Lettsomian Lectures

ON MIDWIFERY AND DISEASES OF WOMEN.

Delivered before the Medical Society of London.

BY
C. H. F. ROUTH, M.D.,

PHYSICIAN TO THE SAMARITAN HOSPITAL FOR WOMEN AND
CHILDREN.

LECTURE II (*continued*).

ON SOME POINTS HAVING REFERENCE TO THE DIFFERENTIAL DIAGNOSIS OF FIBROUS TUMOURS OF THE UTERUS.

III. The principal conditions with which fibrous tumours of the uterus may be confounded are: pregnancy, normal and extrauterine; conditions where fluids are contained within the uterine cavity, as hydrometra and hæmatometra; cancer of the uterus; retention of urine; hæmatocele; cellulitis; ovarian dropsy and fibroid disease; exostoses; encysted peritoneal dropsy, or dropsy of the Fallopian tube; fibrous tumour of the broad ligament; hydatid cysts; and tubercular and cancerous disease of the uterus, or even of the abdomen.

The limits of this lecture will, however, necessarily preclude reference to all of these, particularly as I have already incidentally referred to some of them. I shall content myself with referring to two complications of frequent occurrence, which often make the diagnosis obscure.

Pregnancy. Even with this condition, error in diagnosis has been made. Three cases, at least, have occurred in our London hospitals, in all of which pregnant women, supposed to have had ovarian or fibroid disease, have been operated upon, and have, unfortunately, died. It is seldom, when females have fibrous tumour, unless it be of diminutive size, that the appearance of the abdomen does not at a very early period attract their attention. It becomes larger, and they will often tell you that they feel a tumour. In most cases, especially if married and desiring children, they believe it to be pregnancy; and there are certain symptoms present at such periods which lead them to suppose so.

First and foremost are the *breasts*. Now, I do not think this symptom is sufficiently dwelt upon; but, in several cases of fibrous tumour, I have noted marked changes in these organs. They have been larger, in some cases hypertrophied; and this not only from adipose deposit, but from enlargement of the lacteal vessels. The areola has been marked, and even œdematous; the follicles enlarged; and, on milking the breast, a drop or two of a fluid, which microscopically presented all the characters of colostrum, have been obtained. Add to this, there is occasionally a *pseudo-ballotement* felt. I have detected this on two occasions. I shall best illustrate my meaning here by a case.

Eliza H., aged 37, married twenty years, had had one child and two miscarriages. The first miscarriage occurred nineteen years ago, and was followed by prolapsus, which had persisted ever since, but not to such an extent as it now manifested. The last miscarriage occurred between three and four years ago. She was generally a healthy woman. About

ten weeks before I saw her, she was seized with pain in the left groin and back, very severe, so that she "could not breathe or walk". Two medical men were summoned, who applied mustard poultices and fomentations. One of the medical men in attendance stated that she was pregnant, and about to miscarry. The other said it was inflammation, etc. She kept her bed fourteen days, and her room three weeks. There was no unusual discharge *per vaginam*. She had been regular every month, the catamenial period lasting three days. The discharge was copious; and the catamenia persisted even during the time when she was suckling. After her recovery, and so soon as she was able to go out, she began to experience unusual feelings about the abdomen. These movements were exactly similar to those she had felt when pregnant before. She occasionally suffered from morning sickness, bringing up sour water. The abdomen also had been gradually enlarging. On examination of her breasts, I found that they were much enlarged; and she stated that for three weeks back she had noticed their sensible increase, and felt them unusually painful. This enlargement was not merely of adipose tissue, but of large lacteal tubes. The areola was very large, covered with follicles of the same colour as the areola; and those on the right side were less developed than those of the left side. On attempting to milk her, a few drops of a milky-looking fluid were obtained, microscopically consisting of a large abundance of milky globules, but with a deficiency of liquor lactis. The abdomen was large, and felt heavier than usual to her. There was considerable dulness over the lower part of it; but, as she was an unusually fat woman, the limits of the enlargement could not be made out at all accurately. It seemed, however, to extend to the umbilicus. There was no vaginal discharge; and connexion gave her no pain. The appearance of the external parts was peculiar. Projecting from the vulva was a fleshy-looking body without rugæ, not unlike a glans penis. There was an opening into it, which was very large, so as to admit the finger an inch. This proved to be the cervix and patent os; it was three inches long. Inclusive of the cavity, the sound penetrated five inches. The uterus was very large. Between the cervix and rectum was a large tumour, directly connected with the uterus, which seemed to fill up the pelvic cavity. This was very hard. It seemed, however, to be separated by a furrow, which to the finger closely resembled that of the sagittal suture. At any rate, it distinctly marked out the existence of two tumours. Both were hard and resistant; but one half seemed to be softer than the other.

