(Imperfect)

1905

University of Edinburgh
1904 - 1905

Clinical Medicine.
Gynecology.

Wightman Prize Competition

Case VIII

Cervical Stenosis & Uterine Anteflexion.

Mrs Betsy Clarke, aet 29
Ward 35 (Professor A. R. Simpson)

Admitted: May 8th 1905
Discharged: June 3rd 1905

Record & Report by Charles McNeil.

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Case VIII

Mrs Betsy Clarke.
Age 29.
Housewife.
Married.
Nullipara.
Residence:- Edinburgh.
Admitted to Ward 35 on May 8th 1905
Case taken on May 16th 1905

Complaint. Pain at the menstrual period.
Duration. Ten years.

## General History

### Of Present Attack.

Patient has suffered from pain at the menstrual period for about ten years. It came on gradually & insidiously. At the time of its onset, she was nineteen, and engaged in domestic service where she had pretty hard work. Apart from the fatigues of her work, she knows of no other possible cause of her trouble. She was in vigorous health at the time.

Before this, she had menstruated regularly since she was fourteen, without unusual discomfort, and certainly without the distress of which she now complains.

Since the onset of her pain, it has been constant at every period up to the present; its character & severity have not changed.

The pain precedes the invasion of the flow by half a day: it is then severe but not excruciating and is felt in the bottom of her abdomen. With the appearance of discharge, it becomes much worse and remains very acute for one day. During this day, she is always sick, & vomits much: often also she has diarrhoea.* The menstrual discharge is at this time scanty, & consists of thin blood-stained fluid. The pain is felt as before in the bottom of her abdomen, and sometimes under the nipples. It is so bad,

*She keeps her bed all this day, and eats scarcely anything.

Case VIII ~~That patient~~ Mrs Clarke's Case. General History

Present Attack (continued)

(bad) that patient ~~occasionally~~ takes laudanum for its relief.

After twenty four hours, of this distressing pain, the discharge comes away more freely & abundantly: and with freer outflow, there is considerable relief of pain. The flow continues for three days more, & is characterised by relatively profuse discharge, and by pain which is still acute, but much less so then it was during the first day. Patient is now able to be up, & to attend to her duties.

With the drying up of the flow, the pain disappears, though a feeling of "soreness" remains in the pelvis for a day or two after.

Her menstruation has otherwise been perfectly regular: she has never missed a period.

Such has been patient's condition during the last ten years. Her general health has not suffered. In her intermenstrual life, she has enjoyed robust health, and has been quite fit for her work.

Three years ago patient was married. She thinks that her menstrual pain has slightly increased since. There has been some dyspareunia.. She has never missed a period since marriage.

Eighteen months after her marriage, she consulted Dr Dickson of Edinburgh. He performed an operation upon the neck of the womb, which patient describes as "splitting & dilatation." This improved the pain for a few months, but a year after it was as bad as before. Some further operative interference was then made, the nature of which is unknown to the patient. This again relieved the symptoms, but again for a short time only.

In August last, she began to have a constant intermenstrual discharge. This was a thin, whitish, rather offensive fluid: it was moderate in quantity. It has continued since.

For the last five months menstruation has been more profuse, and of longer duration, than before.

Case VIII — Mrs Clarke's Case. General History.

## Previous Health.

Patient had Typhoid Fever, and Scarlet Fever in childhood. She never had rheumatic fever

**Diathesis** is not marked.

## Social Conditions & Habits.

Patient has a comfortable home, and no want of good food. Her house duties are comparatively light. She takes alcohol occasionally, but only for the relief of her symptoms, and never to excess.

## Family Health.

Her father died, aged 59, of pneumonia
Her mother is alive: suffers from rheumatism.
Two brothers & one sister are alive & well.
None of the family are dead.

## Sexual History.

### Menstruation

A. Normal. Began at age of fourteen
Type. Twenty-one days
Habit:- Duration. Four days (~~lately five~~)
Quantity. Two diapers daily (~~lately three~~)

B. Morbid

Amenorrhea. None

Menorrhagia. For last five months (see History)

Dysmenorrhea. (see History)

Case VIII

## Mrs Clarke's Case.

### Sexual History.

Intermenstrual Discharge.

Leucorrhea. A thin whitish offensive discharge: continuous: moderate in quantity

| | |
|---|---|
| Pregnancies | None |
| Abortions | None |

### Local Functional Disturbances.

Occasional diarrhoea on the first day of the menstrual period. Nothing in bladder: or in pelvic nerves & muscles.

### General Functional Derangements.

Nervous System. Doesn't sleep well

Respiratory, Circulatory, Digestive } Nothing

Emunctories are healthy

## Physical Examination

### General Appearance & Configuration

Patient is a healthy looking, well nourished woman of good development

### Mammae.

Breasts ~~Less~~ pendulous
Breast-Tissue: of fair amount
Areolae: non pigmented: no Montgomery tubercles
Nipples: small: no secretion
No striae

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## Mrs Clarke's Case. Physical Examination.

Abdomen:-

Inspection. Flat. Umbilicus depressed. No linea nigra. No striae.

Palpation. No tumour or resistance.

Percussion. Everywhere tympanitic.

Auscultation. Negative.

External Pudenda:- Nulliparous.

Per Vaginam:-

Orifice admits one finger.

Walls:- moist & rugose.

Cavity:- fairly roomy.

Roof. All fornices empty, save anterior where there is slight resistance.

Cervix: looks down & back: is short, & small: a scar is felt on its posterior surface.

Os is more or less circular: nulliparous: not unduly small.

Bimanual Examination:-

Uterus: not enlarged: of pyriform shape: hard in consistence. sensitive: the body lies forward with a somewhat sharp anteflexion. It is mobile.

