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Letters to the Editor

Spontaneous rupture of the spleen in association with idiopathic thrombocytopaenic purpura

Sir,

I would take issue with Winslet *et al.*[1] who describe the rupture of the spleen of a patient with idiopathic thrombocytopaenic purpura as *spontaneous* after repeated palpation by examinees at the M.R.C.P. clinical examinations. This case to fulfil Orloff's first criterion for spontaneous splenic rupture,[2] namely the complete absence of trauma, since the search for a spleen by palpation by an anxious candidate (let alone several) during an exam can be forceful!

In contrast, I have recently seen two patients with undoubted atraumatic spontaneous splenic rupture in whom the diagnosis was only made at laparotomy. In both cases the patients were awoken from sleep by severe generalized abdominal pain, with no preceding history of trauma of any kind. Neither patient had localizing abdominal signs, but both had a tachycardia over 100/minute and leucocytosis (white cell counts 14.1×10^9/l and 23×10^9/l). At laparotomy both patients had large haematomas in the left subphrenic space, with small amounts of residual splenic tissue. Subsequent histological examination of both spleens was entirely normal, and monospot tests for infectious mononucleosis, blood films and autoantibody screens were negative.

All these cases illustrate the difficulty in making the diagnosis of splenic rupture with no preceding history of trauma. A neutrophil leucocytosis (greater than 10×10^9/l), haemoglobin concentration of less than 12 g/dl and abdominal pain are the three most sensitive markers of atraumatic splenic rupture,[3] however, these criteria have limited specificity. If the diagnosis is suspected, splenic rupture can be confirmed by ultrasonography or CT scanning, and conservative management and/or splenic salvage can be considered.[4] However, if rupture is only discovered at laparotomy the opportunities for conservation are reduced and haemostasis must be the primary consideration.

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References

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An unusual case of distant colonic carcinoma metastasis

Sir,

A 53 year old man presented with a short history of malaise, weight loss and abdominal pain. Barium enema suggested an infiltrating lesion and at operation, a massive tumour was found with local lymph node involvement. Extended left hemicolectomy was performed. Histopathology showed a Dukes' stage C1 neuroendocrine tumour characterized as a poorly differentiated high-grade small cell carcinoma. The patient made a good postoperative recovery.

Ten months later he developed a mass high on the left side of the neck. Fine needle aspiration showed this to be a metastasis from the previous colonic tumour. Investigation showed no evidence of other metastatic disease or of another primary.

The patient received three courses of methotrexate, cyclophosphamide and etoposide without much response. A course of palliative radiotherapy followed and the mass shrank away. However, 3 months later it recurred. Again investigations revealed no evidence of disease elsewhere. The patient was referred for radical neck dissection of the node deep to the upper end of sternomastoid. Histopathology confirmed a single lymph node metastasis, with other nodes in the specimen negative. Postoperatively the patient made a good recovery and remains disease and symptom free to date.

Small cell undifferentiated carcinomas, as presented in this patient, are rare. They account for less than 1% of all malignant epithelial tumours of the colon and less than 30 such cases have been reported to date.[1-5]

Local lymph node metastases occur in 35–40% of all colonic carcinomas and are invariable in those cases of small cell carcinoma reported.[1-5] Spread occurs in a contiguous fashion. That is, if one node is involved, all the intervening nodes between it and the tumour are also involved. Direct invasion of veins draining the tumour and associated bowel segment is well described, particularly in high-grade malignancy and with lymphatic metastases. Distant metastases are presumably from such circulating colonic cancer cells.

This patient presents an unusual situation with a single distant lymph node metastasis from a high-grade small cell carcinoma of the colon, without evidence of other metastatic disease or of another primary. All other reports of small cell carcinoma of the colon with distant lymph node metastasis have shown other sites to be involved, particularly the liver.[2] Spread to the neck through the blood stream would almost certainly have been through the portal system and one would have expected hepatic metastases to have become evident in this time span. If spread had been through the lymphatic duct then nodes lower in the neck would have been expected to show some evidence of disease, but this was not so. Implantation was not possible.

Small cell carcinomas of the colon are described as extremely aggressive with the longest previously reported duration of survival being 14 months.[2,5] This patient is now 40 months after colonic resection with no evidence of other metastatic disease.