I do not stop here to dwell upon minor points. I have mentioned enough to show that, if the sound had not been used, the case would have deceived, and might deceive a second time, a medical man. In noting carefully the condition of the breasts in similar cases, we may observe several points of difference. 1. The appearance of the breasts is unsymmetrical. This is not usual at all in pregnancy, but is very common in fibroid and ovarian disease. On one breast you may have several follicles; on the other none, or only one or two. The sizes of the follicles also differ on both sides. 2. The follicles were of the same colour as the areola, and did not become white on being tightened—*i. e.*, when the skin was pulled aside. 3. True vesicular or papuloid follicles—*i. e.*, white follicles—separate or clustered, are never found in a pure case of fibroid tumour, but are common in pregnancy. 4. The follicles, of the same colour as the areola, are most numerous near the nipple in fibroids; very few, if any, being on the outer border of the

areola. The reverse is the case in pregnancy. 5. The peculiar white honeycomb layer external to the dark areola is, I believe, never found in cases of fibrous tumours. In the above-mentioned case, we were fortunate in not making an error of diagnosis. A very remarkable case, in which this error was made, occurred in the service of M. Bouillaud (*Bulletin de la Société Anatomique*, vol. xxii, p. 178.)

A patient, aged 40, married and regular, but not of very bright intellect, was admitted. She complained of labour-pains. The abdomen was large, hard especially on the left side, where a sort of ball could be felt under the hand. The first day, the quick and rapid pulsations of the fetal heart were supposed to have been heard; but no notice was taken at the time whether they were synchronous or not with the pulse of the woman. The *toucher* made by M. Capuron revealed an uterus low down in the pelvis; the head of the child could be felt, also the triangular fontanelle. Everybody present agreed to this diagnosis. The cervix of the uterus was completely effaced, and the os placed very high behind the symphysis. No dilatation occurred of this os for the subsequent fifteen days. On the contrary, the cervix seemed to elongate; and after a time the pains, although closely resembling labour-pains, also ceased. For several hours, however, during their prevalence, a largish quantity of yellow white matter, supposed to be the shew, continued to flow. The *toucher* was practised several times. The diagnosis was always the same—impending miscarriage. In a few days, however, fever set in; pain and œdema of the extremities supervened; and diarrhoea, with very fetid stools. Fifty-two days after admission the patient died. At the *post mortem* examination (beside many very interesting appearances in the bladder, which was empty, but hypertrophied; the ovaries, which were enlarged to the size of an egg; the Fallopian tubes, which were full of small cysts, etc.), the uterus was found pushed to the right side; a fibroid tumour, hard and rounded, smooth, and of the size of a fetal head of five or six months, occupied its left side. It was this tumour which during life simulated the feel of a fetal head. The same sensation was even communicated by the *toucher* after death.

This is a remarkable case, but by no means an unique one. I have seen one of, perhaps, the most eminent accoucheurs in London mistake a fibrous ovarian tumour for a foetus, and actually assert that he could feel the foot of the child. The *post mortem* examination revealed his mistake. The case quoted by Dr. Bradford, in his *Midwifery*, is an eminently interesting one, yet exceedingly sad in its results, as the false diagnosis led to the young lady's death.

2. The double cardiac or single cardiac sound are so seldom absent in cases where fibrous tumours assume large proportions, that their absence alone ought to make us doubt. The aorta, it is true, is sometimes heard through a child's head, or some solid part of its body, when the abdominal sounds are attentively listened to; but the movement of the part leads at once to the extinction of the sound.

3. The projecting umbilicus in pregnancy, and its puckering in cases of fibrous tumour, forms a marked diagnostic difference.

