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A CLINICAL

CONTRIBUTION TO GYNECOLOGY

BY

EDWARD J. ILL, M.D.,

Surgeon to Woman's Hospital, Newark, N. J.

Reprinted from THE AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XVI., No. III., March*, 1883.

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In presenting this contribution to the profession, I offer no excuse. Both cases seem to me, at least, of great importance, the first case as to diagnosis and the second as to the possible etiology of some forms of insanity.

Case I.—*Cyst of Broad Ligament with Peculiar Fluctuations in Size; Operation; Death.*—About April 3d, 1882, I was asked to see, through the kindness of Dr. Chas. M. Zeh, Sister I. (Sister of Charity), with the report that the patient had a rapidly growing abdominal tumor.

I found the patient in bed, feebly looking, slightly anemic, of small stature, about thirty-two years of age, and of pleasant disposition. She had been confined to her bed about two weeks, complaining of severe "stretching" pain in the right inguinal region. She had become so very large within a fortnight, that she was unable to attend to her duty as a school teacher. About a year ago she had some soreness in the right inguinal region and at times noticed a distinct swelling, which would again disappear. Her physician distinctly remarked the tumor at one time, but the next time he saw her it had entirely vanished. The disappearance of the tumor was not noticed to take place with the occurrence of any function.

At times she would suffer greatly from nausea, vomiting, and acid dyspepsia, still she was well able to fulfil her peculiar duties, until about two weeks before I saw her.

She was a native of Ireland, first menstruated at the age of thirteen years, was very regular, nearly painless, lasting three days, and had no leucorrhœa. Physical examination, in the dorsal position, revealed a large distinctly fluctuating, apparently monocystic tumor, equally filling the abdomen anteriorly. There was tympanitic resonance in both flanks, and above the middle, between umbilicus and ensiform cartilage. The patient now being placed on her side, no marked difference was noticed in the area of dulness.

No further examination was made at this time, but the patient was requested to enter my service at the Woman's Hospital, of Newark, N. J., for further observation.

There the circumference of the abdomen was measured and found to be thirty-two inches over the umbilicus. The distance from xyphoid cartilage to symphysis pubis fifteen inches.

The cervix uteri was high up in the pelvis, a little towards the

left and just behind the os pubis. There was no fluctuation in the cul-de-sacs.

The body of the uterus could not be detected and a sound was not used as the patient's right side was still very tender.

Examination per rectum revealed nothing of importance. Urine was normal.

A small quantity of fluid was removed from the tumor and given to Dr. F. M. Prudden (to whom I am much indebted and here wish to express my special thanks) for examination.

He found nothing but red blood-corpuscles. This was rather confounding, as the diagnosis of a rapidly growing monocystic ovarian tumor was made. In the mean time the patient menstruated. This lasted three days and the quantity was small.

On the last day of her menstruation the tumor became *softer* and within six days after the period it *could hardly be felt.*

The patient was free from pain and could go about. As I was perfectly at loss about a diagnosis, no operation was thought of at this time.

An increase in the size of the tumor took place again by the next menstrual epoch, so that it increased over its former size. After this second menstrual epoch the tumor again decreased, but not to the same extent as before.

The following are actual measurements taken at different periods:

July 2d, menstruation expected, circumference of abdomen over umbilicus 37″, from os pubis to ensiform cartilage 17″.

July 5th, menstruation ceased, circumference of abdomen over umbilicus 34″, from os pubis to ensiform cartilage 15″.

July 25th, menstruation appeared, circumference of abdomen over umbilicus 39″, from os pubis to ensiform cartilage 18″.

July 27th, menstruation ceased, circumference of abdomen over umbilicus 37½″, from os pubis to ensiform cartilage 17″.

Sept. 1st, menstruation expected, circumference of abdomen over umbilicus 41″, from os pubis to ensiform cartilage 19″.

Oct. 5th, the patient measured forty-two inches around the abdomen and twenty inches from xyphoid cartilage to os pubis. I now removed sixteen pints of a dark yellowish-red fluid by tapping with the aspirator.

After tapping she measured thirty-eight inches around the abdomen and seventeen inches from os pubis to xyphoid cartilage. Dr. Prudden kindly reported the following as the result of his examination of this fluid:

"Fluid dark-red, neutral reaction, odor of carbolic acid, specific gravity 1022, completely solidifies on boiling and with nitric acid. It contains 11.93 per cent of albumin by weight, no paralbumin and no mucus and no paraglobulin.

