Two Unusual Small Intestinal Neoplasms, both with Anaemia

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The first was an annular carcinoma in a single woman of 50. She was first admitted to the London Hospital under the Gynaecological Dept. with bilateral ovarian cysts. The Hb. was 46%. The stools were not examined. At laparotomy the ovarian swellings were found to be secondary neoplastic, and the primary tumour was seen in the jejunum about 9" below the duodeno-jejunal flexure. The ovarian cysts and uterus were removed. The annular carcinoma of the jejunum was removed with end-to-end anastomosis. Following operation her recovery was satisfactory. The Hb. rose but she was later found to have secondaries in the pelvis.

The pathological records at the London Hospital from 1908 to the end of 1952 record 13 cases of primary carcinoma of the jejunum. Of these, 13,9 were at or very close to the duodeno-jejunal flexure. 12 of the 13 were annular and the remaining 1 was polypoid.

The second was a leio-myo-sarcoma of the duodenum in a married woman aged 46. Since just after the war – about 1946, she had had fainting attacks. Early in 1952 these had been much more severe

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and she had consulted her doctor about them. Later in the year she was seen in hospital where, following a gastro-intestinal haemorrhage a lump was felt.

At a later examination the lump could no longer be felt. Barium meal and barium enema revealed no abnormality. She had a further haemorrhage and laparotomy was therefore carried out. The tumour was found arising from the lowest part of the second portion of the duodenum. It was extending forwards into the meso-colon. The tumour had drawn a pouch of duodenal mucosa into its substance to form a diverticulum, this contained blood. The tumour was excised. Later a gastro-enterostomy was necessary, as in closing the duodenum the lumen was constricted. After this her recovery was satisfactory.

The London Hospital records over the same period show 5 cases, with similar histological reports, in the small intestine – the small intestine being defined as that part of the gut between the pylorus and ileo-caecal valve – one other occurred in the duodenum. In this the contents were infected and had ruptured giving rise to peritonitis. At P. M. the patient was found to have cirrhosis of the liver. Of the 4 cases in the ileum and jejunum, 3 had grown outwards with pseudo-diverticula formation. The contents of 2 were pus and in 1 blood. The fourth case, a solid tumour growing into the lumen of the gut, had presented with an intussusception.

Discussion

Dr. Denys Jennings: There are one or two points of clinical interest in Mr. Richardson's second case of a duodenal leio-myo-sarcoma. When she was admitted to hospital urgently after a bad haemorrhage in July 1952, the physicians felt a mass at the site of the tumour. A few days later, the mass could no longer be felt, and no one took the initial finding sufficiently seriously. A

barium meal showed nothing amiss. A barium enema was reported as negative, but actually one film shows what is obviously an extrinsic tumour indenting the transverse colon. Six weeks later, towards the end of August, the patient had a second bad haemorrhage, and the mass again became palpable.

As soon as we saw the specimen at operation, the explanation was obvious. I had a vague memory of having read of similar cases in the older literature. An intramural neuroma or leiomyo-sarcoma grows outwards and forms a pedunculated sub-peritoneal tumour. This breaks down and cavitates. A pseudo diverticulum, which is sometimes very large, communicates with the lumen of the gut by a narrow neck. Digestive secretions accumulate inside it and, sooner or later, there is massive bleeding. The soft-walled diverticulum becomes tense with blood, and forms an easily palpable mass. Later on, as the blood digests and drains away into the gut, the tumour becomes soft again, and it is impossible to palpate it.