A Case of Chorion-Epithelioma of the Fallopian Tube.*

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C.O., aged 28, was admitted to the Jessop Hospital on August 22nd 1908. Her third and last child had been born seventeen months previously. It had been weaned at the expiration of ten months. Two months later menstruation recommenced; profuse losses, lasting 8 to 10 days, had occurred every three weeks since. For five months there had been constant pain in the back and across the lower abdomen. Three attacks of severe abdominal pain and tenderness had kept her in bed for two and three weeks at a time. She did not think she was pregnant, nor had anything occurred during the illness to suggest a miscarriage.

On admission, she was a pale, thin but fairly well-nourished woman. A free menstrual loss existed during the first ten days after admission, and each night the temperature rose to about 99·2°, the pulse rate being below 90.

On bi-manual examination the uterus was found to be slightly enlarged, tender and but slightly mobile, whilst on each side of it there was an irregularly ovoid, fixed, tender swelling, the left being the larger.

A diagnosis of subacute endometritis with bilateral salpingo-ovaritis was made and a course of appropriate treatment ordered.

On September 12th, bi-manual examination was followed by an attack of severe abdominal pain, which, however, only lasted an hour or two. At this time the swelling on the right was distinctly smaller, the uterus was more mobile and the pelvic tenderness much less. A week later, during the night, a more severe attack occurred; the patient vomited, but did not feel faint nor was the pulse rate accelerated. Next day, the left-sided swelling was found to be larger, and there was a sense of fulness in the pouch of Douglas. The diagnosis was now altered to that of a left tubal gestation, which was leaking or in process of aborting. On September 21st, the abdomen was opened, and the left tube was found to be enlarged, in its inner half, forming a cylindrical swelling $3\frac{1}{2}$ inches long and $1\frac{1}{2}$ inches in diameter. Bright blood was oozing from a minute opening on its posterior aspect, near the uterus. The outer portion of the tube was healthy and the ostium patent; there was a small cyst at the fimbrial extremity.

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There was recent blood-clot in the pouch of Douglas and in the utero-vesical pouch, in all about a teacupful. The right tube was œdematous but otherwise normal. The ovaries were healthy, and the uterus showed a slight general enlargement.

The left tube was excised on the supposition that it contained a molar pregnancy. A small nodule of adherent blood-clot was picked off the peritoneum covering the bladder on the right side; an oozing surface was left; this was covered by sewing a fold of peritoneum over it. The true significance of this oozing surface was unfortunately not realised until later.

Examination of the tube showed that the outer part (3·75 cm.) was normal and its lumen patent. The inner part was enlarged to a cylindrical hard mass, measuring 8·75 cm. in length by 3·75 cm. in diameter. The surface was slightly nodulated at one place. On section, it appeared to consist of organising blood-clot; there was no sign of a gestation sac. (See Fig. 1.) Microscopical examination of peripheral portions of the tumour showed typical chorion-epitheliomatous tissue deeply invading the wall of the tube. No chorionic villi were found in the portions examined.

The uterus was therefore explored and curetted, but only a thin mucous membrane was found. The curetting on microscopical examination showed no decidual or chorion-epitheliomatous tissue.

Rapid recovery followed these operations, but the patient did not regain her strength and colour. At one time she had a cough with blood-stained sputum, but no physical signs of growth in the lungs were ever found. The pelvis was examined bi-manually from time to time, but it was not until November 2nd, more than six weeks after the first operation, that it was certain that there was a recurrence in the left broad ligament; on the same day an ovoid elastic nodule, of purplish colour, was found in the anterior vaginal wall. There had been no sign of this five days previously.

With some difficulty the patient was persuaded to submit to a third operation.

On opening the abdomen (Nov. 7th) a tumour was found at the root of the mesentery of the small intestine. It was nodular, of about half the size of one's fist, and was taken to be a mass of enlarged lymph glands. It was obviously impossible to remove it and unwise to remove a portion for examination.

Total hysterectomy with removal of the healthy right appendages and the left ovary was then performed. No special difficulty was experienced in excising the recurrent mass of growth ($1\frac{1}{2} \times 1\frac{1}{2} \times 1\frac{1}{4}$ inches) in the left broad ligament. (See Fig. 2.)

