

A PLEA FOR CONSERVATIVE OPERATIONS ON THE OVARIES,

FROM A NEUROTIC STANDPOINT, WITH REPORT OF CASES.*

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The subject of ovarian neurosis is one of the most difficult the gynecologist has to deal with to-day, because of his inability to fix a standard from which to determine the beginning of surgical treatment. Hence the question is of diagnosis rather than of surgery, and the thing to decide is whether the woman's symptoms arise directly or indirectly from pelvic disease. This decided, the treatment is simplified, but should the pelvic disease not enter into the case further than one of many other factors, then it is not a surgical case, and should be treated accordingly; and it is this very factor which complicates the subject and has given discredit to legitimate surgery and brought to view the shining light of the operator, while the conscientious surgeon prevents damage to the patient and injury to his profession.

It is my purpose to emphasize the importance of a better knowledge on the subject of diagnosing such cases and point out the mistakes likely to occur in doing so, because no class of patients suffer more or longer with less prospect of relief than do these. They are fully convinced that, directly or indirectly, all their grief emanates from the pelvis, and oftentimes this idea is fostered and materially augmented by their friends. The headache, backache and tired feeling, combined with pain in iliac regions, are considered indications of pelvic disease, but when these symptoms are accompanied with disordered menstruation, dysmenorrhea and leucorrhea, then there is no doubt about the diagnosis, especially if some kind friend or thoughtless doctor confirms their opinion.

The real cause frequently originates from abortions, gonorrhea, endometritis and pelvic inflammation, which keep up an irritable condition of the ovaries, and the woman suffers for years, and it is no wonder she is willing to resort to any means that will promise relief. However, the all-important question arises in all such cases as to whether surgery is an advantage or disadvantage, or whether it will do the patient harm or good. Opinions of leading gynecologists differ on this point, although the bulk of authority is against the assumption that pelvic disease is not the cause, but result of neurosis.

The intimate relationship existing between diseased conditions of the reproductive organs of the female and functional disturbance and organic changes in other parts of the body should be better understood; also that fermentation and putrefaction within the intestinal canal will produce autoinfection, and that intoxication will produce ptomaines and leucomaines, which are the most prolific and common cause of nervous disease. We should know that excretions retained within the body, as well as waste tissue, are absorbed and bring about pathologic changes in the blood, which, in turn, causes malnutrition of nerve centers, and thereby materially interferes with and abridges healthy functions in all the vital organs.

Other causes than pelvic disease may operate to produce this abnormal nervous condition, we must admit,

and that the functional disturbances within the pelvis may be the effect and not the cause of the pathologic nerve state, is equally true.

Many surgical procedures, heretofore undertaken with confidence, have been sadly disappointing, and have utterly failed to relieve the condition for which they were advised. The neurasthenia and functional disturbances have remained, and both patient and surgeon have lived to regret the treatment adopted. Many operations which, a few years ago, were very popular with the profession for relief of supposed ovarian nervous troubles, have grown in disfavor, and are now seldom done, which ought to teach us all an important lesson not to take up fads, hobbies and phantom neuropsychosis, but to take a broader and more comprehensive view of the subject and be less radical and more conservative in our treatment of such cases.

A few gynecologists condemn oöphorectomy in neuroses, and deny the existence of genital neurasthenia. This is, in my opinion, an extreme view of the subject, and is as injudicious, in the face of clinical facts, as are the teachings of those who report such large numbers of these patients as cured by the removal of the ovaries.

The experiences of Lieberman and Baldy coincide so nearly with mine that I quote, in abstract, from remarks made by them on the subject:

"On the one side we often see extremely nervous women, in whom the anatomic and functional conditions of their sexual organs are normal, and, on the other hand, all sorts of diseases of the sexual organs may occur, without the presence of nervous disturbances. Neurotic cases cured by local gynecologic treatment are rare. Many cases are cured in whom the sexual organs remain unchanged. The conclusion, then, must be that neurotic cases are rare that are wholly dependent on diseases or abnormalities of their sexual organs, and yet it is equally true that abnormal irritation of the same functions are conditions especially fitted to cause nervous manifestations."

I began five years ago to examine the right ovary in all cases of appendectomy in women, and was surprised seldom to find an ovary normal, from an anatomic standpoint, but many cystic ones and in some diffused edema. A few conservative operations were done on such ovaries with negative results, and now the ovary is removed or dropped back unmolested, unless prolapsed or congested, then suspension should be done.

