On the closure of the ostium in inflammation and allied diseases of the Fallopian tube / by Alban Doran.

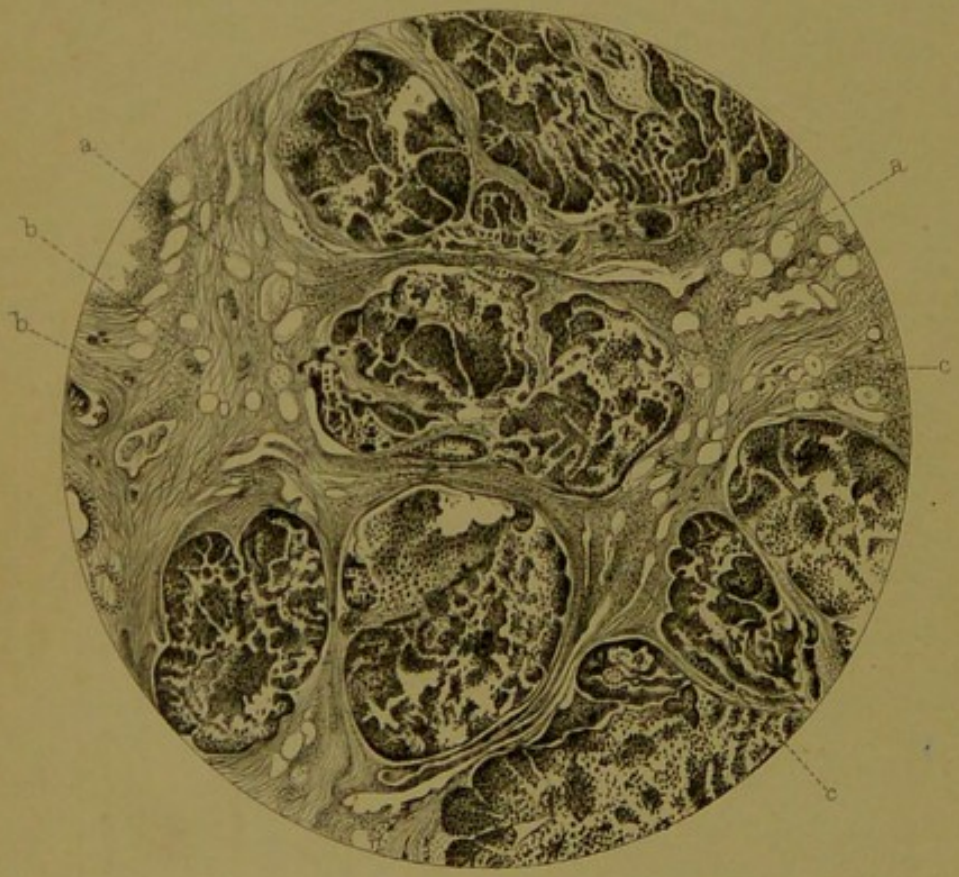
26) **Alban Doran.** Weiterer Verlauf des Falles von primärem Tubenkrebs, berichtet in dem 39. Band der Verhandlungen der pathologischen Gesellschaft in London.

(Sonderabdruck aus den Verhandlungen der pathologischen Gesellschaft in London 1889. 8. p. 8. Mit 1 Tafel Abbildungen.)

Am 1. März 1888 hatte Thornton eine Geschwulst abgetragen, welche sich als die krebsig entartete Tube herausstellte. Schon im September wurde ein Recidiv entdeckt, den 23. Januar 1889 erfolgte der Tod. Es fand sich Krebsentwicklung im Stumpf der linken Anhänge, so wie im Uterus, der Blase, auch war im rechten Ovarium, welches von Thornton theilweise zurückgelassen war, eine kleine runde Neubildung vorhanden, etwa $^3/_4$ Zoll im Durchmesser. Thornton konnte nur wenig von dem Ovarium zurückgelassen haben, da zur Zeit des Todes, 1 Jahr nach der Operation, die Neubildung noch so klein war. D. sieht daher seine Annahme bestätigt, dass die große Krebsgeschwulst in der Tube damals als primär aufzufassen war, während die kleine Geschwulst in dem Eierstock, so wie die später auftretenden sekundär sich entwickelten.

