

SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class).

I.

Three Cases of Primary Cancer of the Fallopian Tube.

By HERBERT R. SPENCER, M.D., B.S., F.R.C.P.,

Obstetric Physician to University College Hospital.

THE following are brief notes of three cases of primary cancer of the Fallopian tube which have been under my care.

In adding to the list of published cases which, owing to the indefatigable industry of Mr. Alban Doran, is found to number one hundred cases, it is essential that two questions be answered in the affirmative: the first of these is, "Is the tubal disease cancer?", the second, "Is it primary?"

The first question is easily answered in my three cases; for in all the growth is columnar-celled carcinoma and gave rise to secondary deposits.

The second question is more difficult; but I think undoubtedly it may be answered affirmatively for the following reasons:—

In Case i the only cancerous growths in the body were in the tube and in the vagina. The growths were columnar-celled carcinoma. The growth in the tube was as big as a pigeon's egg. The growth in the vagina was not bigger than a haricot bean.

In Case ii the malignant growth found at the operation was in the tube: the corresponding cystic ovary was not affected. Small secondary growths were found in the adjacent intestine only. The only other growth found was a uterine tumour as big as a cocoanut which had all the physical signs of myoma and not those of cancer.

In Case iii the only growth found at the first operation was in the tube and adjacent broad ligament to which it had extended. After removal of these there was no sign of other growths. The growth

PLATE A (Case 1).

Illustrating Dr. Herbert Spencer's "Three cases of primary cancer of the Fallopian tube."

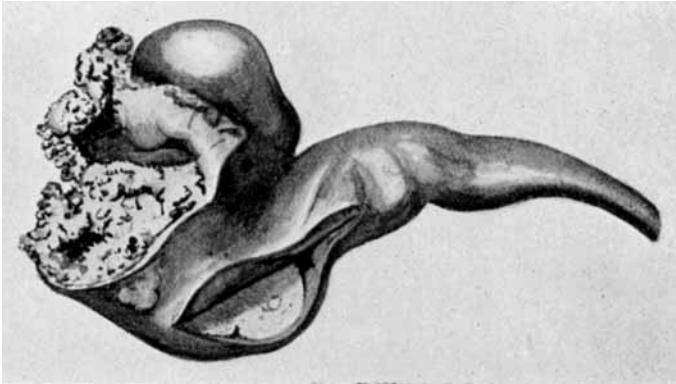


FIG. 1. The left tube, natural size. Its outer half is occupied by cancer. It has been torn open during removal, the warty growth being thus exposed. The growth does not extend quite to the abdominal ostium, the lining there being smooth and communicating through a dark aperture of the size of a crow-quill with the perimfimbrial cyst (a). A segment has been cut out of the wall exposing the white solid growth. Between the cut and the tear is a small tag of fat.

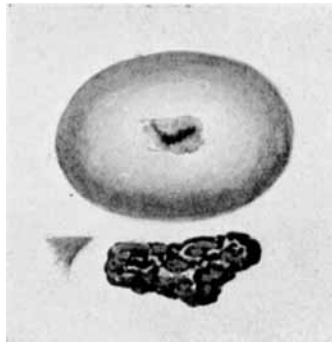


FIG. 2. The secondary growth in the posterior fornix; natural size; from a sketch made immediately before operation. The growth is separated by an eighth of an inch from the cervix. To the right of the growth is a triangular depression due to an old scar,

recurred locally, and up to the present time there is no sign of a primary growth in any other organ.

CASE I. M.A.M., a feeble multipara, 64 years of age, was admitted to University College Hospital on July 21, 1905, complaining of falling of the womb and of a greenish offensive discharge. Her womb had been prolapsed for 40 years, for which period she had worn a variety of pessaries, including a Zwancke, but this kind was worn only for a few days.

In February, 1905, she noticed blood in the discharge. She went to a hospital, where she was told she had a growth in the passage, and ought to have it operated on. On March 10 the small growth was removed from the vagina.

