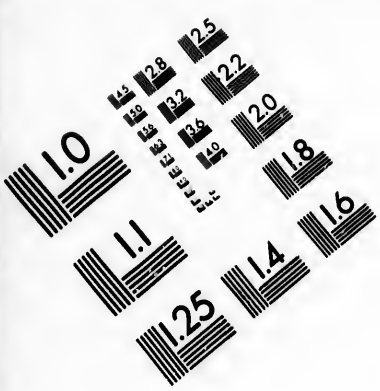


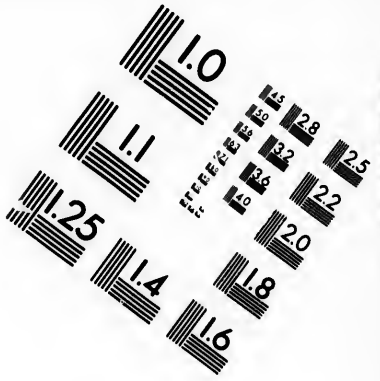


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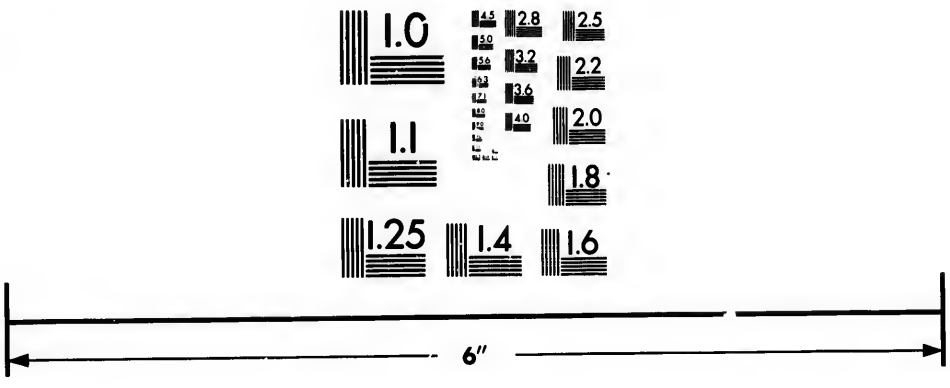



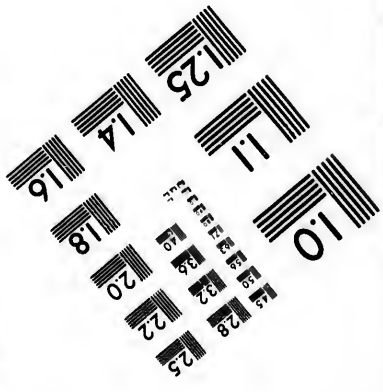


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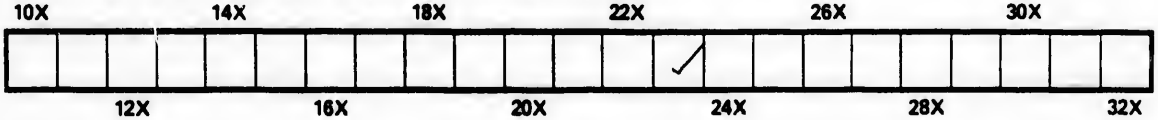

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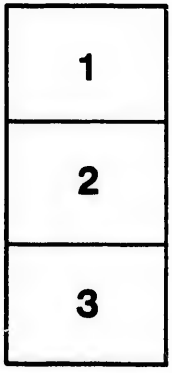


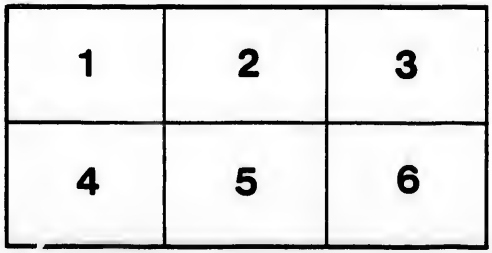


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# ON A CASE OF RETROPERITONEAL LIPOMA (LIPOMA MYXOMATES) WITH ACCOMPANYING RETROPERITONEAL FIBROMA (CHONDRO-MYXOFIBROMA.)

BY

WILLIAM GARDNER, M.D.,

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Three years ago one of us in these pages discussed at some length the condition of Retroperitoneal Lipoma,* bringing together some 40 cases already on record and describing two cases that had come under his notice. Since that date some half dozen or so more have been placed on record, resembling in all important details those previously described. Briefly, it may be said that these are slowly growing tumours which may attain an enormous size, the largest so far recorded (Waldeyer's case) weighing as much as 63 lbs.; they are situated most often more to one side than the other, are accompanied by little disturbance of general health, save progressive emaciation and eventual dyspnœa, are crossed in general by a length of the large intestine and give signs of fluctuation, so that time and again the first diagnosis is that of ovarian or other cystic growth, until the insertion of the trocar failing to bring away any fluid, this diagnosis has to be modified.

