

NOTES ON A CASE OF VESICULAR MOLE.

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L. D., single, aged 24, was always regular and normal in her menstruation. Early in July, 1902, she menstruated as usual. About a month later she incurred the risk of pregnancy, and the period then due did not appear. There was amenorrhœa up to the 9th October, when she was probably nine weeks pregnant. On this date profuse loss from the vagina commenced, and lasted five or six days. Again on the 23rd October there was a profuse loss. She had been to the Soho Hospital to ask what was wrong with her, and shortly after leaving the hospital she had so profuse a loss in the street that she was brought to the Royal Free Hospital, and was at once admitted.

On admission patient looked ill, was somewhat collapsed, and was passing medium-sized clots. There was in the abdomen a central elastic tumour reaching as high as the umbilicus; it was freely movable from side to side. The linea fusca was well marked.

Per Vaginam. The vagina was hot and moist; pulsating arteries could be felt in the vault. The cervix uteri was soft; the os uteri was closed. On bimanual examination the abdominal tumour was ascertained to be the uterus, continuous with, and moving with, the cervix.

The breasts showed a slight increase of pigmentation round the nipple; no secretion could be obtained by pressure. None of the certain signs of pregnancy were present, although the size of the uterine tumour corresponded to a pregnancy of at least five completed months. The uterus was uniformly hard, and neither on admission nor after, until the 10th November, was there any "alternate contraction and relaxation." No foetal movements were felt, no foetal heart was heard, no ballottement could be obtained. As to the symptoms, from the beginning of October there had been sickness, especially in the mornings. Hæmorrhage from the 9th to the 15th October recurring on the 23rd.

The patient was admitted with profuse loss and slight collapse; the pulse rate was rapid, and maintained an average of about 120, varying from 100 to 130. The temperature was irregular, but within small limits, varying from 97° to 99°, and only once touching 101°. The general condition was not satisfactory. The patient was drowsy, nauseated, and constipated. She had abdominal pain at times,

Blood-clot.

Vesicular villus.

Langhans' layer.

Syncytium.

Mass of Langhans' cells.

Syncytial bud.



referred to the region about the anterior superior spinous process of the right ilium.

Several diagnoses were suggested, no one of which could be made definitely. It appeared clear that the patient was pregnant; the nine weeks' amenorrhœa, the morning sickness, the mammary signs, and the enlarged uterus all concurred to make this diagnosis reasonable. It was, however, difficult to say whether the pregnancy was of nine or of twenty weeks' duration. The history pointed to the former, and the size of the uterus to the latter. On the whole the comparatively slight mammary development and the very moderate softening of the cervix inclined the balance of probability to the shorter period. How, then, could we account for the size of the uterus? It was suggested:—

1. That the pregnancy was really of at least 20 weeks' duration, but that the foetus was dead, and that miscarriage was in progress. This theory tallied with the physical signs and with the absence of foetal movements and heart sounds. The absence of ballottement and the hardness of the uterus could be explained by rupture of the membranes having possibly occurred before the patient's admission; but the absence of alternate contraction and relaxation was not so easy of solution.

2. *Abnormal Pregnancy.*

- (a) *A Carneous Mole.* This, as the only condition present, was very improbable, the size of the uterus greatly exceeding that likely to be associated with a carneous mole.

- (b) *Vesicular Mole.* In favour of this theory was the discrepancy between the alleged and the apparent duration of pregnancy; but against it were:

1. The uniform and unvarying hardness of the uterus, which was never detected in a doughy or soft condition.

2. The discharge consisting of blood and clots, without any watery or pink discharge, and the absence of the characteristic vesicles. The discharge of vesicles is far from being a constant sign in cases of vesicular mole, but their absence was an additional reason for discrediting the diagnosis.

Extra uterine gestation was mentioned only to be excluded. The history of the case suggested a nine weeks' ectopic gestation with rupture, or tubal abortion; but the physical signs were entirely against this diagnosis.

3. *Pregnancy complicated with Fibroid.* This theory explained the co-existence of a tumour representing a pregnancy of 20 weeks' duration with a history of nine weeks, and an absence of those signs

of gestation which become available only after the first four months. The uniform and persistent hardness was exactly such as one finds in a fibroid uterus containing an early ovum. The hæmorrhages might well have been caused by the increased blood supply, normal in gestation, and by the changes in the mucous membrane that occur early in pregnancy. The discharge was slightly offensive, and this, with the mildly septic state of the patient, suggested retention and decomposition, such as might occur in a uterus in whose cavity there was a want of symmetry.