Menstruation began at 13, was regular in time and amount; it ceased at the age of 48. She had had rheumatic fever, and had a systolic murmur at the apex.

A brother died of cancer of the bladder.

On examination a small red growth (see Plate A, Fig. 2) was found in the posterior vaginal fornix.

The notes are incomplete on the bimanual examination, but my recollection is that some thickening of the left appendages led me to decide, in spite of the patient's age and poor condition, on performing an extended abdominal hysterectomy.

This was done on July 29, 1905. In order to check hæmorrhage the operation was partly performed with the galvano-cautery. The patient took the anæsthetic badly, and the operation was difficult, lasting 1 hour 55min. There was a good deal of shock and vomiting of black fluid after the operation, and death occurred on July 31.

At the autopsy there were some adhesions of coils of intestine in the pelvis and some old endocarditis. There was no new growth found in any part.

The specimen (see Plate A, Figs. 1 and 2) consists of a uterus and appendages and part of the vagina. The uterus is atrophied and measures $6.7 \times 4 \times 2.5$ cm. The upper part of the body is distended by mucus to the size of a pea. The portio is atrophied and normal. The uterine mucosa is atrophied throughout. In the posterior fornix is a puckered scar, and the surface is eroded and a small tag of growth is still attached there: this is part of a red cockscomb-like growth which was removed before the hysterectomy. The right tube is normal except for a few slight adhesions. The left tube has its outer half distended to the size of a pigeon's egg by a growth which is warty in appearance where the diseased tube has given way during removal. The extreme outer end of the tube has been distended by fluid, but is not affected with growth; it has attached to it a lymph cyst. The ovary is not affected, but was adherent to the outer portion of the tube.

Under the microscope the growth is a primary columnar-celled carcinoma of the Fallopian tube with a secondary growth in the vagina. The tubal growth has originated by proliferation of the epithelium of the rugæ which form extensive epithelial masses, some of which have infiltrated the wall. Masses of epithelial cells of similar structure are found in the vaginal wall at the spot from which the vaginal tumour was removed. The neighbouring vaginal epithelium is not altered. (Plate A, Fig. 3).

CASE II. A.R.R., a virgin, aged 35, consulted me on February 5, 1906, complaining of aching pain in the abdomen and back and an abdominal tumour. She had always had a large abdomen. She had first noticed the lump 18 months ago; but it had only increased in size of late. Pain had been present only during the last 3 or 4 months: for the last 3 or 4 weeks it had been very severe and mainly on the left side. She had, however, been able to carry on her arduous work as a nurse till quite recently. Menstruation was irregular, occurring every 3 to 4 weeks, and was slightly excessive in amount. She had had no discharge except a little leucorrhœa before the flow. This had always been present.

Micturition was normal.

She had a loud presystolic murmur over the heart, but was otherwise in fair general condition, but was somewhat cyanosed.

On examination the abdomen was distended by a hard tumour, which reached up to 5 inches above the pubes in the middle line and to 6½ inches on the left side. The tumour on the left side extended into the iliac fossa and was fixed there. There was a small irreducible hernia on the left side. The abdominal veins were enlarged. The hymen was intact. The cervix was small and in the middle of the pelvis: continuous with it and surrounding it was a hard tumour which had the characters of a fibroid. It was continuous with the tumour of the abdomen. There was no swelling of the lower limbs.

The case was regarded as a myomatous uterus with inflammation around the left appendages.

Cœliotomy was performed on February 20, 1906. A large quantity of blood-stained fluid was present. Above the incision and to the left the intestines were firmly adherent. On separating the adhesion an ovarian cyst of the size of a lemon was exposed: it contained no growth, and ruptured during its removal. The left Fallopian tube was full of brittle growth. The cyst and tube were removed after tying the pedicle with silk. Many small white nodules were now seen in the wall of the adherent intestine. The uterus was as big as a cocoanut, and evidently contained fibroids. It was not removed. There was a good deal of oozing from the separated intestine, which was checked by gauze pressure. The

PLATE A (Case 1).

