AN ADDRESS¹ ON OVARIAN HERNIÆ, AND THE PROTRUSION OF THE APPENDAGES THROUGH RUPTURE OF THE VAGINAL WALL.

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[ABSTRACT.]

GENTLEMEN,—Ovarian displacements are of various kinds. Sometimes an ovary is protruded in the inguinal region, either above or below Poupart's ligament. When it is displaced in the groin it occupies the position and exhibits the appearance of an ordinary inguinal hernia. Occasionally it is found in the sac of a femoral hernia; an ovary is often displaced within the pelvis backwards and downwards into Douglas's space; when lodged behind the uterus it can be recognised by vaginal or rectal exploration as a small and elastic swelling filling the recto-vaginal fossa. Occasionally the vaginal wall is ruptured, and the appendages are protruded into the vagina or even appear externally.

In some cases of ovarian inguinal hernia the displacement is congenital, and arises from a slight error in the early development of the organ. In its descent from the lumbar region it undergoes a considerable change of position, attended by the shortening of a band which corresponds to the gubernaculum testis in the male. Now this band consists of a fold of peritoneum containing involuntary muscular fibres, and it extends downwards from the lower part of the Wolffian body towards the rudimentary uterus, where the ovary is normally arrested in its downward course. Occasionally, however, the organ takes too much the direction of the testis, and by the atrophic shortening of this band it becomes fixed to the skin of the groin which is destined to become the scrotum. Thus, by a slight error, the ovary gets attached a little out of its normal position, and is drawn towards the abdominal ring, and ultimately escapes into the open vaginal process of peritoneum and is protruded into the labium. This form of ovarian hernia is in my experience always irreducible, for the proximal end of the canal soon becomes obliterated.

In the acquired form of ovarian inguinal hernia the protrusion may take place into the sac of an old rupture, and this accident generally occurs soon after labour. Women who have had several children seem prone to this displacement, and I think this can be traced to the relaxed condition of the abdominal walls and the elongated state of the broad ligaments; for the uterine appendages must undergo very considerable stretching before an ovary can find its way into the inguinal canal. The displaced organ is always liable to inflammatory changes, and occasionally it has been known to undergo cystic or sarcomatous degeneration.

Now, as regards diagnosis, an ovary displaced into the inguinal or femoral region presents many of the characters of an ordinary hernia. Whenever it occupies the sac alone, it is usually a small oval and non-resonant tumour, it never gurgles on manipulation, and it does not feel soft or doughy. When of small size it really presents very much the appearance of a swollen inguinal gland.

I do not think it is often possible to recognise an ovary in a hernial sac. Schroeder² states that in one of his cases the diagnosis was remarkably clear. "While the left ovary could be felt lying rather far back but in every other respect normal, nothing resembling an ovary could be found among the uterine appendages on the right. On this side, however, the uterine appendages were drawn down towards the inguinal canal, and in front of them lay a body of the size and form of an ovary in a little hernial sac. This body was only slightly sensitive on deep pressure, and the patient had not noticed that it ever appeared swollen during the men-

strual periods. On grasping it externally with one hand and with the other pushing the uterus backwards and towards the left, a decided traction could be exerted upon the body in the hernial pouch; it would slip upwards and outwards from between the fingers which held it, but it could not be drawn through the inguinal canal, nor could it be replaced by external manipulation."

Sometimes the diagnosis has been assisted by changes occurring in the tumour during the menstrual epoch, as the displaced organ may become enlarged and painful from functional activity, and then as soon as the period passes off these symptoms gradually subside. These changes, however, do not always occur in ovarian hernia, and therefore their absence cannot be regarded as conclusive evidence that the protrusion does not contain an ovary. In the following case of acquired inguinal ovarian hernia pain, swelling, and obstinate nausea followed a miscarriage which was attended with considerable hæmorrhage.

