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TUMORS OF THE VAGINA,

Considered in the Obstetrical Point of View.

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A CLINICAL LECTURE DELIVERED AT THE SUFFOLK DISPENSARY
ON MARCH 16, 1895,

BY CHARLES GREENE CUMSTON, B. M. S., M. D.,

*Instructor in Clinical Gynæcology, Faculty of Medicine, Tufts' College;
Member of La Société Française d'Electrotherapie de Paris.*



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GENTLEMEN:—Some of you will remember the young married woman who consulted us for a pregnancy, which was about five months along, and who presented a cyst in the posterior wall of the vagina. This cyst was the size of a small walnut, and when I punctured it, after all due antiseptic precautions had been observed, a rather thick, transparent liquid escaped. A simple dry dressing of eorophen and carbolized gauze was all that was required to complete the operation; and, let me say in passing, that I consider eorophen one of the best, if not the best, powders for dressing the vagina after minor or plastic operations that I have ever experimented with, and well worthy of your attention and trial.

I shall take this case, gentlemen, as the text for this lecture, as tumors of the vagina are of considerable importance, especially when the patient is pregnant, on account of difficult or impossible delivery, and I desire to put before you the various growths which may be met with in the birth canal. They may be divided into five groups, as follows: (1) cysts; (2) fibrous tumors and polypus; (3) carcinoma; (4) sarcoma; (4) hæmatoma.

Of all the neoplasms in the vagina complicating pregnancy, cysts are the most common. Their situation, as well as their size, are most varied, while the difficulty of extracting the child during labor is not always in proportion to their volume.

Winckel and von Preuschen have

long since studied the formation and aetiology of cysts of the vagina. Winckel found in fifty cases of cysts, nineteen times the growth was on the anterior wall, fourteen on the posterior, and five times on the lateral walls of the vagina. The same writer relates five cases in which the cysts were present in pregnant women.

In one case it was situated in the last third of the anterior vaginal wall and was about the size of a walnut. The neoplasm was incised, the woman having a normal labor thirty-five weeks later.

In two cases the cysts were the size of chestnuts and were situated on the posterior wall at the entrance of the vagina. They were also incised and labor took place without any complications. Winckel's third case was a IV para, who noticed a discharge of pus from the vagina at the end of pregnancy. The vagina was covered, on both anterior and posterior walls, with small cysts, some of which were shaped like and attained the size of a cherry. Labor took place spontaneously, and, six weeks after, all the cysts had disappeared. In the remaining two cases the two small cysts had likewise no effect on the labor.

Pregnancy complicated by *colpo-hyperplasia cystica* I will pass over, as in this affection the growths are so small as not to interfere with labor. In the Berlin clinic three cases of cysts complicating the progress of labor were observed, and I would like to give them to you in a few words.

CASE I.—Woman, aged twenty-five, I para; menstruated for the

first time at the age of twenty; menses were irregular. On examination, a small pediculated growth, the size of an egg, was found on the posterior vaginal wall. The tumor felt quite elastic, prolapsed when the patient stood up, but returned into the vagina when she sat down. The patient said that she first noticed the tumor at the end of pregnancy, and that it was not painful. At labor, which was spontaneous, the cyst was flattened by the head of the child, but was afterwards perceptible to the touch. The postpartum was uneventful, and thirteen days later, when the patient left the hospital, the cyst was like a flabby, withered sac, but did not prolapse.

CASE II.—Woman, aged thirty-four, III para; menstruation, which was irregular, began at the age of twenty-one. Both preceding labors were normal. On the left side, at the entrance of the vagina, a cyst the size of a hazel-nut was found. The cyst was punctured, giving issue to a serous fluid, and part of the wall removed. Labor occurred several days later, and was uneventful.

CASE III.—Woman, aged twenty-seven, I para. Menses appeared at eighteen; regularly every three weeks. On the right side of the vagina a cyst the size of a fifty-cent piece was found, which, when punctured, gave issue to gas. Labor uneventful.

Other cases are reported in which labor took place spontaneously, or where puncture was performed before labor began. In the French edition of Churchill's work, a case of follicular mucous cyst is reported, which

was situated in the vesico-vaginal septum, directly behind the urethra, and was mistaken for a cystocele. Labor took place without complication, and several days later the cyst was removed by cauterization.

Puech reports a case in which the passage of the foetal head was prevented by a vaginal cyst. This was punctured, resulting in a normal delivery. In a case reported by Morlanne, the cyst had an elongated shape and protruded at the vulva with each pain. It burst spontaneously, and the rest of the labor was normal.

McClintock described, under the name of *cystpolypus*, an elongated tumor embedded in the posterior vaginal wall, but which did not prevent a normal labor. The contents was a gelatinous fluid.