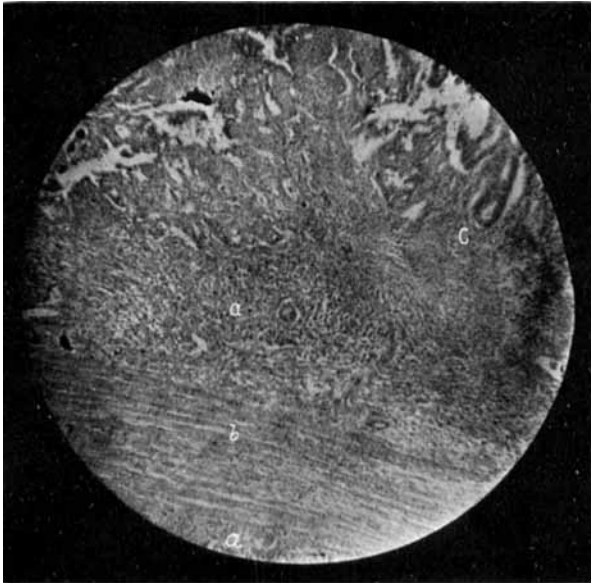


FIG. 3. The greater part of the section is made up of columnar-cell carcinoma (*a*) infiltrated with small round cells: *b* is a strand of fibro-muscular tissue. At *c* is a tube of columnar epithelium; the cancer to its left is due to proliferation of the epithelium, all stages being visible in the section though not reproduced in the photomicrograph.

PLATE B (Case 2).

Illustrating Dr. Herbert Spencer's "Three cases of primary cancer of the Fallopian tube."

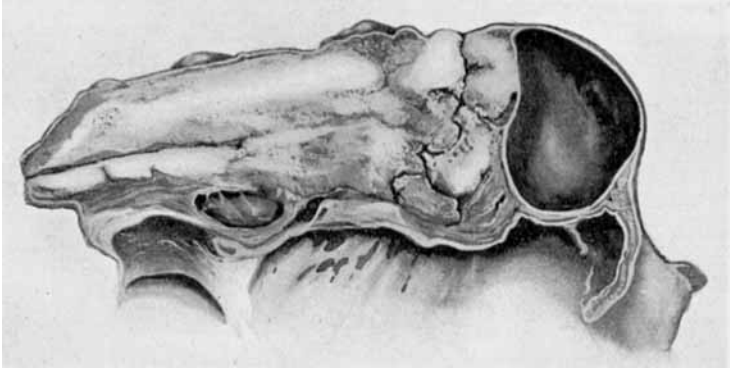


FIG. 1. The left Fallopian tube (natural size), with a portion of the ovarian cyst. The wall of the tube, nearly to its extreme end, is seen to be filled with a whitish brittle growth. At the end of the tube is a lymph cyst.

PLATE B (Case 2).

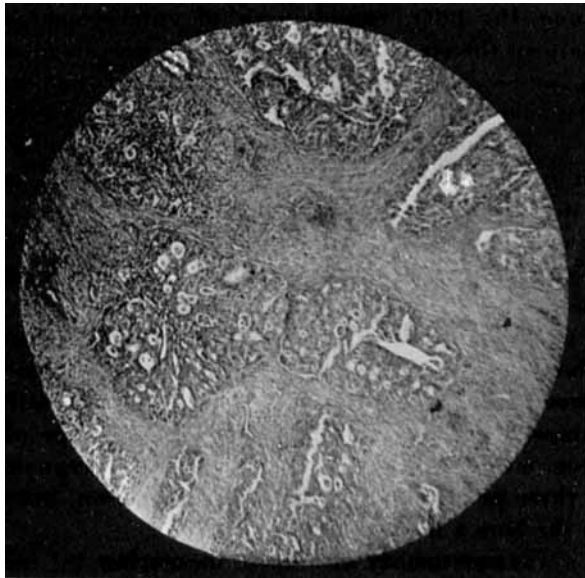


FIG. 2. Masses of columnar-cell carcinoma are seen in a dense fibro-muscular stroma. Degeneration of the cells in the central portions of these masses produces a cystic appearance in some of the masses.

wound was closed by through stitches of silkworm gut, buried silk for the fascia and silkworm gut for the skin. It healed by first intention. After leaving the hospital the patient remained fairly well for a short time; then pain and wasting set in, and she died with growths in the abdomen and also in the abdominal incision just a year after the operation.

