

The left ovary was enlarged to $2\frac{1}{2}$ inches and cystic, and was also removed. The pelvis was found to contain a considerable amount of material similar to the contents of the dermoid cyst, and at the time it was not apparent how it came there, in view of the fact that none was spilled when the cyst was emptied. The cavity was cleansed and drained and the abdomen closed. The patient made a good ether recovery, but the pulse rose to 150 on the night after operation. There was some abdominal pain and moderate distention, relieved by enemata; the abdomen was always soft and not tender. The temperature had risen to 101° F. on the second day, with pulse at 160, and the patient died, apparently of shock, on the third day.

The cyst measured 22 by 18 cm.; color, reddish to gray. On one side a thick pedicle with injected vessels and thickened walls. The whole surface of the cyst was roughened by adhesions, and the wall was 0.4 to 1.5 cm. in thickness. The cavity was filled with soft, yellowish, fatty material, showing cholesterin crystals, and embedded in this material were several balls of very coarse, golden-yellow hair; no bone or teeth were found. On what was, at the time of operation, the posterior surface of this cyst was a smaller cyst containing a thick mass of inspissated material, but no hair. On the discovery of this subsidiary cyst, the presence of the material found free in the pelvis and above alluded to seemed to me adequately accounted for. It seemed evident that this smaller cyst had originally contained the material, and had ruptured long enough before operation for the opening to have closed before removal, or to have escaped detection afterwards. Pathological diagnosis: Dermoid cyst, with necrosis and inflammation.

All authorities agree that "dermoid cysts are more likely to undergo axial rotation than other ovarian tumors, and hence twisting of the pedicle is comparatively frequent in this variety of cystic growth."¹ Malcolm Storer, in his valuable paper on axial rotation read before this Society nine years ago,² states that "In about 83% of the 248 cases of torsion collected by him from various sources, the tumor was either polycystic, solid, or dermoid, that is, presumably, of more or less irregular outline and varying weight, the irregularities affording convenient points for the exercise of the force needed to produce rotation, and the varying weight tending to produce disturbance of equilibrium."

CASE V. E. P., aged fifty-nine, had had one normal labor and afebrile puerperium in 1872, and had been a widow for two years; she had not menstruated for fourteen years. She had had good general health, and said she had never had an attack similar to the present one. Three days before I saw her she had been seized with excruciating pain in the left lower quadrant; the pain lasted one day, and the second day thereafter the pain returned and became general over the whole abdomen. There were no chills, but she had vomited and had had slight fever. The abdomen was distended, tympanitic throughout, and tender. The vaginal vault was puckered, and in the apex was a small atrophic cervix. On the left was a mass reaching nearly to the umbilicus and slightly movable independently of the uterus. The following day there was slight jaundice, which disappeared the next day; pain disappeared in a few days. The diagnosis lay, to my mind, between cyst of the left ovary and pedun-

culated subserous fibroid, with a possibility of malignant growth; and operation was advised and accepted.

On opening the peritoneum a mass was found made up of adherent omentum, intestine, and a tumor proceeding from the left broad ligament; the tumor had the shape and appearance of an enormously distended Fallopian tube; the ovary could not be differentiated and was presumably involved in the tubal mass. The tumor had rotated once around from without inward, and the pedicle thus twisted was so small that it was tied off with a single ligature. The mass had a necrotic appearance, and it was obvious that degenerative changes must have taken place in consequence of the torsion of the pedicle. The right appendages were shrivelled and adherent, and were not disturbed. On the anterior surface of the atrophied uterus was a sessile, egg-shaped myoma, 4.5 by 3 cm., which was enucleated and the bed closed in with buried sutures. The abdomen was closed without drainage, and the patient made a rapid and uneventful convalescence.

Subsequent examination of the strangulated tumor showed that it consisted of tube and ovary; the ovary, cystic, the capsule-like wall, tense, dull, dark red in color, slightly roughened by exudation, with dimensions 10.5 by 8 cm.; the contents consisted of dark, reddish-brown fluid in which were numerous blood cells and cholesterin crystals. The tube measured 7.5 by 1.8 cm., with walls dark red and softened and lumen distended with dark blood.

On comparing the pathological conditions found with the patient's statement of her symptoms, it seems incredible that such extensive changes could have occurred in so short a time. It is a fair inference that the ovary was cystic and that the tube had been the seat of a chronic process for perhaps some time without having given rise to symptoms that led the patient to seek advice. And it is quite probable that the attack of excruciating pain occurred shortly after a sudden axial rotation of the tubo-ovarian mass, from whatsoever cause, with the consequent torsion of the pedicle, resulting in hemorrhage into the lumen of both tube and ovary, and in the inflammatory and necrotic changes noted.

A CASE OF ACUTE TORSION OF THE FALLOPIAN TUBE WITH HEMATOSALPINX.*

BY W. L. BURRAGE, M.D., BOSTON.

THE patient, Mrs. H. M. W., twenty-six years of age, first came under observation Dec. 9, 1898. She was a blonde of average height, poorly nourished and anemic; five brothers and sisters enjoyed good health; her father died of cancer at sixty-nine years. She had been married two years and had not been pregnant; always considered herself delicate; menstruation painful for the first twenty-four hours, every twenty-eight days, five to six days' flow, three to four napkins. The catamenia had been irregular up to four years previously. She applied for treatment because of dysmenorrhea. The uterus was found to be anteflexed, enlarged (the cavity measured $3\frac{1}{2}$ inches) and retroposed; the right ovary was prolapsed but not enlarged and not adherent; cavity of the uterus very sensitive to the sound and bleeding easily. I did a Dudley operation at this time, and careful examination under ether confirmed the diagnosis. The result was good and the patient was

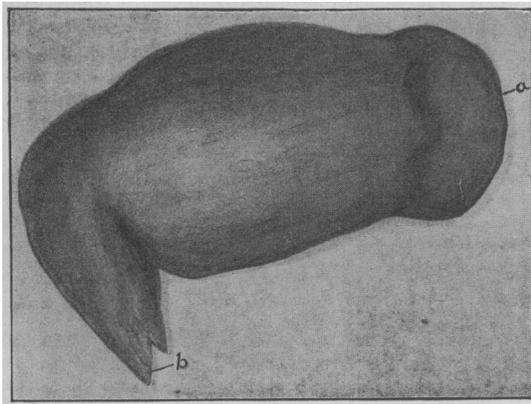
* Read before the Obstetrical Society of Boston, Jan. 23, 1906.

