Clinical Reports.

OVARIOTOMY IN THE CASE OF A LARGE MULTILOCULAR CYST WHICH RUPTURED FOUR DAYS BEFORE OPERATION. RECOVERY.

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Mrs. E., act. 24, was married in July, 1895. She had always been a healthy girl, though slight and small in stature. She remained in good health until April 1896, when she first began to notice an enlargement of the lower part of the abdomen. It was believed to be due to pregnancy by her friends, and little attention was given to it. During the months of April and May, her menstrual periods ceased. In June a physician was called and said he supposed she was pregnant, but no examination was made. She was seized with a somewhat profuse flow in July, and after this time her "turns came off and on" until I saw her on October 1st, in consultation with Dr. G. M. Campbell, who, when called a few days before, suspected something more than pregnancy in her case. On my first visit with Dr. Campbell, I found a little, weak and emaciated woman with an enormous swelling filling up and distending the whole abdominal cavity, reaching from above the ensiform cartilage, which was pushed outwards by the growth, to the pubes. She was unable to lie down on account of the size of the tumor.

At that consultation a thorough examination was made. To our surprise, we found an almost imperforate hymen with a very narrow vaginal passage admitting the forefinger with great difficulty and pain. She then admitted that she had had no intercourse with her husband since their marriage, on account of the great pain the effort produced. Abdominal palpation and percussion indicated the presence of fluid: resonance could only be found in one flank. Under the circumstances I did not hesitate to use the sound, as pregnancy was likely out of the question. The vaginal roof was hard and unyielding in all directions. With some difficulty the sound passed into a small uterus crowded forward between the mass and the pubes.

We decided that she should go at once to the Victoria general hospital for operation, as it was likely a case of large ovarian cyst.
On the night of the examination (October 2nd) she was seized with a sudden pain in the abdomen, accompanied by great weakness and vomiting, with fever. She went to hospital October 6th. When admitted she was in very bad condition, very weak, had some pain and much distress, pulse 120, temperature 100.4° F. I had appointed Thursday, the eighth, for the operation, but on account of her condition I operated the day after admission. Anaesthesia was by ether, and after very thorough antiseptic precautions the operation was begun.

On opening the abdomen, a large quantity of dark, thickish fluid escaped. It was evident that one of the cysts had ruptured, probably on the day she first had the pain and other bad symptoms. We found an immense multilocular cyst. There was a good deal of fresh adhesion, but none that was not easily separated. A large abdominal opening had to be made, and with some difficulty—for many of the cysts could not be emptied—the tumor was lifted out and the pedicle tied off. The peritoneum presented an alarming appearance, being deeply congested in all directions, granular looking, and coated here and there with lymph spots of a dark unhealthy hue.

The toilet of the peritoneum was made as thorough as possible, but at this stage we had to make great haste as the collapse was very marked. The dressings were hurriedly applied and the patient removed to a warm bed. This state of shock continued for three days, when her condition seemed altogether hopeless. During this time the pulse ranged from 140 to 150 and was very weak; temperature from 100.3° to 101.4° F. On the fourth day the heart's action improved, and the pulse came down to about 126, the temperature continuing to range from 101° to 103° F. The improvement was now very slight for the next fifteen days, after which her symptoms indicated the possibility of recovery. Subsequently she made a slow but good recovery. During the period of collapse a bed-sore had formed, which was troublesome. She was able to sit up in the fifth week and was discharged from hospital on December 9th.

Among the cases of abdominal section we have had in the hospital during the past year this one was the most severe, and presents a number of points of interest which warrant me in giving the history publication. The case illustrates, in the first place, the difficulty of diagnosis which obtains in all cases of abdominal tumor, for every operator soon learns that he never knows, even after most careful study of symptoms, what condition he is going to find in a case of abdominal section, until he has the abdomen opened, and even then it is not always easy. The diagnosis is especially troublesome when pregnancy is suspected.
The case also teaches us the lesson we so often learn, the danger of delay in deciding upon a definite plan of treatment in any case where a radical operation may be required.

As a general surgical rule it may be said that early operation, where surgical interference is called for, means success, while a late operation is likely to be followed by a fatal result.

The great danger of allowing a case, which even gives promise of critical symptoms, to drift, is one of the most serious faults of our practice.

It is due to every patient that at least an accurate diagnosis, based upon a complete and careful examination, should be made.

It is especially cases of chronic disease, such as growing tumors or tubercular joints, that are allowed to drift along, often until, when the operation is performed, the delay has lessened the chances for the patient, perhaps fifty per cent.

The general practitioner, who gives the most careful attention to a case of acute disease, makes two or three visits a day, watches pulse, temperature, and other symptoms for any indication of serious change, in other words is careful and thorough in his treatment, will often allow a case of chronic disease which may require a surgical operation for its cure to drift on from day to day without an accurate diagnosis and a prompt decision based upon it. The fatal result which is nobly fought in the acute case is actually courted in the case of chronic disease.

I believe also that this patient's recovery was due to the fact that the peritonitis which existed at the time of the operation and continued afterwards, was irritative (if I may use that term), not septic.