But, again, if the difficulty of diagnosis between a case of ordinary pregnancy and one of fibroid uterine tumour be not small, the differential diagnosis between *extrauterine pregnancy* and these tumours is still greater. I believe that the chief difficulty here has relation to the value of symptoms observed in the

early history of the case, more especially the catamenial function. There seems to be no very precise knowledge of the normal character of this flow in extrauterine pregnancy. Some believe that it is almost always arrested. If I am not misquoting an eminent authority, Dr. F. Ramsbotham, that experienced accoucheur informed me, in conversation, that of eighteen cases which he had seen of this affection, in all there was suppression of the menses. It can scarcely be otherwise than often so.

In one of Dr. R. Lee's papers in the *Medico-Chirurgical Transactions*, on the Membrana Decidua which surrounds the ovum in cases of tubal gestation (vol. xl.), he has given us some twenty cases of extrauterine gestation in which the decidua existed in the uterus, and in several the uterus was plugged by mucus. If so, it is difficult to understand how the catamenia could go on. The absence, in this way, of this secretion would in some measure assist us in concluding that the case was not one of fibrous tumour within the cavity or projecting into it. On the other hand, the catamenia do occur, and these are the cases in which more difficulty would be found. Not to enter further upon this point, I may allude to cases mentioned in the volumes of the *Obstetrical Transactions*.

One was narrated by Dr. Drage (vol. ii, p. 254), in which the catamenia recurred three times between the period when first seen by him in January, when she supposed herself three months gone, and the following March. At the end of June, there was considerable hæmorrhage. In July, all symptoms of pregnancy, except that the sounds of the fetal heart were noted. In August, it ceased. From this time, she continued quite regular. The fetus came away *per vaginam* as an abscess two years after. The other case is that related by Mr. Grace (p. 49), a case of tubal pregnancy, in which the patient had menstruated copiously before being seen by him. She was then in collapse from rupture of the sac. Again, Dr. J. H. Davis relates a case of extrauterine gestation, in which menorrhagia had been very prevalent, and persisted for six weeks at a time. This case turned out, in the sequel, to have been a case of ovarian pregnancy.

To determine the relations of the catamenia in these cases, I have made the following analysis. The table might be very largely extended.

Out of twenty-seven cases, the state of the catamenial function was stated in twenty-one. Of these, in seven cases, it was entirely suppressed; in seventeen, it was suppressed for periods varying from one to three months, and then followed by menorrhagia, sometimes very profuse. In two, it recurred normally after suppression, in the one case of one month, in the other of nine months; and in two, there were slight uterine losses, but not of any consequence.

The probable explanation is, that there is a stoppage so long as the decidua exists; but when this is thrown off, then menorrhagia follows, owing to the uterine excitement, and precisely as after a labour, owing to the loss of the mucous membrane. The second case I shall quote is a proof of this explanation.

In this very remarkable case, an extrauterine pregnancy was diagnosed as a case of fibroid or ovarian tumour. It is given in the *Annales de Chirurgie* (vol. xiv, p. 249), and occurred to M. Jobert de Lamballe. This woman was a multipara; had three times had symptoms of pregnancy and miscarried, eject-

ing, as she said, tumours *per vaginam*. The catamenia, when present, were very copious. In April 1844, they stopped, only a few drops passing away. This suppression was followed by lumbar and inguinal pains, colicky pains, and vertigo. In July, pains like labour-pains supervened. A medical man now consulted diagnosed a polypus uteri. Next month, the breasts began to enlarge as well as the abdomen. The movements of a child were felt internally by herself and could be felt externally by the hand. In February 1845, there was recurrence of labour-pains, constipation, and difficult micturition. Eight days subsequently, a kind of membrane (*decidua?*) came away *per vaginam*, followed by catamenia for three days. From this time, all foetal movements ceased. The general pains and other symptoms recurred from time to time. The tumour had moved apparently from the median line to the left side. An eminent Parisian accoucheur, now consulted, diagnosed a fibroid tumour in the uterus or ovarian disease. On June 3, the catamenia recurred, and lasted six days.

On admission, the following were the symptoms observed. *By Palpation, etc.*: Large abdomen; round hemispheric tumour, more on the right than on the left side; percussion dull anteriorly, clear in the lumbar regions, extending from six *centimètres* below the xiphoid cartilage to the pubes over a space of thirty *centimètres*; circumference, seventy-five *centimètres*; no uterus to be felt, nor fluctuation; external veins not enlarged. When she was placed on her side, the tumour fell to such side, but without pain. There was no souffle. *Vaginal Examination*: The cervix lay rather to the left side, and hypertrophied, behind the pubes; flattened from before backwards. The os was open, admitting the index finger. Between the vagina and rectum, in the posterior *cul-de-sac*, a tumour filled the cavity. There was no feeling of a foetus. M. Jobert diagnosed extrauterine pregnancy and a dead foetus.