Fallopian Tubes & Ovaries:- not palpated

Peritoneum & Cellular Tissues: healthy.

Bladder, Rectum, Pelvic Bones: nothing to note.

Use of Speculum, Sound etc

see under Treatment

Case VIII — Mrs Clarke's Case

## Physical Examination.

No physical changes, in Nervous, Circulatory, Respiratory, & Digestive Systems were found.

Urine: sp. gr. 1026: acid: no albumen; sugar; bile or blood. Free deposit of mucus & phosphates

Skin: no eruptions or ulcerations

## Diagnosis.

Stenosis of the cervical canal, with morbid anteflexion of the body of the uterus, the condition being probably congenital. This has resulted in sterility since marriage, the patient apparently never having conceived. It explains the long history of dysmenorrhea. The more recent endometritis indicated by menorrhagia, & leucorrhea, is also due to it.

That leucorrhea does not come from the cervix: its thin creamy character shows it to be from the endometrium of the body of the uterus. Its offensive nature is probably due to its being partly pent up in the uterus, some so that some decomposition occurs in it before it can escape.

The diagnosis of anteflexion is already secured by the bimanual examination. But that of cervical stenosis is in the meantime provisional only: it will be found to be confirmed later by the measures taken under treatment. But it is indicated in the history, where it is said that the cervical canal was twice dilated, with temporary relief only. That would suggest that a narrow cervical canal had been an important cause of the dysmenorrhea: & that after dilatation it soon contracted again with the return of the old symptoms.

The diagnosis is therefore, cervical stenosis, with anteflexion of the body of the uterus: also with some slight endometritis, of recent date.

Case VIII **Mrs Clarke's Case**

## Prognosis.

This must be guarded. Twice apparently the cervical canal has been dilated. The very temporary relief of pain obtained, suggests that the cervical tissues are very resilient. It would be rash to promise more permanent benefit after further dilatation. Again, even should the dysmenorrhea be cured, the chances of conception are not necessarily improved. The anteflexion may remain, though the cervical stenosis ~~may~~ were ~~be~~ removed, and prevent conception.

Appropriate treatment in such a case may both relieve the dysmenorrhea, and allow conception. But on the whole, and especially if the condition is a congenital one, it is more likely that it will do neither. Of the two, the prognosis as to sterility is worse than that for dysmenorrhea.

## Treatment.

On May 25th 1905 patient was chloroformed. Bimanual examination confirmed that one already made. The cervix was dilated with graduated metal bougies, & finally with Sim's dilator. Dilatation was effected with difficulty, the cervical canal being specially unyielding near the internal os. A Galvanic stem pessary was left in the cervical canal to procure more permanent dilatation. Patient took chloroform well and recovered without any ill effects.

## Progress & Termination.

She complained of pain on May 28th: this was relieved by the onset of menstruation which continued till June 1st and without pain.

Patient was discharged on June 3rd still wearing the stem pessary.

Case VIII Mrs Clarke's Case.

Commentary:

In this case, as in that of Mrs Cox's, the following case, the peculiar character of menstruation gives a clue to the diagnosis. Such a history of a divided period, the earlier portion characterised by severe pain, and scanty discharge, and the later by freer flow & moderation of pain, is almost conclusive in itself, either of a stenosis in the cervical canal, or in the lower part of the body of the uterus. In this case both are present.

The condition in this case is probably congenital. There is no history of any local mischief, such as a utero sacral cellulitis, or peritoneal adhesions, that might have caused a forward flexion of the uterus: and the physical examination is equally negative in this respect.

But if this condition has existed since birth, how, it may be asked, have there been some five years of menstruation without pain? It is not easy to find a satisfactory answer. It is however a fact of clinical experience that many similar cases, which, in absence of any local causes, may fairly be classed as congenital anteflexions, permit painless menstruation for the first few years. It may be supposed that menstruation is only established gradually: that in the first few years there is not a sufficient swelling of the mucous membrane during the period to obstruct the canal of escape; and that it is only towards the time of complete maturity of the reproductive organs & functions that menstruation produces a turgescence sufficient to cause a difficult & painful escape of discharge.

In this case, as is common, stenosis of the cervical canal, and anteflexion of the corpus uteri are found together. It is not known if both conditions are congenital. It may well be so. But it is not impossible that the stenosis of the cervix is alone present at birth, with of course that amount of forward flexion which belongs to the normal uterus. With the onset of menstruation, or rather, with the onset of painful menstruation, the uterus has greater difficulty, & exerts greater force in expelling its contents. In its contractions, it erects itself, but

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## Mrs Clarke's Case

Commentary (continued)

(but) not perpendicularly. (that is, to the horizontal plane of the earth) Flexion therefore is not completely undone: and the increased intra-uterine pressure, acting at a greater advantage on the lower and anterior uterine wall, may gradually cause that exaggerated anteflexion so commonly associated with cervical stenosis. This however is only of theoretical interest.

Under the head of "History" in this record, it was noted that the patient suffered acutely on the first day of menstruation, and that the moderation of pain thereafter was accompanied by more profuse discharge. Under the head of "Treatment", it was stated that the dilatation of the cervical canal was only effected with difficulty owing to the rigidity of its muscular & connective tissues. These two statements, when placed side by side, are found to be related. The rigidity of the cervical canal gives the explanation of the first day of extreme dysmenorrhea. These rigid walls resisted mechanical dilatation by bougies. They yielded equally obstinately to the physiological dilatation of the fluid uterine contents. For twenty four hours of steady pressure & expansion from above (causing severe pain), they only permitted a small quantity of thin fluid to filter through. They then opened more, & allowed free exit, and with the fall of the hydrostatic pressure of the pent-up fluid, there was much relief of pain.