"The microscopical examination shows numerous red blood-cells, comparatively few leucocytes, a small amount of granular fibrin, and a few rod bacteria, and nothing else."

This agreed fully with my own examination. The tumor now rapidly began to refill. On October 20th, it measured just as

much as *before* the tapping, and on October 27th, the patient measured fully forty-four inches around the abdomen.

The patient was candidly told of her chances by an operation and of the possibility of an exploratory incision only.

She took her chances and on October 29th, after one week's careful preparatory treatment, the operation was done with assistance of Drs. Balleray, Hollister, Bennet, and Dr. J. C. Young administering ether.

The incision was made as in ordinary ovariotomy. After all bleeding had stopped, the peritoneum was opened. The tumor presented a purplish striated appearance, which might be taken for muscular fibres. The hand was introduced and a few adhesions found with the anterior parietes. The growth was now carefully examined as to its origin. It was evident that it was connected with the uterus and right ligamentum latum, and there seemed no doubt of its being a cyst of the posterior wall of the uterus. It was deemed safe to remove the tumor. The fluid was evacuated and several adhesions to intestines, vermiform appendix and omentum, ligated and cut; a number of smaller cysts were broken with the hand, and the tumor was then lifted out of the abdomen.

The pedicle, which consisted of the uterus and both ligamenta lata, was surrounded by a strong elastic tube, so that all hemorrhage was controlled. The tumor with both ovaries attached was cut away. The tumor with its contents weighed twenty-five pounds. The pedicle was now treated after the method of Hegar and Kaltenbach (p. 437, Operative Gynækologie, 1881), the peritoneal cavity cleansed, drainage established, and the abdominal wound closed. The operation lasted sixty-five minutes. The patient rallied rapidly from shock and did well until 6 P.M., when her temperature rose to 102¾, pulse 140, and respiration 39. About midnight the patient complained of severe pain in the abdomen, she became tympanitic, and had some inclination to vomit. The drainage tube was washed out with one-per-cent sol. carbolic acid until clear fluid returned.

At noon, twenty-four hours after the operation, the patient died.

An examination was made two hours post-mortem. The intestines had already lost their usual gloss, a slight quantity of bloody fluid was found in the posterior cul-de-sac and the double elastic ligature surrounded the uterus just above the os internum. The patient died of very acute peritonitis. The tumor was sent to Dr. Prudden who kindly furnished the following report:

"The specimen you have sent me is a cyst of the broad ligament. The fragment of uterus contained two small myomas. The tube was dilated in its intra-mural portion and nearly occluded further out by new-growth of connective tissue around the mucosa. The uterine mucous membrane in the small portion which I had was thickened. Both ovaries alike showed the lesions of chronic oöphoritis. The cyst-wall was in general composed of fibrillar connective tissue, in some places dense, in other loose in texture. In many places the thin-walled veins were greatly dilated, contained old thrombi and the connective tissue in their vicinity

infiltrated with blood or contained much blood-pigment both free and in connective-tissue cells. The cyst-wall had in most places no distinct cellular lining, in some parts was lined with a single layer of flattened cells; in still others was covered with a dense layer of fibrin. The abundance of very thin-walled blood-vessels in many parts and evidences of persistent extravasation would account for the character of the cyst-fluid, but I discover nothing morphologically to account for the curious fluctuation in the contents."

I have described this case at length because it presents so many points of special interest. I am not aware that any similar case has been described anywhere in the text-books or journals. The impossibility of making a correct diagnosis was therefore excusable. The fluctuation in the contents of the tumor is not fully understood. The probable explanation would be, that as the menses appeared the general congestion of the pelvic organs, which accompanies that function, produced an increased exudation into the cyst and even ruptured some of the thin-walled veins. The rupture of some of these veins explains also the result of the examination of the contents. As a rule, cysts of the broad ligament are unilocular, this was multilocular and encroached strongly upon the uterus. Tapping usually cures cysts of the broad ligament, this tumor rapidly refilled.

I have given the history of this case at length, even at the risk of becoming tedious, and hope it may be of some use to others in similar cases in forming a diagnosis and prognosis, and may assist in the course of treatment to be pursued.

