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Five Cases of Ovariotomy in Women over Seventy Years of Age

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REPRINTED FROM

THE AMERICAN JOURNAL OF OBSTETRICS

Vol. XXXIV. No 2. 1896.

NEW YORK

WILLIAM WOOD & COMPANY, PUBLISHERS

1896

FIVE CASES OF OVARIOTOMY IN WOMEN OVER SEVENTY YEARS OF AGE.[1]

In the *Johns Hopkins Hospital Reports*, vol. iii., Baltimore, 1894, page 509, I collated and tabulated, with Dr. Mary Sherwood, one hundred and fifteen cases of ovariotomy in women over 70 years old.

I then reported in full two of my cases, aged respectively 75 and 73 years. The first was one of a rapidly growing right ovarian multilocular cyst with elongation of the adherent uterus up into the abdominal cavity (ascensus uteri). The tumor was removed June 18th, 1890, and the patient made an uncomplicated recovery. She died nine months later after an attack of grippe.

The second case was a left ovarian cystoma with areas of adeno-carcinoma. The tumor was removed July 11th, 1892, and the patient recovered rapidly.

The three cases which I now add to the list are as yet unreported.

Case III.—Mrs. N., patient of Dr. Fenby, aged 74½ years; menopause between 45 and 50 years. She had noticed the presence of a tenseness of the abdomen for one year past; there was no pain, but a constant languor, and a bearing-down in the pelvic region. The distension grew and she lost flesh apace, and for several months there had been nausea and indigestion.

[1] Read before the Gynecological and Obstetrical Society of Baltimore, May 12th, 1896.

I found a large *multilocular ovarian* cyst filling the abdomen, which was 102 centimetres in circumference and measured 42 centimetres from pubis to ensiform. The tumor was uniform in its outlines, but I diagnosed a multilocular cyst by noting the marked difference in tension between the fluids contained in the upper and lower poles while palpating it bimanually.

Operation August 28th, 1895. A long incision was made through fat abdominal walls, exposing the nacreous surface of the cystoma, which was tapped, evacuating 2,600 cubic centimetres of dark, bloody fluid, specific gravity 1020. There was an area of omental adhesions on top of the tumor, covering a surface 6 by 4 centimetres. The cyst was turned out, and its very vascular pedicle, 5 centimetres broad, on the left side, was tied off. The uterus lay in anteflexion. The opposite ovary was not diseased. The incision was closed with four layers of sutures, using continuous catgut for the peritoneum, silver wire through the fascia, and continuous catgut for the fat and subcuticular layers. The cyst was peculiar in that the mesosalpinx was obliterated, spreading the tube out flat on its surface. The patient recovered rapidly, sitting up on the eighteenth day. The incision at the time of her discharge, twenty-five days after the operation, looked like a fine hair line.

Pathologist's Report.—Specimen consists of ovarian cyst 23 by 23 by 15 centimetres in size. The upper part of anterior surface presents area of omental adhesions 8 by 4 centimetres. Remainder of surface smooth, glistening, and traversed by delicate, branching blood vessels. Fallopian tube, 12 centimetres long, is attached to the cyst by mesosalpinx, and the fimbriated extremity is stretched out over its surface, covering an area 13 by 4 centimetres. The cyst contains a large cavity, 14 centimetres in diameter, and numerous smaller ones divided by fibrous septa. Its walls average 1 millimetre, in one or two places, however, reaching 2.5 centimetres. These thickened portions consist of a honeycombed network of fibres containing small cyst cavities. Cyst contained dark brownish-red, hemorrhagic fluid. Histologically the cyst walls are composed of fibrous tissue lined by one layer of cylindrical epithelium. Many portions contain necrotic areas; there is also evidence of old hemorrhages into the tissue, especially surrounding the necrosis. Fallopian tube is normal. Diagnosis, multilocular adeno-cystoma of ovary.

Case IV.—E. J., 71 years old, and thirty-one years past the menopause, was sent into the hospital from the dispensary by Dr. W. W. Russell, complaining of an "abdominal tumor." She had first noticed an enlargement in the abdomen four or five months before, which increased steadily up to the time of her admission ; she had constant pain and cramps at times and was very sore to the touch. Her feet and ankles were more or less swollen, especially the left foot and ankle. Micturition for several months past had been difficult, and there was a constant irritability of the bladder. She had lost much flesh, was anemic and sallow, and had a bad cough.

Examination.—The abdomen was distended by a dome-like tumor, most prominent on the left side between the umbilicus and symphysis. The pelvic organs were senile and the uterus crowded down on the floor under the tumor.

Operation for *left ovarian adeno-cystoma*, April 25th, 1896. As the tumor was adherent to the entire lower anterior abdominal wall, the incision was made from symphysis to umbilicus and the abdominal cavity first opened above. The tumor was punctured and 3,500 cubic centimetres of yellowish, mucoid contents evacuated. The adhesions to the abdominal wall were then stripped off with the fingers and the tumor turned out, its broad pedicle clamped and divided, freeing the growth. After ligating the vessels at each end of the pedicle, a large hematoma was found dissecting its way up along the ovarian vessels above the sigmoid flexure. The vessels were completely hidden in this, so I drew the descending colon toward the median line and incised its mesocolon 6 centimetres above the brim on the outer side and exposed the ovarian vessels there, well above the hematoma, and tied them, preventing further hemorrhage. It was then easy to squeeze out the blood below and catch the vessels at that point also. The edges of the incision into the mesocolon lay in such good apposition that I did not suture them. In seeking out the ureter above and below the brim I was confused for a while by finding a calcareous, spindle-shaped enlargement of the internal iliac artery just below the bifurcation, feeling like a stone in a ureter ; the common and external iliac above this were soft and pliable. The abdomen was closed without a drain and the patient made a good recovery. She is still in the hospital.

