Transactions of the North of England Obstetrical and Gynaecological Society.

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ORDINARY MEETING

HELD AT

SHEFFIELD

ON

FRIDAY, MARCH 27TH, 1908.

Present: DR. A. J. WALLACE (President) in the Chair, 15 Members and 1 Visitor.

A vote of condolence on the death of DR. WILLIAM WALTER, of Manchester, was recorded.

CASE OF UTERUS BICORNIS UNICOLLIS WITH ATRESIA OF THE EXTERNAL OS, AND ABSENCE OF THE VAGINA, RETAINED MENSES, HYSTERECTOMY.

By MILES H. PHILLIPS, M.B., B.S. (Lond.) F.R.C.S.

On February 5th, 1908, M.C., nearly 16 years of age was sent into Hospital by Dr. Frank Mason, of Handsworth, to whom I am indebted for the following

history. In October last he first attended her for what he considered a mild attack of appendicitis, pain in the right lower abdomen, with slight vomiting and obstinate constipation being the symptoms, whilst on examination he found a slight rise of temperature and pulse rate, rigidity of the right rectus and tenderness over McBurney's spot. The attack lasted three or four days. Similar attacks occurred in November, December and January. Dr. Morris saw the patient, for Dr. Mason in November, and he also diagnosed appendicular colic. The last attack was the most severe and the pain and tenderness were then found to be lower in the abdomen—just above the right Poupart's ligament. Dr. Mason then suspected the possibility of retained menses and found that the girl had not yet menstruated, but also that her four elder sisters and her mother had not commenced to menstruate before 17. The patient's mother stated that previously to October the girl had enjoyed splendid health, though for some months she had been noticed to be dull and stupid.

Condition on Admission. The patient is well grown for her years, slightly anæmic, very nervous and rather dull. She does not look ill and has no pain. The temperature, pulse, respiration, and urine are normal. The breasts and pubes are fairly well developed. The abdomen appears normal and is soft, there is slight tenderness on firm pressure just above the right Poupart's ligament; no tumour can be felt. On proceeding to make a rectal examination, it was noticed that, though the vulva appeared to be normally developed, there was no vaginal orifice. Per rectum a rounded, smooth, hard swelling of about the size of a duck's egg, could be felt

in the middle of the pelvic cavity ; its lower pole was about two inches above the anal orifice and presented a shallow dimple behind and to the right.

Bimanually the tumour was felt to extend considerably to the right and its upper pole could be just felt behind the right Poupart's ligament. There was no similar extension to the left. A diagnosis of a more or less complete atresia of the vagina with hœmatometra and probably right hæmatosalpinx was made.

Operation. On February 10th, she was anæsthetised and examined in the lithotomy position. The vulva was found to be normally developed, except that in the situation of a vaginal orifice there was only a small circular shallow depression, about a quarter of an inch in diameter. This was almost surrounded by two lateral, crenated, fleshy folds, each about one-third of an inch long and one-sixth of an inch thick, which, meeting in front just below the meatus urinarius merged, without meeting, behind with the mucous membrane of the fossa navicularis. They evidently represented the hymen which had retained its infantile labial form. By means of an easy perineal dissection, through loose areolar tissue, the lower pole of the pelvic tumour was reached at a depth of two and a quarter inches. Its deep situation and the apparent thickness of its wall pointed to a uterine rather than a vaginal collection of fluid.

A gauze plug having been left in the wound, and the patient put in the Trendelenburg position, the abdomen was opened by a median incision extending from the pubes to the umbilicus (five inches). It was at once obvious that we were dealing with a bicornuate uterus, whose single cervix and right cornu were

considerably enlarged. The right Fallopian tube remarkably tortuous and distended lay to the right of and behind the uterus. Normal appendages were attached to the rudimentary left horn. The round ligaments were not hypertrophied. The distended tube was now raised out of the rather deep pouch of Douglas, after some thin adhesions between it and a coil of pelvic colon and the back of the uterus had been divided. There was no free menstrual blood in the pelvis.

The whole mass, excepting the normal left ovary which was left in situ, was then removed intact by the ordinary peritoneal flap method special care being taken to press aside and avoid the ureters. The uterine arteries were both small and the dilated cervix was easily enucleated from its connective tissue bed. The larger vessels were ligatured with silk and the peritoneal flaps brought together by a continuous catgut suture. The vermiform appendix was seen to be healthy. The abdominal wound was closed in three layers.

Finally the gauze plug was removed and a thin strip of gauze inserted into the lower half of the perineal wound. The patient bore the long operation well and left the theatre with a pulse rate of 84. She made an uninterrupted recovery and was sent to a convalescent home on the twenty-fourth day.

