Malignant vaginal polypus secondary to an adrenal tumour of the kidney / by Alban Doran.

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Malignant Vaginal Polypus Secondary to an Adrenal Tumour of the Kidney.

BY

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

Surgeon to the Samaritan Free Hospital, London.

SHERRATT & HUGHES
London: 60 Chandos Street W.C.
Manchester: 34 Cross Street

OBSTETRICAL SOCIETY OF LONDON,

20, Hanover Square, W.

Abstract of Paper

To be read on Wednesday, May 1st, 1907.

A CASE OF MALIGNANT VAGINAL POLYPUS SECONDARY TO AN ADRENAL TUMOUR OF THE KIDNEY.

By Alban Doran, F.R.C.S.,

surgeon to the samaritan free hospital.

(Received April 3rd, 1907.)

A married uniparous woman, aged 40, suffered from rigors and sweats in September, 1906. A mass was detected in the vagina, and a small tumour in the right iliac fossa. The vaginal growth was a racemose body attached by a well-defined pedicle to the lower part of the anterior wall of the vagina; its lobules, more or less necrosed, were shed from time to time. Three sessile growths lay in the posterior wall, the mucosa over one was pigmented. In November the author removed the abdominal tumour, which proved to be a malignant adrenal growth in the upper part of the right kidney. The patient declined to allow a second operation for the extirpation of the vaginal growths; lobules of the pedunculated tumour continued to come away. She survived the nephrectomy three months. After death secondary deposits were discovered in the liver and right lung; their presence in the lung had been diagnosed before death. On microscopical examination it was found that the vaginal tumours, as well as the growths in the liver and lung were of the adrenal type, and therefore secondary to the tumour in the kidney.

In this case a pedunculated tumour developed in the vagina, the slow, constant sloughing of its lobules probably accounting

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A. Doran Esq F.R.C.S.
9 Granville Place
Portman Square
London
W

Malignant Vaginal Polypus Secondary to an Adrenal Tumour of the Kidney.*

By Alban Doran, F.R.C.S.,

Surgeon to the Samaritan Free Hospital, London.

Introductory Remarks.

Primary sarcoma of the vagina in the adult is clinically and pathologically a disease of high interest, about which much has been written during the past twenty years by many British and foreign gynæcologists. In the course of that same period, general surgeons and pathologists have bestowed much attention on a far more frequent yet, until of late, hardly more recognized form of new growth "hypernephroma" or adrenal tumour of the kidney, so called because it originates in "rests" or tracts of tissue resembling that which makes up the normal zona fasciculata of the supra-renal capsule.

I will now relate a case where a malignant pedunculated tumour developed in the vagina of a woman, aged forty, some of its lobes coming away from time to time, whilst one amongst three sessile adjacent growths showed "pseudo-melanosis" (Horn, Morestin) of the superjacent vaginal mucosa. All these features have repeatedly been recorded in cases of what is specifically known as "primary sarcoma of the vagina in the adult." Nevertheless the tumour proved to be secondary to an adrenal adenoma of the kidney. Nephrectomy was performed, the patient surviving the operation for three months. After death, metastatic deposits were detected in the liver and lung as well as the vagina.

History of the Case before Operation.

Mrs. E. H., aged 40, was admitted into my wards in the Samaritan Free Hospital on November 7th, 1906. She had been referred to me by Dr. W. T. Evans, of Gloucester Terrace, who had detected an

* Read before the Obstetrical Society of London, May 1st, 1907.

abdominal tumour and a polypoid growth in the vagina. The patient had been married nineteen years. Her sole pregnancy ended at term two years after her marriage. Dr. Evans could find no history of any serious illness since or before her confinement. Early in September, 1906, she complained of a "chill and tightness of the chest." She kept in bed for a few days, and felt extremely weak when she got up. Thenceforward she began to be troubled with profuse sweats which, as will be seen, continued after the operation. After August, 1906, the catamenia ceased abruptly. They had previously been regular with moderate hæmorrhage for about four days. On recovering from the "chill" the patient discovered that the abdomen was swelling, and it slowly increased in size.

The patient was rather thin and distinctly sallow. An oval, elastic tumour occupied the right iliac region. It was of about the size of a cricket-ball, and could be moved laterally to the extent of two or three inches, but could not be pushed far backwards or upwards. On percussion, there was resonance which varied from day to day. The kidney could not be defined in the loin, and there were no enlarged glands in the inguino-femoral region.

There was hardly any vaginal discharge. On the posterior commissure lay a flat nodule under an eighth of an inch in diameter, and its surface bore papillæ. A pedunculated morbid growth of somewhat unfamiliar type sprang from the mucous membrane of the vagina two inches above the vulval orifice anteriorly and a little to the right of the middle line. It was racemose rather than polypoid, consisting of several outgrowths varying in shape and size; some were like grapes, others cylindrical, elongated and irregularly bent. They were for the most part dark grey in colour. The entire growth was attached to the vaginal wall by a stout, fleshy pedicle about three-quarters of an inch in length; the secondary branches of the pedicle running to each outgrowth were, on the other hand, short, thin and friable. Two lobules came away after admission, before the operation. They were sent to the College of Surgeons. (Fig. I.) I detected, on further examination, three sessile growths in the mucous membrane of the posterior part of the vaginal wall. The largest was about half an inch in diameter, and there was a black patch on its surface. They were not adherent to the subjacent tissues, and the rectum was free from new growths.

The cervix appeared quite healthy and moved freely with the rest of the uterus. There was no deposit above the vaginal fornices, and the tumour in the right iliac fossa could not be pushed down below the pelvic brim.

The tongue was rather raw but not glossy, the appetite was bad, and the bowels were neither constipated nor relaxed.

The patient had observed that the urine had been very thick ever since the chill, but declared that it had never contained blood. It

was loaded with bright pink urates, yet the specific gravity never exceeded 1022; about twenty fluid ounces were passed daily. No albumen could be detected.

The temperature fluctuated considerably during the seven days between admission and operation. The maximum was 102° (November 11th, evening), the minimum (November 13th, morning before operation) 98·6°.

The pulse was 108 on admission, and never fell any lower before the operation. It was fairly full and very soft. My clinical assistant, Major S. Colin Evans, I.M.S., to whom I am much indebted for help in preparing these notes, detected a faint organic systolic murmur at the heart's apex, but no abnormal pulmonary signs.

I diagnosed the vaginal growth as a pedunculated sarcoma, a type noted of recent years by many writers, some of whom have observed its tendency to undergo necrosis, so that its lobes come away one by one. About the tumour in the right iliac region I felt much less certain. I believed that it was either an enlarged kidney or an ovarian dermoid held back by adhesions and bearing adherent intestine on its anterior surface.

The Operation.

The operation was performed on November 13th, with the assistance of Major S. Colin Evans and Dr. W. T. Evans, Mr. W. S. Morley administering the anæsthetic. My intention was to excise the vaginal growths after removing the abdominal tumour.

When the peritoneal cavity was opened by a median incision about one pint of clear ascitic fluid escaped. A dull white tumour bearing small red wattle-like outgrowths on its surface lay behind the ascending meso-colon. The uterus and ovaries were normal, and in no way connected with the growth. The intestines showed no signs of disease, and there were no adhesions. I made a longitudinal incision through the layer of peritoneum which passed from the ascending colon on to the parietes in the flank, encapsuling the outer part of the tumour. I then enucleated that part, and set free the front of the tumour without damage to the colon. The ascending meso-colon, strongly adherent to the tumour, was torn but without injury to the vessels, which were much dilated. I passed my hand under the lowest and innermost part of the tumour, which proved to be the greater part of the right kidney, almost unchanged and rotated downwards and inwards so as to lie over the lumbar spine. A great deal of fat was now detached from above and behind the tumour and much oozing ensued. The renal vessels lay in a thin, tense band, which ran upwards from the hilum and looked like an old adhesion; the band was divided and the kidney itself set free. This stage of the operation proved easy; the ureter was very thin. On the other hand, I had great difficulty in securing vessels in the oozing surface above. I was obliged to push up the liver, which

was pale and thin and apparently free from new growths. The gall-bladder was slightly distended. I detached some firm nodules, apparently glands, from the oozing tissues close to the vena cava.

The patient's condition being very unfavourable, I did not proceed to remove the vaginal growths, as I had originally intended. I flushed the peritoneal cavity with saline fluid, applied deep interrupted sutures to the abdominal wound, poured more saline fluid into the peritoneal cavity, and, lastly, closed the abdominal incision.

I must admit that, at the conclusion of the operation, I felt anxious about immediate results. I could not feel certain that the tumour was not situated in the supra-renal body itself, and when separating it from its upper connections, I thought of a specimen, presented by Dr. Lediard to the Museum of the Royal College of Surgeons (Pathol. Series No. 3514), removed from a subject after death from Addison's disease. It reads: "A supra-renal capsule with the adjacent vena cava. . . . . It is abnormally close to the vena cava, and compresses its own vein." These words were my own, written after examination of the specimen many years ago. But I have never forgotten them, and in consequence do not feel comfortable when operating on anything which may be the supra-renal capsule, as anatomical relations are not always easy to define in the course of an operation, and I know that even during the removal of a purely renal tumour the vena cava may be wounded.

The Renal Tumour.

The parts removed at the operation consisted of the right kidney surmounted by a tuberous mass, which was separated from the kidney in front by a distinct groove (Fig. II.), whilst posteriorly it blended with the adjacent pole of the kidney without any visible sign of demarcation.

The vertical measurement from the uppermost part of the tumour to the opposite pole of the kidney was 5½ inches. The tumour alone measured 4½ inches horizontally, 2¼ inches vertically, and 2½ inches antero-posteriorly. Its surface was somewhat tuberous, and bore masses of fat. The kidney was of about the normal size, and its capsule was not adherent.

