economic and other reasons stand in the way of relieving them from the non-professional work of prisons, which leaves them very little time to devote to such important inquiries.

In these days of rapid communication between all parts of the world, it is, perhaps, unnecessary to emphasize the risks that are run of the introduction of tropical affections into temperate climates, and to the desirability of studying and preventing them.

A CASE OF ABDOMINAL HYSTERECTOMY FOR RETROPERITONEAL CERVICAL FIBROID

(WEIGHING 13½ POUNDS).

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THE case recorded in the following paper is the sixth case of fibroid of the cervix that I had operated on within the last three years. I cannot remember having met with a case before October, 1899; at all events, I have never operated on a case of retroperitoneal fibroid of the cervix before that time. In all six cases the patients made good recoveries.

M. H., a single woman, aged 42, a Board School teacher, was admitted into the London Hospital under my care on June 3rd, 1902.

Present Illness.—She had first noticed a swelling in the abdomen about three or four years ago, and from that time it had gradually increased in size. Twelve months ago she began to have a feeling of weight in the abdomen, and a dragging pain, chiefly on the right side. The pain had been worse just before menstruation, and had been less severe immediately after the period; the pain had also been relieved by lying down. It had not been sufficiently severe to actually prevent her going on with her work. She had, however, suffered from a feeling of increasing weakness and prostration, and from slight attacks of faintness when the pain had been severe. Of late the legs had swelled after standing. The bowels had been regular and the appetite poor. There had been no trouble as regards micturition.

Menstrual History.—The catamenia appeared at the age of 14. Menstruation had never been regular; there had been intervals of five, six, or eight weeks between the periods. The period had generally lasted about four days; the amount lost had been normal. During the twelve months before admission menstruation had occurred more regularly. The periods about twelve months ago had lasted five or six days. During the three months preceding admission to the hospital, however, less and less had been lost at each period.

Previous Illnesses.—She had had typhoid fever, complicated with pneumonia and haemorrhage, eight years ago. She had always been subject to "colds" and "sore throats."

State on Admission.—The abdomen was markedly prominent from the epigastric region downwards. On palpation an irregular swelling was felt reaching in the middle line 4 in. above the umbilicus. In the right nipple line the tumour extended to the ribs, and reached far back into the right flank. In the left nipple line the highest point of the tumour was 2 in. from the costal margin. A loud uterine souffle was heard at

various places over the surface of the tumour. The circumference of the body at the umbilicus was 36 in. A little fluid was pressed out of the right nipple, but none could be pressed out of the left.

On vaginal examination it was found that the hymen admitted the finger without tearing. The posterior vaginal wall was bulged downwards and forwards by a fixed elastic swelling, having, it was judged, a transverse measurement of between 3 and 4 in. The vaginal portion of the cervix could not be reached. I came to the conclusion that the tumour was probably a large uterine fibroid. The presence of the fixed portion bulging down the posterior vaginal wall led me to expect that an operation to remove the tumour would be more than usually difficult.

Operation (June 5th, 1902).—The abdomen was opened by the usual incision in the middle line and the incision was subsequently extended upwards so as to measure ultimately about 9 in. The body of the uterus was readily seen. It was uniformly enlarged so as to be about the size of the uterus immediately after delivery, but as regards its shape it was not in any way deformed. It became evident at once that the greater part of the mass forming the tumour lay behind and below the posterior

