CORRESPONDENCE

Family planning—birth control

To the Editor:

In a systematic in-depth study on common concepts about birth control among a sample of 166 Negro women in several locations, J. F. Kantner and M. Zelnik established that the term "family planning" was not in the minds of the women related to "birth control, child spacing and family size" (Studies in Family Planning No. 47, 1969, "United States: Exploratory Studies of Negro Family Formation—Common Conceptions About Birth Control").

The findings of the two authors have been confirmed in personal interviews over several years with thousands of young women residing in the Borough of the Bronx, New York, and surrounding areas. To these patients from less than affluent segments of the population (ethnic distribution of Black, Puerto Rican, White, 40:40:20), who visited our Outpatient Department. Clinics requesting contraceptive devices or related counseling, "family planning" very frequently denotes many things other than birth control. For one thing, they believe that its service is restricted to married couples or women who are engaged. The second most frequently voiced notion is that of an agency advising in matters of household budgeting particularly in regard to the funds one needs to raise and provide for schooling of children, etc. Last, they believe family planning means counseling and assistance related to infertility or miscarriages. This is especially true of the single woman and the formerly married among them who are first acceptors of any contraception. These women represent a sizable portion of our total clinic population. The term "birth control," by contrast, is most frequently associated with the pill. It follows that existing facilities for family planning in public institutions are far less used by a substantial population group, one that perhaps needs it most.

We, therefore, urge readers of the JOURNAL to examine the situation in their respective communities and, if it turns out that our experience is duplicated there, to initiate appropriate action.

Our suggestion regarding such action is to use the term "birth control" side by side with the term "family planning" to identify clinics and other public institutions offering contraceptive counseling and service. It is also essential that this term be carried in all directories including those printed by telephone companies.

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Familial ovarian hyperthecosis

To the Editors:

The article, "Familial ovarian hyperthecosis: A study of two families," by Givens and associates (AM. J. OBSTET. GYNECOL. 110: 959, 1971), presented an abundance of interesting genetic and biochemical findings. Since the accuracy of diagnosis, however, is so important in the interpretation of the data presented and since the diagnosis rests on the histologic details, it is regrettable that no reference was made to histologic and histochemical enzymatic studies of hyperthecosis, or thecosis, more recent than Shippel's[1] article of 1955. These studies[2-4] indicate that the nonneoplastic abnormalities of the theca interna and the stromal theca cell

can be divided into three groups. The first consists of multiple follicular cysts and superficial collagenization, the so-called Stein-Leventhal ovary or theca interna thecosis; the second, which is infrequent, is a combination of the first and transformed stromal cells with enzyme activity. The latter cells are also called stromal theca cells or luteinized stromal cells. The third group is stromal thecosis in which only transformed stromal cells are present. The first two groups, which occur in the younger age groups, may be connected, but there is no evidence that the third group of thecosis which occurs predominantly in the postmenopausal woman has any relationship to the first two groups in Shippel's sense of a common disorder (Taylor[5]). According to the gross and microscopic observations listed in the article in question, Case IV-52 belongs to the second group. Cases III-22 and III-23 as well as II-18 belong to the first group. No cases of Group Three or stromal thecosis as described by Novak and colleagues,[6] Scully and Cohen,[7] and Fienberg and Cohen[3] were included.

Another point of importance which is not always recognized by endocrinologists is the lack of a steady-state Stein-Leventhal syndrome.[9] The basic feature of the syndrome, apart from the superficial collagenization (not a thickening of the capsule), is the lack of rupture of the follicles and discharge of the ova with occasional cystic transformation. The clinical manifestations as pointed out years ago by Dutoit[8] may range from hyperestrinism to androgenic effects. The endometria may vary from proliferative and hyperplastic to atrophic. Microscopic study discloses variable findings in the lining of the follicular structures with cystic formation and occasional luteinization. Only with histochemical enzymatic procedures is it possible to be definite about luteinization.[4] Certainly, large follicular cysts, as the authors state, are not essential for the Stein-Leventhal ovary, and a paucity of primordial and developing follicles must be expected in the end stages. A proper understanding of the dynamic process[9] at work in the Stein-Leventhal syndrome with continuous evolution and involution of the unruptured follicles and the accompanying variable hormonal secretion, both qualitative and quantitative, would go far toward a meaningful interpretation of biochemical findings. Certainly, further investigation which includes histochemical enzymatic studies in conjunction with biochemical studies is needed to elucidate the enigma of thecosis, both of the theca interna and the stromal theca cell types.

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REFERENCES

1. Shippel, S.: J. Obstet. Gynaecol. Br. Commonw. **62:** 321, 1955.
2. Fienberg, R.: Obstet. Gynecol. **21:** 687, 1963.
3. Fienberg, R., and Cohen, R. B.: Am. J. Obstet. Gynecol. **92:** 958, 1965.
4. Fienberg, R., and Cohen, R. B.: Obstet. Gynecol. **28:** 406, 1966.
5. Taylor, H. B.: *In* Sommers, S. C., editor: Pathology Annual, New York, 1966, Appleton-Century-Crofts, Inc. pp. 127-147.
6. Novak, E. R., Goldberg, B., Jones, G. S., and O'Toole, R.: Am. J. Obstet. Gynecol. **93:** 669, 1965.
7. Scully, R. E., and Cohen, R. B.: Obstet. Gynecol. **24:** 667, 1964.
8. Dutoit, D. A. H.: Polycystic ovaries, menstrual disturbances, and hirsutism, *in* Hyperthecosis, Leiden, 1951, H. E. Stenfert Kroese's Uitgevers-Maatschoppis, N. V.
9. Fienberg, R.: Bull. Am. Soc. Clin. Pathol. **7:** 72, 1966.

Reply to Dr. Fienberg

To the Editors:

An accurate histologic diagnosis of ovarian hyperthecosis is important in interpreting our data and especially in relating it to the work of others. The term *ovarian hyperthecosis* was used rather than the Stein-Leventhal syndrome because of the following histologic details: (1) Multiple large follicular cysts were not a common feature of the ovaries of our patients (with the exception of Case II-18), and atretic follicles were present in large numbers; (2) there was a paucity of primordial, developing, and Graafian follicles; (3) hyperplasia of the theca interna of the atretic follicles was present (Fig. 4, Am. J. Obstet. Gynecol. 110: 959, 1971); and (4) numerous clusters and, in some cases, large islands of "theca-like" cells with sudanophilic cytoplasm were distributed throughout the stroma (Fig. 6). Thus, our patients had both interna and stromal thecosis.

We do not agree that our Cases III-22 and III-23 belong to the Fienberg Group One which comprises the Stein-Leventhal ovary because both patients had interna and stromal thecosis. As a matter of fact, Fig. 6 of our paper utilizes the ovary of Patient III-23 to illustrate a large island of "theca-like" cells in the ovarian stroma. Cases III-22 and III-23 therefore belong in Group Two and not in Group One. Case II-18 belongs in Group One.