SHOEMAKER (Geo. E.)

Dermoid Cyst;
Broad ligament Cyst;
Vicious Union of cervix with vagina.

SURGEON GEN'L'S OFFICE. LIBRARY.

SURGEON GEN'L'S OFFICE. 522 LIBRARY.

Reprinted from ANNALS OF GYNÆCOLOGY AND PÆDIATRY, April, 1894.

Dermoid Cyst; Broad Ligament Cyst; Vicious Union of Cervix with Vagina.[1]

BY GEORGE ERETY SHOEMAKER, M.D.,
PHILADELPHIA.

THE following case presents an atypical history of a dermoid tumor.

CASE I.—The patient, an unmarried girl, was 19 years old. There was nothing in her childhood or early menstrual life to indicate any abnormality. Menstruating first at 15, she was very regular and had no pain until within a few weeks of applying for treatment. A tumor was first noticed nineteen months earlier, soon after a fall. It was then on the right side, as large as two fists and painless. Gradual enlargement took place until at the time of the first examination the abdomen resembled that of a pregnant woman near term. She had swelling of the feet in the morning, which disappeared during the day, no doubt owing to the pressure upon the vena cava being relieved by the sagging forward of the tumor when the body was upright. The uterus was very small and the cervix high up and flattened against the pubic arch. A thin-walled cyst distended Douglas's sac, while the main portion of the tumor was semi-solid to the touch. Another sac of thin fluid lay in the left hypochondrium. The patient returned to her home in New Jersey to consider the operation advised, and while there was thrown from a wagon, hurting her chiefly in the left side. This fall caused a disappearance of the thin-walled sac of fluid in the upper abdomen by rupture, but no harm followed. Operation June 17, 1893. The tumor completely filled the abdomen and no reduction could be made in its size by tapping. This made it necessary to prolong the incision two inches above the umbilicus in order to deliver it. The omentum was attached with great firmness to the front wall and required to be ligated off entirely as its vessels were large. Strong adhesions to colon on both sides and to small intestine were tied off or separated, and with difficulty the tumor delivered. The sac which had bulged into the vagina behind could now be emptied. It contained about one pint of straw-colored, thin fluid. The pedicle was not larger than two fingers. It was one of those growths where few adhesions are encountered in front except to the omentum, but where strong, tight bands, almost out of reach behind, render the delivery of the tumor a matter of considerable difficulty. The solid part of the growth weighed six pounds. A loose band looking much like small intes-

[1] Read before the Obstetrical Society of Philadelphia, March 1, 1894.

tine passed horizontally across the front of the tumor above the bladder reflection. It contained, however, two veins as large as lead-pencils and led directly to the side of the uterus below the round ligament, which was itself hypertrophied and very distinct. It probably belonged to the ovarian ligament. Left ovary cystic, size of two walnuts. Left tube had a rounded end with no fimbriæ, and as it was completely buried with the diseased ovary in strongly-organized adhesions both were removed. Flushing. No drainage. Buried silkworm-gut sutures. Aseptic recovery. Up in three weeks. Reported herself well and working six months later with no symptoms.

CASE II.—M. A., 36 years old; married. Broad ligament cyst. One child 16 years old. No miscarriages. Applied for treatment because of pain in the back and right side, which had lasted five months and was increased by walking, working, and lying on opposite side. She had had no attacks of peritonitis. Menses began at 14 years, and had been normal up to the time of the beginning of pain in back five months before, since which they had appeared every three weeks. Examination disclosing a thin-walled cyst of the size of a child's head in the right pelvis; operation by median three-inch incision was performed September 17, 1892. The cyst dissected up the posterior fold of the broad ligament and peritoneum nearly to the anterior superior spinous process.

The hypertrophied tube lay closely applied upon its anterior face, looking like collapsed small intestine. The corresponding ovary was beneath and in front. After tapping and removing about two pints of thin, clear fluid, it was possible to enucleate the cyst and tie off its base completely. There was no pedicle. The left tube and ovary were normal and were not removed. There were no adhesions. Abdomen closed without drainage. The convalescence was normal and without incident. Patient seen and examined after sixteen months. She was well, having no symptoms and no return of the growth, nor was any thickening palpable on the side operated upon.

CASE III.—Vicious union of cervix with vaginal wall. Mrs. X., aged 30, applied for the repair of a severe laceration of the cervix as well as of the perineum. The only peculiarity of the case consisted in a round band or cord of connective tissue, about half the size of a lead-pencil, which began at the outer angle of the cervical tear and extended downward a little more than an inch to the right vaginal wall, where it was attached to a small area of cicatricial tissue. The presence of this scar-tissue at both attachments of the band leads to the following theory as to its causation: After the labor, at which a tear both of the cervix and vaginal wall occurred, the two torn surfaces were held in contact long enough for union to take place. A loaded bowel may have crowded the uterus down and to the right. As involution occurred and the normal movements took place to which the uterus is subject, including probably the influence of coition, stretching of the tissues resulted in the formation of the band. The occurrence of vicious union of the cervix after labor, though not very common, has been repeatedly described.