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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.)

On a Case of Adenomyoma of the Uterus involving the Rectum.

By Sir John Bland-Sutton.

It is well known that the morbid condition of the uterus known as adenomyoma may involve the whole, or, be limited to a definite area of the endometrium. Even when the whole endometrium is implicated, bud-like processes of adenomyomatous tissue often project from the peritoneal surface of the uterus and resemble subserous fibroids so closely that the distinction is only possible with the aid of a microscope.

The specimen considered in this communication is an example of localized adenomyoma with the naked-eye features of a subserous fibroid.

A primipara, aged 35, complained of pelvic pain, rectal discomfort and menorrhagia. She was thin, anæmic and ill. On examination the uterus appeared to be larger than normal; its fundus was fixed to the floor of the pelvis and seemed to be adherent to the rectum. On rectal examination a rounded lump, the size of a golf-ball, could be felt resembling a subserous fibroid on the posterior wall of the uterus.

An operation was performed. When the parts were exposed through the usual median subumbilical incision the uterus was found retroflexed; an oval lump, the size of a golf-ball, projected from the fundus and adhered firmly to the rectum. With care the adherent surface of the tumour was detached from the rectum; although the tumour-tissue had implicated the wall of the bowel I succeeded in detaching it without inflicting any serious damage to the muscular coat. The uterus, ovaries and tubes were removed by the subtotal method and the patient recovered easily and quickly.

On bisecting the uterus in such a way as to split the tumour also, the latter maintained the appearance of a sessile subserous fibroid (Figure), but the unusual manner in which the tumour tissue had invaded the wall of the rectum raised my suspicions and induced me to examine it microscopically. The mass was proved to be a localized deposit of adenomyomatous tissue. The glandular elements of this deposit could be traced, by means of successive sections through the

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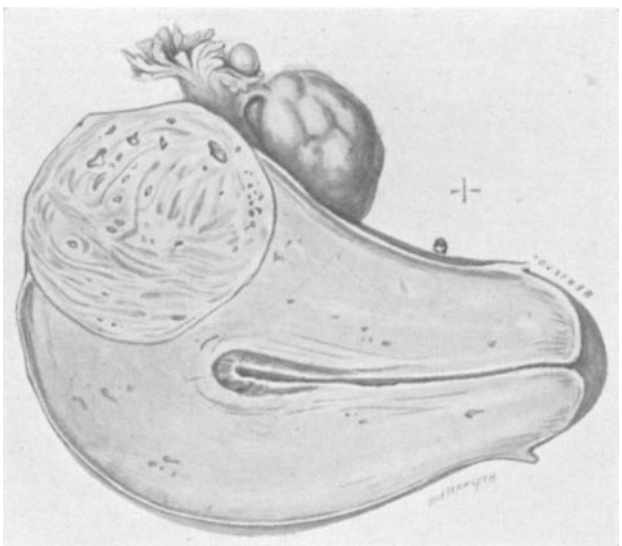

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uterine wall, until they became continuous with the endometrium at the fundus of the uterus.

This is the first example I have seen in which adenomyomatous tissue arising in the endometrium spread beyond the uterine tissues and implicated adjacent organs. This invasiveness is a common feature of cancer.

The pathological features of adenomyoma of the uterus indicate that it is an epithelial overgrowth with a responsive increase of the connective tissue in which the glands are implanted. This epithelial activity is probably prompted by micro-organisms, and the frequency with which the relics of inflammatory action are associated with adenomyomatous uteri supports this contention, as well as the fact that adenomyomatous masses are occasionally tuberculous.

A serious clinical feature of the disease is its simulation of cancer. This would not signify much if it only led to the removal of the uterus, for this, with our present knowledge is the only useful method of treatment, but it has its serious side. Cuthbert Lockyer described, with his usual care and frankness, a case in which a woman, aged 35, had a hard mass in the posterior vaginal fornix, fixed to the supra-vaginal portion of the neck of the uterus and adherent to the pelvic floor. No definite diagnosis appeared to be possible, and, as the poor woman's health was seriously impaired, total hysterectomy was performed. In the course of the operation the neck of the uterus and the rectum were found so firmly fused together, that the implicated section of the rectum was removed with the uterus, the proximal end of the divided bowel secured to an opening made in the left flank (inguinal colotomy).

When the excised parts were examined, the new growth, which implicated the uterus and the rectum, displayed the microscopic structure of adenomyoma. The pathological features of this rare condition are made easily intelligible by Lockyer's excellent illustrations. It is startling to find adenomyomatous changes involving the supra-vaginal segment of the uterus and extending into the pelvic connective tissue like malignant disease. The case which I have described shews also that the disease may penetrate the serous covering and invade adjacent organs. This is a feature of this interesting disease as yet imperfectly appreciated by surgeons. Judging from the remarks made by the speakers in the debate on Lockyer's communication, it is evident that the myth which attributes the origin of adenomyomatous disease of the endometrium to epithelial vestiges of the Müllerian and Wolffian ducts, dies hard.

REFERENCE.

Lockyer, C. "Adenomyoma in the Recto-uterine and Recto-vaginal septa," *Proc. Roy. Soc. of Med.*, 1913, vi, *Obstetrical Section*, 112.

Fig. A uterus in sagittal section. The tumour bisected at the fundus of the uterus is a deposit of adenomyomatous tissue: it had invaded the rectum. (From a primipara, aged 35.)

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