The specimen consists of a bicornnate uterus with a single cervix, and its attached right appendages and left Fallopian tube. The cervix is enlarged to the size and shape of a hen's egg. The left cornu is a small solid fibro-muscular body, projecting laterally from the upper end of the cervix. The right cornu is a rounded elongated body almost equal in size to the cervix, to

which it is attached at an angle of 120°, the left Fallopian tube appears normal to the naked eye, but has a lumen in its outer half only. The right ovary is normal in size and is attached to the cornu by a well marked ligament The right Fallopian tube is considerably enlarged into a series of saccules. It is bent once upon itself, the two limbs being adherent to each other and the abdominal end of the tube to the corresponding ovary. In this manner is formed an irregularly lobulated mass, pendant from the outer end of the cornu, and exceeding in bulk the whole uterus. After hardening, superficial slices were removed from the posterior aspect of the uterus, the various parts of the right Fallopian tube and the ovary. All the cavities thus opened were found to contain a chocolate-coloured coagulum, which has been removed. The cornual cavity communicates with that of the cervix by a short circular channel, about ½ an inch in diameter, their walls vary from ⅓—½ inch in thickness and show smooth inner surfaces. The cavity does not extend towards the rudimentary cornu. The saccules of the Fallopian tube are thin-walled, the larger being translucent, they are incompletely separated from one another by thin perforated septa. The outermost saccule is closely adherent to the lower pole of the ovary, there is no sign of an ostium abdominal nor of fimbriæ. It was found possible to pass a thick bristle from the cavity of the cornu into the first saccule of the tube. The section of the ovary opened a small blood cyst; otherwise it appears to be normal.

Microscopically the wall of the cervix shows a normal fibro-muscular coat with a very thin mucous membrane, whose epithelial lining is complete and composed

of a single layer of cubical cells. The underlying glands are compressed, so that their long axes are parallel to the surface, in some the epithelium consists of tall columnar cells with basal nuclei and shows various stages of secretory activity.

The fibro-muscular wall of the developed cornu appears normal, its mucous membrane is thin but typically that of a corpus uteri and characteristically altered by surface pressure.

The wall of the hæmatosalpinx is markedly thinned ; the vessels in its outer coats are much engorged, it shows a few stunted plicæ ; the epithelium is composed of low cubical and flattened cells, poorly staining. The section of the ovary is well stocked with ova in various stages of development ; though the blood cyst is a distended simple Graafian follicle and not a corpus luteum, there are several corpora albicantia and areas of lutein cells in the stroma.

Remarks. The association of complete absence of the vagina, with the presence of well developed external genitals and a menstruating (if malformed) uterus, is, so far as I can judge, of extreme rarity.

Dr. Ballantyne, in Allbutt's System says : " Complete absence of the vagina is a very rare condition—probably it is always associated with absence of the uterus Fallopian tubes and external genitals."

Clinically, the similarity of the early symptoms to those of appendicitis is of interest in view of the case recently reported by Dr. Thos. Wilson (Proc. R. S. Med., Jan. 1908) ; his patient was sent into hospital as an emergency case of acute appendicitis.

With regard to the treatment employed, no more

conservative procedure was feasible, and indeed in this literature of the subject, there is evidence that surgeons have frequently considered it advisable to remove the healthy ovaries when performing hysterectomy in somewhat similar cases of atresia. In spite of the fact that no attempt was made to form a vagina, I considered it right to leave the unaffected ovary.

A CASE OF FIBROMA OF THE VAGINA.

By D. Lloyd Roberts, M.D., F.R.C.P.,
(Manchester).

Notes by Dr. Moffet.

M. L., Ashton-under-Lyne, aged 46, a widow, engaged in housework, was admitted to St. Mary's Hospital, under the care of Dr. Lloyd-Roberts, on January 20th., 1908, complaining of a tumour in the vagina and pain and difficulty of micturition.

She first menstruated at 15 years of age, she has been irregular for 13 months, and has had a sanious discharge constantly during that time.

She has been pregnant 6 times, the first was 25 years ago and the last 7 years ago.

She has aborted twice. Each labour was difficult but the puerperium was uneventful each time.

The patient gave a history of metrorrhagia and dragging pains in the abdomen, extending over 12 months. Before her present trouble she had occasionally been irregular in her menstrual periods. She says that she was told, 7 years ago, that she had a tumour.

On examination of the abdomen, nothing abnormal was noticed, but bimanual examination revealed some general enlargement of the uterus which was not bound down at all and was not tender.

The vagina was lax. A mobile, sessile mass, rather larger than a walnut, was found springing from the left fornix and pressing on the urethral meatus and cervix uteri. The tumour was covered by vaginal epithelium.

The os and cervix uteri were of the parous type ; the os was irregular in shape and its anterior lip was thickened. A sanious discharge was seen to come from the uterus.