Statistical reports of the surgical and non-surgical aspect of ovarian neurosis does not convince me that either extreme should be adhered to, and that an intermediate position is preferred between the two extremes, not laying down any specific rules to be governed by, but judge each case on its own merits.

During the past year several cases have come under my professional care, or have been seen in consultation, on which conservative operations on the ovaries had been performed with negative results, and now they seek a secondary operation for relief. I will report two of such cases which have occurred in my own practice, and two were from other physicians.

CASE 1.—Jan. 6, 1901. Mrs. B., aged 35; good family history. Examination showed she was suffering from metritis and prolapsed and diseased ovary; had severe pain in loin and back of head, which had existed for months without an intermission, producing a general hyperesthesia of the nervous system, insomnia, loss of appetite and emaciation. I put her to bed, using local and constitutional remedies for four weeks without satisfactory results. February 16 I removed the diseased ovary, and she had an uninterrupted convalescence. Her

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nervous troubles seemed relieved for a few weeks, but gradually returned in an aggravated form; in fact, hysteria. Two years after the operation I saw her again, and symptoms were unchanged. I advised her to try medicinal treatment for a few weeks, and if the results were not satisfactory that she should have the uterus and right ovary removed; my advice was not carried out, and I have not seen her since.

CASE 2.—March 20, 1901. Miss S., aged 22. Her family history was negative, and so were most of her subjective symptoms; so far as contributing to the reflex nervous condition, eliminating a diseased condition of the left ovary, which an objective examination fully verified. An operation was advised as the best way out of her trouble; this was refused, although she had suffered almost continually, and often severely, for about three years.

I put her on a medicinal treatment, constitutionally and locally, and put her to bed for four weeks, and quiet for twice as many more, during which time the treatment was continued, but with negative results. June 25, 1901, I removed the left ovary and tube, both being badly diseased; the right ovary and tube and womb seemed normal. She had an uneventful recovery, and for a time seemed relieved; then her nervous condition returned and remained. She has repeatedly requested the right ovary and uterus removed, with hopes of relief; this was refused, because no conditions existed warranting such procedure, hence it is problematic how the case will terminate.

CASES 3 and 4.—Give similar histories of three and four years' standing and operations, by other gynecologists, of single and double oöphorectomies failed to give relief, and the patients consulted me with a view of another operation, and, if I thought best, a complete hysterectomy. After receiving the full histories of the cases and making a thorough examination, and not finding pathologic changes warranting such a procedure, I declined to operate, and these, like the preceding two cases, must look for relief from other sources.

These cases go to show that relief in many cases is not secured from one or even two operations, yet many are benefited, and conservativeness should not be pushed too far, because cystic degeneration in many cases is progressive.

CONCLUSIONS.

1. Operations on the ovaries that preserve the menstrual and reproductive functions should be employed, when possible, in lieu of complete extirpation.

2. Healthy displaced ovaries may be anchored to posterior surface of the broad ligament or by shortening the infundibulo-pelvic ligament.

3. Sterile women and married women who are using means to avoid pregnancy are unfavorable subjects on which to do conservative operations on the ovaries.

4. Conservative operations should be avoided on all pus cases, as a general rule.

DISCUSSION.

DR. ROBERT T. MORRIS, New York City, said that the psychoses must be separate from the reflex neuroses. Patients have been operated on who should not have been operated on. Recently a surgeon said to a neurologist that he could clean out his office of patients if he were allowed to step in. To which the neurologist responded that he had no doubt of it. The fact of the matter is that neither was quite familiar with the work of the other. Many patients having a fundamental psychosis give pelvic symptoms. Patients classified as neurasthenics are often patients with a psychosis, with incipient melancholia and with pelvic pains. They must be classified carefully if physicians are not to be subjected to the humiliation of doing unnecessary and harmful surgery.

