attacks the efferent loop of jejunum was seen to enter the stomach. The patient underwent an immediate operation but no evidence of an intussusception was found. It had evidently undergone spontaneous reduction.

Cases have been reported following partial gastrectomy as well as following gastro-enterostomy, Allen E. Grimes (1949) and W. L. McNamara (1944). They made the observation that there seemed to be no correlation between the incidence of intussusception and the size of the stoma. That would appear to be a widely held opinion.

Shackman has made a plea for early diagnosis. He states that of those cases not operated on within the first 24 hours 50 per cent. die. As has previously been noted, early diagnosis can be extremely difficult. When a patient develops recurrent attacks of colicky epigastric pain with repeated blood-stained vomit, combined with upper abdominal distension and absence of rigidity, the diagnosis is relatively easy, but may have been made too late. The condition should be considered in any patient who complains of abdominal pain and vomiting following a gastro-enterostomy.

Treatment

It is now generally realized that provided the condition is recognized early enough, manual reduction of the intussusception can be carried out at operation without any difficulty, and the results will be satisfactory in all cases.

Before the first operation in this case there was a delay of 36 hours. However, the patient did not develop the severity of vomiting which develops in cases where operation is delayed, mainly due to the fact that she had a Ryle's tube down, which was aspirated hourly, and her fluid intake was maintained by intravenous infusions of isotonic saline and 5 per cent. dextrose. On both occasions there was no difficulty in manually reducing the intussusception, but in both cases an attempt was made to prevent recurrence. Because of lack of previous knowledge it turned out that I had performed the same manoeuvre which had been carried out at the first operation, namely the hitching up of 4 in. of the efferent loop of the jejunum to the transverse colon. Therefore there seems to be no reason why she should not develop an intussusception for the third time.

Various measures have been suggested for preventing recurrence, namely:

1. Undoing the gastro-enterostomy and reforming it.
2. Entero-enterostomy between the afferent and efferent loops.
3. Partial gastrectomy.

Naturally, as this is only the second case of recurrent gastro-jejunal retrograde intussusception to be reported, it is very difficult to judge the efficacy of these methods.

Shackman reported the occurrence of a case even though entero-enterostomy had been carried out at the time of the gastro-enterostomy.

My thanks are due to Mr. D. McK. Sutherland, under whose care the case was admitted, for permission to publish this article.

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**NON-OSTEGENIC FIBROMA OF BONE**

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The term non-osteogenic fibroma of bone was first used by Jaffe and Lichtenstein in 1942 in order to describe a benign neoplasm of bone which, in their opinion exhibited characteristic clinical, radiological and pathological features. They defined the lesion as a benign tumour derived from mature marrow connective tissue which showed no evidence of ossification. In the latter respect it becomes distinguishable from other fibromas of bone in which evidence of osseous metaplasia is always present and it is for this reason that the prefix ‘non-osteogenic’ has been employed.

**Clinical Appearances**

All cases hitherto recorded have occurred between the ages of 6 and 21 years and with the
Radiological Appearances

The lesion occurs in the upper or lower third of the shaft of a long bone and is always an inch or so removed from the epiphyseal plate of cartilage. It appears as an eccentrically placed area of rarefaction showing confluent or discrete locules with an encapsulating sheath of bone on its medullary aspect. There is no sign of sub-periosteal new bone formation and the cortex of the bone may appear either to be thinned or expanded but its continuity is always intact. It occurs in order of frequency in the tibia, fibula, femur, ulna and humerus and Lichtenstein (1952) describes the lesion as 'hugging the cortex,' but he emphasizes the fact that in a narrow tubular bone such as the fibula or ulna, it may come to occupy the full width of the bone, thus increasing the likelihood of pathological fracture and also adding to the difficulty of radiological diagnosis. It is entirely a solitary lesion and the remainder of the skeleton reveals no other abnormality.

Pathological Appearances

On macroscopic examination the lesion appears as either brown or yellow foci of firm fibrous connective tissue which may be outlined by a thin shell of sclerotic bone. Microscopically the brown foci are composed of a stroma of spindle cells arranged in whorls in which are scattered multinuclear giant cells. Granules of haemosiderin are found in the cytoplasm of both the stromal and the giant cells and it is this feature that is responsible for the brownish colour. The yellow lesions are basically similar in appearance to the brown with
the addition of nests of lipoid containing foam cells. Generally speaking the more yellow the focus the more foam cells and the less haemosiderin granules and giant cells does it contain. The significance of this reciprocal incidence of foam cells on the one hand and haemosiderin granules and giant cells on the other is not fully understood. In any one individual lesion both yellow and brown foci together with intermediary stages between them may be found, but in no cases has there been any evidence of osteogenesis.

Case Report
H.A., a male child of 11 years, first came to hospital because he had sprained his knee three weeks previously. On examination his discomfort was considerably less than at the time of injury and there were no abnormal physical signs present in or around the knee, yet an X-ray examination revealed an eccentrically placed loculated area of rarefaction situated in the lower third of the femur about 2 in. away from the epiphyseal line. There was a thin encapsulating sheath of sclerotic bone on the medullary aspect of the lesion and although there was some slight expansion of the bone, there was no thickening of the cortex nor sub-periosteal new bone formation (Figs. 1 and 2). No other abnormality was found in the remainder of the skeleton and the blood chemistry was in all respects normal.

