COVER SHEET

Title: Tumors of bone
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Publication Date: June 1930
Name of Journal: The Leech being the University of the Witwatersrand Medical Journal
Volume: 3
Issue: 1
Pages: 22 - 26

Accessed from http://wirespace.wits.ac.za
There are a few beds at Nelspoort Sanatorium but it has many disadvantages. It is situated in the middle of a desert, miles away from anywhere. Segregation does not mean isolation. The tuberculous is a human being; he wants to see his friends, even his relations occasionally. It is the only Sanatorium for the whole of the Union. The result is that each patient’s stay is limited, they have to give way for the new arrivals instead of being able to stay long enough to ensure a good result. For children with surgical tuberculosis we have no accommodation at all except the Sick Children’s Hospital.

For natives we have no accommodation at all. If they don’t die in the Non-European Hospital they just go out and disseminate their bacilli amongst their friends until they die. No steps of any kind are taken to prevent this wide sowing of the seed of tuberculosis.

We have got a very big native population on the Witwatersrand and it seems that it would be a reasonable idea to try to do something for these sufferers. It also seems reasonable to stop the wholesale distribution of bacilli which may infect not only the native, but the white. If a Dispensary were started it would be a step in the right direction. One was started here some time ago but no attempt was made to educate the native about it. It might as well have been part of the Out-patient Department of the Hospital and so it died.

One realises that there would be all sorts of difficulties in running a Dispensary for Non-Europeans but it could be done and finally will have to be done. It will be heart-breaking work for the man who runs it. The people will resent his coming to their dwellings and making them live a fairly hygienic life. We had the same trouble in London with the first Dispensary but with tact and hard work the objection to our “interference” was slowly overcome. The same opposition will undoubtedly be encountered in this country, but the enormous benefit which will accrue from such an institution will more than compensate for the difficulties of its inception.

Tumors of Bone.

By A. Lee McGregor, F.R.C.S. (Eng.), M.Ch. (Edin.).

The classification of bone tumours has been almost as unsatisfactory as that tumours of the testis. A great deal of confusion has been caused by people using the same term with a different meaning and by the use of different classification by the pathologist, the radiologist and the clinician.

In 1923 The Clinical Pathological Association of the United States appointed a committee to go into the matter and establish a classification of general utility. The result was the adoption of the classification acceptable at once to pathologist, radiologist and clinician. Further it was decided to circumscribe the entire profession and incite Medical men to send their specimens of bone tumours to institutes where trained pathologists could make exact diagnoses and keep records for purposes of reference.

The greatest advances made in our science in this country have been in this sphere and it seems obvious from what has already been done, that
INFLUENZA

INFLUENZA, or "the flu,"
Is "the grippe" that catches you,
Whether young or racked with wheezes,
Whether poor or rich as Croesus:
Babies, children, fathers, mothers,
Politicians, poets, lovers,
Spinster, bachelors and sailors,
Merchant princes, tramps and tailors—
Humble brains or intellectual,
Influenza will infect you all!

'FLU can roam the world, but it is
Always at its worst in cities:
 Everywhere that people meet—
 Works or office, shops or street,
 In the 'buses, trains and tramways,
 Parks and promenades and prom-
 ways,
 Dance Halls, cinemas and school-
 rooms,
 Theatres, "at-homes" in full rooms,
 You will see some sneezing stranger
 trumpet influenza's danger.

IF "the flu" has come to plague you,
First you shiver with an ague,
Then comes fever and a thirst,
Till your head is like to burst,
Every limb is racked with pain,
Morbid fancies fill the brain,
Sickness, misery and dread
Make you wish that you were dead.
Thus for days, until at last
(If you're lucky) it is past.

HOW disarm this dreadful slayer?
Chiefly through the help of Bayer!
What the wise man never lacks is
Thorough buccal prophylaxis,
Which, we beg to state, you have in
Every tablet of Panflavin:
Mouth and throat are thus protected—
If too late, and you're infected,
Never mind! you may retard an
Early exitus with Gardan!

G.H.M.

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any increase of knowledge on this difficult matter will come from America.

There are welcome signs, that the American Classification is becoming known in South Africa. This is of little use unless it be used here as universally as in America.

THE CLASSIFICATION.—Every tumour affecting bone falls into one of the following groups:—
1. Metastatic Tumours of bone.
2. Periosteal fibrosarcoma.
3. Osteogenic Tumours.
   (a) Benign
   (b) Malignant.
4. Inflammatory Conditions.
5. Benign giant cell tumours.
6. Angioma.
   (a) Benign.
   (b) Malignant.
7. Ewing’s Tumour.
8. Myeloma.

