NOTES ON CLINICAL GYNÆCOLOGY.[1]

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CASE I.—*Large suppurating cyst of right broad ligament in which the pedicle became twisted during woman's removal to Western Infirmary.*

Mrs. N., aged 35, was admitted to the Western Infirmary on 11th August, while I had charge of Professor Murdoch Cameron's ward.

She stated that she had three children, and that the last was born fully a year ago. After her last confinement she "fevered," and had to remain in bed for a considerable time. She had never been well from that date, she said, and three months ago she took to bed, and had been confined to it ever since. She frequently suffered from sickness and vomiting.

On admission she was quite collapsed, had a feeble, rapid pulse, and complained of a swelling in the lower part of the abdomen. The swelling, she thought, she had first noticed about three months prior to admission.

On examination of the abdomen, a large tumour, elastic to the touch, and about the size of the adult human head, could be felt, lying rather more to the right than the left side. By bimanual examination it seemed to arise from the right ovary. It was only slightly movable, and there was some tenderness over it and the abdomen generally.

The day after admission patient complained of severe pain over the tumour. She was also very sick, and vomited frequently. The two following days the pain continued, but was less severe, as also was the sickness.

On the fourth day after admission she was rather better, so I decided to open the abdomen. On doing so, I found a large cyst connected with the right broad ligament. I punctured it to allow of its collapsing, and so permit me removing it without extending the abdominal incision. In so doing, a small quantity of pus (the whole contents of the cyst were of pus) escaped into the abdominal cavity. The pus was sponged away as carefully as possible. The removal of the cyst after the evacuation of the contents presented no great difficulty.

[1] Specimens shown at a meeting of the Glasgow Medico-Chirurgical Society held on 3rd November, 1899.

The adhesions that had to be separated were loose, and of very recent origin. The pedicle was twisted two turns from right to left. Although the cyst was not acutely strangulated, it was markedly congested. The circulation had evidently only been partially interfered with by the torsion of the pedicle.

The abdomen was not washed out, and no drainage-tube was inserted.

The pus (90 oz.) removed from the cyst had no smell. Professor Muir very kindly made an examination of it, and found only streptococcus pyogenes present.

Several portions of the tumour were examined microscopically.

The conclusion come to was that the cyst was an old broad ligament one, which had become infected during the last puerperium. The ovary seemed quite healthy, and was flattened out on the cyst wall, and the tube could be followed throughout its whole length.

The woman died on the fifth day after the operation. Unfortunately no *post-mortem* examination was allowed.

The manner in which this woman died was very striking. During the days preceding her death there was absolutely no tenderness or distension of the abdomen, the temperature was never higher than 99·8°, and usually much below that figure, except on one occasion, when it registered 100·2°. The tongue was always moist and fairly clean, and she persisted in saying up to the end how exceptionally well she felt. The only indications of a probable fatal termination occurring were given by the pulse, which, on the third day, ran up from 95 to 116, and by the exaggerated feeling of well-being.

I have several times seen cases of very severe and fatal sepsis after abdominal section, and during the puerperium, where there was very little rise of temperature, very little tenderness or distension of the abdomen, but never one —I consider this patient died of sepsis—in which there was such entire absence of all local symptoms.

The pulse here early gave an indication of the seriousness of the condition. It is always so. The pulse is an infinitely more valuable guide to the condition of a patient after operation, or during the puerperium, than the temperature. The feeling of well-being was very striking. It, with the rising pulse on the third day, led me at that time even to entertain very little hope of the patient's recovery.

The twisting of the pedicle must, I think, have occurred during the patient's removal to the infirmary, as the adhesions were very loose and of quite recent origin.

Before the operation, I mentioned to some students who were present that we might possibly find the pedicle twisted, but, on the whole, I was inclined to think that the localised peritonitis was from infection of the peritoneum by some of the cyst contents. I came to this conclusion because the patient had been suffering much pain from time to time in the abdomen, and sickness for months, before her admission to the infirmary.

