

Malformations of the Fallopian tube / by Alban Doran.

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Publication/Creation

London : Printed by J.E. Adlard, 1886.

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MALFORMATIONS *S.*
OF THE
FALLOPIAN TUBE.

BY
ALBAN DORAN.

Read July 7th, 1886.



1006
[*From Volume XXVIII of the 'Transactions of the Obstetrical Society
6171 of London.'*]

LONDON:
PRINTED BY
J. E. ADLARD, BARTHOLOMEW CLOSE.
1886.

MALEFORMATIONS

ETHIOPIAN TUBE

ALBAN DORAZ

Good for you

PRINTED BY

ED. BATHOLOMEW & CO.

1886

MALFORMATIONS OF THE FALLOPIAN TUBE.

By ALBAN DORAN.

THESE specimens represent every example, with one exception, of malformations of the Fallopian tube which I have discovered in the course of the examination of over 1000 uterine appendages since the year 1878. Five out of six cases were removed in the course of operations performed at the Samaritan Free Hospital. Thus, having noted 769 of these surgical proceedings, the percentage of the malformations in question only amounts to 0.65 per cent.

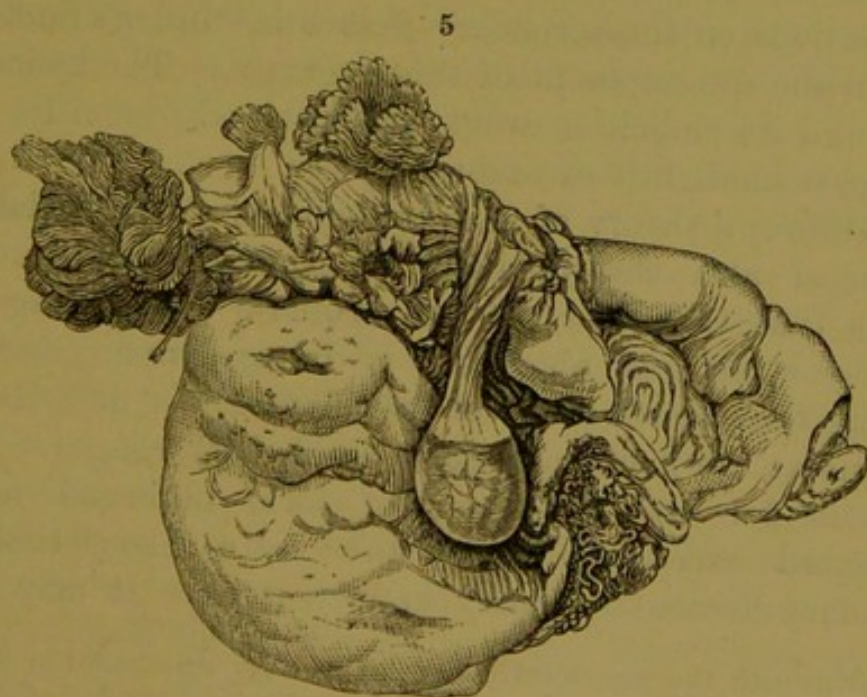
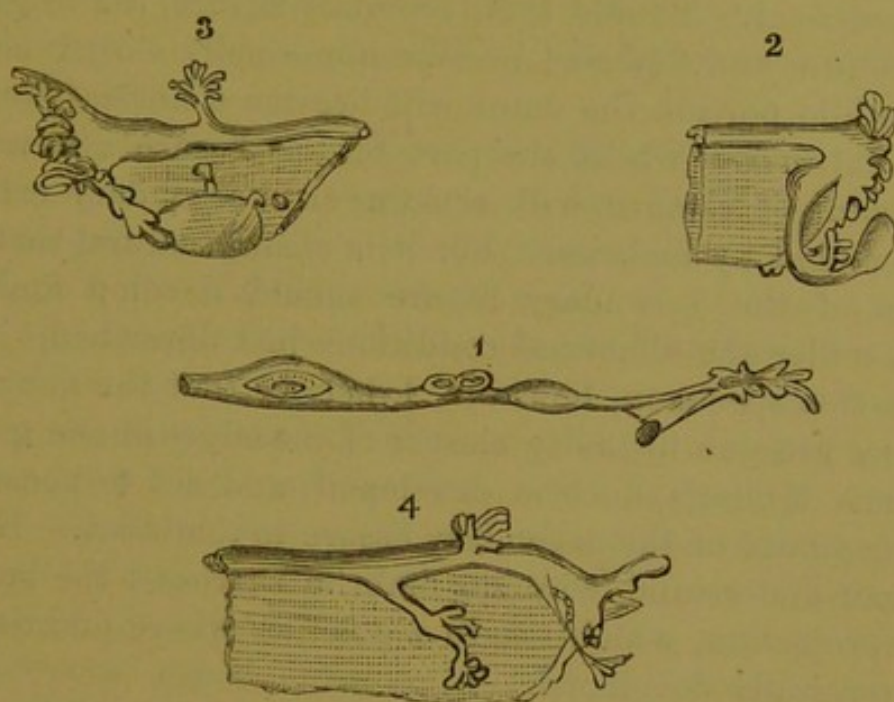
The first specimen (fig. 1) throws much light on the manner in which accessory ostia are formed. It was taken from a monstrous foetus, the dissection of which I described in the 'Journal of Anatomy and Physiology,' vol. xv, January, 1881. There was fissure of the abdominal walls and complete ectopia of the bladder. That organ consisted of two unsymmetrical portions, whilst the right and left halves of the genital tract departed still further from natural symmetry (loc. cit., pl. xix). Fig. 1 represents the right internal organs. They formed a curved tube nearly two inches in length. The inner portion was thick-walled and fusiform; in the sketch it is laid open to display its walls and its cavity. It was, in fact, a monstrous uterus resembling one of the uteri of the true opossum (*Didelphys*), a monstrosity already noted in our species. Beyond the uterus was a flat, button-like projection over three tenths of an inch in diameter. It was perforated by two apertures completely separated by a thick septum. The more internal led into the canal of the half-uterus, which opened into one of the two portions