D. glaubt, dass der Krebs in den Tuben in papillomatösen Wucherungen derselben entstehe, meist nahe der Menopause, in Begleitung mit Scheidenausfluss. Sein Verlauf ist hier langsamer als in anderen Organen, besonders im Eierstock. Außer diesem Fall sind nur noch 2 Fälle primären Tubenkrebses bekannt, einer von A. Martin in Berlin, einer von Kaltenbach. Von primärem Sarkom der Tuben sind nur 2 Beobachtungen veröffentlicht, von Senger und Landau.

Contrelbl f Gyn Nov 29/90. **Lühe** (Königsberg).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DESCRIPTION OF PLATE XIII.

FIG. A.—To illustrate Mr. Doran's account of a case of Primary Cancer of the Fallopian Tube.

Section of a carcinomatous mass on the stump of the left tube, which wa free from cancer when the operation was performed (see text), showing collections of large cells in wide spaces, bounded by broad trabeculæ.

a a. Circular holes in the trabeculæ.

b b. Cells occupying similar holes. These cells appear under a high power identical with those which fill the large alveolar spaces.

c c. Small-cell infiltration in the trabeculæ. ($\frac{1}{2}$″ obj.)

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7.

ON CLOSURE OF THE OSTIUM IN INFLAMMATION AND ALLIED DISEASES OF THE FALLOPIAN TUBE.

By Alban Doran.

(Received September 26th, 1889.)

(*Abstract.*)

The author, in this communication, dwells on the frequency of closure of the ostium in salpingitis; but the obstruction is often temporary. Obstruction of the uterine end is due to swelling of the mucous membrane or to the development of "Chiari's bodies" from that membrane. Permanent closure of the tube is almost synonymous with closure of the ostium. Salpingitis and perimetritis are the causes of closure of the ostium. Three essential factors in relation to the subject are considered at length. 1. The nature of the ostium and its fimbriæ. 2. The nature and varieties of salpingitis, and also of perimetritis as far as it affects the tube. 3. The precise manner in which the ostium is closed in perimetritis and salpingitis. In adhesive perimetritis the fimbriæ of the tube are bound down by bands, which thus obstruct the ostium. In salpingitis the ostium is obstructed, incompletely at first, by the swelling of the mucous membrane which involves the fimbriæ; but permanently in bad cases by great infiltration of the submucous tissue and middle coat which swell over the ostium, and cover in the fimbriæ. The perimetritic and salpingitic varieties of closure of the ostium, often blended, are demonstrated by specimens and diagrams. The question of timely conservative operations on obstructed non-suppurating tubes is discussed. Dr. Skutsch's "salpingostomy," where a small piece of the tube is excised, appears to be a promising step in that direction.

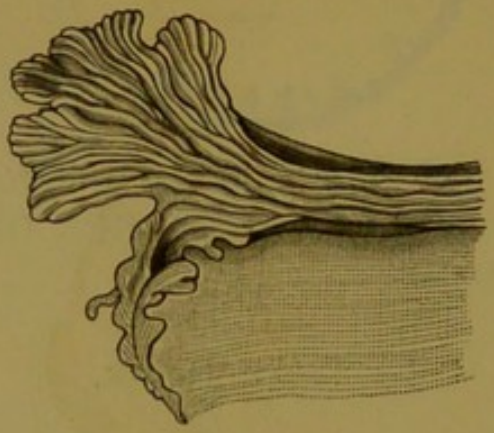

FIG. 1.—Ostium of normal Fallopian tube laid open, showing the continuation of plicæ into fimbriæ, and the dichotomous division of the fimbriæ. The ovarian fimbria is well-formed.

