

## SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class.)

### I.

#### Case of Chorionepithelioma following Vesicular Mole.

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ON the 9th of March, 1906, I was asked by Dr. Brownridge, of Paisley, to see his patient, Mrs. S., aged 38, the mother of three children. She was about three months pregnant, and for six weeks had suffered from sickness and vomiting and red discharge from the vagina. This discharge lately had been at times very profuse, so much so as to cause faintness on several occasions. One specially severe hæmorrhage had taken place just before I saw her.

The uterus was larger than was accounted for by the duration of pregnancy, and on examination *per vaginam* it had a peculiar feeling as if its surface was irregular from innumerable small nodules. Although there had been no discharge of vesicles in the blood, I expressed the opinion that it was a case of vesicular mole, and advised that if it were not expelled within a day or two the patient should be sent to hospital for its removal.

She was admitted to Ward 30 on the 14th of March, when the following report was made:—

Mrs. S., æt. 38, married 14 years; 3 children, the last 4 years ago; no abortions; labours normal. Menstruation 4-weekly, lasting 2 or 3 days with slight pain occasionally. Is well nourished, but pale. Mammæ enlarged, secreting; areolæ dark. Patient complains chiefly of sickness, vomiting and weakness. Her last menstrual period was in the second week of December. She felt very well for 5 weeks after that, when she lost her appetite. In the sixth week she had a slight red discharge, and sickness and vomiting started. The discharge lasted 2 days, then stopped for 2 days, and then came on again for a day. Sickness and vomiting became so troublesome that she sent

for her doctor. He gave her powders which helped her, but slight sickness and vomiting have continued ever since. Discharge again started 10 days ago, and was very profuse for 2 days. It gradually ceased, but 3 days later it again came on for 1 day. Last night she had profuse discharge again. No clots have been passed. There has been no pain. But for the discharge and the sickness she would feel well.

*Physical Examination.* The abdomen is rather large, moderately thick-walled. The hypogastrium is occupied by a mass reaching about two finger breadths from the umbilicus and from about the level of the middle of right Poupart to  $1\frac{1}{2}$  inches from the left A.S. spine. This mass is slightly movable from side to side, and is rather more prominent to the right of the middle line.

*Per Vaginam.* The cervix is low, considerably enlarged and expanded, soft and irregular on the surface. The mass felt in the abdomen is the enlarged uterus, over the lower part of which arterial pulsation is very marked. There is no pain on examination.

On the evening of the 15th, four laminaria tents were introduced into the cervix, and on the morning of the 16th the uterus was emptied of a large vesicular mole, over the lower part of which a mass of blood-clot was attached. The interior of the uterus was carefully curetted, and then packed with iodoform gauze. The patient was extremely collapsed, both before and after the operation, and had two saline transfusions and frequent hypodermic injections of strychnine for the following two days. The gauze was removed next morning, and there was no further bleeding.

On the 22nd, under local cocaine, several small cysts—like vesicles of the mole—were excised from the lower part of the posterior and lateral wall of the vagina.

The patient went home well on the 26th, nothing malignant having been discovered either in the vesicular mass removed from the uterus or in the vesicles excised from the vagina. Her doctor, however, was informed that after vesicular mole there was sometimes a development of chorionepithelioma, and he was asked to report to us as to the progress of the case.

She was re-admitted to the ward on April 23rd with the following report:—Since leaving the ward, 4 weeks ago. she has felt very weak, only sitting up for an hour at a time, and then feeling quite exhausted. A fortnight ago, there was a faint, straw-coloured discharge from the vagina, which was always darker coloured in the morning. This continued more or less for a week. On the 13th of April a very profuse hæmorrhage set in, and continued from 2 p.m.



FIG. 1.—Uterus opened along anterior surface showing tumour depending from left angle; the upper part pure chorionepithelioma, the lower part blood clot.

