Correspondence

Gastrointestinal carcinoid tumours

SIR, — Rees *et al* (*Gut* 1984; **25**: 211–7) present a patient with massive bleeding from an ileal carcinoid diagnosed by colonoscopy. We would like to present a similar case in which colonoscopy would not have aided the diagnosis and to add our experience of gastrointestinal carcinoids.

A 56 year old man was admitted to the Royal United Hospital in Bath with a four day history of passing both dark red blood and melaena per rectum. He had long standing hypertension in the presence of a hydronephrotic horse shoe kidney which was well controlled on Minoxidil 40 mg, Atenolol 400 mg with chlorthalidone 100 mg daily. There was no history of haematemesis nor abdominal pain, neither was there a history of flushing, diarrhoea, nor attacks of wheezing. On admission, his pulse was 100, blood pressure 140/80 mmHg. He was not clinically shocked although his haemoglobin was 8.0 g/dl. During that day he was transfused three units of whole blood and his observations remained stable until the early evening when he became shocked (pulse rate 130, blood pressure 80/50 mmHg). This was accompanied by profuse dark red rectal bleeding. He was given a further five units of whole blood and an upper gastrointestinal endoscopy was performed urgently which was completely normal with no blood in the stomach. It was technically impossible to enter the duodenum. Further deterioration precluded angiography and a laparotomy was undertaken immediately. In the terminal ileum, a small 1 cm pedunculated lesion was noted. Blood was present for 15 cm proximal to this lesion and throughout the small and large bowel distal to the lesion. Several other nodules were present for 6 cm either side of the lesion, and there were enlarged glands in the mesentery. The liver contained one small nodule. A 20 cm resection of small bowel was carried out taking all the macroscopically obvious lesions with the mesenteric glands. The continuity of the small bowel was restored by end to end anastomosis, and the small nodule in the liver was excised. Histology confirmed the presence of carcinoid tumour in the small bowel, mesenteric nodes and in the liver.

Postoperatively he made an uncomplicated recovery and he was discharged on the 12th day after his operation having had no further rectal bleeding.

His blood pressure continues to be well controlled on the above anti-hypertensive regimen. At no stage has he exhibited the features of the carcinoid syndrome, with flushing, diarrhoea, nor bronchospasm.

We agree that such small tumours are difficult to diagnose before surgical exploration. This is reflected on reviewing 27 cases of gastrointestinal carcinoids in Bath from 1970–1983 (unpublished data). Of the 15 non-appendiceal tumours 40% presented with features of the carcinoid syndrome implying metastatic disease. Massive gastrointestinal bleeding is increasingly reported in the literature^{1 2} as a presenting feature of carcinoid tumours and should perhaps no longer be regarded as rare. The above case represents 6% of our small series compared to 9% according to Zeitels *et al.*³ The other presenting features in our series were those of small bowel obstruction (five), small bowel perforation (one), incidental to Crohn's stricture (one) and as diarrhoea due to a rectal polyp (one).

Small bowel carcinoids are therefore likely to remain elusive to diagnosis before metastatic spread or laparotomy despite such advances as colonoscopy. Gastrointestinal bleeding has favoured early diagnosis as in Rees *et al*, but this was not so in our case where regional and distant metastases had occurred so reducing his expected five year survival from the 75% for ileal carcinoids quoted by Godwin.⁴

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References

- 1 Schwartz GF. Carcinoid tumours of the small intestine associated with acute gastrointestinal haemorrhage. *Am J Surg* 1966; **111**: 553–4.
- 2 Hui K, Reza MJ, Busuttil RW. An unusual case of massive gastrointestinal haemorrhage. *JAMA* 1978; **239**: 2690–1.
- 3 Zeitels J, Naunheim K, Kaplan EL, Strauss F. Carcinoid tumours – a 37 year experience. *Arch Surg* 1982; **117**: 732–7.
- 4 Godwin JD. Carcinoid tumours – an analysis of 2,837 cases. *Cancer* 1975; **36**: 560–9.

Correction

Colorectal screening by a self-completion questionnaire. (*Gut* 1984; **25**: 445–7) Farrands and Hardcastle. The work on this paper was performed in the Department of Surgery, University Hospital, Nottingham and not at Southampton as stated.