On *section* the new growth was seen to invade the substance of the kidney to a considerable extent at its apparent upper pole. (Fig. III.) A piece was cut off the border of the kidney posteriorly, where the fusion was as above stated, most marked, so as to include a portion of the tumour. This piece was preserved for microscopical examination. On the kidney, at the point where the piece had been cut, an isolated tract of new growth, with a well-defined almost circular border was exposed; it lay in the cortex of the kidney about half an inch away from the lower limits of the tumour.

The bisected tumour and kidney have been preserved, the anterior half in the Museum of the Royal College of Surgeons, the posterior in Dr. Cuthbert Lockyer's private collection. The cut surface shows the yellow tissue, with spaces filled with blood, characteristic of adrenal growths.

Microscopical Appearances of the Renal Tumour. I examined with Mr. Shattock, some sections of the tumour at its point of junction with the kidney. (Figs. IV. and V.).

On the renal side of the section true cortical tissue was seen, free from new growth. The tubuli uriniferi were well-formed, bearing normal epithelium, but a certain amount of fibrosis was present.

The kidney substance was separated from the new growth by a narrow but very distinct tract of fibrous tissue.

The tumour was made up of large cells with big and well-formed nuclei. These cells were arranged in somewhat irregular columns strongly simulating, in Mr. Shattock's opinion, the arrangement of the cells of the zona fasciculata of the cortex in the supra-renal body. The new growth was very vascular, especially at certain points where groups of blood-vessels were seen, some empty and others full of blood. There was very little stroma, so that the cells seemed to rest on the capillaries.

Mr. Shattock, after carefully dissecting the preparation, has pointed out to me that the ureter lay in the hilum *anterior* to the artery. I have no doubt as to the position of the tumour when I operated, the kidney was displaced downwards and inwards so that it lay very conspicuously across the lower lumbar vertebræ with its outer or convex border downwards. Hence the position of the ureter would imply that the tumour had really developed in the *lower* pole of the kidney (probably movable before it became diseased) and that the organ with the new growth had undergone rotation, bringing the tumour and the lower pole uppermost. This fact in no way modifies the pathological aspect of the case in respect to the nature of the vaginal and visceral growths.

The Vaginal New Growth.

The lobules which, as I will relate, came away after the operation were in a markedly necrotic condition, unfavourable for a study of the histology of the tumour. The two which broke off from the pedicle before the kidney was removed were in a much less altered state, although not absolutely free from necrotic changes. From one lobe, oval and half an inch in its long diameter, some successful sections were made at the Royal College of Surgeons. (Figs. VI. and VII.).

Microscopical Appearances. The tumour was made up of large cells with big nuclei, and, as in the renal tumour, the cells showed in many parts of the section a tendency to a columnar arrangement.

The groups of cells were separated by connective-tissue, forming very fine lines excepting at certain points where the tissue was much thickened by free fibrinous exudation.

Mr. Shattock considers that these appearances indicated that the vaginal tumour was secondary to the adrenal growth connected with the kidney. It had none of the microscopical characters of a pedunculated primary sarcoma of the vagina, which it so closely resembled to the naked eye.

I must add that near the periphery of the section, corresponding to the surface of the tumour, was a necrosed area separated from the unchanged tumour tissue by a well-marked layer of fibrin. In this area there was much fibrinous exudation, the tumour cells had almost disappeared, and there was distinct small-celled infiltration towards the free surface of the tumour.

History after Operation.

The patient recovered from shock sooner than I had expected. She passed urine naturally within four hours after the operation, and never required the catheter. There was very little vomiting, no distension and no difficulty in the passage of flatus, which passed freely within twelve hours. For a week the temperature seldom rose above 99·2°, and the maximum was 100·2°, and the pulse became rather stronger and slower than before the operation. In the course of the third week cystitis set in, probably from discharge from the stump of the right ureter and from irritation due to the urine which was as full of pink urates as before the operation, and could not be kept clear without large doses of citrate of potash, etc.

On November 24th, the sweats, which had never entirely ceased, became profuse. The thorax was examined, and dulness on percussion was detected in the right side up to the third rib. There was increased roughness of breathing-sounds over both lungs and crepitation at the left apex. These symptoms disappeared within a fortnight, but the dulness never cleared up. On December 2nd a mass of necrosed new growth protruded from the vagina, and was easily broken off from the pedicle without much subsequent hæmorrhage. At that date there had already been a rise of temperature for a few days, once reaching 102° in the evening. This rise was, apparently, accounted for by the development of a tender body above the right iliac fossa, representing inflammatory exudation around the ligatured tissues, but, as I will endeavour to explain, it was more likely due to another cause.

The patient, contrary to my advice, desired to go home; I had hoped to improve her condition so that she might be able to bear the removal of the vaginal growths. She was discharged on December 12th, a month after the operation. The swelling about the right iliac fossa had grown larger, but was distinctly less tender. As on

November 24th, there was dulness in the right mammary line up to the third rib without cough, hæmoptysis or dyspnœa. The edge of the liver could be defined three inches below the ribs in the mammary line; it was thin, firm, smooth and not tender. The abdomen itself was not distended, or tender on palpation. The three growths on the posterior wall of the vagina had not increased, in fact they were necrosing; the pedunculated growth on the anterior wall still bore several lobes. Just as when the patient was admitted, the upper part of the vagina was free from growths, and there was hardly any vaginal discharge. The urine was still charged with bright pink urates; the ropy mucus had disappeared after free washing out of the bladder.

The patient was clearly in very weak health. I referred her again to Dr. W. T. Evans. We both feared that she would never be in a condition which would allow of an operation to remove the vaginal growths.

On January 2nd, 1907, Dr. Evans informed me that the patient was losing ground, and that at times she was troubled with cough. "To-day the monthly period began; it is rather profuse." Considering how weak the patient had become, this return of the catamenia, after suppression for five months, was remarkable. The patient, notwithstanding her extreme weakness, lived until February 8th, dying twelve weeks and three days after the operation.

Dr. W. T. Evans was permitted to make a post mortem examination, and to him I am indebted for the following report:—

The body was greatly emaciated, and the skin uniformly sallow. The *abdominal wound* had healed perfectly.

There was no free fluid in the *peritoneal cavity*, or any secondary deposits on the parietal peritoneum. The *stomach* was extremely dilated, its greater curvature almost touching the pubes. The *small* and *large intestines* were almost empty; the rectum contained some soft fæces. There was no sign of obstruction, or any trace of secondary deposits. The rent in the ascending meso-colon had closed. The structures forming and surrounding the *pedicle of the right kidney* were removed for examination, as well as an oval body, apparently an enlarged lumbar gland, above them; the right supra-renal body could not be distinguished. When examined, no collection of pus could be discovered in or around the pedicle, and there was but little inflammatory effusion into its tissues, though adhesions were very dense. (The lump in the right side had not increased since the patient left the hospital.)

The *left kidney* and *supra-renal body* showed no outward sign of disease, and were put aside with the *spleen*, which was small and firm. The *liver* was large, almost of the normal colour, but slightly mottled at certain points. There were no inflammatory adhesions between it and the diaphragm and viscera. Several secondary

deposits were found in its substance, pale yellow and firmer than the hepatic tissue. One lay superficially in the anterior part of the right lobe, and was as big as a filbert; another of about the same size in the left lobe, but it was ill-defined. Two others, well defined, lay in the substance of the right lobe. The anterior edge of the liver and its under surface showed no signs of secondary deposit. The *gall-bladder* was somewhat distended with dark bile; there were no calculi in its cavity, or in the ducts.

An incision was made in the diaphragm; the right *pleura* was found to be free from adhesions and effusion; the right *lung* appeared normal in consistence, but several secondary growths, similar to those in the liver, were found in the lower part of the inferior lobe, which, together with the liver, was preserved for further examination.*

The *uterus*, *ovaries* and *vagina* were removed and preserved. Douglas's pouch and the parts around it showed no signs of any secondary growth; but soft adhesions (not existent at the date of the operation) had formed between several coils of small intestine and the posterior surface of the uterus.

The preserved parts were transferred to my care, and I submitted them to Dr. Lockyer and Mr. Shattock for microscopical examination.

The left kidney and supra-renal capsule proved to be free from new growths or any other visible morbid condition. The same was the case with the spleen, which, considering the long-standing high temperature, was unusually small and firm. The uterus and ovaries bore no secondary growths.

The pedunculated tumour in the vagina had almost entirely broken down. The three sessile growths in the posterior wall had become necrotic.

The Secondary Growths. There was some difficulty in preparing satisfactory sections of the secondary growths in the right lung and the liver, as they were very soft. At length some sections were successfully cut and stained; under the microscope they showed all the appearances characteristic of adrenal tissue.

Having related my case, I will now review what has been written about connective-tissue tumours of the vagina and adrenal growths of the kidney.

Vaginal Fibroma and Sarcoma.

Solid tumours of the vagina are not common. Richard R. Smith published, five years ago, a good monograph on *fibro-myomatous tumours* of the vagina. He collected 101 cases. They are nearly always single, Strassmann and Olenin have reported the only two

* The remaining thoracic viscera and the cranial cavity were not examined; the necropsy was made in the house where the patient died.

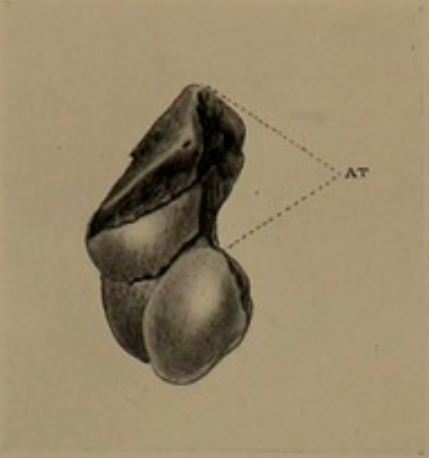

Fig. I.

