Removal of a rapidly growing ovarian tumour in a patient who had recently been confined, and on whom ovariotomy had been performed previously / by A.C. Butler-Smythe.

Removal of a rapidly growing Ovarian Tumour, in a Patient who had recently been confined, and on whom Ovariotomy had been performed previously.

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A. C. BUTLER-SMYTHE, F.R.C.S.Ed.

Surgeon to the Samaritan Free Hospital for Women and Children, and to the Grosvenor Hospital for Women and Children.

Reprinted from "The British Medical Journal" of June 16, 1894.

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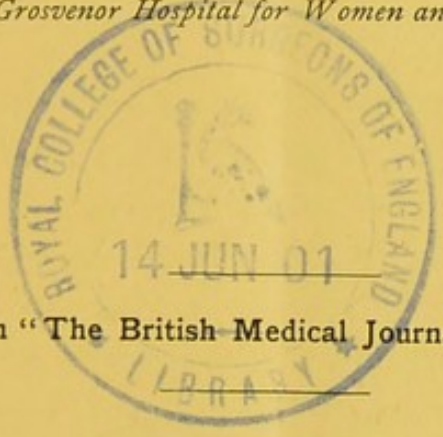

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Surgeon to the Samaritan Free Hospital for Women and Children, and to the Grosvenor Hospital for Women and Children.

E. F. W., aged 24, a married woman, consulted Dr. Seccombe, of Terrington, Norfolk, in March, 1892, on account of pains in her stomach which were at first thought to be due to flatulence. A tumour was discovered which was diagnosed, in consultation with Dr. Plowright, of King's Lynn, to be an ovarian cyst. The patient was sent to the Samaritan Free Hospital, and was admitted under my care on April 30, 1892. The following history was elicited from her. Menstruation first appeared at 12 years of age, and since then the periods had been regular, though scanty. She had been married two and a-half years, but had not become pregnant. In June, 1891, she had influenza, and in the following August very nearly succumbed to an attack of measles which left her in a delicate state of health. Her first experience of abdominal pain occurred in February, 1892, and as it became worse she sought medical advice.

On admission, the patient, who was much emaciated flushed and feverish, complained of great tenderness in her abdomen, and was evidently suffering from extreme distension, the circumference at the umbilicus being forty-eight inches. Her breathing was rapid and shallow, pulse 120, temperature 101°, tongue coated, urine acid, sp. gr. 1015, clear, and no trace of albumen. The abdomen was œdematous and the vulva and thighs were swollen. Her appetite was fair, but she had been losing flesh steadily for the last few months. Of late she could not lie on her right side because of a dragging pain in her abdomen to the left of the navel.

The abdomen was distended by a tense swelling which fluctuated freely. There was dulness up to the ensiform cartilage and in both flanks. The tumour was adherent to the parietes. Vaginal examination showed that the uterus was behind the tumour, which almost filled the pelvis. The uterine cavity measured two and a-half inches, and the uterus could be moved laterally.

On May 4 Mr. Stormont Murray administered ether, and assisted by my colleague Dr. Rutherfoord, and in the presence of Dr. Seccombe and other visitors and colleagues, I opened the patient's abdomen, separated the parietal adhesions, and tapped the tumour, thirty-four pints of dark viscid fluid being drawn off. After a tedious operation owing to the universal adherence of the cyst in the abdomen and pelvis, I succeeded in removing the tumour, the pedicle of which was doubly twisted and adherent to the large intestine. The right ovary was then brought to the surface and carefully examined, and as it appeared to be healthy and was not enlarged, it was returned into the abdomen. The peritoneal cavity was then washed out and a drainage tube inserted, and the wound closed with silkworm-gut sutures.