C. D., a stout woman, aged 34, was admitted under my care into the Royal Portsmouth Hospital in November, 1894. She was the mother of eight children, and had had three miscarriages. On examination an ovoid tumour, about the size of a small egg, was found in the right groin. The swelling was both firm and fixed, and it occupied the position of an inguinal hernia. She stated that it had never exhibited any enlargement or tenderness at the menstrual period. It had existed ten years, and had never caused her any inconvenience until her last miscarriage, but since that occurrence it had become larger, often very painful, and the slightest pressure excited a sickening uneasiness. On account of these urgent symptoms she was very anxious to have it removed, and at her request I excised the tumour. It contained an ovary, and the sac and its coverings were much thickened by chronic inflammatory changes. On section it exhibited a well-marked corpus luteum. The patient returned to the hospital some weeks after her discharge in good health.

A few words as regards treatment. In ovarian inguinal herniæ all efforts at reduction are generally useless. In the congenital form it is impossible to return the organ into the abdominal cavity, as the neck of the sac becomes occluded in a similar manner to the normal closure of the canal after the descent of the testicle. Whenever the displaced ovary excites very little inconvenience surgical treatment is scarcely necessary. If the organ becomes inflamed our efforts must be directed to relieve pain and congestion. I have never seen an abscess occur as the result of acute or chronic inflammatory changes, but whenever this is a sequel it should be treated in the ordinary way by free incision. Herniotomy with replacement may be occasionally possible in recent cases of acquired hernia. When pain and swelling are distressing at the time of menstruation, and the patient becomes a chronic invalid, excision is the only remedy. Occasionally an ovary, like a displaced testicle, may undergo sarcomatous or malignant degeneration, and under these circumstances early operation would be the only hope of relief.

The treatment of displacement of the ovary into Douglas's space is often a very simple matter, and in a large number of cases the symptoms can be greatly relieved by rest in the prone position, attention to the action of the bowels, and the application of a well-adjusted pessary. This displacement is sometimes associated with other serious disorders, such as an ovarian tumour, a uterine fibroid, or a chronic malposition of the uterus. Whenever the organ is the seat of hopeless structural change, and is exciting both local and constitutional trouble, surgical treatment is absolutely necessary.

RUPTURE OF DOUGLAS'S POUCH AND PROTRUSION OF THE APPENDAGES.

Prolapse of the abdominal or pelvic viscera through a rupture of the vaginal wall is a very uncommon accident, and is scarcely referred to by any English writers on gynecology. In all the recorded cases this laceration has been associated with some abnormal condition which has weakened and stretched the vaginal wall. The small intestine and the uterus have been prolapsed through a vaginal rent, and in the case I shall briefly narrate, the appendages were suddenly protruded and strangulated.

Breisky³ states that spontaneous rupture of the vaginal

¹ Delivered before the Southern Branch.
² Diseases of Female Sexual Organs, p. 356, *Cyclopædia of the Practice of Medicine*, Ziemssen.

³ Billroth and Luecke, *Deutsche Chirurgie*, Lf. 60, s. 40.

wall occurs almost exclusively during labour. A few cases only have been recorded as occurring under other circumstances. Grenser has reported a case in which in a pregnant woman suffering from ascites the retroverted uterus, which was the size of the fist, passed through a rent in the posterior vault of the vagina, and became prolapsed through the vulva. Death in this case was hastened by surgical interference. In another case (Samples) rupture of the posterior vault of the vagina occurred three months after parturition. A finger could be passed through the rent into a cavity which did not communicate with the peritoneum. The rent was closed with a couple of sutures and the patient got well. Breisky agrees that it is probable that the rupture in this case was due to the bursting of a hæmatoma. In another case reported by Fehling, the woman, who was 63 years old, and had had 11 children and 1 abortion, had been in the habit of forcibly replacing a prolapse, which had existed for fifteen years, when it was brought down by exertion. In this case there was rupture of the posterior vaginal wall and prolapse of intestine. Rokitsansky recorded a case in which a similar accident was found *post-mortem*, but there was no clinical history.

