

Clinical and Pathological Reports

SKIN AND SUBCUTANEOUS TISSUES

MURRAY, M. R., and STOUT, A. P. [Coll. of Physicians and Surgeons and Presbyterian Hosp., New York, N. Y.] **THE GLOMUS TUMOR. INVESTIGATION OF ITS DISTRIBUTION AND BEHAVIOR, AND THE IDENTITY OF ITS "EPITHELIOD" CELL.** *Am. J. Path.*, 18:183-203. 1942.

The glomus tumor is reputed to arise from the glomic structure (the highly specialized arteriovenous anastomosis), which has been found only in certain parts of the hands and feet at the cutaneous-subcutaneous junction. However, glomus tumors have been found in areas widely scattered over the surface of the body and also in deeper tissues such as striated muscle and those of the joint capsule. As a result of tissue culture studies of material from an infiltrative glomus tumor as well as from 2 benign glomus tumors, the authors have concluded that the characteristic "epithelioid" cell is the "pericyte" of Zimmermann (*Ztschr. f. Anat. u. Entwicklungsgesch.*, 68, 29-109. 1923) found around capillaries in numerous organs. This identification offers a satisfactory explanation of the occurrence of glomus tumors in regions where the normal glomus has not been demonstrated.

In the tissue cultures from the infiltrative glomus tumor, growing capillary buds were observed to become encrusted by "epithelioid" cells (pericytes); the latter cells were characterized by delicate branched pseudopodia and by a globular nucleus with 1 or 2 nucleoli and, commonly, with clear vacuoles. Silver impregnation methods were necessary to bring out the details of the processes completely. No myofibrils were seen in the pericytes, nor was any cell seen to contract. Morphologically the epithelioid cell resembles the pericyte as described by Zimmermann, and although it is related to the common adventitial cell of Clark and Clark (*Am. J. Anat.*, 66:1-49. 1940) it is thought to be a distinct type.—H. B.

RULISON, R. H. [New York, N. Y.] **MALIGNANT MELANOMA.** *J. A. M. A.*, 119:1254. 1942.

Report of a case in which 9 years and 3 months intervened between the removal of a malignant melanoma of the skin and the appearance of metastatic growths.—H. G. W.

FEMALE GENITAL TRACT

COLLINS, C. G., BEACHAM, W., and SCHATTEBERG, H. J. [Tulane Univ. Med. Sch., New Orleans, La.] **ARRHENOBLASTOMA OF THE OVARY.** *New Orleans, M. & S. J.*, 94:589-592. 1942.

The report of a case.—H. G. W.

CROSSEN, H. S. [St. Louis, Mo.] **THE MENACE OF "SILENT" OVARIAN CARCINOMA.** *J. A. M. A.*, 119:1485-1489. 1942.

In the author's opinion, the danger is great enough to warrant removal of the involuting ovaries whenever the abdomen is opened under circumstances which permit such removal. The author stresses also: insistence upon regular periodic pelvic examinations; utilization of every opportunity afforded by anesthesia for a minor vaginal operation, to make deep accurate palpation of the ovarian areas.—H. G. W.

FOX, R. A. [New York Post-Graduate Med. Sch. and Hosp., Columbia Univ., New York, N. Y.] **BRENNER TUMOR OF THE OVARY. CASE REPORTS, DISCUSSION AND BIBLIOGRAPHY.** *Am. J. Path.*, 18:223-235. 1942.

The author adds 4 instances of Brenner tumor of the ovary to the 166 found in the literature. In 3 of the new cases and in 10 of those previously reported the tumors were bilateral. In the 4 cases described the tumors varied in size from tiny nodules to masses as large as a man's head. They were either entirely solid or occurred as nodules in the wall of an ovarian cyst. Microscopically they were composed of an abundant fibrillary connective tissue in which there were small solid nests of polyhedral cells with at times "cystic degeneration" in the center. The cyst-like spaces in the centers of the nests were lined by radially arranged columnar cells and contained mucoid secretion. The histogenesis of this benign and physiologically inert tumor is unknown.—H. B.

GNASSI, A. M., FAISON, J. B., and FELLMAN, M. [Medical Center, Jersey City, N. J.] **GRANULOSA CELL CARCINOMA. REPORT OF 2 CASES.** *Am. J. Roentgenol.*, 47:458-462. 1942.

Two cases are reported in which rapidly fatal granulosa cell tumors with metastases occurred in women during the reproductive age. Most of these tumors are radiosensitive but not radiocurable; complete surgical removal is advised. Seven photomicrographs are presented.—C. E. D.

