CARCINOMA OF THE STOMACH.

Another Contribution to the Difficulties of Diagnosis.

By A. E. MORTIMER WOOLF, F.R.C.S.

(*Surgeon to Queen Mary's Hospital for the East End, etc.*)

Dr. Maurice Davidson's article in the June number of "The Post-Graduate Medical Journal"* on some of the difficulties in the diagnosis of carcinoma of the stomach, and the full account of his two very interesting cases, prompts me to record another unusual case, in order to accentuate the moral he has pointed.

In 1918, a man then aged 51, was operated on by the late Mr. Tyrrell-Gray for acute appendicitis with peritonitis. As far as I can gather from the records, in view of the extreme sepsis no sutures were inserted into the peritoneal or muscle layers; the abdomen was closed by partially suturing the skin alone, provision being made at the bottom of the wound for drainage. This was, I believe, the practice adopted by Sir Arbuthnot Lane in such cases, the idea being to prevent undue intra-abdominal tension. As these wounds, when sutured (even partially) do commonly break down with a resultant incisional hernia, this method of not closing the peritoneum and muscles would appear to be sound in principle. However, as this case shows, the non-closure of the parieties has its disadvantages.

On April 29th, 1935, I was asked by Dr. Hearty of Plaistow to see this patient, as he was complaining of a painful swelling in the right iliac fossa. The history was as follows. After the operation by Mr. Tyrrell-Gray, a small swelling appeared in the region of the scar, presumably an incisional hernia. This had never completely disappeared; nevertheless it had never caused him any trouble until the last three or four months, when he noticed that the swelling was increasing in size, and for the past fourteen days had been causing him considerable pain.

On examination there was a depressed, rather wide scar in the right iliac fossa. In the centre of this, and adherent to it, was a small, hard, rounded swelling, the size of a walnut. On the outer side of the scar was a large, soft elastic mass, extending outwards to the antero-superior spine. The mass was confined to the outer side of the scar and above reached nearly to the level of the umbilicus, and below to a finger's breadth above Poupart's ligament. In two places it was hard, and felt of the same consistency as the small knob adherent to the scar. The swelling was somewhat tender, dull on percussion, could be moved laterally and was situated in the abdominal wall. The man complained of no other symptoms, and the bowel action had not been interfered with. His sole reason for seeking advice was the increasing size of the swelling and the pain connected therewith.

The swelling was diagnosed as an interstitial hernia, but it was difficult to account for the hard areas, which raised the suspicion of malignancy. As the percussion note was dull, the mass was thought to be omentum, which had penetrated between the layers of the abdominal wall.

Operation was carried out on the 2nd May, 1935. The scar was excised, and the swelling to its right proved to be a large mass of congested omentum, burrowing between the external oblique aponeurosis and the internal oblique muscle. The knob adherent to the scar was found also to be omentum, continuous with the main mass. This, together with the two other indurated areas were white on section, and as I thought them to be very suspicious of new growth, they were sent for histological examination.

*Post-Graduate Medical Journal, 1935, xi, 221.

Some difficulty was experienced in freeing the main mass, as it had burrowed far into the muscular layers, both upwards and downwards, and it was necessary to sacrifice a portion of the external oblique aponeurosis. After the omental mass was freed, it was ligatured and removed from the main portion of the intra-abdominal omentum, which had a normal appearance. The opening in the parietes, which was quite small, was closed by the usual over-lapping method. The stitches were removed on the 8th day, when the wound was healed and apparently sound.

The report on the three indurated areas which had been sent for microscopical examination showed that the tissue was carcinomatous—"There is a generalized infiltration with spheroidal cells, many of the nuclei showing mitotic figures. The stroma shows much fibrosis and there is a fairly acute infective process superadded." The pathologist (Dr. Marshall) thought that the stomach was probably the primary focus. Two days later the patient was not so well. He had been running a slightly irregular temperature throughout his period of convalescence, and now the temperature dropped to sub-normal. There was nothing obvious to account for his condition. He appeared to be sinking, and died on the 14th day after the operation.

A post-mortem examination showed that there was a large carcinoma involving almost the whole of the cardiac end of the stomach. The remainder of the mucosa was studded with nodules; there were a few secondaries in the liver and many secondary growths in the mesentery and in the great omentum.

Here, then, was a case of carcinoma of the stomach whose symptoms were entirely secondary in character. This is a feature not so very uncommon, as exemplified by the two cases recorded by Dr. Maurice Davidson. Indeed, carcinoma anywhere in the intestinal canal is a very silent disease from the point of view of local manifestations. Is not this true of the colon? Colonic carcinoma reveals its presence almost entirely by secondary manifestations—frequently by a sub-acute, sometimes an acute, attack of intestinal obstruction. Unless a tumour can be felt (and apart from the cæcum and ascending colon this is not very common in my experience) local manifestations are almost entirely absent. Of course this is well known. But there is one situation in which local symptoms do predominate, although frequently for want of examination the diagnosis is missed in the early and curable stage. I allude to carcinoma of the rectum. Here there is usually a history of constipation, or at least alteration of the bowel movement, which has more or less suddenly occurred, combined with perhaps a little morning diarrhoea. How often has a rectal examination been omitted in such cases until a carcinoma of the rectum extends, perhaps half way round the bowel? Again a truism, but nevertheless a tragedy, as any surgeon to a general hospital can testify.

There is, however, a type of case of carcinoma of the stomach in which the symptoms are local, but are apt to be confusing. I refer to carcinoma high up in the stomach, involving the oesophagus. My own experience has been that a patient complaining of dysphagia, who can locate the obstruction low down in the chest, or more rarely at the top of the epigastrium, is probably suffering from a carcinoma of the upper end of the stomach. The point can usually be confirmed by a barium meal examination, but the growth may extend upwards along the oesophagus and confuse the radiographic appearance. The importance of this differentiation is the question of treatment. In my view, carcinoma of the oesophagus is best treated by intubation, and the tubes devised by the late Sir Charters Symonds (with slight modifications) are the best for this purpose. But when dysphagia is caused by a carcinoma high up in the stomach, intubation is not so successful. These cases are best treated by gastrostomy.