What is the nature of this rigidity of the cervical sphincter? Is it spasmodic; or organic; or both? In labour a spasmodic rigidity of the cervix may occur, the cervical canal not opening with the contraction of the corpus uteri, but shutting closer instead.

In the expulsion of the menstrual fluid, the same reflex mechanism should give simultaneously, a contraction of the body of the uterus, and a dilatation of the cervix. Here too, from causes that are obscure, this mechanism may be at fault, and the whole uterus, body & neck, may contract at once

But though possibly at times spasmodic, cervical stenosis with

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rigidity is more commonly organic. This case ~~certainly~~ belongs to the organic group. If it is so, the treatment indicated for such cases would be continuous or intermittent dilatation of the cervix.
A urethral stricture which is not dilated at intervals, inevitably returns and gives trouble. It may be so also in many cases of cervical stenosis + rigidity. This patient's history shows that on two occasions her cervix was dilated, but with no permanent relief. But if at intervals, whose length would be found by experience + which would vary in different cases, the cervical canal were dilated by bougies, the improvement might be made more permanent.
This dilatation could be carried out in the period of least fertilisation-probability, that is, in the week before menstruation was due. It is true that a fertilised ovum might already be implanted, and by such interference might be destroyed. But, again, if by such means the former obstacle to impregnation were removed, the probability of conception would be much increased. And where one ovum, less than a month in age perished, many more would be securely implanted and would reveal their presence by one or more periods of amenorrhea before the next date for dilatation had arrived.

Even supposing that fertilisation never took place, it need not be because of the treatment advised, but might be from reasons altogether different: and in any case the relief of suffering at each menstrual period would amply justify the treatment.

In conclusion, if cervical stenosis is sometimes due to organic rigidity of the muscular + connective tissues of the cervix, in such cases it cannot be hoped that a dilatation at one sitting will keep the canal permanently open. If dilatation is to be effective, it will have to be carried out at regular intervals.

It is possible again to imagine cases where the cervical rigidity has produced a stenosis sufficient to give trouble at menstruation, but not enough to prevent the entrance of spermatozoa, and the fertilisation of the ovum. In such cases, conception, + gestation if it run its course, will end in labour. And labour, with its enormous dilatation of the cervix, may be expected to put an end for ever to the stenosis, and prevent

# Mrs Clarke's Case. Commentary

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future dysmenorrhea. Cases of painful menstruation before marriage, and conception, that disappear after parturition may belong to this class. If this is so, the inference is that the immense dilatation of the cervix accomplished in labour is an effectual + permanent cure, while the partial + small dilatation secured by bougies + dilators, often brings only temporary relief. Does Nature here, as often, seem to point to the remedy? Is the extent of dilatation usually produced by bougies sufficient? If it were possible to be safely increased, would it be likely to be more permanently effective? It is not forgotten that the mechanical dilatation of the cervix is prepared for by a physiological softening + dilatation; and that in the nongravid uterus the capacity of the cervix for distension is infinitely less. The question raised is whether the most extreme dilatation of the cervix of the nongravid uterus, possible within the limits of safety, would be successful in permanently loosening + stretching the resilient cervical tissues of such cases as this under review

It would perhaps be better to recognise cervical stenosis and cervical rigidity as two distinct conditions which may be, and often are, found together. Thus extreme stenosis might exist in the form of a pinhole ~~external~~ os; and at the same time the canal might open freely during menstruation. In such a case cervical stenosis would be present, but cervical rigidity would be absent; and though conception might be prevented, menstruation would be free from pain. Again there might be no cervical stenosis, but marked cervical rigidity with dysmenorrhea, but with no hindrance to conception. In the present case both conditions are present, but cervical rigidity forms the great ~~feature of the case~~ and leading feature. That is beautifully illustrated by the character of the menstruation; at first scanty + painful while the cervix still resists dilatation; then more free + less painful when it yields at last + expands.

University of Edinburgh
1904 – 1905

Clinical Medicine. Wightman Prize Competition
Gynecology.

# Case IX

## Endometritis & Recurrent Abortion:-

Mrs Catherine Cox, aet 27.
Ward 35 (Professor A. R. Simpson)

Admitted: April 7th 1905
Discharged: May 6th 1905

Record & Report by Charles McNeil.

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# Case IX

Mrs Catherine Cox.
Age 27
Married.
Nullipara.
Occupation :- Housewife

**Complaint** :- Excessive discharge, & pain, at her periods
Duration. Fifteen months

Admitted to Ward 35 on April 7th, 1905.
Case taken on April 8th, 1905.

## History
### Of Present Attack.

Fifteen months ago, on January 5th, 1904, patient had a severe flooding. For three months before this, her periods had occurred at the usual times, but the discharge, she noticed, was less in quantity, paler in colour (being pink instead of dark red), and shorter in duration. During these three months of diminished discharge, she does not remember being troubled with morning sickness. When the flooding occurred, a doctor was called in. He told her she had had a mishap. No local treatment or interference was used.

For four months following, patient was losing blood continuously, and remained in bed during that time. She wore a rubber ring pessary, inserted by her doctor.

Early in May, 1904, the discharge ceased. But the patient, feeling very weak & exhausted, came to the Royal Infirmary, Edinburgh, Ward 35 for advice, and was told to return in a fortnight. She did not do so.

In three weeks, discharge had begun again. It was not now continuous, but at intervals of two or three weeks. The flow lasted for three or four days, and was profuse. Her general health remained

Case IX   Mrs Cox's Case.   General History.

