A SERIES OF MISTAKEN GYNECOLOGIC DIAGNOSES.

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While it is advisable to chronicle our successes in diagnosis and treatment, I think it is equally necessary for us occasionally to look back and see where we have failed to make an accurate diagnosis before operation, or to critically review our judgment in a given case to ascertain if, in a subsequent and similar case, we could not do better.

From a perusal of the literature one is often led to believe that the exact nature of abdominal tumors is easily determined before operation. While this is undoubtedly true in the greater number of cases, yet it is well to remember that in a goodly number of instances, before operation, it is only possible to determine that the operation is necessary, the exact nature of the malady only being ascertainable when the abdomen is opened. From the accompanying group of cases, which I report in detail, the surgeon who does not always make a positive diagnosis before operation, or the one who may perchance render an erroneous opinion, will possibly derive a certain amount of comfort.

CASE 1.—Diagnosis: Very large ovarian cyst. Actual condition: A partially parasitic uterine myoma, associated with 51 liters of ascitic fluid. (Fig. 1.) Recovery.

***Patient.*—Woman, aged 54, unmarried, was admitted to the Church Home, Oct. 29, 1902, complaining of marked abdominal enlargement.**

***Examination.*—Her face presented a drawn, pinched appearance, and she was very thin. The abdomen was tremendously**

and uniformly distended. From the pubes to the sternum in the mid line there was dullness, in both flanks tympany, and on percussion a very distinct wave of fluctuation was easily detected. A diagnosis of ovarian cyst was made, and after a delay of a few days, on account of a slight bronchitis, the abdomen was opened.

Operation.—We found the peritoneum much thickened. The great distension was due to ascitic fluid. Attached to the fundus by a very small pedicle was a myomatous nodule 16 cm. long (Fig. 1). Plunging into the upper or free surface of this nodule were a large number of blood vessels, each about 3 or 4 mm. in diameter, tortuous and closely resembling angle worms. On tracing them upward they proved to be the enlarged omental vessels. The omentum as such was recognized as a fringe not more than 5 mm. long, projecting from the lower edge of the transverse colon. The altered omental vessels were exceedingly friable and ruptured on the slightest manipulation. The parasitic myoma derived part of its blood supply from the bladder, to which it had become intimately attached. After tying off the blood supply of the myoma, this growth was removed and the patient made a rapid recovery.

In this case I had to rely entirely on the physical signs, as the patient was of unsound mind, and up to the day of operation no history could be obtained. The facial expression and the abdominal signs tallied in every particular with those referable to an ovarian cyst, and without the clinical history a correct diagnosis was impossible. The tympany in the flanks is, on first thought, difficult of explanation, but when we remember that this myoma with the omental vessels attached stretched almost the entire length of the abdomen, it is readily seen that the small intestines were held back and at the same time forced out laterally. Under any circumstance there would have been dullness over the entire anterior abdomen, as the intestines, even if not held back by the tumor and omental vessels, could not have reached the surface, their mesentery not being long enough. I know of no instance in the literature where such a large quantity of ascitic fluid was associated with a myoma. The condition in this case was analogous to that found where a fibroma of the ovary exists. In the latter we have a solid tumor so moving that there is

often partial torsion of the vessels bringing about the outflow of ascitic fluid. In our case the myoma rolled around so much that the omental vessels were partially twisted. This was undoubtedly the case, as is shown by the fact that there has been no further appearance of the ascitic fluid since removal of the myoma. Had this patient been in the possession of her mental faculties the diagnosis would have been fairly certain, as the family physician told me at the time of operation that he had first noticed a hard abdominal tumor attached to the uterus and that the ascites had developed subsequently.

Schwarzenbach[1] reports a most interesting case. The patient was 30 years old and the mother of six children. In 1896 she had a pelvic hematocele, with pronounced symptoms of internal hemorrhage. In 1897 a subperitoneal myoma the size of a child's head was detected. In 1899 she gave birth to a child, and in 1901 an exploratory abdominal section was made. Numerous arteries and veins springing in the vicinity of the stomach lay perfectly free in the abdomen, and passing downward spread out on the surface of the subperitoneal uterine tumor. Considerable ascitic fluid was present in the abdomen. The abdomen was closed, as the growth was thought to be malignant. The patient improved, and in 1902 the abdomen was again opened. The omentum, which at the first operation showed marked atrophy, had now entirely disappeared. The patient was two months pregnant. The large vessels were tied and the myoma was removed. The pregnancy was in no way disturbed. All trace of the pelvic hematocele had disappeared except for the presence of some pelvic adhesions.

