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Celiotomy for Painful Abdominal Growth of Obscure Nature —Sarcoma of the Ovary with Cystic Degeneration

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CELIOTOMY FOR PAINFUL ABDOMINAL GROWTH OF OBSCURE NATURE—SARCOMA OF THE OVARY WITH CYSTIC DEGENERATION.[1]

THESE cases are reported as furnishing clinical experience unusual in character and hence worthy of record as giving information of practical value.

The first case, Mrs. B., a florid-looking German woman, had been subjected to operation by an experienced abdominal surgeon between three and four years before coming under observation. She stated that a tubal abscess had been treated at that time. Celiotomy was performed, from which the patient made a good recovery. She continued in comfortable health for several months, when she began to notice an enlargement of the abdomen, especially prominent in the left epigastric region. As this increase in size continued she suffered from sharp pains in this region, for which she sought relief at the various gynecological clinics of this city. She first returned to the operator who had originally treated her, and was informed by him that she must not allow a further operation, as it would certainly prove fatal. At another clinic she received a prescription for iodide of potassium. At another clinic no diagnosis was stated and she was asked to return for further observation. At another hospital she was prevailed upon to enter the wards, and as she suffered from indigestion her stomach was washed out, which caused her to leave in disgust. She was sent to me with the request that I examine her to ascertain the nature of her trouble. The patient's general health was very little, if any, impaired. A moderate amount of fat was present in the abdominal wall. The scar of the former operation indicated by its breadth and thinness that a drainage tube had been employed. On the left side of

[1] Read before the Gynecological Section of the College of Physicians of Philadelphia.

the abdomen, about the level of the umbilicus, could be outlined an area of indistinct fluctuation. The sensation conveyed to the hand was that of a thick fluid in a tense cyst, or the peculiar sensation sometimes designated "fatty fluctuation." Palpation did not cause pain; the patient, however, referred her pain to the area of fluctuation. Vaginal examination disclosed an atrophied uterus, freely movable. As the patient earnestly requested relief and willingly consented to celiotomy, this operation was performed at the Polyclinic. She was placed in the Trendelenburg posture and the abdominal wall opened in the old scar. The intestines were not adherent to the scar. The pelvis was found free from abnormal conditions, the tubes and ovaries having been removed. On inserting the fingers in the direction of the enlargement, the omentum was found to be gathered in a mass at that point and to be largely adherent; this was cautiously pulled down, and as much as could be made accessible by a moderate traction was ligated in several portions and removed. The edges of the old scar were carefully dissected and the abdomen was closed without drainage. The patient suffered from considerable pain for the first three or four days after the operation; this gradually disappeared, and she describes herself at present as relieved of her former distress and in good health. The abdominal wound healed by first intention.

When the abdomen was opened in this case nothing could be seen or felt of the omentum; whether it had been replaced at the time of the first operation cannot be known. It occasionally happens in patients who grow fat either after the menopause, or after the cessation of menstruation following oöphorectomy, that an excessive deposit of fat in the omentum causes distention and abdominal pain. While the condition can scarcely be considered dangerous, the distress which it causes in nervous patients may be so great that celiotomy is earnestly desired for the relief of the condition. A diagnosis of this must be made largely by exclusion, as the sensation conveyed by a mass of omentum is not perfectly characteristic and the nature of the growth cannot always be positively recognized.

The second case reported was that of Mrs. S. R., aged 49 years, who entered the Polyclinic October 30th, 1894, suffering from an abdominal tumor. Her family history was negative. She had had four children and no miscarriages. For nearly a year amenorrhea had been present. For five years previous to

that her menstruation was painful and profuse, for the last three years the flow being almost constant. Pain in the back and in the right side had been complained of, and this had increased during the past two weeks.