HARRIS, W. H. [Tulane Univ. School of Med., New Orleans, La.] **GRANULOSA CELL TUMORS OF THE OVARY.** *Surg., Gynec. & Obst.*, 75:245-251. 1942.

A case is reported of granulosa cell tumor of the ovary with metastases to the terminal ileum. There was evidence of endocrine activity, as manifested by the hyperplastic proliferative endometrium.—H. G. W.

HOBBS, J. E. [Washington Univ. Sch. of Med., St. Louis, Mo.] **PRIMARY CARCINOMA OF THE FALLOPIAN TUBE.** *South. M. J.*, 35:733-737. 1942.

A case report.—H. G. W.

MEZER, J. [Harvard Med. Sch., Boston, Mass.] **METAPLASIA AND CARCINOMA IN CERVICAL POLYPS.** *Surg., Gynec. and Obst.*, 75:239-244. 1942.

Cervical polyps are common, being found in from 1.5 to 10% of gynecological patients. A third of the polyps studied were subject to squamous metaplasia, which is neither a precancerous nor a malignant process. Of 1,636 polyps studied, carcinoma arose in but 5.—H. G. W.

RESNISKY, A. F. [Hartford, Conn.] **CARCINOMA OF THE UTERINE FUNDUS.** *Connecticut M. J.*, 6:173-174. 1942.

Dilatation and curettage, pathological examination, and careful subsequent observation should be carried out as a routine in any type of bleeding after the menopause.—R. C. R.

MALE GENITAL TRACT

ALYEA, E. P., and HENDERSON, A. F. [Duke Univ. Sch. of Med., Durham, N. C.] **CARCINOMA OF THE PROSTATE. IMMEDIATE RESPONSE TO BILATERAL ORCHIECTOMY; CLINICAL AND X-RAY EVIDENCE.** *J. A. M. A.*, 120:1099-1102. 1942.

A series of 40 cases of carcinoma of the prostate in which bilateral orchidectomy has been done shows remarkable im-

mediate favorable results. Pronounced subjective improvement is associated with lowering of the serum acid phosphatase, x-ray signs of healing of bone metastases, and the disappearance of pulmonary metastases. Diethylstilbestrol causes a similar improvement but not in the same degree. No prophecy is made as to what the results will be after the first postoperative year.—H. G. W.

BELT, E. [New York, N. Y.] **RADICAL PERINEAL PROSTATECTOMY IN EARLY CARCINOMA OF THE PROSTATE.** *J. Urol.*, 48:287-297. 1942.

Of 50 patients operated upon by radical perineal prostatectomy, 58% have not shown a return of the disease for various periods, 24% having been free of the disease for over 4 years.—H. G. W.

CAMPBELL, H. E. [Harvard Med. Sch., Boston, Mass.] **INCIDENCE OF MALIGNANT GROWTH OF THE UNDESCENDED TESTICLE. A CRITICAL AND STATISTICAL STUDY.** *Arch. Surg.*, 44:353-369. 1942.

It has been the prevalent belief heretofore that the abdominal testicle is less liable than the inguinal to malignant change. This gave rise to the practice of putting the inguinal testicle back into the abdomen if it could not be conveniently returned to the scrotum. In a critical analysis of the data reported the author concludes that the undescended testicle is more susceptible to malignant change than is the scrotal, and that the abdominal is more prone to malignant disease than the inguinal testis. The ratio of malignant tumors in the inguinal testis to those in the abdominal testis is 1 to 4. Thus one in about 20 abdominal testicles shows malignant change as compared with one in about 80 inguinal.—R. C. R.

CREEVEY, C. D. [Univ. of Minnesota Med. Sch., Minneapolis, Minn.] **THE DIAGNOSIS AND TREATMENT OF EARLY CARCINOMA OF THE PROSTATE.** *J. A. M. A.*, 120:1102-1105. 1942.

Radical perineal prostatectomy alone offers any real hope of cure, although its rate of applicability is low. The role of endocrine preparations in the therapy of the disease in its early stages offers interesting possibilities.—H. G. W.

DOCKERTY, M. B., and PRIESTLEY, J. T. [Mayo Clinic, Rochester, Minn.] **DERMOID CYSTS OF THE TESTIS.** *J. Urol.*, 48:392-400. 1942.

Only 3 dermoids were found in a series of about 400 testicular tumors surgically removed at the Mayo Clinic.—H. G. W.

