CLINICAL SECTION

I. *An Unusual Case of Dysphagia*

A man aged 54 years, of Polish extraction, was admitted to hospital complaining of increasing difficulty in swallowing of four months' duration. The food appeared to 'stick in his throat' and he had a feeling of 'food remaining in the throat after swallowing.' The dysphagia was more pronounced with dry or hard food and regurgitation occurred from time to time. The patient said he often had to 'swallow twice to get the food down.'

He gave a history of a similar attack in 1942 when he had been told that 'something was growing in his chest.' There was no indigestion but he said he suffered from 'colitis' after eating certain foods so that he had to be careful of his diet. His appetite was normal but he had lost some weight; average 8 st. 7 lb., now 7 st. 5 lb.

He had a mild unproductive cough which had been present for many years, but no dyspnoea or pain in the chest. He had no complaint referable to the cardiovascular, urinary or central nervous systems.

Past History. 'Colitis' for 20 years. Haemorrhoidectomy in 1942 after which he had pruritus ani. 'Rheumatism' in the shoulder for which he was having physiotherapy.

Family History. Father died from an operation on the stomach, cause unknown. Mother, aged 78 years, alive and well. Nine siblings all alive and well except some have 'rheumatism.'

Social History. The patient was 34 years with the Polish Army as a major, but is now unemployed. He does not drink spirits or smoke.

On Examination. The patient was cheerful and cooperative, but rather nervous. General condition, only fair. B.P. 115/75; pulse regular, 90 per minute. The apex beat could not be located but the right jugular vein was dilated. No palpable glands in the neck. Chest, marked kyphosis and scoliosis mainly to the right. The trachea was grossly displaced to the left. The chest was emphysematous in appearance and hyper-resonant in all areas, with decreased liver dullness. A few scattered rhonchi could be heard. No clubbing of the fingers was present. Abdomen, no abnormality beyond two easily reducible inguinal herniae.

Investigation

An X-ray of the chest showed a large, rounded, smooth shadow in the upper part of the mediastinum extending upwards into the neck. Some calcification is seen within it or in its walls and the trachea and oesophagus are displaced to the left. It moved slightly on swallowing but did not pulsate. Beyond this nothing abnormal was seen in the chest except for an old calcified tuberculous focus in the left lower zone.

Further X-rays, taken in 1947 and obtained from another hospital, showed that there had been a definite increase in size of the mediastinal swelling during this time. The basal metabolic rate proved to be +6.

Diagnosis

A diagnosis of intrathoracic goitre with calcification was made, but a dermoid cyst or an aneurysm of the innominate artery were considered as alternatives. In view of the increase in size causing dysphagia by gross displacement of the oesophagus and trachea, operative removal was advised.

Operation

Anaesthesia: Pentothal, gas, oxygen, Flexadil. The patient was placed on his left side and the thorax opened by an incision along the fourth rib after division of the scapular muscles and retraction of the scapula forwards. Good access was obtained to a large mass, rather larger than the clenched fist, situated in the posterior mediastinum. The mass extended into the root of the neck downwards as far as the azygos vein, and medially to the innominate vein. It was encapsulated with a well-defined plane of cleavage and its vascular pedicle was attached to the upper pole.

It was enucleated without great difficulty, the separation from the trachea being the most difficult part of the operation. After removal of the mass the trachea and oesophagus could be seen in the tumour bed.

The mediastinal pleura was resutured and the chest closed in layers with an intercostal drain.

