

Papilloma of the Fallopian tube and the relation of hydroperitoneum to tubal disease / by Alban Doran.

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Doran, Alban H. G. 1849-1927.
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Publication/Creation

London : Printed by Adlard and Son, 1887.

Persistent URL

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PAPILLOMA OF THE FALLOPIAN TUBE

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AND THE

RELATION OF HYDROPERITONEUM TO TUBAL DISEASE.

BY

ALBAN DORAN.

Read October 6th, 1886.



[*From Volume XXVIII of the 'Transactions of the Obstetrical Society of London.'*]

LONDON :

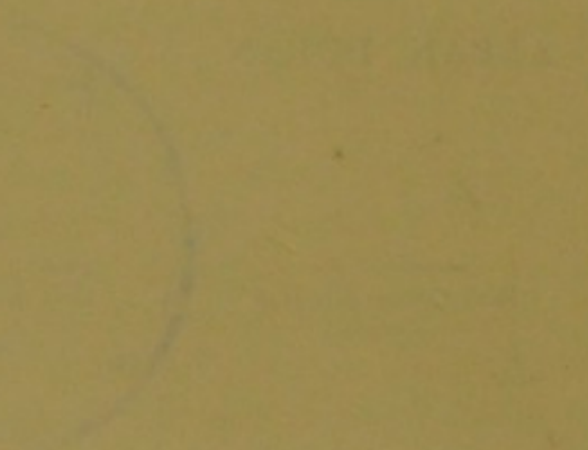
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ADLARD AND SON, BARTHOLOMEW CLOSE.

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PAPILLOMA OF THE FALLOPIAN TUBE AND THE RELATION OF HYDROPERITONEUM TO TUBAL DISEASE.

By ALBAN DORAN.

IN systematic works upon the pathology of the female organs papilloma of the interior of the Fallopian tube is still noted as a curiosity. Rokitansky, Hennig, and other authorities speak of the papillomatous outgrowths as small excrescences, each about the size of a pea or a bean. They are generally described as an occasional complication of dropsy of the tube. Of papilloma of the tube, as a distinct disease producing clinical symptoms, very little is said in contemporary literature on the diseases of women. That little consists of brief references to a case under the care of Sir Spencer Wells and Mr. Bickersteth in 1879. A full report of the pathology of the case, with a short clinical history, prepared by myself, was published in the thirty-first volume of the 'Transactions of the Pathological Society of London.' Sir Spencer Wells noted the case in his 'Diagnosis and Surgical Treatment of Abdominal Tumours.' It has been referred to in several clinical text-books, such as Dr. Graily Hewitt's well-known work. Dr. Winckel quotes my pathological report,* but his own observations on the disease in question consist of a single line of text informing the reader that Hennig has found papillary growths on the mucous membrane of the tube. Dr. Bandl† merely observes that in chronic tubal catarrh papillary growths are found on the inner surface of the tube. To Professor Schröder's observation on my case I shall presently have occasion to refer.

It happens that, within seven years, I have seen two

* 'Lehrbuch der Frauenkrankheiten,' Leipzig, 1886, p. 579.

† "Die Krankheiten der Tuben, &c.," 'Deutsche Chirurgie,' Lieferung 59, 1886, p. 39.

cases of papilloma of the Fallopian tube, in both of which, contrary to all previous experience, the disease gave rise to definite symptoms. I cannot, therefore, help thinking that the disease must have sometimes been overlooked, and that it is not so rare as even I myself supposed until I observed the second case. I shall proceed to describe that case. Afterwards, some reference will be made to features of clinical and pathological importance in the first. Lastly, I shall make some observations upon the relations which, on the evidence of certain clinical phenomena in the first case, I believe may exist between hydroperitoneum and tubal catarrh.

The second case (I shall use this term specifically throughout this memoir to distinguish it from Mr. Bickersteth's or "the first case") occurred last winter under the care of Dr. Bantock, to whom I am obliged for the following notes. The patient was a married woman, aged 45, under the care of Mr. Johnstone, of Maidstone. Menstruation ceased a year before the operation, which was performed in December, 1885. The patient since the cessation of the catamenia had suffered from pelvic pain, frequent difficulty in micturition often requiring the use of the catheter, and severe pain during defæcation. The pelvic cavity was filled by a tumour, very resistant but obscurely fluctuating. The uterus was pulled up to the level of the pubes, the cervix was obliterated, and the fundus could be felt above the symphysis. The patient was fairly healthy, but had an expression of suffering. The tongue was clean. The bowels were very troublesome, owing to costiveness and to the pressure of the pelvic mass on the rectum.

