AN OESOPHAGEAL TUMOUR

REPORT OF A CASE

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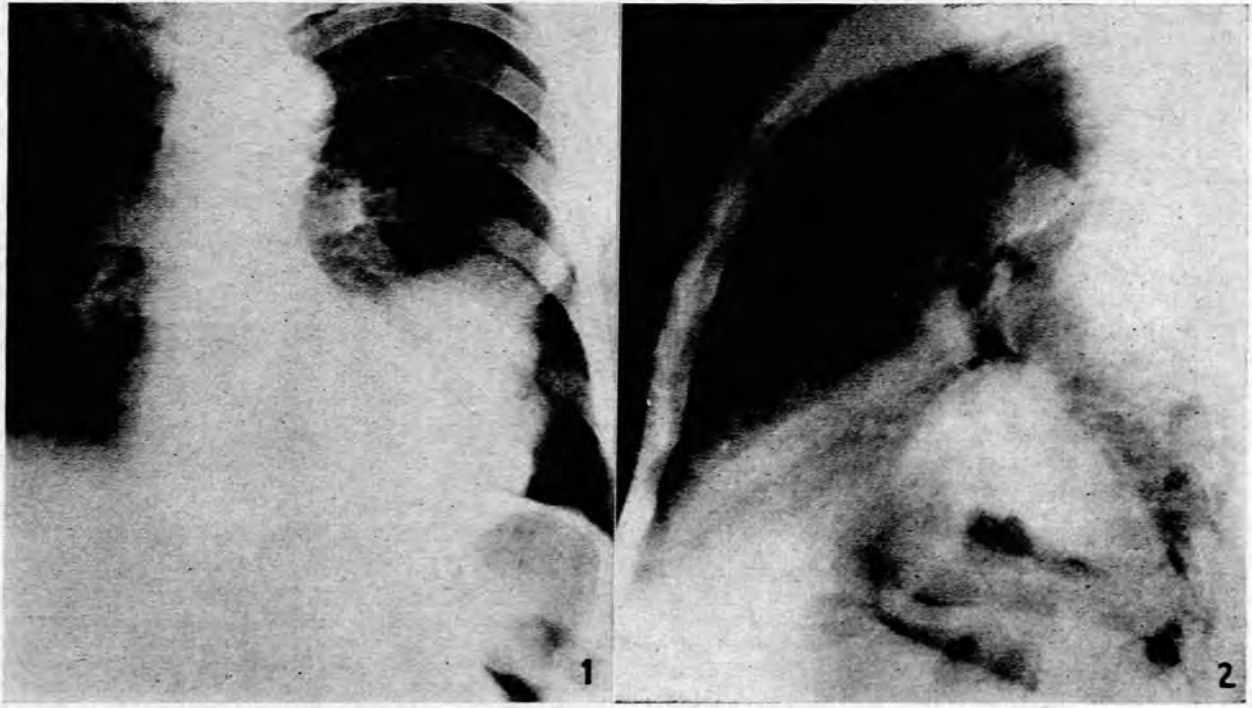
A Coloured male aged 47 presented with a 5-months history of pain in the right upper quadrant of the abdomen, and anorexia. On one occasion, 2 years previously, he had vomited a small amount of fresh blood.

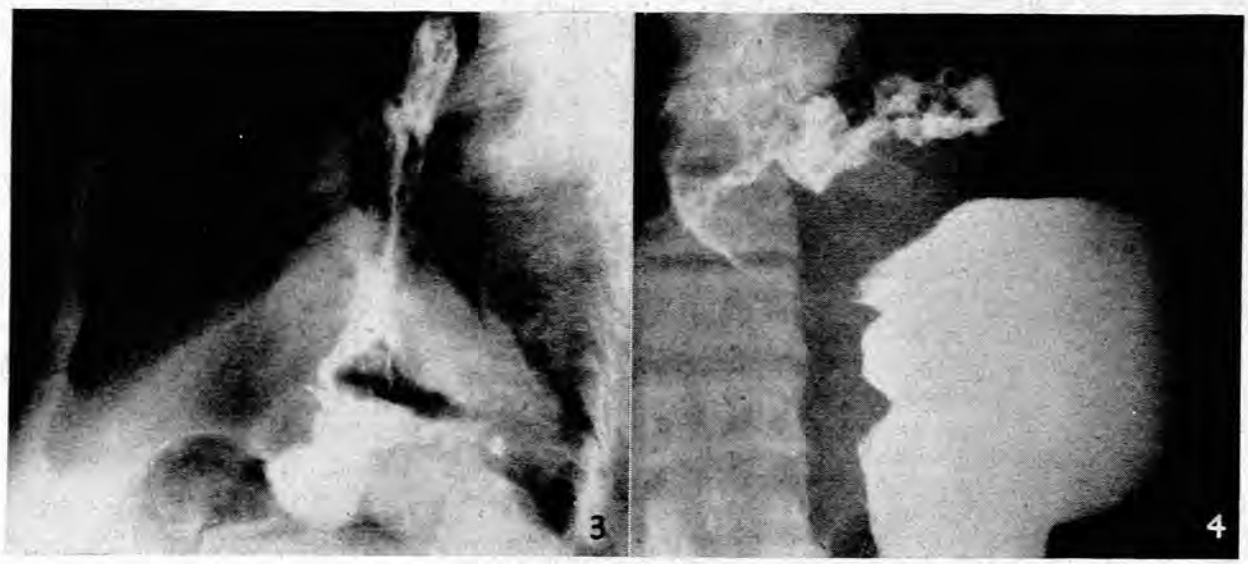
On examination evidence was found of marked loss of weight and a 6-finger hepatomegaly.