The specimen (see Plate B, Fig. 1) consists of a Fallopian tube distended with cancer and the adjoining ovary. The ovary contained a cyst of the size of a lemon, which was ruptured during removal. There are numerous adhesions around the ovary and tube, and several lymph cysts are attached to the tube. The Fallopian tube measures 9 cm. in length and 2.5 cm. in thickness at the distal end to which is applied a lymph cyst (2.5 × 2 cm. in diameter). The whole of the tube is full of growth which has slightly perforated the wall at one spot where it has been torn during removal. The growth has an opaque yellow colour, and has completely destroyed the wall of the tube except at its cut uterine extremity. The growth has practically obliterated the lumen of the tube.

Under the microscope the growth is a carcinoma, being made up of masses and tracts of epithelial cells of the columnar type. In some of these masses spaces are seen which are due to degeneration of the central cells. There is but little small-cell infiltration of the stroma. (Plate B, Fig. 2).

CASE III. A.C., aged 58, was admitted to University College Hospital on June 16, 1909, complaining of enlargement of the abdomen and pain in the epigastrium. Until six weeks ago she had noticed nothing amiss. She then thought her womb had dropped and that her abdomen was enlarging as her corsets felt tight. The swelling increased gradually till a fortnight ago, but rapidly since. She also noticed great frequency of micturition, having to pass water every time she stood up. The bowels were regular.

Pain had only been present during the last ten days; it was usually in the epigastrium, and was much worse after taking food.

Two days before admission the ankles began to swell.

The patient had had no discharge from the vagina for some years. Menstruation began at the age of 12½ years, was regular every 28 days and lasted 6½ days; it varied in amount; she generally used a good many diapers. The menopause occurred at the age of 48.

She had been married 41 years, and had been pregnant four times; the first three pregnancies terminated in abortion, but on the fourth occasion she bore a living child.

The abdomen was enormously distended, measuring 38½ inches in girth four inches below the umbilicus; from the ensiform cartilage to the pubes measured 18½ inches. The abdominal veins were distended on both sides and a large amount of free fluid was present

in the peritoneum. On vaginal examination a large cystocele was found. The uterus appeared to be retroflexed and to be connected with a very hard tumour in the left side of the pelvis as big as a fist: this was thought to be part of an ovarian tumour, and on account of its hard consistence a papillomatous or malignant tumour was suspected.

On July 19, 1909, cœliotomy was performed. Many pints of pale straw-coloured fluid escaped through the incision. A papillomatous tumour was felt in Douglas's pouch, and was thought to be a papillomatous tumour of the left ovary. After separating some adhesions and removing the main growth a small portion of the papilloma was found to have grown through the wall on to the left broad ligament. This part of the ligament, together with the growth, was therefore removed and the raw surface stitched over. The broad ligament with its attached growth and ovary was unfortunately thrown away so that the relation to the ovary can not be given; but the ovary was but slightly if at all enlarged. The uterus was normal and the right appendages, though slightly adherent, appeared to be free from disease and were left behind: the whole of the growth appeared to have been removed, and there were no secondary growths in the intestines. The operation lasted 41 minutes. The wound healed by first intention.

On October 14 a mass of recurrent growth as big as an orange was found in Douglas's pouch.