DR. A. GOLDSPOHN, Chicago, considers that the difficulty is one that is solved by making better diagnoses. The gynecologist, like all specialists, is often accused of finding too much in his sphere and, therefore, every other part of the body should be examined before the pelvis; of course, having

the history in detail. Gynecologic diagnosis begins, at least, with the mouth, and sometimes with the eye. The ophthalmoscope ought to be used occasionally to see whether there is an organic lesion of the eye, rather than to regularly use the uterine sound that leads the physician astray frequently in ordinary minor cases. Successful gynecologists must be general medical men first, and be able to distinguish the thoracic symptoms of abdominal or pelvic origin from those that arise from thoracic diseases. Likewise to distinguish the symptoms of kidney lesions, and of diseases of the bile passages and others which arise from traction on peritoneal structures, particularly the suspensory ligaments of the intra-abdominal organs, such as enteroptosis and gastropptosis, from the referred symptoms of pelvic disorders. After that, make a bimanual examination, but to do this thoroughly the physician needs practice quite as much as an average housewife needs to have practice on the piano in order to play that instrument respectably. This fact of cultivating the touch, of having developed eyes in the fingers, is not appreciated enough. It is not the size but the consistence of an ovary that is of importance. It may be twice as large as it should be and yet be healthy; and an ovary half the normal size may be the source of serious trouble and require extirpation more than many an ovarian tumor of the size of a fist. This examination should be impressed on the patient as being a difficult feat, for which she must be prepared. The surgeon should not stake his name and reputation on an examination which he makes on a case as it comes to him; with aggravated sensitiveness, with an abdomen full of feces and gas, and with the bladder distended. It is a mistake to attempt an examination under these conditions. Send the patient home with instructions to come prepared properly, and tell her that an anesthetic is sometimes necessary, although it is a disadvantage in that the physician can not tell when he hurts the patient or when he touches a tender spot. And, having enlisted her good will and intelligence to assist in this examination, try to elicit the facts. With such an examination, together with the subjective history and a complete knowledge of the patient's habits, occupation and surroundings, it is usually possible to discover the psychoses.

DR. W. H. HUMISTON, Cleveland, Ohio, stated that in cases of neuroses there is frequently found a leaky mitral valve, an enlarged heart, a prolapsed kidney or a dilated stomach, and the pelvic organs are found to be normal, although the patient may complain of backache and bearing-down sensations. The gynecologist shines in those cases of acquired insanity in women, with no family history of insanity. Repeated examinations have been made by men who have not the eye in the end of the finger, but when examined by a competent man it is found that the ovary is smaller than normal, hard, corrugated and occasioning continuous suffering. In these cases operative results are brilliant; the patient is restored to full mental faculties and her long suffering is relieved. Even in conjunction with the operation these other associated conditions are often found.

DR. F. F. LAWRENCE, Columbus, Ohio, said that this question seems to hinge on the meaning of the term conservatism. Every man who is doing operations tries to do what is right and what is for the best. The patient with a nervous disease should receive the advantage of exactly the same methods of treatment for relief as one who has no mental nor nervous disorder. The fact that a woman is insane is no reason why she should be denied relief from a gross lesion of any kind. In other words, the determination as to whether operative procedures should be adopted depends on the absence or presence of gross pathologic lesions, no matter what the lesion may be. True conservatism means to do promptly and thoroughly that which will replace a pathologic condition by a physiologic, or which will remove gross pathology.

DR. H. O. MARCY, Boston, emphasized the relation of pelvic disease to insanity. Several years ago he asked the late Dr. Bucke, who had charge of the insane asylum in Ontario, containing over 500 insane female patients, what he knew with reference to pelvic disease in these women. Dr. Bucke

said that he had never thought of that. Dr. Marcy advised him, on his return, to have all these patients examined carefully and to report results. Over one hundred of these women were operated on for serious pelvic disease, and over 70 per cent. were permanently restored to their normal mental condition.

DR. G. B. MASSEY, Philadelphia, called attention to the cataphoric diffusion through the vagina of mercuric ions, in inflammation in the pelvis. It does not matter whether this inflammation is in the uterus, in the tubes, in the ovaries or in the parametrium, it is still inflammation. There is something between these two alternatives of pelvic disease and psychosis that must be considered at times, and that is abdominal neurosis, not psychosis. Eliminate hysteria, exclude psychosis, and though hysteria is a manifold complex disease, it can seldom be mistaken, but do not treat cases of abdominal neurosis as hysterics. Do not put them in bed; it will make them worse. Correct the abdominal condition. Decide in every case the output of solids in the urine. See that there is no kidney constipation, and many of these cases will recover.

