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INTERALIGAMENTOUS OVARIAN CYSTOMATA.*

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In the hope of being definite and sufficiently comprehensive, I have chosen the term "intraligamentous ovarian cystomata," to designate the class cases of which I propose to discuss.

In order to define this matter as clearly as possible, I may state that I have observed ovarian and parovarian cystomata connected with the broad ligaments of the uterus in three different forms. First, the cystomata developed from the follicular portion of the ovary, and that were attached to the broad ligament by a small pedicle, composed mostly of an elongated portion of the peritoneum. Second, parovarian cystomata having a sessile attachment composed of peritoneum, derived from the posterior fold of the broad ligament, the anterior fold of which remained without material change. And lastly, cystomata developed from the ovary and situated completely within the folds of the ligament. The latter forms constitute the true intra-ligamentous cystomata which differ essentially from all others in being neither pedunculated nor united to the ligament by sessile attachment, but surrounded by a capsule formed from both folds of the ligaments. It is claimed by some that these intra-ligamentous cysts are usually of parovarian origin, but I am satisfied that they are also developed in many cases from the ovary, generally, perhaps, from the paroöphoron, and it is to this class that I propose to limit my attention on this occasion.

The essential difference between these and the ordinary ovarian cystomata is in the position they occupy in relation to the ligaments of the uterus. The location may be called an unnatural one, because it differs from that which ovarian neoplasms usually occupy.

They are comparatively rare, a fact which indicates that they occur in this location under circumstances that are exceptional to the general laws of pathology which obtain in ovarian neoplasms. This raises the question regarding the causes operative in determining their peculiar characteristics. Two theories have been advanced to explain the morbid anatomy of these cystomata. The one assumes that owing to some error of development the ovary during embryonic life finds its way in between the folds of the broad ligament in place of remaining in its normal position.

If a cystoma occurs in an ovary so dislocated it is bound to convert the ligament into a capsule for itself. I am not aware that there is any positive evidence that this theory is correct. There are a number of cases on record of malposition of the ovaries which may fairly be attributed to lesions of development, but not any in which the ovary has been found within the folds of the uterine ligaments.

The second theory is, that during the growth of the cystoma it burrows, so to speak, into the ligament which forms a ligamentous capsule for it. In order that this may come about it is necessary that the ovary, by a special formation, be closely attached to the ligament, or fixed there by inflammatory adhesions. At the same time the cyst develops in the deeper structures of the ovary, and, meeting resistance on the free peritoneal surface, pushes its way in between the folds of the ligament, instead of growing towards the abdominal cavity. There is evidence that this theory is correct in the fact that these cystomata come from the paroöphoron, the portion of the ovary which is the most closely connected to the ligament, and are therefore predisposed to burrow and become intraligamentous. Furthermore, I have in one of my own cases found the ovary from which the cystoma came, imbedded in the posterior folds of the ligament. It would be more correct perhaps to say that the ovary was spread out upon the posterior fold of the ligament. It was so changed in form that I would have overlooked it, had it not been that there were several small cysts in it, surrounded by what appeared to be an ovarian

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