IV.—RARE CASES OF MALIGNANT DISEASE OF THE FEMALE SEXUAL ORGANS.

Observed in the Buchanan Ward, under Professor Simpson, by Fourness Simmons, M.B., Buchanan Scholar.

(Read before the Edinburgh Obstetrical Society, 8th July 1885.)

(Continued from page 558.)

Case III.—Sloughing Sarcoma of Posterior Vaginal Wall; Removal; Death a Month subsequently from Recurrent Haemorrhage.

A. M., æt. 19, married, was admitted into the Buchanan Ward on 27th November 1884, on the recommendation of Dr Freeland Barbour, complaining of a sanious discharge from the vagina, and pain in the lower part of the abdomen.

Her illness commenced seven weeks previously to admission by what appeared to be an ordinary menstrual flow, but the discharge continuing copiously for a fortnight she grew alarmed, and sent for a medical man, who gave her some medicine which greatly checked it. This continued uninterruptedly until five days before admission, when a sudden gush of blood took place from the vagina, and this recurred the following day whilst straining at stool, when, for the first time, it was noticed to have an offensive odour. A fortnight since patient noticed a small lump in the vagina, which came down during defecation, but never caused any pain. About a month after the onset of the discharge she was troubled with pain in the left iliac region, extending to the small of the back, and down the left leg as far as the knee.

The patient was anæmic to the last degree; expression careworn and anxious. There was a loud bruit de diable in the neck, and loud murmurs (probably organic) in the mitral and auricular areas. On everting the posterior vaginal wall with the finger in the rectum, a circumscribed swelling about the size of a walnut is brought into view, covered with vaginal mucous membrane, except on the lower and left side, where there is an irregular patch about the size of a sixpenny piece, which presents a blackened, sloughy appearance, and has an irregular surface. The margins of this patch are irregular, somewhat sharply defined, especially on the right side, but neither thickened nor hard. To the left of the posterior raphe of the vagina the mucous membrane has a bluish, patchy appearance, alternating with its hyperæmic condition around. This tumour had a solid consistence, not nodular; surface smooth, except over the sloughing patch alluded to, and was readily pushed outwards from the vagina by coughing or forced expiration. The vagina elsewhere, cervix, and uterus are healthy.

On admission (27th Nov.) she was ordered a hypodermic injec-
tion of ergotin (3 gns.) each night, and the following mixture internally:

**Rx**
- Tinct. ferri. perchlor., . . . 3iij.
- Tinct. digitalis,
- Acid. phosphoric. dil., . . . āā 3j.
- Aquam ad., . . . . . 3vj.

Sig. 3ss. ter in die post cibum.

30th November.—Copious viscid, yellowish, very fetid discharge from vagina. No haemorrhage.

2nd December.—Profuse discharge of blood from vagina during defecation. Checked by pressure of fingers in the vagina and rectum. Professor Simpson constricted the base of the tumour by two pairs of dressing forceps, the handles of which were kept in apposition by silver wire wrapped round them. Silver wire sutures were then passed below the tumour, which was then removed by the knife. The edges of the wound in the vagina were brought into accurate apposition by the silver wire, and dressed with powdered iodoform.

11th December.—Stitches removed. Incision healed, and looking quite healthy.

19th December.—Wound firmly cicatrized. Vaginal discharge quite ceased. Patient appears perfectly well, with the exception of the general weakness due to the anaemic condition, produced by the loss of blood previous to the operation.

From 23rd to 31st December unfortunately haemorrhage repeatedly recurred, at times very profusely. During this period the treatment consisted in the administration of haemostatics and local plugging of the vagina, and may be summarized as an unsuccessful attempt to restrain the haemorrhage, to which the patient eventually succumbed on the morning of 1st January 1885. No autopsy was allowed.