The bowels were constipated, there was partial retention of urine, pain on micturition and the orifice of the urethra was reddened.

Operation. On Jan. 23rd, 1908, the patient being prepared in the usual way, the tumour was removed by excision. A catheter was passed into the bladder and by this means the attachment was seen to spring from the deeper layers of the vaginal wall in close contact with the urethra and the left side of the cervix uteri. Hæmorrhage was free, but was arrested by deep sutures and by packing the vagina with gauze ; the patient was then returned to bed.

From the second day onwards there was considerable trouble from hæmorrhage from the site of the pedicle. The vagina was douched daily with hot antiseptic lotions and then packed with gauze, but the hæmorrhage continued for ten days. At the end of that time it was arrested by packing the vagina with gauze soaked in a solution of adrenalin-hydrochloride. Packing the vagina was discontinued after Feb. 8th, and the patient was discharged from hospital on Feb. 22nd, 1908.

The tumour is a hard, elastic, nodular mass of about the size of a walnut, the cross-section showing white, shining, fibrous bands.

Microscopically, there is seen a mass of white, fibrous tissue, in which are distributed a few, unstriped muscle-fibres. All the cell-nuclei are well formed, and the tumour, which is enclosed in a pseudo-capsule of fibrous tissue, shows no sign of degeneration. The structure is that of a true fibroma.

Fibroid tumours of the vagina are very rare compared with fibroid tumours of the uterus. They are more frequently situate in the anterior, than in the posterior wall of the vagina. Less frequently (as in this case) they are found in one or other of the fornices. The tumour was sessile in character, and was covered with mucous membrane, it bulged somewhat on the urethra, which, doubtless, was the cause of the retention of urine from which the patient suffered. The mucous covering rolled freely over the growth, and, although it was easily removed, troublesome bleeding followed the operation. Hæmorrhage after removal of deeply-seated growths in the vagina is not uncommon and, although deep sutures were inserted in the sac, bleeding ensued, requiring the application of adrenalin.

A CASE OF ACUTE COMPLETE INVERSION OF THE UTERUS: MANUAL REDUCTION ON THE 20TH DAY AFTER LABOUR.

By H. Briggs, M.B., F.R.C.S. (Liverpool).

Reported by Marian Mayfield, M.B., B.S., London,
Assistant House Surgeon to the Hospital for Women, Liverpool.

Mrs. G., aged 28, a primipara, four years married, two miscarriages (1) seven weeks (2) about four months. She became pregnant again and went to the full term.

During a slow labour the membranes ruptured spontaneously and prematurely, at 4 a.m., on Friday, December 6th, 1907; slight pains throughout the next day, Saturday, effected very little progress. At 8 p.m., the doctor was sent for. The delivery of the patient, under chloroform, with forceps, occupied nearly two hours. The female child was born alive and is now in good health.

During the third stage of labour fundal pressure was used on account of severe hæmorrhage

For three weeks at home the only nursing she received was from a friend, 68 years of age, who, early in life, had had some hospital training.

There was early and continuous fever, 101° to 105°, one definite rigor on the nineteenth day; severe abdominal pain with profuse vaginal bleeding; dribbling and incontinence of urine. A rubber catheter was repeatedly used and a vaginal douche of lysol solution was given twice daily by the nurse.

A vaginal examination was not made until the 19th

day, and then the removal of the patient to Hospital was agreed upon.

On arrival at the Hospital on the 20th day after labour (Dec. 27th, 1907) she looked extremely ill: pulse 120°: temperature 99° after the journey of 7½ miles.

Examination. Abdominally, negative. Within the vagina lay the completely inverted, enlarged uterus, its lining membrane slightly ulcerated and uneven, the ring of cervix, above, was faint and sharp.

There were two large, gluteal bed-sores. The perineum was intact. The urine was alkaline and purulent.

Treatment. After ether had been administered by Dr. T. E. Walker, the well-marked uterine cup became palpable on bimanual examination. The bimanual force was persistently exerted and gradually increased: the fingers of the left hand to widen and steady the cup, the fingers of the right hand to exert upward pressure. After 20 minutes the body of the uterus was raised through the thin cervical ring without damage. The finger within the uterus confirmed the replacement; an intra-uterine douche of sterile water at 120° was then used.

After-Progress. The intra-uterine douche of sterile water was repeated three times during the first seven days. The bladder acted normally, the pus in the urine gradually diminished, phlebitis in the right lower limb manifested itself on the thirteenth day, the fever—the daily rise of temperature being 101° to 102°—continued, with six rigors, during the first three weeks; her physical strength gradually improved. She left the Hospital in good health on February 25th, 1908, eight weeks after the reduction of the inversion of the uterus and eleven weeks after the labour.