The patient was re-admitted to the hospital on Oct. 18, 1909, and an exploratory operation as undertaken to see if the growth could be removed. A small quantity of blood-stained fluid escaped. The pelvis was found to be occupied by a mass of growth spreading under the bladder and involving the rectum. A mass of friable growth as big as the top of the thumb projected from the stump of the left pedicle. The right appendages were adherent to the pelvic wall, and on the surface of the ovary, which contained a few translucent cysts, were some small warty nodules of growth. The peritoneum covering the uterus and the parietal abdominal peritoneum were studded with growths, one of which was removed for microscopic purposes. The abdominal wound was then closed and healed by first intention. The patient left the hospital on November 17 feeling fairly well.

The specimen (Plate C, Figs. 1, 2 and 3) consists of a Fallopian tube containing a large mass of carcinoma. The uterine end is normal for about half a centimetre and rapidly expands to a thickness of 4 cm. and terminates in a great expansion partly covered by irregular smooth membrane through which the ragged growth has burst at one spot where it adhered to the left broad ligament.

The mass formed by the tortuous tube measures altogether 11×9 cm., and the section shows that the tube forms the wall of the whole of the mass except at the outer extremity where the growth

PLATE C (Case 3).

Illustrating Dr. Herbert Spencer's "Three cases of primary cancer of the Fallopian tube."



FIG. 1. The left Fallopian tube (natural size). The cut uterine end is healthy. The tube rapidly expands and towards its outer part the wall is invaded and the growth has burst through in the region of the ostium abdominale.

PLATE C (Case 3).

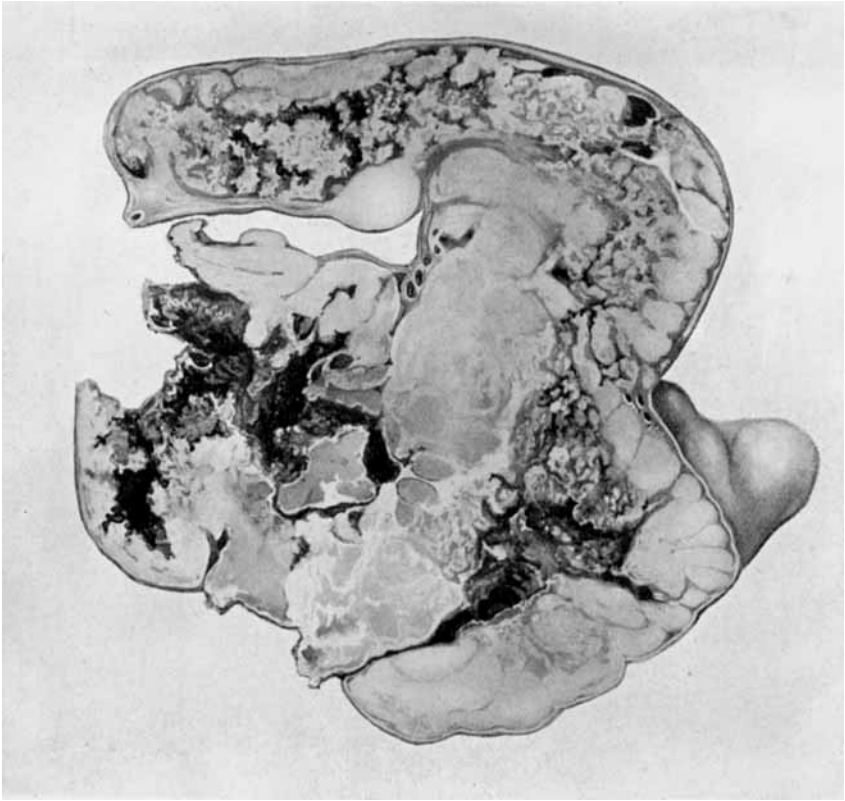


FIG. 2. The same tube in section showing the tubal wall surrounding the growth which has broken through in two or three places. The base of the growth consists of opaque white masses; the more central parts of the growth are papillomatous.

PLATE C (Case 3).