EVANS, N., BARNES, R. W., and BROWN, A. F. [Los Angeles County Hosp., Los Angeles, Calif.] **CARCINOMA OF THE PROSTATE. CORRELATION BETWEEN THE HISTOLOGIC OBSERVATIONS AND THE CLINICAL COURSE.** *Arch. Path.*, 34:473-483. 1942.

From a study of 100 cases, it is concluded that a histologic grade of carcinoma of the prostate based on the degree of abnormality of the acini, the cells, and the nuclei, is of use in predicting the length of survival of the patient. The grade of the carcinoma indicates the probability of the occurrence of metastasis. The higher grades of carcinoma occur slightly earlier in life than do the lower. Roentgen therapy appears to lengthen survival time, especially in patients with the higher grades of carcinoma.—H. G. W.

GUTMAN, A. B. [Coll. of Physicians and Surgeons and Presbyterian Hosp., New York, N. Y.] **SERUM "ACID" PHOSPHATASE IN PATIENTS WITH CARCINOMA OF THE PROSTATE GLAND. PRESENT STATUS.** *J. A. M. A.*, 120:1112-1116. 1942.

Acid phosphatase is elaborated by the acinar epithelium of the prostate gland, but its function is not yet known. Carcinomatous prostate tissue contains large amounts of acid phosphatase. This may have some causal relation to the common osteoplastic character of the bone metastases, and accounts for the increased amount demonstrable in the blood in most cases of prostatic carcinoma. Elevated values for acid phosphatase were obtained in about 85% of a total of 177 cases of proved or suspected metastatic prostate carcinoma, while about 90% of patients with prostatic carcinoma without x-ray evidence of bone metastases gave figures within normal limits. Serum alkaline phosphatase also is usually increased after metastatic spread of the carcinoma and depends on the osteoplastic reaction of bone at the site of the osseous metastases. In cases of carcinoma of the prostate in which castration is performed there is usually a sharp fall in the serum acid phosphatase. The determination of serum acid phosphatase is of great value in differentiating other carcinomas with bone metastases, and Paget's disease of bone. It is useful also in detecting the presence of metastases before they are recognizable by x-ray examination.—H. G. W.

HAMM, F. C. [Brooklyn Hosp., Brooklyn, N. Y.] **CLINICAL ASPECTS OF CARCINOMA OF THE PROSTATE. REVIEW OF 38 OPERATIVE CASES.** *J. Urol.*, 48:174-186. 1942.

A clinical study.—H. G. W.

HECKEL, N. J., and KRETSCHMER, H. L. [Presbyterian Hosp. and Univ. of Illinois, Chicago, Ill.] **CARCINOMA OF THE PROSTATE TREATED WITH DIETHYLSTILBESTROL. HISTOLOGIC ALTERATIONS.** *J. A. M. A.*, 119:1087. 1942.

Pronounced hydropic degeneration and vacuolation of the neoplastic cells were shown by biopsy.—H. G. W.

HERBST, W. P. [Georgetown Univ. Med. Sch., Washington, D. C.] **BIOCHEMICAL THERAPEUSIS IN CARCINOMA OF THE PROSTATE GLAND. PRELIMINARY REPORT.** *J. A. M. A.*, 120:1116-1120. 1942.

The biochemical control of cancer of the prostate is based on the maintenance of a low androgen and acid phosphatase blood level. Control has been maintained for as long as 22 months by the use of estradiol dipropionate and for as long as 2½ years or more by castration. Chute advocates castration and large doses of diethylstilbestrol. Testosterone elevates blood phosphatase and therefore should be administered with caution. The dose of estrogens to be administered should not be more than that required to maintain control of the malignant process. In some instances, the malignant process may be accelerated by diethylstilbestrol. Should the cancer cease to remain quiescent in the castrated patient, as carcinoma of the breast sometimes shows renewed activity after a quiescent period following bilateral oophorectomy, it would seem likely that control may be regained by giving estradiol dipropionate or diethylstilbestrol and possibly other biochemical agents not yet utilized or available.—H. G. W.

KAHLE, P. J., OGDEN, H. D., Jr., and GETZOFF, P. L. [Sch. of Med., Louisiana State Univ., New Orleans, La.] **THE EFFECT OF DIETHYLSTILBESTROL AND DIETHYLSTILBESTROL DIPROPIONATE ON CARCINOMA OF THE PROSTATE GLAND. I. CLINICAL OBSERVATIONS.** *J. Urol.*, **48:88-98.** 1942.