History of Present Attack (continued)

(remained) unsatisfactory: she was tired out, and unfit for work, and at her unwell times had to go to bed. This continued to October, 1904, when patient began also to have pain in the right side. This pain was never entirely absent. But it became intense a week before her period was due, remained severe, though less acutely so, during the flow, and again increased as the discharge dried up. It then abated. The pain seemed to come from under her right breast, and was acute with a sensation of dragging tension. During the period, she had also great weakness in the bottom of her back.

Her periods continued to be irregular in their occurrence: the intervals varying from two to three weeks. A white intermenstrual leucorrhea added itself about this time. It was of the consistence & colour of raw white of egg, and occurred during the week before her menstruation set in: It was not offensive in odour

Her condition has remained as above for many months up to the time of her admission into Ward 35. Her general health, and fitness for household duties, have been extremely unsatisfactory. Of late, her condition has got still worse: her periods coming every fortnight, and lasting a week. The second last period before her admission lasted for eighteen days.

Previous Health.

Six years ago patient had pleurisy in the left side.

Shortly after this, she had rheumatic fever with pain & swelling in wrists, elbows, and shoulders.

In 1899, from shock of bad news she had a stroke of paralysis, affecting leg, body, and arm of the right side; for it was first a cramp, and then a paresis. Her muscular power in these parts is now completely restored.

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## Mrs Cox's Case. General History

**Diathesis** is not marked.

**Social Conditions & Habits.**

Patient has always had a comfortable home, with sufficiency of wholesome food. Her husband is a soldier, and she has had several times since her marriage to shift her home with the regiment. She does not take alcohol.

**Family Health.**

Both her parents are alive & well.

They have had ten of a family, of whom three sons are dead. One was killed in the late South African War. Another died, aged ten years, of blood poisoning. A third died in infancy. The rest are alive & well.

## Sexual History

(1) **Menstruation**

(a) **Normal.** Began at the age of twelve
Type. Twenty-eight days
Habit:- { Duration. Four days
Quantity. Moderate
Ceased. ———

(b) **Morbid:**

**Amenorrhea.**

(i) Three years ago, in the early months of 1902, patient had four or five months' complete amenorrhea.

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During Mrs Cox's Case. Sexual History

Menstruation:-

Morbid. Amenorrhea

During this time she had morning sickness, and her abdomen was getting big. Her amenorrhea ended in a foul watery discharge, in which there were sometimes solid shreds, like pieces of skin. She then lost much clotted blood, which gave severe pain in passage. She was told by her doctor that she had ~~had~~ a false conception. No local interference was used. She continued losing blood heavily for several months after. It was in the end of this year that she was in Ward 35 for ten days.

(2) For three months previous to the flooding of January, 1904, her periods were lighter than usual. (vide History of Present attack)

Menorrhagia: vide History above

Dysmenorrhea: " "

Intermenstrual Discharge.

Metrorrhagia: vide History

Leucorrhea: vide History. Its character was clear + gelatinous; and not foul. In quantity moderate.

Pregnancies. Apparently two. The first in the early months of 1902. The second + last, in the later months of 1903.

Abortions. Two.

Character of Labours }
Puerperia } ——
Lactation }

Case IX

Mrs Cox's Case.

Local Functional Disturbances, in Bladder, Rectum, and Pelvic nerves & muscles, are absent.

General Functional Derangements
Nervous System. Patient is neurotic.
Respiratory & Circulatory Systems. Nothing
Digestive System. Occasional dyspepsia.
Emunctories are healthy.

Physical Examination.

General Appearance & Configuration.
Patient is of moist, sallow & unhealthy complexion. No evidence of anaemia in lips, gums, or conjunctivae. In face & body she is thin, but well formed.

Mammae. Breast tissue very scanty. Areolae are pigmented, & show Montgomery's tubercle. No striae. Nipples small & retracted: no secretion.

Abdomen. ~~Ins~~
On Inspection is flat. Umbilicus is depressed. There is a slight linea nigra below the umbilicus. There are no striae.
Palpation is negative.
Percussion gives everywhere a tympanitic note
Auscultation is negative.

External Pudenda
Nulliparous.

Case IX  Mrs Cox's Case.  Physical Examination.

Per Vaginam.

Orifice admits one finger.
Walls are rugose & moist.
Cavity roomy.
Roof. All the fornices are empty, except the anterior in which slight resistance is felt.
Cervix looks down & slightly back: it is of usual size. The os is linear, oblique in direction, the right end being anterior, and the left posterior. Its shape is the result of the operation performed by Professor Simpson in November 1902.

Bimanual Examination.

Uterus: is slightly enlarged; pyriform in shape: a little soft; and tender. The body lies forward, without acute flexion: but appears to be farther from the symphysis than usual (retroposed): it is mobile.

Fallopian Tubes. The Right is palpable; is a little thickened. The Left was not palpated.

Ovaries The Right was palpable. The Left was not palpated.

Peritoneum & Cellular Tissues. No adhesions. No cellular thickenings.

Bladder. Rectum. Pelvic Bones. Nothing to note.

Use of Speculum, Sound etc
See under head of Treatment below.

Case IX | Mrs Cox's Case. | Physical Examination.

Physical Changes in other Systems.

Nervous. None

Circulatory. No haemic or organic bruits heard over the heart. No venous hum present in the neck

Respiratory. To percussion & auscultation, the chest was perfectly healthy.

Digestive. None

Emunctory Organs. Nothing

Skin No eruptions: or ulceration.

Bones. Nothing to note.

Diagnosis.

Endometritis both of the body & cervix of the uterus. Inflammation of the Right Fallopean tube & ovary. These accompanied by, and probably causing Sterility.

The causes that have produced this condition are discussed in the commentary below.

