gastric pedicle with no signs of distant nodal or hepatic metastases.

A subdiaphragmatic total gastrectomy was carried out with Roux-en-Y oesophagojejunual reconstitution. Following operation oral feeding was started on the sixth post-operative day; the patient was discharged fully mobile on the eighteenth post-operative day.

The macroscopic specimen showed two ulcerating lesions, the larger lying in the posterior wall of the body of the stomach, the smaller being on the greater curve aspect of the pyloric antrum.

Microscopy revealed an anaplastic tumour containing bizarre giant cells, multiple mitotic figures and numbers of spindle cells. The agreed opinion was that the appearances were those of a pleomorphic leiomyosarcoma.

Comment

Leiomyosarcomata account for some 1% of all gastric neoplasms.

In their clinical features and prognosis leiomyosarcomata behave differently from other neoplasms of the stomach. A long history of dyspepsia is common and bleeding is often a prominent feature when mucosal ulceration has occurred. The tumours often attain a large size, sufficient in many cases to be easily palpable. Cachexia is not a prominent feature. Repeated radiological examinations are often required before the tumour is demonstrated.

A five-year survival as high as 70% has been given from the Lahey clinic series (Marshall & Meissener 1950), but a more recent series reported from Britain (Garvie 1965) puts the survival at 22%.

REFERENCES

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Intrathoracic Meningocele and Neurofibromatosis

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Miss S W, aged 46

History: Patient first presented in September 1963 complaining of tiredness, dyspnea on exertion and curvature of the spine. She had had multiple neurofibromata for many years, her father and several members of his family were similarly affected.

On examination: A tiny woman with gross kyphoscoliosis, the boss being on the left just below mid-thoracic level. There were multiple neurofibromata and café-au-lait spots. Over the left side of the chest posteriorly percussion note was dull and there was no air entry, but air entry was good anteriorly. There were no abnormal neurological signs.

Investigations: X-ray taken at age 14 was said to show mild scoliosis. X-ray taken in June 1958 showed gross kyphoscoliosis with the kyphus opposite the 8th and 9th thoracic vertebrae. There was marked separation of ribs 7 to 10 on the left, the 8th and 9th ribs, and to a lesser extent the 10th, being very thin. There was a large mass lying posteriorly in the left chest (Fig 1).

X-ray in January 1963 showed the kyphoscoliosis to be worse, the ribs thinner and more spread apart. The mass was larger so that it filled the posterior part of the left chest while the compressed lung lay anteriorly (Fig 2 A, B).

Left thoracotomy (10.10.63): There was an enormous cystic swelling with thinned out intercostal nerves stretched over it. It contained clear cerebrospinal fluid and emerged from the 8th intercostal foramen through a hole about 4 × 2.5 cm. Another much smaller cyst came through the 9th space, and the 10th space was enlarged so that dura was easily palpable through it although not bulging. The cysts were removed and the opening closed with fine silk reinforced with a flap of muscle. There was no blood loss at the time of operation, but afterwards 1.5 litres of blood-stained fluid drained through the tube; it probably originated from the subdural veins. The lung expanded rather slowly and blood-
stained fluid was aspirated on several occasions from the left chest.

When the patient was discharged on 1.11.63 the lung had expanded satisfactorily. At no time were there any abnormal neurological signs.

**Progress:** The patient has remained well. Her exercise tolerance has improved, with no dyspnea on exertion. X-ray (Fig 3) shows that the left lung is well expanded with no recurrence of the meningocele.

**Comment**

Intrathoracic meningocele was first reported in 1933. By 1963 there were 37 cases in the literature of which only 9 did not have von Recklinghausen's cutaneous neurofibromatosis (Bogedain et al. 1963). It has been thought that the meningocele was secondary to a defect in the posterior neural arch (Hilton et al. 1959). Most cases are associated with kyphoscoliosis and some bony vertebral abnormality. Symptoms may be due to irritation or compression of intrathoracic structures; there are usually no neurological symptoms.

The diagnosis may be made by myelography (Hillenius 1959) and should be considered in any patient with von Recklinghausen's disease, kyphoscoliosis and a posterior mediastinal mass, particularly as neurofibromatosis is seldom associated with posterior mediastinal neurogenic tumours.

Operation should be advised for large cysts causing pressure symptoms. Among the reported cases which have been treated surgically there is a high incidence of spinal pleural fistula so it is advisable to reinforce the closure of the spinal cord with muscle.

**REFERENCES**

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