These tumours being so rare it is right to place on record each case that occurs. The following is the history of what is the first case of this nature that has come to operation at the Royal Victoria Hospital, the only case met with so far in our (W. G.'s) practice.

The patient, Mrs. F., æt. 35, first menstruated at the age of 14, and had never been other than regular in her periods, menstruation being unaccompanied by pain. Her first labour was a breech presentation at full term, the second a miscarriage at the third month three years ago, her third and last pregnancy ended 14 months ago.

About a year preceding the last pregnancy the menstrual flow became somewhat profuse and some slight pelvic pain was noted during menstruation.

On admission to the hospital in January, she had but just weaned her baby and had not menstruated for about two years. During this period she has had occasional bearing down pains which since the birth

of the last child had been more severe, while there was distinct "falling of the womb" and occasional frequency of micturition. The protrusion from the vulva was first noticed about three weeks after the birth of the last child and since then had been noticed whenever the patient had been on her feet for any time, and also after straining at stool; there was, however, no difficulty in replacement of the parts.

The respiratory, circulatory and nervous systems were found normal, the urine normal, except for a few epithelial and pus cells. (There was a moderate degree of leucorrhœa.) There was some pigmentation of the navel and also of the mid-line from three inches above the navel to the pubes, while the superficial veins over the chest and abdomen were quite visible.

The abdomen was large, somewhat distended and *fluctuating*. On percussion a clear note was elicited in the right lumbar and epigastric region, in the left lumbar region the percussion note was dull, both when the patient was lying on her back and when she was on her right side. The perineum was partially torn and extensively relaxed, and there was descent of both vaginal walls. The pudenda were in parts dusky in colour. Upon bimanual examination the cervix was found soft, but the vaginal roof was depressed by a firm rounded smooth lobular tumour which was movable. This tumour depressed the uterus to the floor of the pelvis where it was quite movable independently of the tumour. The cervix and os appeared quite healthy. A guarded diagnosis was made of fibromatous growth in the pelvis with some accumulation of fluid of uncertain origin in the abdomen.

Upon January 17th, abdominal section was performed, an incision being made from the pubes to three or four inches above the navel. Upon opening the abdomen there was complete absence of parietal adhesions and it at once became apparent that there were two tumours, the larger one—abdominal in position—giving a sensation as of fluctuation the smaller—pelvic in position—much firmer. Both were obviously subperitoneal as shown by the membrane which covered them, with its network of vessels, and by the fact that the descending colon passed over both in a perpendicular direction. This relationship was especially well marked over the larger abdominal tumour and by the growth the colon was pushed over so as to lie to the right of the mid-line.

These tumours were removed by incision through the peritoneum to the outer and left side. After this incision enucleation proceeded with relatively little difficulty and very little hæmorrhage, the larger tumour being the first to be removed. This lay well over to the left side having completely displaced the intestines to the right and having separated the layers of the descending meso-colon. Upon inspecting

the bed of this tumour it was seen that it had lain close to the lower end of the left kidney, but had not deformed it in any way. At no point was it firmly adherent, being removable everywhere without great difficulty. The sigmoid flexure was depressed into the pelvic cul-de-sac.

The smaller tumour mass lay well within the pelvis more to the right side, it also was not firmly adherent anywhere.

The opening into the peritoneum was closed by a running catgut suture and normal saline solution was left in the peritoneal cavity; the abdominal incision was closed by a triple suture of catgut, linen and silk worm gut. Recovery was uneventful.

To the naked eye the larger tumour resembled a mass of light brownish jelly and was of a jelly-like consistence. A considerable amount of rather glairy fluid oozed slowly from it; it weighed 3½ kilogrammes. The smaller tumour was of a wholly different character, firm and fibroid in appearance, yellowish in colour and weighed 475 grammes, and in parts there were definite hard calcareous areas.

The weight of the larger tumour, if we may so express it, was disappointing; the size was such that no glass vessel in the laboratory could contain it, and when placed in an enamel tin bucket it more than half filled it, and even here, although it was placed in abundant formalin it became distorted by pressure against the sides so that it is now impossible to give the original dimensions. After placing it thus in formalin it hardened with difficulty. Upon attempted dissection, the tissue came away in successive irregular layers, coat by coat, here and there, however, could be seen paler, more opaque, more fatty-looking foci.

Upon microscopical examination the tissue was in the main myxomatous, but everywhere throughout the section could be seen small or larger clusters of fat cells tending to be separated from each other by the great mucoid infiltration. Briefly, the appearance given was that of a tumour primarily lipomatous which had undergone development or reversion into mucoid tissue.

