Sloughing fibroid of the left uterine cornu : abnormal relations / by Alban Doran and Cuthbert Lockyer.

SLOUGHING FIBROID OF THE LEFT UTERINE CORNU; ABNORMAL RELATIONS.

BY

ALBAN DORAN, F.R.C.S.,

AND

CUTHBERT LOCKYER, M.D.

Read November 6th, 1901.

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

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1901.

SLOUGHING FIBROID OF THE LEFT UTERINE CORNU; ABNORMAL RELATIONS.

By Alban Doran, F.R.C.S., and Cuthbert Lockyer, M.D.

(Received October 3rd, 1901.)

(With Plate XV.)

(*Abstract.*)

The specimen was from a single woman æt. 30, subject for a month to symptoms of pelvic inflammation with fever. There was an irregular moveable mass in the left fornix, rising into the left iliac fossa, and connected with a small anteflexed uterus. Mr. Doran performed supra-vaginal hysterectomy, removing the uterus and tumour with the left appendages; the right tube and ovary were spared. The patient recovered. The tumour, five inches in long diameter, was much larger than the uterus, projecting outwards rather than upwards from that organ. It was a true fibro-myoma in a necrotic condition, and adhered to intestine and omentum at its blunt-pointed outer extremity. This degenerative change apparently accounted for the febrile symptoms. At first sight the tumour simulated a fibroid in an undeveloped uterine cornu, but the Fallopian tube and ovarian ligament arose posteriorly, and not externally, and were attached to a deep groove between the uterus and the tumour. The left round ligament arose from the under surface of the tumour somewhat posteriorly, passing under it and forwards to the inguinal canal. A tumour with somewhat similar relations to a uterus much smaller than itself has recently been figured without any clinical history by Doederlein in Küstner's 'Kurzes

Lehrbuch der Gynäkologie' (fig. 146). This outward growth of a fibroid of the cornu without outward displacement of the corresponding tube and ovary is very unusual. The sloughy state of the tumour demanded its removal, and the uterus could not possibly be separated from a growth of this kind, so that it was also removed.

In text-books it is justly taught that in a case of any tumour of the Fallopian tube the round ligament will lie internal to the tumour, which is clearly situated in the appendages entirely outside the uterus. On the other hand, in a case of tumour of an undeveloped uterine cornu the round ligament, and also the tube and ovary, will lie external to the tumour which is interposed between them and the uterus.

When a fibroid tumour develops in a normal cornu the displacement of the tube and round ligament is less regular. The round ligament lies more or less external to the tumour, and always anteriorly. The uterine attachment of the tube is displaced more or less outwards, and lies more or less on the anterior or posterior aspect of the tumour, owing to the irregular growth of the latter, which rotates the attached structures backwards or forwards.

In the following case a fibroid developed without doubt in the left cornu, and grew very markedly outwards in the direction of its horizontal axis. The dislocation of the attached structures was very unusual. The Fallopian tube arose from the innermost limits of the tumour, quite posteriorly. The round ligament was carried a little outwards, but sprang from the inferior-posterior aspect of the tumour. Lastly, the tumour itself, though not large, greatly exceeded in size the uterus.

D. G—, aged 30, single, was admitted into Mr. Alban Doran's wards in the Samaritan Hospital on April 9th, 1901. Her physician, Dr. John Williams, of Connaught Street, W., sent in the following note:—"She came to see me three or four weeks ago, saying that she was

unwell, and had dysmenorrhœa, and I gave her belladonna and bromide. Next day she had a temperature of 101° or more, with pains two or three inches internal to the left anterior superior spine, and she was suffering from constipation. She said that she had caught a chill two or three days before. I regarded it as ovaritis, and treated it with counter-irritation, rest, aperients, and hot water injections into the vagina and rectum. Two evenings later the temperature rose to 102°; it came down to normal in a week. As the pain persisted I examined the abdomen, and found a swelling at the seat of pain. If it is a neoplasm I think it must be inflamed, but that you will decide." This diagnosis, it will be seen, proved correct.

