Primary carcinoma of the jejunum is of rare occurrence. The actual number of cases so diagnosed is difficult to determine since carcinomas of the three divisions of the small intestine are generally grouped together in autopsy and operative statistics. Bollag recently collected 9 cases, to which he added one of his own. His paper includes a discussion of the incidence, symptoms, diagnosis, and results of treatment.

The following case was seen in the Santa Clara County Hospital, San Jose, California.

**Case Report**

D. S., age fifty-four years, a white, male, restaurant worker, was admitted to the Santa Clara County Hospital, on Nov. 2, 1933. He had been perfectly well until six weeks before admission, when he experienced severe pain in the epigastrium with nausea and vomiting. One week later he had an attack of pain in the right lower abdomen, also associated with nausea and vomiting. Pain continued to recur spasmodically, and for three weeks prior to hospitalization the patient was unable to hold anything in his stomach. He had had no bowel movement for five days, in spite of repeated enemas. No blood had been noticed in the stool. There had been a loss of ten pounds in weight.

Physical examination revealed marked emaciation, the patient weighing only 113 pounds. There was considerable tenderness in the right lower abdomen, with a mass in this area which disappeared on pressure. Peristaltic waves were visible. Rebound tenderness was present over the entire abdomen; there was no definite rigidity. Other physical findings were normal. The blood pressure was 110/80.
The findings on x-ray examination were as follows. The duodenum cap formed well, was smooth in contour, and not particularly tender. The second and third portions of the duodenum appeared normal. The barium passed rapidly into the jejunum and greatly distended its first few inches, the shadow appearing to stop at this particular point. There was some tenderness in this region. The head of the six-hour meal was in the transverse colon. At this time the loop of the jejunum was still seen; it was greatly distended, and vigorous peristaltic waves were visible, passing through it. There was considerable gastric residue after twenty-four hours. The small intestine was not evacuated, and the barium was distributed from the cecum to the splenic flexure. There still seemed to be a small amount of barium in the small intestine corresponding to the level of the pubes. On the left side, below the stomach and between the stomach and splenic flexure, was a dim, rounded shadow which appeared to be due to a small amount of barium in the jejunum, at the site of the lesion observed in the earlier examination.

The x-ray studies indicated obstruction of the jejunum, 6 to 8 inches beyond the duodenal junction. Regurgitation back into the stomach appeared to be from the dilated jejunum, proximal to the point of obstruction. A rounded defect at the point of obstruction suggested a possible growth within the bowel, possibly polypoid in character.

Laparotomy was performed and a stenosing tumor mass was found in the jejunum, 14 inches distal to the ligament of Treitz; it was the size of a small lemon and adherent to the right iliac fossa. The proximal jejunum was hypertrophied to 2.5 inches in diameter. There were nodular enlargements of the lymph nodes of the jejunal mesentery which were too extensive to remove. A portion of the jejunum about 10 inches long was resected with the tumor, and a lateral anastomosis was done. On its completion there was vigorous peristalsis in the gut below the anastomosis. The patient made an uneventful recovery and was free of pain. He was discharged on Nov. 15, 1933.

Gross Appearance of Removed Jejunum: The specimen consisted of a piece of small intestine (jejunum) 16 cm. long. The serosa was smooth, moist, glistening, and dark grayish-red. There was an annular constriction in the mid part of the intestinal wall. On opening the lumen, a fungating tumor mass, measuring about 3 to 5 cm. in length, was found which completely encircled and stenosed the gut to about pencil size. The tumor mass was gray, friable, and partially covered with blood. On transverse section through the wall, the tumor mass was found to infiltrate its entire thickness, almost to the serosa. The adjacent parts of the intestinal mucosa were well preserved, slightly edematous, and dark grayish-red.
Microscopic Findings: Sections through the tumor mass and wall showed a complete destruction of the mucosa, which was replaced by an irregular, glandular, tumor mass. The glandular structures consisted of single or multiple layers of elongated, cylindrical cells. The lumen contained some desquamated epithelial cells showing mucoid degeneration. The stroma was very scanty and found mainly in the superficial part of the tumor mass, and was infiltrated with polymorphonuclear leukocytes and lymphocytes. The tumor mass was not sharply demarcated from the normal mucosa. It infiltrated the entire wall and extended into the submucosa, which was greatly edematous and infiltrated with polymorphonuclear leukocytes and lymphocytes.

Reference