layer of the peritoneum. The fibroid had evidently grown from the supravaginal cervix, burrowing below the peritoneum which formed Douglas's pouch and raising this completely from the pelvis. It was impossible at this stage to move the tumour appreciably, and it was clear that the only way to remove it would be to incise the peritoneum forming the covering of the mass and to enucleate it gradually from the extensive retroperitoneal "bed" where it lay. I began by tying the left ovarian vessels and then opening up the left broad ligament. Incisions were carried somewhat transversely across the peritoneum over the tumour, one in front of and below the body of the uterus and one behind. All the usual relations were so much altered by the manner in which the tumour had grown that it was impossible to follow the usual steps of an abdominal hysterectomy, making the peritoneal flaps at one stage, finding and tying the uterine arteries at another stage, and so on. The large vessels were tied as they came into view or after they were divided. Working first on one side and then on the other, the mass was gradually enucleated from its attachments. I was, of course, well aware of the probability that the pelvic part of the tumour would be in close proximity to one or both ureters, and on the left side of the pelvic off-shoot of the tumour I found, and fortunately recognized, some 3 in. of the left ureter, tightly stretched, like a

Fig. 1.—Retroperitoneal cervical fibroid removed by abdominal hysterectomy. A, body of uterus enlarged but not deformed; B, tumour; P, cut edge of peritoneum.

piece of narrow white tape, over the left convex surface of this part of the tumour. It looked white, and not unlike a piece of thickened fibrous tissue. It was carefully freed from the tumour, and the enucleation continued. I did not see the right ureter.

Ultimately the whole tumour was freed from its attachments behind the peritoneum, and it was then found to be continuous with the uterus at the level of the supravaginal cervix—that is to say, the tumour was a retroperitoneal cervical fibroid. Several portions of the tumour had become cystic, and some of these cysts were opened in the course of the operation in order to make the mass smaller. They contained thin bloody fluid. The whole mass, consisting of the body of the uterus and tumour, was then cut away, leaving little more than the vaginal portion of the cervix. The remaining portion of the cervical canal and external os uteri was opened sufficiently to admit the finger. A few silk ligatures were required to control bleeding from the cervical stump. These were passed so as not to occlude the lumen of the

cervical canal. A large number of ligatures were required to secure bleeding points at various parts of the "bed" from which the tumour had been dissected. A sterilized gauze drain was passed through the cervix into the vagina, and the peritoneal flaps were sutured together over the stump and the end of the gauze drain projecting from it. A second gauze drain was also left in the lower angle of the abdominal wound, the rest of which was closed in the usual way.

The patient ultimately made a good recovery, and left the hospital on July 22nd, 1902. There was moderate fever during the first three weeks after the operation, no doubt due to imperfect drainage.

She came up to see me at the hospital some months after, and I examined her. The scar was quite sound, and the sinus at the lower end of it had healed completely. She had resumed her regular work.

Note on the Specimen.—It was examined immediately after the operation was over. It consisted of the body of the uterus and part of the cervix, both sets of uterine appendages, and of a mass of very irregular form attached to the lowest part of the uterus (see Fig. 1). The body of the uterus was uniformly enlarged. Its extreme length was about 8 in., its greatest width about 7 in., and greatest thickness from before backwards about $3\frac{1}{2}$ in. On section a small fibroid was found in the anterior uterine wall. The left ovary was enlarged to about three times the normal size.

The irregular mass which formed the tumour was attached to the back of the cervix, and perhaps partly also to the lowest part of the body of the uterus. Its greatest diameter was about 13 in.; its greatest thickness from before back was about 8 in. From the surface several cysts were seen projecting, varying in size from that of an orange downwards (see Fig. 2). The lowest part of the mass was cone-shaped, and was the part of the tumour pressing down the posterior vaginal wall. The tumour weighed $13\frac{1}{2}$ lb.

Two years ago I read a paper before the Medical Society of London on fibroids of the cervix uteri,¹ in which four cases of this condition on which I had operated were recorded in detail. In two of those cases the tumour was interstitial. As regards the other two, in one the tumour was retroperitoneal, and in the other chiefly retroperitoneal. In the case recorded in the present paper the tumour was entirely retroperitoneal, and considerably larger than the largest met with in the four cases previously referred to, the largest among which only weighed $9\frac{1}{2}$ lb. These large fibroids originating in the cervix form a class