It might be well argued that the main mass of the tissue being mucoid, this tumour should be described as a myxoma; I am led to classify it with the lipomata because of arrangement of the fat cells, that arrangement giving us the impression that these are the older elements in the growth. We seem to be dealing with a lipoma which in the course of development has reverted to a more embryonic type of tissue; and the term "Lipoma myxomatodes" adequately expresses this condition.

The smaller tumour consisted of two lobules of about equal volume, the one firm and globular the other more gelatinous and lenticular, lying over it and above. Of these the latter was an almost pure my-

xoma ; large fat cells were present in scanty numbers in its peripheral portion ; only immediately beneath the thin capsule were they clustered together. The firmer rounded mass was in the main fibrous with some mucoid change—a soft fibroma or myxo-fibroma. The centre had undergone degeneration and necrosis, resulting in the production of an irregular cavity filled with clear fluid. Upon microscopic examination, abundant islets of hyaline cartilage were found scattered throughout the tissue with rarer areas in which the cartilaginous matrix had become impregnated with calcareous salts and osteoid (as distinguished from osseous). No fat cells were recognizable. We were thus dealing with an osteoid chondro-myxo-fibroma.

From a histological point of view this case is peculiarly interesting as an example of the metaplasia of connective tissue. Previous cases have shown that in these large tumours we may have practically every form of tissue, from fibrous connective through pure lipoma, to lipoma complicated by mucinous, cartilaginous and even bony development on the one hand, and on the other to embryonic tissue—to sarcomatous development.

Here the larger tumour would seem to have originated as a fatty tumour, which has assumed a myxomatous or mucinous change, while the other tumour, developed apparently from the same tissue, has remained more fibroid.

It may be added that while the majority of these cases on record show one large mass, a few in which the growths have been multiple and distinct, are on record:—Dreschfeld quotes a case of lobules on the two sides mata containing osseous nodules in which the lobules on the two sides were of independent origin. Spencer Wells' case would also seem to have been made up of large, more or less, separate nodules. In Broca's case there was both a lipoma, weighing about 15 kilos, and in connection with this a fibro-lipomatous nodule, and in Roux's first case, while the note is very brief and imperfect, the lipomatous was stated to be growing in the right iliac fossa in association with a fibroma. Belkowsky's case in its characters most nearly approximates to the one here recorded. In it there was one growth in the right iliac fossa which was of fibromatous nature, while a large lipoma had developed apparently in the meso-colon of the sigmoid flexure and was extending upwards along the line of the left ureter.

Where tumours become so large it is difficult to say with precision the point of origin. The probability here is that both tumours originated within the meso-colon of the lower end of the descending colon. In the paper by one of us, already referred to, attention was called to the fact that these growths might develop in association with the kidney fat. The whole history and appearance of the tumours in this case is against

that origin. It is true that the left kidney was closely pressed upon by the lipoma, but it was not distorted nor firmly adherent, and the fact that the lower and smaller of the two tumour masses was so distinctly associated with the meso-colon lends a distinct support to the view that both had this origin.

It has to be kept in mind that tumours of this order may originate at practically any point beneath the peritoneum. While writing the notes upon this case there were received at the pathological laboratory, portions of a large tumour developing in the anterior abdominal wall. For these we were indebted to W. Jameson, of Rochester, N.Y. The tumour was so firmly adherent to the parietes that it became necessary to remove no small portion of the musculature along with the mass. But upon examination of sections made through the muscle and the tumour, the former is seen to be merely adherent and not infiltrated, and the tumour itself is a well defined myxo-fibroma, curiously like the myxo-fibromatous nodule above described, though without cartilaginous areas. From W. Jameson's description of the relationships found at operation, as again from a study of sections from different portions, the growth clearly originated in the subperitoneal tissue of the abdominal parietes.

Lastly, as to the duration of the growth in these cases. In general these tumours are peculiarly slow-growing; they have been noted frequently for periods extending over from two to seven years or even longer. The absence of systemic disturbance and the soft yielding nature of the tumours renders it possible for them to be present for long without being noticed. In a case such as this where the development has occurred during or after pregnancy, the enlargement of the abdomen might easily be attributed to other causes. Indeed, in this case the patient came to the hospital, not because of the tumour, but because of the falling of the womb. That falling might, it is true, be due to the rupture of the perineum, but on the whole we may attribute it and the bearing-down pains to the presence of the growths. It is quite probable, therefore, taking everything into consideration, that the growths in this case were of more than a year's development and possibly, that the increased menstrual flow with bearing-down pains noted a year previous to the last confinement, were associated with the early stages of the growth. Thus it is quite possible that the duration of growth exceeds two years.