

COMMENT

The patient had been taking two tablets of "veriloid-VP" three times daily after meals for six weeks before admission. The drug had been prescribed for hypertension, first diagnosed five years previously. Each tablet contains 2 mg. of veriloid and 15 mg. of phenobarbitone. On the day of admission she had had her last dose after lunch, and symptoms had occurred when she began her tea.

According to Kauntze and Trounce (1951), some patients taking 12 mg. of veriloid daily had toxic symptoms, including a substernal burning sensation (sometimes amounting to pain), salivation, globus or choking sensation, vomiting, coldness and tingling in the finger-tips, hiccup, and collapse. They stated that toxic symptoms are minimized by combining the veriloid with phenobarbitone and administering the tablets immediately after meals. In our patient the symptoms were so severe as to simulate myocardial infarction, and continued for several hours, but appeared to be controlled partially by atropine and, more effectively, by ephedrine. In a search of the literature we can find no reference to toxic symptoms so severe and protracted as these with moderate dosage of the drug.

Several authors comment on the narrow margin between therapeutic and toxic levels in some patients (Freis *et al.*, 1949; Kauntze and Trounce, 1951), but it is said that the emetic property of the drug precludes serious overdosage. Our patient vomited, but continued to have severe toxic symptoms for several hours. It is therefore clear that vomiting does not always occur in time to prevent very undesirable effects.

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A Case of Meigs's Syndrome with an Ovarian Carcinoma

The association of hydrothorax, usually on the right side, with ascites and fibroma of the ovary was described in 1937 by Meigs and Cass, and since this time Meigs's name has become attached to this syndrome. This is not to say that he was the first to note such an association of clinical findings, for he quotes at length in a later article (Meigs *et al.*, 1943) a report by Lawson Tait (1892) of a typical example successfully operated on. Following Meigs's original article there has been a much more general recognition of the syndrome. Soon it became apparent that hydrothorax, usually on the right side, might occasionally be present in association with any marked ascites, whether caused by an ovarian tumour or cirrhosis of the liver, though the former was most commonly responsible.

There has been some discussion on the way hydrothorax is produced. The following case is reported as there seemed to be a fairly wide channel through which fluid passed readily from peritoneal to pleural cavity.

CASE REPORT

A married woman aged 52 was admitted to hospital on July 26, 1951, with marked ascites. Her haemoglobin being only 58%, 4 pints (2.3 litres) of blood was transfused over the course of the next few days. On July 31 she became dyspnoeic. I first saw her on the following day. Examination then showed a gross ascites, though no tumour could be detected on abdominal or vaginal examination. The right chest was dull to percussion, and an x-ray examination confirmed the presence of a pleural effusion. No underlying lung disease could be detected. A malignant ovarian tumour was suspected and laparotomy advised.

Before the operation repeated aspiration of the right chest was carried out. On August 1 36 oz. (1,020 ml.) of clear

straw-coloured fluid was aspirated, followed by 38 oz. (1,080 ml.) two days later and 40 oz. (1,140 ml.) on August 11.

On August 13 the patient was anaesthetized and placed on the operating-table. Inspection then showed an obvious bilobar swelling lying more to the right side of the abdomen, while the ascitic distension had apparently disappeared. Laparotomy confirmed these findings except for a little ascites, which was cleared with sucker and mops. The upper pole of the tumour was then delivered through the incision. The lower pole was fixed by infiltration of the right ovario-pelvic ligament and adhesions to the rectum. By finger dissection enough mobilization of the tumour was obtained to allow the remaining pedicle to be clamped, and the tumour was removed. There was fairly profuse bleeding from the infiltrated area, and several clamps had to be applied to open gushing veins. Haemostasis was finally obtained, and, as the left ovary and uterus appeared normal and the complete removal of malignant tissue in the region of the pedicle was impossible, the abdomen was closed. There were no obvious secondaries in the omentum or on the peritoneum.

Blood transfusion was given post-operatively as there was some degree of shock, but there were no other complications, and the patient was discharged from hospital on August 29. She was referred for deep x-ray therapy, and received a full course of treatment. When last seen on November 15, 1951, she was well, there being no sign of recurrence, and no evidence of ascites or hydrothorax. An x-ray film of the chest showed no sign of pleural effusion or of metastasis.

Pathological Report.—"The specimen consists of a right ovarian cyst measuring 23 by 15 cm. Microscopically the appearances are those of a papillary adenocarcinoma."

COMMENT

The point of particular interest in this case is the considerable reduction in the amount of the ascites after aspiration of fluid from the chest. This seemed to indicate that there must be a fairly wide communication between these two cavities to allow so rapid a passage of such a large quantity of fluid. The presence of a persistent pleuro-peritoneal canal seemed to explain the features of this case most satisfactorily.

Meigs rejected his original suggestion that the right hydrothorax was due to lack of drainage by the azygos vein. He believed that a persistent pleuro-peritoneal canal was usually incompatible with life, and finally concluded that the fluid found its way through a lymphatic pathway in the diaphragm. This latter theory, however, would not account for the relative rarity of the occurrence of hydrothorax with ascites. Nor would it explain why the right side is favoured. It would, indeed, be reasonable to expect that a bilateral hydrothorax of some degree would occur in all cases of marked ascites.

A congenital opening, then, seemed to us to explain this syndrome most satisfactorily, and especially an opening resulting in a direct communication between the two cavities such as the persistent pleuro-peritoneal canal. Why, however, is the gap usually on the right side, while a diaphragmatic hernia through a persistent pleuro-peritoneal canal is usually on the left side? It is recognized that this type of hernia is uncommon on the right side, as the liver tends to occlude the right-sided openings. As herniation is then prevented, and as an opening on the left side usually results in a herniation incompatible with life, it is suggested that the more frequent occurrence of right-sided hydrothorax is due to lack of survival of those individuals whose persistent canal happens to be left-sided.

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