A nodule was also removed from the upper wall of the bladder, at the site of the oozing surface which was seen at the first operation. It was deeply seated in the muscular coat, but did not involve the mucous membrane which was exposed beneath it. This wound and

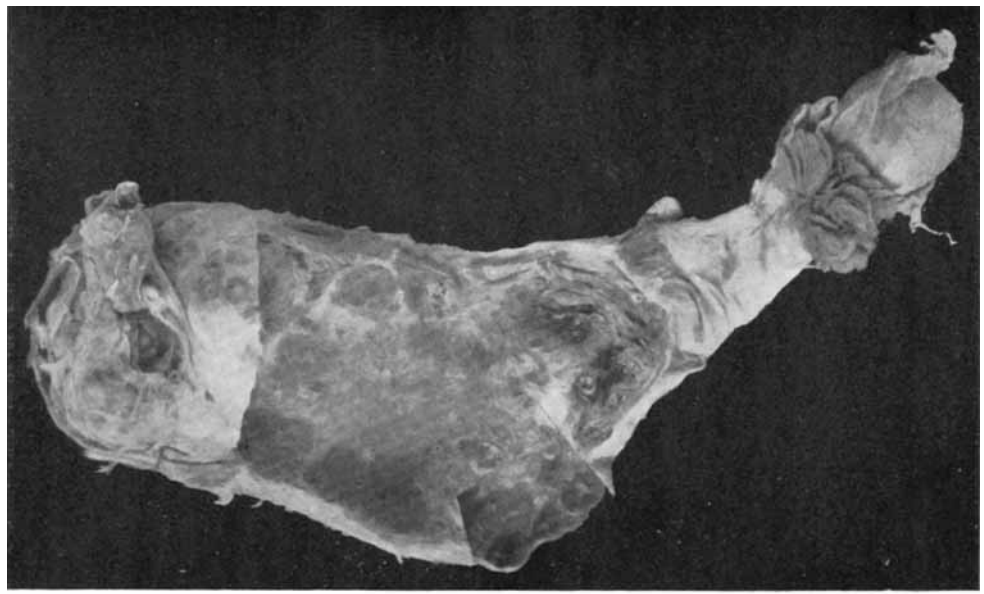

Fig. 1.

Photograph of primary chorion-epithelioma of left Fallopian tube (posterior aspect). A superficial portion has been removed to expose the hæmorrhagic growth, which measured 8·75 × 3·75 × 3·75 cm.

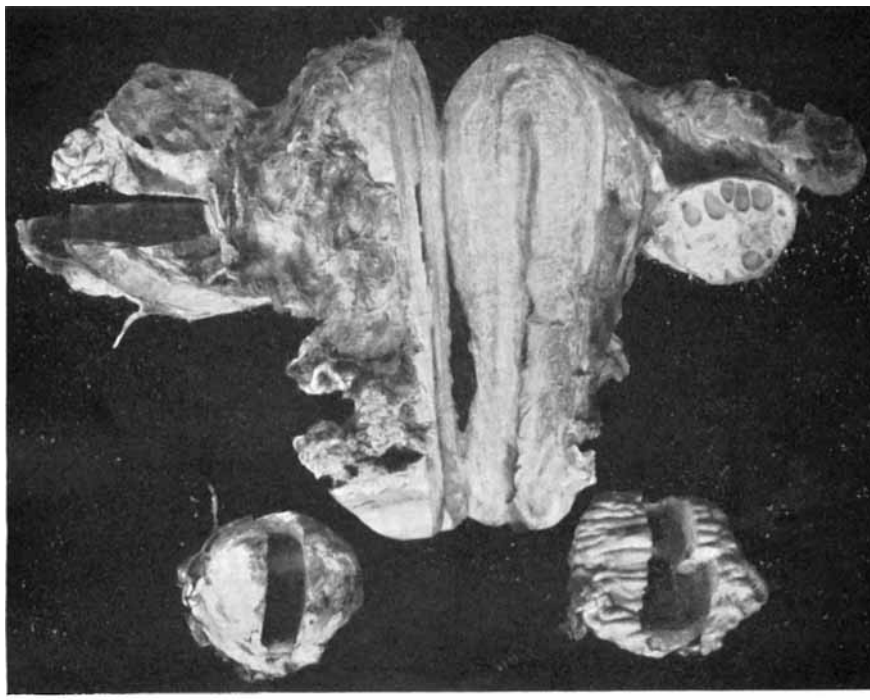

Fig. 2.

Photograph of uterus (posterior aspect) which has been split open, with the normal right appendages and the recurrent mass (surmounted by the ovary) in the left broad ligament. A portion of the mass has been removed for examination. Below are metastatic nodules from (*left*) the bladder and (*right*) the vagina. These measured $2{\cdot}5 \times 2{\cdot}5 \times 1{\cdot}8$ cm. and $2{\cdot}5 \times 2{\cdot}5 \times 1{\cdot}25$ cm. respectively.