Lever was obliged to puncture a cyst, the volume of a child's head, as the pains were not strong enough to overcome the resistance offered by the tumor. It was situated between the vagina and rectum, its contents being an oily fluid containing a great quantity of cholestearin crystals.

Hardwick has put on record a case of a non-pedicated cyst in the recto-vaginal septum which was greatly stretched by the passage of the head. A pint of clear liquid was removed by puncture, the labor ending without any other complication. I may add that Winckel considers this tumor rather as a hydrocolpocele than a vaginal cyst.

Osterloh has also described a case in which he incised a cyst during labor which ended without any further trouble.

During the post-partum these cysts may suppurate, or, if wounded during the passage of the child, may slough, and thus produce a focus of septic infection leading to dangerous accidents. As an illustration of this, I would mention Huguier's case, in which he punctured a cyst of the vagina. It filled again in two years, and the patient at that time was pregnant. During labor the cyst disappeared, and the patient died eight days later from metro-peritonitis. The autopsy showed a cavity the size of a nut in the vaginal wall, communicating with the vagina by an opening two centimetres in length. Suppuration of the cyst was produced by the traumatism of labor.

I have now given you examples where the neoplasm was no hindrance to birth, but there are cases on record in which, on account of the considerable size of the cyst, the progress of labor was interfered with to such a degree as to lead to serious complications, and without surgical interference the expulsion of the foetus would have been impossible. Peter's case is an excellent example.

A woman, aged 34, IV para, who had always menstruated irregularly and had been confined naturally three times, presented a cyst the size of an orange, occupying almost the entire posterior vaginal wall. The growth was soft to the feel, rather movable backwards. The pains, which were good in quality, were not sufficient to overcome the obstacle and even traction with the forceps could not accomplish delivery. On account of the pressure of the head, the tumor was pushed against the rectum, and

by this the anus was considerably dilated. Profiting by this condition, Peters punctured the cyst per rectum, after which he applied the low forceps and easily delivered a living child. The post-partum was normal. The contents of the cyst consisted of about a pound of yellowish liquid.

Cysts due to the echinococcus are met with in the vagina, although I am not aware that any case has been reported in America. They are usually situated in the para-vaginal tissues, or in Douglas' cul-de-sac. This variety of cyst is not without importance in the obstetrical point of view, as the few cases recorded in medical literature demonstrate.

Gebhardt describes a case in which the anterior pelvic wall was distended by a cyst the size of a fist. The pains with good contractions caused the tumor to burst, and suddenly blood and echinococcus vesicles were expelled per vaginam. High forceps were quickly applied in order to avoid collapsus.

In a case reported by Pauls, the patient was pregnant for the third time; the other two labors had been normal. A trial with the forceps for half an hour was fruitless. When the fetal head was pulled on, a pear-shaped tumor the size of a large walnut appeared, situated on the posterior vaginal wall, and which, if traction with the forceps was stopped, would flatten out and was scarcely visible. Per rectum, the tumor could be distinctly felt, situated in the tissue between the rectum and vagina. By lightly scratching with the fingernail, it was separated from the mucous membrane of the vagina and

underlying tissues and a pedunculated dark-colored tumor the size of a man's foot was brought out. The contents was liquid. A ligature was placed around the base of the tumor and the growth was cut off; the child was easily delivered.

Another case, due to Roux, was that of an echinococcus cyst in the vaginal wall, rendering labor difficult. The cyst had, however, no bad effect on the outcome of the case.

Blot, von Wiener, Park, Porak and Birnbaum have reported cases of echinococcus cysts in the perivaginal tissues, in which various means, such as the forceps, perforation, puncture of the tumor, etc., were necessary in order to bring the child into the world. Although these operations were done before the days of rigorous antisepsis, all the patients recovered, with the exception of von Wiener's case, who died from a rupture of the uterus.

In closing the subject of cysts, I will add two more cases in order to be a little more complete. Under the name of "urethral cyst," Hickinbotham described a large, soft growth, which was situated in the anterior vaginal vault, in front of a hypertrophied cervix, and projected from the vulva. Labor had already commenced and the patient was so exhausted that cephalotripsy was done, delivery being quickly executed. Twelve days after the cyst burst spontaneously, as it had been increasing in size and was painful. It contained a kind of pus. The patient recovered.

Küchenmeister has likewise recorded a similar case under the name

of "urethral cyst." He found a fluctuating point, parallel to the course of the urethra, and quite high up on the anterior vaginal wall. The forceps were removed and the tumor incised, giving issue to about an ounce of pus. The ultimate result is not given.