The main features of individual groups are as follows:—

METASTATIC TUMOURS—The site of election is somewhere about the middle of the length of a long bone. The commonest tumour to metastasize to bone is the hypernephroma. Tumours of the thyroid frequently cause secondaries in bone, and so do spheroidal Carcinomata of the breast and thyroid.

The rule that the existence of metastases is a direct contra-indication to operation in malignant disease, has only two exceptions:—in the case of a hypernephroma or thyroid tumour which is associated with a single bony metastasis, it is justifiable to remove the parent growth and the portion of bone secondarily affected. The view that a bone tumour consisting of thyroid tissue, may take origin from an embolus from a normal thyroid is erroneous.

PERIOSTEAL FIBROSARCOMA.—This term is used in an entirely different sense from that in which it has been used in the past. It is a rare tumour, taking origin from the periosteum or the fascial planes near it. The tumour lies near the bone, may cause superficial erosion of it, but neither commences in, nor invades the bone. The local thorough excision of the tumour holds out a fair chance of recovery.

OSTEOGENIC TUMOURS.—The term as now used by Ewing implies "derived from bone" and not "bone-forming."

a. BENIGN.
   1. Exostosis.
   2. Osteoma.
   3. Chondroma.
   4. Fibroma.

These tumours are too well known to require detailed description. They are all essentially of the same type, being stages in the development of tissue, which is going to form bone. When affecting a long bone they lead to projecting processes near its growing end. If thoroughly excised, and the structure of the tumour is not too cellular or atypical they do not recur.

b. MALIGNANT.—These sarcomas grow from tissue intended to form bone. They occur near the growing end of a long bone. It is of the greatest importance to remember that tumours growing from such tissue may be osteolytic and destroy bone, or osteoblastic and from bone—thus giving rise to vastly different X-ray appearances. These processes, however, usually go on side by side. The tumour frequently lays down spicules of new bone on and at right angles to the shaft of the bone. The shaft is not distended by the tumour, and the former may frequently be seen in the centre of the tumour mass.
Any subdivision of this class of tumour serves no useful purpose.

The clinical appearances vary greatly. The tumours may appear slowly or so rapidly and acutely as to be mistaken for acute osteomyelitis. It may be hard, or so vascular as to simulate an aneurysm.

INFLAMMATORY CONDITIONS.—
1. Osteo-periostitis: (a) Traumatic.
   (b) Syphilitic.
   (c) Infectious.

2. Osteites fibrosa.

BENIGN GIANT CELL TUMOUR.—This of course is the tumour so often spoken of as Myeloma. It occurs at the end of a long bone. It expands the shaft, differing from the Malignant osteogenic sarcoma. It is traversed by bony septa, giving a soap-bubble appearance.

It is locally malignant, and may spread along the connecting ligaments to an adjacent bone. No single instance of metastases is known (Codman).

ANGEIOMA.—These may occur in bone just as in any other tissue. They are one of the types of bone aneurysm.

EWING’S TUMOUR.—This is a type of undifferentiated sarcoma, which tends to involve most of the shaft of a long bone, is not bone forming, is difficult to distinguish clinically and radiologically from osteomyelites. In an X-ray, the bone has striated appearance owing to the separation of its lamelle by round cells. The shaft is thus thickened. The tumour regresses rapidly under radiation, but invariably recurs, metastasizing the other organs.

MYELOMA.—This a myelocytic tumour, producing no new bone. Reactive new periosteal bone may occur. The tumour is always multiple, tending to affect the flat bones e.g. ribs, ilium etc.

PROGNOSIS.—Most important feature of this arrangement is that the prognosis in each class is fairly definite, so that it is vastly more useful to know in which of the groups a particular tumour belongs, than to know in what subdivision of the group it should be placed.

METASTATIC TUMOURS.—The prognosis is most unfavourable.

PERIOSTEAL FIBROSARCOMA.—Prognosis is unfavourable; better than that of Osteogenic sarcoma.

OSTEOGENIC TUMOURS.—If benign, the prognosis is good. If malignant the outlook is hopeless.

INFLAMMATORY CONDITIONS.—The prognosis is unfavourable.

BENIGN GIANT CELL TUMOUR.—Prognosis favourable.

ANGEIOMA.—Favourable.

EWING’S TUMOUR.—Prognosis bad.

MYELOMA.—Prognosis bad.

CONCLUSION.—It will be seen that the essential basis of this arrangement is simple and useful, little mental effort being necessary to remember the main divisions and subdivisions of the classification.