

Case Reports

BENIGN PAPILLOMATA OF THE GALL-BLADDER AND BILIARY DUCTS*

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The occurrence of primary intra-biliary benign papillomata is rare, and its recognition clinically, as a cause of partial or complete obstructive jaundice, offers considerable difficulty in diagnosis, which usually must be only pre-operative and suggestive. "No one living is infallible in the differential diagnosis of obstructive jaundice; the diagnosis is always difficult, and the chance of a life saved so important that I advise operation in all cases." (Moynihan).

The incidence of painless, incomplete obstructive jaundice in patients of middle or later age is so often thought to be due to carcinoma of the pancreas (which, as regards a cure, is beyond the relief of surgery) that I believe patients who are suffering from benign papillomata are often not operated on. Although, even if carcinoma, which is usually impossible to remove, be found, the misery of the terminal months of jaundiced life may be prevented by a short-circuiting operation, analogous to gastroenterostomy for carcinoma obstructing the pyloric antrum. The gall-bladder may be anastomosed to the stomach or the duodenum, or the common duct to the duodenum, with relief from the obstructive jaundice.

Papillomata occur as benign tumours in the gall-bladder, in the cystic duct, in the common duct, or in all three areas. One growth may seed itself elsewhere in the biliary tract in many places, and may cause obstruction at any point therein. The Mayo Clinic, in the twenty years ending January 1, 1930, had only 4 cases of benign tumour and 49 cases of primary carcinoma in the extra-hepatic bile ducts.¹ In the Montreal General Hospital benign papillomata of the bile ducts have been extremely rare, though A. T. Bazin² reported one such case in a male, aged seventy years, with repeated attacks of colic together with

jaundice of temporary duration. It was noted that the attacks of pain were less severe than is usual in gallstone colic. This tumour was removed from the common duct. Marshall³ stated that he could find only 12 cases reported in the literature of benign papillomata of the bile ducts. It is obvious that this condition is sufficiently rare to make it advisable to report all such cases, and to emphasize the necessity of operation, even if a malignant growth is diagnosed as the cause of the obstructive biliary symptoms.

Mrs. J. B., aged fifty-five years, was admitted, walking, to the private service of Dr. D. Grant Campbell, in the Montreal General Hospital, on April 19, 1932. She had been ill since Christmas, 1931, had lost about twenty-five pounds in weight, had upper abdominal discomfort, anorexia, and a distaste for fat or oily food; she tired easily and was slightly jaundiced. In 1929 she had had a tonsillectomy done, with post-operative hæmorrhage, and had not regained her usual health. She had had no severe colic, but had "soreness" in the right upper abdomen. She showed hypertension; her blood pressure was 178 systolic and 110 diastolic; she had a distended abdomen with tenderness and a large mass in the region of the gall-bladder; the liver was not palpable. She had some fever. There was a marked secondary anæmia; the red blood cells were 2,430,000; the hæmoglobin 60 per cent. Diminished sugar tolerance and delayed assimilation were present. Urobilinogen was present in less than 1 in 10 dilution: and there was non-visualization of the gall-bladder after the intravenous dye.

Here, then, was a picture of incomplete biliary obstruction, coming on over a period of five months. Her medical attendant made a tentative diagnosis of carcinoma of the head of the pancreas or of the gall-bladder. Operation was advised, and, though her medical attendant was somewhat skeptical of its value, it was easily performed under nembutal and spinal anæsthesia, on April 25, 1932. There was hæmorrhagic fluid about the mass, which was a large gall-bladder, larger than a grapefruit, and adherent to adjacent structures. This

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was freed, with the cystic duct, up to the common duct. The cystic duct was quite large, about the size of one's little finger, and on ligating it and cutting it, I went through what I took to be carcinomatous tissue. The common duct felt somewhat pulpy and it appeared un-

dice disappeared and she had no further digestive disturbances; she later regained her weight and got about again.

The specimen removed at operation consisted of a large gall-bladder, 15 by 7 by 7 centimetres, which was tied off at its proximal end.

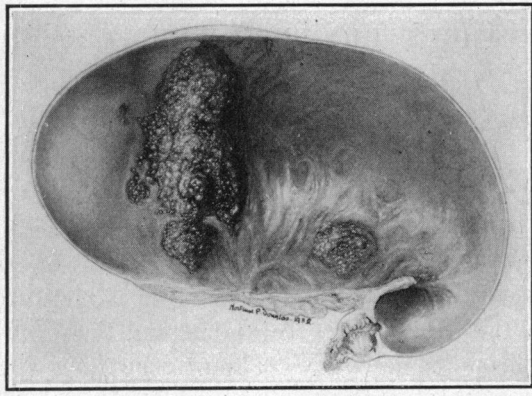


FIG. 1.—Papillomata in the gall-bladder.



FIG. 2.—Shows part of the wall of the gall-bladder and a cross section of the cystic duct filled with the papillomatous growth. This was the cause of the hydrops of the gall-bladder.

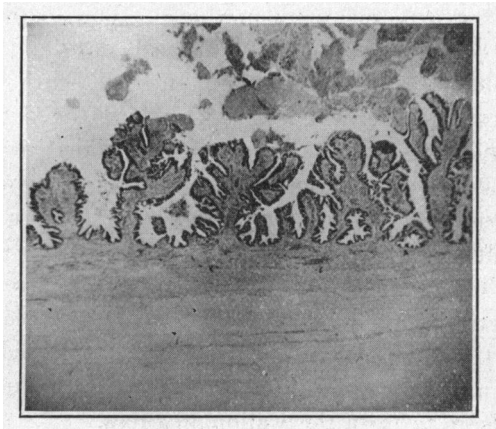


FIG. 3.—Shows the frond-like papillomatous growth in the wall of the gall-bladder. In no place is seen any tendency to infiltration of the submucosa.

wise to explore it farther, as it seemed to be filled with tumour. No bile flowed from the cystic duct where the ligature had cut through. This was re-ligated and further exploration revealed no tumour in the pancreas; no glands were enlarged and no nodules were found in the peritoneum. Until the gall-bladder and ducts had all been freed and dissected out there was no suspicion of an intra-biliary growth being present, and I expected to find a stone in the common duct, with associated cholecystitis.

