one time. No patient can eat often enough to maintain adequate nutrition under these circumstances. Our patient's repeatedly negative serological tests and her failure to respond to a therapeutic test with mercury and iodide made the diagnosis of syphilis untenable.

Other Chronic Granulomas. Tuberculosis, Hodgkin's disease and Boeck's sarcoid may produce large stomach ulcers. Exploratory laparotomy and biopsy are the only means of diagnosing them.

Chronic gastritis might be associated with x-ray findings similar to our patient's. The fever and the palpable spleen are not associated with gastritis. Differentiation of these conditions might be made by gastroscopy in some cases.

SUMMARY AND CONCLUSIONS

Far advanced cauliflower carcinoma of the stomach had been diagnosed by roentgen examination of the subject of this case report. The four year duration of the disease without cachexia, the prolonged septic fever, the splenomegaly and the late appearance of occult blood in the stool led to the speculation that a lymphoblastoma might be present. This was confirmed by necropsy.

The occurrence of these clinical features, separately or in combination, should lead to the suspicion of lymphoblastoma of the stomach. Appropriate diagnostic measures including gastroscopy and a trial of X-ray therapy should be instituted as soon as possible in such cases.

REFERENCES


Carcinoma Of The Esophagus

Transplural Resection and Esophago-Gastrostomy*

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UNTIL quite recently, the surgical treatment of carcinoma of the esophagus was entirely palliative and consisted either of gastrostomy or jejunostomy and had for its purpose the relief of obstructive disturbances and the feeding of the patient. However, as a result of the development of new techniques and with the earlier recognition of the disease in its operable stage, the surgical treatment has become directed toward the actual eradication of the lesion proper. In this country, the first successful resection of the esophagus for carcinoma was performed by F. Toreck (1). In this operation, the distal portion of the esophagus, after the carcinomatous portion had been resected, was closed and the proximal portion was brought out upon the skin forming a permanent stoma at this site. The first case in this country in which the continuity of the esophagus and stomach was re-established, by performing an esophago-gastrostomy after resecting the carcinomatous portion of the esophagus, was performed by W. E. Adams and D. B. Phemister (2). Since then there have been more reports of such successful operations. J. Garlock (3). E. D. Churchill and R. H. Sweet (4) have reported comparatively large series of such cases. H. Lilienthal (5) was one of the pioneer workers in this field and reported a successful case in which the operation was performed by the extrapleural posterior mediastinal approach. In the other reports noted above, the operation was performed by the transpleural transdiaphragmatic method.

It is not only significant but it is also clinically important to realize that carcinoma of the esophagus remains a localized disease for a considerable time and metastasizes quite late in the course of the disease. In a series of postmortem examinations, Watson (6) found an absence of metastatic lesions in 50% of his cases Helsley (7) encountered similar findings in 64% of his autopsy cases and Zuppinger (8) found that 33% of his postmortem examinations showed an absence of metastases. Keeping these figures in mind and noting that 33½% of all deaths from cancer in New York City can be attributed to carcinoma of the esophagus, Watson (6), it is quite obvious that early diagnosis would change the nature of treatment of this disease from merely palliative to truly radical with a corresponding change in the end results. The following case is reported to demonstrate what can be accomplished by radical treatment in these cases even when the condition appears to have reached the stage of inoperability.

CASE REPORT

C. P. §116329 male 62 years old was admitted to City Hospital, New York City, July 30th, 1942. His family and past history were irrelevant and have no bearing upon his present condition. Up to about nine months ago the patient felt perfectly well. At
that time he began to vomit solid foods almost immediately after eating. Shortly thereafter, he began to vomit semi-solid foods and at the present time he is having considerable difficulty in swallowing and retaining fluids. During this time he has had almost continuous epigastric distress. There has been a weight loss of 40 pounds and he has become quite asthenic. Just before admission to this hospital, he was investigated at the Columbus Hospital, New York City, where a diagnosis of carcinoma of the stomach was made.