Remarks by Dr. Briggs. Towards the close of the 20 minutes, when the body of the uterus first moved upon itself, Dr. Briggs' fingers had exerted almost their utmost force. The exercise to this exceptionally high degree of manual force was accompanied by the dread lest the involved tissues should be dangerously contused or lacerated, hence, step by step, their state was tested before each successive increase in the force was made.

The lesson in practical gynæcology was two-fold (*a*) bimanually, great force may be exerted without appreciable contusion or laceration, and (*b*) the manual force which proved successful in Dr. Briggs' case was greater than he would have employed if the exhausted, septic state of the patient had not been unfavourable for section of the tightened cervix by the abdominal route, or the bed-sores had not contra-indicated the use of Aveling's repositor.

Mild manipulation, usually of a hernia, is what the student of practical surgery, the modern student at least, understands by the term taxis. Taxis, in this sense, succeeds in the great majority of cases of acute inversion, discovered and treated within the first 24 hours after labour.

Desperate manual efforts which may be needed in cases of later acute and of chronic inversion, may be safer and therefore more justifiable on the modern aseptic than on the older lines upon which Aveling's repositor became their substitute.

The popular and more recent operative treatment if carried out, in an already septic state of the patient presented too great a risk. The apprehension of that risk

led to the extreme manual efforts in the successful reduction of the inversion on the 20th day in the case now recorded.

A SEVERE CASE OF CONCEALED ACCIDENTAL HÆMORRHAGE: TWO AND-A-HALF POUNDS OF RETRO-PLACENTAL BLOOD CLOT.

By H. Briggs, M.B. F.R.C.S. (Liverpool),

Reported by J. F. Edmiston, M.B., *Obstetric Assistant, University of Liverpool.*

The pregnancy dated from the last day of the last menstruation on May 31st, 1907. The full term was due on March 9th, 1908.

On March 6th, at 3 a.m. the patient felt ill and at 11-30 a.m. she complained of severe pain in the back and in the abdomen, and of vomiting.

At 7-30 p.m. collapse became grave: she was pallid, cold, faint and restless, throwing her arms about and gasping for breath: her expression was one of great anxiety. A thready, intermittent and variable pulse of 152: temperature sub-normal.

Physical Signs. A tense, full-term uterus. Uterine tenderness was present: the fœtal heart inaudible. Vaginally, there was no blood stain on the examining finger: the cervix was soft and admitted two fingers: the membranes were unruptured, but neither placenta nor blood clot could be reached by the finger. Labour pains were absent.

In this condition the patient was admitted to the Liverpool Maternity Hospital, on the recommendation of Dr. Pugh of Edge Lane.

At 9-30 p.m. Dr. Briggs saw her and ordered a hypodermic injection of morphia, ¼ grain, with one one-hundredth of a grain of atropine. Soon after 10 o'clock the patient fell asleep. Total sleep for the night, 5 hours.

On March 7th, at 8 a.m. the pulse had fallen to 120: the restlessness again returned: 6 ozs. of urine were withdrawn by the catheter: the bowels were opened three times after a simple enema.

At 10 a.m. the pulse was 112 to 120.

At 11-30 a.m. the os was found to admit three fingers. The difference in the tense uterus between the pains and during the pains was almost inappreciable. The pulse was 108. To control the restlessness morphia and atropine as before were again administered hypodermically. The patient became quiet and slept. During the intervals of sleep she partook of small quantities of milk and soda water, or milk and barley water.

At 10-30 p.m. the catheter was again passed: 8½ ozs of urine were withdrawn from the bladder, making a total of 14½ ozs. for the 24 hours.

On March 8th, shortly after midnight, labour pains were more pronounced. A speedy and spontaneous 2nd stage was completed by 12-30 a.m. The uterus contracted well.

The pulse at the end of the third stage had risen to 156. The arms and the legs were bandaged; the foot of the bed was raised, and the patient was surrounded by hot bottles.

In addition to the large clot, weighing 2½ lbs., liquid blood and small clots were collected and estimated at 1 pint, by the Ward Sister.

The placenta and membranes weighed 1½ lbs. The fœtus, which had been dead about one week, weighed 7 lbs. 12 ozs.

At 8 a.m. the patient had slept after her labour, she was less restless ; she looked very ill and was very weak.

At 11-30 p.m. the pulse was 132 and the temperature 100°. From this time onwards the pulse gradually fell and the temperature became normal until the 8th day, when the pulse rose to 142 and the temperature to 102°. The involution of the uterus had been tardy.

On the morning of the 10th day an intra-uterine douche of five quarts of sterilised water at 118° was given. The temperature fell to 97·8° and the pulse to 112.