FIG. 2.—End of tube with ostium laid open. The plicæ are prolonged as in Fig. 1, and continued to the end of the ovarian fimbria.

FIG. 3.—A specimen similar to Figs. 1 and 2. Some of the fimbriæ are prolonged so as to form filamentous structures.

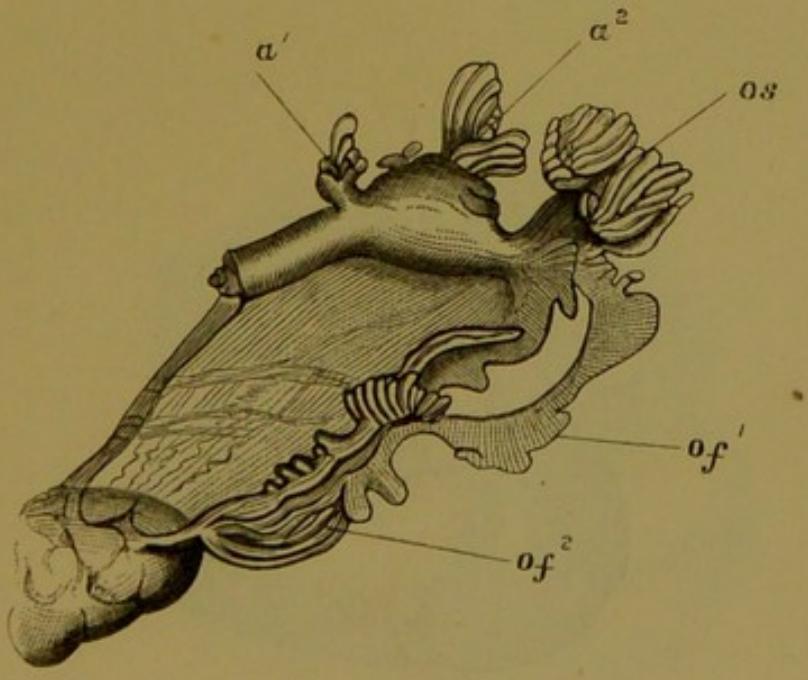

FIG. 4.—End of a tube with two accessory ostia, a^1, a^2, through which the plicæ bulge, forming fimbriæ as at the normal ostium (*os*). The ovarian fimbria is reduced to a thin band above (of^1), and highly developed below (of^2).

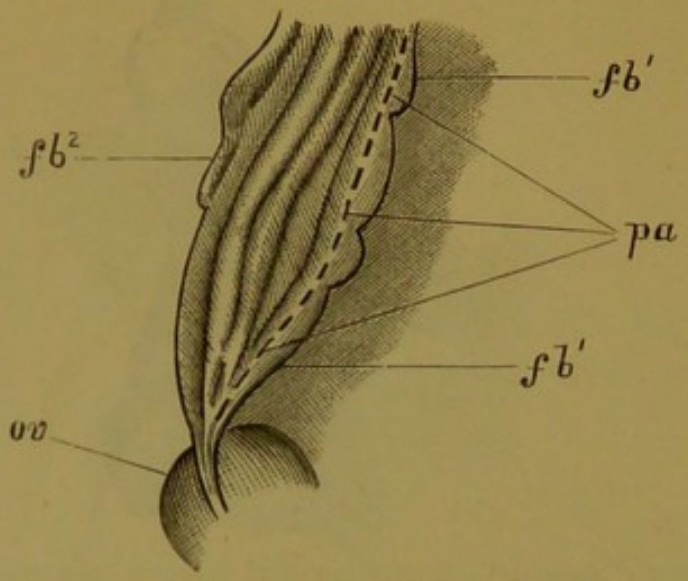

FIG. 5.—An ovarian fimbria moderately developed; about six times natural size. The plicæ are distinct but low. The dotted lines, *pa*, represent the attachment of the edge of the peritoneum, which lies close to one (fb^1) of the free borders (fb^1, fb^2) of the fimbria. *ov*, ovary.