Mr. Doran had seen the case on March 27th, and noted down—"An irregular moveable mass in the left fornix. It rises into the left iliac fossa. Right fornix free. Uterus small, anteflexed." The mass was tender on touch.

On admission the mass was hardly tender at all on touch, but had distinctly increased in size. The uterus was now retroflexed; the sound entered two and a half inches, the uterus falling back directly the sound was withdrawn. The precise connection of the irregular mass with the uterus was not very clear; as moving the uterus caused pain, bimanual palpation without anæsthesia could not be satisfactorily carried out.

The period, about three years before admission, became very free and very frequent, remaining so for about twelve months; from then until the present illness it had been regular, appearing every four weeks, with much pain and moderate show. There was no history of any serious illness.

A tumour clearly existed, most probably a fibroid, but the case was somewhat obscure, so Mr. Alban Doran operated on April 18th.

The patient was placed in the Trendelenburg position. The omentum and two coils of small intestine adhered to

the apex of a conical tumour of a dull yellow-brown colour in the left iliac fossa. Otherwise the peritoneum and abdominal viscera were normal; the tumour lay too far back to allow of parietal adhesions. The mass was drawn up after separation of the omental and intestinal adhesions; it was continuous internally with the uterus, and its apex was directed outwards, not upwards. The left round ligament, very thick, sprang from its inferior aspect almost posteriorly, passing forwards under the growth. The left tube and ovary were attached to its back part. The right appendages and round ligament all lay in normal relation to the uterus.

The parts were removed by retro-peritoneal hysterectomy; the right ovary was left behind with part of the tube. Owing to the singular form of the tumour it was not clear, even when the left round ligament and appendages were separated after ligature, whether it arose from an ill-developed left cornu, or was, as it proved to be on further examination, a tumour in a normal left cornu which had taken on growth chiefly in the direction of its horizontal diameter, and which had originated in front of the insertion of the Fallopian tube, so that the left appendages were not dislocated outwards as is the rule in cornual tumours. The round ligament was distinctly dislocated, at its uterine attachment, outwards, yet not nearly to the outer extremity of the growth, as in cases of fibroid developed in a partially suppressed cornu.

The pointed end of the tumour was carefully covered with gauze throughout the operation, as a few drops of turbid fluid exuded from it when the intestinal adhesions were separated.

The stump of the uterus was small, but Mr. Doran had to dissect out two intestinal growths, of the size of haricot beans, from its substance.

The temperature rose to 102° on the evening of the second day, the pulse not exceeding 100; then it fell steadily, and recovery was uneventful. The patient was in good health two months after the operation.

Dr. Lockyer supplies the following description of the specimen :

The tumour is, as a whole, spindle-shaped with a constriction dividing it into a small right uterine portion, and a larger left neoplastic portion. On the true right cornu of the uterus are seen the stumps of the right tube and round ligament cut quite short. The position of the left Fallopian tube and broad ligament is remarkable. These structures pass from the posterior and lower aspect of the new growth, at the junction of that growth with the left uterine cornu. The left ovarian ligament comes off from the back of the sulcus dividing the uterus from the new growth. The left Fallopian tube appears to spring from the new growth, just external to the sulcus. The left round ligament has been displaced so as to appear on the postero-inferior surface of the growth, and vertically beneath the point of attachment of the Fallopian tube (Pl. XV).