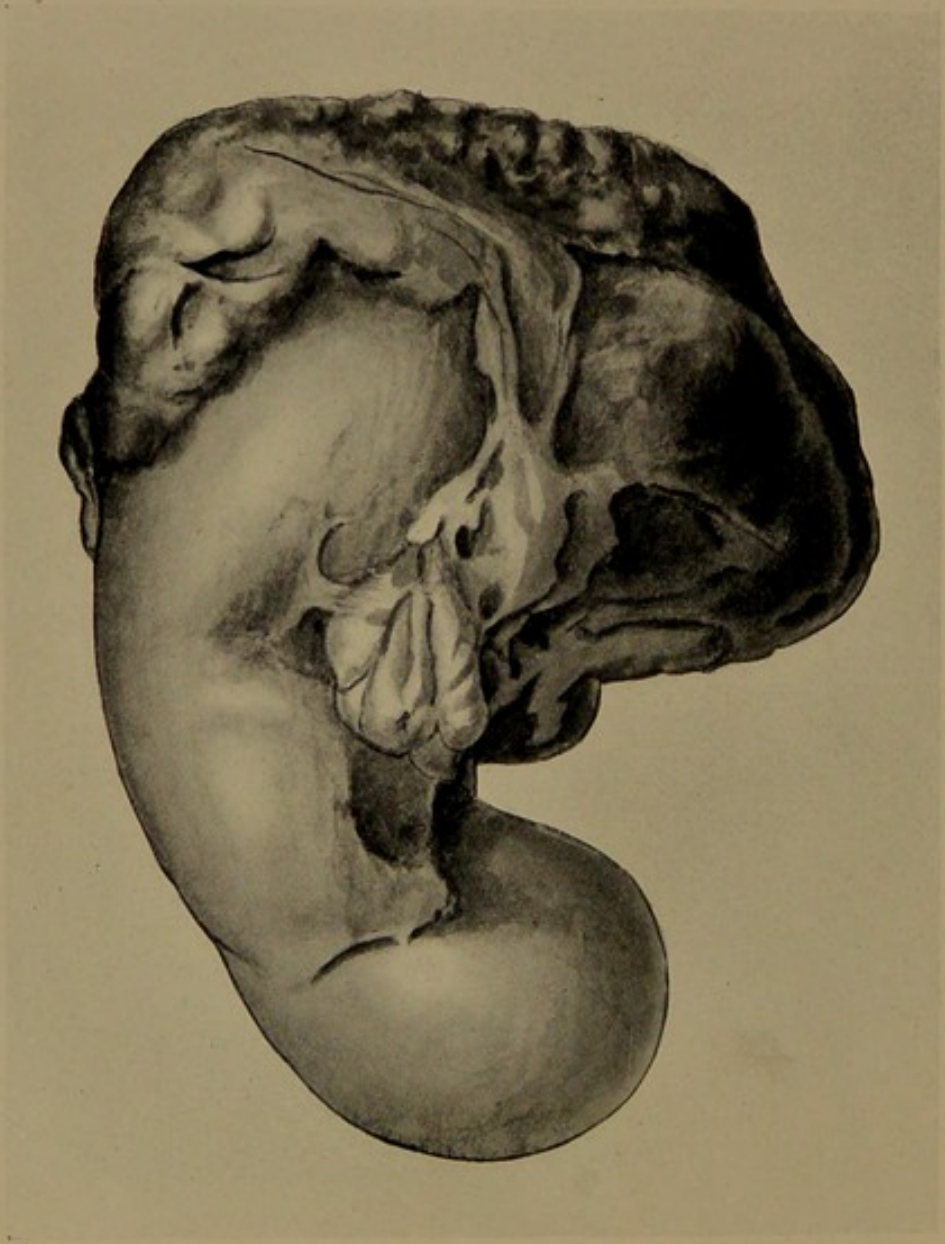

Fig. II.

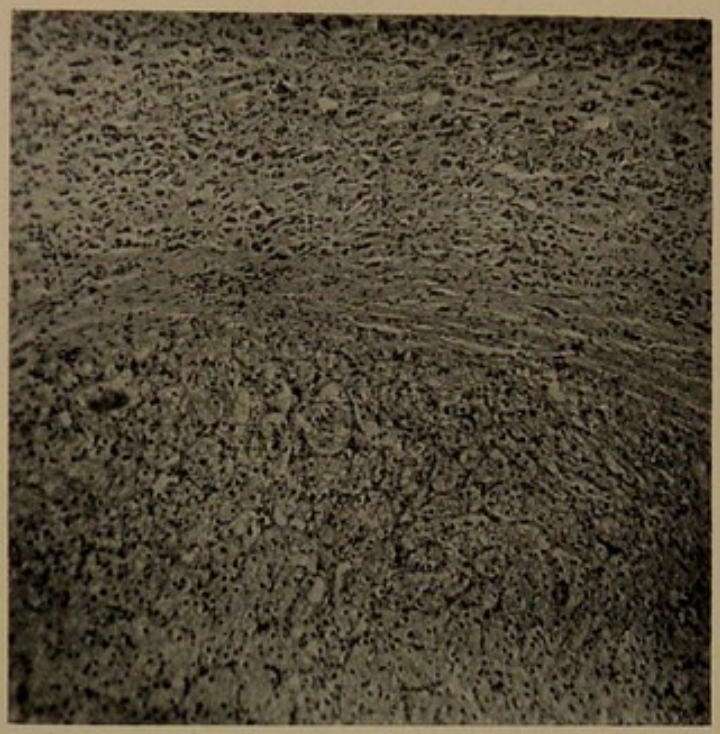

Fig. IV.

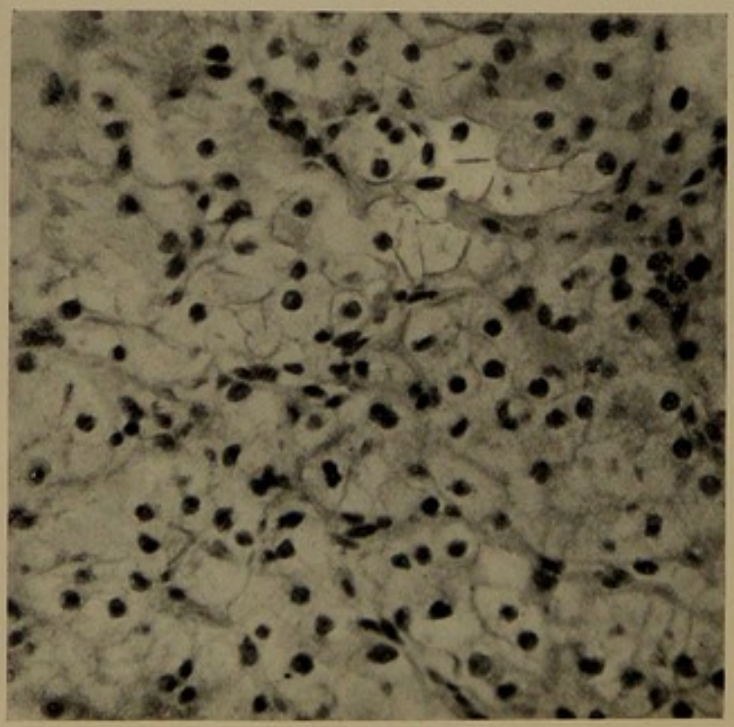

Fig. V.

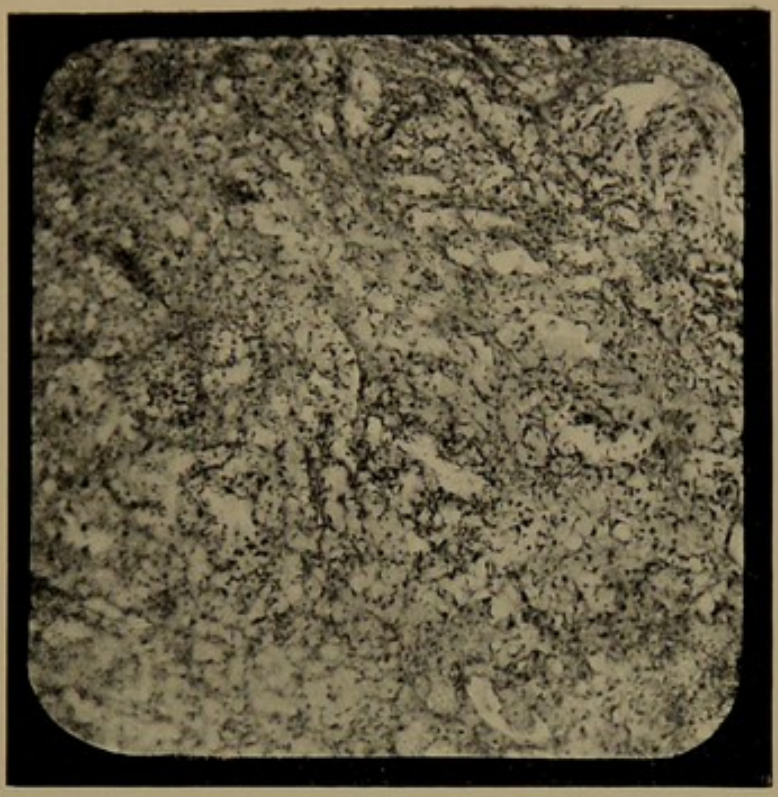

Fig. VI.

