course in the hope that the gastric haemorrhage, which was presumed to have come from the fundus, where adherent clot was found, would not recur.

The patient's condition improved for several days, though intermittent melaena occurred. On April 1 I passed an oesophagoscope into the stomach and found no evidence of bleeding or lesion in the oesophagus, but there was old clot in the stomach. Shortly after this he started to bleed severely, and as the consulting haematologist again found no evidence of blood dyscrasia I decided to do a total gastrectomy.

Second Operation.—On April 1, under a similar anaesthetic, the old incision was opened up and extended. There was a good deal of mild peritonitis due to the previous gastrotomy. Total gastrectomy was performed and a retrocolic jejunal loop was anastomosed to the oesophagus without entero-anastomosis (operative time two hours).

Recovery was uneventful and the patient was discharged on April 26 on an unrestricted diet. He had received 52½ pints (29.8 litres) of blood from March 19 to April 2. He was readmitted on February 3, 1953, with acute intestinal obstruction for which section of a solitary cord adhesion from the mesentery to the posterior abdominal wall was done. In June he was at work again, the blood counts, etc., being satisfactory.

Specimen.—The stomach showed about a dozen small erosions, three or four being in the pyloric region and the rest on the posterior wall of that part opposite to and above the oesophageal opening. The haemorrhage had occurred from the largest of these fundic lesions, which measured about 1 cm. in length and 2–3 mm. in width.

CASE 2

A crane-driver aged 48 was admitted to the City General Hospital on June 27, 1952, with severe haematemesis. His history was as follows: 1930, onset of symptoms of duodenal ulcer; 1941, pyloric obstruction—gastro-jejunostomy; 1947, severe haematemesis—14 pints (8 litres) blood transfused; 1950, further haematemesis—3½ pints (2 litres) blood transfused; 1951, high partial gastrectomy for two anastomotic ulcers. I first saw him at 9 p.m., after he had vomited 38 oz. (1 litre) of blood. His condition was improving under transfusion. The Hb was 62.5%, but, as it fell to 55% in the next twelve hours in spite of drip transfusion, I decided to operate without further delay though the rate of transfusion was increased.

Operation.—On March 28, under gas and oxygen, thiopentone, and D-tubocurarine anaesthesia, oesophagoscopy was carried out. The oesophagus was normal, but there was blood in the stomach. A left postero-lateral thoracotomy was done with resection of the eighth rib. Total gastrectomy was performed with considerable difficulty in 3 hours 10 minutes. Unfortunately, the patient died some 30 hours later, but the cause of the haemorrhage was acute ulceration of the fundus of the stomach.

JUDSON T. CHESTERMAN, F.R.C.S., F.A.C.S., M.R.C.P.

Two Cases of Ovarian Cyst in Childhood

The deceptive presentation of these cases—one as retention of urine and the other as appendicitis—is of clinical interest.

CASE 1

In October, 1950, a girl aged 3½ was admitted to hospital with acute retention of urine. A week previously she had had a sore throat and diarrhoea with much mucus in the stools; this cleared up after three days, but two days later she began to have frequency, and micturition was apparently difficult and painful. The urinary symptoms increased in severity and culminated in acute retention.

On examination of the abdomen a smooth rounded cystic swelling was found rising out of the pelvis half-way up to the umbilicus. This was taken to be the distended bladder. The external urethral orifice appeared normal, there was no fever or any evidence of a neurological lesion, and an x-ray film

of the abdomen and pelvis showed nothing abnormal. With difficulty a catheter was passed and only a few millilitres of normal urine was obtained.

Under a general anaesthetic the cystic swelling previously described, which had been mistaken for the urinary bladder, became disimpacted from the pelvis, and at a subsequent laparotomy was shown to be a large multilocular teratoma of the left ovary, measuring 11 by 6.5 cm. It was removed without difficulty.

The mechanism of the production of urinary retention was possibly the same as that which occurs in retroflexion of the gravid uterus, whereby the urethra is compressed and elongated. The bladder, normally an abdominal viscus in young children, is easily displaced and compressed anteriorly by the impacted ovarian cyst. Disimpaction under anaesthesia allowed the bladder to empty easily and no further dysuria was experienced. Urinary disturbances occur not uncommonly in cases of ovarian cyst in children, but the occurrence of acute retention seems to be quite rare.

CASE 2

In June, 1951, a girl of 4 years 9 months was admitted to hospital with abdominal pain and vomiting. She had had three attacks of constipation and abdominal pain lasting two to three days in the past nine months. The present attack began three days before admission, with vomiting and lower abdominal pain. She had been constipated for three days and had been irritable and had a poor appetite. There were no urinary symptoms.

On examination she was seen to be flushed, with mild pyrexia and tachycardia. There was a tender rounded swelling arising out of the pelvis and extending 2 in. (5 cm.) above the symphysis pubis; slight muscular guarding was present over it. Rectal examination revealed a tender swelling palpable through the anterior wall of the rectum. A catheter was passed readily and 2 oz. (57 ml.) of urine was withdrawn. A diagnosis of pelvic abscess or cyst was made. Under general anaesthesia the swelling emerged from the pelvis and was freely mobile in the abdomen; it was evidently a cyst. The subsequent laparotomy revealed a right-sided unilocular ovarian cyst which had undergone torsion twice in a clockwise direction. It was removed. The left tube, the ovary, and the uterus were normal. Convalescence was uneventful, and the patient was discharged on the eighth day. On section a simple ovarian cyst with haemorrhage into the ovary was reported.

COMMENT

Study of reported cases shows that simple or multilocular cysts of the ovary account for one-quarter to one-third of all ovarian neoplasms in girls under 15 years, while granulosa-cell tumours produce symptoms of precocious puberty, and teratomas can sometimes be recognized by x-ray examination; ovarian cysts may remain unrecognized for a long time. Lower abdominal pain, distension, constipation, and frequency may occur. Torsion leading to acute symptoms may be the first indication of the presence of an ovarian cyst, and differential diagnosis from acute appendicitis may be very difficult; in fact, many series of reported cases show that this is the commonest pre-operative diagnosis, particularly as most cysts are on the right side. Steel (1931) reported 25 cases of twisted ovarian cysts diagnosed pre-operatively as appendicitis.

The most useful procedure to help in diagnosis is probably rectal examination, this fact being emphasized in many reports; it was of great assistance in these cases.

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P. T. BRAY, M.B., B.Sc., M.R.C.P., D.C.H.,
Lecturer in Paediatrics, Welsh National School of Medicine.
L. P. THOMAS, M.B., B.Sc., F.R.C.S.,
Senior Surgical Registrar, Cardiff Royal Infirmary.

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