

CLINICAL MEMORANDA.

NEURILEMMOMA OF THE STOMACH WITH PEPTIC ULCERATION : REPORT OF A CASE.

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Benign tumours of the stomach are comparatively rare constituting about 4.5 per cent of all gastric neoplasms (Lockwood, 1943). In this benign group about 10 per cent are believed to be of neurogenic origin (Minnes & Geschickter, 1936).

In 1939 Mrs. G., a woman aged 57, commenced to suffer from dyspepsia. The symptoms, which were rather indefinite, were followed after a few weeks by an attack of haematemesis. She made a fair recovery and her dyspeptic symptoms became unobtrusive. Haematemesis recurred in 1941, 1943, July 1944, December 1944, April 1945, December 1945, November 1949, February 1952 and April 1952. In June 1945 radiological examination revealed a large mass in the stomach arising from the anterior wall and lesser curvature. There was considerable encroachment on the lumen of the stomach and the surface of the mass was irregular. The radiologist considered that the usual characteristics of a malignant tumour were not present and that the appearances suggested a simple tumour with possibly secondary malignant change. The stomach was mobile. On these findings the possibility of undertaking partial gastrectomy was considered but permission to operate was refused.

Scattered over the trunk and proximal portions of the limbs were a few small subcutaneous swellings suggestive of neurofibromata. A coarsely filiform papillomatous tumour of greyish-brown colour was growing from the anal margin and spreading on to the perineum. Its presence caused considerable discomfort but all treatment for it was refused.

Each attack of haematemesis was treated with blood transfusions and from July 1944 to March 1952 she received 13 pints of blood in eight transfusions. Between attacks her health was comparatively good, but during the attacks she was restless and distressed requiring much sedation. With the passage of time she became a morphine addict. She died in April, 1952 at the age of 70 after a haematemesis.

Autopsy Findings. Post-mortem dissection was restricted to removal of the stomach. The specimen consisted of the greater part of the stomach, the uppermost portion of the cardia and the oesophageal entrance being absent. An irregular nodular tumour ($9 \times 6.5 \times 4$ cm.) was present in the anterior wall of the pyloric antrum. The growth was made up of several partly fused nodules. Dissection revealed that the bulk of the neoplasm lay in the submucosa but portions of the nodules projected into the gastric lumen, and other portions directed outwards formed bosses in the serosal surface. There was ulceration and excavation of one of the internally directed nodules. The cut surface revealed encapsulated nodules of pale pearly grey colour in which slight whorling was visible. The gastric lymph nodes present appeared natural.

The tumour was composed of interwoven fascicles and whorls of rather loosely set filiform cells. In these the cytoplasm was usually filamentous with deeper staining axial threads, and the nuclei were chiefly elongated with rounded poles. Regimentation of the nuclei was pronounced in most areas. With van Gieson's stain the cytoplasm stained pinkish-orange and occasionally red. Many small areas of oedema were notable and there was some hyalinization of the collagen. The submucosal situation, encapsulation, and local ulceration of the neoplasm were confirmed. In one section flattened nerve was seen at the sub-capsular periphery. It was considered that the tumour was a neurilemmoma.

A small satellite nodule of tumour showed identical structure. The lymph nodes recovered were normal. A pigmented warty growth was present in the perianal region and a small nodule of firm tissue, from the subcutaneous tissue of the thigh, was also examined. Microscopy showed the former to be a pigmented papilloma and the latter normal fat.

The identification of neurogenic tumours of the stomach is rendered particularly difficult by the occurrence in the stomach of the leiomyoma which may closely resemble the neurogenic tumours both macroscopically and microscopically. It too



Fig. 1. Pyloric end of stomach, internal aspect showing the nodular ulcerated growth. Note small satellite tumour to the left. $\times 2/5$

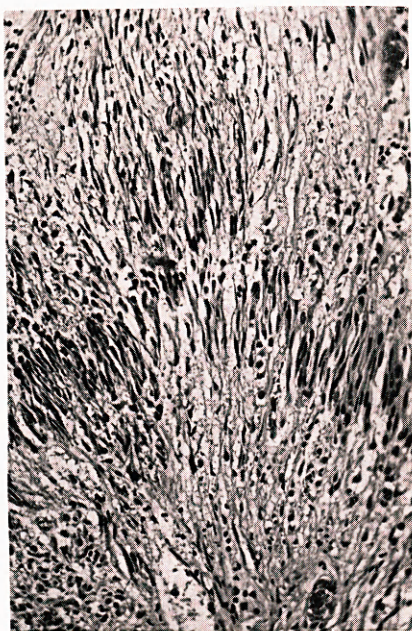


Fig. 2. Section of tumour showing the regimentation of the filiform cells. Dropsical change is also visible. $\times 140$

may display regimentation of the nuclei. Clinically the neuromata and leiomyomata give rise to similar symptoms of which recurrent haemorrhage is the most prominent. They also present a similar radiological picture and both are prone to necrosis and ulceration. Rarely malignant change may supervene in either growth. It occurs slightly more frequently in leiomyomata. In both groups the malignancy is usually only local and metastases are uncommon (Fife & Jarvie, 1952).

References.

- Fife, R. & Jarvie, J. (1952). *Glasg. med. J.* **33**: 490
 Lockwood, B. C. (1943). *J. Amer. med. Ass.* **98**: 969
 Minnes, J. F. & Geschickter, C. F. (1936). *Amer. J. Cancer.* **28**: 136