A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

ST. GEORGE'S HOSPITAL.

TWO CASES OF SARCOMA DERIVED FROM THE PERIRENAL RETRO-PERITONEAL TISSUE ON THE RIGHT SIDE CONTAINING A PSEUDO-CYST.

(Under the care of Dr. H. D. ROLLESTON and Mr. G. R. TURNER.)

THE importance of the subperitoneal tissue as a site for new growths and other morbid processes was not fully recognised before the late Mr. William Anderson's very able paper read at the Carlisle meeting of the British Medical Association. Most of the retro-peritoneal sarcomata grow but slowly; a very good instance of this was reported by Meeringer.¹ Histologically the majority of these growths are spindle-celled sarcomata with a varying amount of fibrous tissue.

CASE 1.—A woman, aged 41 years, was admitted into St. George's Hospital in June, 1899, with the history that she had previously had some signs of more or less intestinal obstruction and was losing flesh. She was a spare woman, with a hard, moveable tumour rather smaller than a cricket-ball in the right iliac and lumbar regions. She had no abdominal distension or signs of intestinal obstruction, but it was thought that she might have malignant disease of the cæcum which did not involve or obstruct the ileo-cæcal valve. After she had been in the hospital for some time she became insane and refused to take her food, so that nasal feeding became necessary. This suggested that there was possibly a secondary tumour in the brain; ophthalmoscopic examination showed that the optic discs were normal. The mental condition continued and, getting weaker, she died.

Necropsy.—At the post-mortem examination, which was performed by Dr. Lazarus-Barlow, the pia-arachnoid of the brain was found to be opaque as in chronic alcoholism, but otherwise the brain presented no gross lesion. In the abdomen a tumour surrounded by a capsule was found lying behind and to the right of the second part of the duodenum and almost in contact with the hilum of the right kidney. The growth had no structural connexion with the kidney, ureter, or suprarenal capsule, all of which were healthy. It was adherent to the right side of the second part of the duodenum. On slitting up the latter a raised crater-like orifice as big as the end of the little finger was found in the lower part of the second portion of the duodenum, well below the opening of the biliary papilla (*vide* Fig. 1). This sinus led into a pseudo-cyst (*vide* Fig. 2) contained in the tumour, evidently produced by breaking down of the white growth. There were no growths elsewhere, and except for a small lipoma attached to the mucous surface of the ileo-cæcal valve the other organs were natural. The tumour appeared to have arisen in the retro-peritoneal tissue over the kidney close to the second portion of the duodenum and subsequently to have become adherent to the bowel. It did not appear to have originated in the wall of the duodenum. The tissues round about the tumour were very lax and readily allowed the tumour to move downwards towards the right iliac fossa. This probably accounted for the tumour having during life appeared to be in the region of the cæcum.

Microscopically the growth was a medium-sized spindle-celled sarcoma showing fibrification; in some places smooth muscular fibres with rod-shaped nuclei were present; but the mass of the tumour was undoubtedly sarcomatous. Sections taken from the wall of the pseudo-cyst showed inflammation and necrotic changes.

For the excellent drawings illustrating this case we are indebted to Dr. E. A. Wilson.

CASE 2.—A man, aged 45 years, was admitted into St. George's Hospital with pain in the right hypochondrium which radiated to the shoulders. In the last three months he had lost a stone in weight. There was no history pointing to the likelihood of hydatid infection and syphilis was denied. Two years before he had jaundice and lead colic. He was a thin man with some emphysema of the lungs, but otherwise the thoracic organs were normal. In the abdomen there was a hard tumour continuous with the liver and in the position of the gall-bladder, which bulged into the loin. The surface of the tumour was irregular and a grating sensation suggesting peritoneal friction could be felt over it. There was no thrill or fluctuation. The percussion note over it varied, being sometimes dull and sometimes partially resonant. The urine was natural and there was no jaundice. The diagnosis lay between a renal growth and a tumour growing from the under surface of the right lobe of the liver. He was put on full iodide treatment but without any beneficial result. After he had been under treatment for a fortnight he had pain in the right testicle pointing to some interference with the renal plexus. As the man desired to have something done to relieve his pain Mr. G. R. Turner saw him and agreed to perform an exploratory operation, with a view of, if possible, removing the tumour.

The operation was performed on May 11th, 1900. An incision made in the right linea semilunaris exposed a tumour of the size of a child's head arising from the region of the right kidney and projecting up under and below the right lobe of the liver from which, except for adhesions to the gall-bladder, it was quite free. The tumour had a vascular capsule, but save for its connexions to the back of the abdomen was not united by adhesions to any of the abdominal viscera except the gall-bladder from which it was peeled off. At the back of the abdomen, however, it appeared to be adherent to the inferior vena cava, above, and to the right of, the mesentery. Considering the freedom of the tumour from adhesions and its large size it seemed probable that it might not be a malignant tumour and that its removal, though a formidable task, was justifiable. The capsule contained a number of large veins and bled freely on being incised. Several layers of fibrous tissue were cut through and it was then found possible to peel the capsule off the tumour. The very deep connexions of the tumour to the back of the abdomen made entire removal so dangerous that it seemed safer to remove as much as possible of the tumour piecemeal. This was accordingly done and resulted in the removal of nine ounces of whitish-grey growth closely resembling to the naked eye a fibromyoma of the uterus undergoing early myxomatous degeneration. There was no cavity or pseudo-cyst in the tumour. Some of the tumour together with its capsule was left behind.

