elderly patient, or those with established hearing impairment. The appearance of hearing loss or deterioration of auditory function would require discontinuation of treatment. Concomitant upper respiratory tract infection or ear infection should perhaps indicate deferring the commencement of treatment with vincristine until the episode is over.

H. Yousif (Al-Najjar)
S.G.N. Richardson
W.A. Saunders

Department of Medicine,
Russells Hall and Guest Hospitals,
Dudley, West Midlands, UK

Correspondence: H. Jousif (Al-Najjar)
P.O. Box 4078
Al Shuwaikh 13041,
Kuwait

References


Chemical de-bulking of desmoid tumours

Sir,

Surgical treatment of desmoid tumours is accompanied by a high recurrence rate. Recent reports have suggested that the use of tamoxifen may induce a remission. Our case adds to the very limited world literature supporting its use in this condition.

A pre-menopausal 51 year old woman with polyposis coli had required a colectomy and ileo-rectal anastomosis for (Duke’s A) carcinoma of the ascending colon. She re-presented 18 months later with abdominal pain and distension. A solid, tender, bi-lobed mass was palpable per abdomen. Computerized tomography demonstrated a mass in the left upper quadrant and a second, 11 × 8 × 8 cm mass to the right of the aortic bifurcation (Figure 1). At laparotomy the former tumour was resected, but the latter was inoperable due to the direct involvement of the inferior vena cava. Histological examination confirmed the diagnosis of desmoid tumour.

Figure 1 Computerized tomogram of the abdomen and pelvis showing a large mass occupying the left upper quadrant.

Figure 2 Section of the resected desmoid showing a moderately cellular spindle cell tumour with very occasional mitotic figures (H&E × 41).
Post-operatively, tamoxifen was commenced at a dose of 40 mg once daily. Within 3 months the remaining tumour had a significantly decreased in size, as felt per abdomen, associated with lessening of abdominal symptoms. She remained well for a further 5 months until the development of a low rectal mass, biopsy of which confirmed a further adenocarcinoma. An abdominoperineal resection was undertaken, during which time the desmoid was confirmed under direct vision to be much smaller than previously recorded.

Desmoid tumours are locally invasive but do not metastasize. They may occur in isolation or be associated with manifestations of Gardner's syndrome.1–4 The standard treatment, where technically possible, is surgical excision. This is notoriously difficult and there is a high recurrence rate.5,6 Radiotherapy has had some success,7 but other treatments including chemotherapy, non-steroidal anti-inflammatory drugs and intra-lesional steroids have proved less effective.

The observation that desmoid tumours may be under hormonal influence,8,9 in particular oestrogens, led to the initial use of the anti-oestrogen tamoxifen. In the very few patients who have been described, tumour regression was clinically evident, with no obvious side effects from the drug itself.10–12 In this case we noted a significant decrease in tumour bulk achieved within the first weeks of treatment. However, at the time of abdomino-perineal excision, some 5 months later, although the tumour was much smaller in size, there had been limited spread into the pelvis and retro-peritoneal tissues.

The use of tamoxifen to treat desmoid tumours has been associated with a clinical response on each occasion. The development and progression of adenocarcinoma of the colon usually limits follow-up. Further work is needed to define the role and mode of action of tamoxifen in the management of desmoid tumours and other fibromatoses.

S.G.E. Barker*  
S. Withey  
P.G. Bentley  
King's College Hospital,  
Denmark Hill,  
London SE5 9RS, UK.  

*Correspondence: Kent and Sussex Hospital, Tunbridge Wells, Kent, UK.

References


Editor's note