Adenomyoma of the Round Ligament, which Menstruated through an Inguinal Incision.

By

Wm. Fletcher Shaw, M.D., B.Ch. (Victoria, Manchester),

Lecturer in Obstetrics and Gynæcology, Manchester University; Hon. Assist. Gynæcological Surgeon, Manchester Royal Infirmary; Hon. Assist. Surgeon for Women, St. Mary's Hospitals, Manchester.

I first saw Mrs. R. in 1914. She had one child in 1913 and was brought to me because of irregular, scanty menstruation with severe dysmenorrhœa and chronic pain in the right side.

I performed a laparotomy in August, 1914, and found a double uterus but I can obtain no further information about this operation as the commencement of the war threw everything into a turmoil and the notes of the case are very deficient.

After this operation the periods were regular but still scanty, and the dysmenorrhœa and chronic pain in the right side were not altered.

Six years later, 1920, the patient had another child, but her symptoms remained the same, and in 1924, 10 years after her first visit to me, she again consulted me with the same symptoms and a swelling in the region of the right groin.

I found she had an anteflexed uterus, enlarged, tender right tube and ovary, apparently adherent to the uterus and a soft fluctuant swelling in the right groin about the size of a golf ball, which I took to be a broken-down inguinal gland.

After her admission into the Infirmary I incised this swelling, and was surprised to find it contained, not pus, but a black tarry fluid. The wound healed except for a small space in the centre which remained open, and four months later the patient again consulted me because the original symptoms—dysmenorrhœa and chronic pain in the right side—had not improved, and in addition, this sinus had not healed, and every time she menstruated there was a discharge of blood from it.

I took her again into the Infirmary and opened her abdomen. I found she had a double uterus with a very short, thick, round ligament on the right side which ended in a mass about the size of a golf ball, deep in the right abdominal wall in the position of the

internal inguinal ring. I removed the uterus and both appendages but did not remove the lump in the abdominal wall, as it would have meant very deep dissection with much damage to the muscular tissue; moreover, if it was an adenomyoma, as I now concluded it was, it would gradually atrophy and cease to function after removal of the ovaries.

Dr. Bailey kindly examined the specimen for me. The right ovary is an adenomyoma but apparently has passed its active phase as the epithelial cells are of a low columnar type and their nuclei in many cases show signs of degenerative change. He could find no trace of adenomyoma in the round ligament, but this was only to be expected as I had cut this ligament internal to the mass in the abdominal wall. I consider the swelling to be an adenomyoma arising from the outer part of the round ligament which, as it grew and became distended with blood, tended to burrow into the abdominal wall rather than along the round ligament, and finally produced this fluctuant swelling under the skin in the inguinal region, which I mistook for a suppurating inguinal gland.

The patient made an uneventful recovery, the inguinal incision closed and the pain disappeared, due in all probability to the adenomyoma in the abdominal wall ceasing to function when both ovaries were removed. When I examined the patient six months after the operation there was no thickening to be detected in her abdominal wall.

Lockyer states that this type of adenomyoma is liable to be mistaken for a hydrocele of the Canal of Nuck, but mentions one case recorded by Mary Scharlieb which was mistaken for a suppurating inguinal gland. I can find no record of an adenomyoma of the round ligament continuing to menstruate through the incision as mine did.