Prognosis.

is doubtful as to the hope of a future pregnancy being carried to its natural termination. The inflammation of the uterus is of such old standing, and apparently so deeply planted, that although it might be greatly allayed in the non-gravid uterus, there would be grave risk of its breaking out afresh in the uterus, should it become pregnant. Farther the inflammation has already spread to one ovary, and has reduced by so much the fertility of the patient. The remaining ovary is in danger of attack. Should this occur, the fertility of the patient would probably be utterly destroyed.

Case IX ~~But~~ Mrs Cox's Case.

Prognosis:-(continued)

But with proper treatment, the uterine inflammation might be subdued to such an extent that the menstrual function might be restored to a much more healthy condition. The menorrhagia & leucorrhea may in that event be hoped to improve much, if not entirely to disappear.

The dysmenorrhea, in so far as it is uterine, will moderate with the improvement of the endometritis. But in so far as it is ovarian, and in this case it appears to be largely of this character, the prospect of its relief is much less hopeful.

In the case of a long & obstinate inflammation of this kind, the prognosis should be very cautious. It is just such cases that may resist the most correct & thorough treatment.

Treatment.

On April 11th, 1905, the patient was chloroformed & examined. The sound was used, and the cavity of the uterus found enlarged ½ inch. There was no anteflexion.

The cervix was easily dilated with graduated metal bougies, & Sims' dilator.

The uterus was curetted. A good deal of blood clot was brought away: but no great thickness of mucous membrane.

The cavity was douched; touched with iodized phenol: and packed with iodoform gauze. The vaginal cavity was also packed. A deep injection of 3 grs of Ergotine was made into the buttock. The patient was taken back to bed. She reacted well to the operation. Her pulse was good: and though she vomited in the evening, she slept well that night.

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## Mrs Cox's Case.

### Progress & Termination.

In 48 hours, the gauze was removed from uterus & vagina.

Progress was uneventful, except that on three occasions patient was suddenly, & without discoverable cause, seized with severe rigor. The temperature went up to 103°, and on one occasion to 105°, with great rapidity; and on the exhibition of Quinine Sulphate as quickly fell, with free perspiration. In view of the woman's neurotic constitution, these rigors were judged to be neurotic & functional. No exciting cause could be found.

~~On Apr~~ Patient menstruated from April 24th. to April 27: the discharge was moderate; the pain was still pretty severe.

Patient was discharged on May 6th. 1905, her general health still unsatisfactory, but her endometritis for the time being, checked & improved.

### Abstract from the record of November 1902

Mrs Catherine Cox.

Diagnosis. Stenosis & Anteflexion

Menstruation. Two days before appearance of flow patient felt tired out. For half a day before there was leucorrhea. For the first two days, the flow was dark, clotted, & profuse (3 diapers per day). On the third day the flow ceased altogether. On the fourth day it resumed as a more watery discharge, of moderate amount, for five or six days more. There was severe pain during the flow: its character is not described.

Treatment:- The posterior lip of the cervix was split: and the internal & external mucous membranes united over the raw surfaces. The cervical canal was also dilated.

Case

# Mrs Cox's Case.

## Commentary.

The patient seems to have had a perfectly healthy menstrual life before her marriage. At that event she was nineteen, and had scarcely therefore reached the ripe age of nubility. This, and possibly the presence of some anteflexion (unaccompanied by menstrual distress) may explain the fact that till the early months of 1902, she did not conceive. Early in that year there is a particular history of a pregnancy of some months duration, terminated by abortion. The account of foul watery discharge, with occasionally shreds of tough skinlike material, and the use of the term "false conception", suggest Hydatid Mole. Patient could give no further particulars as to the nature of the mass cast off by the uterus. But whatever was the nature of this first conception, its early abortion forms the starting point of this clinical history. Before it, the patient was, with the exception of her sterility a healthy woman in respect of her reproductive system. After it, and ever since, she has been the subject of menstrual trouble.

Whether some product of conception was left in the womb, and there planted a vicious & deep rooted inflammation, which has never since been eradicated, or whether a myxomatous degeneration of the chorion had already impaired the healthy structure & function of the uterine surface to an extent which the most skilful & prof. treatment could not undo, it is not possible to say. Whatever the cause, the disastrous consequences of this first abortion are apparent. Months of profuse menorrhagia, and metrorrhagia followed. When she came to Ward 36 in the end of the same year (1902) with a complaint of menorrhagia & dysmenorrhea, the body of the womb was found to be anteflexed, and the cervical canal stenosed.

It is possible that this anteflexion & stenosis were a congenital condition. It is far more likely that they were the effect of the recent abortion: and especially in view of the fact that all her menstrual distress dated from that abortion.

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# Mrs Cox's Case.

~~At the time (1902) the menst~~

## Commentary (continued)

The divided menstruation described at this date is an important indication of some stenosis in the uterine cavity. As a symptom, it is an extremely valuable aid to the diagnosis of such a condition.

The leucorrhea for two days preceding menstruation is also interesting. A continuous leucorrhea is ~~perhaps~~ a commoner occurrence. Its short duration here, and its appearance just before the menstrual invasion would seem to indicate a catarrh of the endometrium, too mild & latent to produce discharge in the greater portion of the intermenstrual period, ~~&~~ and only sufficient to do so in the heat & hyperaemia that precede the menstrual flow.

It is also interesting that this antecedent leucorrhea has again appeared in this patient. Its clear & gelatinous character shows that the cervix is its origin. But as before it ushers in menstruation, and in this repetition, it would seem that the uterus had discovered an old habit which had lain dormant for many months. But a further suggestion may be made. It is possible that all endometrial leucorrheas arise in this way. In their early stages they may only reveal themselves just before menstruation. But as they take firmer & deeper hold, they assert themselves over larger & larger portions of the intermenstrual period, ~~till~~ Finally they are present throughout it.