Having observed that diethylstilbestrol and diethylstilbestrol dipropionate caused retrogression of the epithelium when administered to patients with hypertrophy of the prostate, the authors used these substances in 7 cases of carcinoma of this organ. In all patients treated there was prompt relief from pain and urinary symptoms, a general improvement in health, and a regression of the malignant lesion. The prostate glands became so altered that a diagnosis of carcinoma would have been impossible by rectal palpation. There was a regression of metastases in the lymph nodes in the 2 cases in which metastases were present, and a regression of metastatic lesions in bones in the only instance in which serial roentgenologic observations were possible. These regressions could be readily correlated with the pronounced regressive tissue changes observed in the histologic study of specimens secured by biopsy after treatment.—H. G. W.

NESBIT, R. M., and CUMMINGS, R. H. [Univ. of Michigan Med. Sch., Ann Arbor, Mich.] **PROSTATIC CARCINOMA TREATED BY ORCHIECTOMY. A PRELIMINARY REPORT BASED ON SEVENTY-FIVE CASES OBSERVED FOR AT LEAST SIX MONTHS FOLLOWING OPERATION.** *J. A. M. A.*, **120:1109-1111.** 1942.

Seventy-five cases of prostatic cancer treated by orchidectomy have been observed over periods of at least 6 months. Preoperative elevation in the serum acid phosphatase level was found in 39% of the cases in which the determination was made. Favorable response as determined by both subjective and objective criteria has been observed in 73% of the cases. There have been 20 failures, 10 of which were delayed with postoperative relapse at periods of from 3 to 22 months. This fact offers disquieting implications regarding the ultimate outcome in any instance.—H. G. W.

PRINCE, C. L. [Univ. of Virginia Sch. of Med., Charlottesville, Va.] **MALIGNANT TUMORS OF THE SPERMATIC CORD: A BRIEF REVIEW WITH PRESENTATION OF A CASE OF ANGIO-ENDOTHELIOMA.** *J. Urol.*, **47:793-799.** 1942.

A case of angio-endothelioma of the spermatic cord, the first tumor of this type reported, is added to the 74 cases of malignant tumor of the cord found in the literature.—H. G. W.

PRINCE, C. L. [Univ. of Virginia Med. Sch., Charlottesville, Va.] **RHABDOMYOSARCOMA OF THE TESTICLE.** *J. Urol.*, **48:187-195.** 1942.

Two new cases are added to the 15 reported in the literature. The tumor in one of the new cases weighed 2,050 gm. The histogenesis and structure of rhabdomyosarcomas of the testicle are discussed in some detail and the clinical features of the previously reported cases are reviewed.—H. G. W.

RAVICH, A. [Jewish Hosp., Brooklyn, N. Y.] **THE RELATIONSHIP OF CIRCUMCISION TO CANCER OF THE PROSTATE.** *J. Urol.*, **48:298-299.** 1942.

A survey of over 840 persons requiring prostatic operation reveals 1.7% of cancer among 768 Jewish patients as against 20% of cancer among 75 non-Jews.—H. G. W.

SCHENKEN, J. R., BURNS, E. L., and KAHLE, P. J. [Sch. of Med., Louisiana State Univ., New Orleans, La.] **THE EFFECT OF DIETHYLSTILBESTROL AND DIETHYLSTILBESTROL DIPROPIONATE ON CARCINOMA OF THE PROSTATE GLAND. II. CYTOLOGIC CHANGES FOLLOWING TREATMENT.** *J. Urol.*, **48:99-112.** 1942.

Histologic studies were made on tissues from 6 patients with carcinoma of the prostate who were being treated with diethylstilbestrol and diethylstilbestrol dipropionate. In all 6, definite retrogressive changes in the nucleus and cytoplasm of the tumor cells were observed. The ultimate change that may occur in these neoplastic cells is undetermined.—H. G. W.

SULLIVAN, T. J., GUTMAN, E. B., and GUTMAN, A. B. [Coll. of Physicians and Surgeons and Presbyterian Hosp., New York, N. Y.] **THEORY AND APPLICATION OF THE SERUM "ACID" PHOSPHATASE DETERMINATION IN METASTASIZING PROSTATIC CARCINOMA; EARLY EFFECTS OF CASTRATION.** *J. Urol.*, **48:426-458.** 1942.