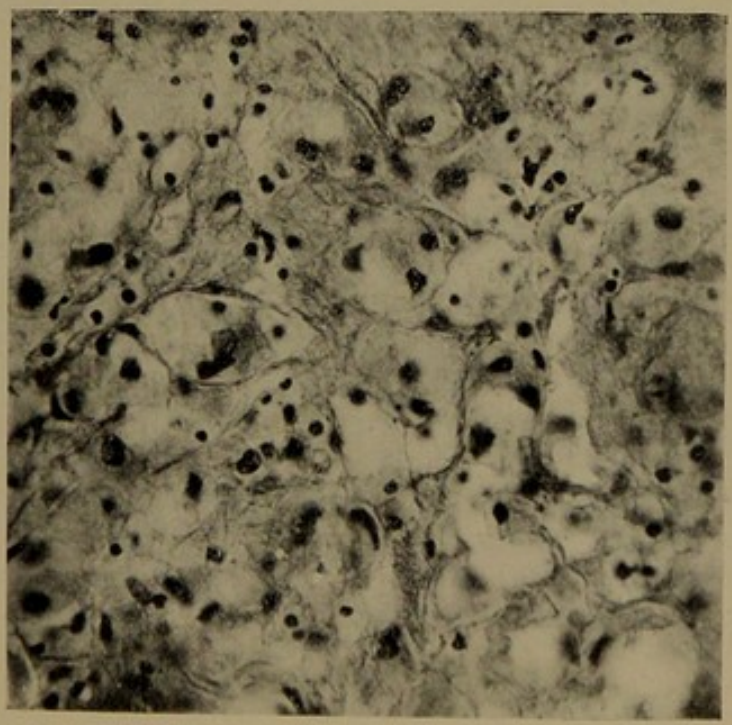

Fig. VII.

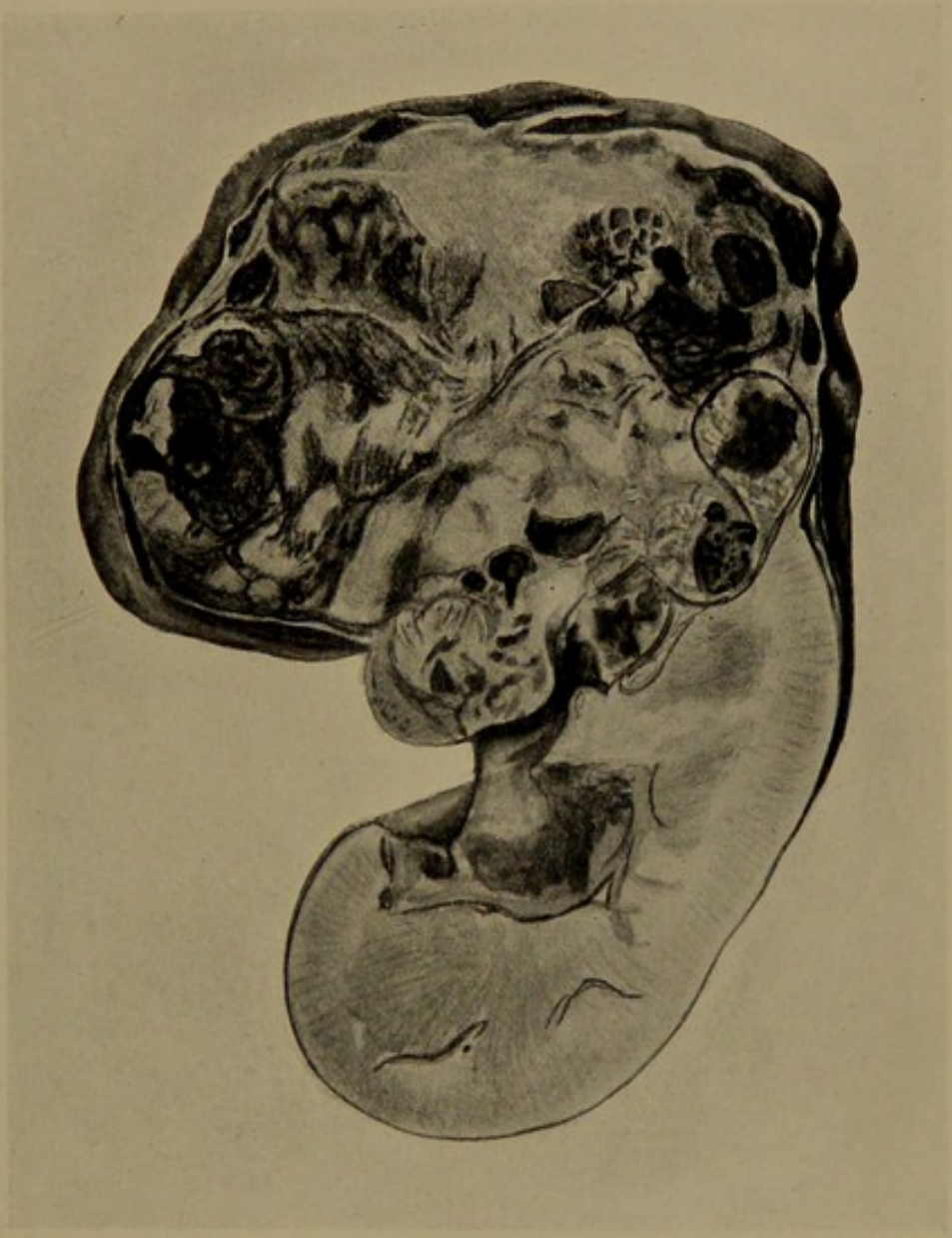

Fig. III.


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authentic exceptions. The nature of the attachment of the growth to the surrounding parts is noted in 66 cases; in no fewer than 39 the tumour was said to be polypous or pedunculated, whilst the remaining 27 were sessile. Observers, however, differ about what the word "pedunculated" may signify. The most important clinical fact made clear by R. R. Smith is the marked tendency of these innocent fibromas and fibromyomas to become necrotic, especially when they grow large. The same change has long been known as frequent amongst malignant tumours of the vagina; but Smith's evidence shows that it is no essential proof of malignancy.[1]

Only twelve days before I removed the kidney above described, I operated on a fibroma of the vagina. The patient was a married woman, aged 55, who had only once been pregnant; her child was 14 years of age. She consulted me on account of a large ovarian cyst. There was a history of suppurating femoral glands when she was 22 years old. On November 1st, 1906, I removed both ovaries for cystic tumour free from any evidence of malignancy. The vaginal tumour, which I had discovered when examining the patient, lay about two inches above the posterior commissure. It was perfectly sessile and of the shape and size of a broad bean. The vaginal mucous membrane over it and around it was quite healthy, but I excised the mucosa very freely; much bleeding ensued, easily stopped when the sutures passed under the wound were tied. Dr. Cuthbert Lockyer examined the growth, and found that it was made up of pure fibrous tissue. He suspected that it might be keloid in type, an interesting point in relation to the genesis of vaginal fibroids.

We are much more concerned at present, however, with the only other form of vaginal growth which we need discuss, namely, *primary sarcoma of the vagina in the adult*. The last three words are always added in systematic works in order to distinguish this new growth from another and a different type which developes *in the infant*. "Primary sarcoma" will be sufficient here to express solely the type observed in the adult.

A great deal has been written about this primary sarcoma, yet the disease is rare, although Meadows turned attention to it nearly forty years ago, and since then Gow, Veit, Roger Williams, Jellett and Earl, and others have published careful analyses of collected cases inclusive of those under their own observation. Yet Jellett and Earl, the latest writers, could only find 39 authentic reports, less than half the total of genuine instances of primary cancer of the Fallopian tube collected by Orthmann and published in 1906. Nevertheless I believe that most gynæcologists appear to be under the impression that vaginal sarcoma must be much less rare. The labours of R. R. Smith, to which I have already referred, bring up the recorded examples of fibroma and fibromyoma to 101, and it is highly probable that many other cases remain unreported. For

innocent tumours are held by many operators as trifles not worth writing about, and, on the other hand, fibroma of the vagina often grows slowly, and gives no trouble, so that it is liable to be overlooked by the patient, as in my own case, where, as I have explained, I discovered the vaginal tumour accidentally when examining a woman subject to ovarian cyst. For the above reasons we may feel sure that, in the vagina, fibroma is commoner than sarcoma.

Veit concludes his remarks on *das Sarcom der Scheide bei Erwachsenen* by solemnly warning all future observers who may come across sarcomatous growths in the vagina not to be satisfied with a cursory examination of a case hurriedly embodied in a brief clinical report, but to make sure of the precise significance of any histological element that they may detect, striated muscular fibre, for instance, and, above all, to satisfy themselves and others as to whether the new growth be primary or secondary. To this view of the question we must all cordially assent, for the collected records of primary sarcoma up to the present date cannot as yet satisfy the pathologist, guide the practitioner or aid the operator.

Veit, I have observed, mentions striped muscle as an element which arrests our attention. My experience shows that it may be arrested by another highly interesting tissue, the discovery leading to the important conclusion that the vaginal tumour is not primary. Since very little was known about these adrenal "rests" until a few years ago, I suspect that even on more than one occasion a secondary tumour of the vagina similar to my own may have been misinterpreted and ranked as a primary sarcoma.

Thus Klien published, as long ago as 1894, a report of a vaginal tumour which he classified as a lymphangio-endothelioma cavernosum hæmorrhagicum. The patient was a multipara, aged 56; two pedunculated, tuberous elastic tumours sprang from the vaginal mucous membrane; they were very friable. Both were amputated, and the patient was discharged on the seventh day; the after-history was incomplete.* The new growth was reticular in structure with the meshes filled with blood. But Neusser, amongst others, reminds us that tumours arising in adherent "rests" are apt to become "almost telangiectatic." I cannot help thinking that Klien's tumour might have been of that type.

I will now dwell for a while on two clinical features common to my case, and to many examples of alleged primary sarcoma of the vagina in the adult, namely, *pedunculation* and *pigmentation*.