Patient left hospital in the end of November 1902. All the treatment called for, had been given, and for some considerable time, the uterus seems to have been restored to more healthy function. During most of the year 1903, the patient enjoyed fair health, and her menstrual discharges were less profuse, less painful, and less exhausting than they had been up to the date of her first conception.

Towards the end of the year 1903, the patient must again

Case

# Mrs Cox's Case

## Commentary (continued)

(again) have conceived. But the extraordinary demands of pregnancy found the uterus unequal, and seem to have stirred up again the old inflammation. The patient never had complete amenorrhea. On careful questioning she remembered that the three periods preceding the severe flooding of January, 1904, ~~were~~ had been of unusual character. The flow was less abundant, of paler colour, and of shorter duration, than usual. Menstruation was, in fact, reasserting itself unnaturally in a gravid uterus: and it was doing so because the uterine mucous membrane, and perhaps the muscular walls also, had become the seat of inflammation. At each menstrual epoch, the ovum grafted on an inflamed organ, was in danger: and, after three had elapsed, it was detached & thrown off at the fourth amid a profuse haemorrhage.

It is perhaps hardly necessary again to postulate some retained conception products in explanation of the sequel of menorrhagia, metrorrhagia, & dysmenorrhea, already described. A proper involution never took place. The uterus may have expelled the entire ovum: but it did not cast off also its inflammation. That had taken firm root, and remained in possession to the perversion of healthy function, and the serious detriment of general health. The appearance of dysmenorrhea later is very probably explained by the spread of inflammation to the right tube & ovary.

Such a clinical history is most instructive. It throws into strong light the obstinacy of uterine inflammations. These are not dangerous because they are fierce, but because they are lingering and slowburning. When it is thought they are utterly quenched, they may be smouldering still, and capable, under small incitement, of breaking out as fiercely as before. That is certainly the history of this case. Abortion, of itself perhaps, or assisted by negligent treatment, ~~the~~ left behind it a uterine inflammation. That for many months was allowed to ravage

Case

## Mrs Cox's Case

Commentary (continued)

(ravage) unchecked. When curettage was at length applied, it was able to restore healthy menstruation, but not to render the uterus capable of tolerating a growing ovum. When conception took place again, inflammation still lurking, was stirred up, and having emptied the uterus, raged violently for many months.

The uterus has again been curetted. It may be hoped that again healthy menstruation will be restored. But should conception again take place, the prospect of uninterrupted gestation is not only no better, but indeed is rather worse than before.

Further, as has been seen, there is ovaritis on one side. And it may be present also on the other. While if one ovary is still free from inflammation, how long will it remain so? This additional consideration makes the prognosis as to sterility gloomier than ever

The case is an illustration of the long train of evils that may follow abortion. It shows how easily abortion may set up the much graver condition of recurrent abortion; and how with each fresh abortion, the chance of a full time pregnancy becomes increasingly remote. It emphasis the necessity of the most careful & thorough treatment of a woman suffering from her first mishap.

(Imperfect)

University of Edinburgh
1904 – 1905

Clinical Medicine. Wightman Prize Competition.
Gynecology.

# Case X

## Recurrent Epithelioma of the Labia Majora.

Mrs Jane Honeyman
Ward 35 (Professor A. R. Simpson)

Admitted: April 19th 1905
Discharged: May 27th 1905

Record & Report by Charles McNeil.

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Case X Mrs Jane Honeyman
Age 63
Housewife
Address. Dean Park Cottages, Belford Road, Edinburgh
Widow

Admitted to Ward 35 on April 19th 1905
Case taken on April 20th 1908

Complaint. Return of growth at the back of the front passage, with slight discharge.
Duration. The present growth appeared three months ago. But the first one occurred in 1890.

General History.
History of Present Attack:-
The last growth was removed in Ward 35 in July 1902, and since then up to three months ago patient had no trouble. But, three months ago, patient became aware of a roughness at the entrance of the front passage towards the back. This at first was a round raised patch hard & button like. It steadily increased in size, spreading downwards, but not at all up into the front passage. The surface of the growth soon became broken & roughened, but its consistence remained hard. There was a slight continuous discharge of thin clear fluid from it which was slightly ~~but not~~ offensive: it was never bloodstained. The growth gave no pain, and no sensation of pressure on other parts. But there is a constant sensation of burning heat both in the tumour and in the lower part of the front passage: this is somewhat relieved by douching. Sometimes also there is slight throbbing in the tumour. Otherwise patient has been in her usual good health. Her appetite has remained good; and she has noticed no loss of strength or weight. Patient has never suffered from pruritus vulvae, or pruritus ani. She has never had eczema, inflammation, or ulceration of those parts.

Case X

## Mrs Honeyman's Case. General History

**Previous Health.**

Patient has been in Ward 35 in 1890, in 1900, & in 1902, and on each occasion had a growth removed from the same site. Of late years she has been troubled slightly with chronic rheumatism, in her knees & ankles. Otherwise she has enjoyed excellent health all her life.

**Diathesis** is not marked.

**Social Conditions & Habits.**

These are very satisfactory. Patient has had a comfortable home all her life. She does not touch alcohol.

**Family Health:-**

Father died, aet 70, of heart disease
Mother died, aet 72, of a paralytic stroke.
One brother died, aet 35, of a paralytic stroke
Three sisters died in infancy: one alive & well.

## Sexual History.

**Menstruation**

A. **Normal.** Began at the age of sixteen
Type. Twenty-eight days
Habit:- Duration. Four or five days
Quantity. Usually two, sometimes three diapers daily.

~~B. Morbid.~~ Menopause:- at the age of 45 (1887)

B. **Morbid:-** **Amenorrhea.** As a young woman before she was twenty, she had a period of six months' amenorrhea: she does not remember whether the flow returned suddenly or gradually.