This is a study of the results of serum acid phosphatase determinations made in 200 cases of prostatic carcinoma. In 33 of the cases castration had been performed. As an indicator of the presence of metastatic carcinoma the method failed (less than 3 units per 100 cc. of serum) in approximately 15% of 130 patients with prostatic carcinoma presenting definite or suggestive roentgenographic evidence of metastases; the remaining 85% showed an increase in serum acid phosphatase, which in extreme cases exceeded 1,000 units per 100 cc. of serum. Approximately 89% of 70 patients with prostatic carcinoma but showing no roentgenographic evidence of skeletal metastases gave values of less than 3 units per 100 cc. as did all 85 patients with diseases of the prostate gland other than carcinoma. Of a control group of 570 patients with nonprostatic disease, 90% had serum acid phosphatase levels of less than 3 units per 100 cc.; 7.5% gave values between 3 and 4.9 units per 100 cc.; and 2.5% gave values of more than 5 units per 100 cc. (maximum 9.0 units per 100 cc.). The conclusion drawn from these observations is that the method is consistent and specific enough to be of value though not an infallible supplement to clinical, roentgenographic, and other procedures for the diagnosis of metastasizing prostatic carcinoma. Castration in 31 patients with metastasizing prostatic carcinoma and serum acid phosphatase levels ranging from 520 to 4.2 units per 100 cc. resulted in an early precipitous fall in serum acid phosphatase until, after 2 or 3 months, an equilibrium was reached. The effect of castration on the serum alkaline phosphatase was more variable but eventually, after many months, equilibrium was reached. Most of the patients showed remarkable clinical improvement following castration.—H. G. W.

THOMPSON, G. J. [Mayo Clinic, Rochester, Minn.] **TRANSURETHRAL RESECTION OF MALIGNANT LESIONS OF THE PROSTATE GLAND.** *J. A. M. A.*, **120:1105-1109.** 1942.

In 95% of cases the disease has spread beyond the confines of the prostate gland when the patient is first observed, so that in but 5% or less radical resection is justifiable. Transurethral resection is the most desirable operation for the relief of obstruction; combined with bilateral orchidectomy and the administration of diethylstilbestrol, it offers the best method of treatment now available for patients who have retention of urine.—H. G. W.

GASTROINTESTINAL TRACT

GOLDMAN, C., and ROBILLARD, G. L. [Cumberland Hosp., Brooklyn, N. Y.] **MALIGNANT MELANOMA OF THE RECTUM. REPORT OF A CASE.** *Am. J. Surg.*, 57:352-355. 1942.

Melanomas of the intestinal tract constitute 2 to 3% of all melanomas and are most frequently found in the rectum. A case is reported.—H. G. W.

JUDD, E. S., Jr. [Mayo Clinic, Rochester, Minn.] **RESIDUAL LESIONS OF ULCERATIVE GASTRITIS. POSSIBLE RELATIONSHIP TO THE DEVELOPMENT OF CARCINOMA OF THE STOMACH.** *Surg., Gynec. and Obst.*, 75:424-432. 1942.

A microscopic study was made of sections from 200 carcinomatous and 78 control stomachs, and the occurrence of certain residual lesions frequent in carcinomatous stomachs is compared to their presence in the noncarcinomatous organ. Evidence is presented to indicate that essentially similar lesions occurring at a distance from a gastric carcinoma suggest that the entire gastric mucosa has undergone a change and that much time has been required for this change to take place. Carcinoma develops in a previously damaged stomach and many years of such injury may be required before neoplastic transformation begins. The pathogenesis of gastric carcinoma is directly related to the disorganized hyperplasia of gastric mucous cells.—H. G. W.

KAHN, M., and BAY, M. W. [Univ. of Southern California Med. Sch., Los Angeles, Calif.] **CARCINOMA OF THE JEJUNUM.** *Am. J. Surg.*, 58:145-147. 1942.

Two cases are reported, with autopsy and surgical statistics.—H. G. W.

MORTON, C. B. II [Univ. of Virginia, Charlottesville, Va.] **TOTAL GASTRECTOMY. INDICATIONS FOR OPERATION WITH A REPORT OF FOUR CASES.** *Arch. Surg.*, 44:72-80. 1942.

The anatomical relationships of the stomach allow the spread of tumor cells to adjacent areas with relative ease, and after radical subtotal gastric resection a microscopically demonstrable tumor often remains. In most cases of subtotal gastric resection the operation of choice would be total resection if the procedure were not complicated by so many technical difficulties. These, together with a general ignorance of the physiological implications of total gastric resection cause a high operative mortality and thus militate against the more radical procedure. It is thought, however, that more total resections should be done, together with widespread lymphatic removal, and 4 cases are reported in defense of this thesis. An operative technic is described.—R. C. R.

