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REPORT OF CASES, WITH PRESENTATION OF SPECIMENS.*

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A Rare Form of Arrest of Development of the Right Uterine Cornu, simulating Ovarian Hæmatoma.

This small specimen which I first present is one of exceeding interest to me because of its unusual and probably unique character. It is a mass of fibro-muscular tissue which resembles the uterus in color and consistence, although not in shape. In its center is a little cavity which is lined by a mucous membrane which resembles the endometrium, but it has no outlet. It had attached to its outer side the right ovary and a portion of the Fallopian tube. By its inner side it had a membranous attachment to the uterus proper.

The patient was an unmarried girl of twenty years, in whom puberty occurred at the normal age, menstruation recurring without event until about two years ago, when she began to suffer pain in the right ovarian region at the menstrual epochs. At first the pain was not severe, but it gradually increased in severity until it became of such intense and excruciating character that the patient would writhe in agony, and, although the usual anodyne remedies, including morphine, would be administered in large doses, she would only obtain relief with the subsidence of the flow. As stated above, the pain was always felt most intensely in the right iliac region. These symptoms led me to suspect hæmatoma of the right ovary, and physical examination confirmed this view, for I found a tumor about the size of a hen's egg occupying the position of the right ovary, except that it was located higher than the ovary usually is under these circumstances; and it was not tender upon pressure, nor was it fixed. The cervix uteri was infantile, the os small, and the uterus deflected to the left.

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In accordance with my custom in the treatment of hæmatoma of the ovary, which gives rise to such serious symptoms, I advised its removal, which is, I believe, the only proper treatment for this condition. This advice was gladly accepted, and I operated about six weeks ago. Under ether, I was a little uncertain as to the correctness of the diagnosis of hæmatoma, because the tumor appeared so firm and elastic, and was situated too high. Abdominal section was made, and the small tumor which I hold in my hand came into view. It had the color and consistence of uterine tissue, and the right ovary was found attached to the mass. Diagnosis of arrested development of the right horn of the uterus was made. The mass was removed, together with the right ovary, which you see attached, after ligation of its membranous attachment to the uterus. The left side, or uterus proper, being in an undeveloped condition, it was thought best to remove the left ovary also. The patient has made a good recovery. Section of the tumor showed it to contain a little cavity which is lined by an endometrium, and which contained a small quantity of menstrual fluid. This cavity had no outlet whatever.

The explanation of the intense dysmenorrhœa from which the patient suffered was evident; there was an effusion of blood into the cavity with each menstrual recurrence, but as there was no outlet, the pain resulted.

In connection with this interesting case I wish to record the following, which has never been reported:

A Case of Double Uterus and Vagina, one Side of which was Patulous and the other closed, resulting in Tumor from Retention of Menstrual Fluid, while Menstruation was Normal from the Opposite Side, in a Girl Fourteen Years of Age.

Instead of a specimen, I will present a diagram which represents the condition found in the following case:

A. B. was sent to me several years ago. She was fourteen years of age, and had begun to menstruate eleven months before I saw her. At the second or third period after the menses first appeared she began to suffer intense pain with each recurrence, and soon after there was evident a swelling in the right iliac region and a smaller tumor or protrusion at the vaginal orifice. Finally the pain and distention became extreme; soon after this I saw her. The history led me to suspect retention of the menses, but the presence of a regular monthly flow was at first puzzling. Physical examination, however, fully explained

the unusual phenomena. The right iliac region was found distended by a tense, globular, fluctuating mass as large as a cocoanut. On the upper border of this mass an elongated firm body, somewhat the shape of the uterus, could be distinctly outlined. Inspection of the vaginal orifice revealed a mass the size of an egg, which occupied a position on the left side of that orifice. It was purplish in color, and resembled the vaginal mucous membrane. Pushing this mass aside, the finger entered what appeared to be a normal vagina, except that it was flattened by pressure from the left side by a tense, fluctuating, elongated mass which was continuous with the tumor at the orifice. At the upper end of this canal a small cervix uteri was located. A sound was now carried along the finger and made to enter the uterine cavity. It curved over the summit of the iliac tumor and passed horizontally to the right, showing that the firm body referred to above was really the uterus or a part of it. The patient had a double uterus and a double vagina, and menstruated from both uteri, but atresia of one vagina existed; hence the retention on that side. I advised operation, and the patient entered my private hospital.