The tumour, weighing 11 oz., was slightly lobulated with a smooth surface and a pedicle at one

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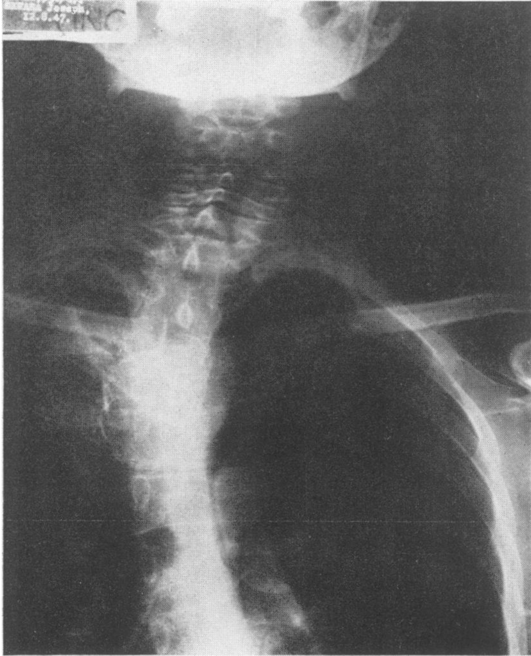

FIG. 1.—X-ray taken in 1947.

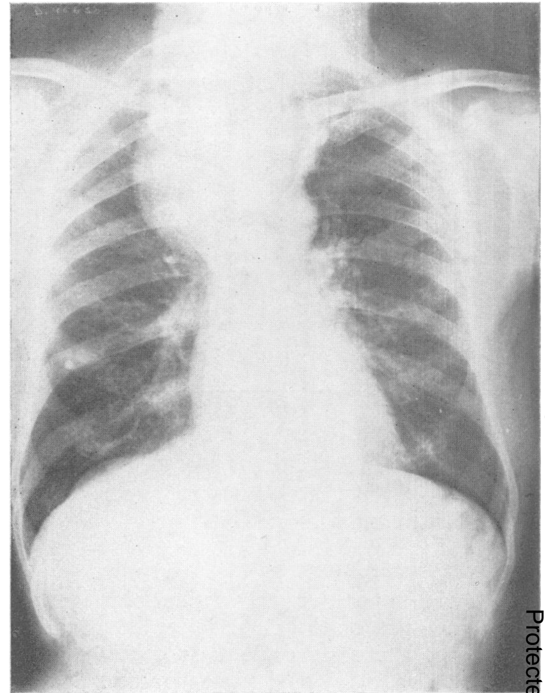

FIG. 2.—Condition on admission (June 1950). Note displacement of trachea.

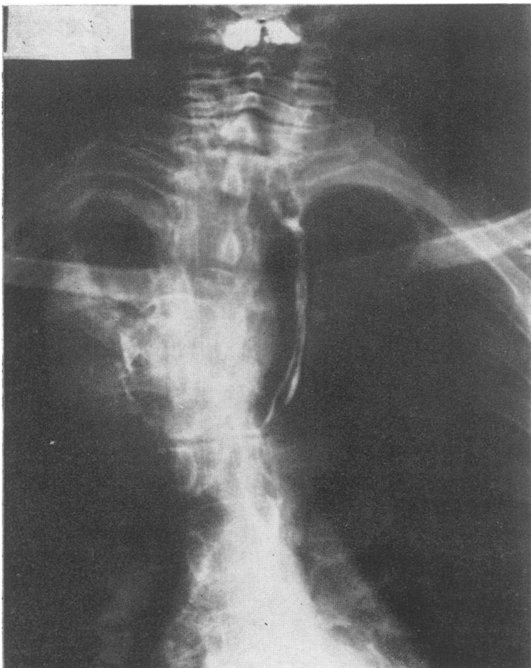

FIG. 3.—X-ray after barium swallow.

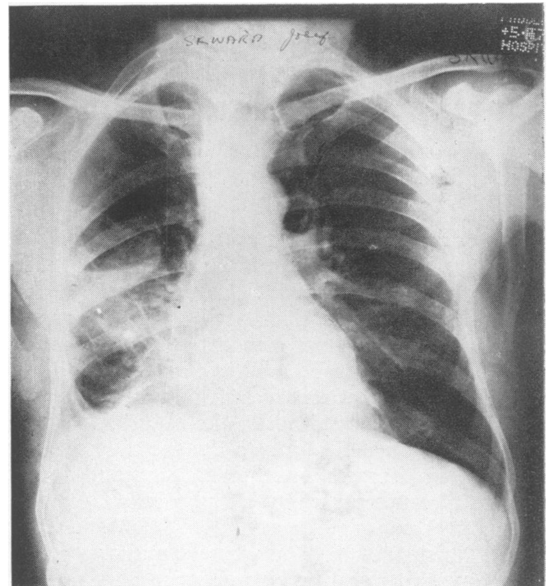

FIG. 4.—Condition on discharge.

