SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class).

I.

Unilateral Hæmatometra of Long Standing Forming a Large Abdominal Cyst.

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THE patient, who was aged 41, was admitted to Guy's Hospital November 6, 1906, on account of an abdominal tumour with acute pain.

The *history* obtainable at the time was very scanty. She had been married for 15 months, and in February, 1906, was said to have had a miscarriage. She had been ill for rather more than a week before admission, and the tumour in the abdomen had been discovered for the first time during this illness. The diagnosis made before admission was one of ovarian tumour with twisted pedicle.

On admission, the patient looked ill, had a temperature of $100\cdot2^{\circ}$, and complained of abdominal pain. The abdomen was held rigid, and was tender on palpation. A tumour, which was elastic and yielded fluctuation, occupied the lower half of the abdomen, reaching to a little above the umbilicus. On vaginal examination the tumour bulged low down in Douglas's pouch. It presented no mobility, either on abdominal or bimanual examination. She was unable to pass her water. I hesitated about confirming the diagnosis of ovarian cyst with twisted pedicle owing to the shape and fixity of the tumour. It bulged down into the pelvis like a broad ligament cyst or an encysted peritoneal collection of fluid. The history obtainable at that time was meagre, and I thought of the possibility of an extrauterine gestation, though I could feel nothing like a foetus in the tumour. I operated the morning after admission.

Operation. An incision was made in the median line. The bladder was found to be drawn high up and to contain urine. This was withdrawn by catheter, and the bladder pushed down out of the way. Filling the lower half of the abdomen was a large cyst, with a wall discoloured by blood, and similar to that seen in the case of an

ovarian cyst with twisted pedicle and extravasation of blood into its interior. The cyst had no pedicle, and was seated largely in the cellular tissue, being covered by peritoneum on its upper and anterior surfaces only.

In its growth it had expanded the meso-sigmoid, so that the sigmoid flexure was applied tightly to the front of the cyst. I thought that I had to deal with a broad ligament cyst. A trochar and cannula were inserted and the contents, which consisted of dark altered blood, were withdrawn. The wall of the cyst was thick and did not collapse. The opening into it was enlarged and the interior washed out with normal saline solution. It was then found to be a unilocular cyst with thick walls. The peritoneum could not be peeled off it, and removal of the tumour appeared to be impossible without resection of the sigmoid flexure. The uterus had previously been seen low down and closely applied to the anterior surface. Further examination now shewed that what was taken to be the body of the uterus was one horn only of a bicornute uterus, and from this proceeded the right Fallopian tube which was stretched out over the surface of the cyst. The cervix was flattened and broad, the right half continuous with the right cornu, the left half spreading out fanwise over the surface of the cyst. No signs of left Fallopian tube could be seen. There seemed to be no doubt that the cyst had resulted from the dilatation of the left horn of a bicornute uterus, and it is possible that the left Fallopian tube shared in the distension. It appeared that much difficulty would attend the removal of the tumour which was found embedded in the cellular tissue, and that resection of bowel would be required in dealing with the loop of sigmoid that was drawn over its surface. From the nature of the tumour it appeared probable that the most satisfactory way of dealing with it would be by drainage. The abdominal wound being closed temporarily the patient was placed in the lithotomy position, and an opening was made through the posterior fornix into the interior of the cyst and a gauze plug inserted. The vaginal portion of the cervix was small and no communication was found between the canal and the distended horn.

The abdominal opening into the cyst was then carefully sutured and the abdominal wound closed.

Subsequent course. The temperature fell after the operation from 100·6° to 97°, but rose again quickly, and the day following had reached 101°. This temperature persisted till December 6th, the daily variations being as a rule from 99° to 101°. The opening into the vagina was enlarged and the sac washed out on two occasions without affecting appreciably the temperature. The tumour diminished gradually in size, and the discharge had ceased before the patient left the hospital on December 30th.

