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Contributors

Palmer, Dudley W.
Royal College of Surgeons of England

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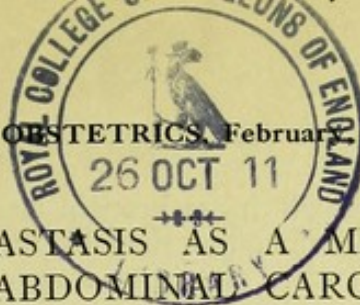
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PELVIC TRANSPLANTATION METASTASIS AS A MEANS OF RECOGNITION OF HOPELESS ABDOMINAL CARCINOMA

By DUDLEY W. PALMER, M. D., CINCINNATI, OHIO
Formerly Surgical Assistant to St. Mary's Hospital, Rochester, Minnesota

IN the treatment of all carcinomata it is quite as necessary to have definite rules for guidance against operation as for operation. It is important to lay stress upon every warning point, as the present necessity for exploration only emphasizes our more or less limited knowledge, and it is our duty to save as many patients as possible from the shock of even so slight an operation as a simple exploration, when by a more thorough examination some of them might at once be definitely classified as hopeless.

It is to routine digital examination of the rectum with the patient in the knee-elbow position, and bimanually with the patient in the lithotomy position, to which we wish to call particular attention in this paper; and no case of abdominal tumor should be operated upon without its being done. By this means alone we have been able to prove over six and one-half per cent of upper abdominal carcinoma to be hopeless.

While reviewing the histories of some four hundred and thirty-five cases of upper abdominal carcinoma seen in the last twenty months at the Mayo clinic, Rochester, Minnesota, we were surprised to find so large a percentage of them showing the following positive contraindication to operation. For example, upon examination a small, hard, nodular tumor is found with the clinical history and laboratory findings of carcinoma of the stomach. It is freely movable and apparently mechanically removable. On rectal examination at a point about three to five inches from the anus along the anterior rectal wall (on what has been termed by Dr. George Blumer the "rectal shelf"), above the prostate in the male, and above and behind the uterus in the female, we may find a hard nodular mass distinctly originating within the peritoneal cavity. These may be single or multiple and may vary in size from a small bean to an orange. Sigmoidoscopic examination shows the rectal mucosa uninvolved. This may remain as a distinct

neoplasm or may, through a process of infiltration, begin the formation of a crescent-shaped area of cartilaginous hardness that partially surrounds the bowel. We have not seen a case that produced any stricture-like symptoms, nor have we seen one that gave symptoms suggestive of rectal carcinoma. The presence of free fluid in the abdomen often indicates a hopeless condition because it is indicative of a considerable peritoneal irritation and usually actual involvement, but implantation carcinomata are often found before free fluid can be distinguished clinically and before secondary masses can be distinguished through the abdominal wall. It must be borne in mind, however, that negative findings are of no value. One must also be guarded against mistaking for this condition, faecal concretions higher up in the sigmoid, and old inflammatory deposits in the pelvis. Tuberculous peritonitis can be differentiated by the "feel" of the mass, its location being more diffuse, taken together with the history of the patient. Dr. Blumer cites a case where a small subperitoneal myoma projecting into Douglas' pouch caused some confusion. He also calls attention to the fact that Houston's fold of the rectum is sometimes thickened.

Once the peritoneal covering of the primary growth has been broken through, the carcinoma cells are spread in more or less numbers throughout the serous cavity by gravitation, intestinal movements, or the normal circulation of the intraperitoneal fluid. We believe that a fair percentage of these cells will early find their way to the lower part of the cavity, and because of the position of the rectum acting as a shelf, they will in many instances lodge thereon. The tendency to gravitate to the pelvis is more pronounced because most of the patients with upper abdominal carcinoma are able to be about and often do light work.¹

¹ This is contrary to those experiments where shot have been introduced within the peritoneal cavity and are found not to gravitate to the pelvis; nevertheless, the clinical evidence seems to warrant this assumption.