The patient made a good recovery, though the pulse never reckoned less than 120, and the temperature kept above 100° till the end of the second week. She left the hospital on June 4, and went to her home where she remained in good health up to November, 1892, when she became pregnant. Her health was excellent up to July 20, 1893, at which date she was delivered of a stillborn male child which weighed over eleven lbs. The presentation was a breech, and the labour very tedious. The child was alive at the commencement of labour, but owing to its unusual size and the marked deficiency of expulsive power, notwithstanding the administration of ergot, it was impossible to save its life. The placenta came away easily, and the patient went on well and got up on the eleventh day. It was remarked after delivery that the mother was as slight as ever she had been, and Dr. Seccombe is confident that no swelling other than the contracted uterus could be detected in her abdomen. On the fifteenth day however, when up and about, she had an attack of pain in her right side which compelled her to go back to bed, where she remained for a couple of days, when the pain passed off and she thought no more about it. A month after her delivery she noticed that her abdomen was rapidly becoming enlarged, and later on she sent for Dr. Seccombe, who examined her and found a large cystic swelling on the right side of her abdomen. He wrote at once to me, and on September 1, 1893, I saw the patient with him and confirmed his diagnosis. It was decided that the case should wait till October, when she could come into the hospital. She was brought to town on October 4, and re-admitted. I found that the tumour had increased so rapidly in the month as to double its size. There was also much free fluid in the peritoneal cavity, and the patient had again emaciated, and was even in a worse condition than when she came up for the first operation.

On October 6 the patient was chloroformed by Mr. Murray, and assisted by my colleague Dr. Bantock, Dr. Seccombe and others being present, I opened the abdomen, and disclosed a dark-coloured swelling, which was adherent to the abdominal parietes, and covered by adherent omentum in its upper part. These adhesions were separated and the tumour tapped, thirty pints of dark thick fluid being withdrawn. It was then seen that the tumour had burrowed into the broad ligament, and had passed across in front of the uterus, between that organ and the bladder completely stripping off the peritoneum from the anterior surface of the uterus. This portion of the tumour was enucleated, and the broad sheet of peritoneum in front of it tied in four pieces, cut across, and dropped back into the peritoneal cavity. The rest of the cyst was then separated from the surrounding adherent intestine, and the pedicle transfixed and tied. The tumour having been cut away, the abdominal cavity was thoroughly washed out and drained. The peritoneum was then dissected off for about an inch round the incision, and the scar tissue cut away. The wound was then closed with three layers of sutures—a continuous suture of thin catgut for the peritoneum, interrupted sutures of thick catgut for the aponeuroses, and silkworm gut for the skin. The patient made a rapid recovery, and went out on November 4 quite convalescent. Curiously enough, after the second operation the pulse and temperature kept above 120 and 100° respectively for the first fortnight, this condition being due to a small abscess in the lower angle of the wound where the tube had rested.

REMARKS.—This is the only instance in which I have met with an ovarian tumour burrowing in front of the uterus and displacing the peritoneum between that organ and the bladder; in other words, completely stripping off

the peritoneum from the anterior surface of the body of the uterus. Tumours burrowing behind that organ and raising the peritoneum from its posterior surface are not infrequently met with, but the former condition is, I believe, uncommon. It is not often that the growth of an ovarian tumour can be dated with any degree of certainty, but in this case it is certain that so far as one could judge by sight and touch, the right ovary was healthy on May 4, 1892. Dr. Seccombe states, "that after the patient's delivery in July, 1893, no swelling other than the contracted uterus could be felt in her abdomen." A fortnight later the patient had severe pain in the right side, and about a month or six weeks after her confinement her abdomen began to get big, when on examination, a cystic tumour was discovered, and this growth increased so rapidly that when seen a month later it was as large again. I presume the disease started during pregnancy, and that after delivery, the pressure having been removed, the growth rapidly developed as such tumours usually do under similar circumstances. The first tumour was a large multilocular growth with dermoid material in parts. The second tumour was very similar as regards size, fluid contents, and so far as one could judge from the history, in the duration and rapidity of growth, but no dermoid material was observed in it. The success attending this case is in a great measure due to the able assistance rendered by my colleagues, Drs. Bantock and Rutherfoord ; and it gives me much pleasure to acknowledge their valuable services. The patient was in excellent health in October, 1894.