CASE II.—*Puerperal Mania; Laceration of Cervix; Operation; Cure.*—On the evening of June 1st, 1882, I was called to see Mrs. E. W., primipara, who had been in labor for twenty-four hours under the care of a midwife. I found the patient sitting in bed extremely restless on the approach of pain, which she described as excessively severe. The membranes had ruptured eight hours before the beginning of the pains. The child could distinctly be felt in the uterus through the abdominal walls and was in the occip. anterior left position.

The head had entered the pelvis by its greatest circumference, the os was dilated almost an inch and unyielding. I ordered a number of hot vaginal injections and several doses of Dover's powder. After eighteen hours the os was dilated sufficiently for interference. The child's heart began to fail and the short forceps were resorted to. Delivery was accomplished with some difficulty. Chloroform had to be administered on account of the restless condition of the mother.

The child was born alive.

On the third day the patient's pulse rose to 110 per minute and temperature to 101 degrees.

There had been no chill and no bad odor to the lochia, still antiseptic injections were ordered.

The next day the patient was in about the same condition, only very quiet and objected to nurse the child.

On the fifth day she absolutely refused to nurse the baby, thought she could never be the same woman as before, had no taste for her food, and her body felt "numb and dead." She had a staring, indifferent look, no interest for her child, her mother, or her husband.

It was evident that the patient was insane. She was now becoming sleepless, and day after day her symptoms increased until complete melancholia and anesthesia supervened.

She would now nurse her baby occasionally and very soon would nurse as often as it was put to her breast, but never took it up herself for that or any other purpose.

To explain her "numb and dead feeling" I have noticed among other symptoms these: She was unable to say whether the injections given per vaginam were hot or cold. No matter what kind of food, whether hot or cold, salted or not, was given her, she would swallow it so long as anybody fed her. A needle was run through the skin of her hands and feet apparently without her knowledge. In the fifth week I asked her to take a walk with her husband, whom at times she really hated. She never complained of getting tired, and thought she could walk day and night, for it was all the same whether she walked or lay down. She would not look after the proper appearance of her dress and person, about which she had always been very careful. Sometimes she wept bitterly about her condition and then would say, "I shall never be the woman I was before.' Suicidal ideas were entertained at times. During the first three weeks her pulse never ranged below 100, but her temperature rarely went above 100 degrees.

Seven weeks after delivery, I made an examination of the uterus and appendages, and found a slight laceration of the cervix, which looked irritable and sore. I questioned her husband about sexual intercourse. He did not deny having had intercourse, but it gave her *no pleasurable sensation.*

I told the family that this laceration was possibly the cause of her sickness, and there was certainly no harm in having it stitched up. They readily consented to the experiment. The operation was delayed until cooler weather should set in, so that the baby could be weaned with less danger.

Her condition remained the same up to the day of operation, October 9th. Her baby was weaned about ten days before. She was taken to the hospital for operation, and after the operation complained bitterly of not having felt any pain therefrom, as no anesthetic was used.

Eight stitches were inserted.

When I saw her on the sixth day, she noticed that the water

used for the vaginal injections that morning was warm, and seemed pleased by this symptom of returning sensibility.

The stitches were removed on the eighth day and complete union found to have taken place. Within two weeks she rapidly improved, requested to see her child and husband, helped herself to her food, which she had not done before.

The anesthesia rapidly disappeared and the patient became homesick.

Four weeks after the operation she was dismissed from the hospital.

I requested her husband to inform me of her desire for sexual intercourse. For about two weeks I saw the patient occasionally with still some slight melancholic symptoms. One day she came to my office most delighted: Since last night she had "completely changed," she was the "same woman as before." There had been a return of *pleasurable sensation at intercourse.*

The patient remains perfectly well to this day, loves her child and husband, is able to do all her housework, etc.

There might be some doubt as to the real cause of insanity in this case. There is a possible chance of her getting well from the change of surroundings and from weaning her baby; still when I consider that the usual course of the disease is a little less than nine months (H. Schülle, vol. 16, Ziemssen's Handbuch), furthermore the rapidity with which this patient improved after the operation, and lastly, the complete restoration to health after the *return of sexual appetite* (see a paper read by the author before the New Jersey Medical Society and published in their transactions, 1882), I cannot but consider this to be a reflex psychosis, such as Schroeder van der Kolk and Flemming have observed in cases of version of the uterus, where the use of a pessary cured the patients, and the removal of the same returned them to their former ailment.