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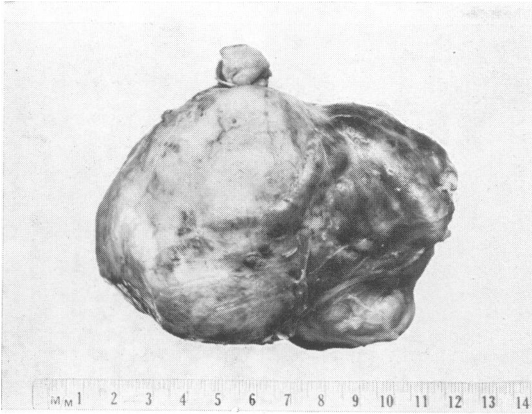

FIG. 5.—Photograph of the tumour after removal. Weight ·· oz.

end. On section the nodules had a colloid appearance with extensive calcification.

Postoperative Course

Following operation the patient developed a partial collapse of the right lower lobe and, in spite of the intercostal drain, fluid collected in the chest.

With aspiration of the fluid and breathing exercises the lung gradually expanded, the patient being able to leave hospital on the 48th postoperative day, free from symptoms other than the rheumatic pains in the shoulder.

Histology of the Specimen

The section showed a nodular colloid goitre with no evidence of thyrotoxic activity.

Summary

A case is presented of an aberrant colloid goitre present in the superior mediastinum. The tumour was giving rise to dysphagia serious enough to cause loss of weight.

The thyroid tumour was removed transthoracically via the bed of the fourth rib without difficulty.

Postoperatively the patient had a collapse of the right lower lobe which responded to breathing exercises, the patient leaving hospital in good health having put on weight.

The writer wishes to thank Mr. D. H. Patey for permission to publish this case, and the Pathological, Radiological and Photographic Departments of the Middlesex Hospital for their work.

2. *A Case of Fibrosarcoma of the Hand*

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The following case is presented as an uncommon condition which poses several pathological, prognostic, therapeutic and medicolegal problems of interest.

Briefly told, the patient's story is as follows:—

In early 1940 the patient, a weaver of 44, received a blow on the palm of her right hand while at work, causing some pain for two to three days, slight bruising but no marked swelling. The condition rapidly subsided.

In May 1943 she developed weakness of the right fingers with 'loss of control,' and noticed a wasting of the muscles of her right hand. This was followed in June 1943 by the development of an aching pain extending up the outer side of the right arm from the thumb to the shoulder, almost constant in character, night and day, and severe enough to cause persistent sleeplessness.

In October 1943 she attended the Manchester Royal Infirmary as an out-patient and was found to have wasting and loss of power of all the small muscles of the right hand, loss of pin-prick sensation over an ulnar distribution and a typical flexion deformity of the fifth finger, with hyperextension of the metacarpophalangeal joint.

In November 1943, after further investigation as an in-patient (during which no other abnormal physical signs were discovered, the C.S.F. was normal and the Wassermann reaction negative), her symptoms were considered probably to be part of a thoracic outlet syndrome, possibly due to a cervical rib or band. X-rays showed an enlarged right transverse process of the seventh cervical vertebra but no definite cervical rib. She was therefore referred to her nearest hospital for a course of physiotherapy. This treatment she had in intermittent courses over a year, without improvement.

From November 1944 to April 1949 she resigned herself to the almost constant pain and went back to work 'to keep my mind off the pain,' but in April 1949 she developed a swelling of her right palm which slowly increased in size, causing such pain that in November 1949 she again attended hospital.

On examination. As shown in Fig. 1 there was

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