Section of Obstetrics and Gynæcology

President John B Blaikley FRCS FRCOG

Meeting November 27 1964

Cases and Specimens

Carcinoid Syndrome Resulting from a Primary Argentaffinoma of the Ovary

J D Ellis FRCS MRCOG

Mrs M S, aged 58

History: Six years' bronchospasm, hypertension and increasing diarrhœa. Five years' increasing facial erythema with severe cold-induced cyanosis. Attacks of severe flushing associated with throbbing in the head, borborygmi and the passage of a watery stool. Two years' increasing ankle œdema and dyspnœa. All ascribed by her medical advisers at the time to 'nerves' and by herself to poison.

Findings on admission: Facial: telangiectasia; flushing and cyanosis together. Cardiovascular: right heart failure with ankle œdema and a large tender liver; tricuspid incompetence. Pulmonary: bronchospasm. Abdominal: large lower abdominal mass producing diarrhœa when palpated.

Investigations: Chromatography of 24-hour urine showed presence of 5-hydroxy-indole-acetic acid.

A diagnosis of malignant carcinoid syndrome was made.

Operation: The heart failure was partially corrected and laparotomy was performed.

An irregular right ovarian tumour (11 × 15 cm) on a small pedicle was readily removed. No other abnormality was found. There was no evidence of another primary or of any secondary spread. The appendix and left ovary were also removed but were normal.

Histology: The specimen was an argentaffinoma. There was no evidence that it had arisen in a teratoma. It did not, in fact, show any affinity for silver salts.

Progress: The dyspnœa, bronchospasm and diarrhœa disappeared at once. The facial erythema and heart failure cleared over three weeks. There were no complications of the operation. The patient remains symptom free.

Comment

Only where the venous drainage of an argentaffinoma by-passes the liver can one find the carcinoid syndrome without malignant secondary deposits of argentaffinoma.

Adenocarcinoma Arising in an Adenomyoma

D F Hawkins PhD MRCOG

Woman aged 37, para-1

History: Irregular, frequent and heavy menstruation for nine months, swelling of the ankles for one year and some difficulty in micturition for three months. She had been infertile for twenty-one years.

On examination: Obese. Slight bilateral ankle œdema. Uterus enlarged half-way to umbilicus by multiple fibromyomata. Cervix, adnexæ – no abnormality.

Investigations: Hb 12·5 g/100 ml, Group O, Rhesus positive, plasma urea 26 mg/100 ml. Chest X-ray showed no active disease. Cervical smear: no cancer cells, 6-phosphogluconate dehydrogenase activity normal.

Operation: Total hysterectomy was advised but the patient did not wish this to be done. A multiple myomectomy was therefore performed, removing 24 fibromyomata (0·5–6·0 cm). The uterine cavity was opened and curettage performed. Excess myometrium was resected and the uterus repaired.

Pathology

The fibromyomata were benign, with some hyaline change and œdema. The curettings were normal proliferative phase endometrium. The resected myometrium contained a small adenomyoma. Histologically there was grade 1 malignant change in the adenomyosis. There was