The above findings, which are brought out better by the rectal examination than by the vaginal, have been of value also in leading to a positive diagnosis of carcinoma of the stomach in cases where no tumor could be palpated even on distention. They are also, if present, positive proof in the differential diagnosis of carcinoma from that little understood class of cases with a stomach history and laboratory findings typical of carcinoma of the stomach, but in which no cancer is present. Findings of this character will also establish the diagnosis between a well starved ulcer case with considerable tumefaction and a carcinoma case. A few cases have been referred to us as being pelvic. Examination showed findings as described above and directed our attention to a stomach history the patient had not emphasized, and here we found the primary and important condition.

Several years ago in this clinic, when attention first began to be paid to these pelvic deposits, a few cases were operated upon, the local condition being such as to indicate a radical procedure, but on slipping the hand into the pelvis the peritoneal deposits were found to be definitely carcinomatous. Through correspondence we found, further, that quite a number of patients similarly affected where operation was refused solely because of the deposits, had died in a few months. As a means to more exact prognosis such deposits demonstrate the life of the patient to be positively limited and to have passed beyond the operative stage.

In the four hundred and thirty-five case histories, were three hundred and seven cases of carcinoma of the stomach, the remainder being of the intestine, pancreas, liver, and gall-bladder. In this number twenty-eight showed secondary deposits on the rectal shelf or in the cul-de-sac of Douglas. No secondary deposits were to be palpated through the abdomen, and with two exceptions, abdominal fluid was clinically questionable or absent. Of the twenty-eight cases, four had palliative operations for obstructive symptoms; two of these were pyloric, one ileocaecal, and one of the ascending colon. Of the nineteen cases not operated upon, the clinical diagnosis was primary cancer or cancer on ulcer in all but

four, and these were diagnosed carcinoma of the liver, and carcinoma of the upper sigmoid. Regarding sex, our series is at variance with some other reported cases as showing a larger percentage of females, namely, ten of twenty-eight cases. The tendency for detached malignant cells to implant themselves upon uterine adnexa was shown by two cases of gastric cancer with secondary malignant ovarian tumors found in the same period. A few cases only showed rectal symptoms of increased constipation during the last few months, and three showed irritable bladder developing. The constipation could hardly have been attributed to the size of the mass; the irritable bladder might have been due to deposits on the bladder wall.

In the series of four hundred and thirty-five cases we found eighteen cases of supraclavicular gland enlargement. Several glands were subjected to microscopic examination, but the majority of patients were refused operation on the clinical findings alone, the supraclavicular glands being the deciding feature. Only two cases showed both supraclavicular and pelvic metastasis. One case showed right-sided, and one right and left sided glandular involvement, and the remainder were left-sided only. These do not include a few cases where we were unable to locate the primary focus.

If the number of cases here reported may be taken as a fair average, then the pelvic deposits are of much more value as a means of decision as to the inoperability of a given case than the supraclavicular metastasis, and by means of pelvic and supraclavicular metastasis more than 10 per cent of the whole shown to be hopeless without exploration. It is only within the last few years that attention has been called to this sign in the current literature by such men as Schnitzler, Kæppeler and Kellog of Germany, Mr. G. Gray Turner of England, and Dr. George Blumer of this country.

Age seems to have little influence as regards whether these warning flags shall be hung in the pelvis or in the shoulder. Both types showed cases in all of the cancer decades.

SUMMARY

1. Rectal examination is absolutely necessary in all abdominal tumors.

2. Of 435 consecutive cases of carcinoma of the upper abdomen six and one-half per cent showed pelvic transplantation deposits as the earliest clinical sign of inoperability. Seven and two-tenths of stomach carcinomas had this sign.

3. Fifty-five per cent more cases were shown

to be inoperable through a thorough rectal examination for pelvic metastasis, than because of the presence of supraclavicular gland metastasis.

4. Pelvic metastasis warrants a most unfavorable prognosis as regards life expectancy.