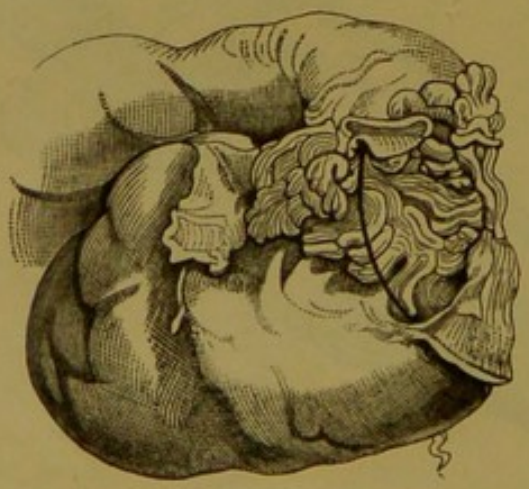

FIG. 6.—An ovary and tube, showing obstruction of the ostium by perimetritic deposit which forms a deep pouch. The fimbriæ have been partly pulled out of the pouch. A bristle passes into the pouch out of the ostium.

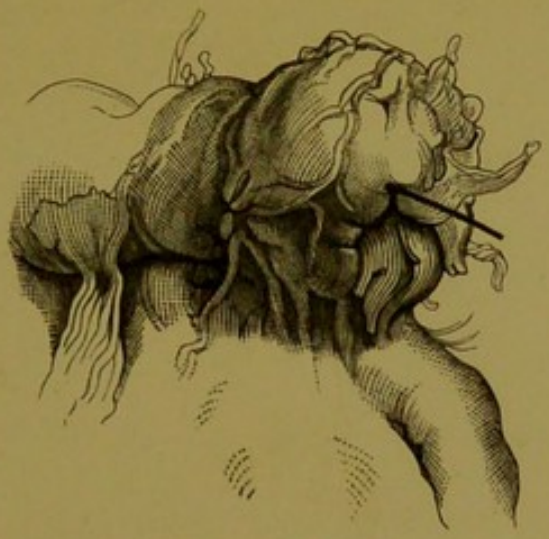

FIG. 7.—Complete obstruction of the ostium, the result of salpingitis. The end of the tube has been detached from the ovary below and the ostium forcibly opened; a bristle passes out of its orifice. The tissues of the tube have swollen over the ostium, completely concealing the fimbriæ, excepting the ovarian fimbria which is seen below the bristle.

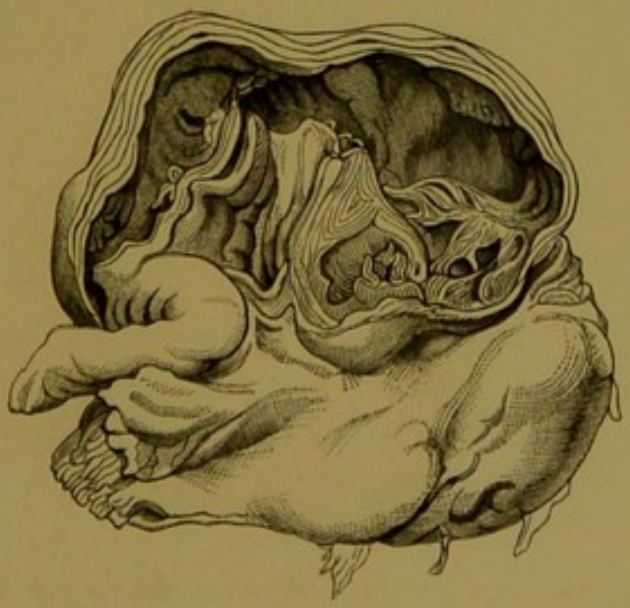

FIG. 8.—An obstructed and dilated tube laid open. The fimbriæ are seen, entirely included within its cavity.