The prognosis of labor complicated by a vaginal cyst is, on the whole, not bad, especially at the present day, when asepsis can be practiced by every physician. As to the treatment: If you are called to a case already in labor, puncture the cyst, using all precautions, such as a free irrigation of the vagina with a solution of lysol, creolin or permanganate of potassium. On the other hand, if you are consulted for a pregnancy, make *one* æseptic examination of the vagina, in order to ascertain the condition of the pelvic organs, vagina etc., and, if a cyst be found, it should be opened, the contents emptied and the vagina again irrigated and dusted with some antiseptic powder and very lightly packed with gauze.

It was with the view of preventing any future complications during labor, in case the cyst increased in size, a fact that should be remembered, that I performed this simple operation, harmless if aseptically done, very dangerous if not, on the patient who presented herself at my clinic.

As regards fibroid tumors, it may be said that they come next in frequency. Güder gives eighteen cases in his thesis in which they were complicated by pregnancy. In this number he includes polypi.

The fibrous and myomatous tumors

occur as infrequently as cysts, but are a most serious complication in labor. Güder gives the following statistics regarding mother and child in eighteen cases taken from the literature:—

	Lived.	Died.	Result Not Given.
Mother	11	4	3
Child	4	7	7

Fibroid neoplasms occur at any age; and, according to Güder, they were found in larger proportion in I para (eight times in primiparæ, twice in multiparæ). This neoplasm may have its seat at any part of the vagina and is usually noticed after labor has commenced. In some cases the growth was pedunculated, so that it prolapsed from the genital tract, and it was consequently detected during pregnancy. In others its presence was indicated during pregnancy by a profuse white discharge of the vagina. Therapeutics in such cases of obstacle to birth of the child are naturally most varied. The first class of cases are those in which delivery takes place spontaneously, although the growth, on account of its considerable size, obstructs the vaginal canal.

The best known case of this kind is the one reported by Porro, in which quite a large fibro-myoma, situated in the vesico-vaginal septum, obstructed the vagina. Nevertheless, there was a spontaneous delivery, the tumor being expelled before the head, and then remained fixed, so that the child's head came down without any difficulty. On the next day the growth was enucleated; the child was dead, the mother recovered.

When the tumor does not cause an

absolute obstacle to the passage of the foetus, the latter may be delivered with the forceps, as is illustrated by the following cases: Gensoul, in a case of vaginal polypus weighing 22 ounces, applied the forceps and delivered both tumor and child.

In a case reported by Fischer, a fibroid tumor the size of a hazel-nut was the cause of obstruction, and the forceps were applied to overcome it. The neoplasm then became larger and the patient again became pregnant, and when seven months along it was extirpated, resulting in a normal labor at term.

There are other cases on record where delivery did not go so easily, both mother and child dying on account of the severe lesions inflicted. Virchow describes a retrovaginal tumor nearly the size of a grape-fruit. During labor, forcible delivery was attempted, resulting in a rupture of the vagina and fracture of the descending branches of the pubis, with death of the mother four weeks later.

Three cases are reported in which natural delivery could not take place and Cæsarean section was performed. In one of these cases the growth was fibro-cartilaginous; its situation is not given. In another the woman died twenty hours after from collapse. In all three cases the children were dead.

It is easily seen from what I have said that fibroid tumors are a most dangerous obstacle to the progress of labor, especially so if the neoplasm be large or immovable; or if, in a case of an immovable growth, labor has considerably progressed, so that one cannot replace or even remove it.

The treatment in cases of fibroids complicating pregnancy is, of course, subjected to the circumstances. If you should see your case during pregnancy I would advise you to remove the growth, especially when it is large, for my experience has been that surgical operations on the external genital organs or vagina of a pregnant woman are rarely followed by any complications or premature labor; but if proper antisepsis is not carried out there is great danger, and in proof of this I may mention McClintock's case, which was as follows: He removed, by the *ecraseur*, a fibroid polypus the size of a small egg, situated on the posterior vaginal wall. The patient was delivered two weeks later, died thirty-four hours after from septicæmia.

We now come to carcinoma of the vagina, which is a very rare affection, and still more so when complicated with pregnancy. There is, however, no doubt that this neoplasm may primarily attack the vagina—and considerable valuable evidence has been recently given by Hect.

One reason for the rarity of pregnancy when carcinoma is present is that coitus is painful or the tumor is an obstacle to the act. Another is that the secretions from the neoplasm appear to kill the spermatozoid; and, lastly, the affection is one usually occurring at an age when the woman is past the fertile period of life. However, this is not always the case, as Coley has reported a case of a woman of twenty-one, and Oliver one of a patient twenty-six, who were pregnant and had a cancer of the genital organs.

