

A Case of Hydrometra.*

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THE patient, aged 54 years, gave a history of acute abdominal pain, on the right side only, for four days. She had been in bed for three days; there had been no sickness. Her medical attendant found the temperature and pulse rate raised. The patient said that it was the worst of "many such attacks." The previous one had occurred two weeks before. She had been married 30 years and had never been pregnant. The menstrual history was peculiar. She stated that she had never "had proper periods"—never blood-stained, only a brown slimy discharge lasting two days every two or three weeks. These started at 18 and ceased several years ago. For the first 12 or 13 years the discharge was accompanied by "terrible abdominal pain with vomiting," lasting three or four days. These pains ceased 13 years ago. The patient first felt an abdominal swelling two years ago. It had steadily increased in size since.

When I saw her on the fifth day of her illness the pain had ceased. The pulse rate was 88 and the temperature 99°F. I found the abdomen enlarged by a smooth elastic swelling of about the size of a seven months' pregnancy. It was acutely tender over one small area only, just to the right of and below the navel. On vaginal examination I found a small portio with a slightly patulous external os. The lower pole of the abdominal cyst could be felt in the upper part of the pelvis. I agreed with the diagnosis of an ovarian cyst with torsion of the pedicle.

Operation. Two days later, on opening the abdomen, a very thin great omentum was found covering the front of the tumour and adherent to the abdominal wall at the level of the pelvic brim. It was torn through and removed in segments, exposing a reddish-brown cystic tumour, obviously uterine. The diagnosis was changed to that of cystic fibroids. On the right side was an ovoid cyst the size of a large hen's egg, of purplish colour, and attached by a short pedicle, which was twisted, just below the right round ligament. It was clamped and removed and found to be a blood cyst of the ovary. Then the round and infundibulo-pelvic ligaments were clamped, an anterior peritoneal flap turned down, and the whole mass easily shelled out of the broad ligaments and removed by cutting across the supravaginal cervix. The cervical stump was small, but its canal was patulous, easily admitting a large artery forceps. The left ovary was atrophic and was removed with its tube. The patient made a very easy recovery.

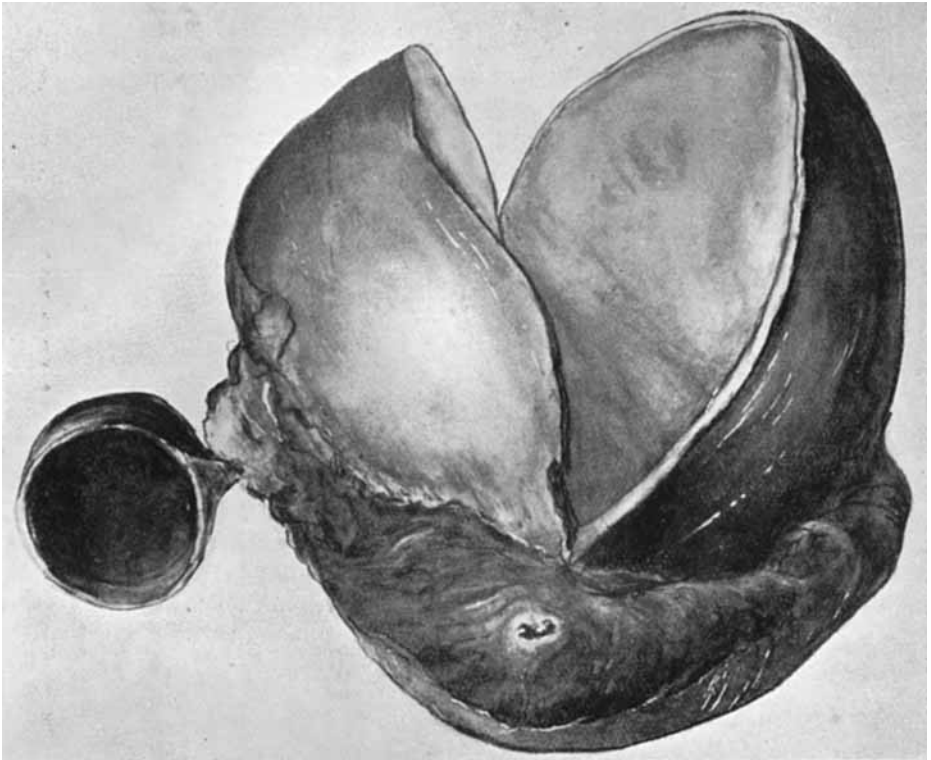
The Specimen. The tumour was the size and shape of a seven months pregnant uterus (measuring 20 by 18 by 16 cm. after

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hardening). Though no fibroid could be seen or felt on its surface, I still looked on it as a cystic fibroid. The short upper end of the cervix showed a patent canal, but a probe could not be passed upwards more than two or three millimetres. After being only two days in fixing solution the tumour was incised, when several pints of thin yellowish limpid fluid escaped. Unfortunately it was not possible to collect any of this fluid for analysis. The sac was unilocular with a pearly white lining, smooth save for two crescentic ridges corresponding to the points of origin of the Fallopian tubes. The wall was very thin, especially at the fundus, where it was no thicker than writing paper and quite translucent. No communication could be found even with a fine probe between the large sac and the small cavity in the upper part of the cervix. The symmetry of the cyst, and the relationships of the cervix, round ligaments, ovaries and tubes to it, proved that it is a retention cyst of the uterus—an unusually large *hydrometra*.

Microscopical Examination. Cyst wall shows a laminated fibro-muscular structure, with occasional small hæmorrhages. The lining consists of a layer of tall columnar epithelium, usually in one layer, and often with the goblet appearance of a cell which is actively secreting. No glandular areas were seen in the portion examined.

Cervix. The cervical stump was split longitudinally and removed with a portion of the contiguous cyst wall. It was cut in serial sections. Cervical glands and epithelium lined the lower three-quarters of this portion, whilst the upper part consisted of fibrous tissue only, in the form of a narrow septum, which lay in immediate contact with the muscular wall of the uterine sac. This septum has not the histological characters of an inflammatory band, nor is there anything in the patient's history to suggest that it was of inflammatory origin, *i.e.*, no history of genital inflammation in childhood or of the use of caustic or cautery in later life. There was no new growth of the cervix nor of the body of the uterus. It therefore appears most probable that the atresia was of congenital origin.



Hydrometra with Atresia of Cervix. Also small Ovarian Blood-cyst with Twisted Pedicle.