The patient made a good recovery, and beyond a slight pulmonary infarct had no complications, and she was discharged on the twenty-fourth post-operative day. Her jaun-

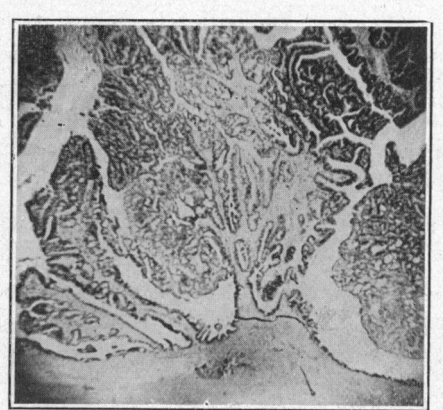


FIG. 4.—Illustrates a transverse section through a stem of a papilla of the gall-bladder. The stem is clear-cut and there is no infiltration of the tumour through the basement membrane of the wall, and the stem shows no cellular infiltration.

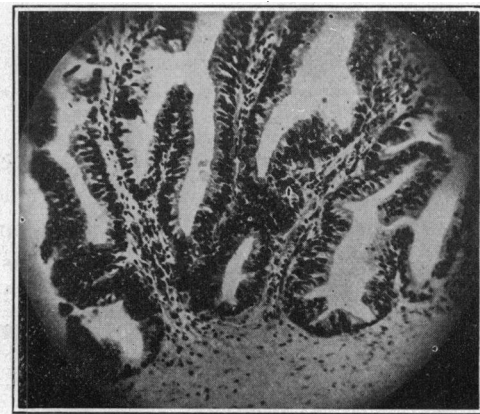


FIG. 5.—Is a high power micro-photograph which illustrates clearly the benign character of these papillomata.

The cystic duct was kinked on to the gall-bladder, and was whitish-yellow, firm and indurated. The gall-bladder was moderately distended, with no stones palpable, and was reddish-pink in colour. On opening it, after fixing in formalin, the cavity was found to be filled with blood and no stones were seen. There did not appear to be any mucosa, the interior being smoothed out, with only faint traces of trabeculation. There was a sessile, verrucous growth, occupying one-half of the circumference at the fundus, 2.5 centimetres in width and extending 6 centimetres around the lumen, with the papillomatous projections making up this tumour of a red colour and covered with adherent blood clot. There were several smaller, isolated tumours, similar in form, some the size of a split pea, and one the size of a ten cent piece, near the valve, the free edge of which was covered with minute papillomata (Fig. 1). Immediately below it, filling the lumen of the cystic duct, was a papillomatous growth which seemed to arise from the wall of the duct and almost obliterated the lumen (Fig. 2). This was bulging from the cut end of the duct. It was white, soft and friable.

The primary origin was likely in the wall of the gall-bladder, and yet the mass in the cystic duct and in the common duct might have been the primary growth; certainly the latter caused the jaundice and the former the dilated gall-bladder.

Dr. L. J. Rhea, Director of the Pathological Department of the Montreal General Hospital, has prepared a series of sections from the gall-bladder and the cystic duct.

DISCUSSION

It is wise to explore all cases of obstructive jaundice, even if apparently due to obstruction from a growth, presumably malignant.

The ducts should be explored, and often a tumour mass may be removed. In the above-described case it would appear that the common duct should have been opened, and possibly more benign papillomatous masses could have been removed. The macroscopic appearance, however, so strongly pointed to cancer that this was not done.

The occurrence of intra-biliary benign tumours, papillomata and fibromata, the latter chiefly in the gall-bladder or in the intra-

duodenal duct portion of the biliary channel, should be constantly kept in mind, even if this happens only occasionally.

REFERENCES

1. MARSHALL, *Surg., Gyn. & Obst.*, 1932, 54: 6.
2. BAZIN, *Ann. Surg.*, 1930, 92: 659.

UTERUS BICORNIS WITH CLOSED ACCESSORY HORN

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Malformations of the uterus are caused by errors in development. The growth of any organ may be simply arrested or it may grow in the wrong way. To understand these conditions it is necessary to know something about the development of the organ.

The first indications of the genito-urinary organs are the Wolffian ducts. These appear in the embryo about the fifteenth day, and the Wolffian bodies appear about the eighteenth day. These structures help to make up the future kidney and genital apparatus. They lie on either side of the mid-line. In the fourth week of embryonic life other ducts appear near the Wolffian body of each side. These are the Müllerian ducts and are those we are directly interested in at the present time. The lower portions of Müllerian ducts become fused to form the vagina and the uterus, while the upper ends go to form the Fallopian tubes.

In the anomaly presented by a bicornuate uterus failure to unite involves the upper section only. There are various depths to the notch between the two horns. The horns vary in size; they may be equal, or one may be greatly distended, as in the case to be presented. The cervix may be single with one opening; it may have two openings; or it may be completely separated into two cervixes, each with a separate opening.

CASE REPORT

H.G., aged 15 years, school girl.

Complaints.—Severe cramp-like pains in the pelvis lasting for six weeks; last menses one month previously, which lasted but one day; constipation for two months. For six weeks the patient had experienced severe cramp-like pains in the uterine region, aggravated by her menses.