A CASE OF TUBO-OVARIAN CYST.

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[Read in the Section of Obstetrics.]

I DESIRE to express my gratitude and indebtedness to the Master of the Rotunda for kindly allowing me to perform this and many other major operations in the hospital and for sanctioning my reading this paper on the subject of one of them.

The specimen which I show was removed from a woman whose abdomen I opened with the primary object of performing a ventral fixation for the cure of an old-standing retroversion of the uterus. I bring the specimen before the Academy for the reason that recorded cases of true tubo-ovarian cysts are distinctly rare, however many may be seen by the gynæcologist.

The patient is aged thirty-six. She has been pregnant ten times and went on to full time pregnancy in seven of these. The three other pregnancies all terminated at about the third month.

She complained when I first saw her, in the dispensary, of a feeling of weight in the pelvis, with pain in the lumbar and sacral regions of the back. Her menstruation was irregular, the duration three to five days, and the amount not excessive. Occasionally the pain during menstruation was extreme. She had a constant leucorrhœal discharge, which was never on any occasion watery.

On vaginal examination the uterus was found to be retroverted and held back by numerous adhesions. The posterior ligaments were exceedingly tender. When the patient was anæsthetised there was felt, lying high up and to the right of the uterus and somewhat posterior to it, what was diagnosed to be a distended and tortuous tube. Her temperature during the few days that she was under observation in hospital previous to operation

showed no variation at all from the normal, nor was there any acute pain during this time.

The diagnosis made was retroversion, with adhesions and a distended right tube.

On 16th February I opened the abdomen by a transverse incision in the skin and fascia, the recti being separated and the peritoneum divided longitudinally, after the method which the Master (Dr. E. H. Tweedy) has described in his paper.* The uterus was found to be retroverted and held back by numerous adhesions, during the breaking down of which there was smart hæmorrhage. This specimen, which I show, was found to be the left ovary and tube, much distended, as you see. The tube as it left the uterus was coiled and twisted on to the posterior surface of the uterus, and lay with its ovary in greater part to the right side of the uterus. Numerous and firm adhesions were broken down during the removal.

As you will observe on examining the specimen the tube is tortuous and distended, while its fimbriated end looks upwards. About the juncture of the outer and middle thirds of the tube you will observe there exists a direct communication between this distended portion and the cystic portion of the ovary. The uterine third of the tube you see shows no distention at all. The cystic portion of the ovary lies entirely between the folds of the broad ligament, and doubtless by pressure on the wall of the tube has gradually forced a communication—or, as is described as more common, the primary condition may have been a sactosalpinx. The condition with which we may confound it—and indeed, apart from tubo-ovarian abscess, the only one—is ovarian hydrocele. This last condition, however, leads to little, if any, distention of the tube. In it the communication exists between the abdominal end of the tube and the ovarian sac, and, further, there is frequently an intermitting discharge of fluid from the tube and so from the uterus. The discharge I made particular inquiries about, and could get no history of its occurrence

* See page 255, *ante*.

at all. In tubo-ovarian cysts there is usually some pre-existing salpingitis, as there would seem from the numerous adhesions to have been in this case, while in ovarian hydrocele no such condition exists.

The specimen was carefully examined by Dr. Neville, the pathologist of the hospital, and he is of opinion that it is distinctly a tubo-ovarian cyst.

After removing the specimen I show, I fixed the uterus to the anterior abdominal wall, according to the method described by Kelly.

The convalescence of the patient was quite uneventful. I have seen her recently, three months after operation, and she is perfectly comfortable, being quite relieved of all her symptoms.