into which the bladder was divided. The outer aperture passed into a canal which tunnelled the remainder of the tube for nearly half an inch. External to this point, the tube suddenly became impervious, ending in a thin cord with small but very distinct fimbriæ at its extremity. There was an opening in the midst of the fimbriæ which admitted a bristle almost as far as to the end of the thick part of the tube. Close below the fimbriæ, and hanging from behind the very short peritoneal fold which held the entire tube to the abdominal walls, was a minute atrophied ovary.

The fusiform inner portion of the entire tube representing the uterus, the remainder must be considered to stand for the Fallopian tube. The tube and uterus are developed from Müller's duct. This duct first appears as a groove in the germinal epithelium. The groove should close in evenly along that portion of the duct which becomes the Fallopian tube. Partial failure in the closure of the groove causes an accessory ostium. In this specimen, the closure has been so faulty that the continuity of the canal has been completely broken. Even should the button-like projection lie on what some may consider to be uterus and not Fallopian tube, it must still have been developed by the same process.

There is another manner in which an accessory ostium may be developed. Müller's duct, after forming a closed tube, appears to split along its outer portion and acquires a communication with the peritoneal cavity.* The edges

* This question of a secondary fissure appears to be still an embryological problem. It is, I believe, possible that the primitive Müllerian groove may naturally remain open at its uppermost part, where its edges may adhere to the peritoneum, which gives way within the area of this adhesion. Thus an ostium communicating with the peritoneal cavity would be accounted for, and the free edges would develop fimbriæ. According to an opposite view, the groove closes along the whole length of the Müllerian groove, and afterwards Müller's duct splits again at its uppermost part, acquiring a communication with the peritoneum, whilst the edges of the fissure develop fimbriæ. In respect to my own observations in this memoir, it is important to remember that there is a fissure in the outer part of the tube which acquires a com-



of the fissure develop fimbriæ. The extreme outer portion of the tube is said to remain closed, forming the hydatid of Morgagni. Should this secondary fissure, the origin of the ostium and fimbriæ, become abnormally closed across its middle portion the outer will become a normal fimbriated extremity, whilst the part of the fissure internal to the point of closure will remain as a secondary ostium, surrounded by fimbriæ. For it is clearly natural that the edges of the secondary fissure should develop fimbriæ, even under the abnormal conditions just described.

In this specimen, however, I believe that the abnormal orifices are due to faulty closure of the edges of the groove whence Müller's duct is developed, and not to perverted development of the secondary fissure in that duct. Hence we can understand why no fimbriæ surround the button-like projection, which lies in a position where fimbriæ are not naturally developed.

