RUPTURE OF A GRAAFIAN FOLLICLE.

"The Dissension Cyst" Diagnosis.

By V. B. GREEN-ARMYTAGE, M.D., F.R.C.P., F.C.O.G.

(*Gynaecological Surgeon, West London Hospital.*)

Case I.

Mary W., aged 14 years, had been attending the out-patient department of the West London Hospital for three months, the complaint being that the menstrual periods lasted ten or twelve days and recurred after an interval of fourteen days. This had been the sequence of events since the onset of catamenia five months ago. The girl was well developed, intelligent but somewhat anæmic. She had been treated with thyroid, iodine, halibut oil and weekly injections of antuitrin S. The periods no longer were excessive and were appearing every three weeks.

At midnight on October 30th, 1934, she was brought to hospital by her mother because of pain in the lower abdomen accompanied by a little fever and vomiting, pulse 110, tongue clean, slight rigidity and tenderness in both iliac fossæ. Obstructive appendicitis was diagnosed and immediate operation performed by the Resident Surgeon. A healthy appendix was seen and removed through a mid-line incision. The pelvic organs were, however, congested, and it was obvious that her symptoms were due to the rupture of a Graafian follicle of the right ovary with effusion of a small quantity of blood into the pouch of Douglas. The right ovary was removed, the left ovary was healthy.

Histological report by Dr. Elworthy states "the ovarian stroma shows œdema, interstitial hæmorrhage and inflammatory exudate. Most of the follicles in the portion sectioned are distended, one containing a little blood. There is one recognisable recent corpus luteum and adjacent to it a blood cyst containing organising and recently shed blood. All the vessels are engorged."

Case II.

Betty W., aged 13 years, recently arrived from the West Indies, was seen with Dr. T. Bishop on the 17th January, 1935, at 6 p.m. Her history was that the previous day she had had an attack of "doubling-up" pain on the right side with a little vomiting. There was no fever; pulse 90. Pain and resistance on deep pressure below the level of McBurney's point. Baldwin's tests negative, and skin hyperæsthesia just above the right Poupart's ligament. Rectally pain and indefinite swelling low down in the pelvis. Diagnosis:—Folliculoma of the right ovary or appendicular colic.

The mother gave an account of a similar attack six to seven weeks previously in Trinidad.

As is so common in girls brought up in tropical climates, there was the usual history of menstruation having commenced at the time of her eleventh birthday, since when the periods had been excessive and extremely irregular. Operation was performed on 22nd January at the Florence Nightingale Hospital. Using a pararectal incision it was at once discovered that the cause of her pain was due to a large unruptured follicular cyst of the right ovary, which exactly resembled a large thin-skinned white gooseberry bulging from the surface of the ovary. This had dropped into the pouch of Douglas. Hemisection of the right ovary with cyst complete was then done, the left ovary was healthy; a healthy appendix was removed.

Discussion.

Rupture of or supertension in a follicle cyst has received little attention in this country, but there can be no doubt that needless emergency operations are frequently performed for physiological aberrations of ovarian function. In saying this I am not referring to pathological hæmorrhages, or hæmatomata of the ovary, wherein large quantities of blood may be effused into the peritoneum, closely resembling in symptoms and signs the typical features of a ruptured ectopic gestation, but rather to those cases which are so commonly met with in schoolgirls and young women, in whom from time to time attacks of sub-acute pelvic pain occur, either between the fourteenth and twenty-fourth day of the menstrual cycle or, if the periods are irregular, at a later date.

Such symptoms are due to the spill of blood and Graafian follicular fluid into the pelvic cavity setting up irritative peritonism.

There can be no question that this is the correct explanation, for there can be but few gynæcologists of experience who have not in the course of routine examination felt one of these cysts to give under his finger. If he is a wise man he will warn such a patient to expect some pain and disturbance for a few hours and ask her to keep quiet, for it is certain that within a very short space of time there will be pain, tenderness and possible vomiting; symptoms very much resembling those of appendicular colic.

Indeed, such cysts in married women have been dubbed "Dissension Cysts" because they so frequently give rise to altercation and differences of opinion. For instance, Mr. A. may notify the presence of such a cyst one day, and because the period is delayed, wish to keep the patient under close observation for a week or so, having in his mind the possibility of extra uterine pregnancy; a month later she sees Mr. B., who fails to discover any cyst whatever and perhaps inclines to pooh-pooh Mr. A's opinion and damage his reputation (the cyst having silently ruptured in the meantime).

