SOME CASES OF OVARIAN MALIGNANCY.

By J. S. Quin.

FROM the earliest days a peculiar interest has always been attached
to tumours and cysts of the ovary. This interest is easy to under-
stand, as in no other organ in the body do tumours of such diversity
and magnitude occur, and it is perhaps natural that it was in connection
with these tumours that the first feeble gropings of the early surgeons,
within the hitherto almost sacrosanct abdominal cavity, took place.
From this early beginning in 1809, by Ephraim McDowel in a farmhouse
in Kentucky, can be said to date the whole romance of modern abdominal
surgery.

My purpose in this communication is not to present a review of the
ovarian neoplasms, but rather to consider the problems that may arise
in the diagnosis, treatment and prognosis of the common malignant
ovarian tumour.

As a general rule the age incidence is around 50, and the majority of
the patients are either single or nulliparous. Menstruation generally
has been normal, or the patient has had a reasonably normal menopause,
while only in about 20%-25% of cases has there been any abnormal
vaginal hemorrhage.

In many cases the diagnosis presents no difficulty, the patient present-
ing herself with a history of pain, swelling in the abdomen associated
with previous vague ill health and recently complicated by one or more
sudden acute attacks of pain accompanied by some degree of collapse.
In other cases the diagnosis is more obscure, and on many occasions
(especially in plump women or the short thick type, with fat round
bellies) there has been a considerable interval during which the possi-
bility of gastric or gall bladder trouble has been under consideration.
In one case, which is at present under my care, another type of the
antecedent history of some of these cases is well illustrated:

CASE 1.—K.M., unmarried, age 46. Normal menopause 2 years previously. First
sought medical aid in Jan., 1946. At this time her complaint was vague, with symptoms
of ill health, palpitations, breathlessness and loss of energy. Routine examination
revealed a marked anemia—Hb. 46 per cent. and R.B.C. of under 4,000,000. Chest,
stomach and duodenum normal to x-ray examination, negative van den Bergh
reaction.

All symptoms completely disappeared on the patient taking iron: Hb. rose to 70
per cent., but fell again. There was a recurrence of her previous symptoms as soon
as she ceased to take the iron prescribed.

I was asked to see her in October, 1946, when I found a normal pelvis but for what
I took to be a thickened tube on the left side. The possibility of an old chronic or
tuberculous salpingitis occurred to me, but I did not consider further investigation
necessary. She had been losing a very little weight since June, there was a faint icteric
tinge and a very slight loss of skin elasticity.

At Xmas, 1946, she was admitted following an attack of acute lower abdominal
pain, with subsequent collapse. Vaginal examination now revealed masses on either
side of the uterus. Laparotomy showed multiple secondaries everywhere present
in the omentum and peritoneum, with double fixed ovarian papillary cystadenomata,
one of which had ruptured, causing the recent acute abdominal symptoms. The
abdomen was closed, and the patient is still in hospital awaiting radiation therapy.

If the diagnosis is sometimes in doubt before the abdomen is opened,
it is still often not certain with what type of case one is dealing even
when the abdomen is open. The clinical appearances of ovarian malignancy, when the abdomen is opened, vary tremendously: practically every tumour type may be met with on opening the abdomen—solid, solid and cystic, cystic, papillary, with all the various other changes consequent on interference with the blood supply, or some degree of infection or necrosis.

Again, in many cases there are not only papillary outgrowths projecting from the surface of the ovarian mass, but secondary tumours of a similar nature all over the surface of the intestines in the area and on the pelvic peritoneum. It is well recognised that such a condition does not contra-indicate removal of the original tumour, for the patient’s life may be greatly prolonged by the operation, and occasionally such metastases, even when malignant, sometimes disappear after the removal of the original growth. Ascites may, however, follow and require paracentesis to relieve the discomfort of the abdominal distention. At times fluid may also accumulate in the pleural cavities, even though the lungs be completely free of secondary growth.

The following cases are illustrative of some of the facts mentioned:

**Case 2.**—Patient unmarried, aged 53. Operated on in 1932 for a moderately large ovarian tumour, which turned out to be a right papillary cystadenoma with secondary papillary in and around the cecum and the peritoneum of Douglas’s pouch. Other ovary and uterus removed. No postoperative x-ray. Patient remained symptom-free for 3 years and then developed ascites. After tapping the abdomen, a fixed mass was found posteriorly in the right fornix, rising up towards the pelvic brim. X-ray now given. The ascites recurred with increasing frequency, and patient finally died with apparently generalised abdominal recurrences, in 1939.

The case is on record of such a patient, who was tapped 299 times in the course of 6 years by Pye-Smith; but the world’s record is easily held by Peaslee, whose patient survived for 13 years, during which time she was tapped 655 times.

In this connection it is interesting to mention the particulars of a good lady, recorded by Bland Sutton, who, for the information of posterity, ordered by her will that an inscription be engraved upon her monument to signify that the tomb contained “the body of Dame Mary Page who died in her 56th year. In 67 months she was tapped 66 times and had had taken away 240 gallons of water without ever repining.”

Before leaving the question of difficulty in diagnosis after the abdomen is opened, it is only right to refer to the pathological difficulties which may occur even when the tumour has reached the laboratory.

**Case 3.**—In January, 1943, I was asked to see an unmarried lady of 51 years, who suffered from some mental disability and was under the care of the Courts in a mental hospital. A large ovarian tumour was obviously present, which from its size was just beginning to cause her some discomfort. Operation was advised and the tumour, a large multiple pseudo-mucinous cystadenoma, was removed, together with the uterus which contained multiple fibroids, and the other ovary. Convalescence was incredibly smooth and the report on the specimen, from an extremely competent pathologist, reads as follows:

"The uterus is a mass of fibro-myo-mata, ordinary fibroids—non-malignant. The ovarian tumour is a straight-forward multilocular cystic papillary adenoma. Parts of the tumour are solid, but are pure adenoma charged with pseudo-muoin. The rest is large multiple cysts. I have examined several sections from different areas of the solid portion and all of it is quite innocent."

With that report one might have felt reasonably safe, but in forwarding an account of the case to the Medical Superintendent for his records, I quoted the report verbatim, taking care to point out the impossibility, in a tumour of this size, of excluding the development of malignant change in some portion of the mass.