the characters of which differentiate it very distinctly from the class of fibroids growing in the body of the uterus. For instance, they are frequently solitary, and the symptoms to which they give rise are mainly such as depend on the size and position of the tumour. Fibroids of the cervix do not seem to give rise to menorrhagia. In the case recorded in this paper it will have been noticed that the menstrual losses had diminished in quantity for some months before the patient came to the hospital. On the other hand, disturbances as regards micturition are not uncommon, though no symptoms of the kind were met with in the case dealt with in this paper. An

important feature, common to most of these cases, is that the body of the uterus is not deformed. It may often be recognized clinically as perched on the top of the underlying tumour. In the present case the body of the uterus was not deformed, but uniformly hypertrophied, probably on account of the presence of a small interstitial fibroid in the body of the uterus itself.

Whether the body of the uterus has been recognized previous to operation or not, it comes into view directly the abdomen has been opened. The fact that it is not deformed is a valuable indication of the true nature of the underlying tumour—namely, that it is probably a fibroid growing from the cervix.

As regards the technique of the operation for removing large fibroids of the cervix, the first difficulty encountered is the absolute fixation of the tumour. No matter what the size of the abdominal incision may be, the mass cannot be brought out of, or even up to, the wound till the peritoneum over it has been incised and the deep attachments of the tumour separated. The risk of injuring a ureter is certainly a very real one. In the present instance some 3 in. of the left ureter were tightly stretched over the convex left side of the deepest part of the tumour, and might easily have been cut away. The only way to avoid such an accident is, in dealing with the deeply-lying part of the tumour, to cut nothing until the nature of it has been examined as well as possible under the circumstances.

Another important point is the question of drainage. The enucleation of such a tumour necessarily leaves a large oozing surface, on which are many ligatures. I thought it better in this case to drain through the cervical canal, as well as with a separate gauze drain in the lower angle of the wound, passing down to the region in which the peritoneal flaps had been sutured, so as to cover the cervical stump. I am inclined to think that this drain might well have been dispensed with, but I still think that some drain should be provided for the serous oozing coming from the "bed" of the tumour behind and

beneath the peritoneum. The patient had moderate fever during the first three weeks after the operation, and this I think was probably due to the drainage through the cervical canal not being sufficiently free. Though the ultimate result was satisfactory, I think it would have been better to have provided freer drainage—for instance, by making a good-sized opening through the posterior vaginal wall.

(The tumour was shown at the meeting of the Medical Society at which the paper was read.)

REFERENCE.

¹ *Trans. Med. Soc. Lond.*, vol. xxiv, p. 106.

Fig. 2.—Retroperitoneal cervical fibroid: another aspect of the tumour showing P, where peritoneum was incised to allow of enucleation of the mass, and D, one of the cavities due to cystic degeneration of the fibroid.

TWO CASES OF RETROPERITONEAL CYSTS:

ONE CAUSING OBSTRUCTIVE JAUNDICE AND THE OTHER SIMULATING AN OVARIAN CYST.

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The following cases of retroperitoneal cyst appear to me to be worthy of record: CASE I.

Large Cyst connected with the Head of the Pancreas, which caused Obstructive Jaundice by Pressure on the Common Bile Duct.

A. T., aged 34, was sent to me by Dr. Collinson, and admitted to the

Bristol General Hospital on December 13th, 1901, with marked jaundice. He had been jaundiced for six weeks and had had two previous attacks of jaundice, the first in November, 1900, and the second in September, 1901. There was no history of severe pain or vomiting preceding any attack; there had been, however, one attack of severe pain in the back below the angles of the scapulae, and extending into the umbilical region during this last attack of jaundice. He had for twelve months been subject to pain at times in the same part of his back, but not of a very severe character.

There was a very hard swelling in the position shown in the chart. It will be noticed that this swelling was nearer the middle line than a distended gall bladder at its upper part. It was noticed that the swelling hardly descended with inspiration to the extent which a liver or gall bladder swelling usually does