It seems quite probable that the hematocele in this case was due to rupture of one of the omental vessels instead of to the rupture of a tubal pregnancy. This case has many points in common with ours.

1. E. Schwarzenbach: Eigenthümliche Entartung des an einem Uterusmyom adhärenten Netzes. Beiträge zur Geburtshilfe und Gyn. Rudolf Chrobak. Aus Anlass seines sechzigsten Geburtstages. Gewidmet von seinen Schülern und Freunden, vol. I, p. 220.

Case 2.—Diagnosis: Myomatous uterus. Actual condition: Adenocarcinoma of the body of the uterus, with secondary subperitoneal nodules. (Fig. 2.)

Patient.—Mrs. C., aged 59, was admitted to the Johns Hopkins Hospital, April 22, 1903. She had had three children. Menses stopped at 49. Four years ago uterine hemorrhages commenced and lasted several months. Since then they have

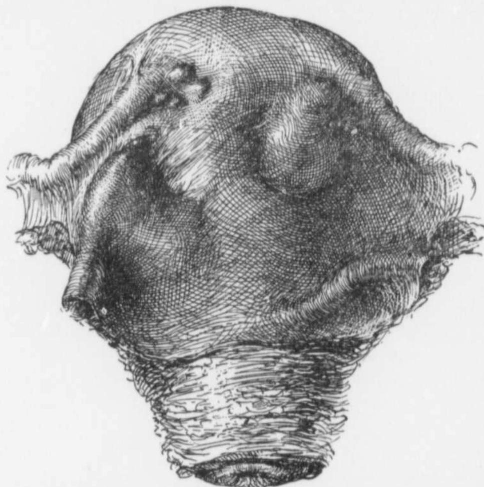

Fig. 2.—Adenocarcinoma of the Body of the Uterus with Subperitoneal Nodules.

The specimen is viewed from the front. The right round ligament is drawn upward by a cancerous nodule situated at its junction with the uterus. Scattered over the surface of the uterus are cancerous nodules varying from a pea to a marble in size. The insertion of the left round ligament is at a much lower level than is that of the right round ligament. The general contour of the enlarged and nodular uterus closely resembles that of a myomatous organ.

been irregular. There is a continual leucorrheal discharge with some odor.

Examination and Diagnosis.—On vaginal examination we found the uterus about twice the natural size. It was quite nodular. As the patient was in good condition and had a nodular uterus which in general contour corresponded closely with a myomatous uterus (Fig. 2), we made a diagnosis of myoma, especially as the hemorrhages could readily be accounted for by

