

IV.

An Unusual Degree of Cystic Degeneration of the Cervix.*

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MRS. A. S., 48 years of age, was admitted to the Jessop Hospital on September 24th, 1907, and gave the following history. Her only pregnancy had ended in an easy confinement 27 years ago; from this she made a good recovery. Eight years later she was treated for "inflammation of the womb"; three or four similar but milder illnesses occurred in the following few years. For fifteen years she had had no pelvic trouble, excepting some leucorrhœal discharge, which was only occasional and never profuse. Menstruation had always been regular (of the 28-day type, lasting 4 days without pain) until six months ago, when it ceased abruptly. For five months she had had occasional pain, never severe, in the right iliac and hypogastric regions, and the abdomen had appeared to be increasing in size. She had consulted a doctor two months ago, and then a vaginal examination was followed by slight hæmorrhage, the first for four months; a month later a second examination was followed by free hæmorrhage which lasted seven days.

On admission she was a healthy-looking, well nourished woman. The abdominal wall was very fat; there was no tenderness and no tumour to be felt. The vulva and vagina were normal and there was no prolapse of the vaginal walls or cervix. The portio vaginalis was only $\frac{1}{4}$ inch in length and normal to the touch. Bimanually the uterus, indistinctly felt through the thick abdominal wall, was judged to be small; it was in its normal position. The appendages could not be felt; there was no pelvic tumour nor tenderness. The examining finger was stained with blood which, per speculum, was seen to come from a small cluster of soft mucous polypi projecting from the external os. There was no "erosion," and no Nabothian follicle.

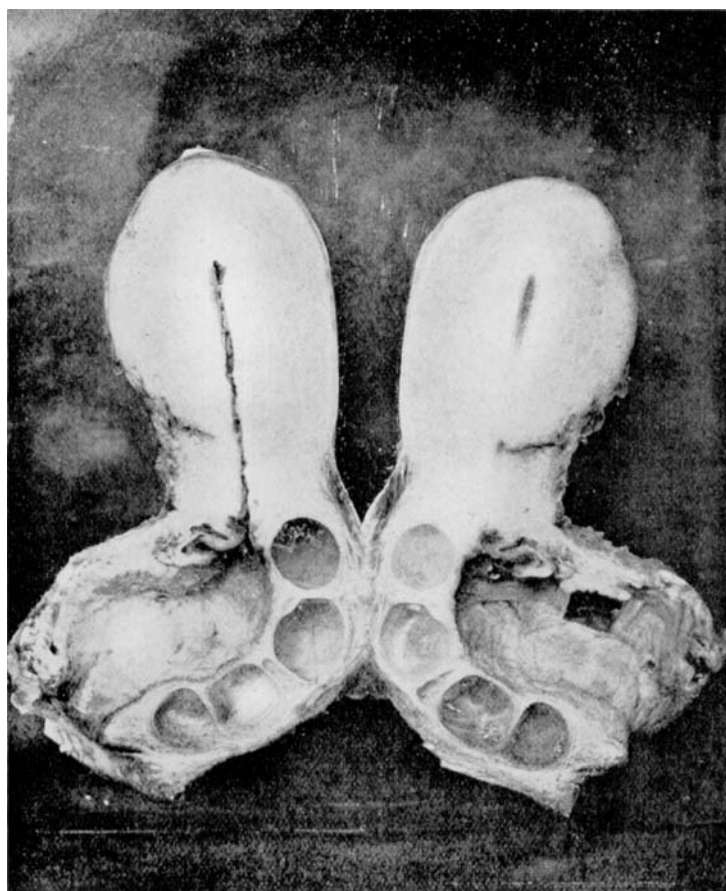
Operation. Under anæsthesia, the cervix was dilated and its cavity curetted, several long, simple and compound, mucous polypi being removed. On digital examination a smooth, rounded, hard nodule, about the size of a cherry, could be felt projecting anteriorly into the canal at the level of the internal os; the rest of the surface was smooth. Intending to enucleate this supposed submucous fibroid, I made a short transverse incision in the anterior vaginal fornix, and

* Specimen shown and described at a meeting of the North of England Obstetrical and Gynæcological Society, Liverpool, February 1908.

exposed the supra-vaginal cervix which I divided in the mid-line for about $\frac{3}{4}$ inch. Guided by touch only, I incised the mucous membrane over the little tumour, with the result that the nodule immediately disappeared and yet no fibroid had escaped. There was slight hæmorrhage but no other discharge was noticed. Uncertain of the nature of the swelling and fearing, from the post-climacteric onset of the symptoms, that it might be of a malignant nature, I judged it wise to remove the uterus. This was performed by the vaginal route, and was rendered somewhat difficult by the thickened right utero-sacral ligament and the unusual length of the cervix. Silk ligatures only were used, and the appendages, either seen or felt to be normal, were not removed. An excellent recovery was made, and when seen, four months later, the patient was in perfect health and quite free from the old pain.