The vaginal septum was divided with scissors from the orifice to the os uteri. A large quantity—fully a pint—of a tarlike semi-fluid escaped. A pin-hole os uteri was now discovered. A free incision was made from this point outward, when at least a quart more of the same fluid escaped. Thorough irrigation of the uterine cavity was made and then the uterine septum was divided to the fundus. This completed the operation. The after-treatment consisted of a daily antiseptic irrigation. The patient made an easy recovery, and has remained in good health since.

A Case of Ovarian Tumor in which Rupture had occurred followed by Chronic Peritonitis.

The large specimen which I here exhibit is one of peculiar interest, because it shows that although the question of early operation in ovarian cystoma has been urged so often that the profession and the laity should both be familiar with the fact that early interference is necessary for the highest operative success, we still too often meet with cases which, like this one, narrowly escape death as a result of delay.

The patient, Mrs. L., aged forty-seven, five children, five years ago consulted the late Dr. Goodell, who made a diagnosis of ovarian tumor and advised its removal, but she declined operation.

Shortly afterward there were symptoms of rupture of the cyst, followed by profuse diarrhœa and micturition, with decrease in the size of the tumor.

She then had great tenderness of the abdomen with tympanites and other evidences of peritonitis. She recovered, and seemed better for a time, the tumor remaining of the diminished size ; but, as usual, the cyst began again to refill. Its growth was slow, however, until about six months ago ; after that date the increase in size was rapid, and the patient became so ill from exhaustion and emaciation, and from the dyspnœa resulting from pressure on the diaphragm, that successful operation was now considered almost beyond reach. Under these circumstances I was requested to see the patient. I found her even worse than described, but I decided to operate. For this purpose she was removed with difficulty to this city, where the operation was performed on April 17, 1895. An incision through the linea alba revealed the bladder drawn up as far as the umbilicus and spread out over the tumor. But I was on the outlook for it, having, several years ago, cut into the bladder in a similar case. (I think Dr. Noble, as well as some other invited guests, was present at that operation. It was the first time that I had been so unfortunate as to wound the bladder. My incision extended at least two inches through the wall of the viscus. I immediately closed it with several silk sutures. No trouble ensued, for the patient made an uninterrupted recovery. I have wounded the bladder once or twice since, no bad result occurring in either case.) But to return to the case in hand : After learning that the bladder was adherent to the tumor, I carried my incision farther up, and came upon the growth just below the umbilicus. The tumor was found to be ovarian, with the thick walls which you see, and it was closely adherent to everything with which it came in contact. The mass was friable, and in manipulating to separate adhesions, rupture occurred. The cyst contained great quantities of cheesy material, as well as a semi-fluid substance. In addition there was a large quantity of fluid in the abdominal cavity. Finally, the tumor was separated from its firm intestinal adhesions and the pedicle reached, the latter being situated low down under the bladder, where it was found to be attached, through the Fallopian tube and broad ligament, to an enlarged and fibrous uterus. Ligation of the pedicle was made, and thorough irrigation continued until the peritoneal cavity was entirely freed from tumor contents. Examination now showed the uterus to be the size of a large cocoanut, but the patient was in such a low condition that further operative measures could not

be considered. After placing a glass drainage-tube in the peritoneal cavity, the patient was returned to bed more dead than alive. Under careful and continued stimulation she finally rallied, and has recovered, much to the surprise of every one who saw her before or at the time of the operation.

This case emphatically teaches the folly of the delay which places the patient, to say nothing of the surgeon, in so hazardous a position and upon a trial so great.

The patient fortunately recovered, but if she had died it is probable that the fatal result would have been attributed to the operation, whereas the operation would have had nothing to do with the death.

I am so firmly convinced of the advisability of early operation that where a tumor, of whatever character, is found to exist I always advise its removal, even though the patient does not then appear to be suffering from its presence.

The next specimen is from

A Case of Intraligamentary Fibrocystic Tumor of the Uterus. Hysterectomy, in which Unusual Difficulties were Encountered.

Mrs. L. G., aged thirty-three years; married two and a half years; sterile.

Puberty occurred at the normal age. She had always had dysmenorrhœa, so that she was obliged to go to bed the first day of the flow. Six or eight months ago she was awakened in the night by a violent cramplike pain in the right ovarian region, and in placing a hand upon the abdomen she felt a "knob" in the right iliac region. From that time on there was an increase in the size of the mass, and shortly afterward she noticed another mass about the size of a goose egg in the left iliac region. She consulted a physician, for the first time for this trouble, in May, 1894. Tumor was recognized, and the patient placed upon ergot without benefit. After this she had repeated attacks of violent uterine tenesmus, lasting five or six hours, and only subsiding after the free use of opiates. The attacks of pain were attended with profuse metrorrhagia. The pain and hæmorrhage caused another physician, whom she next consulted, to think that the tumor was an intra-uterine fibroid, which could be removed by way of the cervical canal, and for that purpose, on September 8th, she was etherized and the cervix dilated, when it was determined that the tumor was intramural. Nothing further was done.

