

CÆSAREAN SECTION FOR LABOUR OBSTRUCTED BY A SUPPURATING OVARIAN DERMOID CYST.

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THE patient, aged 30, II-para, was admitted to the Leeds General Infirmary on Feb. 26th, 1912, in the last month of her third pregnancy. She said that the first labour was terminated by craniotomy. In the second pregnancy labour was induced at the eighth month, when a living child was delivered by forceps. After the second confinement her medical attendant told her that there was a post-uterine tumour, and shortly before admission he examined again, said that the tumour was larger and threatening to obstruct labour, and sent her to the Leeds Infirmary. She was transferred to my care by my colleague, Mr. Walter Thompson.

I found all the signs of normal pregnancy; the head was below in the left occipito-anterior position. Foetal heart about 155. The oblique conjugate measured 4 in.; estimated true conjugate, $3\frac{1}{2}$ in. A rounded tumour could be felt in the pouch of Douglas, not fixed to the uterus and capable of being slightly pushed up. It felt elastic and seemed likely to offer a serious obstruction to labour. The other organs were normal.

On March 14th labour came on at 4.30 A.M. and abdominal section was performed at 7.15 A.M. It was found that an ovarian cyst occupied the pouch of Douglas. It had slight adhesions, but could be pulled up. It was then seen to be leaking and discharging very offensive pus. The cyst was removed. I had hoped to be able to perform a conservative operation, but was afraid to do so in presence of the infected state of the pelvis. After incising the uterus I removed a living female child of $7\frac{1}{2}$ lb. weight. I next amputated the uterus through the cervix, leaving the left ovary and treating the stump in the usual retro-peritoneal manner.

The patient did very well, except that at the end of a week it was found that there was an accumulation of fluid in the pouch of Douglas, and this was evacuated by posterior colpotomy, several ounces of greenish offensive watery fluid being drained away. Nine days later the sinus required to be opened up with the finger, but after this recovery proceeded smoothly, and she was discharged cured on April 13th.

The following report on the tumour is by Dr. M. J. Stewart, pathologist to the infirmary: "The cyst, which is about the size of an orange, is filled with foul-smelling purulent fluid. The cyst-wall is lined for the most part by soft necrotic material, but at one place there is a large teratomatous 'anlage' measuring $1\frac{1}{2}$ in. by $\frac{3}{4}$ in., and raised about $\frac{1}{2}$ in. above the level of the cyst wall. From this a large tuft of fair hair is growing, and there are two unerupted teeth in its interior. On microscopic examination the embryonic rudiment shows the usual epidermic structures of an ovarian dermoid, skin, hair, and sebaceous glands, with much fatty tissue and unstriped muscle. Deeper down lies a small mass of embryonic nervous tissue. There are no hypoblastic structures."

Remarks.—Had this case been delivered without abdominal section the cyst would have been crushed flat and its septic contents extravasated in the abdomen, and probably it would have been necessary to sacrifice the child. Had conservative Cæsarean section been performed it is most probable that the uterine incision would have suppurated. By the course adopted both mother and child have been saved. I am indebted to my resident obstetric officer, Dr. T. Evans, for his careful conduct of the after-treatment.

Leeds.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

OBSTETRICAL AND GYNÆCOLOGICAL SECTION.

Exhibition of Specimens.—*Fibro-Adenomata of the Ovarian Fimbria and the Question of the Accessory Ovary.*—*Retroflexion of the Gravid Uterus.*—*Rupture of Umbilical Vessels during Labour.*

A MEETING of this section was held on April 11th, Dr. AMAND J. M. ROUTH, the President, being in the chair.

The following specimens were shown:—

Dr. T. W. EDEN: Uterus and Appendages from a case of Primary Amenorrhœa.

Dr. R. DRUMMOND MAXWELL: Fibroid Polypus becoming Carcinomatous.

Mr. B. GLENDINING read a paper on Fibro-adenomata of the Ovarian Fimbria and the Question of the Accessory Ovary, in which he described four cases of this new growth, which, in the absence of a critical histological examination, might readily be mistaken for ovarian tissue. He then proceeded to classify the evidence in favour of the occurrence of accessory ovaries, and indicated that in one group the above described growths were probably erroneously included as accessory ovarian tissue.

Dr. J. D. BARRIS read a paper on Retroflexion of the Gravid Uterus complicated by Hæmaturia. The patient, a multipara, aged 35, had her last normal period at the end of September, 1911. On Jan. 8th, 1912, she had an attack of severe abdominal pain, and the next morning could only pass urine with difficulty. For the next seven days the patient continued to suffer from pain over the bladder, and had difficulty in passing urine. During the next fortnight she was only able to hold her urine for an hour, and the abdomen was noticed to increase rapidly in size. She was then seen in the out-patient department by Dr. W. S. A. Griffith, who found the abdomen enormously distended and occupied by a tumour which extended to within one inch of the costal margin. A catheter was passed and 7 pints of clear urine were withdrawn. The patient was admitted to the gynæcological ward, and $3\frac{1}{2}$ hours later another $3\frac{1}{2}$ pints of urine were withdrawn. The abdominal tumour entirely disappeared. On examination by Sir Francis Champneys the cervix was found high up in the vagina almost out of reach, and pointing forwards. The sacral hollow was occupied by the retroverted gravid uterus. The bladder could be felt extending up to one inch above the navel, and when the catheter was again passed 28 ounces of bloody urine were drawn off. The uterus was then replaced and a rubber ring inserted into the vagina. A rubber catheter was inserted for the next 12 hours, after which the urine was drawn off every four hours. There was no more hæmorrhage. Subsequently the patient made a good recovery, and was able to pass her urine without difficulty. There was never at any time any cystitis. In all the recorded cases of hæmaturia the complication had been caused by the accompanying cystitis. In Dr. Barris's case there was no evidence of this, for no micro-organisms were found either on staining film or after cultivation. The hæmaturia might have been caused by rupture of a blood-vessel in the wall of the bladder, or by a tear in the lining mucous membrane, due either to over-distension or to the sudden relief of tension. Grosse was of opinion that a tear in a large varicose vein of the bladder was a common cause of hæmaturia during pregnancy, the varicose condition being due to the pregnancy, in the same way as hæmorrhoids and varicose veins of the vulva. That this condition did occur had been demonstrated by Luys with the cystoscope, and was also observed at a later examination in the case recorded above.

Dr. H. WILLIAMSON read a short communication on Death of the Child due to Rupture of Umbilical Vessels during Labour. In most cases where a child had bled to death from rupture of an umbilical vessel during labour the insertion of the cord had been velamentous. The insertion of the cord was velamentous in about 0.7 per cent. of all human placenta. In twin pregnancies this insertion was more common. V. Winkel found it as frequent as 5 per cent. in the Dresden Clinic. The essential anatomical feature of a velamentous placenta

THE GRESHAM LECTURES, 1912.—Dr. F. M. Sandwith, Gresham professor of physics, will deliver four lectures on May 7th, 8th, 9th, and 10th, at the City of London School, Victoria Embankment, E.C. The lectures, which are free to the public, will begin each evening at 6 o'clock, will deal with the Use and Abuse of Alcohol, and will treat respectively of (1) alcoholic drinks; (2) pre-Victorian liquor laws and the temperance movement; (3) the awakening of the public conscience; and (4) the medical aspect.