REMARKS ON FIBRO-CYSTIC DISEASE OF THE UTERUS.*

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THE diagnosis of fibro-cystic disease of the uterus is still a problem unsolved in the history of the diseases of females. Some authors of repute are silent upon the subject, and in most of those that allude to this disease the notices are very short and meagre. In Scanzoni (*Translated by Gardner*, p. 237) we find the subject thus disposed of: "As we have already said, there are fibrous bodies which are formed by the aggregation of tumours of different sizes bound together by loose connecting tissue, which is rich in blood-vessels. In this tissue there are sometimes formed cavernous excavations filled with blood, the rupture of which often occasions very considerable extravasations of blood. At other times this intermediate tissue is infiltrated with serum, and there results therefrom a sort of dropsy of the fibrous body. There are also observations of the formation in the tumour of a cavity more or less large, filled with a serous, sanguineous, or putrid liquid, which, by the constant fluctuation, render during life the diagnosis of a fibrous body very difficult." This is all that is said about this very important subject by Scanzoni.

Dr. Graily Hewitt, in his admirable work on the *Diseases of Women*, takes notice of this affection, speaking of it as "that rare disease." He thus alludes to the improbability of detecting it during life. "The diagnosis of fibro-cystic tumour of the uterus is one of great difficulty, because we have here the two things combined and a solid outgrowth from the uterus which itself contains cysts. The difficulty arises from the physical resemblance this bears to a case of cystic disease of the ovaries. To estimate aright the difficulties of the question, and the best method of surmounting them, careful study of the cases actually published is essential." He goes on, further, to say: "Mr. Spencer Wells mentions two circumstances of assistance in the distinction. One is that the colour of the cyst-wall in fibro-cystic uterine tumours, when laid bare by abdominal incision, is darker than that of ovarian cysts." Now it is rather too late to obtain information after the abdomen has been opened. What we want is to obtain knowledge of signs that will prevent us from cutting into an abdomen by mistake. That such mistakes have been made, and by the ablest observers, is too truly shown in the records of medicine; and to the credit of the profession, it is to be said that there has been no attempt to conceal any of those cases, but, on the contrary, the greatest publicity has been given, and they have been hung out as beacons to warn others from falling into similar mistakes. In the *Biennial Retrospect* for 1865 and 1866, published by the Sydenham Society, I find seven cases alluded to which happened in the hands of Dr. Routh, Mr. Nunneley, Mr. Spencer Wells, Dr. Routh again, Mr. T. Holmes, and Dr. Hilton Fagge, in which gastrotomy was performed in hopes of finding a diseased ovary. In the volume for 1867-68, there is no notice of fibro-cystic disease of the uterus. These do not include the two cases mentioned by Mr. Spencer Wells in the first volume of his *Diseases of the Ovaries*, in the last and most remarkable of which I was implicated, for I had seen the patient before Mr. Spencer Wells, and had given my opinion that it was a case of ovarian dropsy; and at my suggestion the operation was performed. That the disease is a very rare one there can be no doubt, but it is not unlikely that several examples of it may have been treated by tapping, and, finally dying, have been buried as cases of ovarian dropsy, and their nature never ascertained. However, cases are sufficiently numerous to enter into the calculation whenever we come to examine an abdomen containing a fluctuating tumour. But we have not yet arrived at any positive signs by means of which such cases can be detected. Mr. Spencer Wells says (*Diseases of the Ovaries*, vol. i, p. 362): "Given a large semi-solid tumour, fluctuating in some parts, containing cysts which hold upwards of twenty pints of fluid, moving beneath the abdominal wall, the uterus being movable and not enlarged, so far as measure-

ment by the sound can detect, no sound or arterial impulse to be heard which is not often heard in ovarian tumours, and no history of hæmorrhage leading to a suspicion of uterine disease, and it will be admitted that these characters of the two fibro-cystic tumours of the uterus which I removed so closely resemble those of semi-solid ovarian tumours, that diagnosis must be very uncertain."