The operation was performed by Dr. Bantock, with my assistance, on December 26th, 1885, at a nursing home. An incision about three inches long was made through the abdominal walls. On opening the peritoneal cavity a small mass, the size of a hen's egg, was found in the hypogastrium. It was connected with a knuckle of intestine by a very intimate adhesion troublesome to separate.

The muscular coat of the intestine was laid bare, and several points of continuous suture were applied to the torn edges of the peritoneal investment. The wall of the tumour in the hypogastrium was torn in the separation of the adhesion and some papillary growths were exposed. The mass in Douglas's pouch was then reached. It was cystic and contained about half a pint of a fluid the colour of a strong infusion of tea. After this fluid had been removed, an attempt was made to separate the connections of the cyst posteriorly, but this was found to be impossible. The cyst was torn open in front and allowed to collapse. It was apparently bilocular and did not contain papillary growths.

The mass first exposed was then examined. It appeared, after several adhesions had been separated, as a tumour with smooth, dark red walls. When the uterus was reached, I could see that the tumour was the right Fallopian tube, dilated and stuffed with papillomatous material. The relations of the uterine end of the tube and the broad ligament to the tumour were very plainly seen, but the right ovary was embedded in adhesions. The tubal tumour was removed. The peritoneal cavity was thoroughly washed out with warm water, and a drainage-tube was inserted into Douglas's pouch.

The tumour strongly resembled that which was removed in the first case, which is preserved in the museum of the College of Surgeons, Pathological Series No. 4584, and figured in my report in the 'Pathological Transactions.' The papillary masses were rather rougher and harder, some feeling cartilaginous.* One great difference could be

* This question of chondrification was discussed in my paper on the first case. Since its publication, Mr. Eve has discovered a tissue resembling cartilage in hypertrophied fimbriæ (see Lawson Tait, "An Undescribed Disease of the Fallopian Tubes," 'Obstetrical Transactions,' vol. xxv, 1883, p. 249, and Mus. R. C. S., Path. Series, Specimen 4584 A). Mr. Eve considers the cartilage-like nodules on the fimbriæ to be homologues of the cartilaginous bodies found near the head of the epididymis. There can be no morphological homology; it would appear more correct to regard them as histologically identical.

noted. The fimbriated extremity was completely closed in this second case. It must here be observed that no fluid was found in the peritoneal cavity. I regret to say that this valuable specimen was unfortunately lost. The patient also fared badly, her temperature rose, and she died on the fourth day with complete suppression of urine. The nature of the cyst in the pelvis could not be ascertained. To me it did not appear to be tubal and was certainly not papillomatous.

I will now recapitulate the chief features of the first case. A thin and emaciated spinster lady, living in very comfortable circumstances, and nearly fifty years of age, was attacked by symptoms of inflammation of the right ovary and severe menorrhagia, after absence of the catamenia for several months. Under the care of Mr. Bickersteth, of Liverpool, the patient recovered, after prolonged rest in bed. Five months later she suffered from hydrothorax of the right pleura and was tapped. Hydroperitoneum followed, and the abdomen was tapped three times in six months. These effusions involved no disturbance of the system. There was no rise of temperature, nor any sign of visceral disease. A year after the first tapping of the pleura Sir Spencer Wells examined the case. The abdomen was distended, the physical signs pointed to hydroperitoneum. The abdomen was tapped for the fourth time. The fluid, amounting to twenty-two pints, had a specific gravity of 1022; it coagulated almost entirely when boiled, after the addition of nitric acid. Dr. Caton and Mr. Thornton found, in the deposit, clusters of large, proliferating, vacuolated cells.* I was shown some of the deposit under the microscope and saw the cells; this was in 1879. The patient is yet alive (1886). Thus vacuolated cells do not necessarily imply malignant disease. Professor Schröder, however, observes,† “Ein Papillom der Tube von jedenfalls maligner

* Similar cells had been found by Dr. Caton in the pleural fluid.

† ‘Die Krankheiten der Weiblichen Geschlechtsorgane,’ 7th edition, 1886, p. 361.

Bedeutung hat A. Doran beschrieben." This opinion has, fortunately, not been verified.

