

Medical Memoranda

Synchronous Double Primary Carcinomata

The frequency of multiple primary malignancy has been variously estimated by different authors; in general it would seem to be between 2 and 5% of all cases of cancer. Figures from eight of the more important series are shown in the table.

Author	No. of Necropsies	No. of Malignant Cases	No. Multiple Malignant
Hanlon	3,000	950	18 (1.9%)
Bilello	8,024	1,154	7 (0.5%)
Bugher	4,394	983	30 (3.1%)
Austin	8,124	887	24 (2.7%)
Burke	2,033	583	46 (7.8%)
Tullis	6,836	1,044	21 (2.0%)
Warren and Gates	—	1,075	40 (3.7%)
Warren and Ehrenreich	—	2,829	194 (6.8%)

The following two cases are of interest as they are both synchronous double carcinomata, each showing greatly contrasting histological pictures.

CASE 1

A man aged 61 was admitted to hospital on September 5, 1947, with a six-months history of diarrhoea and the passage of blood and mucus, occasional pain on defaecation, with lack of control and excessive flatus, and some loss of weight. There were no symptoms referable to the genito-urinary system.

Physical examination revealed general wasting. On rectal examination a large irregular ulcer was found above the prostate. The latter organ was rather hard and large. The liver and supraclavicular glands were not palpable. Cystoscopy showed the bladder to be normal. A synchronous abdomino-perineal excision of the rectum was performed on September 19, but the patient died ten days later.

Summary of Necropsy Findings.—A mild generalized peritonitis with soft adhesions between the viscera. No fault in the operative sites. No residual growth in the intestines or in the regional lymph nodes. Serial sections through the liver showed a single deeply placed spheroidal metastasis (3.5 cm. in largest diameter). In view of this finding, the lymph nodes alongside the aorta, though macroscopically normal, were taken for histological examination. Moderate general enlargement of the prostate, which was firm and contained a few white areas. Congestion of the bladder; hydronephrosis on the right side. No significant changes elsewhere. The surgical specimen (50 cm. long) presented a carcinomatous ulcer (10 by 7 cm.) with its lower margin 6 cm. from the recto-anal junction.

Histology.—**Rectal primary:**—A well-differentiated tall columnar-cell tubulo-papillary adenocarcinoma, with a metastasis of similar type in one local lymph node. **Liver metastasis:**—Similar in structure to the rectal primary. **Prostate:**—An adenocarcinoma composed of small simple tubules formed by low cuboidal cells about a wide lumen was infiltrating the gland. **Aortic lymph nodes:**—Deposits of secondary adenocarcinoma, unlike the rectal growth but reproducing the small primitive tubular structure of the prostatic cancer. These were present in two nodes, with localized extracapsular extension from one.

The final diagnosis was adenocarcinoma of the rectum with single metastases in a local rectal node and the liver, and adenocarcinoma of the prostate with metastases in aortic lymph nodes.

CASE 2

A married woman aged 70 was admitted to hospital on March 13, 1948, with a three-years history of a small lump in the right breast, about the size of a sixpence. Nine months

before admission the lump became larger and she began to have dyspeptic symptoms. After ten weeks deep x-ray treatment was begun. She had also noticed flatus, abdominal distension, anorexia, and slight loss of weight.

Physical examination revealed a fungating growth in the right breast (upper outer quadrant) with retraction of the nipple and a palpable hard node in the right axilla, medial wall. On rectal examination an ulcer with hard everted edges was found on the posterior wall at the ano-rectal junction. There was no deep fixation. The liver and supraclavicular nodes were not palpable. On March 15 local mastectomy and proctoscopic biopsy of rectal ulcer were carried out. On April 2 the patient was discharged for post-operative deep x-ray therapy.

Histology.—**Rectal biopsy:**—A well-differentiated tall columnar-cell tubulo-papillary adenocarcinoma with origin from rectal mucosa. Infiltration into the submucosa was seen. **Breast tumour:**—Sections showed an intraduct carcinoma of the main nipple ducts, and also infiltration of the breast and cutis by anaplastic growth, composed of small compact groups of polyhedral cells, in which there were only occasional attempts at primitive tubule formation.

The final diagnosis was adenocarcinoma of the rectum and anaplastic polyhedral-cell carcinoma of the right breast.

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T. B. WILLIAMSON, M.B., B.S.

Case of Polyneuritis after Mumps

Neurological complications of mumps are rare enough in this country to make it worth while reporting the following case.

CASE REPORT

A girl aged 4 had a typical attack of mumps just before Christmas, 1947. After two to three weeks she started to get up but complained of pains down the backs of her legs on standing, made worse by walking, and of pains in her hands when they were washed. She was miserable. On January 20, 1948, she was seen in the out-patient department and rheumatism was suspected. After rest in bed and salicylates for a week her symptoms were worse, so she was admitted on January 27.

On examination the child looked tired and pale, walking was difficult, and she could hardly stand up. There was an ill-defined dithery tremor of her upper limbs; power was equal. Her bicep-jerks were present and equal but the triceps- and supinator-jerks were absent. The abdominal reflexes were absent. The lower limbs were of equal power, but after being put to bed she could not stand up again. All tendon-jerks were absent in the lower limbs, except the right knee-jerk. Plantar responses were flexor. She objected to spine flexion beyond a sitting position. Kernig's sign and neck rigidity were equivocal. She was too unreliable for sensory testing. Her tonsils were large and red and the tonsillar glands enlarged. Her temperature was 99.6° F. (37.55° C.) and the sedimentation rate was within normal limits. A throat swab grew *Str. viridans* and diphtheroids. The haemoglobin was 100%, and the white cells numbered 10,300 (53% lymphocytes, 43% polymorphs, 4% monocytes). The cerebrospinal fluid was not under pressure but contained 70 mg. of protein per 100 ml. and 7 cells per c.mm., of which 80% were monocytes and 20% polymorphs; the sugar and chloride levels were within normal limits. A tentative diagnosis of mumps polyneuritis was made.

On February 6 a high titre of mumps serum antibody confirmed the history of mumps. By February 9 she had not improved and her cerebrospinal fluid contained 60 mg. of protein per 100 ml. and 6 cells per c.mm. No evidence of denervation was found on testing her muscle reactions to faradism.