The points of interest in the case are the entire absence of external bleeding, the large size of the retro-placental clot, and the success of the treatment adopted.

The amount of blood lost amongst Goodell's cases, with recovery, never exceeded 2 lbs. In this case the retro-placental clot alone weighed 2½ lbs.

Ætiology. The patient was a married woman, aged 26, with an excellent record throughout five full-term easy labours. During the last, her sixth, pregnancy, now under notice, her husband had been out of work, and she had, by strenuous efforts, to maintain and look after her family : two of the children had died, one of diabetes and the other of pneumonia : the funeral of the second child took place on March 1st, five days before the mother's illness.

Sometime after her admission to Hospital the patient said she could remember one day catching her dress on the door and falling upon her abdomen, without any appreciable consequences.

A CASE OF CONCEALED HÆMORRHAGE DURING THE FIFTH MONTH OF PREGNANCY, TREATED BY VAGINAL HYSTEROTOMY

By Miles H. Phillips, M.B., B.S. (London), F.R.C.S.

On Feb. 12th last, I was asked by a doctor to see a patient in whom he had found a large pelvic tumour. She came to the out-patient room of the Jessop Hospital and I elicited the following history :—she had had nine children, the last being born one and three-quarter years ago. The amenorrhœa of lactation had ceased when the child was nine months old. Afterwards menstruation was regular and normal with the exception that the three periods before Christmas had been less in amount than usual and that the two since Christmas had consisted of smart floodings, accompanied by hypogastric pain, lasting two and three days respectively. The last had ceased three days ago. There had been no vomiting, no quickening, and indeed, the patient expressed the opinion that she was sure she was not pregnant.

I found her a well-nourished, slightly anæmic woman, not looking ill. A visible central rounded swelling reached from the symphysis to within one and a half inches of the umbilicus. It altered in consistence during examination, presented a palpable hypertrophied round

ligament on each side and a souffle along its left border. The marked hardening and softening strongly suggested pregnancy but no fœtal parts or movements could be felt and no fœtal sounds heard. The vulval and vaginal orifices were patulous, the vaginal walls loose and prolapsing the cervix long and large, unlacerated but hard and chronically inflamed ; the external os was too small to admit the finger tip. Continuity between the cervix and the abdominal swelling was easily made out. The breasts were small and inactive. In spite of the absence of so many of the usual signs and symptoms of pregnancy, I considered that she was probably about 4½ months pregnant and that a miscarriage was threatening, and I advised that she should be kept in bed and be given sedatives. At the same time I told her doctor that I would admit her to hospital and explore the uterus should another flooding occur.

A week later he asked me to admit her as the hæmorrhage had recurred and he thought that the uterus was rapidly increasing in size. I found that she had markedly changed since I had seen her a week before. The anæmia was much more marked, her eyes were sunken, her face drawn and she was complaining bitterly of severe pain in the tumour ; it was of a sharp tearing character and not at all like labour pains, though it varied in intensity at intervals of five or ten minutes. The uterus was greatly increased in size, it reached an inch above the umbilicus and presented an almost globular shape, but there was no localised bulging. It hardened slightly during examination, but was not in contraction when the patients pain was most severe. There was considerable tenderness on both sides of the uterus.

The souffle was still audible, but no signs of a fœtus could be obtained. The cervix was still long and rigid, and its external os too small to admit the finger tip. There was no hæmorrhage, the pulse rate was 96. The rapid increase in size of the uterus suggested the presence of a vesicular mole or possibly of a considerable concealed hæmorrhage. Anyhow it was obviously necessary to empty the uterus and so I inserted a laminaria tent—the cervix would only admit a small one—and tightly packed the vagina with gauze. Saline was injected into the rectum and ergot and morphia given by mouth.

Five hours later the patient's facial aspect was even more disquieting, though her pain was less severe, and the pulse rate a few beats slower. There was now a very obvious bulging of the left uterine cornu ; this was softer than the remainder of the uterus, which was much harder than it had been before, though there were no obvious labour pains. I considered it advisable to empty the uterus as quickly as possible.

