

TABLE 3
HISTOLOGICAL FEATURES AND PRESENCE OF BIREFRINGENT MATERIAL IN AVAILABLE BIOPSY AND NECROPSY SPECIMENS FROM 10 CASES

No. in This Series	Proportion Resembling Fibrous Tissue	Arrangement of Cells Resembling Epithelium						Type of Epithelial-like Cells				Size of Birefringent Particles
		Con-fluent	Alveo-lar	Clefts	Papil-lary	Fronds	Sheets	Pave-ment	Cuboid	Co-lumnar	Poly-gonal	
1F Biopsy Necropsy*†	5% 90%	0 0	0 0	0 0	0 0	+	+	+	+	+	0 +	7 × 1 μ 30 × 3 μ
2F Biopsy not made Necropsy*‡	— 90%	0	0	+	0	0	0	+	+	0	0	3 × 0.5 μ
3M Biopsy (not examined by us) Necropsy*†	Small 70%	+	0	+	+	0	0	0	0	+	+	Not recorded 1 × 0.5 μ
4F Biopsy not made Necropsy	— 95%	+	0	+	0	0	0	+	+	0	+	5 × 1 μ
5M Biopsy Patient alive	0%	+	+	+	0	0	0	0	+	+	0	0
6M Biopsy Necropsy†	60% 100%	+	+	+	0 0	+	+	0 0	+	0 0	+	4 × 1 μ 7 × 5 μ
7M Biopsy not made Necropsy	— 95%	0	0	+	0	0	0	0	0	0	+	1 × 0.5 μ
8M Biopsy Necropsy†	Not available 50% Differentia- tion poor	0 +	+	? +	+	? 0	? 0	? 0	? +	+	? +	10 × 2 μ (yellow)
9M Biopsy Necropsy†	50% 50%	+	+	+	0 0	0 0	0 0	0 0	+	+	+	8 × 2 μ 2 × 0.5 μ
10M Biopsy not made Necropsy	— 10%	0	+	+	0	+	0	+	+	+	0	5 × 1 μ
11M Biopsy Necropsy	20% 50% Tumour in lung only examined	+	0 +	+	+	+	0 0	+	+	+	+	10 × 2 μ Not recorded

* Necrosis present; † Reticulin demonstrated; ‡ Lymphocytic infiltration.

Case No. 6M [London Hospital 40336/47].—This man died at the age of 38 with 'carcinomatosis peritonei'. He was heavily exposed to mixed asbestos dust as a hopper feeder for six months in 1939. After a break of five months he had a further two years' exposure as a 'card' grinder before his war service. From 1946 to 1961 he worked as an engineer's fitter with minimal exposure to dust. Asbestosis was diagnosed in 1954 on routine periodic examination seven years before death. His terminal illness began with abdominal pain four months before death. Three weeks before admission to the London Hospital in 1961 he complained of the sudden onset of dragging abdominal pain whilst opening his bowels. A nagging pain continued, worse on micturition and defaecation, although evacuation was normal. There was some feeling of abdominal distension, possibly related to a recent weight gain of 1 stone (6.35 kg.), mild chronic bronchitis, and some exertional dyspnoea but no other relevant symptoms. The family history and social history contained nothing relevant.

On examination he was a pale looking man. The fingers and toes showed mild clubbing. General examination was otherwise normal. The cardiovascular system was normal. The lungs showed poor expansion and scattered rhonchi. The abdomen was distended with ascites and the liver ballotted. Rectal examination was difficult because of spasm and pain; a possible mass was felt. The central nervous system was normal.

The ascites was confirmed by paracentesis, and a clear green fluid containing lymphocytes was obtained. The fluid was not bloody and no neoplastic cells were seen. On June 7, 1961, laparotomy confirmed the presence of carcinomatosis involving the liver and peritoneum. A peritoneal biopsy (London Hospital 3312, June 1961) was reported as a 'trabecular and mono-cellular, occasionally cystic, apparently mucus secreting carcinoma, compatible with primary carcinoma of the stomach' (Fig. 1). Post-operatively the patient developed a chest infection which improved after a course of chemotherapy. Paracentesis was performed on June 20, 1961,