Thus the left uterine appendages have been displaced backwards by an egg-shaped tumour which has clearly arisen from the left cornu, but in front of them, and has grown outwards, in a horizontal direction, in such a way that the tumour is quite free of the adnexa excepting where it is joined to the uterus. The length of the entire specimen from side to side is 13 cm. Its vertical measurement is 5 cm.; the maximum vertical circumference (which runs through the centre of the growth) is 20 cm. The uterus is dwarfed to some extent, and has been rotated on its vertical axis by the tumour growing from the left cornu. Therefore, on making a sagittal section, more of the right cornu is seen in front of the transverse line, whilst more of the left cornu lies behind that line. This gives the uterus a somewhat bilobed appearance; there is, however, no reason to suppose that the left cornu is improperly developed. The above sagittal section through the uterus and growth shows the cervical endometrium to be thickened; that of the cavity of the uterus is normal. A small,

spherical, healthy white fibroid, 0·9 cm. in diameter, lies on the left cervical wall, contrasting in colour with the large, livid, dead tumour arising in the cornu of the same side.

The growth from the left cornu, which makes up the bulk of the specimen, being far larger than the entire body of the uterus, felt in the recent state as though cystic. It measures 8·5 cm. in its long horizontal diameter, and 6·5 cm. in its short vertical diameter. In shape it is obovate, by its wide extremity it is attached to the left side of the uterus, whilst its pointed extremity is free. To the upper part of the free end are seen the remains of inflammatory adhesions, and the surface of the tumour around these adhesions is of a yellowish-green colour, suggesting an advanced degree of degeneration. At the attached extremity of the growth appear, posteriorly, the uterine adnexa as before described. Between its two extremities the growth is free from attachments of any kind. The sagittal section of the growth was made after hardening in Kaiserling-Pick's solution. No cysts were seen on section; the cyst-like elastic condition felt in the recent state was now seen to be due to a diffuse colliquative necrosis which had caused the growth to break down centrally, and which was spreading gradually towards the periphery. After hardening the central fluid coagulated to form a putty-like substance, which shades off gradually into dull livid tissue resembling frozen muscle. At its attached end the growth is seen to be provided with a capsule derived from the uterine, serous, and muscular coats, and it is here that the growth is most healthy in appearance.

Excepting for its unusual position there is nothing abnormal in the left Fallopian tube.

The left ovary contains small cysts and hæmorrhagic foci.

Microscopic sections of the growth show it to be a fibro-myoma; its central parts are too necrotic to stain with logwood, and stain but faintly with eosin; the com-

ponent structures of the tumour are here almost indistinguishable, the section consisting largely of opaque *débris*. A section near the periphery displayed the typical blending of fibrous tissue and unstriped muscle seen in uterine "fibroid" tumour, but these tissues showed signs of incipient degeneration.

The two features of interest in this case are (1) the cause of the feverish attack shortly before operation, and (2) the singular relations of the tumour.

Cause of the Rise of Temperature.

Intestine and omentum adhered to the apex of the tumour, and on their separation some turbid fluid exuded from the tumour substance. The recent trouble clearly had its focus at this point. Had the intestine after adhesion, through mere peritoneal irritation to the tumour, infected the tumour, or had the tumour become inflamed first, from some cause not evident, and set up local adhesions? Mr. Doran could not feel certain about this point on operative evidence alone.

Dr. Lockyer, after the examination of the specimen above described, considered that the condition of the growth itself accounted for the febrile symptoms before operation. For some reason, having to do probably with its blood-supply, the growth had died *en masse* within its capsule, and the centre of the dead growth had, moreover, liquefied to form a glairy opaque fluid, quite unlike pus. Such a condition is not dependent upon the presence of micro-organisms; and although pyogenic bacilli or cocci were not sought for, they probably were not present, the products of degeneration alone being capable of producing fever.

The amount of peritonitis present was confined to a small area of the size of a florin; it was plastic in character, produced adhesions to the omentum and bowel, and was due to the unhealthy growth having thinned its capsule at this spot, and thus, approaching the peritoneum, caused that membrane to exude a patch of adhesive lymph.

The Relations of the Tumour.