Pedunculation. According to published reports, a large propor-

* Klien (*loc. cit.*, p. 301) states that recurrence took place, but at the date on which his report was published the patient could not be persuaded to return to hospital. The case, he said, was being closely watched. I cannot find any further note of it by Klien himself. Veit (*Handbuch der Gynäkologie*, vol. i., p. 362) suspects that Klien's tumour was a carcinoma. Klien makes no mention of any examination of the abdomen before the removal of the tumour.

tion of all types of primary connective-tissue tumours of the vagina are pedunculated. Such is the case, we have seen, in respect to innocent tumours. The reports of pedunculated and sessile primary sarcoma are, I find, not highly reliable. In the first case, errors have crept into tables and statistics. Thus Gow writes, in describing his original case: "On the lower part of the posterior wall is situated a small, round, *sessile* tumour," and in that writer's tables the same case is entered, under the heading "Clinical Form of Growth" as a "sessile lump." Yet in Veit's tables, widely quoted, Gow's case (No. 14) is entered as *gestielt*. In the second place, as I have already had occasion to remark, authors differ as to what the words 'pedunculated,' 'pediculated,' 'polypous' and 'sessile' precisely signify. We know that they do so when describing subserous fibroids of the uterus. A tumour with a sharp edge overhanging a relatively narrow attachment seems to be considered by some as pedunculated and by others as sessile, the latter description being the more correct. These doubtful cases represent an intermediate stage between the absolutely sessile growth merely projecting from the surface of the mucosa, and the tumour with a distinct stalk, a true pedicle in fact, undoubtedly the later stage of the former type. This fact was demonstrated in my case where the larger, older and sloughing tumour had a very distinct pedicle, whilst the smaller growths were, when I examined them, absolutely sessile. The large tumour was racemose rather than what is understood by polypoid. Ziegler in his *Pathologie* states that vaginal fibromas, myxomas and sarcomas may be racemose as well as polypoid. The primary sarcoma of the infant's vagina is well known to be racemose.

The fact that this pedunculated tumour of the vagina was secondary to an adrenal growth in the kidney shows how careful we ought to be about exploring the patient's abdomen and thorax and also about choosing a really competent pathologist to examine the original growth under the microscope. I was under the impression, until I received Dr. Lockyer's and Mr. Shattock's reports, that there might be coincident vaginal sarcoma and renal hypernephroma, the more so as when I detected evidence of new growth in the base of the right lung, I remembered that such a complication had already been observed in primary sarcoma of the vagina.* The microscope, however, showed that both the vaginal tumour and the new growths in the lung were secondary to the renal growth.

Pigmentation. In this case, as I have already observed in the clinical report, the largest of the three sessile growths in the mucous membrane of the vagina posteriorly bore a black patch on its surface.

* Herzfeld, case where nodules of the new growth were detected in the lungs and pleura at the necropsy; also Bajardi, case where the clinical evidence was strong though no post mortem was permitted. Gow (*loc. cit.*) gives good abstract reports of the two cases.

Unfortunately this appearance was lost because the growth became sloughy before the patient's decease. The pigmentation was very possibly confined to the vaginal mucous membrane investing the growths. In Horn's case of primary sarcoma the mucosa was pigmented, though the tumour itself was free from pigment; yet some secondary growths in the inguinal glands were much pigmented. Later on, pigmentary growths developed on the vulva, whilst a big irremovable encephaloid abdomino-pelvic mass was found to be free from pigment. Horn ascribed the pigmentation, which was so remarkably irregular in his case, purely to hæmorrhages, and gave good reasons for his opinion. Morestin, in examining a pedunculated round-celled sarcoma from an elderly virgin, found that some of the cells were charged with pigment, which, like Horn, he ascribed to blood.* My own experience shows that a secondary adrenal tumour of the vagina may be pigmented, and in all probability from the same cause. Pigmentation seems to be a fascinating subject to many writers; as for true melanosis, I may refer the reader to my friend Professor W. Sampson Handley's Hunterian Lectures on "The Pathology of Melanotic Growths in Relation to their Surgical Treatment" (*Lancet*, April 6th, 1907), delivered last February at the Royal College of Surgeons.

Since the above observations were written, I have come across a third case, recorded by Dr. Boldt ("Primary Melanotic Sarcoma of Posterior Vaginal Wall," with a photogravure. Report of a meeting of the New York Obstetrical Society, *Amer, Journ. Obstet.*, October, 1906, p. 550). The patient was a nullipara, aged 37, the tumour was sessile and made up of "small round cells," the deeper were "laden with dark pigment." Rapid recurrence followed removal.

This case would hardly induce Horn and Morestin to alter their views as to the origin of the pigment.

There remains one more feature in my case interesting in respect to the vaginal tumour.

The Sweats. I have noted that the patient was troubled with free sweats at the beginning of her illness. They never ceased entirely, and became profuse again in the second week after the operation. At the time, I attributed the marked aggravation of the symptom to exudation in the stump of the pedicle, possibly to suppuration. At the necropsy, however, but little evidence was found of inflammation, and there was no trace of pus in the stump or round about it. On the other hand, there were no inflammatory changes in the kidney which I removed, nor, as far as I am aware, does the development of abnormal adrenal tissue cause perspirations.

* Veit includes in his tables Parona's "Melanotic Spindle-celled Sarcoma" with reference "Annal. Univ. Med-Chir. Milano, 1887," but, like myself, was unable to obtain a copy of the original report. Most probably Parona's case resembled those described by Horn and Morestin.

The true cause of this symptom was in all probability septic infection from the sloughing vaginal growths, a complication noted by Howard Kelly in his *Operative Gynæcology* (Vol. i., 2nd ed., p. 332): "There is a great tendency in all of these tumours to undergo necrosis, and this, together with the foul discharges, opens up an avenue for the entrance of an infection, which in the end often causes death." The vagina was kept as clean as possible after the operation, but a considerable amount of absorption was inevitable. The speedy removal of the growths shortly after the nephrectomy might have given temporary relief, but the patient would not consent to any further operation. When I removed the kidney the patient was in a state of collapse after I had secured the numerous vessels divided when the upper part of the tumour was set free. Removal of the vaginal growths, which would have required free dissection of mucous membrane around all of them, was therefore unadvisable.

Cancer of the Vagina. A cancerous vaginal growth does not tend to assume a polypoid form, so that I need not dwell on that type of tumour. I find, however, that Dr. H. Macnaughton Jones has recently described a primary carcinoma of the vagina. He says: "It was botryoidal in character, and the deeper part was pedunculated."

Adrenal Sarcoma or Hypernephroma of the Kidney.

In the present case the primary seat of the new growth was the kidney, and the structure of the new growth resembled that of the supra-renal capsule. There were secondary adrenal tumours in the vagina, one of which was clinically conspicuous; these new growths may put us in mind of Eastwood's case of adrenal tumour of the uterus, but in that instance the tumour was primary.

The above facts compel us to dwell for a while on a very intricate subject. Numerous monographs and essays on adrenal tumours have been made public since that not very remote period the dawn of the twentieth century.

We are not concerned with certain tumours of the supra-renal capsule itself, new growths observed in children and associated with abnormal growth of hair and other marked anomalies. Bulloch and Sequeira have written much about these new growths arising in the supra-renal capsule; we must, at the same time, remember ~~Knowsley Thornton~~'s case, where the patient was an adult, a lunatic aged 32. The face and extremities were extremely hairy. The preparation is now in the Museum of the Royal College of Surgeons (Pathol. Series, 3518 E.).

In the present instance the primary growth lay not in the supra-renal capsule, but in the kidney, so that we must consider adrenal tumour or hypernephroma of that organ. The best summary by a special authority has been drawn up by Neusser. That writer speaks of excessive proliferation of circumscribed portions of the supra-renal

substance giving rise, in the first instance, to small tumours resembling lipomata which have been termed supra-renal strumas or adenomata. "These are situated in the cortex of the supra-renal capsule or, more frequently, in accessory glands occurring in the kidney. In the latter situation the term renal adenoma or 'heterologous renal struma' has been applied. They are small masses varying in size from a pin's head to a pea, yellowish white in colour, sharply defined and surrounded by a connective-tissue capsule. They are histologically identical with the supra-renal cortex, even the typical fatty infiltration of the parenchyma being present." In addition to this formation of metastases, in itself a manifestation of malignancy, supra-renal strumas, after existing for a long period of time, tend to assume malignant characters. These malignant growths become vascular, almost telangiectatic. They are subject to degenerative changes all but exclusively fatty. Hæmorrhagic cysts thus develop.

I have already referred to these changes observed in supra-renal "rests," when commenting on Klien's case of vaginal tumour.

A clear general summary of the characters of accessory adrenal tissue in the kidney will be found in the sixth edition of Mr. Bland-Sutton's "Tumours Innocent and Malignant," page 111; great attention should be paid to the author's observations at p. 116 warning us against confusing primary tumour of the supra-renal capsule with primary tumour of adrenal "rests" developing in the kidney. The fallacy is due to a very natural notion "that some of these tumours arise in the adrenal and gradually become incorporated with the adjacent parts of the kidney."

Such an error might readily arise from a hasty inspection of the kidney which I removed in the case under consideration. Anteriorly the new growth appears to be separated from the upper pole of the kidney by a distinct groove, so that it looks like a supra-renal capsule considerably enlarged. (Fig. II.) But posteriorly there is no such groove, and when the cut surface of the kidney is inspected, it becomes evident that the tumour lies inside the renal capsule and has nothing to do with the anatomical supra-renal capsule. (Fig. III.) I may call attention to Mr. Waring's very similar specimen in the Museum of St. Bartholomew's Hospital (No. 2390 G. 2), where externally the tumour seems at first sight to lie in the supra-renal capsule, on the top of the kidney, though it really lies in the kidney itself.*

When, however, we turn to another specimen in the same Museum (No. 2390 G.) we find a tumour of the same type, but it

* These remarks require modification as far as my specimen is concerned, since the position of the ureter was accurately defined (see above). There can be no doubt, however, that in Mr. Waring's specimen the tumour lay in the upper pole of the kidney.

G. W. Nicholson in "Ad. of Kidney Tumours" Guy's Hosp. Rep. vol LXIII (1910) He believes "that many, at least of the so called "hypernephromata" are really renal & not suprarenal tumours" (loc. cit. p 362)

— PATHOLOGIE CHIRURGICALE —

Tumeur surrénalienne de l'ovaire.

Par M. H. Gaudier.

