The exact nature of the spread of this carcinoma is difficult to determine and it thus represents an unusual case of distant colonic carcinoma metastasis.

M.J. Davies*

J.D. Watson

Department of Plastic Surgery,
St Johns Hospital,
Howden,
Livingston, UK.

*Correspondence: Department of
Cardiothoracic Surgery,
Groby Road Hospital,
Groby Road,
Leicester LE3 9QE, UK.

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Typhlitis complicating acute leukaemia in an adult

Sir,

Typhlitis is a necrotizing inflammation of the caecum recognized as a complication of chemotherapy with leukaemia in children¹ and adults.² We report a case of typhlitis in an adult with leukaemia following the neutropenic phase of chemotherapy.

A 72 year old female was diagnosed as having myelomonocytic chronic leukaemia. She underwent ambulatory therapy with hydroxyurea and etoposide when there was transformation into acute non-lymphoblastic leukaemia. She was admitted for induction therapy with cytarabine, daunorubicin and prednisone. On the seventh day after chemotherapy, she developed a fever of 38°C and ceftriaxone and amikacin was started. On the 14th day she had abdominal pain with marked tenderness in the right inferior quadrant with involuntary guarding and rebound tenderness. X-ray showed dilated small-bowel loops and air-fluid levels in the right lower quadrant. Her white cell count was $0.7 \times 10^9/l$. At laparotomy the caecum, proximal ascending colon, terminal ileum and appendix were resected, and an ileocolic anastomosis was made. Pathological examination showed an oedematous and ulcerated mucosa of the caecum. Microscopically the ileocaecal valve and the caecum had an ulcerated mucosa, marked oedema of the submucosa and multiple and small foci of ischaemic necrosis of the mucosa, some of them colonized with Gram-negative rods. Neither leukaemic infiltration nor intramural haemorrhage was identified. After laparotomy, the patient recovered well and the fever disappeared. As soon as the bone marrow recovered from

aplasia, there was evidence of relapse with 86% blasts in the peripheral blood and she subsequently died.

The pathogenesis of typhlitis remains unclear.³ A combination of factors including chemotherapy,⁴ immunosuppression,⁴ neutropenia,⁵ steroid therapy and malignant infiltration⁶ have been invoked.

Typhlitis appears to be increasing in incidence,⁵ and we believe the clinician has to consider this complication, when a neutropenic patient develops fever and abdominal pain. Early recognition and surgical intervention is crucial for the survival of the patient.

A. Esteban Chicharro

E. Pachó

M.J. Molina

C. Soto

G. Hernández

Servicio de Medicina Interna,
Fundación Jiménez Díaz,
Facultad de Medicina,
Universidad Autónoma de Madrid,
Clínica Ntra. Sra de la Concepción,
C/Reyes Católicos 2,
28040 Madrid, Spain.

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Xeroderma pigmentosum with recurrent infiltrating ductal carcinoma of breast

Sir,

The association of malignant tumours with other diseases is always an important observation. Since xeroderma pigmentosum (XP) has already been associated with various skin and parenchymatous tumours,^{1–3} physicians should be aware of its possible connection with breast cancer as well.

A 63 year old Jewish mother of two presented in November 1992 with a one month history of two enlarging tumours: a 3×3 cm tumour of the right upper lateral breast and a 2×2 cm fungating clinical squamous cell carcinoma (SCC) over the third metacarpophalangeal region of the left hand. She was being followed by the Department of Dermatology for XP. The latter diagnosis was based on typical clinical features, histopathological data, DNA replicase deficiency in fibroblasts and familial history. In 1962 a SCC of her lower lip was excised, and in 1967 a basal cell carcinoma of her cheek was excised. In