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Endometrial Adenoma of Abdominal Wall following Ventri-suspension of Uterus.*

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THE patient was a ii-para, aged 38. Youngest child 12 years old. Both labours were premature and were preceded by four to six weeks' antepartum hæmorrhage. The second labour appears to have been complicated by a placenta prævia.

The patient had an operation for "displacement of the womb" four years ago at Ipswich, and first noticed a lump in the site of operation one year ago. This lump, which has been getting gradually bigger, swells and gets very sore and tender about the time of the period. The swelling subsides and becomes much less painful shortly after the cessation of each menstrual flow.

The menstrual loss was not heavy (D 8) till after birth of last child. Since then the patient has had menorrhagia (D 30). For the past eight or nine years she has had severe dysmenorrhœa. The pain was at first confined to the right iliac region, but recently it has been felt in the left iliac region also.

At operation a diffuse fibrous-looking mass, irregularly circumscribed, but with ill-defined margins, lay under the right rectus fascia, on, and internal to, the rectus muscle, but not definitely in the substance of the latter. Its position corresponded to the site of the operation wound in the lower middle quarter of the subumbilical rectus. The mass measured approximately $1\frac{1}{4}$ inches vertically by $\frac{3}{4}$ inch broad, and was about half an inch thick at its thickest part. It was not encapsulated. It was apparently shut off from the peritoneal cavity by peritoneum only.

The uterus, which was of normal parous size and shape, was suspended loosely to the inner surface of the abdominal wall by a narrow band consisting apparently of peritoneum only—about $r\frac{1}{2}$ inches to $r\frac{3}{4}$ inches long. This adhesion stretched from the site of the under surface of the tumour to the anterior wall of uterus near the fundus. There was no sign of any loss of uterine substance.

The right ovary was enlarged to about thrice the normal size. It was densely adherent posteriorly and inferiorly to the pelvic wall, and appeared to be infiltrating the subperitoneal tissue. In separating the ovary a hæmorrhagic cyst, about the size of a marble,

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was opened. This cyst contained thick dark fluid blood. The left ovary appeared normal. There was no evidence of adenomyomatous masses elsewhere on the uterus, Fallopian tubes, or pelvic peritoneum, but the exploration was not exhaustive.

On gross section the tumour was irregularly honeycombed with small cystic spaces varying in size from a pinhead to a pea. These spaces all contained thick dark menstrual-like fluid. (Operation one week after menstruation finished.) The tumour was moderately vascular. The remains of two or three old catgut sutures were found in the midst of the mass.

Microscopic sections of the tumour show very numerous gland spaces lined with typical endometrial epithelium. In some places the epithelium is columnar, and apparently ciliated. Elsewhere it is more cubical. In some areas there is a well-developed stroma of endometrial type surrounding the gland spaces. Elsewhere the epithelium rests directly on a fibrous tissue stroma, and in places apparently directly on non-striped muscle.

Sections of the right ovary show the hæmorrhagic cysts to be of lutein type. There are no certain endometriomatous areas present, but one area at least resembles some of Sampson's microphotographs of what he considers to be endometrial areas.

The condition here appears to be the result of an implantation of endometrial tissue in the abdominal wall during the operation of ventri-suspension. Whether the tissue was carried there in the too deep passage of the suspending sutures through the uterus, or escaped through the Fallopian tubes, or from similar areas in the right ovary into the raw area of the abdominal wall, it is impossible to say. The probability is, however, that it was carried on the catgut sutures.

The considerable size of the tumour, and the absence of any great quantity of uterine muscle, precludes the possibility of its being merely a "chunk" of corpus uteri imbedded in the rectus sheath. Moreover the uterus showed no gross evidence at all of loss of substance, and was separated from the tumour by a narrow band of peritoneum at least $1\frac{1}{2}$ inches long.

The clinical evidence of the continued steady increase in size of the mass from being impalpable to that of a tumour more than half the bulk of the corpus uteri, and the evidences of functional activity of the gland-tissue, all suggest that this tumour is of the nature of a (non-malignant) new growth, derived from endometrium, and the microscopic invasive appearances bear out this view. These appearances give the strongest support to Sampson's view that endometrial grafts have, under certain conditions, the power to "catch on" when implanted in alien tissues, to proliferate wherever implanted, and to invade surrounding tissues.



Gland spaces lined by columnar epithelium and surrounded by a cellular mantle of endometrial type, the whole lying in a fibrous tissue stroma. \times 60 Diam.



Gland spaces lined by columnar epithelium and surrounded by cellular mantle of endometrial type. Fibrous stroma to left of field. \times 160 Diam.



Gland space \times 160 Diam. Stroma of endometrial type and epithelium columnar to left of field. Elsewhere endometrial stroma mantle absent and more flattened type of epithelium lying directly on general fibrous stroma of tumour. This is a common appearance in adenomyomata and is probably the result of varying degrees of resistance of different type of tissue to increase of pressure within gland space.



Dilated gland spaces to left of field; epithelium flattened columnar; cellular mantle absent. Gland space to right of field shows epithelium more columnar and cellular mantle. \times 60 Diam.