Mr. Doran, in his description of the operation, noted what the tumour appeared to be at the time, and what it proved to be on further examination. He recently published an undoubted case of fibroid in an undeveloped cornu of a uterus unicornis, and exhibited the specimen before the Obstetrical Society.*

In two recent works a tumour of the present type will be found figured; in neither case is it described incorrectly as originating in an undeveloped cornu, but in neither does the author turn attention to its peculiar relations. Doederlein, of Tübingen,† gives a figure of a fibroid of this kind, presumably from his own practice. It is simply intended to illustrate "interstitial or intramural fibroids," in a chapter on uterine myoma in a text-book, and is thus described:—"Fig. 146. Interstitial fibroid well encapsuled (abdominal total extirpation)." The tumour lies entirely on the right of the uterus, except that it is encapsuled in uterine tissue, and, as in the present specimen, its horizontal diameter is proportionately very long. Unfortunately, neither the left appendages nor the left round ligament are represented, though the tumour is clearly connected with a well-developed uterus. The second case is figured in Cripps's 'Ovariotomy and Abdominal Surgery,' pl. xviii, and described as "Fibroid Tumour of the Uterus obstructing Delivery." The fibroid is encapsuled in uterine tissue, but otherwise lies entirely to the right of the uterus, as in the present and in Doederlein's case, but is not so disproportionately long in its horizontal diameter. The left appendages

* "Fibroid in Undeveloped Cornu of an Uterus Unicornis, from a Parous Subject," 'Trans. Obst. Soc. Lond.,' vol. xli, p. 295, and 'Brit. Med. Journ.,' vol. i, 1899, p. 1839 (with references to literature of the subject). See also Josephson, "Ueber die Neoplasmen der missgebildeten Gebärmutter," 'Archiv f. Gynäk.,' vol. lxiv, pt. 2 (1901), p. 376—a valuable essay on the subject.

† Küstner's 'Kurzes Lehrbuch der Gynäkologie,' 1901, p. 171, fig. 146.

"rose from the upper and front part of the mass;"* there is no further allusion to the extremely unilateral position of the tumour, which extended downwards and blocked the pelvis. This may be considered a more common and transitional form between an ordinary spherical fibroid, which, arising from the cornu, displaces the insertion of the tube outwards, and the type exemplified by the present specimen, where the fibroid arose in the cornu and grew outwards to a remarkable length, yet without much displacement of the uterine attachments of the Fallopian tube and round ligament.

It is highly probable that other tumours of this kind have been removed, but that their nature has been overlooked or misinterpreted.

Operative Treatment of the Case.

The somewhat obscure nature of the case, with a history of local inflammation, demanded an exploratory incision. Then it was discovered, as explained above, that the tumour was in an unhealthy condition, perhaps sloughy or suppurating. Its removal seemed the safer course, and the uterus could not be separated from it, so retro-peritoneal hysterectomy was performed, the opposite ovary being saved. As the stump of the uterus was small, the operation involved little trouble and not much risk. The adherent coils of intestine were healthy, and as none of the sanies from the tumour escaped into the peritoneal cavity no flushing or drainage was necessary.