X-ray of the chest showed a lobulated mass in the posterior mediastinum, which extended into the left hemithorax and contained a fluid level (Figs. 1 and 2). Liver biopsy showed infiltration with a spindle-cell sarcoma.

Barium swallow showed an irregular appearance in the lower third of the oesophagus which was moderately dilated. There



Figs. 1 *and* 2. X-ray of chest.



Figs. 3 *and* 4. Barium swallow.

was a communication with the lumen of the mediastinal mass (Figs. 3 and 4).

Oesophagoscopy showed a smooth mass projecting into the lumen, and biopsy gave similar tissue to that already obtained by liver puncture. Mitotic figures were present but not numerous and there was a moderate degree of cellular atypicality. The most likely diagnosis was considered to be leiomyosarcoma with hepatic metastases, and the histological picture was compatible with this (Fig. 5).

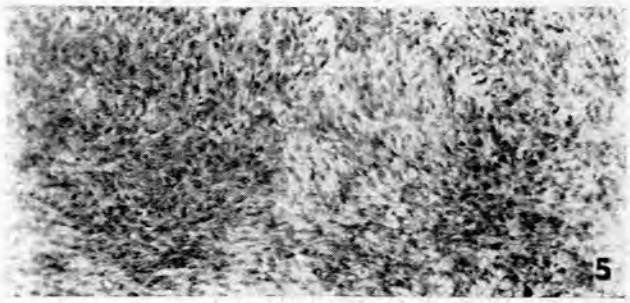


Fig. 5. Oesophageal biopsy.

DISCUSSION

Smooth-muscle tumours of the gastro-intestinal tract are well described,[1-3] and may vary from a few millimetres to many centimetres in diameter. Metastases may sometimes be found. Various authors[2-4] note that it may be difficult or impossible to distinguish histologically between smooth muscle tumours and neurilemmomas or Schwann-cell tumours, which are said not to undergo metastasis.[5]

The presentation of this case is unusual. Only 6 of Golden and Stout's series of 60 cases gave evidence of metastases and probably only 2 presented as a result of them. Lumb states that metastasis is a rare event; he supports the views of others that histological assessment of malignancy may be difficult. The findings here accord with this.

Central cavitation, presumably due to poor blood supply, is a feature of smooth-muscle tumours but is not confined to them nor only to those associated with the gut.[6] It is usually found in the larger specimens, but not always so, and appears to be preceded by colliquative necrosis.[3]

The radiological findings here are typical of the extra-luminal type of growth which tends to expand outward and reach a large size. Obstruction is not usually a feature, but there may be pressure on other organs. A sinus leading into the centre of the tumour may be noted.[2, 7] Martin[7] states that there may be interference with peristalsis round this type of tumour, and air seen on straight X-ray in such a tumour has previously been reported,[3] but we have not seen a similar lesion recorded in the oesophagus. Sinus formation has been reported in several other varieties of tumour—lymphoma and primary melanoma[7] and neurilemmoma[8] are amongst the commonest. Buckstein[9] quotes Lapidaris' case where a filiform sinus was seen leading from a tumour in the prepyloric region. This eventually proved to be a duct in ectopic pancreatic tissue.

The intraluminal variety, if large enough, tends to cause obstruction and so present earlier. A smooth round defect may be seen on barium examination which is not associated with disturbance of peristalsis.[9] Ulceration may be present over the dome of the tumour.[9]

We suggest that a distinction might be drawn between superficial ulceration or niche formation and sinus formation or cavitation. As seen over a radiologically benign tumour, superficial ulceration appears to be a relatively non-specific finding and is presumably due to pressure necrosis, from below, of the overlying mucous membrane. Sinus formation or cavitation, on the other hand, usually seems to indicate the presence of a smooth-muscle tumour, which is one of the commonest mesodermal tumours of the gut. The cavity is presumably produced by the discharge of the preformed fluid contents through a necrosed area of mucous membrane overlying the dome of the tumour.

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by Dr. M. Sacks and Dr. H. H. Golby. The photographs of the X-rays were taken by Mr. B. Todt and the microphotograph by Mr. G. McManus.

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