Viewed under the low power, the section of the tumour will be more conveniently described in two parts—superficial and deep. The superficial is almost entirely composed of cells of various size and shape, with numerous large and distended capillaries traversing its substance, with a few small haemorrhagic extravasations here and there. In the deeper part, a few strands of non-striped muscular fibres and blood vessels separated by large and extensive haemorrhages are seen. In the Bismark brown stained specimen the characteristic cells of the tumour are brought out very clearly, at the expense, however, of its vascular arrangement. Under the high power (see Fig. 3) the tumour is seen to consist of large spindle-shaped and irregular cells, with large finely granular nuclei, infiltrating and separating bands of connective tissue. There are numerous capillaries running between the cells, the walls of which in some places are composed of a single layer of flattened connective tissue cells, whilst at other parts it seems to be absent. Here and there minute extravasations are seen. Many of the characteristic
cells have undergone peculiar degenerative changes,—swelling, becoming more or less rounded and granular, the nucleus undergoing the same changes.

Tumours of the vagina are acknowledged by all writers upon gynecology to be extremely rare. Sarcoma as a lesion in this position has only been quite recently described, and the infrequency with which it occurs may be inferred when it is not even mentioned in such standard works upon diseases of women as those of Gaillard Thomas, Grailly Hewitt, and West and Duncan; while Emmet, in his recent work, says sarcoma "is seldom, if ever, found below the internal os." 1

The points of interest in this case appear to me to be—

1. The age of the patient, viz., 19 years. This is an unusually early age for malignant disease to develop, though it is true cases of sarcoma vaginae have been observed in children three or four years of age. 2

2. The small size of the tumour—being about the size of a walnut—and its sloughing condition.

3. The rapidity of growth of the disease, as shown by the fact that the patient was dead fifteen weeks after the onset of the first symptoms, despite the amelioration following the operation; and the microscopic examination of the tumour was still further confirmatory of this point. Cases of sarcoma of the female generative organs seem prone to run a prolonged course.

**Case IV.—Malignant Disease of the Recto-vaginal Septum. Aspiration of Tumour per Vaginam; temporary Relief; steady Advance of Disease; Patient still Living.**

M. F., æt. 42, widow, was admitted into Ward XXIV. on 28th April 1884, on the recommendation of Dr Maclagan of Berwick, complaining of a constant bloody discharge from the vagina, pain and difficulty of micturition, and obstinate constipation. Her illness commenced in June of 1883, when the menses lasted fourteen days, and at the conclusion of the period she became very costive, feeling as if "something prevented the passage" of the faeces, and at the same time suffered slight pain during micturition. These symptoms improved slightly during the month following, but her menstruation became very irregular—at first there being an interval of fourteen days between the periods, later on only seven days, and during the three months previous to admission there had been a haemorrhagic discharge daily, at all times necessitating the wearing of a diaper. During the past six months there has been obstinate constipation and pain and difficulty of micturition, there being a sensation as if something prevented the excreta being voided.

On examination, the perineum is entire but much distended,

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1 *Principles and Practice of Gynecology*, p. 507.
2 Sänger, Arch. f. Gyn., B. xvi.; and *Centralbl. f. Medic.*, 1880.
and forming the apex of a large body which projects forwards into the vagina and backwards into the rectum. The examining finger, per vaginam, could not reach the cervix owing to the bulging forwards of the posterior vaginal wall, which is distended over a firm, smooth, non-sensitive mass, clearly limited laterally, and, as far as could be made out, superiorly. Through the rectum a similar body is felt bulging its anterior wall backwards. Recto-vaginal touch shows this mass to be lying in the recto-vaginal septum, and about the size of a small cocoa-nut.

On 30th April 1884, Professor Simpson aspirated the tumour per vaginam, and drew off 8 oz. of almost pure blood, which quickly clotted. Microscopically it consisted of blood corpuscles. Subsequently the dysuria passed away, and the constipation was somewhat relieved; the haemorrhagic discharge, though continuing, was by no means as copious as before. Dismissed, 21st May, expressing herself greatly relieved.

