S. 543.
- ⁸ Nichols, *American Practice of Surgery*, 1906, vol. i, 339.
- ⁹ Maylard, *loc. cit.*
- ¹⁰ Salaman, *Transactions of the Pathological Society of London*, vol. lv, Part III, 1904, p. 324.