**Menorrhagia:-** None

**Dysmenorrhea:-** During the last two years of her menstrual life, patient had pretty severe pain at the periods when the flow was drying up

Case X  **Mrs Honeyman's Case.**

**Sexual History:** –

**Intermenstrual Discharge:** – None.

**Pregnancies.** None.
~~Ab~~ Abortions: None.

**Local Functional Disturbances,**
in Bladder, Rectum, & Pelvic Nerves & Muscles: – None.

**General Functional Derangements:** –
There are no unhealthy symptoms in the Nervous, Circulatory, Respiratory, & Digestive Systems.
The Emunctories are healthy.

## Physical Examination

**General Appearance & Configuration.**
Patient is under medium height, but of stout, large, & well nourished frame. Her face is full & ruddy, and has no appearance of cachexia.

**Mammae:** – are large & pendulous.
**Gland tissue:** of considerable amount.
**Areolae:** non pigmented: On both white swollen papillae ressembling Montgomery's tubercles.
**Nipples:** retracted: no secretion.
No striae.

**Abdomen:** – **Inspection:** – Faint linea nigra below umbilicus: flat: no striae
**Palpation, Percussion & Auscultation** give the signs of a healthy non gravid abdomen. The inguinal glands are not palpable on either side.

Case X

# Mrs Honeyman's Case.

## Physical Examination:—

### External Pudenda

The white scars of previous operations are visible over the region of the labia which have been largely removed. On the left side of the orifice a band of thickened tissue runs down to the perineum.

On the right side at the posterior end of the inner surface of the labium maius, a round ulcer is seen, raised on a hard base. It is rather less than the size of a florin: its floor is of an indurated broken red surface, smeared at places with a thin whitish secretion. The ulcer is very shallow: its edges are hard. The thickened band described on the left labium maius, is also ulcerated at several places. The ulcers are only slightly sensitive. But little is visible on inspection.

The perineum is narrow: having apparently been removed anteriorly

## Per Vaginam:-

Orifice admits one finger

Walls: rugose & moist: no growth is ~~felt~~ anywhere: the ulceration & growths at the vulvar orifice have not implicated the vaginal surface at all

Cavity: roomy

Roof: - Fornices all empty: ~~[illegible]~~ the anterior gives no feeling of resistance

Cervix: is small & short: looks down & back

Os is round & nulliparous.

## Bimanual Examination:

Neither uterus, nor other pelvic organs could be palpated, through the thick abdominal wall.

## Use of Speculum, Volsellum, etc.

Not employed.

Case X   Mrs Honeyman's Case.

## Physical Examination.

Physical Changes in Nervous, Circulatory, Respiratory, & Digestive Systems are absent.

The urine is healthy.

The skin is healthy, ~~save~~ except ~~ion~~ at the external genitals where its condition has already been described.

## Abstracts from previous Records.

(1) Mrs J. Honeyman. July 1890: aet. 49.

Tumour on inner surface of left labium of six months' duration: causing heat & slight discharge.

Inspection showed there a raised round ulcer, size of a crown piece of similar appearance & character to that described in the present record.

Treatment. Removed locally by knife. Wound healed in a week.

(2) Mrs Honeyman. March 1900: aet 59.

Tumour on same site of six month's duration: with same symptoms as before. The sore is size of florin, & of same character as above.

Growth removed by knife again. Microscope revealed typical cellnests

(3) Mrs Honeyman. July 1902: aet 61

At the apex of the ~~vestibule~~ left labium, just above apex of vestibule, a whitish excrescence. Now for the first time right labium shows a hard sore similar to the above.

Removed by knife, and Pacquelin cautery.

Pathologist's Report. July 1902.

"Smaller growth (from region of vestibule) shows the stratum "corneum thickened, but no sign of epithelioma.

"The larger mass shows similar thickening of epithelium: it "might be like that of a sebaceous cyst. I cannot satisfy myself that there is invading epithelium."

Case X ~~Diagnosis~~ Mrs Honeyman's Case.

## Diagnosis.

Recurrent epithelioma of the skin over the labia majora.

The former microscopic examinations; and the reappearance of the ~~growth~~ ulcerated growths on the same site, make this diagnosis quite certain.

## Prognosis.

The invasion & proliferation of ~~cells~~ epithelium is in this case very slow. There has been no extension to the inguinal glands. But the malignant growth has been recurrent in spite of repeated free removals. It is doubtful if further surgery would be any more successful. It is possible that X-rays may have a specially powerful effect on an epithelioma so indolent as this. They may not resolve the tumour. But if they only keep it in check, they will permit life to the natural term, which in this case is not far distant.

But with increasing age, the tumour may assume more virulent growth. Should this occur, the prognosis would become very bad: and a further resort to surgery would only postpone the fatal issue.

For the present, and until the result of X-ray exposure is seen, the prognosis is grave. If such treatment restrains further growth, it will become less grave.

## Treatment, Progress & Termination.

On May 9th patient received her first exposure to X-rays: and for ten minutes. Between May 9th & May 27th she had fourteen such exposures. In the left lateral position. the rays did not fall directly on the largest ulcer (on the right labium) once or twice therefore towards the close the genupectoral posture was adopted, & though the position was was exhausting, and could only be maintained for five minutes, the rays had better access to the whole epitheliomatous area. On May 27th patient left Ward 35, ~~but~~ and was to continue coming to the X-ray department as an outpatient. Patient says the ulcers have improved: their secretion is less: and the largest one (on the right labium) feels (to her) distinctly flatter.

Case X

# Mrs Honeyman's Case

## Commentary:-

This patient has suffered from recurrent epithelioma of the labia majora over a course of fifteen years.