I am indebted to Mr. Alban Doran for this reference and to Dr. Brunton, the assistant medical officer at the Asylum for the following notes.

Diagram showing the protrusion of the appendages externally. A Rectal prolapse. B Uterus. C Uterine appendages.

L. B., aged 50, a tall and cachectic-looking woman, and the mother of several children, was admitted into the Portsmouth Asylum, under the care of Dr. Bland, in October, 1893, suffering from melancholia. Shortly after admission she was found to be labouring under severe prolapsus of the uterus and rectum. The uterus was completely prolapsed, and appeared externally like a large sausage-shaped body covered by the vaginal wall. The rugæ were all effaced, and some abrasions existed on the cervix. The rectum protruded about 4 inches, and was marked by many superficial ulcerations. Both organs were reducible by manipulation, but no amount of mechanical support was sufficient to retain them in position for any length of time in consequence of the persistent straining of the patient.

A few weeks after admission the attention of Dr. Bland was called by the nurse to a large swelling that had come

down during the night. On examination, a fleshy and irregular mass was discovered protruding from the vulva directly behind the prolapsed uterus. On December 29th I was called in to examine the case. The protrusion was found to be an ovary and tube in a condition of acute strangulation, which had escaped through a laceration of the vaginal wall. The patient was in a state of great depression and her pulse was quick and feeble. She complained of great pain, and occasionally vomited. The protruding organs were returned at once, the mass was pulled down, secured at the neck by a ligature, and then cut off. The vagina was wiped dry, dusted with iodoform, and a gauze plug inserted into it. During the after-treatment the patient gave a great deal of trouble by tearing off the bandages; her habits, too, rendered it impossible to maintain local cleanliness, although antiseptics were constantly used and the vagina was assiduously wiped out with iodoform.

The protruded organs fortunately gave very little trouble. Two weeks after the operation a little vaginal hæmorrhage occurred. By the end of February the patient had made a good recovery. She is still under treatment. Her mental condition has not improved, but neither organ has been protruded externally for many months.

In this singular case the uterine and rectal prolapse must be regarded as the primary cause of the laceration. The patient, in a state of mental derangement, gave way to violent and persistent expulsive efforts, which greatly tended to stretch and weaken the pelvic structures. During a fit of straining the rupture occurred, and the uterine appendages, including one ovary and tube, slipped out at once through the rent in the vaginal wall. At the time of the operation the protrusion was in a state of acute strangulation bordering upon gangrene; it was deeply congested and thickened, and presented some resemblance to a placenta. The safety of the patient was fortunately secured by adhesive peritonitis around the seat of laceration.

PRESIDENTIAL ADDRESSES

DELIVERED AT THE

ANNUAL MEETINGS OF THE BRANCHES OF THE BRITISH MEDICAL ASSOCIATION.

RATIONALISM IN THE STUDY AND PRACTICE OF PHYSIC.

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[ABSTRACT.]

GENTLEMEN,—By "rationalism" I refer not to any doctrine or set of doctrines, but to an intellectual temper, a mental attitude which recognises a right and a wrong way of approaching even the simplest things and nourishes the desire to take the right way, or at least to avoid the wrong way, though at the risk of temporarily standing still. It is a mental temper in which the results of observation are submitted to the crucible of reasonable reflection with a view to educe some general principle—some general truth or law. Rationalism is, in short, the exercise of common sense in an uncommon degree. Science without common sense amounts to nothing more than vain and barren sciolism. But so long as we bring to bear a shrewd common sense upon the examination of our patients the observation of signs and symptoms and the interpretation of the disturbance on which they depend, and so long as we exercise the same common sense in the selection of remedies, with the effects of which we are daily becoming more familiar, we may claim that our methods are as rational and scientific as those of the student of astronomy, geology, or chemistry.

Again, it is said that medicine is inexact. But I contend that the conclusions or facts of anatomy and biology, on which