A few weeks later complete surgical extirpation was performed by Mr. David Levi. The removed specimen consisted of discrete but contiguous foci of firm yellow-brown connective tissue, some of which were encapsulated with a thin shell of sclerotic bone. Microscopically it revealed a whorled stroma of spindle cells interspersed with small multinuclear giant cells (Fig. 3), and in addition there were numerous nests of lipoid containing foam cells (Fig. 4).

Differential Diagnosis
It is inevitable that there should be some controversy regarding the credentials of this 'new'
clinical entity, yet it differs widely from some of the conditions which at first sight it would seem to resemble most closely.

Undoubtedly non-osteogenic fibroma has previously been recorded as a variant type of giant cell tumour, yet the latter always bears a direct relationship to the epiphysis, does not provoke any bony reaction around its periphery and typically occurs in the twenties whereas the former is well removed from the epiphysis, always excites a perifocal osteosclerosis from the adjacent normal bone and is discovered in late childhood and adolescence. Furthermore, the giant cells in non-osteogenic fibroma are small and sparse and the stromal cells show a strong tendency to lipoid infiltration.

Similarly non-osteogenic fibromas have previously been classified as solitary xanthomas or solitary manifestations of chronic idiopathic xanthomatosis (Hand-Schuller-Christian disease), but Jaffe and Lichtenstein regard this interpretation as invalid because half of their own cases failed to show any foam cells at all, although a most careful and prolonged search was made for them.

Solitary bone cysts or 'localized osteitis fibrosa,' though usually appearing in the metaphysis of the bone are invariably situated centrally. In addition they contain fluid suggestive of old haemorrhage and little or not tissue masses are found adherent to their walls.

Simple fibromas of bone (syn. ossifying fibroma and fibrous osteoma), by their constant content of osseous elements and their almost selective incidence in the bones of the facial skeleton (Mercer, 1950) can hardly enter into the differential diagnosis.

Finally, difficulty may arise in differentiating non-osteogenic fibroma from a low grade fibrosarcoma, yet the absence of nuclear abnormality and mitotic figures should be sufficient safeguard against this. Coley (1949) draws attention to this in recording a case, radiologically indistinguishable from non-osteogenic fibroma in which the histological pattern was sufficiently inconclusive to throw doubt on the diagnosis of malignancy. None the less, it was heavily irradiated, so much so in fact that the degree of radiation osteitis and permanent skin damage necessitated subsequent amputation of the limb. Coley notes that in the past examples of this benign neoplasm have been termed malignant and as such may have been regarded as 'cures.'

**Treatment**

The treatment of this condition is complete surgical extirpation either by incision and curettage
or by excision of the complete lesion. No recurrences following such surgical procedures have so far been recorded.

Summary
The clinical, pathological and radiological features of non-ostegenic fibroma of bone are described and illustrated by a case report. The differential diagnosis is considered and the treatment is mentioned.

Acknowledgments
I wish to record my grateful thanks to Mr. David Levi, M.S., F.R.C.S., for his kind permission to publish his case, to Dr. A. D. Morgan for the photomicrographs and to the Westminster Hospital Photographic Department for the prints.

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Manufacturers' Notes

Menley & James, Limited, Coldharbour Lane, London, S.E.5, announce that 'Furacin' Soluble Dressing—the potent antibacterial preparation specifically for local application—is now available in a convenient and economical 1-oz. tube. The base of 'Furacin' Soluble Dressing has also recently been improved to make it easier to handle in cold weather.

LARGACTIL
Pharmaceutical Specialities (May & Baker) Ltd announce the introduction of 'Largactil' brand chlorpromazine hydrochloride
This product is undergoing clinical study in anaesthesia, psychiatry and general medicine. The pharmacological properties of chlorpromazine and the preliminary reports of its clinical use have aroused so much interest that it has been decided to make 'Largactil' generally available to the medical profession from February 1.
Presentation. For oral administration: 25 mgm. sugar-coated tablets, 50 and 500 tablets. For parenteral administration: 2.5 per cent. solution for injection in 2 cc. ampoules (each cc. containing 25 mgm.), boxes of 10 ampoules and 50 ampoules. 0.5 per cent. solution for injection in 5 cc. ampoules (each cc. containing 5 mgm.), boxes of 10 ampoules.

A NEW CEILING FITTING FOR PHILIPS FLUORESCENT LIGHTING
Philips Electrical Limited, Century House, Shaftesbury Avenue, London, W.C.2, have recently produced a new ceiling fitting for fluorescent lighting—the 'Athlone' (Cat. No. 6020)—using 5 ft. 80 watt lamps and selling at the low figure of £5 10s. od. (excluding lamp).
It is especially designed for rapid and easy fixing at any centre from 36 in. to 51 in. and all control gear and wiring are mounted on an independent gear chassis extending the full length and width of the reflector covers. This arrangement lends to the fitting a smooth, clean line, unmarred by a projecting starter switch.
Although designed for flush ceiling mounting it can be suspended by chain or by conduit as well. In addition, provision is made in the centre of the gear chassis for B.S.S. conduit box fixing and for cable entry.
The 'Athlone' (which measures 64 3/4 in. long by 3 3/8 in. wide by 5 1/2 in. deep over lampholder covers) is finished in high-grade white stove enamel and is available through electrical dealers.

William R. Warner & Co. Ltd., Power Road, London, W.4, advise that sugar is now being used in their Gelusil antacid tablets, with the result that they will be more palatable and harder. The manufacturers claim that these Gelusil tablets should be sucked or chewed.
Non-Osteogenic Fibroma of Bone

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*Postgrad Med J* 1954 30: 206-210
doi: 10.1136/pgmj.30.342.206

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