On the 10th November, 32 days after the first hæmorrhage, it was noted that the uterus, which had grown considerably since admission, had become soft and doughy, that there were alternate contractions and relaxations, that the cervix was softer, and that its canal was dilating. It was evident that an effort was being made to expel the contents of the uterus. These conditions developed during the day, and between 5 and 12 p.m. there was a gradual expulsion of a vesicular mole. The diagnosis was now clear as to the nature of the central abdominal tumour, but the interest of the case was well maintained by the results of an examination made next day. The uterus was found smaller, the fundus reaching to a point about midway between the pubes and umbilicus. To the right of the uterus there was an independent tumour about the size of a large lemon. Its surface was smooth, but not even. It was tender on palpation, and was the seat of pain, apparently the same pain which the patient had before referred to the neighbourhood of the right superior iliac spine. In the left side of the abdomen, immediately above Poupart's ligament, was an ill-defined sense of resistance, and the uterus appeared inclined rather to the left of the middle line.

Per vaginam and *per rectum*, the tumour on the right side could be felt, but not so well as by the abdomen. In the left fornix a mass was distinctly felt. It was not so large as the mass on the right side, and it was lower—a pelvic, and not an abdominal tumour. The diagnosis of the tumour seemed to lie between a dilated tube and an enlarged ovary. The shape suggested a distended tube, but the high position and independent movement of the tumour were like a cystic ovary, and not like a distended tube (which usually lies low in the pelvis and behind the uterus). The low-lying mass on the left side was thought to be an enlarged and distended tube coiled round the ovary. Both masses were tender and painful. The patient's condition was still not satisfactory, the pulse rate being about 110 to 120, and the temperature was rather unsteady. The pathologist's report on the vesicular mole was as follows :—

Macroscopic Examination. The mole consists of masses of blood clot, in which are embedded vesicles of various size, the largest not exceeding that of a small pea. There are also clumps of vesicles floating free, consisting of beaded dilatations of individual villous stalks.

Microscopic Examination. In the section are seen numbers of swollen chorionic villi, masses of cells, and clot. The stroma of the villi is in most cases almost structureless, and the blood vessels have disappeared. Where any structure is preserved it resembles that of embryonic connective tissue. In some villi both Langhans' layer and syncytium, and in others again the syncytium is so flattened by pressure as to be scarcely recognisable. The masses of cells are probably derived from Langhans' layer. Their outline is distinct, protoplasm stains deeply with eosin, nuclei oval and stain deeply.

The questions now arose, What was best for the patient?

1. What was the nature of her tumours?
2. Should she be submitted to abdominal section or not?

The tumour of the right side was probably a cystic ovary, that on the left might be of the same nature, but was more likely to be a diseased tube. In that case it was possible that it was a gonorrhœal pyosalpinx, an extrauterine foetation, or that it contained some deposit in connection with the recent vesicular molar pregnancy. It was therefore determined to open the abdomen. The tumour to the right of the uterus was found to be a multilocular cyst of the ovary, about the size of a large lemon. The growth on the left side was similar in nature, but was closely bound down by adhesions. The uterus itself was flabby, large for the time (17 days) after delivery. It was determined to remove it, partly because a uterus without its appendages is a functionless organ, and no advantage to the woman, partly because it had contained a vesicular mole, and remained in a state of sub-involution; it might be a source of danger by developing new growth. It would not have been right to remove a uterus simply because it had contained a vesicular mole, and might therefore possibly develop malignant disease of the placental site, but it was right to remove such a uterus when the appendages were so diseased as to demand their ablation. It is only necessary to add that the patient made a rapid convalescence.

Placental Site of Vesicular Mole. There is a firm, fleshy mass on the posterior wall of the uterus raised above the general level of the surface. Out of the many sections cut only one showed traces of the vesicular mole in the shape of a dropsical villus and some masses of

cells resembling in all respects those seen in the sections of the mole. Other sections showed only an ordinary placental site.

The chief points of interest in this case were:—

1. The difficulty of diagnosis due chiefly to the great and persistent hardness of the uterus.

2. The association of bilateral ovarian cystomata with the pregnancy.

3. The reminder given of the possible association of vesicular mole with subsequent malignant disease of the placenta site.

The present case proves nothing, because the uterus was removed soon after parturition.

The diagrams and the pathological report are due to the assistant pathologist at the Royal Free Hospital.