"SPONTANEOUS RUPTURE OF AN OVARIAN DERMOID CYST WITH PERITONITIS AND PARALYTIC ILEUS"

by

D. A. JEJURKAR*, M.S.

K. G. DATAR**,

D. B. PATANGE***, M.B.B.S.

and

S. D. PATIL****, M.B.B.S.

Ovarian cysts are liable to undergo certain complications which require immediate surgical intervention. These are haemorrhage, twisting and perforation. Perforation as a result of trauma occurs more frequently than spontaneous rupture which is exceedingly rare. Following case report deals with such a rare complication.

Case History

Z. S.A., aged 35, was admitted in the surgical wards of Medical College Hospital, Aurangabad, on 24th March 1965 with

(i) Pain in abdomen
(ii) Vomiting
(iii) Absolute constipation
since 2 a.m. on 23-3-'65.

O.D.P.: She got up from sleep at about 2-00 a.m. on 23-3-65 with sudden severe pain in abdomen. She sweated profusely and started vomiting. She was attended next day by her physician. Symptomatic treatment did not give her any appreciable relief. She developed absolute constipation and passed only small quantities of urine.

There was nothing significant in her past and personal history.

Menstrual history: regular, painless, normal flow.

L.M.P.: 21st March 1965.

Obstetric history: married for over 4 years, sterile.

She was a well built and nourished young woman.

Temp.: 99.2°F., pulse: 120/min., resp.: 28/min. B.P.: 124/86 mm. Hg. Tongue: dry.

Abdomen: Marked generalized distention, no movement on respiration, and no peristalsis. There was marked tenderness all over, and rigidity which was more marked in the upper abdomen; liver dullness obliterated. Peristalsis was absent all over the abdomen. Renal angles-spine-normal.

C.V.S.: R.S.: N.A.D. P.R.: N.A.D.

Provisional diagnosis: Generalized peritonitis (due to perforated peptic ulcer).

Treatment

(a) Preoperative: (1) Ryle's tube suction. (2) I.V. glucose 5% and glucose saline. (3) I.V. steclin 500 mgm. D.D.

(b) Operation: Was performed under general anaesthesia. Abdomen was opened through a midline incision. Coils of small bowel were congested and showed few mucus flakes. Yellowish-white, slimy (non-smelling) pus like fluid came out in large quantities (about 1500 ml.) mainly from

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*Lecturer in Surgery.

**Jr. Lecturer in Surgery.

***Registrar in Surgery.

****Jr. Lecturer in Pathology, Medical College, Aurangabad.

Received for publication on 30-7-65.

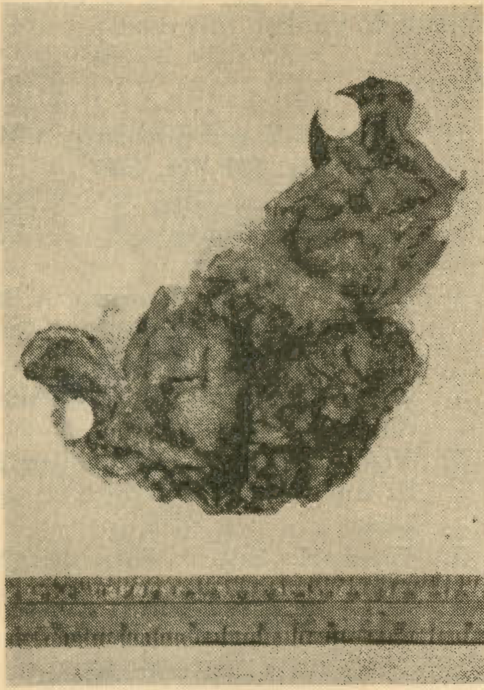

Fig. 1
Photograph of excised specimen.

the pelvis. There was a moderate sized (5" x 4") dermoid cyst of the left ovary leaking into the peritoneal cavity. A leash of hair coming out of the perforation gave us the clue. It was adherent to the left uterine tube. The cyst could not be seperated from the tube and so it was removed together with the tube. Abdomen was closed in layers after peritoneal toilet.

Postoperative: Routine postoperative treatment was instituted and the patient made an uneventful recovery.

Comments

Ovarian cysts are common and manifest themselves in a variety of ways. Some of them are asymptomatic. Others attract attention by growing in size, by pressure effects, or by symptoms produced by complications like twisting, haemorrhage in the cyst or in the peritoneal cavity or rupture which require immediate surgical interference.

Rupture of cyst can occur after trauma (accidental), or during pregnancy or parturition. Ovarian dermoids form a section of such cysts, others being cysts of corpus luteum, pseudomucinous cystadenoma, or even malignant cysts of the ovary.

Chronic rupture of ovarian dermoid occurs very rarely. It forms adhesions with nearby viscera and rupture into them. It has fistulised in the vagina, rectum, recto-sigmoid, and urinary bladder. Rarely rupture in the urinary bladder has produced a hairgrowing bladder diverticulum and also given rise to a vesical calculus.

Spontaneous rupture in the peritoneal cavity is the rarest complication which the ovarian dermoid can undergo. There is no satisfactory explanation as to why it gives way suddenly without any outside injury. It can not be always due to rising tension in a large cyst. In our case it was only moderately large. We were able to get only one reference about such a spontaneous rupture of an ovarian dermoid with subsequent peritonitis and paralytic ileus (Lopez Varela Ela *et al.* 1961). The slimy fluid from the dermoid cyst, rich in sebaceous material is a strong irritant to the peritoneal cavity and hence produces a picture of peritonitis with paralytic ileus. Small quantities of this material remaining in the peritoneal cavity even after peritoneal toilet lead to formation of granulomatous masses with adhesions. These may present great diagnostic difficulties and problem for treatment

especially if second exploration becomes necessary after a few years—(as happened in the case narrated by Prof. Sharma). It would be interesting to follow up this patient for such a development.

Summary:

(1) Spontaneous rupture of ovarian dermoid is an extremely rare complication.

(2) A case is presented of such a rare complication.

We thank Dr. V. Marwah, F.R.C.S., Professor of Surgery, Medical College, Aurangabad, and Dr. G. K. Karandikar, I.B.B.S., F.C.P.S., M.S., Ph.D. (Yale), Dean, Medical College, Aurangabad for granting us the permission to publish this case.

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