On 29th September 1884 she was readmitted complaining of floodings, with shiverings and pain in the left side. She stated that two months after her departure floodings occurred every three weeks, the discharge continuing copiously for a week. Constipation always aggravated the discharge, and she therefore habitually took aperients. The pain in the left side, which has lasted two months, has been worse of late. On physical examination, the condition of matters was almost precisely the same as on her first visit, with this exception—the perineum was not bulged, but there was a well-marked cluster of external piles.

On 10th October she was anaesthetized and examined; but after careful consideration, Professor Simpson determined that nothing of an operative nature could be done for her. The microscopic examination of the blood from the tumour showed spindle-shaped nucleated sarcomatous cells.

The subsequent treatment consisted in the regular administration of cascara sagrada for the obstinate constipation, gall and opium ointment locally for the piles, and occasional administration of anodynes to relieve pain. Micturition, at all times difficult, was frequently impossible, so that catheterization alone afforded relief. Dismissed 13th November 1884. The mass in the septum somewhat enlarged. Since then I have not heard anything of her physical condition.

Case V. — Second Case of Sarcoma of the Recto-vaginal Septum. Laparotomy and Aspiration of Tumour; Growth of Tumour upwards into Abdomen; Aspiration per Vaginam; steady Advance of Disease; Patient still under observation.

C. F., æt. 52, a widow, was admitted into Ward XXIV. on 12th October 1884, on the recommendation of Dr Freeland Barbour, complaining of pain and difficulty in the evacuation of the bowels.
and in making water, with occasional retention of urine, and a copious watery vaginal discharge for the last three weeks. Three weeks ago she suffered from retention of urine, which has recurred six times during that period, and at the same time noticed a dull gnawing pain in the back, especially on exertion. She menstruated last a year ago.

On examination, per abdomen, a firm, smooth, non-sensitive, movable body is felt in the right inguinal region, apparently the fundus uteri. On vaginal and rectal examinations, the condition is almost precisely similar to that felt in the last case (Case IV.), but the combined recto-vaginal touch reveals the lower \( \frac{1}{4} \) of an inch of the septum unintruded upon by the tumour, which is firm, smooth, non-sensitive, and, roughly, about the size of a foetal head, pressing anteriorly on the symphysis, and posteriorly on the sacrum.

As the condition was very similar to that in Case IV., it was determined to open the abdomen, to see if that would throw any light upon the diagnosis and treatment of the lesion. Accordingly, on 20th October, chloroform having been administered, Professor Simpson made an incision in the middle line, through thick, vascular abdominal walls, till the peritoneum was exposed, which was opened with scissors. The fundus uteri was seen raised upwards by a vascular-looking tumour, jammed in the pelvis, lying extra-peritoneally, and pushing upwards the pouch of Douglas (Fig. 4), which, on being tapped, yielded 12 oz. of dark blood, which, on microscopic examination, was seen to consist of red blood corpuscles.
and a few nucleated attenuated cells. The peritoneal cavity was thoroughly cleansed with carbolized sponges, the edges of the incision accurately adapted, a dry iodoform dressing applied, and secured by sticking-plaster.

*Per vaginam* (after operation).—The tumour is to touch considerably smaller.

The temperature never rose above 99°-2 F.; the stitches were removed on the seventh day, and the wound found to have firmly cicatrized. The patient was up and about on the eighteenth day.

11th November to 9th December.—Urine has to be drawn off almost continuously. At times can make water with great difficulty and much pain.

11th December.—A firm, smooth, tender mass felt, occupying the hypogastric, and extending into the right inguinal region, superiorly and to the right of which the uterine fundus is felt. Tumour aspirated per vaginam. Apparently quite solid and very vascular, as pretty profuse haemorrhage followed the withdrawal of the aspiratory needle, which was checked by packing the vagina with iodoform gauze.

18th December.—Ordered extr. cascara sagrada fluid (30 ml bis in die) for obstinate constipation.

15th January.—Since admission a watery, non-offensive discharge continues daily, though not profusely. Catheterization frequently necessary.

*Per abdomen.*—A somewhat irregular, hard, tender mass felt, extending upwards to about 2 inches from the umbilicus, surmounted by the uterine fundus as before. No bruit heard.

