A LARGE MULTILOCULAR OVARIAN TUMOUR.

By F. A. BALDWIN, M.R.C.S., L.R.C.P., L.S.A.,
Manchester.

ON October 23rd, 1899, I was called to see Mrs. S. She was 59 years of age, and had been a widow since she was 30. She had two children, the first when she was aged 23, and the second two years later. Both confinements were of the ordinary type. She never had a miscarriage, and when not pregnant she was always regular. She never complained of any ailment of the genito-urinary tract. The menopause came on without incident at 45 years of age.

About two years after the menopause she noticed that the lower part of the abdomen was swelling. This gradually increased, until from the last four years she had been quite incapacitated from work owing to the size and weight of the abdomen. She has, however, been able to get about the house. For two or three years she has also been much troubled by swelling of her legs. A fortnight previous to the date on which I first saw her she was able for the last time to get upstairs, unaided, by crawling "on all-fours," dragging her abdomen over the stairs, which are steep and narrow, such as are found in workmen's dwellings.

When I first saw her she was seated in an armchair, wrapped in blankets. Any attempt to lie in bed caused such distressing dyspnoea as to render it impossible. The enormous size of the abdomen is well shown in the photograph (Fig. 1). Both forearms rest on the arms of the chair, which are clutched by the hands. Both biceps and pectoral muscles are rigid with the

continuous effort of keeping herself from slipping downwards. Her position is also maintained by the sagging of the bottom of the chair and by a pillow across the front half beneath her thighs. The face expresses weariness from the continual dragging weight of the abdomen. There is no subcutaneous fat on her arms, chest, neck, or face. The veins of the abdomen are large, full, and clearly defined. From the xiphoid tip to the umbilicus measured 27 inches. From the umbilicus to the pubes I was unable to measure; but it was a great deal more than that. From right to left anterior superior spine of the ilium, passing through the umbilicus, was 58 inches. This line, as the patient sat, was almost horizontal. Although the abdomen appeared to be symmetrical, the umbilicus was displaced 3 inches to the right of the middle line.

The most dependent point of the abdomen was 3 inches below the edge of the seat of the chair.

The œdema of the legs (Fig. 2) was due to the pressure of the abdomen on the saphena and femoral veins. It was quite impossible to lift the overhanging abdomen, but subsequently on *post-mortem* examination I found that the thighs above the line of contact with the abdomen were wasted, and in a condition similar to the arms. The œdema was greater in the left leg than in the right, as the following measurements show:—

	Right.	Left.
Ankle	13 inches	14 inches.
Calf	15 "	17 "
Knee	15½ "	17 "
Thigh (about middle)	14 "	19½ "

The upper limit of the œdema in the thighs ran from just

above the knees on the inner side—to the middle line of the limb at the junction of the middle and lower third, and from thence it tapered off to the outer edge of the thigh, about the middle of the limb. This was the line of contact with the abdomen as the patient sat in her chair.

The skin of the thighs where it was in contact with the abdomen was of a dirty brown colour; the capillaries in many places were remarkably injected. The skin on the under surface of the abdomen was brown, brawny, and œdematous.

Fig. 2 shows the lower portion of the abdomen at a slightly nearer focus than in Fig. 1. The umbilicus is in the shade to the left hand side. The spot in the centre is a small scab. The mark on the middle of the left leg is where I pressed my finger to show the œdema.

There had been complete procidentia uteri for about two years. I failed to get a specimen of urine for

analysis, as she was unable to lift herself sufficiently to pass a bed slipper beneath her.

On October 24th (next day) Mrs. S. had been moved on to two mattresses on the floor, and was propped up in a reclining position with pillows and cushions, the lower portion of her abdomen resting on the mattress. She was also able to relieve the feeling of tension in her legs by spreading them apart, a position prevented by the arms of the chair.

She died suddenly and quietly on November 1st, and I was permitted to make an examination of the abdomen. From an incision in the abdomen at X (Fig. 1) I drew off 114 pints of fluid. The first half-dozen gallons of fluid were of a red-brown coffee colour, and fairly clear. The next was thick, and contained many flocculent masses. There were numerous clear colloidal masses adherent to the inner surface of the cyst wall, which varied in size up to half a walnut, and were easily detached. The "well" of this cyst was completely outside-

Fig. 1.

the pelvic brim. Nowhere did its posterior wall pass into the pelvic cavity.