Compared with other parts of the reproductive system, the external genitals are a relatively rare site for cancer. In Hart & Barbour's "Gynecology" cancer of the external genitals is described as at first slow & painless in growth. It is also said that the inguinal glands are early involved. This case conforms to the first statement. But it does not do so to the second. Both in the first appearance of the tumour, and in its first recurrence, there was growth for six months before removal. But it is perfectly evident from the subsequent history that no malignant deposit had taken place in these glands within that time. At the present time no enlarged inguinal glands can be felt. The cancer in this case seems to be of unusually indolent nature: it has grown only on the spot where it first was planted.

In clinical experience it is common to find irritation the forerunner of cancer. Cancer of the tongue, or lip, often grows upon an indurated fissure there. Cancer of the breast seems, not infrequently, to follow a blow on it, or some chronic inflammation. In a large majority of cases, cancer of the cervix uteri develops in a cervix that has been stretched & torn by the mature foetus.

But in the case under review there is a striking absence of antecedent inflammation or irritation. The patient has been married, but has never borne children. Her menstrual life has been extremely healthy. She has never suffered from any intermenstrual discharge, irritating or otherwise. She has never been troubled with itching of vulva, or anus: and has never had eczema, or inflammation of these parts. The cancer seems to have grown in this case on a healthy skin. ~~Cancer is~~ Irritation so commonly precedes cancer that its absence here is interesting.

The epithelioma here is malignant, but in its

Case X

## Mrs Honeyman's Case
&
## Commentary (continued)

(its) malignancy, it is as benignant as it well could be.

Its growth has been slow. It has not widely infiltrated surrounding parts. The inguinal glands, through which the lymphatics from these parts drain, are not enlarged. The ulceration caused ~~was~~ has been slight, in consideration of the tender skin in which the tumour grew. Apart from the sensation of heat, the growth ~~was~~ has been painless. It has caused no cachexia.

The first growth appeared when the patient was forty-nine. Four years had elapsed since her climacteric, and though the menopause had been ushered in for some time with dysmenorrhea, the long interval of four years does not favour the possibility that some irritation in these last discharges fostered this morbid growth.

For four years, uterus, Fallopian tubes, ~~and~~ ovaries, ~~and the whole~~ and the whole reproductive system had been in atrophic change. Yet this malignant process did not select those organs where the changes of decay were most active, but the outside skin where they might be expected to be least. Both for this reason then, and also because of the absence of antecedent irritation, the choice of site by the cancer seems in this case to have been casual & capricious. That it really has been so, is of course not pretended for a moment. The cause ~~whether~~ both primary, ~~or~~ exciting, exists: but is quite hidden.

It is a favourite view to regard cancer as the vegetative faculty of the cell run riot, and free from control. And this would naturally occur at a time of life when the other & special functions of the cell ~~were~~ are declining. Past middle life, the life of certain specialised cells, and notably of epithelial cells ~~into~~ in the reproductive system, is spent in comparative idleness; and in this idleness the remaining functions of the cell are permitted an exuberant & unrestrained activity. If they avail themselves of it, they no longer live in obedience to the needs of the individual

Case X Mrs Honeyman's Case

Commentary (continued)

(individual) of which they are apart; but form themselves into a new & hostile individual, absolutely indifferent to the effect of their growth upon the life of the individual of which they once were a loyal & obedient member.

This unnatural activity varies in degree from extreme to extreme. In some it is so terribly rapid that in a few months the tumour has spread far, and has reached & destroyed organs & structures, indispensable to the life of the individual. In others, and our case seems to belong to this group, the morbid growth is so sluggish that the term of natural life may be reached before any vital part is threatened.

These latter cases are the most favourable for surgical removal and give most promise of cure. But this case teaches in a most striking way, that, even in the most limited growths, the prognosis as to recurrence should be very guarded. The temptation to claim a cure in such cases is great. But not one, but many years, must elapse, before such a claim can be made. The cancerous growth may be entirely taken away; but the tendency to cancer has not been removed. For, cancer, it cannot be too strongly urged, is not merely a visible tumour: it is also an invisible & vicious habit of the cell-life. Its outcrop may be all removed: but its seeds may still lie below & around, hidden not only from the observer's eye, but also from the most powerful microscope.

The case of Mrs Honeyman is very much in point here. After removal of the tumour in 1890, patient had no trouble for ten years. There is no doubt that all morbid tissue had been removed. But the same capacity of perverted growth lurked in the surrounding epithelium, and at last in 1900 asserted itself. This first recurrence was also cut out, and the microscope showed in it cell nests of growing epithelium, piercing down as columns into the underlying tissue. Two years later this depraved activity of

Case X

## Mrs Honeyman's Case

### Commentary (continued)

(of) epithelium was again evident. The excised tissue was again submitted to the pathologist. His report is interesting. He says that of two separate tumour masses examined, the smaller showed the stratum corneum thickened, but no sign of epithelioma: the larger showed a similar thickening of epithelium. But in neither could he be satisfied that there was "invading epithelium." In fact the epithelium was overgrown, but not yet invading. Such overgrown epithelium could not be called epithelioma as yet. But in view of the woman's history, it cannot be doubted that it would have become so. In these recurrent tumours of 1902 we thus get a glimpse of epithelioma in its earliest + most innocent stage.

The result of X-ray exposure has so far been good. It is possible that the X-rays are particularly effective in restraining the growth of such indolent cancers. Time will show whether this is so or not.

The case is a most interesting one. It is epithelioma of unusually benignant character; but at the same time of obstinately recurrent type. In the first respect, it promised success to surgical interference. In the second respect, it has baffled surgery, although it was "successful".