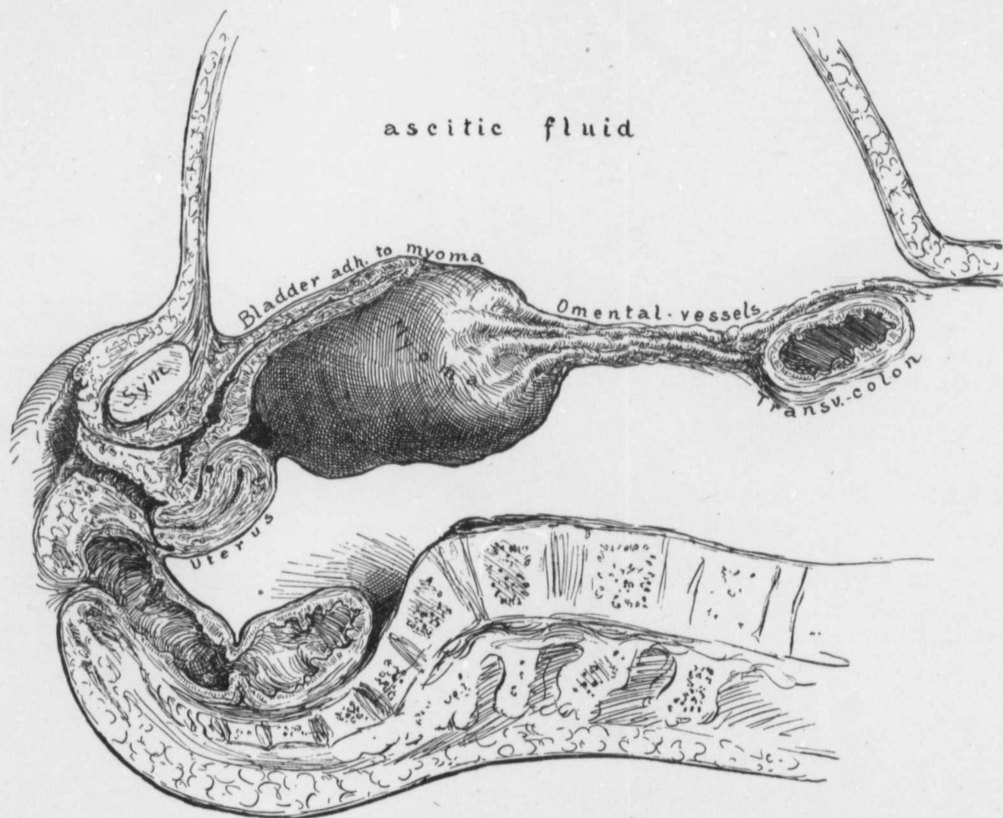

FIG. 1.—A PARTIALLY PARASITIC UTERINE MYOMA ASSOCIATED WITH 51 LITERS OF ASCITIC FLUID.

Attached to the fundus by a narrow pedicle is a subperitoneal myoma. Plunging into the top of the myoma are the omental vessels. The omental fat has almost entirely disappeared. The myoma in intimately blended with the posterior surface of the bladder. The abdomen is markedly distended with ascitic fluid. The small intestines were effectually held back by the tumor and omental vessels.

Fig. 3.—Tumor of the Sigmoid Flexure Due to Rupture of Diverticula Into the Surrounding Adipose Tissue. Small Pelvic Abscess.

The lumen of the bowel below the promontory of the sacrum is considerably narrowed. At this point is a definite tumor made up of adipose tissue. Projecting into it are two diverticula, one seen in longitudinal, the other in cross section. At the point indicated by the three arrows the diverticulum has given way and its contents have percolated through fat. This fat on histological examination showed evidence of acute and chronic inflammation, thus accounting for the denseness of the tumor. Between the tumor and the pelvic floor is a small abscess.

the presence of myomata and since the vaginal discharge was but slightly offensive.

Operation.—At operation we found the uterus as I have described, but the nodules that were supposedly myomata were at points at which the cancer of the body of the uterus had extended to the surface. Here they formed raised nodules beneath the surface and at several places had become attached to the intestines. Complete hysterectomy was performed. The patient made a temporary recovery, but it is doubtful if the entire growth was removed.

In this case mere curettage, even without a microscopic examination, would have been sufficient to establish the diagnosis. But in cases where myoma is diagnosed and hysterectomy advised, we hardly deem it necessary or wise to curette.

CASE 3.—Diagnosis: Subperitoneal and intraligamentary myomata. Actual condition: Hydrosalpinx, adenocarcinoma of the right ovary, involvement of the small bowel and marked extension to the bladder.

Hysterectomy, partial removal of the cancerous growth, resection of a portion of the small bowel; temporary recovery.

History.—On Jan. 25, 1904, I saw the patient, who was 48 years of age. Her menstrual periods continued regularly until she was 44. Since then the flow has appeared every three or four months, and there has been a slight vaginal discharge. Two years ago she passed a calculus, apparently from the left kidney.

Examination.—On vaginal examination I found the uterus half as large again as normal. Projecting from the fundus on the right side, and very prominent, was what appeared to be a subperitoneal myoma about 5 cm. in diameter. The right side of the pelvis was filled by a growth which apparently sprang from the uterus and filled the broad ligament. This growth in contour and consistence resembled a myoma.

Operation.—On opening the abdomen (February 2) I found the uterus moderately enlarged. The supposed subperitoneal myoma proved to be a very tense hydrosalpinx which was kinked forward, thus accounting for its prominence. The growth on the right side was a carcinoma of the ovary. It filled the broad ligament and had infiltrated the bladder wall. Attached to the cancerous mass was the omentum and a loop of small gut. As the gut at this point was markedly constricted, I attempted by gentle dissection to release it, but the bowel was so infiltrated by cancer that it commenced to tear and resection of a portion was imperative. It was decided that the only hope of even temporary relief would be hysterectomy with as thorough removal of the growth as possible. This was done, but a raw, green, offensive, cancerous area, fully 6 cm. in

diameter, remained attached to the surface of the bladder. Three inches of the bowel were then resected and the ends united by means of the Connell suture, supplemented by the Lembert suture. The anastomosed bowel was then placed among healthy loops of gut as far removed from the necrotic area as feasible. The pelvis was drained through the vagina and abdomen. The patient recovered promptly, but naturally still has a small abdominal sinus. We have employed a retention catheter continuously, as even its temporary removal was promptly followed by the signs of ascending renal infection. The patient is now[2] in fairly good condition and has been entirely relieved of abdominal distension and cramps, to which she was subjected for some time prior to the operation.