RUBIN, J. S. [Jamaica, N. Y.] **PROLAPSE OF POLYPOID GASTRIC MUCOSA INTO THE DUODENUM, WITH MALIGNANT CHANGE.** *Radiology*, 38:362-364. 1942.

A case is reported of a patient who had suffered symptoms suggestive of a partial pyloric obstruction for over a year. Roentgenograms are reproduced which led to the diagnosis of "polypoid herniation of gastric antral mucosa into duodenal bulb." Herniation was confirmed at operation. Histological study revealed polyposis of the stomach with malignant degeneration.—C. E. D.

SCHINDLER, R., and ARNDALE, O., (University of Chicago, Chicago, Ill., and Glendale, Calif.) **GASTROSCOPIC DIFFERENTIAL DIAGNOSIS OF BENIGN AND MALIGNANT ULCER OF THE STOMACH. AN ANALYSIS OF THE GASTROSCOPIC PICTURE OF ONE HUNDRED AND THIRTY-THREE LESIONS.** *Arch. Surg.* 44:473-488. 1942.

Gastroscopy is the best mode of differentiating benign and malignant ulcers of the stomach. In comparing diagnoses by gastroscopic and roentgen examination it was found that gastroscopy missed more lesions, but a noncommittal diagnosis was made in only 2 cases, whereas roentgen examination made no commitment in 15.

Gastroscopic signs favoring benign ulcers, signs that are not proof of benign ulcer, those that are not proof of malignant ulceration, and those that suggest malignant ulcer are discussed. It is admitted that in 6 of 113 cases a correct diagnosis could not be made. The simplicity, ease, and obvious value of the procedure make gastroscopy an important diagnostic adjunct.—R. C. R.

SCHINDLER, R., and LETENDRE, P. [Univ. of Chicago, Chicago, Ill.] **ANALYSIS OF RELATIONSHIP OF SURGERY AND GASTROSCOPY IN 95 CASES OF GASTRIC TUMOR.** *Surg., Gynec. & Obst.*, 75:547-557. 1942.

In 5 of 91 cases of gastric cancer the lesion was not detected with the gastroscope, and in 5 others the lesions seen were wrongly interpreted.—H. G. W.

SCHINDLER, R., SANDWEISS, D. J., and MINTZ, L. L. [Univ. of Chicago, Chicago, Ill.] **BENIGN SUBMUCOSAL TUMORS OF THE STOMACH: A GASTROSCOPIC STUDY.** *Am. J. Digest. Dis.*, 9:289-292. 1942.

The diagnosis of submucosal benign gastric tumors is possible at gastroscopy by observation of the symptom of "bridging folds."—H. G. W.

SCHINDLER, R., and SMITH, W. M. [Univ. of Chicago, Chicago, Ill.] **ANACIDITY AND GASTRITIS ASSOCIATED WITH GASTRIC CARCINOMA.** *Am. J. Digest. Dis.*, 9:340-342. 1942.

In 48 cases of gastric carcinoma the uninvaded mucosa was studied gastroscopically, and the diagnosis checked by microscopic examination. Although chronic gastritis was found definitely in 38 instances, there were 4 in which a normal mucosa was found associated with an acidity. These 4 cases indicate that chronic gastritis is not always the cause of an acidity in a stomach invaded by carcinoma.—H. G. W.

SHEARBURN, E. W. [Univ. of Virginia Hosp., Charlottesville, Va.] **IMPORTANCE OF RECTAL EXAMINATION IN THE PROGNOSIS OF RECTAL CARCINOMA.** *J. A. M. A.*, 119:1410-1412. 1942.

In only 36% of a series of 100 cases referred for treatment during the past ten years has an adequate examination been made by the local physician.—H. G. W.

TUTA, J. A., and ROSI, P. A., [Univ. of Illinois Coll. of Med. and Northwestern Univ. Med. Sch., Chicago, Ill.] **LYMPHOSARCOMA OF THE RECTUM.** *Arch. Surg.*, 44:157-163. 1942.

A report of a case with a discussion of histologic features and treatment.—R. C. R.

WESTON, S. [Beth Moses Hosp., Brooklyn, N. Y.] **METASTASES TO THE HUMERUS FROM CARCINOMA OF THE RECTUM.** *Am. J. Surg.*, 57:531-535. 1942.

This article places on record the sixth reported case.—H. G. W.

LEUKEMIA, LYMPHOSARCOMA, HODGKIN'S DISEASE

LÖVGREN, O., and WESTMAN, C. [Central Hosp., Stockholm, Sweden] ON THE ETIOLOGY OF AND THE SUPPOSED RELATIONS BETWEEN LYMPHOGRANULOMATOSIS MALIGNA AND MYCOSIS FUNGOIDES. *Acta Med. Scandinav.*, 108:387-397. 1941.