J'ai pratiqué chez une petite fille de 4 ans l'ablation de l'ovaire gauche, qui avait acquis le volume d'une très grosse orange. Depuis trois ou quatre mois on s'était aperçu du développement de cette tumeur, très mobile dans l'abdomen, régulière et lisse, reliée aux ligaments larges par un pédicule très vasculaire et long, lui permettant des mouvements d'ascension et de latéralité. Il y avait des ménorragies et des métrorragies assez abondantes depuis trois mois. Chez cette enfant, le système pileux est très développé, les petites lèvres fortement pigmentées dépassent les grandes lèvres. Les seins offrent un développement remarquable, vu l'âge du sujet. Ils mesurent 10 centimètres de diamètre, présentent une forme hémisphérique et l'aréole a pris une teinte brunâtre ; sur la surface de l'aréole une série de tubercules de Montgoméry très apparents ; le cercle veineux périaréolaire de Haller est très net.

Intervention sans incident. A la coupe, la tumeur apparaît solide, et quand on y regarde de plus près, on est frappé par toute la masse d'apparence glandulaire. En un point de la portion sphérique, l'on peut reconnaître l'ovaire avec ses nombreux follicules primordiaux, dont quelques-uns forment de véritables petits kystes sous-corticaux.

La forme est irrégulièrement ovoïde, en un point se détache une sorte de pôle supplémentaire largement sessile, la consistance est uniformément dure. Dans son plus grand axe la tumeur mesure 7 cm. 5, et 5 cm. 5 dans son axe le plus petit. L'enveloppe est épaisse, résistante, de couleur nacrée et d'apparence fibreuse, mesurant 0 mm. 5 à 1 mm. 5 en certains points. Sectionnée transversalement, la tumeur offre une couleur ocre. Des cloisons épaisses en certaines régions, plus minces en d'autres, se détachent de la capsule et pénètrent dans l'intérieur de la masse. Ces cloisons présentent parfois l'aspect veineux ; on aperçoit à la loupe des vaisseaux sectionnés. Des cloisons beaucoup plus minces encore et devenant à peine visibles à l'œil nu partagent la tumeur en une série de territoires et lui donnent l'aspect glandulaire. Sur le côté, on aperçoit une portion d'ovaire avec ses follicules.

A l'examen microscopique, l'enveloppe apparaît formée de faisceaux de fibres conjonctives. Des travées fibreuses ayant la même structure se détachent de sa face interne et renferment des vaisseaux à parois internes festonnées (artères) et d'autres remplis de globules sanguins (veines) ; sous l'enveloppe on aperçoit, de ci de là, de larges sections transversales de vaisseaux offrant l'apparence de sinus veineux. En continuité avec les grosses travées, se trouvent des cloisons très grêles, réduites à quelques fibres conjonctives et représentées surtout par des capillaires reconnaissables à leurs noyaux allongés.

Par places, on aperçoit une sorte de large carrefour à contours nets : ce sont des veines où l'on voit aboutir plusieurs capillaires ; le tout représentant une étoile à six, huit ou dix branches. Entre les branches de l'étoile et disposés radiairement, se trouvent les cordons épithéliaux pleins. Ces cordons sont coupés transversalement, obliquement et prennent même en certains points l'apparence fasciculée, leur section étant longitudinale et les boyaux étant juxtaposés. Ils sont constitués par des cellules de formes diverses. Les éléments périphériques volumineux, prismatiques, sont rangés régulièrement : leur noyau est situé en bordure dans la zone basale. Les cellules centrales sont polyédriques plus ou moins arrondies par pression réciproque ; leur noyau est plus central. Les cellules sont moins nombreuses dans le centre du cordon. Le protoplasma prend une apparence reticulée et, par l'acide osmique ou le rouge soudan, on peut mettre en évidence des gouttelettes de graisse.

Certains cordons épithéliaux plus rares offrent un tout autre aspect : ils ressemblent à s'y méprendre à des tubes urinifères, tapissés par une rangée d'éléments cubiques, qui, dissociés, semblent nager dans la lumière du tube. Ils rappellent des sortes de végétations ou proliférations cellulaires. Ce dernier caractère est assez difficile à mettre en évidence.

Cet examen permet d'éliminer d'emblée le diagnostic de sarcome, ces tumeurs n'offrant jamais cette disposition cellulaire et ces capillaires à parois nettes. Le diagnostic est à faire principalement avec le corps jaune hypertrophié et le problème est assez délicat à résoudre ; cependant l'examen complet de la tumeur nous fournit tous les arguments de la discussion. Le corps jaune se trouve aussi pénétré par des bourgeons conjonctivo-vasculaires, mais qui par leur aspect ne rappellent en rien les cloisons grêles que nous avons décrites. Les cellules renfermées dans ces cloisons sont volumineuses, d'aspect polyédrique et disposées irrégulièrement. Riches également en substances graisseuses, leur cytoplasma renferme de la lutéine. Le noyau des cellules est central et le plus souvent, dans les corps jaunes en évolution, on remarque un, deux ou trois noyaux. Cela ne rappelle que de très loin la struc-

ture de notre tumeur, la disposition radiée de cellules bordant des cavités vasculaires et qui rappellent tout à fait l'image de la zone corticale fasciculée de la surrénale. Un œil exercé ne saurait s'y tromper ; s'il restait encore quelques doutes, ils seraient vite dissipés, car la présence de ces cordons épithéliaux creux rappelant l'aspect des tubes urinifères est caractéristique et cette disposition a été constatée par Gravitz dans les tumeurs hypernéphroïdes d'autres organes.

Toute la tumeur est constituée d'un pareil tissu, et il est très probable que nous nous trouvons là en présence d'une hypertrophie d'une surrénale accescesoire du parenchyme ovarien.

* * *

Ces surrénales accessoires sont connues depuis très longtemps, et l'on peut en distinguer trois groupes :

1° Celles développées dans le rein, dans le tissu hépatique, etc. ;

2° Celles développées le long du sympathique abdominal et qui représentent un type un peu spécial constitué de substances médullaires et formant les paraganglions de Stilling ;

3° Celles développées au voisinage des glandes génitales.

Nous ne nous occuperons que de celles-ci et principalement des nodules décrits pour la première fois par l'Allemand Marchand, en 1883. Aichel cite 24 cas de surrénales accessoires dans le ligament large, c'étaient les suivants : Marchand, 8 cas ; Chiari, 1 cas ; Dagonet, 1 cas ; Ulrich, 3 cas ; Rossa, 1 cas ; Michael, 1 cas ; Gottschalk, 1 cas ; Gunkel, 1 cas ; Robert Meyer, 7 cas. Ajoutons à ceux-ci les cas de Pillet et Vaux, omis par Aichel.

Marchetti (1904) relate les premières observations de surrénales accessoires dans le parenchyme ovarien (2 cas). Ulrich signale aussi deux cas, mais où les nodules se trouvent plutôt au hile de l'ovaire. Dans ces surrénales la substance corticale constitue seule la tumeur. Ceci est évident quand on se rappelle le développement des surrénales, et l'on peut considérer ces glandules détachées comme des portions de l'organe principal, et dont le siège résulterait de la migration de l'ovaire.

Ces surrénales accessoires peuvent s'atrophier ou s'hypertrophier, normalement leur taille atteint une moyenne de 5 millimètres, et on les trouve surtout dans le jeune âge ; chez l'adulte ces nodules s'atrophient et ceci probablement à cause de l'insuffisance de connexions suffisantes pour en assurer le fonctionnement.

Elles peuvent aussi s'hypertrophier et constituer ainsi de véritables tumeurs (Weiss, Péham, Pick). Pick n'en a rencontré que trois exemples dans la littérature médicale, auxquels viennent se joindre un quatrième fait observé par lui. (*Écho médical du Nord*, 26 juillet 1908.)

— DIÉTÉTIQUE —

Quelques observations sur la tachyphagie.

Par le docteur Félix Regnault.

Le conseil de manger lentement a été donné de tous temps par les médecins. A M. Fletcher (1) revient l'honneur d'avoir fait une étude systématique de cette méthode. Le premier, j'attirai l'attention des médecins français sur son livre (2). Mon ami, M. Jacquet, vient, par des expériences précises, de démontrer scientifiquement les graves inconvénients de la tachyphagie : cette maladie prend rang dans la nosographie. Je me propose de rechercher ici les causes de cette manière défectueuse de manger. Pourquoi mange-t-on trop vite ? Pourquoi devient-on tachyphage ?

Je distingue deux catégories de tachyphages, ceux qui le deviennent par occasion, ceux qui le sont par tempérament. Chez les premiers, ce défaut dépend du milieu où ils vivent, ils mangent vite par esprit d'imitation, prenant leurs repas avec d'autres tachyphages. Ils mangent vite parce que le travail les appelle, qu'ils n'ont pas le temps de manger lentement. Ils mangent vite parce qu'ils sont préoccupés, le repas devient une corvée dont ils s'acquittent machinalement. Chez les seconds, la tachyphagie est une manifestation du caractère. Ce sont des nerveux constamment excités ; leurs pensées chevauchent les unes sur les autres, leurs paroles sont précipitées, leurs mouvements rapides et heurtés. Ils se dépêchent dans tous leurs actes et ne savent point jouir de la vie ; ils ont l'illusion de beaucoup travailler, mais leur besogne est toujours bâclée. Ils mangent comme ils vivent ; ils avalent sans prendre le temps de mâcher ; les coups de dents sont brefs, insuffisants ; les morceaux se succèdent sans interruption, ils en portent un à la bouche avant que le précédent soit avalé ; attendre est pour eux un supplice intolérable, et ils réclament impérieusement un nouveau plat sitôt le précédent terminé. Ils ont un tel désir d'aller vite qu'ils prennent pour manger des attitudes inusitées, certains mettent les deux coudes sur la table et tiennent la tête baissée, abrégeant ainsi la distance entre l'assiette et les lèvres ; les mouvements de va-et-vient en sont facilités. D'autres, que la bienséance empêche de prendre une posture aussi grossière, penchent fortement la tête vers l'assiette chaque fois que leur fourchette élève un morceau, abrégeant ainsi la durée nécessaire à cette ascension.

