Medical Memoranda

Solitary Neurofibroma in the Stomach

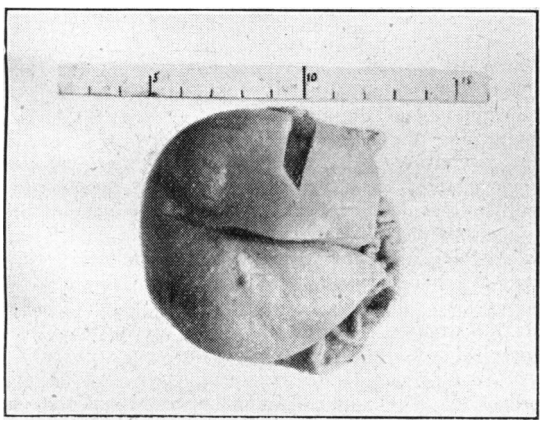
In the stomach, and generally in the digestive system, benign tumours, especially neurofibromata, are seldom seen. These tumours always take their origin from the gastric plexus and grow between the two layers of muscle below the mucosa. According to Askanazy, the nerve tissue seen within the tumour is sympathetic. Usually such tumours are associated with a diffuse neurofibromatosis of the skin. Leriche, and Gerhardt and Westphal, have reported numerous neurofibromata of the alimentary tract in patients with typical von Recklinghausen's disease. Kohtz described an intestinal neurofibroma in a patient with no other signs of neurofibromatosis; and Askanazy writes of a case in which the stomach and small intestine contained as many as 15 neurofibromata, the largest being the size of a walnut. Despite a search of the available literature, I have not found a previous report of an isolated neurofibroma of the stomach. The following case, in which the tumour was larger than any gastric or intestinal neurofibroma hitherto recorded, may therefore be of interest.

CASE HISTORY

On July 2, 1943, a woman aged about 50 was admitted to hospital in a very weak condition. She complained of nausea and occasional vomiting. According to her story, she was taken ill suddenly, a year previously, with violent abdominal pains, and ever since that time had suffered from prolonged, but not severe, abdominal pain with a sensation of gastric distension.

On examination the belly was soft and not resistant. A hard mobile tumour the size of a fist was felt in the centre of the epigastrium. The tumour moved with respiration. On *x*-ray examination a fairly regular filling defect was seen towards the middle of the stomach. Radiographs showed a large, irregular, and somewhat rough shadow. Nothing unusual was noticed in the intestinal canal. A provisional diagnosis of pedunculated tumour or a phytobezoar was made, and it was decided to operate.

On July 10 laparotomy was performed under local analgesia, and at the middle of the lesser curvature a smooth round tumour about 3 in. in diameter, covered with mucous membrane and attached by a short broad pedicle, was seen. The tumour was resected, and the wound healed by first intention. The patient speedily recovered strength and was soon herself again. On July 30, 1943, she returned to her home.



Pathological Examination (Prof. Oberdorfer, Cancer Institute of the University of Istanbul).—A round solid tumour, the size of an apple, weight 200 g., covered on all sides by mucous membrane and with a small broad pedicle, which had no mucosal covering. On section the tumour was seen to be of whitish medullary tissue, clearly distinct from the mucosa. Histological examination showed that the mucous membrane of the tumour was partly atrophied and partly degenerated by inflammation. The muscularis mucosae was somewhat thickened, and both under the mucous membrane and within the muscularis mucosae the infiltration of spindle-cell elements with especially elongated nuclei was clearly seen. Among these cells was a plexus of corrugated and sometimes parallel fibrils. Particularly in the neighbourhood of small vessels, of which there were many, there was a tendency to orderly arrangement of cells. Near the mucosa there was a considerable inflammatory infiltration, consisting chiefly of plasma and eosinophil cells. Fibroma and myoma were excluded by the histology of the tumour, and a diagnosis of neurofibroma was made.

After the pathological report had been received the patient was given another thorough examination, and neither on the skin nor on other parts of the body was anything found to indicate general neurofibromatosis. This case must therefore be accepted as an isolated neurofibroma of the stomach.