DR. D. H. CRAIG, Boston, said that in examining the ovaries of young women more healthy looking ovaries are found than in women a little older who have had nearly as smooth a life as the young women. On investigating the subject, it occurred to him that the ovary of a woman comparatively recently entered on her menstrual life is relatively sound, whereas the ovary of a woman who has menstruated for some years has a scar for each time an ovum has ripened and the follicle ruptured. At the middle or end of menstrual life, therefore, the ovary is a much scarred, contracted organ. In the average normal ovary there are from ten to eighteen graafian follicles in process of maturation, and many follicles attain a diameter of 2 cm. Dr. Craig has seen many a badly scarred ovary which gave no clinical symptoms but which was so apparently cystic that he put a cautery point or knife into the sacs of fluid and evacuated a great deal of material, dropped it back, and the woman went on comfortably. The question arises whether those scars were not the result of previously ruptured follicles and whether the "cysts" he evacuated were not maturing graafian follicles. After removing such ovaries, he has had them examined microscopically and in some instances his suspicions were confirmed. Many of the so-called cystic ovaries removed to-day, that have given rise to no clinical symptoms of ovarian disease, are not pathologic ovaries at all but are ovaries containing graafian follicles which are rather larger than common but are simply in process of maturation.

DR. COKENOWER does not believe that any one who has not been a general practitioner first should be a specialist in any line of work, especially gynecology, a fact that his consultation work with general practitioners and other gynecologists has verified. Physicians are too prone to limit their knowledge to their own subject, thus excluding much that is valuable in other subjects; hence, their observations should be more general and their work broader, thus producing better results.

MANAGEMENT OF THE ACUTE STAGES OF ABDOMINAL INFLAMMATION.*

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Differential diagnosis is of the first importance, and will first engage the attention of the surgeon. This paper is concerned with the management of acute stages after the diagnosis is made, especially with the question of immediate operation, and only acute conditions will be considered. It may be necessary, clinically, to distinguish the following: Suppurative cholangitis;

suppurative cholecystitis associated or not with gallstones; acute suppurative pylephlebitis; various kidney inflammations; peritonitis following the perforation of viscera or of cystic tumors; acute hemorrhagic pancreatitis; ureteral calculus. Among intestinal conditions may be found strangulated hernia; obstruction due to bands; intussusception; volvulus of mesentery or of intestine; acute appendicitis; thrombosis or embolism of mesenteric vessels or those of the spleen. Salpingitis, ovaritis, metritis; postpuerperal, traumatic or due to such infecting agents as the tubercle bacillus or the gonococcus.

Of these conditions certain ones do not call for operation, and are, therefore, to be distinguished. Acute suppurative pylephlebitis, for example, the septic inflammation of the veins of the liver, is an invariably fatal disease. Fortunately, it is usually secondary to an infection along the portal tract, and is, therefore, preventable. A case reported by me was due to acute appendicitis, and another to postperitoneal infection caused by a common pin in the appendix. The primary condition might call for operation, but not the secondary, as the hopeless multitude of liver abscesses and the widespread engorgement of veins by virulent thrombi make radical treatment or even drainage impossible.

Extensive thrombosis of the mesenteric vessels and spontaneous gangrene of the intestine is beyond operative relief, but inasmuch as the area involved may be small enough to make resection feasible, exploratory operation would be indicated were the diagnosis made. It shares with acute pancreatitis certain crucial symptoms. Very sudden agonizing pain, usually above the umbilicus, vomiting, collapse and muscle rigidity. There may also be copious, loose, bloody or coffee-ground stools. The pulse is high and meteorism is very marked. Should the probable diagnosis of acute pancreatitis be made, there is some hope from early operation and thorough drainage. Osler mentions two cases which recovered after partial or total sequestration of the pancreas within an abscess cavity. The mistaken diagnosis of acute intestinal obstruction is very apt to be made in these cases.

Should acute necrosis of the spleen occur from occlusion of its blood supply operative extirpation would be probably useless, but theoretically it would be indicated.

There is a simulation of abdominal inflammation which deserves to be carefully considered, namely, pain referred to the epigastrium or appendix region in the early stages of pneumonia. In most of these rather puzzling cases, however, the real origin of the disease is in the appendix, and the chest symptoms are due to a secondary diaphragmatic pleurisy or to a septic pneumonia. When the onset has been distinctly abdominal, the later development of lung symptoms must not be allowed to befog the diagnosis of appendicitis. We come, then, to a group of conditions in which the treatment, at least, of all the graver types is operative, but in which the indications are to avoid operation in the acute stage, if possible, relieving by simple drainage if compelled to intervene. Operate radically after the primary stages of infection are past. To this type belongs salpingitis in all its forms, gonorrheal, traumatic, tubercular, post-puerperal; also cholecystitis, except the fulminating or gangrenous forms. The gall bladder is, however, like the appendix, much more liable to the treacherous, rapidly fatal conditions of profound infection

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