Pathologist's Report.—Specimen (not examined microscopically) consists of a multilocular ovarian cyst approximately 17

centimetres in size ; for the most part smooth and glistening, but presenting a few adhesions. Numerous small blood vessels radiate from attachment of pedicle over its surface. Springing from the cyst on outer side of pedicle is a pedunculated cystic nodule 9 by 6 by 5 centimetres, consisting of delicate-walled cysts which contain transparent yellow fluid. The pedicle also contains small cyst cavities, on the inner surface of which calcareous material has been deposited. This nodule is encircled by Fallopian tube. The large cyst walls average 2 millimetres in diameter ; large areas, however, vary from 0.5 to 3 centimetres. These thickened portions on their inner surface present delicate cysts ; more deeply are composed of a dense fibrous network, the interstices containing thick, creamy fluid, also small amount of calcareous material. Springing into the cyst from these portions are large, irregular, exceedingly friable masses, also consisting of a fibrillated network in the meshes of which is a thick, creamy substance. The remaining portion of the inner surface of the cyst is covered by yellow, friable material, removed with difficulty, leaving roughened surface beneath Fallopian tube 10 centimetres long. Fimbriated extremity free, patent.

Case V.—Mrs. B. A. W., a patient of Dr. Snively, of Waynesboro, Pa. She was 72 years old and twenty-two years past the menopause. She had always had good health. Between two and three weeks before my examination, while taking a bath, she had noticed a hard lump in her side, low down. She had no pain or other discomfort than frequent micturition.

I found on examination that the pelvis was choked with cystic tumors firmly wedged in and adherent ; the mass extended up into the lower abdomen and was made up of a number of thin-walled cysts.

May 2d, 1896, operation for *papillary ovarian tumors* extending on to the peritoneum. A median abdominal incision was made and the pelvis and lower abdomen found choked by the growths, mostly with thin walls, and everywhere below densely adherent. There were some papillary masses on the peritoneum, and one on the tumor, just under the incision, was removed for examination.

Enucleation was out of the question on account of the adhesions and the invasion of the papillary elements into the general peritoneum, and the abdomen was closed. The patient has recovered from the exploratory operation.

RECAPITULATION OF FIVE CASES.

Case.	Age.	Tumor first observed.	Character of tumor.	Past menopause.	Operation.	Result.
1	75	Two years before.	Right side: Three large cysts, bloody fluid in largest; partly intraligamentary. Ascensus uteri. Uterus 21 centimetres long. Circumference of abdomen 103.5 centimetres.	Twenty-five years.	Cystectomy June 18th, 1890.	Recovery. Died of grippe and heart disease nine months later.
2	73	One year before.	Left ovarian cystoma with areas of adeno-carcinoma. Contents 4,000 cubic centimetres chocolate-colored fluid. Monocyst with septa.	Twenty-five years.	Cystectomy July 11th, 1892.	Recovery.
3	74	One year before.	Left bilocular cyst containing 2,600 cubic centimetres of dark, bloody fluid.	Twenty-five to thirty years.	Cystectomy August 28th, 1895	Recovery.
4	71	Four to five months before.	Left adeno-cystoma of ovary containing 3,500 cubic centimetres of mucoid contents; partly intraligamentary; mesosalpinx obliterated.	Thirty-one years.	Cystectomy August 25th, 1896.	Recovery.
5	72	Two to three weeks before.	Papillary ovarian cysts choking pelvis, spreading on to peritoneum.	Twenty-two years.	Exploratory operation May 2d, 1896.	Recovery.

These 5 cases have occurred in a series of 1,700 abdominal operations—that is, in a proportion of 1 to 340.

During the same period of time I have operated upon about 150 ovarian cysts, making the proportion in old age about 1 to 30.

Out of the 115 cases reported in women over 70 years, 8 tumors weighed over 50 pounds. These were the patients of Dr. L. J. Cooker, 55 pounds; Dr. Joseph Eastman, 50 pounds; Dr. R. B. Hall, 59 pounds; Dr. John Homans (3 cases), 75, 72, 61 pounds; Dr. Peugnet, 55 pounds; Dr. J. M. Sims, 58 pounds.

Thirty cases out of 44 were reported in our list as still living from one to seven years after operation.

The interest of this subject is due to the extreme age of the patients, and the fact that the tumors had developed in organs long past their period of functional activity, averaging twenty-six years after the menopause in my 5 cases.

Women over 60 years of age are apt to look upon an operation for an ovarian cyst as far more dangerous than a like operation in a younger woman, and for this reason they will even postpone any radical procedure indefinitely.

My statistics show that this hesitation on account of age is not well grounded and that the risk is little if any greater at the advanced period of life. This is well shown by the fact that out of a total of 115 cases in the tables, in the hands of

sixty-six different operators, only 15 died. I think this record would hardly be improved, if indeed it could be equalled, in a list of younger women with the same number of operators.

The risk in the aged closely approximates that in children. Bland Sutton states that out of 35 non-sarcomatous ovarian tumors operated upon in young children, 31 recovered, a mortality of 11.4 per cent.

Three of the patients who were over 80 years of age all recovered.

In the *Lancet* for 1895 Matthew Owens reports a successful ovariotomy in a woman 87 years old.

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