*Per vaginam.*—The tumour has a distinctly nodulated surface, extending from about an inch from the vaginal aperture upwards as far as the finger can reach.

19th January.—Dismissed with injunctions to continue the cascara sagrada (30 ml ter. in die).

10th April.—Has had much pain in the back and pelvis generally during the past two months; worse at night; relieved only by anodynes. At first paroxysmal, lately more continuous. During past month has had loss of power of right leg, and difficulty of walking.

28th May.—Much watery vaginal discharge during the past month,—still not offensive. Taking aperients and anodynes—the latter in increasing doses—habitually. There has been no retention of urine since March last. Has become much emaciated. Uterine fundus fell just below level of, and 2 inches to the right of, the umbilicus, raised upwards by the tumour, which has reached a level about 1 inch from the umbilicus. On its vaginal aspect the nodulated character of the swelling is still maintained.

These two cases (*i.e.*, Cases IV. and V.) are almost unique; for on a review of gynecological literature, I am able to find only one reference to this lesion in this position, viz., Primary Sarcoma of
the Recto-vaginal Septum. This single case, briefly related by Dr P. F. Mundé, is of such interest in this connexion, being so closely allied to the cases I have narrated, that I may be pardoned if I quote it in its entirety:—"A woman, 55 years of age, the mother of a number of children, had suffered from an enlargement of the abdomen, accompanied by pelvic pains, which during the past two months had become exceedingly severe. The tumour was very tender to the touch, and was found to lie in the recto-vaginal space, pressing the vagina forward and downward, and the rectum backward. It was tapped on two different occasions through the vagina, and a thick, bloody fluid, readily coagulable, was withdrawn, with a few flocculi of pus. The diagnosis lay between sarcoma with fluid contents and pelvic hematocele. After three weeks, the tumour slowly increasing in size in the meantime, signs of septic infection appeared, and an opening was made through the vagina, and fresh coagula were discharged. The walls of the cavity were found to consist of irregular soft masses, which could readily be scraped out with the vaginal depressor. Microscopic examination showed it to be a round-celled sarcoma, with but little fibrous tissue. The temperature rose to 103°, and the patient died of exhaustion on the fifth day after the operation. Post-mortem examination showed that the disease was limited to the cellular tissue in the recto-uterine space, neither the uterus, the ovaries, nor any of the other organs in the pelvic cavity being in the least involved. He had not been able to find a similar case recorded in medical literature, although sarcoma of the uterus and of the ovaries was not uncommon."

I say that the two cases I have described were sarcoma, because I think the limited microscopic examination of the tumours we were able to make, point in both cases to sarcoma as the lesion; for in Case IV. spindle-shaped sarcomatous cells were distinctly seen in the blood, and in Case V. the nucleated attenuated character of some of the cells was very sarcomatous looking, and I only regret that at the time I did not have drawings made of the appearances. Further, that these tumours are undoubtedly malignant is, I think, abundantly supported by the clinical facts of the cases, and on a review of their history one is struck at once with the remarkable similarity of the clinical features, which may be summarized as follows:—

1. Both patients were of similar age—at the time of life when malignant disease is most prone to develop—viz., 42 and 50.
2. Bladder and rectal symptoms were the first to attract attention, viz., dysuria and retention of urine, together with constipation, both becoming aggravated on the advance of the lesion, and simply the results of pressure of the tumour.
3. Vaginal discharge—hemorrhagic in Case IV., and watery in Case V.—non-offensive up to the present date, but always copious.

1 American Journal of Obstetrics, vol. xvi. p. 946.
4. Pain, at first absent; later, becoming paroxysmal, and subsequently continuous, and relieved only by the regular administration of anodynes; in fact, just the character of the pain of malignant disease.

5. Still further, the steady advance of the disease, the aggravation of the symptoms, loss of flesh and cachectic appearance, which developed in these patients, are all in favour of a malignant neoplasm.