Carcinoma of the vagina, involving the external genitals or the portio vaginalis, is the most common form, the disease usually attacking the vulva and then invading the vagina.

In such cases pregnancy seldom remains undisturbed, for often the symptoms soon appear which bring to notice a disease of the genital tract. Either the patient complains of lancinating pains, or an exceedingly foetid discharge, tinged with blood, will appear, and later on hæmorrhages of considerable gravity and carcinomatous cachexia show only too well the real nature of the trouble. There is one early symptom of carcinoma of the genital organs that I consider of greatest diagnostic value, and which was well illustrated in the case I showed you a few days ago, and that is a *profuse and nearly odorless watery discharge*. You will remember that the patient in question only complained of this symptom, which was rendered slightly bloody by coitus, and that on examination I showed you through the speculum that the cervix was well invaded by the neoplasm.

As in fibroids, the course of labor will be very different in different cases, always according to the extent and malignancy of the tumor. If the neoplasm is small, and consequently not advanced, spontaneous delivery of the child occurs, as in the cases reported by Bailly and Schelle. This is, however, unusual, as labor is the most often difficult, and sometimes is even impossible *per vias naturalis*.

I will give you in a few words some cases taken from the literature

as illustrations. In two cases perforation was necessary. In the first case premature labor was induced and perforation had to be done on the dead foetus. Welponer applied the forceps in his case, whereby he delivered a living child, resulting in a rectovaginal tear, the mother dying twelve days after from sepsis. In a case reported by Olshausen he induced premature labor, while in another he first removed the carcinomatous mass with the sharp spoon and then induced premature labor. Haine extracted a living child by laparo-elytrotomy from a woman who had a perforation of the rectum due to the extension of the carcinoma, the vagina being narrowed to only a small opening.

Cæsarean section has been performed in cases of carcinoma four times to my knowledge. Leopold did Porro's operation, saving both mother and child, on account of a primary carcinoma of the vagina that was well advanced; while Cooke, in his case, did a Cæsarean section and saved the mother. In two other bad cases both mothers died, but both children were saved.

The prognosis of carcinoma complicating pregnancy or labor is very bad. Most of the patients have died in the two weeks following delivery, by sepsis, metastasis or exhaustion. For the child it is a bit better, the mortality being, generally speaking, about 65 per cent.

Surgical measures in this affection are of little value, as the affection appears to be hastened in its progress by the pregnant state, and consequently when the disease is discov-

ered it is generally too late to interfere. There is one local application that has a certain value in cancer of the genital organs, in that it renders the secretions odorless, prevents hæmorrhage to a considerable extent, and has a power to clean up the ulcerated surfaces. This is *terebene*. It should be diluted one-half its bulk with glycerine, and the mixture is applied by means of the tampon. By its use I have seen some really wonderful results in inoperable cases.

Sarcoma of the vagina is still more infrequent than carcinoma, and I am only aware of one case in which the affection was complicated by pregnancy — that reported by Bajardi. The patient, a I para, aged 25, had always been in good health. The neoplasm, which was situated far back on the posterior vaginal wall, had attained a considerable volume when the patient was eight months pregnant. The tumor was removed by the thermocautery snare and labor soon took place. The patient died a year later from a return of the growth.

In such cases, where obstruction at labor from the size of the tumor is forseen, operative interference during pregnancy is absolutely indicated in order to save the child. The chances for the mother by a radical operation are so small, as the neoplasm is sure to return, that a capital operation is out of the question.

Hæmatoma of the vagina is not often observed, although this tumor is often met with on the external genitals, extending more or less up

into the birth canal. Its formation before labor, and as an obstacle to the act, are also infrequent in occurrence, but many cases are reported where hæmatoma was a post-partum complication.

Reich speaks of a case of a pediculated hæmatoma of the vagina which was found during pregnancy. A profuse hæmorrhage occurred on account of a too great effort that the patient made. The tumor was opened and the sack put back into the vagina. Labor came about four weeks later, the tumor being then only a small nodule in the vaginal wall.

Schneider and Vogler have each reported a case of pregnancy which was complicated by a vaginal hæmatoma, and interference was necessary. Vogler applied the forceps, withdrawing a dead child; Schneider opened the tumor and quickly terminated labor. Perregaux opened a hæmatoma of the vulva which extended into the vagina, and then stuffed the cavity with iodoform gauze; the child was born on the same day without any complication before or after birth.

The prognosis of hæmatoma, in general, is not very good. According to Deneux, 22 patients died out of 62 cases of the affection, while for the children 41 survived.

As to treatment, open the tumor as soon as discovered, with great aseptic precaution, gently curette the interior of the sack with the dull spoon and pack the cavity with iodoform or eucrophen gauze.