As soon as she was anæsthetised, saline infusion was commenced into the axilla, and two drachms of ergotin was injected into the buttock. The vaginal plug and the tent were removed. The rigid cervix would not admit a finger and so, after cleansing the vagina, I made a transverse incision through the anterior vaginal fornix and separated the supra-vaginal cervix and the lower segment of the uterus from the bladder up to the peritoneal reflection. Pulling down the cervix by means of two vulsella—one on each side of the anterior lip—I divided, in the mid line, with stout scissors, the cervix which was nearly 2½ ins. long and the lower 1½ ins. of the lower uterine segment. Neither surface bled. An

opening which admitted three fingers was thus obtained, and through this by means of fingers, sponge forceps and external compression of the now actively contracting uterus a large amount of old and recent blood clot was removed. Ultimately, high up on the left side an intact ovum was reached, its aminon was then ruptured and the contained fœtus quickly extracted by traction on a foot and perforation, with scissors, of its skull. The placenta, the greater part if not all of which was still attached, was then removed and finally the uterus was cleared by means of a blunt flushing curette. It contracted splendidly, and there was little or no fresh hæmorrhage. Its cavity was then packed with gauze and the wound closed by eight thick catgut sutures. There was no difficulty in inserting these as the cervix was easily drawn down to the vulva. The vaginal wound was closed by a continuous fine catgut suture and the vagina packed with gauze.

During the next twenty-four hours several pints of saline were injected into the rectum and strychnine and digitalis were given hypodermically every three hours.

She then appeared to be out of danger, and in the course of the next three weeks she made a complete recovery. Twelve hours after the operation I was alarmed to find the temperature had risen to 102°, but on removal of the gauze it fell to normal and there remained.

The lowest stitch in the vaginal cervix came away prematurely and allowed the lower half inch to gape. It would have been better to have used silk-worm gut sutures for the vaginal cervix.

The blood clot which could be collected filled a two-pint measure. The fœtus was eight inches long and of

about 4½—5 months' development ; it was not macerated. The placenta and fœtal membranes appeared quite healthy. So far as I could judge the hæmorrhage had collected in the decidual cavity.

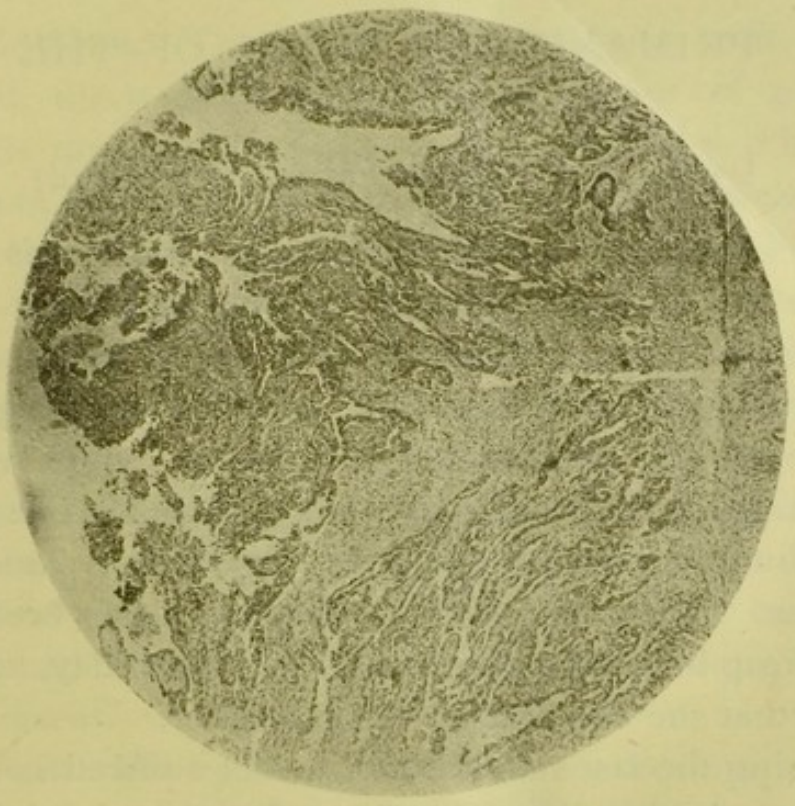
Remarks. The concealment in the uterus of a large amount of blood during the first half of pregnancy is, to judge from the scanty notice given to it in text books, of unusual occurrence, if we omit, of course, cases of vesicular mole.

As the hæmorrhage in my case was apparently not placental in origin, it would be incorrect to describe it as a case of accidental hæmorrhage. Two similar cases in the fifth month of pregnancy have been in the Jessop Hospital during the last twelve months, but as they were not associated with hypertrophy and rigidity of the cervix they required other means of treatment. By the courtesy of Mr. Favell I saw the first of these cases and made an incorrect diagnosis of vesicular mole.