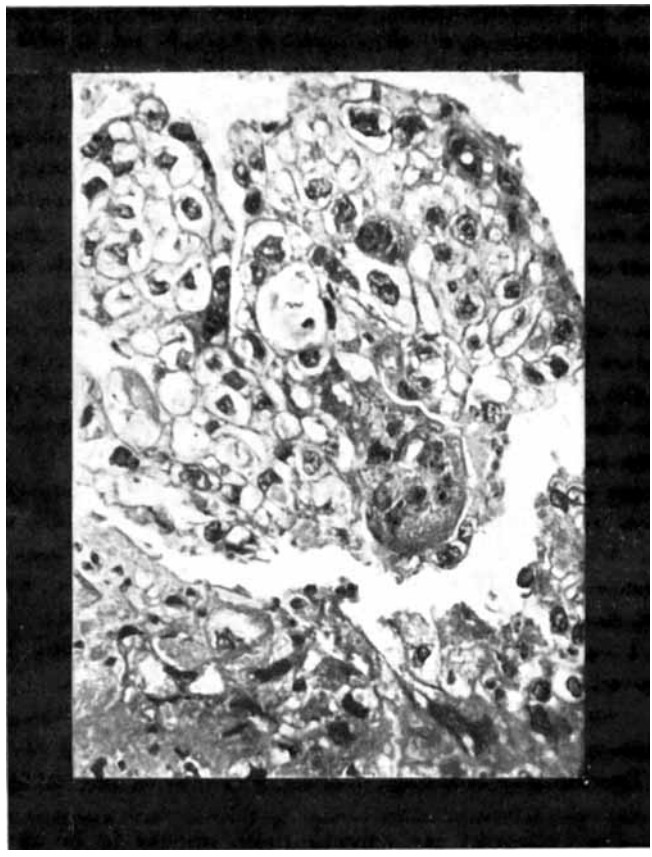

Fig. 3.

Photo-micrograph (high-power) of a portion of the vaginal metastatic growth. (I am indebted to Mr. Graham Simpson for this photograph.)

the abdomen having been closed, the patient was put in the lithotomy position, and the vaginal growth ($1 \times 1 \times \frac{1}{2}$ inch), with the overlying mucous membrane, excised. It lay close to the upper urethra and neck of the bladder, but could be easily removed without injury to either.

The broad ligament growth and the two metastatic nodules appeared to the naked eye to consist merely of more or less organized blood-clot, but on microscopical examination typical chorion-epitheliomatous cells and masses of syncytium were found in each of them. No growth was found in the uterus itself.

Again the patient made an easy recovery, and three weeks later she went home. In spite of the bad prognosis, which I felt obliged to give to her husband, she steadily improved in weight and strength. I have kept her under observation ever since. The mesenteric tumour, which was easily palpable as long as she was in hospital, gradually lessened in size, and ten months later had quite disappeared.

I last examined the patient on March 9th 1911, two years and four months after the radical operation. There was then no sign of recurrence in the pelvis or elsewhere, and the patient was in better health than she had been for years. (December 1911. This is maintained. No examination.)

Judging from the number of cases reported, chorion-epithelioma of the Fallopian tube is a very rare disease. In 1905 Risel collected 11 cases. Mr. Alban Doran, who keeps careful records of cases of malignant disease of the tubes, has kindly informed me that only two other cases have been recorded since Risel wrote his paper.

So far as I can judge from the short abstracts available, the disease has proved rapidly fatal in all but two of these cases.

Recovery, even after the formation of metastatic growths, in cases of chorion-epithelioma of the *uterus*, has been several times recorded, and Teacher has carefully studied the pathological changes involved.

As regards the origin of the growth there appear to be three possibilities. It may have arisen: (1) in a tubal pregnancy; or (2) from the epithelium of villi, transported from the placental site of the pregnancy, which had terminated a year before the onset of the illness; or (3) as a teratoma.

In this case it does not seem possible to decide which of these obtained, though I am inclined to the theory that the disease originated in a tubal gestation.

Diagnosis of the condition would appear to be impossible in the absence of characteristic secondary deposits in the vaginal wall, or of a history of recent removal of an aborted tubal ovum without excision of the affected tube. This actually happened in a case reported by Lörrqvist in 1909.