There was no history of taking other drugs known to cause gynaecomastia. Despite the lack of other penicillamine-related side effects, the drug was discontinued. Two months later the gynaecomastia receded, and over the next two years his breasts remained normal.

Comment

Our patient developed gynaecomastia, which is not a recognised extra-articular feature of rheumatoid arthritis, while receiving penicillamine, and this receded after the drug was discontinued. Although the problem had not been described or reported to the manufacturers, the occasional association with breast gigantism²⁻⁵ in women suggests that gynaecomastia may be a rare adverse side effect of treatment. The Committee on Safety of Medicines have a single report of gynaecomastia in a 56-year-old man with rheumatoid arthritis who had received penicillamine for seven days with several other drugs not known to be associated with this complication. His unilateral gynaecomastia regressed after stopping all drug treatment; and, interestingly, he had previously developed gynaecomastia in response to cimetidine.

Gynaecomastia usually results from an alteration in the ratio of circulating unbound testosterone to oestrogens. More rarely changes in the concentration of sex-hormone-binding globulin or prolactin may be implicated and changes in sensitivity of the target organ may occur. No endocrine abnormalities were found in our patient but we did not measure sex-hormone binding globulin, diurnal plasma concentrations of sex hormones, or hormone excretion rates.

The gynaecomastia disappeared after withdrawal of penicillamine, and this differs from the course observed in those patients reported with breast gigantism.²⁻⁵ Indeed, mastectomy and prosthetic surgery were necessary in one case² and danazol in another.⁵ Whatever the pathogenesis of the breast enlargement, potential reversibility may depend on the duration of the inciting stimulus.

We thank the MRC Reproductive Biology Unit for undertaking the hormone assays and the Arthritis and Rheumatism Council for continuing financial support.

¹ Lyle WH. Penicillamine. *Clin Rheum Dis* 1979;5:569-601.

² Desai SN. Sudden gigantism of breasts: drug induced? *Br J Plast Surg* 1973;26:371-2.

³ Passas C, Weinstein A. Breast gigantism with penicillamine therapy. *Arthritis Rheum* 1978;21:167-8.

⁴ Thew DCN, Stewart IM. D-penicillamine and breast enlargement. *Ann Rheum Dis* 1980;39:200.

⁵ Taylor PJ, Cumming DC, Corenblum B. Successful treatment of D-penicillamine-induced breast gigantism with danazol. *Br Med J* 1981;282:362-3.

(Accepted 6 August 1982)

Rheumatic Diseases Unit, Northern General Hospital, and University Department of Medicine, Western General Hospital, Edinburgh EH4 2XU

D M REID, MB, MRCP, lecturer

A G MARTYNOGA, MB, MRCP, senior registrar

G NUKI, MB, FRCP, professor

Spontaneous expulsion of a large colonic tumour

Examination of the faeces of a patient with abdominal symptoms, though useful, is often neglected because it is unaesthetic. In the following case what was found in the bedpan provided the diagnosis, which could not otherwise have been made.

Case report

A previously fit 43-year-old man presented with a four-day history of colicky lower abdominal pain and blood staining of a formed stool for two days. He had had a haemorrhoidectomy 15 years earlier with no recurrence of symptoms. Examination showed tenderness in the left iliac fossa and blood in the rectum, but no lesion on sigmoidoscopy. The symptoms settled promptly, but five days later he was admitted to hospital with severe central

epigastric pain and tenderness, vomiting, and a low-grade fever. Twelve hours later he passed a formed but bloodstained motion, which on inspection also contained a tumour 7×5×5 cm and weighing 54 g. An urgent barium-enema film (figure) was interpreted as showing a carcinoma of the transverse colon which had perforated through the bowel wall.

Barium-enema film interpreted as showing perforated carcinoma of transverse colon.

At laparotomy a localised abscess was found adjacent to the perforated lesion; an extended right hemicolectomy was performed with ileocolic anastomosis. Histological examination showed the tumour to be a necrotic submucous lipoma of the colon, a non-malignant lesion. No evidence of malignancy was found in the resected specimen, and the patient made an uneventful recovery.

Comment

The lipoma had presumably arisen from the transverse colon, produced an intussusception, and had been passed in the faeces. Finding a lipoma made us consider conservative treatment, but the subsequent barium enema showed perforation of the transverse colon with a peritoneal abscess, confirmed at laparotomy. Submucous lipoma of the intestine, an unusual benign tumour, may present as intussusception, intestinal obstruction, rectal bleeding, or anaemia¹ but most often remains undiagnosed or is discovered as an incidental finding.² Some 65% of such tumours arise from the colon, especially the proximal colon.¹ Mayo *et al*¹ reported 164 cases treated surgically over 27 years, 47 of which were associated with carcinoma of the colon. Rectal lipoma has been known to prolapse through the anus,³ and the disappearance of symptoms in cases of obscure intestinal obstruction may sometimes be due to expulsion of a lipoma⁴; however, we can find no previous report of passage of such a tumour per rectum with intestinal perforation. The cause of the perforation would have remained obscure in this case, which illustrates vividly the value of stool examination in patients with gastrointestinal symptoms.

We thank Mr R Sage for the laparotomy.

¹ Mayo CW, Pagtalunan RJG, Brown DJ. Lipoma of the alimentary tract. *Surgery* 1963;53:598-603.

² Ryzberg CM. Lipoma of the colon: report of four cases and review of the literature. *Acta Chir Scand* 1956;111:45-53.

³ Yadoo S, Dintzman M, Chaimoff C. Lipoma of the rectum. *American Journal of Proctology, Gastroenterology and Colonic and Rectal Surgery* 1971;2:120-2.

⁴ Davis L, Tschersich H. A disappearing colonic tumour. *J Med Assoc G* 1975;64:45-6.

(Accepted 6 August 1982)

Department of Medicine, Selly Oak Hospital, Birmingham B29 6JD

D A F ROBERTSON, MB, MRCP, registrar in gastroenterology

W SAWEIRS, MB, MRCP, senior registrar in gastroenterology

T S LOW-BEER, BM, FRCP, consultant physician and gastroenterologist