It fell to my lot to be consulted about one of these cases a short time ago, and I was fortunate enough to make a correct diagnosis, and thus prevent the addition of another to the list of unfortunate operations. The case was under the care of Dr. John Morgan, in Mercer's Hospital, Dublin, and I was invited by him to see and examine the patient. Dr. Morgan has kindly given me permission to make use of the case, and has furnished me with the following particulars.

"M. R., aged 22, married three years, came under my observation on March 15th, 1871. She had been a domestic servant, and always enjoyed good health until about one year after marriage, when she observed rather unexpectedly a small tumour in the left iliac region, which remained of the same size for a year, when she found a similar one commencing in the right iliac fossa. In about three months these growths seemed to have coalesced into one, and had enlarged considerably, giving the appearance of a woman in about the seventh month of pregnancy. She stated that the tumour had rapidly gained this size, and then remained stationary for the last six months. She suffered much from a sensation of weight and bearing down, with a distressing feeling of oppression of the respiration. There was considerable pain in the back and also in the epigastrium, the latter being particularly marked after her admission into hospital. Menstruation had continued rather profusely and at intervals of three weeks. On examination, the abdomen was found to be occupied by a tumour bearing great resemblance in every way to an ovarian dropsy. It was dull on percussion, was of an oval outline, uniform to the feel, and deep fluctuation could be perceived. In order to test fully the nature of the tumour, I tapped it on the left side with a small-sized trocar tube of the *aspirateur* on March 23rd, and I removed twelve or fourteen ounces of a dark-coloured fluid nearly of the colour of beer, of rather viscid consistence, and highly albuminous. As the patient fancied herself relieved by this procedure, I tapped her again on March 30th with the *aspirateur* trocar, and removed about the same quantity of fluid. The trocar was introduced about three inches lower down than on the first occasion. Neither of these operations was followed by any untoward symptom. She now underwent a rather profuse menstrual period of eight days' duration, after which, as the case was one of difficulty, I requested the assistance of Dr. Beatty, who, in company with Dr. Atthill, kindly examined the case. In some days afterwards, Dr. Churchill saw the patient, and on the same day I tapped the tumour on the opposite side with the *aspirateur* trocar, and withdrew nearly three pints of the same kind of coloured viscid fluid. During the succeeding twenty-four hours, symptoms of peritoneal inflammation showed themselves. She became collapsed, constant greenish vomiting came on, and she died on May 7th, 1871."

Post Mortem Examination.—The body generally was in good condition; the abdomen was much distended by gas. There was a considerable amount of purulent matter in the cavity of the abdomen and around the tumour. There were some adhesions between the omentum and the tumour, and in three places these were tolerably firm. The surface of the tumour was uniform, and from the upper part a curious offset had grown, which had apparently given way and caused the peritonitis. There was no evidence of inflammation in the vicinity of the punctures. On raising the tumour, the ovaries were found in their normal position, and free from disease. The tumour was found to have grown from the upper part of the fundus uteri. The large cyst in immediate connection with the uterus was opened, and showed the remarkable figure of the interior.

When I examined the woman, the tumour in the abdomen resembled in size and shape the gravid uterus between the seventh and eighth month. There was evident fluctuation, and it seemed as if the fluid was in one large chamber, but the walls of the cavity felt thicker under the fingers than is the case in a single cyst of ovarian dropsy. There was a doughy feel when pressed deeply, as if thick flesh formed the walls of the cavity, and the tumour could be traced deep down into the pelvis. On examination *per vaginam*, the os and cervix uteri were found in a natural condition, and the sound passed in gave evidence of the normal size of the organ; but it was fixed, and would not be moved in any direction. The length of time the tumour had taken to arrive at its present development was well considered. This is an element observed upon by Dr. Graily Hewitt in his work on the *Diseases of Women*. He considers it as a diagnostic mark between uterine and ovarian tumours, the growth being lower in the uterine than in the ovarian cases. I was fortunate in the case with which I

* Read in the Midwifery Section at the Annual Meeting of the British Medical Association in Plymouth, August 1871.

