Laidley, (L. H.)

"COMPLIMENTS OF THE AUTHOR. FOR REVIEW."

Papillomatous Cystic Tumor of Ovary,

With a Hernial Pouch Developed in the Cicatrix of the Abdominal Wound from a Former Ovariotomy.

BY

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PROFESSOR OF GYNECOLOGY BEAUMONT MEDICAL COLLEGE; SURGEON TO PROTESTANT HOSPITAL; CONSULTANT TO ST. LOUIS FEMALE HOSPITAL.

Read before the St. Louis Medical Society, March 10, 1888.

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PAPILLOMATOUS CYSTIC TUMOR OF OVARY, WITH A HERNIAL POUCH DEVELOPED IN THE CICATRIX OF THE ABDOMINAL WOUND FROM A FORMER OVARIOTOMY.

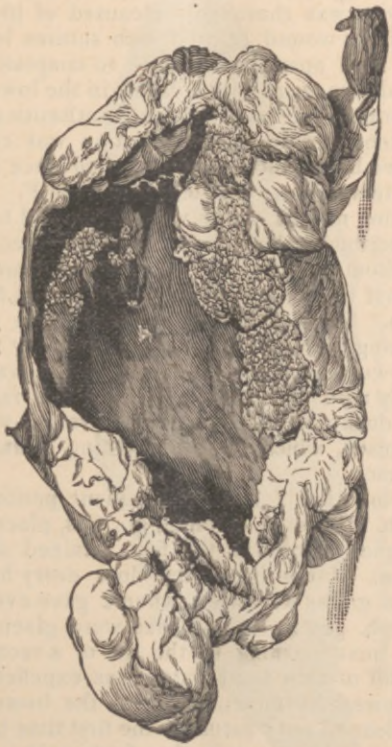
Mrs. C., æt. 39, American, married, had one child which is now eight years old, gave the following history: She was of healthy parents, menstruated at 14 years, was a healthy girl, married at 22. Eight years ago she had an ovarian tumor removed from the left side (it was a large, multilocular, benign ovarian tumor). One year after the operation she was delivered of a child at full term. The recent operation and the pregnancy developed a large hernial pouch, which allowed the bowels to protrude, forming a tumor as large as a child's head at full period. No instrument could be made to keep the hernia in position, and for the past two years she was confined to the house. Eleven months prior to my first visit another tumor made its appearance, beginning in the right iliac region; it developed rapidly, occupying a position on the right side which could readily be felt through the hernial sac. Five months after its first appearance a "magnetic doctor" was allowed to treat the case, which he did by "the laying on of hands," in this case rather roughly, as the results will show. This doctor claimed "to coax the fluid out through the Fallopian tubes." When the tumor was pressed upon the patient noticed a great rush of water with blood from the vagina. This was repeated some time afterwards with the same results, the tumor almost disappearing.

I was called last November, and found a deplorable state of general health; anæmic, appetite poor,

and patient so weak that she could not go from her chair to the bed without considerable fatigue. She had a distinct mitral bruit, weak and rapid pulse, temperature 100° F. I continued to visit her for one month, feeding and administering medicines to build her up. She urged an early operation. An examination of the abdomen revealed a tumor in the right iliac region as large as the head of a child at full period, which was fluctuating, movable, and easily defined by percussion. The uterus was plainly felt through the hernial pouch, separate from the tumor. Change of position did not influence its shape. No œdema of lower extremities, nor abdominal dropsy. Examination *per vaginam* showed a violent vaginitis with an opening through the floor of Douglas' cul-de-sac, which allowed the passage of a sound in the direction of the base of the tumor. A fluid escaped through the opening; pressure on the tumor increased the flow. That which escaped was white in color and mixed with blood. The amount of flow a day was estimated by the patient to be one pint. Diagnosis: Cystic tumor of right ovary, probably uniocular, with fistulous opening into vagina.

An operation was performed December 6, with every antiseptic precaution, assisted by Profs. Coles and Graves, and members of the senior class of the Beaumont Hospital Medical College. An elliptic incision was made over the site of the tumor at least seven inches in length, the tumor exposed and the fluid drawn off, which was the same that flowed from the opening into the vagina. There was only one adhesion to the tumor; that of the extremity of the appendix vermiformis. This was torn off with the finger nail, and the end cauterized, completely controlling hæmorrhage. (Greig Smith reports his having to remove the entire organ without serious results.) The tumor was lifted from its broad base, which was transfixed at its attachments to the floor of the pelvis, the ligature tied, and all that remained

of the sac charred with a hot iron. Another ligature was placed below, and entirely around the pedicle, so as to close any opening that might exist with the fistula leading to the vagina.



