Fibroma of the ovarian ligament weighing over sixteen pounds : removal, recovery.

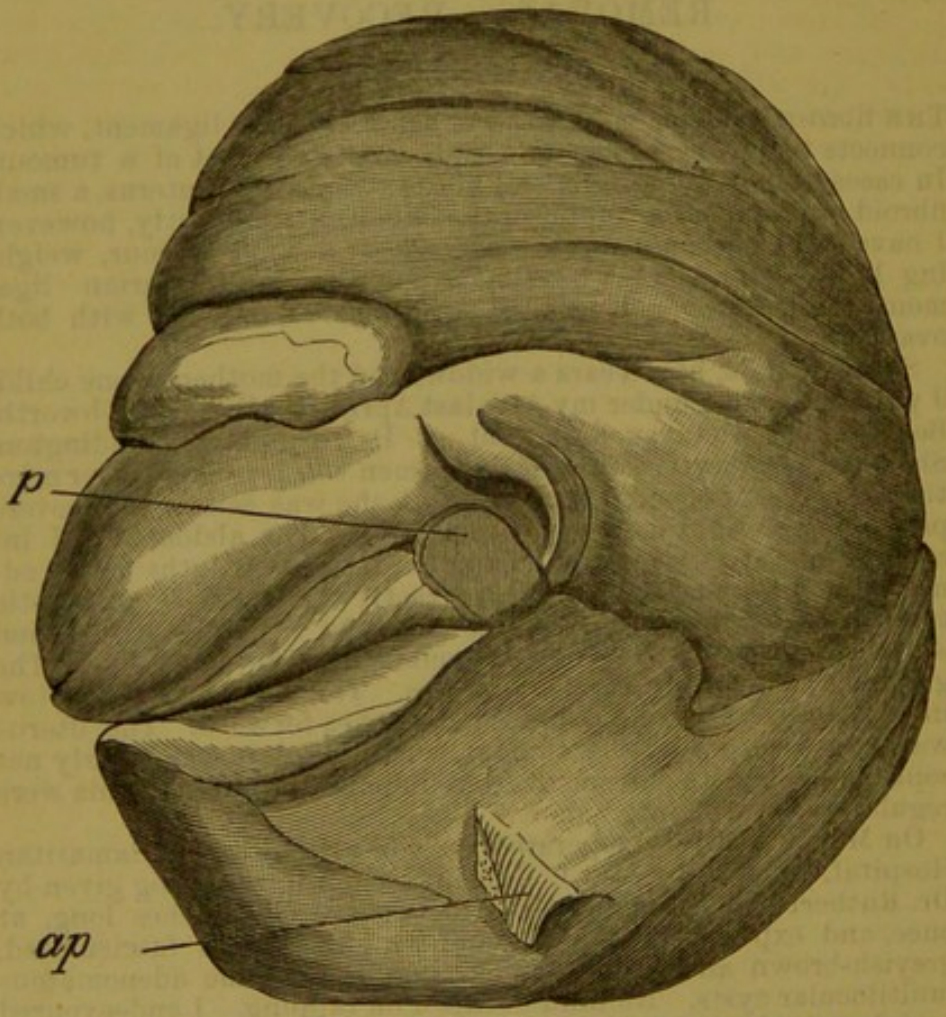
FIBROMA OF THE OVARIAN LIGAMENT WEIGHING OVER SIXTEEN POUNDS: REMOVAL: RECOVERY.

The fibro-muscular band, known as the ovarian ligament, which connects the ovary to the uterus, is rarely the seat of a tumour. In cases of multiple interstitial fibro-myoma of the uterus, a small fibroid is occasionally found in that ligament. Recently, however, I have had under my care a case where a solid tumour, weighing 16 lbs. 4 oz., was developed in the right ovarian ligament. This tumour I successfully removed, together with both ovaries.

S. G., aged 32, nine years a widow, and the mother of one child, 9 years old, came under my care last April; she lived at Tebworth, Bedfordshire, and was a patient of Dr. Waugh, of Toddington. She had first observed that her abdomen was growing larger more than two years ago; soon afterwards she was seized with severe pain over the right side of the swelling. The abdomen had increased in size very rapidly during the last few months before admission. I found the abdomen greatly distended by an elastic tumour, which reached from the pubes to the epigastrium, and extended towards the flanks, especially on the right side. The girth at the umbilicus was 41 inches. The cervix uteri was low in the pelvis; the sound passed 3½ inches forward. The uterus was pressed down by the tumour, with which it was clearly not continuous, but its movements were impaired. The catamenia were regular, with moderate "show."