had to deal, for it was not of great size like that one in which Mr. Spencer Wells had operated at my suggestion (the girth of which was fifty-six inches); but the walls, instead of being spread out and thinned by distension, had still a considerable amount of thickness, which gave the peculiar doughy feel to the fingers, while the cavity was still so large as to give a very distinct fluctuation. This symptom, though available to me on this occasion, would not be of equal value in a case wherein the walls had become thin by distension, and therefore I do not offer it as a diagnostic mark in all cases of fibro-cystic disease of the uterus, but I think it would be useful in those that had not attained a great magnitude. The profuse and repeated occurrence of menorrhagia suggested the existence of fibroids, and the fixity of the uterus, though natural in size and shape, showed that it was attached intimately to something above it, and that being a soft, fleshy-feeling, doughy tumour with fluctuation, led me to the conclusion that the case was one of fibro-cystic disease of the uterus, an opinion which I then communicated to Dr. Morgan. I have much pleasure in being able, through the kindness of Dr. Morgan and Dr. John Barker, the Curator of the Museum of the Royal College of Surgeons in Ireland, to exhibit the specimen and the cast of the tumour, taken before it was opened. The length, including the uterus, from which it grew, was 14½ inches; the circumference at the middle was 25½ inches. The tumour grew from the upper surface of the uterus, which up to that point is perfectly natural and healthy. On slitting up the uterus, the interior was found in a normal condition, and a very perfect *arbor vitæ uterina* occupied the canal of the cervix. The tumour, on being cut open, displayed the large irregular rough cavity which you see; and this extended into the small projection from the upper part of its periphery. The ovaries are both healthy. The urinary bladder is shown *in situ* with a close adhesion to the tumour.

I think it is a misnomer to call this a cystic disease; for, in point of fact, there is no proper cyst in it. There is no lining membrane to the irregularly shaped cavern, at least in its progressive stage, as this specimen is; but the chamber seems to be composed of a number of cavities, all thrown into one or more large ones, with rough irregular folds of fleshy fibrous material hanging into it on all sides. It appears that Scanzoni's description of the origin and formation of the disease is correct. Speaking of the composition of fibrous tumours, he says: "In this tissue there are sometimes formed cavernous excavations filled with blood, the rupture of which often occasions very considerable extravasations of blood. At other times, this intermediate tissue is infiltrated with serum, and there results therefrom a sort of dropsy of the fibrous body. There are also observations of the formation in the tumour of a cavity more or less large, filled with a serous, sanguineous, or putrid liquid, which, by the constant fluctuation, render during life the diagnosis of a fibrous body very difficult."

As examples of this disease are very rare, I have thought it right to produce this specimen at this meeting of the British Medical Association, as a caution to all who investigate tumours in the abdomen.

Since writing the above, I have read the case of fibrous tumour of the uterus, removed from the uterus by Mr. Spencer Wells by means of gastrotomy and the *écraseur*, published in the *Medical Times and Gazette* of July 29th, 1871. That most remarkable case recovered after many struggles, and is the first of its kind in these kingdoms. It will, no doubt, give fresh courage to operators; and in the case just detailed it might have been imitated, for the connexion between the uterus and tumour could have been easily cut through by the *écraseur*.

ABDOMINAL PUNCTURE IN TYMPANITES.

In the *JOURNAL* for October 21st, page 464, Mr. J. H. Wathen mentions that the earliest case of the use of "Puncture of the Colon for the Relief of Tympanites" which he has discovered, was by Mr. Teale, in February 1869.

I find the following remarks in the late Mr. T. P. Teale's Address on Surgery at Sheffield, in July 1845, at page 119 (*Transactions of the Provincial Medical and Surgical Association: new series, vol. ii, 1846*).

"*Paracentesis of the Intestine for Tympanites.*—The practice of paracentesis of the abdomen has been lately adopted by Sir Henry Marsh, for the relief of excessive distension of the abdomen from flatus, with the most soothing effect, and without any injurious consequences. The operation was performed with a fine trocar, and repeated several times, with great relief to the patient. M. Levret has also adopted the same practice. After evacuation of the air, immediate relief was obtained, and the patient rapidly recovered."

It may be further added that this mode of treatment also received the high sanction of Sir Philip Crampton and Mr. Cusack twenty-seven years ago.