The difficulty in distinguishing Hodgkin's disease, clinically and pathologically, from mycosis fungoides is illustrated by 3 cases. The patients had skin eruptions considered to be characteristic of the latter disease, but microscopic examination of enlarged lymph nodes disclosed typical signs of lymphogranulomatosis. A description is appended of a case of generalized lymphadenopathy without cutaneous manifestations, which proved microscopically to be reticulum cell sarcoma.—M. J. E.

REED, E. B. [Lincoln, Neb.] SOME CLINICAL ASPECTS OF LEUKEMIA. *Nebraska State M. J.*, 26:429-433. 1941.

A general review based upon the observation of 40 cases.—M. J. E.

SLAUGHTER, D. P., and CRAVER, L. F. [Memorial Hosp., New York, N. Y.] HODGKIN'S DISEASE. FIVE YEAR SURVIVAL RATE; VALUE OF EARLY SURGICAL TREATMENT; NOTES ON FOUR CASES OF LONG DURATION. *Am. J. Roentgenol.*, 47:596-606. 1942.

Two hundred and sixty-five cases of histologically confirmed Hodgkin's disease are reviewed. The average survival time from the beginning of therapy was 33.8 months. Of the patients 17.7% survived 5 years and 3.4% 10 years or more. Sixty-two per cent were males and 38% females. There was no correlation between the histopathology of the tumor and the course of the disease. As a rule treatment is limited to palliative radiation and general measures. When a single group of accessible lymph nodes is involved, "obliterative" radiation or surgical extirpation is warranted.—C. E. D.

CANCER CONTROL AND PUBLIC HEALTH

MAXFIELD, J. B. [Lovelace Clinic, Albuquerque, N. Mex.] PRESENT CONCEPT OF THE CANCER PROBLEM. *Southwestern Med.*, 25:4-9. 1941.

This paper presents a brief review of the cancer problem and discusses the etiology, diagnosis, and treatment of the disease. A plea is made for education of the laity, for the referring of patients to specialists by the general practitioner, and for the dissemination of knowledge by cancer specialists to the other members of the profession.—J. L. M.

OHLMACHER, J. C. [Vermillion, S. Dak.] THE MEDICAL PROFESSION'S RESPONSIBILITY IN THE CONTROL OF CANCER. *Journal-Lancet*, 61:441-445. 1941.

A general discussion of the problems of early diagnosis and treatment.—M. J. E.

SKINNER, E. H. [Kansas City, Mo.] THE PHILOSOPHICAL AND PRACTICAL ASPECTS OF THE ECONOMICS OF CANCER CONTROL. *Am. J. Roentgenol.*, 47:1-10. 1942.

This Janeway Lecture discusses the responsibility of America as the scientific repository of the world at war and cites the objections to substituting governmental responsibility for individual initiative and enthusiasm. Cancer control programs succeed or fail in proportion to the contagious ambition and drive of the director.

Cooperation of the general practitioner and an educated public in striving for the early diagnosis of cancer is the first necessity in effective control. Specialized consultation should be made available to country practitioners through periodic rural clinics attended by competent urban specialists. Such decentralization of specialists would be valuable in cardiology, tuberculosis, psychiatry, and orthopedics, as well as in cancer.—C. E. D.

WETHERELL, F. S. [Syracuse, N. Y.] ROLE OF THE GENERAL PRACTITIONER IN THE CURE OF CANCER. *Southwestern Med.*, 25:67-70. 1941.

This editorial emphasizes the importance of a thorough examination of the patient, the type of information patients should be given, and the educational functions of cancer control bureaus.—J. L. M.

ORGANISATION FOR THE TREATMENT OF CANCER. National Radium Commission, London, England.

Introduction

The Registrar General's Report shows cancer to be the second most common cause of death in England and Wales, accounting for 68,605 of 478,829 deaths in 1938.

The Commission has been impressed by the fact that the death rate continues to rise, although the centers with which the Commission deals treat a constantly increasing number of cases with a slow but persistent improvement in the number of patients who survive several years after treatment. There are some remediable factors which contribute to this state of affairs, and among them are:

1. Late diagnosis, which is due to: (a) unsatisfactory conditions under which many patients are seen for the first time, e.g. ill-equipped consulting rooms and inadequate facilities for examination and note-taking; (b) inexperience of cancer on the part of some medical men who see only a few cases a year; (c) ignorance and fear of the disease among the laity.