¹ Ashton's Practice of Gynecology.

² BOSTON MEDICAL AND SURGICAL JOURNAL, Nov. 5, 1896.

relieved. She was seen several times in the spring of 1899.

Nov. 20, 1899, Mrs. W. was seized with severe abdominal pain accompanied by intense nausea and was sent to St. Elizabeth's Hospital as a case of pelvic abscess on Nov. 26. I saw her on entrance and made out a tumor the size of a duck's egg in the region of the right tube. It was exquisitely sensitive to light pressure; there seemed to be no exudate about it or about the uterus; the temperature was under 100°; pulse good; face had an expression of great suffering.



Right Fallopian tube. Case of Mrs. H. M. W. Reduced about one third. Exact size—length 9.5 cm., width 4.5 cm., thickness 3.5 cm.; color, dark reddish brown; consistency, soft, fluctuating. *a*, Fimbriated end. *b*, Isthmus where twist of two turns to the right was situated.

An abdominal operation was performed on Nov. 28, and the hematosalpinx removed, and both ovaries, which were riddled with small cysts, were resected. The left tube was normal. There was no free blood in the peritoneal cavity; the omentum was thin and adherent to the pelvic brim and to the distended right tube; the tubal tumor, 9.5 cm. long and 4.5 cm. wide, was adherent to the bladder over a broad surface. There were two complete turns like the thread of a right-hand screw in the pedicle of the tube, which was formed at its isthmus by the tube and its mesosalpinx. The hematosalpinx was dark reddish brown in color, of a soft fluctuating consistency and measured 9.5 by 4.5 by 3.5 cm. When opened the pathologist found only blood clot but no chorionic villi. The patient made a normal convalescence.

In this case the torsion was undoubtedly acute. The patient had been seen a year previously, had been examined under ether and the diagnosis made at that time was unquestionably correct because of the thinness of the abdominal walls and the absence of fat in and about the pelvis. She had been examined a few months before the onset of the acute symptoms and the pelvic condition was as noted. During the time she was under observation,—from 1898 to 1902,—there were no symptoms or signs of pregnancy and no indications of gonorrhoea. We are left at sea as to the cause of the hematosalpinx and of the torsion of the tube.

THE TRAINING OF NURSES.—According to the *Medical Record*, on March 29 a symposium on the training of nurses will be held at the New York Academy of Medicine, to discuss the question of the overtraining of nurses and to suggest remedies.

Medical Progress.

PROGRESS IN THORACIC DISEASES.

BY MARK W. RICHARDSON, M.D., BOSTON.

INTRATHORACIC DERMOID CYST.

SHAW and Williams¹ report a case of intrathoracic dermoid cyst, together with a review of the previous literature on the subject. Only 35 cases are on record. The age at which patients first seek treatment may be anywhere from twenty to sixty. Generally they are first seen between the ages of twenty and thirty. The two sexes seem to be equally affected. The expectoration of hair occurred in 7 of the 35 cases. The cysts are most often seen in the upper part of the chest, and have their origin apparently in the mediastinum. They vary in size from that of a pigeon's egg to that of a child's head. A tendency to invade surrounding organs is common, and pulmonary involvement is followed not infrequently by hemoptysis. In the absence of hair in the sputum the diagnosis is very difficult. Surgical treatment alone offers any hope of relief.

The case seen by the writers was a woman, twenty-six years of age, who had had a cough for several years. There had been on several occasions hemoptysis, and the sputum had frequently contained hairs. For six months there had been wasting, dyspnea and night sweats. X-ray examination showed the position of the tumor to be in the right chest just below the clavicle. No tubercle bacilli could be found in the sputum. Patient was discharged from the hospital unrelieved.

BY WHAT ROUTE DO TUBERCLE BACILLI FROM THE MOUTH AND THROAT REACH THE LUNGS?

According to Beitzke² three different routes have been mentioned as possible: (1) Cervical glands, truncus lymphaticus, superior vena cava, heart, lungs; (2) cervical glands, supraclavicular glands, top of pleura, lung; (3) cervical glands, bronchial glands, lung.

Beitzke showed by the injection of anatomical preparations that the cervical glands were never connected with the bronchial glands, and very rarely with the supraclavicular glands. Injection fluid, moreover, never reached the top of the pleura. Beitzke thinks that although infection in animals may, possibly, be produced by way of cervical glands, truncus lymphaticus, superior vena cava, heart, lung (route 1), in children, at any rate, the primary lesion is in the lung, and that the bacilli are inhaled. Whatever tuberculosis is found in the cervical glands is coincident, and bears no direct relation to the pulmonary condition.

To assist in the early diagnosis of pulmonary tuberculosis in those cases in which sputum is lacking Blume³ recommends the following procedure: An ordinary glass slide is placed in a small, specially made holder. This slide is held

¹ *Lancet*, 1905, Nov. 4.

² *Berl. Klin. Woch.*, July 3, 1905.

³ *Ibid.*, Aug. 21, 1905.