On May 4th, 1889, I operated on the patient at the Samaritan Hospital, assisted by Mr. J. Malcolm; chloroform being given by Dr. Rutherfoord. I made a free incision, about 3 inches long, at once, and exposed a large tumour; its surface was fasciculated, greyish-brown and gelatinous-looking, as in some adenomatous multilocular cysts. No fluid escaped on tapping. I endeavoured to reduce its bulk by thrusting my hand into its interior, but its substance was very tough, and I could not find any septa to break down; very little blood was lost during the attempt. I prolonged the abdominal incision nearly three inches above the umbilicus, and found a strong omental adhesion on the uppermost part of the tumour; the vessels in the omentum were very large, and required careful ligature. To the right and left of the tumour were omental and parietal adhesions; one was very troublesome to secure. I transfixed it with No. 2 silk, but the ligature slipped, and fresh transfixion was necessary later on. Then the great tumour could be drawn out of the abdominal wound, some lobulated masses which fitted into the right iliac fossa projecting from its right side. Two appendices epiploicæ of the sigmoid flexure adhered to

its lowest part. The tumour was connected to the right side of the uterus by a flat pedicle about 1½ inch long. I compressed it with an elbowed large pressure-forceps (or "cyst-forceps"), and transfixed with No. 3 silk immediately below the forceps, after Dr. Bantock's method, as figured in my *Handbook of Gynæcological Operations*, p. 281. The tumour was then cut away; as I missed the usual elements of a normal pedicle, I feared at the time that the substance of the pedicle might be infiltrated with malignant material, defacing its natural structures. The left ovary, though small, bore several unhealthy-looking cysts; I therefore removed it. Then I carefully inspected the right pedicle. To my surprise I found below it the right tube and the ovary, which was cystic, and about 2 inches in long diameter. The stump of the pedicle projected between the uterus, which bore no fibroid



Fibroma of the Ovarian Ligament removed by Operation, seen from behind. *p*, raw surface representing pedicle; it is surrounded, especially below, by small lobules of the tumour. *ap*, an appendix epiploica, which connected the tumour to the sigmoid flexure of the colon.

growth, and the ovary on which it encroached. In fact, the tumour sprang from the ovarian ligament. The great bulk of the tumour had rendered a thorough search of the structures around its pelvic attachment very difficult, hence its true nature was not detected till it was cut away, so that the stump of its pedicle could be carefully inspected. Lastly, I removed the right appendages. The peritoneum was freely flushed out with hot water, and a drainage tube passed into Douglas's pouch. The operation was very tedious, owing to the multiplicity of adhesions, parietal

and omental; it took over two hours. The tumour weighed 16 lbs. 4 oz., after much serum had escaped from its interior. It bore all the characters of a soft, œdematous fibroma, as microscopic examination proved. In its vertical diameter it measured about nine inches. Posteriorly it was lobulated, especially around its pedicle; anteriorly it was smooth.

The temperature rose to 103°, with high pulse, ten hours after the operation, and after the skin had begun to act, so the ice-cap was applied. Two days later, flatulent distension of the abdomen occurred, flatus ceasing to pass for about ten hours. Then spontaneous action of the bowels took place, and recurred several times in twelve hours, with great relief. At the same time metrostaxis set in (the last true menstrual period had ceased on April 30th), with considerable constitutional disturbance, such as is often seen after double oöphorectomy, and in operations where uterine tissue is ligatured. The pulse ran high, the tongue became dry, and the vaginal temperature ranged for two days from 100.6° to 102°. The ice-cap was kept on during this period, as I knew from experience that high temperature is in itself mischievous in these cases of metrostaxis after abdominal section. On the sixth day I removed the tube; at first I had emptied it every two hours; at length the fluid which came away was scanty, very pale red, and perfectly scentless, so that the tube was no longer needed. After thoroughly syringing out the vagina, the sanguineous discharge, at first fœtid, became quite odourless, and ceased within a few days; but before it disappeared, namely, by the seventh day, the constitutional disturbance had ceased. Throughout the whole of the first week, from the moment the patient was placed in bed, she never vomited, and during the metrostaxis she had an appetite, although of course she was fed very sparingly. No nutrient enemata were employed, nor any alcohol or opium given except on one occasion, when the repeated actions of the bowels had caused some exhaustion. By the end of the first week the patient was convalescent; she left the hospital at the end of the month. There was no trouble with the long abdominal wound.

The flatulence and obstruction followed by diarrhœa probably represented an attack of peritonitis, which was presumably localised, else vomiting and other well-known symptoms would have been present. Want of space prevents me from entering into questions relating to the beneficial or evil effect of actions of the bowels, spontaneous or otherwise, during the first week after abdominal section. Nor can I dwell on certain minute details of treatment except that I must observe that in my opinion careful and frequent emptying of the drainage tube greatly contributed towards saving this patient. I only wish to emphasise the essential features of the case in respect to the nature of the tumour. The case proves that a new growth in the ovarian ligament may develop so as to form a large, solid tumour, bearing a pedicle which may be safely secured by ligature. Owing to the fact that the ovarian ligament is practically uterine tissue, ligature of its pedicle apparently causes disturbances often seen in other operations where uterine tissue is tied or clamped. I observed similar disturbances in a former case where I removed a sessile ovarian cyst with a small portion of the adjacent cornu of the uterus; the opposite ovary was left alone, and the patient still menstruates. I relate this because the fact that I removed both ovaries in the present case must be taken into account, nor can I doubt that the double oöphorectomy at least had a share in causing the profuse metrostaxis.

Tumours of the Ovarian Ligament

Sitzenfrey "Abnormen des rechten Ligamentum ovarii proprium" Zeitschr f. Geb u Gyn Vol 67, p 30, 1910.

Hamilton W. P "Report of 3 Unusual Cases" Trans. Amer. Gyn. Soc. Vol 35, 1910 p 8 (Case of Tubroid of the Ovarian Ligament. p. 17)