In adolescents and young unmarried women, the sudden onset may suggest the obstructive type of appendicitis, for there may be a tale of previous slight attacks of abdominal pain. But on the rupture of a hyperdistended follicular cyst the pain is not agonising nor is it umbilical, it is hypogastric and usually low down in both iliac fossæ. Vomiting is very slight. Rigidity is not marked. The pulse rate though first increased tends to slow down. The quiescent period remains quiescent. A leucocytosis though slight tends to return to normal after a few hours. Rectally there may be pain deep down in the pelvis on either side of the uterus.

Such features combined with anomalies of menstrual function may suggest a correct or tentative diagnosis, and the wisdom of withholding immediate surgical intervention.

The cause of such ovarian dysfunction probably lies in the hypophysis and thyroid gland, and treatment for some months on these lines will in most cases prevent recurrence of attacks.

In the event of any doubt in the interpretation of such symptoms, particularly in young people, the safest course is operation because of the high mortality associated with the obstructive type of appendicitis. In the Tropics, possibly due to hormonal dysharmony, rupture of a Graafian follicle or corpus luteum causing peritonism is a very common occurrence. This fact must be borne in mind by every surgeon, for in any country to remove a healthy appendix without inspecting or suspecting the ovary is likely to prejudice the reputation of the surgeon who is confronted with a recurrence of symptoms after operation.

In married women the problem, though difficult to the general surgeon, is by no means so to the gynaecologist, for though he would primarily eliminate the possibility of an inflammatory or obstructive type of appendicitis he would quickly come to a decision as to whether the symptoms were due to salpingitis or a pelvic inflammatory exudate. If infection could be ruled out, including *B. coli* manifestations, he would then consider the possibility of ectopic gestation, the rupture or torsion of a tumour, the bursting of a chocolate cyst (endometriosis) or diverticulitis.

Every woman with a history of abdominal or subumbilical pain should be examined by a gynaecologist primarily. This would be a gain to the patient, save many indifferent diagnoses, and make for better treatment.

REPORT OF AFFILIATED SOCIETY.

The St. John's Hospital Dermatological Society (incorporating The London Dermatological Society.)

A Meeting of the Society was held at St. John's Hospital for Diseases of the Skin, 49, Leicester Square, W.C.2, on Wednesday, January 24th, at 4.15 p.m. Dr. J. E. M. Wigley, the President, was in the Chair.

Clinical cases were shown at 4.30 p.m., and at 5 p.m. Dr. R. R. Wettenhall of Melbourne read a paper on "The Practice of Dermatology in Melbourne, Australia."

The following cases were shown:—

Case 1, Dr. Dore.—A case for diagnosis. The patient, a young man, had suffered from an eruption on the body for several months. It followed a course of anti-syphilitic treatment consisting of injections of bismuth—this drug being used as he responded badly to the first arsenical injection. He was said to have had a positive Wassermann reaction at first, but this became negative after the course of injections, and was negative again when he first attended St. John's Hospital.

At this time he had a widespread scaly eruption resembling seborrhœic dermatitis, for which he was treated in the in-patient department for 10 weeks. On leaving the hospital there was still a widespread patchy, erythematous-figured eruption in the groins and on the trunk and limbs, and on the hands and fingers. The curious pattern of the erythematous patches, leaving areas of white skin of irregular shapes, and the intense itching and glandular enlargement suggested a possible diagnosis of the pre-mycotic stage of *Mycosis fungoides*, but alternative diagnoses were Parapsoriasis or a toxic Erythema.

Dr. MacLeod said that when he saw the man in the in-patient department, he presented what he thought was seborrhœic

dermatitis with a scurfy scalp. The present condition was certainly quite different from the previous one.

Dr. O'Donovan suggested it was a toxic erythema, and that arsenic was probably the attributing cause.

Dr. Goldsmith said that although the distribution was that of a seborrhœic condition, he thought that there might be some super-added toxic influence due either to arsenic or, possibly, to the bismuth which had been given.

Case 2, Dr. Dore.—A case of Lichen planus of long duration. This patient had been under the care of Dr. Griffith, at St. John's Hospital, 15 years ago, when a diagnosis of Lichen planus was made. He presented a widespread but scattered dark red papular eruption, in some areas, especially the legs, showing rings (Annular Lichen planus). There were also some lesions in the mouth.

The exhibitor commented on the length of time the eruption had been present, almost continuously, and although he had seen a case of the same eruption which had lasted for 30 years, this had been intermittent.