FIG. 3. The dark masses are columnar-cell carcinoma, and the lighter patches consist of blood and cellular debris. The dark masses are papillary growths from the surface: at *a* is seen a central vessel with its surrounding connective-tissue. The deeper parts of the growth have very little stroma except the vessels, and resemble sarcoma or perithelioma.

has broken through. The wall in some places is invaded to its peritoneal coat, which appears to be perforated at two spots. The growth is of a yellowish-white colour and completely fills the tube, but is somewhat broken and papillomatous along the centre where the growths from the two sides come in contact.

Under the microscope the growth is a columnar-celled carcinoma consisting of masses of epithelial cells with scanty stroma which causes it to resemble closely a sarcoma in its deeper parts, but in other parts thick masses of proliferated epithelial cells on papillary processes show its cancerous nature.

II.

Primary Carcinoma of the Fallopian Tube Associated with Acute Inflammatory Mischief.

By WALTER TATE, M.D., F.R.C.P.

MRS. C., aged 52, had had three children, the last having been born seventeen years ago. The menopause occurred at the age of 48, and for the last two years there had been a yellowish vaginal discharge occasionally blood-stained. There had also been some pain and discomfort in the pelvis during the same period. The patient, however, kept in good health till the commencement of the present illness, which occurred within twenty-four hours of a motor accident, in which she received a severe shaking. On the day after the accident she did not feel at all well, and complained of some abdominal pain. She was seen by her medical attendant, who found some tenderness over the lower abdomen and a temperature of 100°F. On the following day the patient had a severe attack of pain in the lower abdomen on the left side, accompanied by vomiting and severe collapse. She was seen by the writer in consultation with Dr. White of Putney on the same afternoon. The patient was looking a little flushed and anxious. There was some distension of the abdomen and marked tenderness over the left iliac and hyogastric regions. The uterus was retroverted and its mobility impaired. A tense swelling as large as a hen's egg was felt in the left side of the pelvis, and a similar swelling was present in the situation of the right appendages. It was decided to watch the patient for a time in the hope of deferring operative measures till the acute symptoms had subsided. As, however, the patient had a good deal of abdominal pain during the night, and her condition the following morning showed no improvement, it was decided to explore the abdomen without further delay.

Abdominal section was performed on July 21, 1907. After opening the abdomen there was a good deal of distension of the coils of intestine visible. On separating a few adherent coils in the pelvis round the left appendages, several ounces of turbid fluid escaped. The left Fallopian tube was distended, and appeared to contain pus. After transfixion of the broad ligament the tube and a portion of the left ovary were removed. After separating some recent adhesions round the right ovary and tube, these structures were removed. Owing to the condition of the patient, and the acute inflammation present, it was not thought wise to attempt removal of the uterus, which was slightly enlarged. Moreover, at this stage of the operation, the malignant nature of the tubal disease was not suspected. After cleansing the cavity of the pelvis with warm saline solution, the abdominal wound was closed in layers without drainage.

Parts removed. The right Fallopian tube was five inches long, and somewhat tortuous. It measured one inch in diameter. The outer surface was injected and presented a few torn adhesions over the surface. On section of the wall, it was considerably thickened, and the cavity of the tube was filled completely with a soft friable growth, which broke away from the wall when touched. The left tube was smaller than the right, but presented a similar appearance externally.

On section it was found to contain about one and a half ounces of muco-purulent fluid. The inner surface of the tube was covered with lymph. A few warty growths were seen springing from the inner surface of this tube. These were very friable and resembled papillomatous growth.

The microscopic examination by Dr. Cuthbert Lockyer was as follows:—"The larger (right) tube is the seat of a glandular carcinoma of the columnar type. There is extensive development of fibrous tissue and the cancer cells group themselves into masses, and hollow tubes in alveolar spaces within the fibrous stroma. The smaller (left) tube is thickened and infiltrated (by inflammatory products) in all its coats. The mucous membrane is almost totally destroyed and replaced by granulation tissue. There is no sign of malignancy in this tube."

The uterine discharge entirely ceased after the operation, and the patient made an uneventful recovery. She was last seen by the writer on October 5, 1909, that is, two years and three months after the operation, and was then perfectly well, and had put on weight.