Physical examination shows the patient to be markedly cachectic. The abdomen is scaphoid, the skin is loose and wrinkled with almost complete loss of subcutaneous fat. No other abnormalities were noted. Clinical impression—carcinoma of the lower esophagus or of the cardia of the stomach. On August 3rd, 1942 a barium Roentgenogram of the esophagus or of the cardia of the stomach was made. The above findings indicate an organic lesion. This is most likely a carcinoma.

In view of the marked asthenia and cachexia, a radical surgical procedure at this time could not be carried out safely. A jejunostomy was planned as a preliminary operation with the idea of (1) overcoming the marked undernourishment and starvation by the introduction of a high caloric diet directly into the intestines and (2) of putting the esophageal lesion at complete physiologic rest and thus reducing the secondary inflammation which invariably accompanies an ulcerating carcinomatous lesion.

On August 7, 1942, a jejunostomy was performed. The stomach and the distal portion of the esophagus were palpated at this time. The abdominal portion of the esophagus was found to be markedly indurated, thickened and fixed. The lymph nodes in the gastro-hepatic omentum near the cardia were enlarged and quite hard. The patient made an uneventful postoperative recovery and picked up rapidly with the high caloric jejunostomy feedings and blood transfusions. By August 24, 1942, his general condition had improved to such an extent that a radical excision of the carcinoma could be done.

Pre-operative diagnosis, Carcinoma of the lower third of the esophagus.

Post-operative diagnosis, Same.

Operation Transthoracic and Transdiaphragmatic Resection of the lower third of the esophagus and of the cardia of the stomach with primary esophago-gastrostomy.

Findings. Lower third of the esophagus was firmly attached to the surrounding structures. Clump of hard fixed lymph nodes in the gastro-hepatic ligament near the cardia about the size of walnut.

PROCEDURE

With the patient lying on his right side, an incision was made in the left seventh interspace from the mammary line anteriorly to a point midway between the line of the angle of the scapula and the vertebral bodies, posteriorly. Segments, \( \frac{3}{4} \) inch in length were removed subperiosteally from the seventh and eighth ribs near the posterior angle. The pleural cavity was now opened through the seventh intercostal space. The wound was retracted widely and very satisfactory exposure of the pleural contents was obtained. The lung was now covered with warm pads and retracted leaving the mediastinal structures and the diaphragm in full view. The movements of the diaphragm were now quieted by crushing the phrenic nerve. The mediastinal pleura above the neoplasm was incised longitudinally and this part of the normal esophagus was freed from the surrounding structures by blunt dissection. The dissection was now carried down toward the diaphragm freeing the organ to the hiatus. At this point the adhesions were so dense that it was necessary to cut the diaphragm radially from the esophagus toward the chest wall for a distance of five inches in order to continue with the dissection of this structure from the abdomen. With this maneuver the freeing of the neoplasm became comparatively simple. The superior portion of the gastro-splenic ligament was ligated and cut. The left portion of the gastro-hepatic ligament and the gastric artery were now ligated and severed. The cardiac portion of the stomach was thus mobilized and could be readily brought up into the pleural cavity. A rubber covered clamp was now placed across the esophagus about two inches above the upper part of the neoplasm. A similar clamp was placed across the stomach about two inches below the lower part of the tumor. The neoplasm was now removed with a normal zone of esophagus above and with the cardia of the stomach below. The opening in the stomach was closed with two layers of sutures thus forming a closed upper pouch. The free end of the remaining esophagus was now anastomosed to the gastric pouch making the union on the anterior wall of the stomach about one inch below the blind upper extremity. The esophago-gastrostomy was of the end to side variety employing the customary two layers of sutures. The inner layer of sutures was interrupted throughout in order to avoid the possibility of stricture formation at the site of the anastomosis, which is much more apt to occur when a continuous suture is used. In order to avoid drag and tension on the suture line as a result of movements of the adjacent viscera, several interrupted sutures were placed through the sides of the gastric pouch attaching it firmly to the adjacent parietal pleura and endothoracic fascia. In this manner, the possibility of a leak at the site of the suture line is reduced to a minimum. The inner portion of the incised diaphragm was now closed by sewing it to the stomach about an inch below the line of anastomosis. The outer portion was closed with a continuous catgut suture. A second layer of sutures was applied to assure an effective closure. The chest wall proper was now closed by applying three stout