After the fourth tapping, the uterus could be felt freely movable and so low down in the pelvis that the cervix almost protruded from the vulva. Behind the uterus was a hard nodular mass. There was evidence of a small amount of fluid in the right pleural cavity. On April 28th, 1879, Sir Spencer Wells removed the tumour. Seventeen pints of fluid escaped from the peritoneal cavity. The tumour consisted of an oval body the size of a large orange, formed by a dilatation of the right Fallopian tube, stuffed with papillomatous growths. A bristle could be passed through the channel of the tube at the point where it had been cut through, close to the uterus. This bristle could also be made to traverse the growths and emerge at the ostium, which was unobstructed and surrounded by the shortened and thickened fimbriæ. A semi-opaque mucoid fluid dripped from the ostium. The right ovary was removed with the tube. The uterus and left appendages were perfectly healthy. The minute pathological characters of the tumour are described in the 'Pathological Transactions,' as above indicated. After a rapid recovery, the patient was attacked with pleurisy, on the right side again, in August, 1879. There was no effusion. This complication subsided. The patient was in perfect health when last heard of, in the summer of 1886.

The pathological significance of this disease is not easy to decide. It is not clear whether it be pathologically identical with papilloma of the hilum of the ovary and parovarium. If it be identical it is not comprehensible why papillary growths, so common in the last-named structures, should be so rare in the tubes. There is no morphological relation between the said structures, relics of the Wolffian body, and the tube, developed from Müller's duct. In the first case—I mean, as already explained, Sir Spencer Wells's case—the ovary and broad ligament were absolutely free from disease. I examined them

carefully after the exhibition of the specimen before the Pathological Society in October, 1879, because Mr. Thornton then suggested that the papillomatous disease might have arisen in the broad ligament. The papillary growths might have been due to hypertrophy of the longitudinal folds of the mucous membrane of the tube. In the second case I failed to detect any evidence of papillary disease outside the tube, but only a small part of the right appendages could be removed and none of the left could be taken away. However, as above noted, the papillomatous disease of the tube precisely resembled that in the other case.

It is very reasonable to suspect that papilloma of the tube may be inflammatory; a form of salpingitis, in fact. The first case especially suggests this theory, which is important in relation to the question of hydroperitoneum yet to be discussed. The papillomata then would be allied, not to the papillomatous masses found in tumours of the hilum of the ovary, but rather to the masses of warts seen around the vulva in unclean subjects affected with chronic gonorrhœa. Whilst, however, other undoubtedly inflammatory diseases of the tube are now known to be very common, papilloma of the tube is exceedingly rare. Still, papillomatous growths, very small, it is true, have long been observed in hydrosalpinx,* a disease of inflammatory origin, where adhesions have closed the fimbriæ and ostium. In the two cases there was strong clinical evidence of inflammation of the appendages. Lastly, the absolute non-malignancy of the papillary growths in the first case, notwithstanding certain formidable symptoms, strongly favours the inflammatory theory.

The first case, where the patency of the ostium caused

* I found some small growths of this class in a dilated tube removed, together with a cystic ovary, by Mr. Thornton a few years ago. I made a note of this specimen in 'Clinical and Pathological Observations on Tumours of the Ovary, &c.,' but as the case could not be considered a pure example of the disease under discussion I have not described it here. The tube was closed, and there was no peritoneal effusion.

escape of fluid and consequent hydroperitoneum, is very suggestive. May not hydroperitoneum be frequently due to tubal catarrh, though not necessarily to papilloma? Let the ostium remain unobstructed, an exceptional condition in salpingitis, and it is easy to understand how hydroperitoneum might soon arise from the constant irritation of inflammatory exudation dripping out of the tube into the peritoneal cavity. It must be understood that I employ the term hydroperitoneum to a certain extent after the definition of Dr. Matthews Duncan. That is to say, I signify a case "in which there is no organic or tangible disease discovered, beyond the conditions of the peritoneum itself, to which the collection of fluid can be referred."* This is the clinical definition of the case. I believe that pathology may prove that there is sometimes a tangible disease beyond the condition of the peritoneum. That disease is salpingitis with unobstructed tube. For convenience, however, the term hydroperitoneum may be retained.