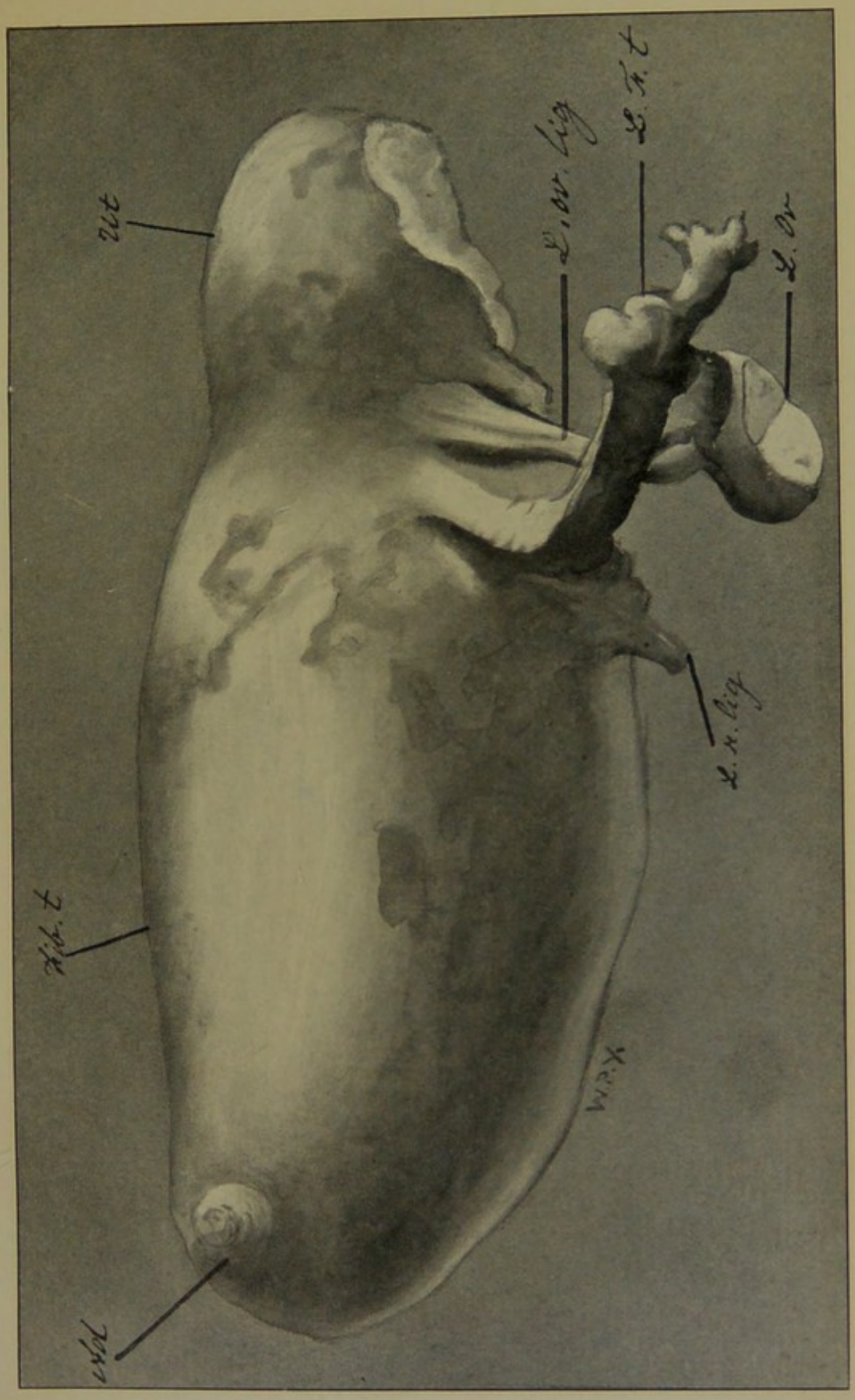
* Loc. cit., Case 83, p. 501; also C. Hubert Roberts, 'Outlines of Gynæcological Pathology,' fig. 72.

DESCRIPTION OF PLATE XV.

Illustrating Mr. Doran and Dr. Lockyer's specimen of "Sloughing Fibroid of the Left Uterine Cornu; Abnormal Relations."

The parts removed by hysterectomy.

Ut. Uterus. *Fib. t.* Fibroid tumour. *L. r. lig.* Left round ligament. *L F. t.* Left Fallopian tube. *L. ov.* Left ovary. *L. ov. lig.* Left ovarian ligament. *Ad.* Site of adhesion to intestine and omentum where the tumour tissue was breaking down.



Illustrating Mr. ALBAN DORAN'S and Dr. CUTHBERT LOCKYER'S Paper on Sloughing Fibroid of the Left Uterine Cornu; abnormal relations.

Engraved and Printed by Bale and Danielsson, Ltd.


24ColorCard
CameraCraze.com
20cm
STAINLESS STEEL