I think the history clearly points to the infection of the cyst having occurred during the last puerperium, for, as she said, she fevered then, and had never been well from that time.

CASE II.—*Cyst of right ovary—Infantile uterus—Ovulation without menstruation.*

Miss A. S., æt. 23, was sent to me by her medical attendant, Dr. Prentice, of Kilmarnock, in the beginning of the present year. He informed me by letter that the uterus was very small, and that there was a swelling to its right side. On examining the patient, I confirmed his diagnosis. I found the uterine cavity measured only 1½ inch in length, and that there was a sausage-shaped swelling at the upper part of the right broad ligament. I could feel no ovary in the right side, but made out the left one quite distinctly. I found the woman well developed, both mentally and physically; the breasts were well formed, and hair was present both in axilla and over mons veneris, and altogether she looked the picture of health. Briefly her story was as follows:—

From the age of 16, at regular intervals, she suffered from most severe pain in the lower part of the abdomen. This pain lasted usually two days, and was so severe that it prevented her from attending to her household and other duties, and frequently necessitated her taking to bed. Along with these severe attacks of pain, there were always the feelings of general discomfort that are commonly the accompaniment of menstruation. *She stated, however, that she had never once menstruated.*

Tonics and sedatives were recommended and tried, but had no effect. No attempt was made to make the uterus menstruate, either by emenagogues, electricity, or stem pessaries, &c.; the uterus was too imperfectly developed for that. I agree with Herman when he says, in his most excellent text-book on gynæcology, "I advise against any attempt to make an imperfectly developed uterus menstruate."

About three months ago the patient returned to see me,

and informed me that the pain was nearly unbearable, and that she could not stand it any longer. I examined her again, and found the pelvic organs in the condition I have already described. I advised that the cyst and other ovary be removed. This was done with no great difficulty. The right ovary, which I pass round, was cystic. The left had one or two distended follicles on its surface. I examined it microscopically, and found Graafian follicles in various stages of development.

The woman made an excellent recovery, and her doctor informs me that she has had no pain since the operation.

The interest attaching to this case is the fact of this patient having had periodic congestions of the pelvic organs, and, presumably, ovulation, and yet having never menstruated. It seems that for menstruation to occur, not only must the ovaries be present and the cyclical periods of congestion, but there must also be a well-developed uterus.

Reading the other day Hirst's *Text-book of Obstetrics*, published a few months ago, I found, on p. 64, reference to a case exactly similar to the one I have related. Hirst says—"Finally, I was once obliged to remove the ovaries in a case of ill-developed infantile womb, associated with well-developed ovaries, in which there was a violent exaggeration of the menstrual molimen every month, without a discharge of blood, and the consequent relief of menstrual congestion. The ovaries were found, after their removal, to be filled with well-developed Graafian follicles and numerous depressions, representing corpora lutea. In one of these ovaries there was a corpus luteum that would have answered for an illustration of the yellow body of pregnancy."

CASE III.—*A large myoma of uterus, with adhesions, removed by enucleation.*

J. N., æt. 35, single, asylum attendant, was sent to the Western Infirmary by her medical adviser, Dr. Todd, Maryhill, while I was acting for Professor Cameron there in August last. She was admitted on the 18th, complaining of a large abdominal swelling and of great pain in the lower part of the abdomen, which was always specially severe after eating or taking any purgative medicine. She stated that she had altered regularly since she was 14 years of age, and that, in addition to pain at the times mentioned, it was always very severe during the week preceding a menstrual period.

An examination was made, and the diagnosis of her doctor,

that the tumour was a fibromyoma of the uterus, was confirmed.

On more careful examination under chloroform, the large hard swelling, which I pass round, was felt. It occupied the middle line of the abdomen, and had a slight depression on its upper surface. It was connected with the uterus at the fundus, but not very extensively. The tumour seemed to be freely movable. The uterine cavity was not appreciably enlarged. The diagnosis of a pedunculated subserous fibromyoma was made, and an operation recommended.