In this case the clearly outlined subperitoneal nodule associated with the growth on the right side gave us a clinical picture very characteristic of multiple myoma, and this diagnosis was further strengthened by the healthy appearance of the patient. Some may doubt the wisdom of attempting any operative procedure in these cases, but in the liberation of the constricted and friable intestinal loop the bowel was opened, and then the more radical procedure seemed to offer the best chance of temporarily relieving the patient. In this case an absolute diagnosis would have been impossible without opening the abdomen.

Case 4.—Diagnosis: Pelvic abscess, with retroverted myomatous uterus. Actual condition: Rectal diverticula, with rupture into the surrounding rectal fat, producing a definite tumor. Small abscess between the tumor and the pelvic floor. (Fig. 3.)

History.—This patient was seen early in February, 1904. She was 60 years of age. For some time she had experienced slight difficulty in defecation, and for a few days had been running a temperature varying from 100 to 103° F.

Examination.—On vaginal examination, I found the uterus somewhat enlarged. Posterior to it, and apparently continuous with it, was a globular mass. This was very hard and resembled a myoma in contour. There was, however, a hard ridge over its lower portion, as is so often noted where pelvic abscess exists.

Operation.—On February 13 I made a small incision in the vaginal vault just posterior to the cervix, and after peeling back the mucosa entered Douglas' pouch with a pair of blunt

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2. Aug. 22, 1904.

artery forceps. A very small amount of pus and a few flakes of fibrin escaped, but the mass was in no way diminished in size. Realizing the presence of an unusual condition, I packed the opening in the vault and immediately entered the abdomen from above. Filling Douglas' sac almost completely was a tumor mass evidently springing from the sigmoid flexure, which had rotated 90° and had become firmly embedded in the pelvis. It closely resembled a rectal cancer. On careful manipulation it was brought out of the pelvis, and on inspection no lymph glands were demonstrable. The diseased segment of gut was removed and an end-to-end anastomosis done with Connell and Lembert sutures, the former being employed at the mesenteric junction and for about two-thirds the circumference of the gut. A portion of the descending colon was brought up into a small incision in the left inguinal region and made fast, so that if occasion demanded it could be opened with a thermocautery at a moment's notice. Drains were then introduced into the vagina and also through the lower angle of the abdominal incision. At the end of the fourth day there was considerable abdominal distension and the patient was very weak. We accordingly opened the descending colon at its point of attachment to the abdominal wall and at the same time forced the patient's nourishment. She promptly recovered. The small fistulous opening was a few weeks later readily closed under local anesthesia, and the patient is now perfectly well.

Examination of Tumor.—On laying the tumor open we found that there were two rectal diverticula passing out into the adipose tissues, and communicating with the lumen of the gut by openings not more than 1 mm. in diameter (Fig. 3). The larger diverticulum was 1 cm. in diameter and filled with a fecal mass. The floor of this diverticulum had given way, and the surrounding fat was everywhere infiltrated by inflammatory products. The excessive hardness of the tumor was due to the fat being in many places replaced by recent connective tissue. The small abscess between the tumor and the pelvic floor was due to the extension of the inflammatory process to the peritoneum of Douglas' pouch. The diverticula were lined by atrophic mucosa. A rectal examination of this case would have yielded little beyond some narrowing of the lumen of the bowel, which is often present in cases of pelvic abscess. In this case cancer of the bowel might very readily have been diagnosed and a colostomy made.

It will be readily admitted that the preceding cases are unusual ones, and that a positive diagnosis before operation would have been extremely difficult. The possibility of such conditions should always be borne in mind when we are dealing with cases that at first sight seem

so easy of diagnosis. While it is always very gratifying to be able to make an absolute diagnosis, yet in many cases it is only possible for us to give a tentative opinion before operation. In this group of cases, notwithstanding our inability to solve the riddle prior to operation, the outcome was as satisfactory as we could have anticipated under the existing circumstances.