On October 16th the patient was placed in my charge. She had

then been bleeding continuously for almost a month, and was generally in a very low condition. She had lost considerable flesh, and was cachectic in appearance. Examination revealed a tumor occupying the entire pelvis, especially on the right side, and extending into the abdomen. It was immovably fixed and very firm, but obscurely fluctuating. The cervix was carried far up behind the symphysis pubis, so that it was almost entirely out of reach. The left iliac region was occupied by an irregular mass, which was determined to be the uterus, as it appeared to be almost one with the tumor.

Diagnosis.—Intraligamentary tumor of the uterus or ovary. The patient entered a private room at the Polyclinic Hospital, and was placed upon preparatory treatment, which was continued about a week.

Operation October 23, 1894. Abdominal section exposed the tumor. It was found to be entirely subperitoneal within the folds of the broad ligament, which were widely separated and carried upward into the abdominal cavity. The right Fallopian tube and ovary were spread out over the surface of the tumor. The uterus was comparatively small, and was located on the left side of the tumor. The mass looked very vascular, and the operation for its removal appeared formidable. I first placed a ligature, after the method which I have introduced for supravaginal hysterectomy, upon the left broad ligament. Severing the latter, I next ligated the left uterine artery. After careful examination of the relation of the cervix to the tumor, I determined to pursue a different method from that which I usually follow. I immediately amputated the cervix, and came upon the uterine artery of the right side and then ligated it, thus controlling all arterial hæmorrhage. But the real operation only now began—that of enucleation of the tumor from its very deep and intimate pelvic connections. Many veins were severed in this manipulation and hæmorrhage was free, but with pressure forceps and packing with balls of sterilized gauze as I proceeded, I was enabled to soon tear the tumor from its capsule. This was rendered more easy because the tumor was found to contain some liquid in its interstices evacuating, which reduced its size somewhat. Finally the mass was removed leaving an immense vascular cavity in the pelvis. This cavity was made up of the widely separated folds of the right broad ligament and the pelvic peritonæum, which had been lifted up by the growth of the tumor. The packing was next removed, when it was found that the hæmorrhage had about ceased. The peritonæum was now folded and stitched over the tumor cavity, and the abdominal cavity then closed without irrigation or drainage.

This is the sort of case in which gauze packing is sometimes placed and allowed to remain for the purpose of checking hæmorrhage and to serve as a drainage apparatus. I was only once guilty of leaving gauze in the pelvis for this purpose, and that once was sufficient. I never found it necessary for the purpose of controlling hæmorrhage, and certainly it is not necessary for drainage. Hæmorrhage can and should always be controlled without such a clumsy procedure. When drainage is necessary it should be done thoroughly with the glass tube, but I so seldom find it necessary that it is quite unusual for me to place a drainage-tube. I am constantly closing wounds without gauze packing or drainage in cases of this character and in pus cases, and my patients are better for it, I am sure. Of course I am always careful to remove all pathological products, leaving only healthy tissues.

The method pursued in this case is one which I have followed in several other instances of broad-ligament fibroids—that is, ligating one side and then amputating the cervix, and afterward ligating the vessels on the other side before proceeding to the enucleation of the tumor.

The second case that I operated upon by the supravaginal method was one of somewhat similar character to the one just related. It was a fifty-pound fibrocystic tumor, in which several electro-punctures had been made, rendering the contents of the tumor purulent in character. I was somewhat frightened by the large size of the venous channels upon and around the tumor mass. There was considerable bleeding during the operation, and for hæmostasis I packed into the wound balls of sterilized gauze, which were removed before closing the abdominal incision. This operation was so formidable in character from hæmorrhage and the shock to the patient that it was thought by all present that she would certainly die on the table; but she rallied and recovered. I closed without gauze packing, but made great compression by strapping a large roll of gauze on the external surface of the lower abdomen immediately over the tumor cavity. I believe this woman would have died if I had left this packing within the pelvis, for the additional healing processes would have been a far greater drain upon the vital forces.