The question may be asked, would it be justifiable to make a puncture with an exploratory needle in a case of dubious pregnancy, in the hope of being able to obtain a small quantity of amniotic fluid, and thus diagnosing the correct nature of the case? It seems hazardous to answer this question. Yet it would appear wiser to do so, than to make an exploratory incision and cut down upon the pregnant uterus, as has now been done some three or four times, and always with a fatal result. The opinion of Scarpa might be quoted, who dreaded no evil effects from paracentesis abdominis in pregnancy, and who believed the gravid uterus might be safely punctured, and supported his opinion by cases related in the writings of Campa, Brown, Sarquis, and Reiscard. (*Cycl. of Prac. Med.*, iv, p. 385.) In Dr. Hall Davis's case of ovarian pregnancy, the woman was tapped when pregnant, and lived twenty-six days afterwards. So did one of M. Rostan's. In these cases, however, an ordinary trocar was used. A very small opening might not have had the same result; and, by affording a smaller quantity of fluid for examination, might have cleared up the difficulty.

The subject of *hydrometra* and *hematometra* need scarcely detain us. The stoppage of the catamenia and fluctuation present would in themselves show that the disease was not of a fibroid character; so, also, in the case of retention of urine. The introduction of a catheter would remove the difficulty in the diagnosis; and this should always be done in all doubtful cases.

[To be continued.]

Illustrations OF HOSPITAL PRACTICE: METROPOLITAN AND PROVINCIAL.

ST. GEORGE'S HOSPITAL.

OBSERVATIONS ON CEREBRAL HÆMORRHAGE, FROM
AN ANALYSIS OF FORTY FATAL CASES.

By THOMAS JONES, Esq., Assistant Resident Medical
Officer at the Hospital.

[Continued from page 494 of last volume.]

2. *Tremors, Twitchings, Convulsions, Rigidity, and Spasms.* At variable periods after the attack of hæmorrhage into the brain, one or more of the above forms of altered motility supervened in 14 cases out of the 40, *i.e.* in 35 per cent. In four, two or more of these symptoms were observed in the same patient simultaneously or alternately, but not necessarily affecting the same parts. Thus, in one case there were observed tetanic spasms and tremor affecting the whole body, while there existed at the same time persistent rigidity of both arms. In others, spasms and rigidity were confined to one side, but there were convulsive affections of the whole body.

Tremor. This symptom was noted as having been observed in four of the fourteen cases. It affected the parts paralysed in three, and in the other it was general, while the paralysis was confined to one side. What is its relation to the seat of the clot? In three of the cases the clot was situated in one or more of the ganglia in the neighbourhood of the base; in the other, however, it was situated in the substance of the right middle lobe, but to such an extent, and so near the ventricle, as to completely obliterate it. Thus we find that the clot existed in close contact with the origin of the motor nerve-fibres in all the cases. Again, in three cases, the clot was confined to one side of the brain, in two of which tremors were general, but in the other this symptom was confined to the opposite and paralysed side. In the other case, the clot was situated in the central parts of the pons Varolii, and the tremor was general. In two of the cases, there existed softening of the parts around the clot; in the other two, it is distinctly stated that there was no softening. In the former two, the tremor was slight and occasional; and in the latter, this symptom was more severe and continuous. There seems to be a decided connection between the urgency of this symptom and the duration of life; for in the two cases in which it was severe and general in its extent, the patients lived but few hours; while in the other two in which it was either confined to one side, or to both, but to a slight degree, they lived as many days.

Muscular Twitchings. This symptom was only observed in two cases. It affected the side opposite to the one paralysed in one, and the hand in the other; the muscles of the eyeballs and face alone were mentioned as being paralysed in the latter. The clots in both cases were situated in the meshes of the pia mater over the cerebral hemispheres; in one, there was also some blood in one of the lateral ventricles. No softening was observed around the clot in either of the cases. The patients lived two days after the supervision of this symptom.

Convulsions were noticed in seven cases. The time