(1) Fletcher a publié sur ce sujet un livre volumineux : *The A. B. C. of our nutrition*. New-York, 1903, où, à travers beaucoup d'erreurs et d'exagérations, on peut trouver quelques vérités nouvelles et utiles.

(2) Voir mon article sur le Fletchérisme dans l'*Avenir médical*, janvier 1905. Voir aussi l'Art de manger, dans *la Revue*, ancienne *Revue des revues*, numéro du 1er nov. 1906.

lies on the *lower* pole* of the affected kidney. I inverted the bottle containing this specimen, when I examined it, and then it struck me how very much the tumour resembled a diseased supra-renal capsule on the top of the kidney. Several other instances of adrenal tumours in the lower pole of the kidney have been recorded (Eastwood, etc.).† They are good object lessons settling the once disputed question on naked-eye evidence. For the supra-renal capsule is not in the habit of growing on the lower pole of the kidney, and in No. 2390 G. "both supra-renal bodies were present in their normal positions." On the other hand, in cases of tumour of the supra-renal capsule itself, the kidney is as a rule quite intact. (Bulloch and Sequeira, Adams; see also Knowsley Thornton's specimen, Museum of the Royal College of Surgeons, Path. Series 3597 B.).

The invasion of the lung in my case is a complication already noted in association with "Hypernephroma" of the kidney, indeed it is frequent because, as Bland-Sutton observes, the tumour is apt to invade the renal vein or its branches. This question of the advance of the tumour reminds us of another subject of clinical interest. The new growth, it has been asserted, does not tend to invade the renal pelvis. Hence hæmaturia is said to be exceptional.‡ In one case (Mr. Waring's, which I have already noticed) the patient, a man, aged 47, suffered from "painless hæmaturia on several occasions." On inspecting the kidney in the Museum of St. Bartholomew's Hospital (2930 G. 2) I found that the growth had replaced not only the cortex, but also the upper pyramids, and has reached the renal pelvis.

However, it is hardly necessary for me to dwell any longer on adrenal tumours of the kidney, for there can be no doubt that such was the character of the renal tumour in my case, and that the vaginal growths were secondary, like the deposits in the liver and lung.

Fig. 1. The vaginal polypus. Lateral view of the largest detached portion, natural size. *A.T.* Line of attachment to pedicle.

Fig. 2. The right kidney and tumour seen from without (anterior surface). The tumour seems to lie on the upper pole of the kidney as though it had developed in the suprarenal capsule. In reality it lies within the lower pole which, owing to rotation of the kidney, lay uppermost.

Fig. 3. The right kidney and tumour showing their cut surface.

* See also Fig. 6 in Owen Richards' "Growths of the Kidney and Adrenals" (Guy's Hosp. Rep., vol. 59) where the tumour occupies the lower pole (Golding Bird's case), Richards, however, is not absolutely certain of the nature of the tumour.

†An adrenal tumour may stretch the kidney over its outer surface (Fairbairn), but in that case the observer could hardly be deceived as to the organ in which the new growth had originated.

‡ I find that, according to Owen Richards, it is not so rare as other writers lead us to believe (26 out of 41 cases, *loc. cit.*, p. 245).

The tumour is seen to lie within the capsule of the kidney invading the lower portion of that organ (see Fig. 2). It bears the naked-eye characters of an adrenal growth.

Fig. 4. Microscopical section of the renal tumour separated from the adjacent portion of the kidney (above) by an area of fibrous tissue. The tissue of the tumour (below) resembles that of the zona fasciculata of the suprarenal capsule. Low power.

Fig. 5. The same (lower portion) under a high power. The tumour is chiefly made up of large cells with big and well-formed nuclei.

Fig. 6. Microscopical section of a lobule from the vaginal tumour. Its tissue resembles that of the renal tumour (Fig. 4, lower portion), but it is wider meshed and less distinct. Low power.

Fig. 7. The same, under a high power. Its resemblance to the renal tumour (Fig. 5) is evident, although its tissues are affected by necrotic changes in its neighbourhood.

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mass of the tumour showed it made up of cells of the shape and arrangement of the cells of the supra-renal cortex.

I have already stated that the tumour had caused no symptoms, but apart from the pathological interest of this case, I would like to draw the attention of general practitioners to the necessity for always making a careful examination of a patient whenever possible, since "accidentally" one not infrequently comes upon conditions of great moment to the patient and of a nature quite different to that which one is looking for or expecting. The surgeon may note with great satisfaction the hard usage to which the colon had to be subjected by its separation from the mass, without any ill effects following. The area of adhesion was extensive. I am much indebted to Dr. Walton, Assistant Pathologist, London Hospital, for his kind observations on this case, and I may state that a good account of some similar cases may be found in vol. ii, "Surgical Diseases of the Kidney and Ureters," Henry Morris.

A CASE OF CHRONIC DISSEMINATED MYELITIS.

By E. Arthur Saunders, M.B., M.R.C.P.

(A Case shown at the Clinical Meeting in November.)

The term chronic disseminated myelitis is applied to this case, not in the sense of having been chronic in origin, but rather as a chronic condition the result of damage to the cord by an acute attack.

This little boy, now aged 6, was attacked with scarlet fever a year ago, this being followed a fortnight later by the onset of paraplegia, with anæsthesia of the legs and the greater part of the trunk. His condition has remained practically stationary since that time. There is no pain.

He was admitted to the West London Hospital about a fortnight ago with a bedsore on the buttocks, which with careful nursing has now healed.

The anæsthesia, the upper limit of which is well defined, is complete from the area of distribution of the fifth dorsal nerves downwards. Over the area of the fourth dorsals sensation is blunted. Over the area of the third dorsals and above sensation is unaffected. There is no dissociative anæsthesia, sensation over these areas being normal, blunted, or absent for stimuli of all kinds—touch, pain, and temperature.

It is worthy of note that the nipples, as to the nerve supply of which there has been some discussion, are just included within the area of total anæsthesia. This points to their nerve supply

The Mirror of Practice.

A PARANEPHRIC TUMOUR ORIGINATING IN THE SUPRA-RENAL GLAND OR ADRENAL "RESTS."

By A. J. Rice Oxley, M.D.

In July last I was called to see a patient, Miss X., middle aged, who was suffering from pain in the left side. This pain I found affected the side and back of the left thorax and was increased on movement. There was no cough but some tenderness on pressure. Temperature 102° F. Miss X. had a day or two previously put on thinner clothing and had been exposed to draught. I diagnosed muscular rheumatism. While examining the painful and adjacent parts I came upon a large, fixed swelling, in part soft, in part hard, coming from under the ribs and somewhat far back. There were absolutely no symptoms which could be traced to this swelling, of the existence of which the patient was quite ignorant.

Mr. Mansell Moullin, whose aid I called in, diagnosed the case as probably a hydronephrosis, and operation was decided upon and carried out a few days afterwards. On opening the abdomen a large tumour of a "mixed" character was revealed in the kidney region. The cystic portion of it, the size of a cocoanut, was covered by the descending colon, which was spread over and adherent to its surface. The tumour was then punctured, a material of the consistency of brain and yellow in colour, together with broken-down blood-clot, escaping from it. Dissecting out the tumour, Mr. Mansell Moullin found it occupied the upper part of the kidney, a small part of the kidney remaining free below. The operation was completed, the whole mass with the kidney being removed, and the patient did very well, and is now, nearly six months afterwards, in good health. On section the lower pole of the kidney remained apparently healthy.

The upper part was occupied by a large cyst, the walls of which were half an inch to an inch thick. Between the cyst and the lower part of the kidney there was no capsule, but irregular outgrowths of the tumour invaded the remaining kidney substance, this growth being white with irregular bright yellow areas. This yellow pigment was also well marked on irregular projections which lined the cystic portion of the tumour. There was no normal supra-renal tissue attached either to the upper part of the tumour or to the remaining portion of the kidney. Sections of the

Histologisch zeigt unser Knötchen verschieden gestaltete cystische Räume mit teils hohem, teils niedrigerem, stellenweise flimmerndem Zylinderepithel, die ohne Vermittlung cytogenen Gewebes direkt in das fibromyomatöse Grundgewebe eingelassen sind. Ein Zusammenhang mit dem Epithel der Fimbrien oder gar mit der Serosa läßt sich nirgends erbringen, so daß die Annahme eines echten Urnierenadenomyoms nach dem Gesagten sehr nahe gelegt ist.

2) Von größerer praktischer Bedeutung ist der zweite Fall, in dem es sich um eine Scheidenmetastase handelt, welche 1½ Jahr nach einer wegen »Sarkom« vorgenommenen linksseitigen Nierenexstirpation aufgetreten war. Die exstirpierte Metastase hatte als kirschgroßer Knoten links neben der Urethra auf der vorderen Vaginalwand gesessen und der Pat., einer 56jährigen XVIpara seit ½ Jahr erhebliche Blutabgänge verursacht. Der mikroskopische Befund zeigte ein metastasiertes, malignes, heterotopes Hypernephrom. (Auch Demonstration des kindskopfgroßen Primärtumors.)

Selten beteiligen sich in diesen alle drei Nebennierenschichten, am häufigsten, wie auch hier, die Zona fasciculata mit ihren stark fetthaltigen Zellen. Das Scheidenepithel umzieht wie eine Reflexa das Knötchen, ist aber an der Peripherie in ausgedehntem Maße durch mächtige Blutergüsse zersprengt, welche aus dem enormen blutbazillarreichen Geschwulstgewebe stammen.

