

A Case of Primary Carcinoma of the Female Urethra.

By JOHN S. FAIRBAIRN, M.A., B.M. (Oxon.),
*Obstetric Physician, with charge of Out-patients, St. Thomas's
Hospital.*

IN view of the case recorded by Dr. Beckwith Whitehouse (p. 269 of this number of the JOURNAL) and his discussion of the subject, I have thought it a suitable occasion to record a case of like character which occurred in my hospital practice five years ago.

The patient was a married woman, of 34, who had had two children, the last three years before her admission to St. Thomas's Hospital on April 17 1906. She had only noticed symptoms of her trouble for about three weeks; at first some difficulty in micturition, which rapidly increased until four days before admission, when complete retention occurred and persisted till she was relieved by the passage of a catheter in the Hospital. The bladder reached to the umbilicus and contained three pints of very dark urine. The urethral orifice was the centre of a small sloughy crateriform growth, which, on examination, with a finger in the vagina, appeared to involve the urethra and extend to the neck of the bladder. The hard indurated growth was not fixed and the tissues round not involved, and no glands were detected in the inguinal region or in the pelvis. The passage of the catheter was not easy and gave rise to great pain; the difficulty appeared to be in finding the urethral canal in the base of the ulcer in the vestibule. The catheter was passed three times a day, and on each occasion the urine drawn off was of dark-red colour and towards the end mixed with blood. The deposit, examined microscopically, consisted of pus and red blood cells.

On April 19, the patient was anæsthetized with a view to operation. The growth was small, consisting only of an indurated breaking down ulcer at the site of the meatus, not large enough to admit the tip of the little finger, and, though the induration could be felt surrounding the urethra upwards, the tissues round were soft and without evidence of infiltration. The complete retention and the pain with each passage of the catheter made it essential that something was done, and the small size of the growth and the freedom of the tissues round it, appeared to offer a fair prospect of complete extirpation. An incision was made round the growth and the dissection carried up, outside the infiltrated tissues, to the neck of the bladder. It was then discovered that the indurated area extended up to and involved the urethral orifice of the bladder, so that the whole length of the urethra had to be removed, leaving an opening into the bladder which admitted the index finger. The bladder was washed out and its walls stitched to the cut edge of the vulval mucous

membrane. A rubber tube was inserted into the bladder and the wound packed round with gauze. The growth was examined in the Clinical Laboratory and returned as squamous-celled carcinoma (Dr. Dudgeon).

The patient was given boracic baths twice a day, and, except for some local swelling and some trouble from phosphatic deposits on the edges of the wound, she made a good recovery, and was discharged from the hospital on May 19, wearing a rubber urinal.

She was re-admitted on June 12 because of a painful swelling in the right groin. This was found to be a breaking down gland, and as enlarged glands could be felt in the left groin also, the glands in both groins were removed. The glands on the right side were much larger than on the left, and the large one contained dirty brownish pus. Microscopically, the glands proved to be squamous carcinoma like the primary growth.

The wound in the groin healed quickly, but the patient suffered from pains in the pelvis and about the neck of the bladder and irritation of the vulva. She remained in hospital till July 25, and from there went to a Home for Incurables, where she died some weeks later. She began to go downhill about the middle of June, the pulse rate rising to 100 and 120, and by the middle of July the temperature rose at times to over 100°. By this time there was definite evidence of local recurrence in the shape of thickening round the edges of the bladder fistula. There was no post mortem examination.

This case presented the features described by Dr. Whitehouse as the second type of vulvo-urethral growth (*l.c.*, cp. p. 272)—a breaking down ulcer with indurated margins and a sloughing base on the floor of the vestibule at the urethral orifice. The symptoms were noteworthy in that complete retention occurred and that only a fortnight after the trouble on micturition had been first noticed. In spite of the ulceration no discharge or bleeding had been noticed by the patient. I take it that the retention was caused by the involvement of the neck of bladder. The case also supports Dr. Whitehouse's contention that the inguinal glands ought to be excised in all cases where there is a possibility of extirpation of the local disease, for the patient returned with glandular metastases seven weeks after the removal of the primary growth. Being a young woman of 34, the spread would naturally be much more rapid than in older patients. To me, the most striking feature of the case was the small size and apparently circumscribed nature of the primary growth, its extension along the whole length of the urethra as discovered when its removal was undertaken, and the rapidity with which glandular recurrence, and probably also internal metastases, occurred. Local recurrence was not noticed till shortly before her discharge from hospital.