Cases of suspected hydroperitoneum pure and simple have often proved to be instances of effusion, the result of papillomatous tumours growing free in or above the pelvis, or of the rupture of cysts containing papillomatous, adenoid, or malignant growths. Strange to say, widely diffused papilloma of the peritoneum, even when secondary to ovarian disease, is not invariably malignant, as Thornton and others have observed. In my first case there was papilloma and hydroperitoneum. When the former was removed the effusion never recurred. Here the papilloma had not diffused itself and did not prove malignant. Hence one fact is proved: hydroperitoneum may be due to non-malignant papillomatous disease, and the site of that disease may be in the Fallopian tube.

Still, hydroperitoneum has repeatedly been observed when no papillomatous growths could be found within or adjacent to the peritoneal cavity. In one case under my own observation, chronic ovaritis or some kindred affec-

* 'Clinical Lectures on the Diseases of Women,' 3rd edition, lecture xiv.

tion of the ovaries existed.* Dr. Bantock removed the ovaries; the peritoneal effusion did not recur.

Lastly, I must return to the proposition already discussed when considering that papilloma of the tube may represent a form or result of inflammation of the tube. The first case proves that papillomatous salpingitis, as the disease should be termed under this theory, causes hydroperitoneum if the ostium be not obstructed. Let the papillomatous complication be subtracted, and only chronic catarrh remain, may not hydroperitoneum still develop itself? This brings me back to another proposition already made in this paper, namely, the theory that catarrhal fluid escaping from the tube may irritate the peritoneum and cause effusion.

If this last theory be correct, as I firmly believe, why is not hydroperitoneum from tubal disease more common? This question brings us once more round to another subject already discussed. Salpingitis almost always causes closure of the ostium of the tube, so that the peritoneum is protected. In other cases the disease sets up local peritonitis, causing adhesions of the ovary, broad ligament, tube, and other structures. These adhesions very soon close the tube by bands which press on its outer surface, or by effusions which mat its fimbriæ together. In this manner the general peritoneal cavity is saved from irritation. All this local peritoneal mischief appears to me to represent an acute form of salpingitic complication, of which hydroperitoneum is a mild form. In fact, salpingitis cannot set up hydroperitoneum except it be so mild and so purely catarrhal as neither to cause closure of the ostium nor to inflame acutely the pelvic peritoneum. Hence the salpingitis of childbirth, abortion, and gonorrhœa can seldom, if ever, cause simple hydroperitoneum, though it is a fertile source of hydrosalpinx, pyosalpinx, and pelvic peritonitis. This closure of the ostium is a most fortunate complication in so far as it protects the

* "Hydroperitoneum traced to Chronic Ovaritis; Oöphorectomy; Recovery," 'British Medical Journal,' vol. ii, 1881, p. 699.

peritoneum. In my second case, the closure of the papillomatous tube saved the patient from hydroperitoneum. But if severe salpingitis be so common, a milder form must be more frequent, and it is this milder form which is probably a frequent cause of hydroperitoneum.*

In conclusion, I will summarise my opinions and observations.

1. Papilloma of the Fallopian tube is a rare disease, but may exist and produce marked symptoms. The papillary growth may represent not so much a true tumour as a product of inflammation. It is at least not malignant.

2. A pelvic tumour, which may extend into the hypogastrium, always exists. Pain does not appear to be essential and when present is possibly due to other pelvic disorders.

3. In one case under my observation the diseased tube was closed, the symptoms were entirely pelvic, and no hydroperitoneum was present. Under these circumstances, then, papilloma of the tube may simulate hydrosalpinx and pyosalpinx, but the symptoms would probably be, as a rule, less acute.

4. In the other case, the ostium of the tube remained patent and hydroperitoneum persisted till the diseased tube was removed. The evidence that secretion escaped from the ostium was positive.

5. For reasons given at length in this memoir, this case suggests that hydroperitoneum may frequently, though not invariably, be due to mild chronic catarrh of an unobstructed Fallopian tube.

On the motion of Dr. ROUTH, seconded by Dr. HORROCKS, the discussion was adjourned to the November meeting.

* "Lately I have seen a large hydroperitoneum and right hydrothorax following an abortion with much bleeding. The fluid has all disappeared during the fourth month following the abortion" (J. Matthews Duncan, loc. cit.). Observe that precisely the same kind of effusion existed in my first case. The presence of mild salpingitis in Dr. Duncan's case was highly probable.

*note to Champneys' diffuse papilloma
pub. case of tubal carcinoma in 4 yrs*

