CASE FOR DIAGNOSIS

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The following case is of interest because of the difficulty in diagnosis and the unusual nature of the condition.

The patient, a woman aged 36, was admitted to King's College Hospital complaining of pain in the back, flatulence and a feeling of abdominal distension after meals. This was accompanied by a dull ache in the epigastrium. She stated that she had lost a stone in weight in the past year. Her menstruation had been irregular and scanty and she was breathless on exertion. The feet and ankles had been swollen for two months. Further points in her history were as follows:—1936, fractured skull; 1939, normal pregnancy, since when she stated that she had been anaemic; 1940, operation for prolapse of the uterus.

On examination she was pale; koilonychia was present; the haemoglobin was found to be 54 per cent. with a colour index of 0.41. There was tenderness to the right of the umbilicus and in the right subcostal margin. A tumour was palpated in the left loin and was thought to be due to splenic enlargement; a barium enema showed that the splenic flexure of the colon was displaced centrally. A preliminary diagnosis of primary achlorhydric anaemia was made.

Because of the abdominal discomfort a barium meal was carried out and this showed that the pyloric antrum was rigid and infiltrated, particularly along the greater curve. A radiological diagnosis of leather bottle stomach was made. Gastroscopy showed that there was reddening and irregularity of the mucosa in the pyloric antrum. No peristalsis was observed. The mucous lake contained a considerable quantity of mucus with inflamed rugae showing through it. The appearance was thought to be compatible with malignant infiltration. A histamine test meal showed complete absence of free acid; a trace of blood was present in one specimen. The pre-

Barium meal showing rigidity and infiltration of the pyloric antrum particularly along the greater curvature.
satisfactory and normal appearance. At this point a Wassermann reaction was carried out on account of the splenic enlargement, and was found to be strongly positive. Treatment with bismuth and arsenic was begun, and this was followed by a rapid improvement in the abdominal symptoms. Iron, as ferrous sulphate, was also given; the haemoglobin rose steadily and was 88 per cent. two months after admission. A further gastroscopy carried out at this time showed that a large quantity of purulent residue was still present and a number of superficial ulcers were scattered over the surface of the stomach. When seen four months after admission the splenic mass had disappeared. A barium meal showed no alteration in the appearance of the stomach. The patient continued to improve, and at gastroscopy carried out 18 months after her first admission the appearance of the stomach was normal, except that peristalsis was still absent in the prepyloric region.

The patient was last seen three years after first attendance (April, 1949). A barium meal was carried out by Dr. A. M. Rackow who reported as follows:—'I have screened this case carefully and have found no sign of infiltration in the prepyloric area of the stomach; peristalsis here is quite satisfactory and I am prepared to exclude neoplasm.' Gastroscopy at this time also showed an entirely normal appearance. The patient looked and felt well. She had no symptoms. Haemoglobin was then 82 per cent; B.S.R. 8 mm. in one hour; the W.R. remained positive. The final diagnosis in this case was syphilitic linitis plastica.

The patient's age, her recovery maintained over three years with regression of the abnormal gastroscopic and radiological findings, and the positive Wassermann reaction, leave no doubt that this was the correct diagnosis. Bockus (1946) states that linitis plastica of syphilitic origin resembles the invasive type of carcinoma; it is diffuse and often associated with superficial serpiginous ulceration, limited to one area, or multiple. Approximately 70 per cent. of described cases show a pyloric defect, 22 per cent. show an hour-glass type of deformity and 8 per cent. a diffuse involvement of a large part of the stomach. Palmer and others (1943) describe an almost identical case in a man of 38, with similar radiological and gastroscopic findings, in whom the stomach was removed at operation. The pylorus was narrowed with a shallow ulcer extending right round its circumference. The prepyloric region was thickened and nodular. Sections showed the typical appearance of syphilitic granulation tissue, with inflammatory changes in the blood vessels characteristic of syphilis. Eckhoff (1931) records the case of a woman aged 23 with symptoms of gastric ulcer in whom an hour-glass constriction in the prepyloric region was observed radiologically. Following
anti-syphilitic treatment the symptoms were relieved, but narrowing of the stomach was still present radiologically eight months after treatment had been started. In spite of this persistent deformity the patient had put on three stones in weight. In cases of this type where residual deformity persists after treatment, a genuine stenosis with obstruction may develop at a later date, even in the absence of active syphilis.

Eckhoff points out that it is characteristic of syphilitic lesions that the symptoms fail entirely to respond to the usual medical treatment for ulcer. The diagnosis of syphilis of the stomach may be made if:—

1. The patient has a history resembling that of gastric ulcer or neoplasm.
2. Radiological appearances indicate diffuse infiltration of the stomach, with absence of peristalsis in the affected area, and rapid emptying time even when there is some narrowing of the stomach itself or of the pylorus.
3. The serological tests for syphilis are positive.
4. There is no response to an ulcer regime.
5. There is speedy symptomatic improvement with anti-syphilitic therapy.

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FALSE LOCALIZING SIGNS IN CEREBRAL TUMOURS

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Two cases, recently seen, showing symptoms due to the effects of chronic intracranial hypertension, are considered to be of sufficient interest to warrant a review of the literature relating to false localizing signs in cerebral tumours.

Case 1

A woman, aged 46, was admitted to hospital with a four years' history of occipital headaches which occurred in attacks every few days. For the past year she had been having transient attacks of amaurosis, and for the past six months she had developed a complete anosmia which she had particularly noticed when cooking. Her relations had found that she had recently become somewhat dull and depressed.

Examination showed an alert and co-operative patient with no abnormality on neurological, cardiovascular or respiratory examination, except for a complete bilateral anosmia and a chronic papilloedema with secondary optic atrophy. A lumbar puncture showed a pressure of 280 mm. of water, the cerebro-spinal fluid itself showing no abnormalities.

It was considered that the patient had an olfactory groove meningioma with serious visual loss from chronic intracranial hypertension. A ventriculogram, on the other hand, showed appearances suggestive of a tumour at the posterior end of the third ventricle, and the patient was eventually discharged without any biopsy findings. This patient’s anosmia was probably due to the effects of chronic intracranial hypertension.

Case 2

A man, aged 37, was admitted to the Frenchay neuro-surgical unit with a six weeks' history of headache and vomiting. On examination the patient was found to be talkative, rational and co-operative, with a moderate nominal dysphasia, slight dyslexia and marked dysgraphia; an ‘explosive’ character to his speech was noted as a prominent feature, suggestive of a cerebellar type of defect. The cranial nerves were normal except for bilateral blurring of the optic disc margins, a right upper quadrantic homonymous hemianopia, and a weakness of the lower part of the right side of the face. Appreciation of pain, temperature, touch and stereognostic sense was normal over the whole of the body, but there was found to be...