I saw her again on January 27th, 1907. I was surprised to find

that all trace of the cyst had disappeared. The uterus was freely movable and there was no thickening to be felt around it. As the cyst contracted it had settled down on to the right horn and the only thing that could be felt was a uterus that was rather broader than usual. The drainage opening was represented by a depression which appeared to be on the cervix itself.

On December 6th of the same year I found the condition practically unchanged. The depression due to the drainage opening was no longer obvious on vaginal examination. The cervix presented nothing unusual except that it was a little thicker than the normal. The body remained broader than usual and a trifle uneven. The periods had recurred, but latterly had been a little irregular, the last one being overdue. There had been no pain except a little at the periods.

After her recovery the patient kindly supplied me with the following *history* in answer to certain questions of mine:—

(1) "The periods were always free from pain, but about two years before the operation they began to come more frequently—once in three weeks, or sometimes more often than that. The stoutness of the abdomen was an old trouble. I can remember my mother complaining about it before I was twenty years of age, but of course it was only at the last that it became so noticeable.

(2) "I was only two months gone when I thought I had a slight miscarriage (in February, 1906).

(3) "The stoutness of the abdomen certainly increased more rapidly from February, 1906, to November last. I think I had the tumour for a good many years, and for this reason: For many years—quite fifteen—I suffered from great weakness of the body. The back passage would not keep in place. If I stood for a little while or walked a short distance the rectum used to drop down and it was necessary to push it back or it would bleed profusely. I used to lose large quantities of blood from this cause." She goes on to say that since the operation the bowel does not come down, and she attributes the trouble to piles due to the pressure of the tumour.

(4) "I sought medical advice on November 1st, 1906, because I had acute pain in the abdomen and great difficulty in passing urine, also a high temperature."

(5) And, lastly, she has been regular since the operation.

I think no doubt can exist as to the nature of the swelling. The one horn and Fallopian tube being present and the spreading out of the left half of the cervix or perhaps lower part of body on to the cyst wall point to it as being a dilated left horn with possibly dilatation of the corresponding Fallopian tube.

The most interesting feature is the age at which it was first detected. The patient was 41 when admitted to hospital and the swelling had been discovered only within the week previous to

admission. She had, however, noticed herself getting stouter since the February preceding, when she appears to have had a miscarriage. We have, further, her statement that as a young woman of twenty her mother mentioned the stoutness of her abdomen. It does not appear that between twenty and forty years of age there was any very appreciable increase in size. It is difficult to know what stress to lay on the different stages in her history, but it seems reasonable to assume that the distension of the horn commenced with menstruation and became obvious about the age of twenty. We must assume then that the amount subsequently poured out was very small in amount, or that owing to pressure the endometrium was so altered that secretion ceased. I regret that I did not remove part of the wall of the cyst for examination. It was only after the miscarriage in February that she began to grow stouter. This at first raised the question of an extrauterine or cornual pregnancy. The history of miscarriage was not conclusive and what she passed might have been a decidua. There was, however, present no sign of foetus or products of conception. Moreover, the nature of the swelling pointed to slow distension. The cyst was largely extraperitoneal, the distended cornu having pushed up the peritoneum, obliterating both broad ligaments and spreading out the meso-sigmoid.

Why the swelling increased after the February miscarriage is not clear, unless the pregnancy, by causing congestion, brought about fresh hæmorrhage into the interior.

The pain and rise of temperature of the last week was no doubt due to infection of the contents, the temperature persisting in spite of the drainage and washing out for some weeks.

An interesting feature is the subsequent return of the parts to a condition but little distinguishable from the normal. The sac contracted with great rapidity on to the uterus, and two months later nothing was to be felt of the inflamed thick-walled cyst outside the uterus, the horn having again returned to something like its original condition. All that was felt was a broad, somewhat uneven uterus, such as one might expect to find in a bicornute uterus. Although menstruation persisted, there was no evidence in eleven months' time that any recurrence was taking place.