Microscopically the tumour was a fibrifying sarcoma composed of medium-sized spindle-cells with oval nuclei. In places there was commencing necrosis of the new growth. A few muscular fibres, with rod-shaped nuclei, probably derived from the subperitoneal tissue where they are normally present, were seen.

A considerable quantity of blood-stained discharge necessitated the dressings being renewed twice in the first 24 hours. Sickness then set in, but was relieved after the plugs of gauze were removed. The patient slowly recovered, and the wound having almost healed he left the hospital, but he returned in August with increase in the size of the tumour and pus discharging from a sinus about the middle of the wound. The patient developed a hectic temperature, had rigors for a week before death, and rapidly went down-hill.

Necropsy.—At the post-mortem examination, which was performed by Dr. O. F. F. Grünbaum, it was found that there was a large white tumour adherent to the scar, the under surface of the right lobe of the liver, and the small intestines. It arose from the retro-peritoneal tissues over the right kidney, and though readily separated was adherent to the outside of the capsule of the kidney in its anterior third. The right suprarenal body was healthy and independent of the growth. The growth, which was lobulated and of the size of a man's head, contained a central cavity filled with about three-quarters of a pint of dark brown very offensive fluid—sanious pus. There were no secondary growths in the body.

Microscopically, the growth was adherent by its capsule to the surface of the liver; but there was no invasion of the liver by new growth. The tumour had evidently contracted

¹ Wiener Allgemeine Medicinische Zeitschrift, 1898, No. 34.

FIG. 1.

Interior of the second part of the duodenum showing crater-like orifice through which the pseudo-cyst in the sarcoma discharged. The outside of the tumour is also seen. A pointer is shown passing through the perforation. (Case 1.)

FIG. 2.

Pseudo-cyst in the sarcoma opening into the duodenum showing ragged internal aspect of growth. A pointer is placed in the communication between the pseudo-cyst and the duodenum. (Case 1.)

inflammatory adhesions as the result of the operation to the neighbouring parts, and had softened down in the centre into a pseudo-cyst. In other respects it was much the same as at the operation. Microscopically, it was a medium-sized spindle-celled sarcoma. As in the growth removed at the operation there were areas where the growth was fibrifying. Examination of the walls of the pseudo-cyst showed necrotic changes and infiltration with red and white blood corpuscles.

Remarks by Dr. ROLLESTON and Mr. TURNER.—The points of interest are as follows. 1. The occurrence of encapsulated sarcomata arising from the retro-peritoneal tissue over the right kidney. Retro-peritoneal sarcomata are uncommon; Gurlt found that in 14,630 tumours examined at Vienna, of which 894 were sarcomata, there was only one from the retro-peritoneal space. In an analysis of 61 recorded examples tabulated by Dutton Steele¹ it appears that the right side of the body is more often affected, but no explanation for this is forthcoming. 2. Though histologically sarcomatous, parts of both tumours presented an appearance which might be taken to suggest that a fibromyoma had become transformed into a sarcoma. That this was the case in this instance we do not believe; it is more probable that the smooth muscular fibres were included in the growth and were those found in the retro-peritoneal space. Smooth muscular fibres were present in two retro-peritoneal sarcomata collected by Steele. It may, however, be pointed out that retro-peritoneal leiomyofibromata have been described² and that uterine fibromyomata may undergo sarcomatous change.³ 3. The freely moveable condition of the tumours (in Case 1 at the necropsy and in Case 2 at the operation), their encapsulation, the general absence of infiltration, and the fact that there were no secondary growths show that in spite of their sarcomatous structure the growths were comparatively benign. 4. The formation of pseudo-cysts in the centre of both these tumours. This would appear to be fairly common in tumours derived from the retro-peritoneal space; in his 61 cases Steele found this change in 35 per cent. It is probable that in our cases the cyst formation was due to inflammatory and necrotic changes set up by infection, in Case 1 from the duodenum and in Case 2 from the operation wound. 5. The great difficulties that may arise in the complete removal of growths derived from the retro-peritoneal space, even when, as in our cases, the tumours are more or less pedunculated. In Case 2 the growth was adherent to the inferior vena cava and so could not be entirely removed, while in Case 1 the duodenum would have to have been opened had removal been undertaken. In other cases of retro-peritoneal sarcomata that we have seen the growth has been flattened and spread out behind the peritoneum, and operation, which was not suggested, would, if attempted, have been quite futile.

¹ American Journal of the Medical Sciences, March, 1900, vol. cxix., p. 311.