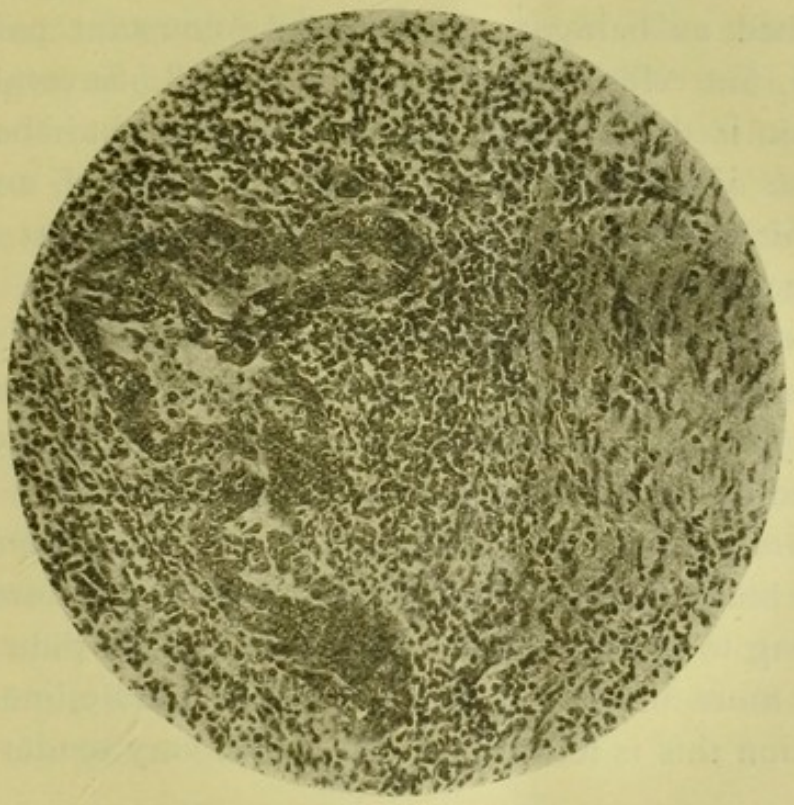
With regard to the method of emptying the uterus employed, I must say that I can imagine nothing simpler, more surgical, or more satisfactory than vaginal hysterectomy during the early months of pregnancy. In the last two months I should prefer the abdominal route.

My technique would have been improved by using two stout ligatures as suggested by Whitridge Williams instead of vulsella on the cervix ; the vulsella were considerably in the way during the evacuation.

PRIMARY ADENO-CARCINOMA OF THE FALLOPIAN TUBE.



Objective 1/3



Objective 1/6

PRIMARY CARCINOMA OF THE FALLOPIAN TUBE.

By J. E. Gemmell, M.B. (Liverpool).

J. O., æt 45, married 28 years, nullipara, was sent to me by Dr. Clay, of Holyhead, on July 2nd, 1907.

History. The patient complained of pains in the abdomen and constant, yellow, offensive discharge.

The trouble commenced with a free, white, vaginal discharge twelve months ago, which later became yellow in colour, watery in consistence, very offensive and very profuse. The quantity of the discharge has been such as to keep her constantly "wet" night and day, and she states that she has become much thinner.

During the last six months she has suffered considerable pain in the abdomen; first referred to the right iliac region, but later mainly to the left iliac region, and described as being a more or less constant pain, not severe, but "like something gathering." Several times the pain in the abdomen has necessitated rest in bed, and the use of local hot applications for its relief, and has, she thinks, been accompanied by enlargement of the abdomen.

Menstruation. Commenced at 13, regular; of the 28 day type, lasting seven days, and the discharge used to be *profuse*. Since the constant watery discharge commenced, there has been only a "slight show."

Examination. The abdomen is swollen, the enlargement being in the hypogastric region, the swelling reaching to a point about one inch above the pubes, and being more marked to the left of the middle line. On palpation this is felt to be hard, and is very tender.

Per Vaginam. The cervix is nulliparous, hard and nodulated, the nodules being about the size of peas, above this and almost filling the true pelvis, is a hard fixed mass, "knobby" in parts, apparently continuous with the cervix, mesial in position but extending upwards and to the left, reaching above Poupart's ligament; the left appendage cannot be made out, but the right appendage is enlarged, the swelling being about the size of a hen's egg.

Diagnosis. The diagnosis was that of multiple fibromyoma uteri, with chronic inflammatory right appendage disease, and with the history of fœtid watery discharge, we presumed that there was a sub-mucous sloughing fibroid present.

Operation. On opening the abdomen the lumps felt in the pelvis, were seen to be enlarged, distended, Fallopian tubes, which were firmly adherent to the floor of the pelvis and to the back of the uterus, the enlarged appendages, and uterus, forming together the solid hard irregular fixed tumour, felt on vaginal examination. There was no ascites. The dissection necessary to free the appendages, was difficult, and the right tube and ovary were first removed: and then the larger left tube, and part of the left ovary, the ovary being cut through, on separation of the tube. The abdomen was closed in three layers, with catgut suture, and the subsequent convalescence was uneventful, with union of the wound by first intention.

