SARCOMA OF SMALL INTESTINE.

REPORT OF THREE CASES.

BY

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THE article by Messrs. Moir and Walker on sarcoma of the small intestine, in the *British Medical Journal* of December 29th, 1928, prompts me to record three further cases.

CASE I.

Mrs. J. P., aged 59, was admitted to the Auckland Hospital complaining of passing much dark blood per rectum for twenty-four hours. She had not vomited. She had suffered from indigestion for years. Her condition was very low from loss of blood. A transfusion of blood and a subcutaneous injection of

Sarcoma of duodenum (Case I). A, Pylorus. B, Bristle emerging from bile duct. C, Centre of one half of tumour. D, Other half of tumour; area of haemorrhage. E, Termination of duodenum.

normal saline were given, but the patient gradually sank, and died within twelve hours of admission.

Necropsy revealed the scar of a healed ulcer in the first part of the duodenum. On the lateral aspect of the lower end of the second part of the duodenum a spherical solid tumour the size of a walnut was found. It appeared to be growing from the muscular coat of the duodenum, being well encapsuled where it lay in contact with the head of the pancreas. It projected slightly into the lumen of the duodenum, being covered loosely, in this area, by mucosa, except at the most elevated portion. At this point the termination of a vessel about 1 mm. in diameter was seen lying in the tumour, its lumen plugged with recent clot. This vessel had doubtless been the source of the haemorrhage. On section the tumour was whitish and firm, except in two or three areas where haemorrhage had occurred. Microscopically the tumour was a spindle-celled sarcoma, remarkably uniform throughout, with areas of haemorrhage. No metastases were found.

CASE II.

Mrs. E. K., aged 23, was admitted to the Auckland Hospital in a very exhausted and toxic state. Two gallons of fluid were withdrawn from the abdomen. The patient sank, and died the next day. Three years before her death she had had a lump removed from the left groin. It was a well-encapsuled egg-shaped growth in the region of the femoral glands, and was black on section. Microscopically it was a melanoma, intensely pigmented, with no trace of lymphoid tissue. The wound was slow in healing. A melanotic mole one-eighth of an inch in diameter was noticed on the calf of the leg. Sixteen months before her death she had been again admitted, this time for nagging pain in the right side of the epigastrium of three months' duration. A mass could be felt, and x-ray photographs showed constant irregularity in the upper half of the descending portion of the duodenum. Laparotomy revealed a "large pyloric and duodenal mass which was melanotic." A small portion was excised for microscopical examination and the abdomen closed.

At necropsy a large melanoma occupying the whole circumference of the wall of the second and third parts of the duodenum was found. The lumen was greatly enlarged and was lined by the necrotic surface of the tumour. The common bile duct was obstructed. At no point did the growth penetrate the peritoneal coat of the duodenum, and at its upper and lower limits its edges were heaped up and sharply defined, as in an epithelioma. No other metastases were found. Microscopically the growth was a heavily pigmented melanoma, submucous in origin, though the mucosa was lost everywhere except at the edges.

CASE III.

Mr. D. M., aged 60, sought advice on account of increasing pallor, which was causing anxiety to his family. He said also that he suffered from vague nausea and anorexia, slight constipation, and a loss of business acumen. Ten years previously he had had a mole removed from behind the right ear, and nine years previously a large mass of glands from the right side of the neck. Neither of these tissues was examined microscopically, but the former was believed to be a melanoma, and the latter malignant, and secondary to the mole. A bad prognosis had been given after the second operation, which was undertaken at the wish of the patient.

Examination revealed a marked pallor suggesting pernicious anaemia. The blood picture showed the changes of an ordinary secondary anaemia, without abnormal cells. In the abdomen a mass the size of a large orange could be felt to the left of the umbilicus. It was apparently free from the spleen, kidney, and stomach, being mobile but not influenced in position by respiratory movements. It was slightly tender.

Operation was undertaken, and a large bulbous growth in the jejunum, 16 inches from the duodeno-jejunal flexure, was resected and an end-to-end anastomosis performed. No metastases were discovered in the mesenteric glands or liver. Normal convalescence was reported until the fifth day, when sudden death occurred. This was attributed to a cardiac condition. A post-mortem examination was not made.

Examination of the specimen showed a segment of jejunum about three inches long to be greatly enlarged by a heavily pigmented growth occupying the whole circumference of the wall of the bowel. The thickness of the growth varied from half an inch to one and a half inches; its edges were sharply defined and heaped up; the lumen was enlarged, and lined by the surface of the growth, which at no point penetrated the peritoneal coat. Microscopically the tumour was a melanoma.

I am indebted to Mr. Eisdell Moore, Mr. Kenneth Mackenzie, and Mr. Frank Macky, under whose care these patients were admitted, for permission to publish these notes, and to Dr. W. Gilmour, director of the Auckland Hospital laboratory, for advice on the pathological side.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TELESCOPIC MOVEMENT IN FRACTURES.

THE above is a sign I have not previously seen described, but have found very useful in deciding if one has secured end-to-end apposition in the reduction of fractures of long bones. It is comparable to the "telescopic motion" in congenital dislocation of the hip-joint, but is more easily and certainly elicited than the sign in hip-joint dislocation. It is particularly useful in transverse, or approximately transverse, fractures of the shafts of those long bones which are well covered by muscles, such as the forearm, the thigh, and to a less extent the tibia.

End-to-end apposition. No telescopic movement.

Failure of reduction. Telescopic movement present.

For example, take the common fracture of both bones of the forearm with displacement of the fragments, causing loss of end-to-end apposition. With the patient under ether anaesthesia, helped if available by a radiogram, the fractured ends of the radius are palpated, and then, by increasing the deformity, a purposive movement is made to secure end-to-end apposition of the radius. The limb is then straightened, and a gentle attempt to telescope the forearm is made. If end-to-end apposition has been secured no telescopic movement can be obtained. It may be necessary to manipulate several times before telescopic movement is lost. The ulna with its palpable subcutaneous