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Herpes Zoster with Underlying Pleural Rub

The following case is of interest because it illustrates one difficulty which may be encountered in the differential diagnosis of pleurisy. It is well recognized that pre-herpetic pain may be mistaken for pleurisy of pulmonary origin, but in this case of herpes there was in addition a pleural rub.

A woman aged 46, with a 20-years history of asthma and bronchitis, was admitted to hospital complaining of three days' pain in the left side of the chest on deep respiration and coughing. During the previous month her cough had been worse, with green and yellow sputum, but no haemoptosis. She was afebrile, pulse 80, respirations 20. Physical examination showed no abnormality except rales over the whole chest and tenderness over the seventh and eighth intercostal spaces in the posterior axillary line on the left side. No pleural rub was heard at this time. Radiographs showed evidence of chronic bronchitis, but no abnormality in lung or in pleura in the area concerned. On the fourth day after admission a small crop of typical vesicles of herpes zoster appeared over the tender and painful area. Three days later a pleural friction rub appeared, directly underlying the herpes. The rub persisted for several days, gradually diminishing in intensity, and was not heard after the fourth day. The pain disappeared at the same time, but the vesicles healed slowly, with scarring in the usual manner. No other evidence of pulmonary or pleural involvement appeared, and she was discharged two weeks later. The blood sedimentation rate remained throughout within normal limits.

The interest of this case lies in the coincidence of the herpes with underlying pleural rub, and it was thought that this was due to herpetic lesions occurring on the surface of the parietal pleura. A similar case was reported by W. R. Brain (1932, 1940). It appears to be uncommon for a pleural rub to be heard with herpes zoster.

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Perforated Solitary Diverticulum of Caecum

Diverticulosis is a common condition of the large bowel, and much has been written about it. The condition was described by Cruveilhier in 1849, and in 1858 a case was reported to the Pathological Society of London (Jones, 1858–9). Since that time many statistics have been published. Generally speaking, the results show that diverticulosis and diverticulitis are rare under the age of 30, that they predominate in men, that they are usually confined to the distal half of the large intestine, and that single diverticula of the caecum are very rare. The case presented is that of a girl of 17 with a solitary diverticulum of the caecum which had become acutely inflamed and had perforated, giving rise to an "acute abdomen."

CASE HISTORY

The patient had had rheumatic fever twice in 1937 and once in 1938, but no previous attacks like the present one (Nov., 1942). Twenty-four hours before admission to hospital she had a sudden acute pain in the right iliac fossa and vomited shortly afterwards. The pain continued increasing in intensity up to the time of admission, and she vomited twice more. Menstruation was imminent, and the patient suffers from dysmenorrhoea. Examination showed her to be a well-built, apparently robust girl; tongue dry, pulse 112, temperature 100. There was nothing abnormal in the chest. The heart was not enlarged; mitral first sound roughened, pulmonary second sound accentuated. The abdomen did not move well on respiration. Tenderness was marked in the right iliac fossa directly over the caecum. Guarding was present. No mass was palpable. A diagnosis of acute appendicitis was made, and laparotomy was done.

Operation.—The abdomen was opened through a McBurney incision, and on opening the peritoneum free faecal matter was seen lying over the caecum. The cause of this was found to be a perforated diverticulum on the lateral side of the caecum. The diverticulum was cone-shaped, and the base was about half an inch across. This area was acutely inflamed, and at the tip there was a perforation about the size of a split pea. The edges of the perforation were sutured and invaginated with two further rows of sutures. The wound was cleaned, and gloves and towels were changed. The appendix was normal, but it was removed. Sulphanilamide suspension was injected into the peritoneal cavity, and the wound was closed with drainage.

The patient made an uninterrupted recovery, and 15 days after operation a barium enema was given. The report was: "Apparently normal colon." The patient was discharged. Five months later a further barium enema was given. The report was: "Rectum and colon as far as caecum distended with barium. Large gut fills easily and slides up and down in ascending colon, leaving no pockets of barium. *Supine:* Some segmentation of barium, but not pocketing. No abnormality detected to-day." The following day: "Apart from a small amount of barium in the ampulla of rectum all the barium has been evacuated spontaneously—i.e., large gut is functioning well and without any disability whatsoever."