Two or three days later I removed the tumour. This was accomplished, however, with the greatest possible difficulty. Instead of being freely movable in the abdominal cavity, as I thought, the tumour was attached by strong adhesions to the abdominal wall; indeed, it was part and parcel of the wall, and seemed to derive its blood-supply from there rather than through its connection with the uterus. It was also closely adherent to the transverse colon and mesocolon.

I first separated the tumour from the abdominal wall, then enucleated it from the uterus, and, finally, detached it from its connection with the bowel. The bleeding was dreadful. The woman became absolutely collapsed, and all present expected she would die on the table. As quickly as possible I ligatured all bleeding points after detaching each part, stitched the uterine wound, and brought the raw surfaces of the mesocolon and colon together and stitched them. As far as I could judge, all bleeding was arrested. I put in a drainage-tube, however, so that I might see if any bleeding occurred after the patient recovered from the shock. Finally, I stitched up the abdominal wound in one layer, applied the dressings and bandages, and injected two pints of saline solution into the submammary tissue, and put the patient to bed. She recovered consciousness soon, and seemed very well, but about six hours after the operation blood began to escape from the tube, and the pulse got weaker. I therefore reopened the abdomen, found two bleeding points on the abdominal wall, and some oozing from the intestinal surface; none, however, from the uterine wound. I got all the bleeding stopped again by ligatures, closed up the abdomen, but did not introduce a drainage-tube. I then bound up the patient very tightly, and again injected some saline solution.

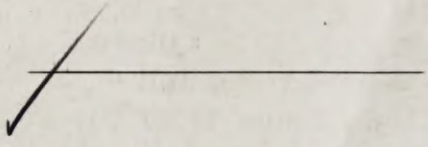
I need not trouble you with the after-history of this patient, suffice it to say that she made a most uneventful recovery.

This case is one of great interest in many respects. The

extensive adhesions and large quantity of ascitic fluid are conditions found very rarely accompanying myomata of the uterus. As I have said, the connection with the abdominal wall was so intimate that the tumour seemed to derive its blood-supply from there, rather than through the uterus. Doubtless the tumour was more mobile because of the ascitic fluid present.

Of special interest in connection with the adhesions was the pain complained of by the patient after taking food or purgative medicine, for, no doubt, these discomforts were caused by the tumour being adherent to the transverse colon.

As regards the wisdom of using a drainage-tube for the purpose of indicating the occurrence of hæmorrhage I am very doubtful, for with a drainage-tube in the abdomen one cannot bandage up a patient so tightly as one can when there is none.



CASE OF EPITHELIOMA OF THE ŒSOPHAGUS INVOLVING THE PNEUMOGASTRIC NERVE WITH ITS RECURRENT BRANCH ON THE RIGHT SIDE, AND WHERE THE SYMPTOMS CLOSELY POINTED TO ANEURYSM OF THE ARCH OF THE AORTA.[1]

By J. SOUTTAR M'KENDRICK, M.D., F.R.S.E.

WITH the kind permission of Sir William T. Gairdner, in whose wards the following case occurred, while I acted as his house-physician, I have the privilege of bringing before the Society notes of a case where the symptoms (although not exclusively) pointed to aneurysm of the aorta, but which ultimately (*post-mortem*) were found to depend upon an extensive epithelioma of the œsophagus.

Although the symptoms resulting from epithelioma of the œsophagus are, as a rule, pathognomonic of the disease, this is by no means the only case where such a difficulty has arisen, and where the symptoms of the one have been almost identical with those of the other. Dr. Newman,[2] for example, quotes a case of epithelioma of the œsophagus at the level of the bifurcation of the trachea, wherein the symptoms bore a close resemblance

[1] Read before a meeting of the Glasgow Medico-Chirurgical Society held on 17th November, 1899.

[2] Newman, *Malignant Diseases of the Throat and Nose.*