² Vide Anderson: Surgery of the Subperitoneal Tissue, Brit. Med. Jour., vol. ii., 1896, p. 1093; Sheild: Transactions of the Royal Medical and Chirurgical Society, London, vol. lxxx., p. 205.

³ Finlay: Transactions of the Pathological Society of London, vol. xxxiv., p. 177; Doran, Ibid., vol. xli., p. 206; and Dickinson, W. L., Ibid., vol. xlv., p. 184.

HEALTH MATTERS IN POPLAR.—The energetic medical officer of health of the borough of Poplar, Mr. F. W. Alexander, has recently issued a circular to the owners and occupiers of wharves, factories, and workshops dealing with the question of rats and the plague. He asks that if any unusual mortality is detected among rats he should immediately be informed of the same. He also gives notice that arrangements have been made with Dr. E. Klein for the bacteriological examination of the body of any rat which it is thought desirable should be examined. Mr. Alexander has also made a report to the Housing Committee of the borough which embodies various opinions and suggestions already made as to the best manner of carrying through a reform in the all-important question of the housing of the poor. Besides these opinions Mr. Alexander adds some suggestions of his own which are eminently practical. The sanitary authority has also issued some admirable hints regarding the management of infants, drawn up by their medical officer of health for gratuitous distribution. The appalling manner in which the children of the poor are fed is only too well known to every hospital physician and so far as instructions go those of Mr. Alexander are admirable, but poverty, laziness, and, we must add, the despair born of the perpetual struggle for bread and money for the rent go far to do away with the effect of any instruction.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Exhibition of Cases.

A CLINICAL meeting of this society was held on April 26th, Sir R. DOUGLAS POWELL, the President, being in the chair.

Sir HUGH BEEVOR exhibited two Healthy Left-handed Adults to illustrate the normal thoracic resonance in left-handed persons. They afforded positive proof that the lesser resonance of the right chest in right-handed persons was due to the greater muscular development on that side. He remarked that in the absence of emphasis upon this point in text-books mistakes were still often made and disease was wrongly suspected. Dr. W. H. Brazil¹ had emphatically called attention to this point in left-handed persons. It might be noted in these cases that the pulmonary resonance did not rise so high above the left clavicle as above the right. The diminished resonance, or higher note, could be detected below the clavicle quite distinctly in the younger man. He had found no reason to suspect that either patient was the subject of disease. These observations were repetitions of others which he had made formerly upon left-handed persons.—The PRESIDENT asked Sir Hugh Beevor whether he had invariably noticed that in right-handed persons the percussion resonance extended higher on the right than on the left side.—Dr. PERCY KIDD asked whether the normal defective resonance was chiefly in the apical region or whether it was universal.—Sir HUGH BEEVOR in reply, said that he had not found the difference on the two sides an invariable rule, but it was a common occurrence. It was his practice to carry the resonance up above the clavicle as high as possible, and it did not generally extend as high on the right as on the left whereas in these left-handed persons it extended highest on the right.

Dr. F. G. STILL exhibited a case of Unusual Obesity in a Child, aged seven and a half years, who weighed 4 stones 11½ pounds and measured only 42½ inches in height. He was very thin a year ago, when he became rapidly fatter; since that time there had been a steady increase of fat, and during the last two months he had been somewhat short of breath. Within the last three weeks the lower part of the abdomen and the upper parts of the thighs had shown irregular bluish-red lines, where the skin was thinned and shiny with dilated venules, evidently analogous to "lineæ gravidarum." A month ago he awoke one morning quite blind, but otherwise in his usual health; the blindness lasted 48 hours. Sight was normal when the child awoke on the third morning. He complained occasionally of some pain "like pins and needles" over the vertex of the head; but otherwise there had been no pain anywhere. At the age of three and a quarter years the child had some severe illness which began with convulsions and was called "peritonitis." It lasted four months and since then the abdomen had always been rather large. With the exception of an attack of measles at the age of four years the child had had no other illness. One brother had had pulmonary tuberculosis, and there was some more distant history of tuberculosis. The other members of the family were all thin. There was some hair over the pubes, which was said to have been present for two years; the child's voice was not gruff. The right testicle was normal; the left was not felt. The thyroid gland could not be felt; it was certainly not enlarged. The viscera seemed to be normal. The heart showed nothing abnormal except an occasional slight irregularity of rhythm and marked accentuation of the second sound in the aortic area.—Dr. NORMAN DALTON remarked that this case, excepting in point of age, resembled one which he had seen last year. The patient was a woman, aged 30 years, who in the course of a few months had developed obesity, a growth of hair on the face, a dark complexion, with certain symptoms of Graves's disease—viz., thyroid enlargement and tachycardia. The child in Dr. Still's case had a rapid pulse. His (Dr. Dalton's) patient had rapidly entered the typhoid state and had died. He believed that the two cases resembled each other.—Sir DYCE DUCKWORTH had met with sporadic

¹ Brit. Med. Jour., Oct. 26th, 1889.