Diese kongenital abgedrängten Nebennierenkeime sind in der Peripherie der Niere nichts seltenes. Fangen sie zu proliferieren an, so entwickeln sich leicht sehr maligne Geschwülste, die frühzeitig metastasieren. Solitäre Metastasen, speziell der flachen Knochen, sind oft beobachtet, daher nach Exstirpation solcher Dauerheilungen beobachtet. Sonst ist die Prognose dieser Geschwülste ungünstig (vgl. Albrecht).

Im vorliegenden Falle bestehen wahrscheinlich schon Lebermetastasen. Der Blutreichtum solcher Metastasen ist bekanntlich bedeutend. 14 Tage nach Exstirpation derselben in unserem Falle mußte die Operationswunde wegen plötzlicher profuser Nachblutung aufs neue umstochen werden.

Die primären Hypernephrome bleiben häufig lange symptomlos, kennzeichnen sich schließlich durch Auftreten von Hämaturie. Für den Gynäkologen von Wichtigkeit ist es, bei Metrorrhagien nach vorausgegangenen Nierenoperationen an Metastasen solcher Hypernephrome zu denken, besonders wenn die vordere Scheidenwand nächst der Harnröhre ergriffen ist.

Diskussion. Herr Veit macht auf die Wichtigkeit des Unterschiedes im Sitz der primären und der sekundären Scheidentumoren aufmerksam. Gewiß ist mancher Fall von maligner Scheidengeschwulst nicht primär. Die schlechte Prognose der malignen Scheidengeschwülste wird dadurch wenigstens für diese Fälle verständlicher.

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2) Fränkische Gesellschaft für Geburtshilfe und Frauenheilkunde.

Sitzung vom 30. Juni 1907.

A. Vorträge:

Herr Hofmeier (Würzburg): Über die Verwendung von Chlorzinklösungen bei der Behandlung der Endometritis.

H. berichtet über einen Fall von intra-uteriner Applikation einer 50%igen Chlorzinklösung mittels der Braun'schen Spritze mit nachfolgendem Tod der im übrigen gesunden 22jährigen Patientin. Die Obduktion ergab, daß das Ätzmittel das Uterusinnere überhaupt nicht erreicht hatte, vielmehr direkt oder indirekt durch Rückfluß aus der Cervix in das hintere Scheidengewölbe gelangt und sich dort auf einem zurückgelassenen Wattebausch angesammelt hatte. Es stellten sich alsbald zunehmende peritonitische Reizerscheinungen ein, und die Patientin starb trotz aller Gegenmittel nach 21 Stunden. Die Sektion ergab frische Pelveoperitonitis, aber weder eine Perforation des Uterus oder Scheidengewölbes, noch eine Verätzung des Uterusinnern oder der Tuben. Außerdem war die Patientin in der 6. Woche Gravida. Um den in der Scheide gebliebenen Tampon war das

schluß mit voller Sicherheit bis in die Tiefe der Plica vesico-uterina geschaffen werden könnte.

Dem Grundsatz ist gewiß zuzustimmen, nach Vollendung der Entbindung die provisorischen Peritonealnähte wieder zu lösen und definitiv die Wundränder so zu vereinigen, wie sie vorher waren.

Herr Veit: Der Querschnitt im unteren Uterinsegment muß möglichst vermieden werden, weil die seitlichen Venen sonst leicht unnütz verletzt werden können. Auch die Drainage ist möglichst zu vermeiden. Wichtig ist der sichere Abschluß der Bauchhöhle, und diesen angeregt zu haben, ist ein Verdienst von Frank. Die Längsinzision des unteren Uterinsegmentes ist natürlich auch mit dem Pfannenstiel'schen oder Küstner-Bardenheuer'schen Querschnitt zu erreichen.

Handelt es sich um hochvirulente Streptokokken, so kann man natürlich nichts erreichen; aber bei saprischen Gefahren ist die Methode tatsächlich gut.

IV. Herr R. Freund (Halle a. S.) demonstriert zwei Tumoren, die auf kongenital versprengte Keime zurückgeführt werden müssen.

1) Ein Adenomyom auf der Fimbria ovarica, einem bisher dafür noch nicht beobachteten Ausgangsort; es ist von Linsengröße und wurde zufällig bei Betrachtung eines exstirpierten Uterusadnexes entdeckt.

Der Streit um die richtige Deutung der Adenomyome in genetischer Beziehung reicht noch bis in die heutige Zeit hinein. Die v. Recklinghausen'sche Hypothese, welche die epithelialen Cysten in Myomen auf die Urniere zurückgeführt wissen will, wird in ihrer Ausdehnung von Robert Meyer mit Recht sehr beschränkt, da nachweislich Versprengungen der Serosa und besonders der Mucosa des Genitalschlauches im embryonalen, sowie bei Entzündungen im postfötalen Leben für die Adenomyomgenese so sehr in Betracht kommen, daß wohl der größte Teil der bisher beschriebenen Adenomyome wenigstens des Uterus in diesem Sinn und nicht als Urnierenderivat gedeutet werden muß.

Ja in vielen Fällen handelte es sich gar nicht um echte Geschwülste, sondern um entzündliche Hyperplasien, also nicht um Adenomyom, sondern um Adenomyometritis usw. (Robert Meyer), denn die Knoten können sich zurückbilden (v. Franqué).

Auch dem histologischen Bau, den v. Recklinghausen und seine Schule, vor allem Schickele, immer wieder als Beweis für die Urnierenabstammung in die Wagschale zu werfen geneigt ist, darf nach Robert Meyer kein zu großer Wert beigemessen werden. Bau und Anordnung der drüsigen Schläuche in Adenomyomen erinnerten nach v. Recklinghausen an den Aufbau der Urnierenkanälchen. Hiergegen wendet Robert Meyer ein, daß die Formation der drüsigen Einschlüsse keinen Rückschluß auf die Urnierengenese gestatten und hauptsächlich durch das umgebende fibromyomatöse Gewebe willkürlich beeinflußt wird.

Als ein weiterer wichtiger Grund gegen die Verallgemeinerung der Urnierenhypothese ist die Lage der Urniere und ihres Blastems zu nennen. Vergegenwärtigt man sich die Lage der indifferenten Anlage des Urogenitalsystems, so ist eine eventuelle Verlagerung von Urnierenkanälchen in den Abschnitt des Müller'schen Fadens, der zur Tube wird, und in deren Nachbarschaft (Lig. latum) sicherlich möglich, in den zum Uterus verschmelzenden Teil indes so gut wie ausgeschlossen. Hier käme allenfalls der Wolff'sche Gang in Frage, aber auch der ist, wie Robert Meyer zeigte, ein seltener Gast in den uterinen Adenomyomen. Demzufolge sind sicher nachgewiesene Urnierenadenomyome, abgesehen vom Mediastinum, lediglich an und nächst der Tube bis zum Tuben-Uteruswinkel (hier bisweilen schon nicht mehr einwandsfrei) beobachtet worden.

Unserem Präparat am nächsten kommen die von Robert Meyer bei Föten, von Schickele bei Erwachsenen erhobenen Befunde von teils schlauchförmigen cystischen oder adenomatösen Gebilden im Subserosium der ampullären Tubenwand. Schickele sah drei bis hanfkorngroße solcher Knötchen.

Alamartine & Mouriquand "Les hypernéphromes génitaux de la femme (tumeurs du ligament large et de l'ovaire à type surrénal)" Rev. de Gynéc. et de Chir. Abdom. Vol XVIII, p.1 (Jan 1912)

Scudder "Some Metastases of Hypernephroma", Publications of the Massachusetts General Hospital Vol I. (June 1907) no 3. p. 82. Library. Royal Soc. Med.?

Veit. A case like mine, shortly to be reported

Rice Oxley "A Paranephric Tumour originating in the supra-renal gland or adrenal "Rests" & "West London Med. Journal" Vol XIII. no 1 (1908) p. 47.

Freund, R. (Halle a/S). "Zentralbl. f. Gyn." no 9. 1908 (Feb 29). 16-para aged 56. 1½ yrs previously, left kidney removed for hypernephroma. 6 ms post uterine haemorrhages. Swelling size of cherry, anterior wall of vagina to left & close to urethra removed, proved to be "ein metastasierten, malignen, bisher to fest Hypernephroma" 14th day death. After operation wound to that fresh metastases was needed. (Report of meeting of Obst. in Leipzig, November 1907) & Zentralbl 1908, p. 303.

Gideon Wells "Atypical Forms of Malignant Renal Hypernephroma & consideration of their chemical characteristics" "International Clinics" Vol II, 18th Series (1908) p. 272.

Reich "Fibroid Tumour of Vagina" ♀ 23. in 22 m. dyspareunia Amer. Journ. Obstet. Sep 1908 p. 258. 1/4 0/4

Rendu "Congenital absence of left kidney. Left suprarenal only present. Lyon Médical May 10. 1908. Bladder had no trigone, no trace of left ureteral orifice

& Gaudier "Tumeur surrénalienne de l'ovaire" Echo méd. du Nord July 26. 1908 & Revue franç. de méd et de chir 1908. ♀ 20 hypernephroma left ovary. ♀ 4 mens. lin. after proces (Report enclosed in this reprint)

Pekam Ein Fall von Hypernephrom des linken Niere mit einer Metastase in der Vagina. Zentralbl. f. Gyn 1906 p. 425

Grafenberg Eine Nebennieren Geschwulst der Vulva als einzige Metastase eines malignen Nebennierentumors der linken Seite. Virchows Archiv Vol 194. p 57 (Oct 1908)

Gardner & MacCleary Malignant Tumors of the Ovaries. (Case 1. Hypernephroma of the Broad Ligament probably Ovarian. "Surgery Gynaecology & Obstetrics. Chicago p. 669–684

Halban "Myoma der Vagina" Zentralbl. f. Gyn. no 16, 1909. p 572 Virgin 36. Nt hypernephroma removed 6 yrs previously. Tumour 300 gr (.66 lb) caused dysuria & haematuria. Ant. wall vagina enucleation easy. Retained by spinal anaesthesia. Halban believed that the vag. tumour simply caused the hydronephrosis