On examination the abdomen was seen irregularly enlarged, and on palpation a large, hard, irregular tumor was felt high on the right side of the abdomen and apparently originating from the uterus on the right side of the pelvis. Vaginal examination showed the cervix enlarged. A firm, slightly movable tumor filled the pelvis which could not be separated from the uterus. The patient complained of headache, anorexia, and persistently dry and fissured tongue. Constipation had become obstinate during the past year. On exertion she suffered greatly from dyspnea, palpitation, and precordial pain, at intervals lasting about an hour, and accompanied by dizziness. She had been losing flesh for several months. An examination of the urine showed it to be without pathological ingredients, the amount of urea being 1.4 per cent. The patient desired an operation because of the obstinate pain, which was becoming worse, the rapid failure in general strength and health, and the well-marked pressure symptoms. When the abdomen was opened the tumor was found to be a solid and cystic tumor which had originated in the right ovary, dissecting up the right broad ligament, crowding the uterus down and to the left, forcing the bladder down upon the pelvic floor and toward the patient's right. The pelvis was almost filled with the solid portions of the tumor, which had contracted numerous adhesions. The anatomical landmarks usually found in the pelvis were entirely gone, and the ovarian artery of the right side was greatly elongated upon the surface of the tumor. Between two and three quarts of a thick, dark fluid, resembling the dregs of beef juice, were evacuated. Adhesions were liberated, a pedicle made, and the tumor in large part removed. The solid portion had penetrated the capsule of the tumor, and masses of firm, pinkish-gray tissue were abundant in the pelvis. The abdomen was thoroughly douched with sterile water, a glass drainage tube carried to the bottom of the bed of the tumor and surrounded by iodoform gauze. During her preparation for the operation, and during the latter portion of the operation, the patient vomited a dark, grumous fluid which somewhat resembled the contents of the cyst. She suffered considerably from shock, but reacted under

stimulation and saline transfusion. The wound was redressed nine hours after operation, when free drainage of reddish serum without hemorrhage was found. The patient's temperature, however, rose steadily after the operation, and she died thirty hours after the removal of the tumor, with a temperature of 107½° F. The abdomen remained flat; the patient passed fifteen ounces of urine, and also flatus. She was conscious until a short time before death, and complained of no pain. She had feared cancer, and her first inquiry was regarding the character of the tumor. A post-mortem examination could not be obtained.

The tumor was found to consist of two portions—a solid, pinkish-gray, firm portion which resembled in outline the ovary, but was three times the size of a normal ovary, becoming at one border a cyst; from that portion of the tumor from which the cyst sprang the solid masses already referred to apparently had their origin.

On microscopic examination the structure of the tumor was such that a satisfactory permanent slide could be obtained with great difficulty. Thorough examination of the solid portion of the tumor showed it to be a round-cell, alveolar sarcoma in which the alveoli had dilated and undergone cystic degeneration.

Sarcoma of the ovary is most often met with in young women and in children. A superficial examination of this tumor at the time of its removal showed many resemblances in gross structure to papillomata of the ovary described by Sutton as arising from the paroöphoron. The interior of these tumors is frequently studded with warty growths, which infect the peritoneum. Peritoneal warts are generally soft in structure, bleeding easily upon handling, or else in a condition of calcareous degeneration. Sutton, however, states that papillomatous cysts are sometimes associated with sarcomata. In the tumor in question, although its anatomical situation was that of a papilloma, yet its structure and the clinical history of the case emphasized the malignant character of the growth. The solid portion of the tumor, the enlarged ovary, was firm upon section, and of the pinkish-gray color seen in sarcomatous growths when freshly cut. The metastatic deposits in the connective tissue of the pelvis resembled the enlarged ovary in character, and, while moderately vascular, did not bleed as do peritoneal warts. The fluid contained in the tumor resembled most closely that observed in malignant growths of a cystic nature.

From my first observation of this patient the element of constitutional infection was well marked. Her severe pain, the dry and fissured tongue her attacks of syncope, and the vomiting of dark-colored, grumous matter, resembling the dregs of beef juice, which occurred while preparing her for the operation, pointed to the malignant nature of the disease. No prognosis was given to the patient or her friends, but the statement was made that she was suffering from tumor from which her only relief lay in immediate operation. It is an interesting illustration of the delay to which patients are subjected through the ignorance of medical advisers, that, but a short time before operation, the patient was assured by a graduate of medicine in this city that she had no tumor and that she would soon be well. Her symptoms after the operation were those of profound poisoning without the phenomena of inflammation. The fact that the abdomen remained flat, that the patient passed flatus from the intestine, that a considerable amount of urine was secreted, and that she did not suffer pain, with the free drainage of pinkish serum from the location of the tumor, shows that peritonitis was probably not present. In the absence of a post-mortem examination, it seems reasonable to ascribe her death to the rapid absorption of malignant poison from the metastatic portions of the tumor which it was impossible to entirely remove.

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