Clinical and other Notes

seeing the case and for kindly carrying out the electrocardiographic examination.

The radiographic picture is reproduced to show the unusual features referred to above.

BILATERAL OVARIAN DERMOID CYSTS WITH LEFT OVARIAN MULTILOCULAR CYSTOMA.

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The clinical description of this case is compiled from the notes of Major H. H. Blake, R.A.M.C., and of Major A. S. Fry, I.M.S., who was called in consultation and performed the subsequent operation. It is reported with the consent of the officers commanding the hospitals concerned.

A Eurasian woman, aged 30, married to a British soldier, was admitted at 7 in the morning on February 16 to a British family hospital in India. She had been married for eight years, but had never been pregnant. Menstruation was regular, and she suffered from habitual constipation. As a child she had kala-azar, and six years previous to the date of admission had been in hospital for a fortnight with a "cold in the bladder."

About a week before admission she had an attack of pain on the right side of the abdomen accompanied by rigidity and vomiting. This was relieved by the application of hot-water bottles to the abdomen. The pain was felt all over the right side of the abdomen with its maximum intensity low down in the right iliac region. It gradually disappeared, and she felt well until the day before admission, when the pain recurred during the night and was accompanied by two bouts of vomiting.

She was a woman of fair general development who did not look very ill. The temperature was normal. The pulse was 82 per minute, regular, and of good volume. The abdomen was flaccid, slightly distended, especially on the left side, and moved freely on respiration. Palpation disclosed a large tumour the size of a fetal head on the left side of the abdomen, dull on percussion, and unconnected with spleen or kidney. There was an area of tenderness low down in the right iliac region. Menstruation commenced on February 18.

On March 1 examination of the abdomen revealed a large central swelling extending rather more to the right than to the left side, and reaching to three fingers' breadth above the umbilicus. The contour of the swelling descended gradually to the epigastrium and steeply to the pubes. Below, the tumour appeared to be anchored within the pelvis by a pedicle passing down in the suprapubic region. It could, however, be pushed up almost to the xiphisternal notch, and was freely mobile from side to side. It felt smooth, tense, and elastic, and there was no tenderness
on palpation. The percussion note over the tumour was dull, and in the flanks tympanitic. Bimanual vaginal examination disclosed a normal cervix and body of the uterus. There was a rounded, tense, rather tender fullness of the right fornix; the left fornix appeared normal.

On March 3 laparotomy was performed under general anaesthesia, by a right, paramedian, subumbilical incision displacing the rectus outwards. The right Fallopian tube was found to be rotated clockwise on its axis through about 270°, and was greatly thickened. The right ovary was enlarged to the size of a tangerine orange, of a purplish colour, and adherent to the anterior abdominal wall and omentum. The right tube and ovary were excised. The large tumour was found to arise from the left ovary, and had contracted numerous omental and posterior parietal peritoneal adhesions. There was a thin pedicle two inches broad which was ligated, and the tumour removed intact, leaving the tube in situ. The uterus appeared normal. The appendix was removed, and the wound closed in layers. The patient left the theatre in excellent condition, convalescence was apyrexial and uneventful, and she was discharged fit and well on March 24.

Examined fresh and unopened, the right ovary was found to measure 3½ inches by 2¼ inches, and to weigh 4 ounces 5 drachms. It felt solid, and the wall was of a dark, mottled purple colour. The thickened tube was attached. The left ovarian mass measured 7½ inches by 4 inches, the greater part being thin-walled, cystic, and translucent. Close to the site of attachment of the tube was a small triangular area of recent haemorrhage. It weighed 27 ounces 3 drachms.

After hardening, the specimens were cut longitudinally and the following condition discovered:—

The right ovarian mass was largely composed of two rounded, dermoid
cysts, to the smaller of which was applied a triangular wedge of fibrous tissue supporting the thickened cord. The larger of these cysts contained a light yellow, greasy, granular material, intermingled with a tangle of hair, and with some bright red blood in the centre. The smaller cyst contained a similar material, of a light anchovy-paste colour with a small quantity of hair intermixed.

When the contents were removed, there was discovered embedded in the wall of the smaller cyst, at the point marked 1 in the photograph, a hard projection closely resembling a small bicuspid tooth. At the point marked 2 in the larger cyst was a similar double projection, but of fibrous consistency, from the circumference of which sprang a tuft of coarse, black hair. At point 3 is the fimbriated end of the thickened Fallopian tube.

Section of the left ovarian mass liberated from the large thin-walled cystic portion a clear, yellow, serous fluid, and showed the multilocular arrangement. The more solid portion contained three cavities marked 4, 5 and 6 in the photograph. Of these, numbers 4 and 5 were filled with a light, reddish grey, greasy material, and number 6 with a yellow, sebaceous material intermixed with hair. Evacuation of the contents of 4 and 5 displayed smooth walls, but when the contents of 6 were removed there was found to be a rather irregular semicircle of bone, with rounded projections, rather suggestive of a primitive vertebra, embedded in the wall. This bony semicircle had to be forcibly broken to allow of the specimen being completely opened out. At point 7 was embedded a round semi-translucent nodule of cartilage. Point 8 indicates the site of attachment of the Fallopian tube.

The condition was one of multiple dermoid cysts of both ovaries, with a multilocular ovarian cystoma on the left side.

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**Echoes of the Past.**

**A SURGEON OF THE ROYAL ARTILLERY.**

**By MAJOR OSKAR TEICHMAN, D.S.O., M.C., T.D.**

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Towards the end of the year 1798, the British Government became aware that Napoleon was about to invade Palestine, with the intention of crushing the Turkish army in that country, before the chief Ottoman force (which was assembling at Rhodes) should have time to reach Egypt by sea.

Although Nelson had destroyed the French fleet at Aboukir Bay in August of the same year, Napoleon had by this time gained a strong footing in Egypt. His Majesty's Ministers decided therefore to send to the Dominions of the Grand Seignior a British Military Mission, which was to