The next specimen, fig. 2 (Mus. Royal College of Surgeons, Path. Series, No. 4579), represents a highly developed hydatid of Morgagni, bearing a fringe. The fimbriæ of the tube are short and thick. The above observations on the secondary fissure in Müller's duct may explain the development of this anomaly. The hydatid is large and its pedicle is stout and flattened; from its edge springs a small tuft of fimbriæ.

Waldeyer's theory of the development of the hydatid of Morgagni also throws light upon this specimen. He asserts that the outer part of Müller's duct, being held fast by structures above it, is dragged upon, and not sharing the process of secondary fissure just described, it remains as the pedunculated hydatid of Morgagni. Klob accounts for the variations of form observed in the fimbriated extremity of the tube by a theory that the secondary fissure may vary in its extent. It may reach

munication with the peritoneal cavity and becomes surrounded by fimbriæ. Whether the fissure be primary or secondary, in the sense indicated above, is of secondary importance for the present purpose. I employ the term "secondary" above, in accordance with the more-widely accepted theory.

completely to the blind extremity of the duct. In this case there would be no hydatid of Morgagni; on the other hand, if the secondary fissure does not extend so far outwards as possible, the hydatid will be large and will bear a long pedicle.

Fig. 3 represents a specimen taken from a dermoid ovarian cyst removed some years ago by Mr. Thornton (Museum Royal College of Surgeons, Path. Series, No. 4516). A small pedunculated bunch of fimbriæ springs from the upper surface of the tube, half an inch from the normal fimbriæ. The tube exhibits no other abnormality of any kind whatever. Two small pedunculated cysts spring from the broad ligament, and a large cyst, half an inch in diameter, lies on the site of the parovarium. The pedicle of the accessory fimbriæ is impervious. I examined, four years ago, a similar case, from a subject with ovarian cystic disease. In this instance the pedicle had atrophied, so that the fimbriæ appeared to lie loose in a fold of broad ligament.

Fig. 5 is a fine drawing, by Mr. Lewin, representing a tube with several interesting anomalies, from a case of oöphorectomy performed last spring by Dr. Bantock.

An inch from the fimbriated extremity is a wide accessory ostium, surrounded by a very thick tuft of fimbriæ. This ostium freely communicates with the channel of the tube in both directions. Dr. W. S. A. Griffith has recently shown me a specimen where this condition existed. About a quarter of an inch external to this accessory ostium is a bunch of fimbriæ on a short impervious pedicle. A little further outwards is a hernial protrusion of the mucous membrane of the tube. Kessner

I believe that all the above malformations are due to partial closure of the secondary fissure. Hence arose the accessory ostium and the hernial protrusion, at least. The pedunculated fimbriæ were probably developed, in part, before the abnormal closure of the middle part of the fissure. Still, there is room for the opposite theory, that the primitive groove forming Müller's duct never closed

in at the site of the accessory ostium. The margins of that groove do not, however, naturally tend to produce fimbriæ; those of the secondary fissure do produce them. That the hernial protrusion represents imperfect closure, primary or secondary, there can be little doubt. Some German authorities would attribute it to tubal inflammatory disease, possibly intra-uterine. I believe that this theory is very faulty. Inflammatory disease would close the tube and probably obliterate the fimbriæ. It could never produce a complicated over-development of those structures.*

In this specimen, the hydatid of Morgagni is converted into a small fimbria on a very long pedicle, a condition which I have frequently observed. There is also a large pyriform pedunculated cyst springing from the broad ligament close to the tube.

Fig. 4 is from a specimen belonging to a case of cystosarcoma of the right ovary. The left ovary was converted into a cyst four inches in diameter, and this specimen was attached to it. The tube bears an accessory ostium with thick fringes, and a blind secondary tube bearing a fringe at its extremity and at one side, springs from the main tube inferiorly, a little internal to the accessory ostium. This remarkable accessory tube was probably developed through an eversion and prolongation of one of the edges of the primitive groove of Müller's duct. In this specimen the hydatid of Morgagni is represented, as in the last, by a bunch of fimbriæ on a long pedicle.

I will conclude these observations with some reference to the records of others.

The first systematic writer on the subject was M. A.