6. A remarkable similarity in the physical signs of the pelvis, the tumour being of the same consistence and in the same position primarily in both cases, though it is true in Case V. it subsequently became abdominal; and furthermore, its vaginal aspect came to have the nodulated feel of a malignant new growth. At first the contents of the tumours are fluid to some extent, for they can be withdrawn by aspiration; but subsequently they become quite solid, and the only effect of aspiration is to create smart haemorrhage. The fluidity of the tumour at an early date was most probably owing to the fact that a portion of it was cystic—in fact, a cysto-sarcoma—and that haemorrhage had occurred from the lining of the cyst wall. One might readily understand the occurrence of haemorrhage in these cases, for during the act of defecation (especially in the existence of obstinate constipation, as in both these patients), the pressure of the bowel contents from behind, and the increased intra-abdominal force from above, would be quite sufficient to account for the rupture of badly supported vessels at their weakest points, which, even if only capillary oozing resulted, would in time suffice to fill a cavity such as I venture to think existed. Or, yet again, the fluid contents may have simply been the result of considerable blood extravasation into the midst of a solid tumour, which had a more loosely constructed centre. Or, it is possible, though quite improbable, that there was a cyst formation primarily, and a secondary sarcomatous growth around it, which, after invading the cyst wall, would allow capillary oozing to take place into the previous cystic contents for the mechanical reasons just mentioned. The subsequent solidity was simply the result of the removal of the fluid contents, collapse of the walls around, and possibly some increased cell proliferation from the irritant action of the aspiratory needle. These are, of course, mere theories—to my mind, plausible—though quite subservient to facts. The fluidity of the tumour does not prevent its being sarcomatous, for in the only case on record, we know there was an abundance of fluid contents.

The differential diagnosis requires to be made from two lesions—haematoma and carcinoma. Cases of haematoma in the rectovaginal septum are very rare, though (1), the displacement of organs produced in Case V., the uterus being raised upwards into the right inguinal region; (2), the hard feeling of the tumour; and (3), the pressure symptoms resulting—dysuria, retention of urine, and constipation—were all in favour of this view. But in
Case V. the patient had passed the menopause, and the prolonged subsequent history of both cases makes this view quite untenable, as absorption of the swelling or suppuration in it would have occurred. These cases were not carcinomatous in their nature for two reasons—(1), there was never any evidence of ulceration in these tumours; and (2), there was a total absence of secondary deposits. Both of these changes would have occurred if the lesion had been cancerous.

The treatment most advisable would appear undoubtedly to be aspiration of the tumour per vaginam (using every antiseptic precaution), as this accomplishes all that can be done by any operative procedure; for although there is very little danger following the abdominal section, its adoption cannot furnish us with any further reduction of the tumour. The plan followed by Dr Mundé in his case of making an opening into the tumour through the vagina and scraping out its interior did not have a favourable termination, probably because a septic condition arose before the operation, which was quite sufficient to justify its adoption. The relief thus given by any operative procedure is not very encouraging; and later on, when the symptoms become aggravated, they must be treated as in malignant disease generally, by anodynes. The obstinate constipation was best met by the constant use of cascara sagrada in gradually increasing doses.

V. — ON THE TREATMENT OF LABOUR DELAYED BY OBSTRUCTION AT THE PELVIC BRIM.

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(Read before the Society, 11th November 1885.)

As a preliminary to my remarks on the treatment of labour delayed by obstruction at the pelvic brim, it will be necessary to define the nature of this obstruction. It must be remembered that an abnormally large head may be obstructed at a normal brim; but the treatment of such a case will not be materially different from that for a case of labour where an average head is detained at a contracted brim. Not to complicate the question unnecessarily, I shall also omit all mention of cases where the brim is contracted, only or mainly, in the transverse diameter. Of such cases I have met with several examples. They are numerous, however, and I shall not consider them in this paper. Obstruction in the conjugate diameter, on the other hand, is the most common cause of delay in labour; and, to the treatment of such delayed labour from this cause, so much attention has been directed by the ablest obstetricians of the day, that