THOMAS LITTLETON, M.B., F.R.C.S. Eng.

Plymouth, October 31st, 1871.

ABSTRACT OF A CLINICAL LECTURE

ON A

CASE OF SEVERE INJURY TO THE LOWER END OF THE FEMUR.

By PRESCOTT HEWETT, Esq., F.R.C.S.,

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GENTLEMEN,—The subject which I bring before your notice to-day is one of great interest, and one which may be to you, by-and-bye, in practice of the utmost importance, and which might, in some measure, affect your reputation: I allude to the case of the girl in the Wellington Ward, in the third or fourth bed on the right. She was admitted into the hospital on the 21st September last, and, as it is now the 17th of October, she has been a month in the hospital. She was walking down a flight of stairs at the International Exhibition, and, while doing so, she caught her foot on the edge of a step and fell, sustaining, it was supposed, a fracture of the end of the femur. She wore high-heeled boots. I do not know how it has happened, but there have been a great many accidents in the International Exhibition. I suppose they must have arisen partly from the height of the stairs, and partly from the height of the ladies' heels. Ladies are anxious to look tall, thinking that their appearance is improved, and therefore they wear high-heeled boots. Such accidents are not always, however, due to the high heels, for a lady whom I knew fell by tripping on the stairs at the Exhibition, and came down on the cheek-bone, breaking it, and having ecchymosis on the right side of the face for months afterwards. But the first thing to which I would call your attention in this case is the high heels of the boots. Ladies will, for the most part, wear them; but they could not do a worse thing, for their feet are placed in a difficult and most unnatural position. They are very tenacious about this fashion, but you must be as tenacious against it: the number of accidents in consequence is very great. To show you how very tenacious ladies are on this point, last year I was sent for to see a young lady in one of our London hotels. She wished to consult me about her foot. On seeing it, I thought its state depended upon her boots, and I asked to see them. The boots were brought in by the lady's maid, but the only thing I could observe about them was an immensely high heel. I said: "It is the high heel of your boots that causes the mischief, and unless you diminish this I can do nothing for you." She became quite angry, and said she could not alter them. "I cannot do it, and I will not." Suddenly again she toned down, and said: "Pray, sir, what would people say if they saw me walking about the park without high heels?" I said: "It is simply heels *versus* brains. If you have brains, you will cut off the heels; if you have no brains, you will continue to wear them." She fortunately had brains, cut off the heels, and her foot got quite well.

To return to our patient. On admission to the hospital, this girl was, as I said, supposed to have a fracture of the lower end of the femur, close to the joint, and the injury was all but compound. A long splint was applied, but it was very difficult to keep the fragments in their proper place; and, as the surrounding parts became very swollen and painful, the patient was put on an Earle's bedstead on the 26th, and then matters went on until I returned from my holiday, when I took charge of my patients on the 2nd of October, and saw this girl, being told there was great difficulty in keeping the fragments in their proper position. On examining the leg, after taking off the short splints, I found that there was a large projection on the outside of the thigh-bone, due to the upper piece of the bone pressing against the skin. And now, a closer examination of the parts led me to think that, after all, the case was perhaps one of separation of the epiphysis, and not a fracture. The injury is close to the knee-joint. The bone projecting is certainly not more than an inch above the condyle; the fragment, instead of being sharp, is obtuse; in addition to which we have the age of the girl, 17, and the nature of the accident. This case is then, I think, one of separation of the epiphysis of the femur.

Severe injuries to the lower end of the femur may be of two kinds—a fracture close to the knee-joint, and a separation of the epiphysis; the former is by far the more common form of the injury—the latter being, indeed, rarely met with in adults. It is but a few years ago that we were first quite clear as to what happens in the separation of the epiphyses, and all the cases published then were cases of children. I presume that you know we have a line of cartilage at the lower epiphysis of the femur. So long as this exists, so long may a separation take place. The question then arises, At what time of life does this piece of cartilage disappear and the condyles become joined to the shaft? The age varies in different individuals. The cartilage sometimes exists up to the age of 25 years. You will find in most of the authors no allusion