* Rokitansky ('Lehrbuch der Pathologischen Anatomie,' 3rd edition, 1861, vol. iii, p. 434) traces certain pedunculated accessory fimbriæ to the tubes of the Wolffian body. These fimbriæ spring from the surface of the broad ligament a little below the tube. The theory is ingenious, but exceedingly faulty. The pedunculated fringes are apparently outrunners from Müller's duct, from which they have become separated. They are generally, if not always, associated with other anomalies of the tubes, as in Merkel's interesting case (see Schröder, 'Die Krankheiten der Weiblichen Geschlechtsorgane,' 7th ed., 1886, fig. 146, and p. 349.)

Richard.* About the year 1850, in searching thirty female bodies he found accessory fimbriæ five times. He was more successful in his search than any subsequent observer. In two cases there were two accessory fimbriæ on one tube; in one of these cases the subject was a foetus at term, in the other a girl aged fifteen. The remaining three cases were in adults. In all cases the fimbriæ lay at a distance of from two to three centimetres from the root of the normal fimbriæ. Lastly, Richard declared that all communicated by an opening with the canal of the tube and at the other extremity with the peritoneal cavity. M. Richard was certainly very fortunate in finding so many examples of the anomaly in its most perfect form in thirty subjects.

Rokitansky† published fresh researches on the subject a few years later, dwelling on the remarkable fimbriæ seen on the surface of the broad ligament, often at a perceptible distance from the tube. Klob noted the occasional presence of a dilatation of a segment of the calibre of the tube, a small bulging surface of the coats of the tube, somewhat thinned, near the root of the normal fimbriæ.

Winckel,‡ the most recent writer on the subject, has not enjoyed the good fortune which fell to M. Richard. He has only seen an abnormal orifice twice, notwithstanding the fact that he entrusted his house surgeon with the task of searching over a large series of tubes in order to note every anomaly that could be discovered.

Fleming§ speaks of the pedunculated fimbriæ, especially when of the character seen in Fig. 4, as accessory tubes (*Nebeneileiter*). He has observed them three times in 100 female bodies, and traces them to outrunning pro-

* "Pavillons multiples rencontrés sur des Trompes Utérines," 'Gazette Médicale de Paris,' 1851.

† "Ueber accessorische Tubarostien und ueber Tuberanhänge," 'Allgem. Wiener med. Zeitung,' 1859, 32.

‡ 'Lehrbuch der Frauenkrankheiten,' 1886, p. 569, and fig. 80.

§ 'Die Krankheiten der Eileiter und die Tubenschwangerschaft,' 1876, p. 10.

cesses which have been discovered on Müller's ducts in the embryo. I have already given my own opinion on their development.

Lastly, the possibility of the escape of an ovum through an accessory ostium so large as in Fig. 5 must not be overlooked. Winckel* has found the hydatid of Morgagni adherent to the back of the uterus. This complication would, he believes, favour abdominal pregnancy by interfering with the movements of the Fallopian tube. The pedunculated fimbriæ might produce the same condition after adhesion to the neighbouring structures.

* Loc. cit., p. 570.

"Grossere Tube développée dans un Gaudant
Accessoire" Annales de Gynéc et Obstet. Oct
- nov. 1902 (Vol IV. III) p 241.

Bab. "Ueber Duplicität der Fallopian tube
ihre Entwicklungsgeschichtliche Genese." Archiv
f. Gynäk. Vol 70, P. II, p. 394 (1906)

Walthard Junges menschliches Ei in Mesos-
salpingium einer kleinen Nebentube
Zentralbl. f. Gynäk. 1911, p. 964. The ovum
was not in the paratubal cavity nor embedded
in the paratubal mucosa. It lay in the connective tissue
of the process of mesosalpinx reflected on to the paratube

13) Parona (Novara). Ein Fall von Lipom am rechten Ovar und Tube.

(Ann. di Ost. e Gin. 1891. No. 2.)

Verf. stieß gelegentlich einer Kastration wegen Myom bei Hervorwölzung der rechten Adnexa auf ein gut birngroßes, 80 g schweres Lipom. Die Geschwulst haftete theilweise dem Lig. latum an, und an derselben hing gestielt das normale Ovar. Die Tube war im Tumor gebettet, und nur das Fimbrienende war theilweise sichtbar. — Supponirter Ausgang der Geschwulst eine Tubenfimbrie.

? Fat outside in broad ligament
Tumors. Path. Soc. Vol X. p. 202 Gattorno (Triest).