A CASE OF ADENOMATOUS PAPILLOMA OF THE DUODENUM

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(With Special Plate)

The rarity of this condition is evidenced by the following short review of the literature. Camp¹ in 1924 reported a case of myoma of the duodenum. Golden² in 1928, from a thorough review of the literature on non-malignant duodenal tumours, collected seventeen cases, and recorded two others from his own clinic. A further survey was undertaken by Balfour and Henderson³ in 1929, when four additional cases were placed on record, all of which were proved to be adenomata, one being of the polypoid type. Bookman⁴ in 1930 described another case, and Waters⁵ in the same year reported a case of papilloma in the duodenum prolapsing through the pylorus from the stomach.

CASE HISTORY

The patient, a woman of 63, had from early adolescence experienced gastric symptoms, which apparently became more pronounced ten years ago. Since then she had constantly been under dietetic and alkaline treatment. From 1926 onwards symptoms suggested duodenal ulcer, and during this period she experienced several attacks of melaena. A radiological diagnosis of duodenal ulcer was made in November, 1926. In October, 1929, as no improvement had resulted from careful medical treatment, a further investigation was carried out.

On examination, the patient was in poor general condition, and suffering from a secondary anaemia. Except for some tenderness over the upper part of the right rectus muscle, there were no physical signs in the abdomen. A test meal showed complete achlorhydria. Occult blood was found in the stools.

X-RAY INVESTIGATION

Owing to the weakness of the patient, a radiological examination had to be made in the supine position. A breakfast-cupful of barium was given. The stomach was of good tone, and showed very active peristalsis. Barium output was small, and the stomach took five hours to empty. A skiagram taken soon after the meal showed a contracted duodenal cap, but a dilatation of the descending limb (Fig. 2 on Plate). A second skiagram, taken some ten minutes later, showed that about eight inches from the duodeno-jejunal flexure a small length of jejunum was dilated, with a narrowing beyond. (Fig. 3.) The passage of barium was held up at this point for a space of five to ten minutes. Dilatation of the duodenum was now less apparent. The remainder of the gastro-intestinal tract showed nothing abnormal.

The presence of a contracted cap and the slow emptying of the stomach led to a diagnosis of stenosed duodenum resulting from duodenal ulcer. To explain the dilated duodenum and jejunum was much more difficult. All the known lesions of the duodenum and jejunum were considered, but a definite diagnosis could not be made, and the remote possibility of a hair-ball was suggested. In view of the x-ray findings and the unsatisfactory response to prolonged medical treatment, operation was advised.

FINDINGS AT OPERATION

The first and second portions of the duodenum were distended, and a sponge-like mass was seen shining through the wall. On palpation this could be pushed down to within a few inches of the duodeno-jejunal flexure. The duodenum was opened longitudinally, and a cauliflower-like mass (Fig. 1), was found attached to a point on the posterior wall about one inch distal to the pylorus, by a pedicle two and a half to three inches in length. The mass completely filled the lumen of the intestine. The base was excised, and

the wound in the posterior wall sutured with catgut. The incision in the duodenum was continued through the pylorus into the stomach, and a modified Mikulicz pyloroplasty performed. The appendix, which was found to be very thickened and adherent to the caecum, was removed. The patient made an uninterrupted recovery. The pathological report stated: "The growth is a simple adenomatous polypus on a fairly narrow-stalked base. The character and arrangement of the glandular tissue do not suggest any malignant tendency."

CONCLUSIONS

1. In this case, as in similar cases already recorded, great difficulty was experienced in establishing a diagnosis. The clinical features strongly suggested either a prepyloric or a duodenal ulcer. A mild duodenitis, resulting from the continued mechanical irritation of the duodenum by the tumour, might account for the symptoms.

2. Persistent melaena was a constant feature.

3. With a tumour of this size, having such an unusually long pedicle, it is surprising that no obstructive symptoms arose.

4. The x-ray appearances do not conform to those in cases already reported. The curious appearance of the distended jejunum was misleading, and may have prevented the making of a correct diagnosis. The question of polypus had been considered.

5. As far as can be ascertained, these papillomata do not show any tendency to malignant degeneration.

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ATROPHIC COARSE CIRRHOSIS OF THE LIVER IN A CONGENITAL SYPHILITIC

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The following case appears to be of sufficient clinical interest to warrant a detailed account of the various stages leading to the development of a coarse atrophic cirrhosis of the liver. Owing to the continuous detention of the patient in a mental defective institution from the early age of 8, alcohol, the common causal factor, can be completely excluded.

There has always been some doubt as to the exact etiology of cirrhosis of the liver. Muir¹ states that "the same causal agent does not always produce the same result, nor is a given type of cirrhosis always produced by the same cause." Muir, Delafeld, and Prudden,² however, agree that a coarse nodular cirrhosis may develop as a sequel to the rarer form of congenital syphilitic cirrhosis. The case described below seems to confirm this view.

F. Y., a young female imbecile of 8, was admitted to the Darent Training Colony in 1903. She suffered from congenital syphilis, was rather dull, and required constant attention. She was transferred to Caterham Mental Hospital in 1909. Her general health appeared to be quite good until 1922, when she was confined to bed for one week on account

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COMMON BILE-DUCT

FIG. 1.—Specimen showing the opened dilated common duct and its relation to surrounding structures.

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OF THE DUODENUM

FIG. 1.—Growth removed from duodenum. (Piece of match is 1 inch long.)

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FIG. 2.—First radiograph, showing contracted cap with dilatation of descending limb of duodenum.

FIG. 3.—Second radiograph (10 minutes later), showing dilatation of jejunum with constriction below. [Relatively reduced.]