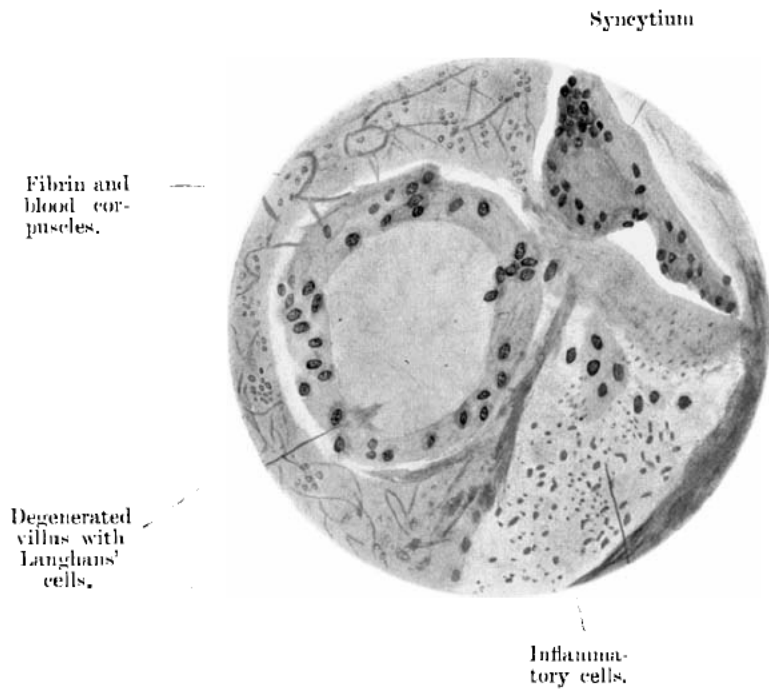
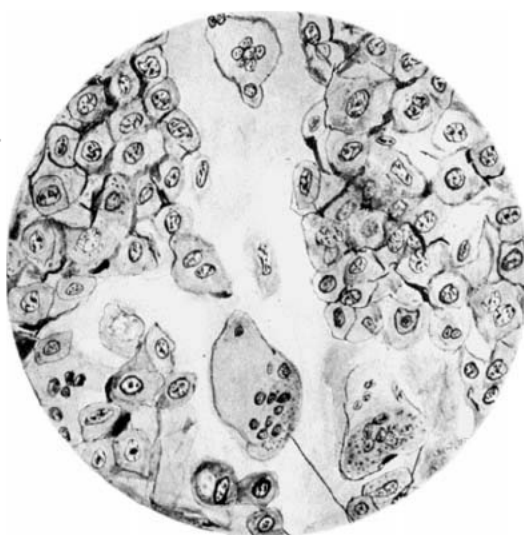


FIG. 2.—Section from Mole. Objective 3, Ocular 6.

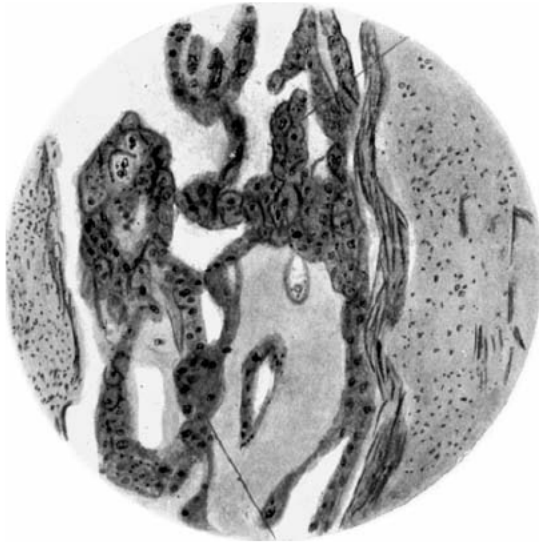
Langhans' cells.



Syncytium,  
with nuclei  
broken up.

FIG. 3.—Section from Tumour. Objective 1, Ocular 6.

Langhans' cells.



Syneytium

FIG. 4.—Section from Tumour. Objective 1, Ocular 10.

till 10 p.m. It continued in less amount for 3 days, then stopped for a day, and again recommenced and continued in moderate amount till the 20th, with small clots in the discharge. On the 20th she had a very profuse hæmorrhage with large cysts. Her doctor found her almost pulseless, and plugged the vagina. She felt faint, but did not faint altogether. On the 21st a smaller plug was put in as the bleeding was not so severe, and the plug was left out on the 22nd. The bleeding returned in the early morning of the 23rd, and her case was considered hopeless, when I saw her and, after firmly packing the upper part of the vagina, had her removed in an ambulance to the Royal Infirmary. There was no further bleeding, and on the morning of the 24th I performed an abdominal hysterectomy, removing ovaries and tubes as well. She made a smooth recovery, and left the ward on the 14th of May; up to the present time (June 25th) she continues well.

Immediately after the operation the uterus was laid open by a longitudinal incision along the middle of the anterior wall, and a small polypoid tumour was found projecting from the neighbourhood of the left tubal opening, and from the lower end of this mass a small blood-clot hung down into the internal os (Fig 1). On microscopic examination this tumour showed the characteristic structure of chorionepithelioma (Figs. 2, 3 and 4).

During the removal also an orange-sized cyst of the right ovary was ruptured and gave vent to pale, straw-coloured fluid. The wall of this cyst showed the ordinary structure of the corpus luteum.

This case illustrates the connection, which is now so well known, between vesicular mole and chorionepithelioma, and also the connection between cyst of the corpus luteum and vesicular mole which is insisted upon by L. Fraenkel and others.

As to the concurrence of cysts of the ovary with chorionepithelioma, I may refer to a case which I had in the ward last year (to be published shortly in the *Glasgow Medical Journal* as part of the Transactions of the Glasgow Pathological and Clinical Society, to which it was shown). In this case, which was one of extraordinary malignancy, from a small chorionepithelioma in the anterior uterine wall there were metastases in the vagina, heart, spleen, lungs, kidney and brain, and the ovaries, which were also infected, were both cystic (each equal in size to a Jaffa orange).