On displacement of the ovaries / by Thomas More Madden.

On Displacements of the Ovaries

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ART. VI.—*On Displacements of the Ovaries.*[a] By THOMAS MORE MADDEN, President Obstetric Section Academy of Medicine in Ireland; Obstetric Physician Mater Misericordiæ Hospital; Physician, Hospital for Sick Children, Dublin; Consulting Obstetrician National Lying-in Hospital; Formerly Examiner in Obstetric Medicine and Gynæcology, Queen's University; and Vice-President British Gynæcological Society, &c.

DISPLACEMENTS of the ovaries, apart from those caused by ovarian disease, until recently were generally ignored by gynæcologists, and still attract less attention than their pathological importance demands. From clinical experience I have been long convinced that ovarian herniæ are of more common occurrence than is supposed even by Dr. Barnes, by whom this subject has been ably discussed in the *American Journal of Obstetrics*. In every-day practice a certain proportion of our gynæcological patients complain *inter alia* of some degree of dull sickening left-side pain, the situation of which, though not always clearly defined, is usually referable to the inguinal region. If further investigation be instituted in such cases we may, in not a few instances, be able to trace this pain to ovarian displacement, which, however, is too commonly passed over without recognition, owing to the greater prominence of other symptoms.

Ovarian herniæ may be found in the inguinal region, and may be either direct or oblique. In the former the tumour appears in the groin above Poupart's ligament; in the latter it follows the course of the canal downwards and forwards, and makes its way into the labium. Occasionally the displacement is observed in the femoral region, immediately below Poupart's ligament, and to the inner side of the femoral vessels. But still more frequently the

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ovary is displaced downwards into Douglas's space, and this prolapse may, for all practical purposes, be here considered as a form of ovarian hernia. In these cases the left ovary, as from its anatomical position might be anticipated, is that usually prolapsed into the recto-vaginal fossa, where, on examination, it may be discovered as a small, oblong, elastic and highly sensitive tumour, bulging into the post-cervical vaginal *cul-de-sac*.

Although in some instances congenital, these herniæ most commonly occur in patients whose abdominal parietes have been relaxed, and viscera compressed, by repeated gestation. They may also be induced by similar immediate causes as other herniæ—such as the violent muscular efforts of the second stage of labour, lifting a heavy child, straining at stool, &c. But in the most frequent of all forms of ovarian displacement—namely, that downwards into Douglas's space—the causes of the protrusion are more commonly gynæcological, as, for instance, the *vis à tergo* of abdominal or uterine tumours, or the direct tension on the uterine appendages occasioned by displacements of the uterus.

Symptoms.—Ovarian hernia manifests itself by the sudden occurrence of a small ovoid tumefaction possessing certain distinctive characteristics, and making its appearance in either the inguinal or femoral regions, or in the labia, or directly downwards in Douglas's space. This tumefaction, as observed in its ordinary condition, is about the size of a large walnut, and when inguinal is usually very slightly sensitive. Before the menstrual periods, however, the extended ovary invariably becomes enlarged—in one instance recently under my care it increased to the size of a small orange—and then gives rise to a dull aching pain, which gradually subsides, so that shortly after the termination of the menstrual epoch the displaced organ resumes its previous condition, and generally ceases to give any active trouble until its functional activity is again stimulated by the approach of the next catamenial period. In some instances, however, these symptoms do not thus disappear in the interspace, the dull sickening pain remaining permanently, and the congestive hypertrophy of the displaced organ continuing to increase until relieved by suitable treatment.

Diagnosis.—That the differentiation of ovarian displacements was formerly very imperfect is, I think, evident from the scant notice of such cases by the older gynæcologists, by whom their existence was either ignored or confounded, when external, with enlarged inguinal or femoral glands, or, when labial, with other

tumours in that situation; whilst ovarian protrusion into Douglas's space was apparently in many instances taken for pelvic abscess, subperitoneal pedunculated fibromata, hæmatocele, or the reflexed fundus uteri. We at least have now no excuse for similar errors in the diagnosis of ovarian herniæ. These, whether inguinal or femoral, may be readily distinguished from enterocele by the entire absence of the characteristic smoothness and globular form, gurgling on compression and resonance on percussion of the latter, whilst from epiplocele they may be differentiated by contrasting the firm, clearly-defined ovoid tumour observable, if it be ovarian, with the soft, doughy feeling and irregular, ill-defined outline of the hernia, if omental. From enlarged inguinal or femoral lymphatic the ovarian tumefaction may be recognised by the smaller size and multiple character of the former. From pelvic, psoas, or other abscess, the distinction of an extended ovary is obviously rendered easy by the history of the case, as well as by the presence or absence of fluctuation. Lastly, ovarian prolapsus into Douglas's space is distinguished from a posterior uterine displacement, or a fibro-myoma by recto-vaginal examination and the use of the sound. Whilst from the tumefactions in the posterior vaginal *cul-de-sac* that may be occasioned by cellulitis, rectocele, tubal or parovarian cysts, or abscesses, or pedunculated subperitoneal fibromyomata, ovarian prolapsus may be differentiated by the methods of examination just alluded to, which will enable us to determine not only the existence of any uterine mal-position, but also the character of the tumour and the presence of any fluctuation therein. If the uterus be thus found normal in size and position, if there be no fluctuation discoverable, and if at the same time in the posterior *cul-de-sac* we discover a small, well-defined, firm, ovoid tumour, enlarging regularly at each menstrual period, and which, on slight pressure, gives rise to peculiarly sickening dull pain, we need have little hesitation in concluding that we have to deal with a case of prolapsed ovary.