Pathological report. Macroscopical. The uterus, with a narrow rim of vagina, was placed in a formalin-saline solution, after the cervical canal had been lightly packed and the incision in the cervix sutured. After hardening it was divided in a sagittal plane, slightly to the left of the mid-line, in such a way that the two portions were left attached by a hinge of cervical tissue. (See plate.) The corpus is normal in appearance and size (length, 5 cm.; width, 5 cm.; thickness, 3.3 cm.) whereas the cervix is considerably increased in bulk ($4 \times 5 \times 3.5$ cm.). This is partly due to the persistent artificial dilatation of its canal, but chiefly to the presence of a number of cystic spaces in its walls. Those occupying the posterior wall have been laid open by the section. Each was filled with a colourless jelly-like material which has been removed, revealing rounded cavities whose walls are more or less flattened by mutual compression. Four of these are of considerable size—8 to 12 mm. in diameter, in the plane of section;—the uppermost one extends 13 mm. in the transverse plane. Their walls are smooth and on the deep aspect of the lower three cysts they consist simply of thin transparent septa, bounding other, laterally-placed, cysts. Two small cysts have been compressed to mere slits. The anterior wall presents, just below the internal os, the puckered wall of a collapsed cyst, obviously the remains of the "nodule" which was incised. No other cyst projects into the cavity. The presence of several other cysts is indicated by their semi-transparent superficial walls, which cause slight rounded eminences in the canal. One of these has been removed, from the left side, for microscopical examination. (See plate.) The lining of the cervical canal is smooth and shows no remains of the mucous polypi nor anything suggestive of a malignant growth.

Microscopical. The cyst is lined by a single layer of epithelium, which varies from short columnar cells to cubical and even flattened cells with flattened nuclei. The columnar cells have all the appearances, except as regards their size, of the epithelium of normal cer-



Photograph (9/10) of Mr. Phillips' specimen of Cystic Cervix. Note the collapsed cyst on the anterior cervical wall, just below the internal os.

vical glands: the round, darkly-staining nucleus is at the base, the superficial part is more or less distended by unstained secretion, there are no cilia. In the only cyst examined the columnar cells are confined to the superficial, and the flattened to the deep wall of the cyst. The cysts are obviously only dilated cervical glands (Ovula Nabothi). The mucous membrane lining the canal is largely devoid of epithelium (a result of the curetting and plugging), but that which is present shows no evidence of malignant proliferation. A few normal cervical glands open on the surface; there is no increase in number of these glands, nothing suggestive of an adenomatous growth. The fibro-muscular wall shows an abnormal preponderance of fibrous over muscular tissue, and there are several clusters of fibro-blasts adjoining areas of young-looking connective tissue fibres. There is no small cell infiltration; nothing, excepting engorgement of some of the capillaries, pointing to recent inflammatory changes.

The condition is evidently one of fibrosis of the supra-vaginal cervix, leading presumably (there is no microscopical evidence of this in the sections) to closure of some of the ducts with consequent distension of the glands. Whether the fibrosis in this case represents the last stage of a chronic cervicitis, of which there is but little clinical evidence, or is simply an atrophic process, is open to discussion. Certainly I have several times seen similar, though fewer and much smaller, cervical cysts in atrophic uteri removed in the post mortem room.

Remarks. A diffused dilatation of the cervical glands is, I believe, unusual; generally such cysts occur in localized portions of lacerated cervixes which form pedunculated growths (follicular hypertrophy of the cervix). Dr. Herman describes a specimen (*Obstetrical Transactions*, 1880) which consisted of a mass pendant from the anterior lip, and honey-combed by cysts varying in size from an ordinary marble downwards.

As regards the treatment employed, hysterectomy may be thought to be a severe measure for so benign a condition; as we have seen, it was performed in view of the possible malignant nature of the disease. Had a correct diagnosis been made I might have been content with removal of the wall of the collapsed cyst. Then, probably, the patient would not have been relieved of her pain for, I think, we must consider that the diseased cervix was its source. Supra-vaginal amputation of the cervix would, possibly, have obtained as good a result as the hysterectomy and at a somewhat smaller risk.

I have to thank Dr. J. W. Martin for permission to publish this case; the patient was admitted to his wards but handed over to my care.