rence of bleeding into the cyst and subsequent rupture to cause an acute abdominal emergency is an unusual presentation. The more common complaints are of pain in the side, swelling, malaise, anorexia or anæmia. (3) The pathological type is uncommon. The commonest cyst of the adrenal is the pseudocyst due to hæmorrhage into a diseased or normal gland. This variety has often blood clot surrounding the wall and shows no endothelial lined spaces as in the present angiomatic type. Calcification may occur in either. It is usually

impossible to distinguish between lymphangiectatic cysts and cystic hæmangiomas (Adderley and others, 1954). (4) The palpation of a normal-sized spleen in the epigastrium is rare, and was due to its forward displacement on the dome of a large retroperitoneal tumour, giving the false impression of enlargement.

We wish to thank Mr. P. H. R. Ghey for permission to treat and publish the case, which was admitted under his care. We also thank Dr. J. H. Rack for the pathological report.

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MASSIVE INTRAPERITONEAL HAEMORRHAGE FROM A RUPTURED CORPUS LUTEUM CYST

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DURING the process of physiological evolution of the corpus luteum, some hæmorrhage from the perifollicular blood vessels of the theca is a normal event, but massive leakage of this hæmorrhage into the peritoneal cavity is rare. Fitzgerald and Berrigan (1959) called it an 'ovarian vascular accident' and rarely is it accurately diagnosed before operation. This condition is more common than generally thought, and often small hæmorrhages from a ruptured corpus luteum or corpus luteum cyst are found at laparotomy on patients who had been diagnosed as having appendicitis—when operation is performed at mid-cycle.

Case Report

An unmarried girl, aged 17 years, was admitted to Princess Alice Hospital on 15.2.62 from the Casualty Department. She complained of sudden acute pain in the right iliac fossa and nausea. L.M.P. 30 days previously, lasting for seven days. Menstrual history: 3 to 4 days/28 days, regular.

On examination she was found to be pale, of ashen-grey complexion. Pulse 92/min.; temp. 98.4°; B.P. 120/80 mm. Hg. Abdominal examination revealed guarding and tenderness in the right iliac fossa, but there was no rigidity. Her breasts were not active. There was no hæmorrhagic vaginal discharge.

On vaginal examination she was found to have a retroverted, slightly bulky uterus. The cervix was rather soft. Her right adnexæ were extremely tender, but no definite mass could be felt. A provisional diagnosis of appendicitis was made, but the possibility of an ectopic pregnancy was kept in mind.

FIG. 1.—Shows hæmorrhage in the cavity of corpus luteum cyst. There is also marked congestion in the perfollicular blood vessels of the theca.

On the evening of the same day laparotomy was performed; 43 oz. of blood was removed from the peritoneal cavity. The right ovary contained a corpus luteum cyst of the size of a walnut. There was a tear in its wall about 2 cm. long from which blood was slowly leaking. Right oophorectomy was carried out; 4 pints of blood were transfused.

A further exploration was necessary 12 hours later because of secondary hæmorrhage as the mesovarium was bleeding at the site of transfixion by the ligature.

During the post-operative period her hæmoglobin was 68% (10 g./100 ml.). Her blood group was O Rh. negative.

Discussion

Intraperitoneal hæmorrhage from a ruptured corpus luteum cyst is not so rare, and its possibility should be kept in mind whenever a case of suspected appendicitis during childbearing period, or a case of suspected ectopic pregnancy, is operated on. Another condition in differential diagnosis is a twisted ovarian cyst. It is not an uncommon experience that a normal-looking appendix is removed, when in fact the patient has a small hæmorrhage into the peritoneal cavity from a ruptured corpus luteum cyst. Whenever the diagnosis of appendicitis is in doubt in such women, a paramedian or pfannenstiel incision should be used.

The clinical picture of such a case is a fairly definite one. Usually she complains of pain in the right or left iliac fossa, nausea, vomiting, fainting and collapse. Depending on the amount of blood loss, signs and symptoms of shock would be present. Unlike ectopic pregnancy, signs and symptoms of pregnancy would not be present. Another important differentiating point is that there is no large abdominal mass palpable because the ovarian cyst has ruptured.

Gurewicz and Thomas (1960) reported a case of massive intraperitoneal hæmorrhage from a ruptured corpus luteum as a complication of long-term anti-coagulant therapy. Hunter and Hill (1960) reported a case as a complication of leukæmia.

According to Rosenthal (1960) the range of age is 20 to 35 years. He reported a series of 11 cases, the youngest of 13 years. Posterior colpotomy and culdoscopy has been recommended in some cases, but in many cases only the presence of blood in the pouch of Douglas would be confirmed.

Summary

(1) A case of massive intraperitoneal hæmorrhage resulting from a ruptured corpus luteum cyst is described.

(2) Whenever a woman in the childbearing period of her life presents with acute pain in the iliac fossæ and signs of intraperitoneal hæmorrhage, the possibility of this condition should be kept in mind.

(3) In cases of small hæmorrhage from a ruptured corpus luteum, the patient has to be observed in the hospital, and conservative treatment may suffice in such cases.

We are grateful to Mr. E. Harford Rees and to Mr. T. Henry Wilson for their guidance in publishing this case report. Also we thank Mr. J. Coulter, of Armour Pharmaceutical Laboratories, for getting us the photomicrograph of the histological slide of this case.

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BRONCHIAL CARCINOMA PRESENTING AS CARDIAC TAMPONADE

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BRONCHIAL carcinoma is a common disease but this manner of presentation and mode of death are unusual.

Case Report

Ten days before admission this patient, a male, aged 39, had a rigor and went home from his work to bed. He later developed a slight cough and purulent

spit and gradually became more breathless. He was treated as a case of influenza by his practitioner, but because of his lack of response to treatment he was sent in as an emergency to hospital. There was no relevant previous or family history and he was a non-smoker.

Examination on admission showed him to be extremely dyspnoeic and cyanosed. Temperature was 97°, pulse rate 102/min., blood pressure 92/50 mm. Hg.