2. Scarcity of beds.

3. Failure to select the most appropriate treatment, owing to the absence, in most hospitals, of any organized system for consultation, before treatment is started, between the various specialists.

4. Inefficient treatment in inadequately equipped centers, due to the natural ambition of every hospital to carry out all kinds of treatment.

Suggestions for a Cancer Organization on a Regional Basis

The functions of a cancer organization are:

1. To put before the public those facts about cancer which ought to be generally known.

2. To secure the diagnosis of cancer at the earliest possible stage.

3. To secure prompt and adequate treatment of every case.

4. To improve established methods of treatment and devise new ones.

The area to be served by a cancer organization should be of such a size that not less than 1,000 cancer cases are

treated in a year. Such a number can be expected from a population of about a million, and this should normally be the smallest number of people for which a cancer organization should be established. This number is necessary so that: (1) each member of the medical team shall see a large enough number of patients to become expert; (2) the available radium and x-ray apparatus shall be used to capacity; (3) each type and site of growth may form a group large enough for statistical analysis in a few years.

A whole time director of the cancer organization should be appointed, although it might be advisable to allow him private patients within his own hospital, but not outside it. It is important that his position at the headquarters hospital should be assured, and he should be able to meet the members of the honorary staff on equal terms and be in full and effective control of the arrangements made for carrying out the treatment of cancer.

The staff of a cancer organization, besides the whole time director, must include physicians, surgeons, E.N.T. surgeons, gynecologists, radiotherapists, pathologists, radiodiagnosticians, and physicists, who should meet in frequent consultation. Each specialist must deal with enough cases to ensure that he becomes expert.

The housing of a cancer organization, in view of the staff requirements mentioned above, will almost certainly have to be in, or in close association with, one or more large general hospitals where a special block or department should be devoted to the work. The segregation of the cancer work makes the team more "cancer minded."

Arrangements for the Diagnosis of Cancer

General medical practitioners will have to be persuaded to send promptly to the cancer organization all patients in whom any symptom calls for investigation. Treatment of cancer in any patient should be undertaken only after consultation between members of the team. The treatment, having been settled at consultation, is then carried out by one of the specialists of the team, and at appropriate intervals or at the end of the treatment the patient is again seen in consultation. The treatment of cancer by surgery might be carried out at several of the hospitals taking

part in the cancer organization, but it is essential that it should be done only by the surgeons of the team (who have special experience of the operations needed) after consultation with the radiotherapist.

The Treatment of Cancer by Radiotherapy

The radiotherapist should be in full charge of all radium and x-ray therapy of the organization, although it will be necessary for him at times to work with the help of the surgeons. The pathologist must be familiar not only with all forms of cancer, but with the habits of mind and methods of work of all those engaged in the cancer organization and should be in personal contact with all members of the team. Radiodiagnosis is necessary not only for the diagnosis but in the treatment and subsequent examination of the patient; hence there must be an efficient radiodiagnostician with modern apparatus. A physicist is essential in any radiotherapy clinic and should be allowed facilities for research and be provided with a well equipped laboratory and workshop and a whole time mechanic. The setting of every patient each time he is treated should be done by one of the radiotherapists or under his direct supervision, but the physicist will frequently be needed to aid in beam direction and to see that patient and staff are adequately protected from stray radiation.

The beds for the cancer organization should be in a special block in which the x-ray therapy plant is situated and radium treatment carried out. Not less than 75 beds will be needed for the cancer organization.

The Follow-Up of Cancer Patients

The patient should attend at regular intervals and be seen by those members of the team who originally planned the treatment. All cancer patients should be followed up for at least 5 years, though much may be learnt by continuing to examine them for 10 years, or even longer.

The records of a cancer organization must provide a basis for statistical analysis of the results obtained by treatment; there should be a special case paper for the cancer organization, which should be independent of the ordinary hospital in-patient case paper.—E. L. K.

Correction

See: Proceedings of the American Association for Cancer Research, Inc., 35th Annual Meeting. *Cancer Research*, 3:120-139. 1943.

P. 125. Abstract entitled "The Distribution and Prevalence of a Carcinogenic Factor in Human Livers" by Paul E. Steiner. This paper is not the one published

in Vol. 2, pages 425-435, as stated in the Proceedings. It is, however, to be published in *Cancer Research*, Vol. 3, 1943, with the title "The Incidence of a Carcinogenic Factor in the Livers of Cancer, Noncancer, Cirrhotic, and Negro Patients."