Treatment.—The treatment of ovarian displacements is necessarily dependent on the situation of the extruded organ in each case; or, in other words, whether it be found at either of the abdominal rings, or in the labium, or in the recto-vaginal interspace. In the first of these, whether the ovarian hernia be above or beneath Poupart's ligament, an effort should in the first instance be made at its reduction by taxis. In the majority of cases, however, such herniæ are irreducible when seen by the gynæcologist,

and even in those few instances in which reduction is possible, the retentive pressure of a truss is neither endurable nor effectual. In most cases of this kind we must, therefore, be content to protect the ovary if protruded externally from further extrusion or injury by a well-fitting hollow truss. But before this an attempt should be made to lessen the local hyperæsthesia of the generally hypertrophied displaced gland by sedative applications, and, if necessary, by leeching, &c., whilst the constitutional irritation almost always present in such cases should be allayed by suitable constitutional treatment.

When, however, these measures prove ineffectual in relieving the almost constant, worrying, dull aching pain which at each monthly period in these cases becomes accentuated into acute suffering—when, too, the patient's health is endangered by the gastric disturbance and constitutional irritation occasioned by this apparently trivial and too often neglected displacement—we should then fall back on the extirpation of the dislocated and probably diseased gland as the only resource available under the circumstances.

In my own practice I have more than once been thus obliged to resort to this procedure. In one case the ovarian hernia occupied the right labium, the patient being an unmarried woman about forty years of age, who, when admitted into hospital, was completely broken down by dull, dragging pelvic pain, anorexia, and nausea. She was greatly emaciated, despondent, and hysterical. Menstruation was scanty and somewhat irregular, and physical examination failed to disclose any other local complaint than a tumour, almost as large as a hen's egg, within the right labium, any handling of which occasioned severe pain and nausea. This swelling she had only noticed a few months before admission into hospital. The patient having been etherised, my colleague, Dr. Kennedy, and myself proceeded to remove the tumour, which was found to extend through the canal, to the walls of which it was firmly adherent in many places up to the abdominal ring, where it tapered off to a narrow pedicle, which was secured by double ligature and divided. In the several adhesions free, general, large vessels had to be secured, and subsequently from the surface a free, venous oozing took place, which was arrested by packing the cavity with styptic cotton, and subsequently bringing the edges together with wire sutures and roller and compress externally. It is needless to add that the operation was thoroughly aseptic. That night she

slept fairly; the temperature 101° and pulse good. Next morning she had some retching, but was able to retain a little iced champagne and jelly, still she was extremely weak; the temperature was only 99° and pulse 120. That afternoon, however, she suddenly became collapsed and died, and we were not able to secure permission for a *post-mortem* examination, which we were anxious to obtain. The tumour removed, on careful investigation, verified our diagnosis, proving to be a greatly hypertrophied and disintegrated ovary.

In the next case of ovarian hernia that came under my observation the issue was more fortunate. In this instance the displacement was situated in the left inguinal region, just above Poupart's ligament; the patient being a young lady who shortly after marriage commenced to suffer from dragging pelvic pain, irritability of stomach, loss of appetite, and consequent wasting and debility, further increased by menorrhagia. She also now became extremely hysterical and despondent, and for nearly two years before I saw her had been under almost continual gynæcological treatment abroad and at home—during this time having, *inter alia*, worn almost every form of pessary for the relief of some supposed uterine displacement. Ultimately a small ovarian hernia, which became very troublesome at each monthly period, was discovered in the left inguinal region, and being then irreducible, after the failure of other treatment, its removal was proposed and agreed to. Accordingly I extirpated the dislocated and hypertrophied ovary, after which she made a rapid and complete recovery.

Last autumn another case of the same kind, occurring in a young unmarried woman, was under my care in St. Monica's ward; but as the patient declined operation at the time, she left, promising to return for this purpose as soon as the hospital re-opened for the winter session, but up to the present she has not done so. To these cases of true ovarian hernia I might, did time permit, add the history of four or five cases of prolapse of the ovary into Douglas's space which have come under clinical observation in the hospital within the last seven years. In only one of these was vaginal oöphorectomy found necessary, the other being sufficiently relieved by the application of a suitable air-pad pessary.

I need hardly observe that ovarian herniæ requiring removal of the ovary are still more exceptional than cases of the displacement referred to; nor is the performance of oöphorectomy under such circumstances always devoid of risk. Hence, in no instance should

this step be resorted to without urgent necessity, and until a fair trial has been first made of other remedial and palliative measures.

In considering the treatment of prolapsus of the ovary, its ætiology must be carefully borne in view. Thus, the extrusion may be due, as already pointed out, to the pressure from above of a uterine or ovarian tumour, or from the traction of a uterine displacement on the broad ligaments, and obviously these abnormalities must be removed or relieved before any successful re-position of the prolapsed ovary can be made. When this condition is due to some accidental circumstance, or to a relaxed state of the parts occasioned by constitutional causes, we may, with greater probability of permanent success, attempt to return and retain *in situ* the displaced viscus. For this purpose the patient—being first etherised in order to permit of the necessary manipulation of the generally highly-sensative and tumefied ovary—should be placed in the left lateral semiprone position, when by firm but gentle, steady, conjoint bimanual pressure through the rectum and vagina, upwards and forwards, we may be able to lift the extruded ovary out of the recto-vaginal fossa and to push it up into its normal position, where it may then be retained by either a Greenhalgh's or Arnold's glycerine pad pessary. When, however, as more generally happens in long-standing cases of this kind, the re-position of the ovary cannot be thus effected, the support of a well-fitting pessary will, in the majority of instances, be found effectual, not merely in preventing any further prolapse, but also in relieving the discomfort and suffering caused by such displacements. And finally, in cases where these measures fail, and where the local and constitutional effects of the ovarian prolapsus are urgent and are otherwise irremediable, we may, as happened in one of my cases, be obliged to resort to vaginal oöphorectomy.