A second large cyst occupied the upper abdomen; from it I took 2½ pints of fluid similar to that from the first cyst.

I detached the upper cyst from the diaphragm, to which it was adherent on the left side to within a couple of inches of its posterior margin. The rest of this cyst wall was free, but in contact with the intestines. The omentum was free, but crumpled up into a small ridge or oblong pad, and was pushed up into the left hypochondriac region. The cyst rose high up under the left costal margin.

At the root of these cysts were two smaller ones—one on either side, each about the size of a cocoanut. All four cysts sprung from a thick fibrous base, mushroom-shaped, and about 3 inches in diameter. From the under surface of this base ran a twisted pedicle about 3 inches long and about the thickness of a thin umbilical cord.

The total amount of fluid obtained from the cysts were 18 gallons, and I estimate the weight of the tumour at 185½ lbs.

The uterus and left ovary were normal; the abdominal wall above the level of the umbilicus was very thin. Nowhere could I find much fibre in it. I removed the tumour, and when all the cysts were empty the mass weighed 5½ lbs.

Both kidneys were normal; the spleen slightly enlarged; the liver was displaced upwards, so that the highest point was on a level with the upper border of the third rib in the nipple line. The lower (anterior) border of the liver was very thin, and about 2 inches above the costal margin.

In deference to the relatives' wishes I did not open the thorax in the usual way, but by opening the diaphragm, which was highly arched, I found that the heart was displaced towards the middle line, the apex being rotated forwards, and was situated at a point in the middle line of the sternum level with the junction of the fourth rib; the heart was small and firm. Both lungs were cramped up in the thorax, their apices being higher than usual above the level of the clavicles; there were no pleural adhesions.

A COMBINED RECTO-VAGINAL OPENING IN THE HUMAN SUBJECT.

By J. G. MODLIN, M.D., B.S.,
Hon. Surgeon to Monkswearmouth Hospital.

In September, 1899, I was asked to operate on Mrs. X. for deformity in the perineal region. On examination I found a well-formed perineum, and a slight dimple in the position of the anus, but no rectum or sphincter. The vulva seemed normal; but on separating the labia a movable septum was

seen, which proved to be formed by the posterior vaginal and anterior rectal walls. It was about one-sixteenth of an inch in thickness, and was freely movable from before backwards. The condition was not one of cloaca. The vagina and rectum were, excepting at their orifices, distinct. But the urethra, vagina, and rectum all opened into one common vulva. The vaginal and rectal tubes may be compared to the two barrels of a double-barrelled gun, the muzzles of which were seen on separating the labia.

Mrs. X. was 24 years of age, had been married four years, and had had two abortions. The condition described had given rise to no symptoms beyond obstinate constipation, and the unpleasantness due to the abnormality. The constipation had probably been to some extent caused by the patient putting off the act of defæcation as long as possible, owing to the pain and discomfort produced. The act usually took about half an hour, caused such severe pain that the patient nearly always fainted, and always caused hæmorrhage.

After the usual preparation, the patient being anesthetised with chloroform, I first cut through the perineum in the middle line from the posterior angle of the vulva to the normal situation of the anus. I continued the incision upwards through the fibrous tissue filling in the space between the rectum and the coccyx. I then separated the posterior wall of the rectum for about two inches. The next step was to dissect up the recto-vaginal septum, thus separating the two passages. The rectum was then detached from the surrounding tissue, so that its lower end was freely movable. I brought it backwards through the opening I had made to its normal situation, and sutured it with fine silk sutures posteriorly and laterally to the skin of the perineal incision. I then again brought to the middle line the two flaps produced by the first incision to

Fig. 2.

form the new perineum, and sutured them together with silk sutures, deep and superficial. The posterior border of this new perineum was sutured to the anterior wall of the rectum, thus completing the new anus; and the anterior border of the new perineum was sutured to the raw surface of the posterior vaginal wall, thus completing the vagina. The case did well, the temperature never rising above 99.8° for twelve days after the operation, when constipation proved very troublesome; there had been a motion every day, but scybalous masses formed, so that chloroform was again administered, and the scybala broken down with a Volkmann's spoon. From this time the patient made an uninterrupted recovery. The present condition is most satisfactory. There is a good, firm perineum an inch a-half long, the vagina is perfectly normal. The constipation is greatly improved and is still improving under treatment. There is no hæmorrhage with defæcation, and the act is easily performed.