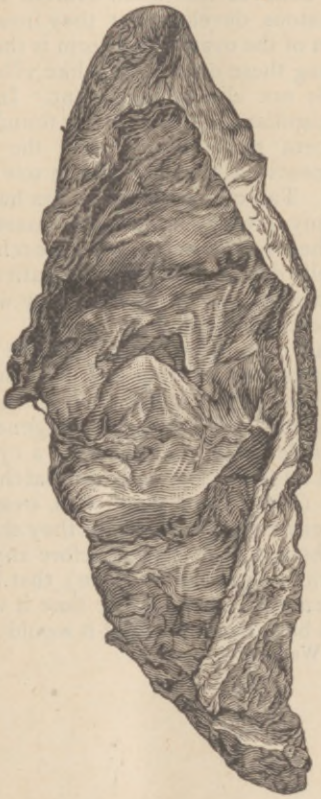
Papillomatous cystic tumor of ovary.

Attention was now given to the hernial sac. Before operating the line of incision was mapped out with iodine so as to remove all the pouch, and at the same time be able to approximate the walls. The

measurements before operation were seven inches by four and a half inches; a portion of the mesentery was attached to the cicatrix of the old wound, and it was ligated, cut and returned to the abdomen. The cavity was thoroughly cleansed of blood, the edges of the wound (closed with sutures less than one-half inch apart) were made to coaptate accurately, a drainage-tube was placed in the lower angle of the wound, the parts dressed antiseptically, and the patient put to bed. Reaction was complete within two hours, and for the first time since November her temperature was less than 100° F. A most aggravating nausea, which would not yield to any of the prescribed remedies, necessitated feeding per rectum from the first day. The temperature range for the first twenty-four hours was 99° to 99.8°, pulse 72 to 80. She did not sleep more than one-half hour during the night. On the second day the temperature continued less than 100° until 9 P.M., when it rapidly rose to 103.8°; the pulse was rapid and weak, a dusky hue of the face was present with constant nausea, which forbad anything remaining in the stomach.

Believing that I had an incipient peritonitis to deal with, I ordered calomel, grs. ijss, placed upon the tongue, which was the first retained since the operation. I continued the dose every half hour until ten grains was used, when I gave every hour mag. sulph. grs. xx—two doses were given. At 2 A.M. the next morning, by the use of a rectal tube, a half pint of thin fecal matter was expelled, which was followed by an enema, and the bowels thoroughly cleaned out; flatus for the first time began to pass; the patient became free from pain and slept for six hours. The temperature went down to 99.6°. From this time she retained food, and showed nothing unusual in the progress of the case. On the seventh day the stitches were all removed (the tube having been removed on the fifth day) showing the

walls had united by first intention. A well-fitting truss, made from the cast of the abdomen, was adjusted four weeks later, which allowed the patient to go about the room with comfort. Examined three



Hernial pouch, showing the shallow secondary pouches in the peritoneum.

months later, she was much improved in health, the fistulous opening into the vagina had closed, and

the operation had proven entirely satisfactory. I submitted the tumor for examination to Dr. Adolf Alt, who said it was of the papillomatous form.

Coblenz believes that when ovarian tumors show a papillomatous development they invariably arise at the hilum of the ovary; this form is the most common affecting these organs, and like villous growths elsewhere is not always malignant. In the malignant form papillary growths will be found in patches upon adjacent structures, or else the womb and broad ligaments are also involved in one cauliflower-like tumor. Tait observes that he has had two cases of ovariotomy in which he left large masses of papilloma attached to the womb, yet in each case these masses wholly disappeared and the patients are both in perfect health. If this is true, may we not hope that this specimen is a benign tumor?

This tumor was roughly handled five months before the operation, causing the fistulous opening. May we not conclude, if it is true, as Tait and Bantock claim, that tapping hastens degeneration, and after an accidental rupture of such a cyst the peritoneum will be found studded with patches of papillary cancer (hence they argue that ovarian tumors should never be tapped and that they should be removed in their earliest stages before any malignant transformations have taken place), that had this tumor been removed entire at the time it was injured, there would be no question that it would not return?

Grand and Washington Aves.