Specimen. The right tube was closed at its fimbriated end, distended to about the size of a hen's egg, with clear fluid, simple hydrosalpinx; the ovary was adherent to it, not enlarged and apparently normal.

The left tube was sausage-shaped, closed at its fimbriated end, and was so much distended that its diameter measured 3 inches, whilst at the uterine end the diameter was 1 inch.

On incision, the tube was seen to contain pus in considerable quantity, and the mucous membrane was enormously thickened and swollen, forming papillary processes, having the appearance of pink coloured active granulation tissue bathed in pus, and increasing the thickness of the mucous membrane to about ½ inch. (Papilloma of Doran.)

The portion of the left ovary attached to the tube was normal, neither ovary was enlarged. Now, the diagnosis became that of chronic inflammatory appendage disease, probably of a gonorrhœal infective origin, resulting in papilloma of the tube.

Histology Microscopical sections were prepared for me by Dr. H. Leith Murray. Section, of the left tube, demonstrated the papillomatous growth to be adeno-carcinoma.

The endo-salpinx shows great proliferation of the epithelium throughout the whole of the section; the cells are piled up in many layers and show great variation in size of the nucleus and considerable vacuolation. There is practically no penetration of the muscular layers, which, however, show some deposit of small round cells similar to those in the malignant processes of the endo-salpinx.

Right tube, simple salpingitis, ovaries normal.

Note.—Cancer of the Fallopian tube, either primary or secondary, is apparently of rare occurrence, and there is no record of any case of primary cancer of the tube

prior to that of Orthmann in 1888, probably due to the fact that abdominal exploration was not practised so frequently up to that time.

Personally, out of 90 cases of hysterectomy, vaginal or abdominal, for cancer of the cervix or uterus, in only 3 have I found the appendages involved secondarily, and of 12 cases of ovariotomy for carcinoma of the ovaries, in none were the Fallopian tubes implicated.

The study of primary cancer of the Fallopian tube has been made easier by the papers of Doran, contributed to the Journ. of Obs. and Gyn. Brit. Emp., and especially by the collection and tabulation of 60 cases in vol. VI., 1904, since which several cases have been recorded by different surgeons, and Orthmann, in March, 1907, published a list of 84 cases.

Neoplasms of the tube were thought to be of very little practical interest, because they were generally small, could not be diagnosed and when found did not seem to be doing much harm, and generally were discovered with affections of greater importance in neighbouring organs; their own importance being thus overshadowed.

Cancer *secondarily* to the ovaries does not occur until late, and frequently has been preceded by the adhesion of a tube, into which the malignant growth from the ovary has made its way by direct extension, the serous coat of the tube being invaded, and the growth in the lumen of the tube being really free from the mucous membrane. When the cancer develops in the mucous membrane of a normally formed tube, whether, from malignant change in a papilloma or directly from the tubal mucous membrane, is a controversial point—but

the balance of opinion seems to be in agreement, that a predisposition to cancer of the tube, may usually be traced to inflammatory changes, the coincident papillomatious growth of the mucous membrane paving the way for the malignant change.

The occurrence of the disease in the middle and external portions of the tube, indicate that it is a sequel to inflammatory trouble.

Macroscopically it is difficult to distinguish between exuberant inflammatory product and new growth.

Tedenat states that in chronic endosalpingitis, we see papillomatous, villous, arborescent, cauliflower masses, identical to the naked eye with new growths, the innocence or malignancy of which cannot be determined in their early stages, except by the aid of the microscope.

The disease is generally uni-lateral, but may be bi-lateral, and the growth, although commonly limited, may be diffuse

Clinically. The history usually is that of a patient about 45 years of age and onwards, approaching the menopause, who has suffered from long standing pelvic inflammatory troubles, and with some recent pelvic pain.

Discharges, varying in quantity, often profuse, sanious or watery, and with some abdominal swelling.

The pelvic tumour rarely reaches above the pubes, and ascites is not always present.

The diagnosis is seldom made, most frequently it is thought to be pyosalpinx, and in several of the cases, as in this, has the tumour been looked upon as myomatous.

There is no doubt that in cases where cancer of the tube is suspected, that the best line of treatment is complete removal of tubes and uterus.

In this instance, the tubes having been removed entire, the case being considered pyosalpinx, it was not until the operation was completed that the papillomatous growth was seen in the tube, otherwise I should have adopted the radical operation.

I base my diagnosis of primary carcinoma upon the evidence of the microscopical section of the tube : the clinical signs : and the macroscopic appearance of the ovaries and right tube.

In a letter dated March 16th, 1908, patient states she has been very well, and is better at present than she has been for many years.

Recurrence and metastases are said to be rapid and fatal, yet Boxall recorded a case of carcinoma of the tube, secondary to the ovary, where there was no recurrence five years later.