

*Hernia of the Ovary.*

At the meeting of the Royal Medical and Chirurgical Society, held Jan. 24, Dr. ROBERT BARNES read a paper on "Hernia of the Ovary," giving an abstract of cases hitherto reported, and relating two cases observed by himself. The first case was admitted by him into St. George's Hospital in 1877. The patient was single, aged forty-one, and had always enjoyed good health. At twenty-four she sustained a rupture in the left groin, and wore a truss; at thirty-eight she observed a second swelling behind the first. The swelling and tenderness of the ovary were observed before and during the menstrual periods. Corresponding sphygmographic observations showed distinct rise of tension preceding the flow and subsiding when the flow set in. The ovary was removed; a description and illustration of it were submitted by Dr. Goodhart. He referred to Dr. Chambers's case in the Obstetrical Transactions in which bodies simulating ovaries turned out to be testicles. He discussed the etiology of hernia of the ovary and uterus, citing Cruveilhier's views, and referred to the frequent complication of anomalies of development of the genital organs in association with hernia of the ovary, also with extra-uterine gestation. He enumerated the varieties of hernia of the ovary; referred to the supposed greater frequency of inguinal hernia, when the ovary is concerned; to the greater frequency of congenital hernia; the complications with intestine and epiploon; the dependence of hernia of the uterus upon pre-existing hernia of the ovary, citing Cruveilhier's theory and the confirmatory conclusions of Puech, Deneux, and Caesar Hawkins. The author then discussed physiological points, illustrated by the observation of the herniated ovary; how the ovary swells concurrently with increased tension of the vascular system before menstruation; how the round ligaments swell. He described the order in which the phenomena of menstruation occur, arguing that the ovarian nixus is the *primum mobile*, that nervous and vascular tension follow, and lastly, the menstrual flow, resting greatly upon sphygmographic observations. He suggested that the recent practice of oöphorectomy on Battey's principle will supply opportunities for deciding this and other questions, and proposed that sphygmographic observations should be made upon the subjects of this operation. He then discussed the diagnosis and treatment of hernia of the ovary, contending that it furnishes a legitimate motive for Battey's operation *quoad* this affection at least.

Dr. ROUTH said the facts related left little doubt that menstruation starts in the ovary. He mentioned the case of a young unmarried lady with a prolapsed ovary in Douglas's pouch on left side; it was adherent, and pressure produced distressing sexual excitement. He had always noticed that pressure on the prolapsed ovary produces great sickness. This was pointed out as diagnostic by Dr. Greenhalgh. Had Dr. Barnes met with either of these symptoms in his cases?

Mr. HULKE supposed there were but few engaged in hospital practice who had not met with such cases. Of course, in the absence of dissection, precise diagnosis must be difficult. In 1871 many cases were recorded by Englisch—viz., thirty-eight cases of external hernia of the ovary; of these as many as twenty-seven were cases of inguinal hernia, and ten or twelve of them were double, and where double it was almost always congenital. It is possible that in the case operated on by Mr. Pollock the process of peritoneum, etc., was obliterated by the previous pressure of the truss. When the hernia is congenital it is accompanied by the Fallopian tube. In the greater number of instances there is a persistent patent process of peritoneum, so that there is a risk of peritonitis following removal. Each case must be adjudged on its own merits, as regards operation. He had seen cases where the pressure of a truss could be borne, others where it produced great misery. The influence of menstruation was well marked in a

case under Mr. G. Lawson's care some years ago; the suffering was so great that the patient begged for the removal of the ovary, which was done by Mr. Lawson.

Mr. LANGTON said there was always a difficulty in deciding whether the swelling is an ovary or not; for even in Dr. Chambers's case, the true nature of the gland (it was found to be testicle) was only discovered by microscopical examination. His own experience of twenty years at the Truss Society showed him that there were a number of movable tumours in adults and infants which were doubtless ovaries. In the last nine years at the Truss Society there had been 4084 cases of inguinal hernia, 589 congenital, the rest acquired; no less than 67 were instances of these tumours, all of which were inguinal, with one doubtful exception (? femoral). Of these 67, 42 were congenital, and 25 acquired. The number of irreducible congenital cases was 13; and of the 29 irreducible, all but 2 were afterwards reduced. This was contrary to English's statistics (New Sydenham Society's Biennial Retrospect, p. 291, 1871-72). Of the 25 non-congenital cases, 8 were reducible and 17 irreducible; which also was at variance with English's statement. In the congenital cases, all but 2 were double. The effects with regard to the menstrual period varied very much; in some they swelled materially with fluid, which, on receding, left the ovary the size of a walnut. In those cases not influenced by menstruation, the prolapse probably takes place early, so that the ovary is ill-developed. In the 4 or 5 where there was periodic excitement a hollow pad gave comfort, and in all others the application of a truss behind the ovary prevented the intrusion of any epiplocele or enterocoele. In congenital hernia of the ovary—if on the right side—five per cent. were irreducible; if on the left, twice that proportion: a ratio which holds also for adult cases, and is similar to the same condition of the testis.

Dr. HEYWOOD SMITH thought Dr. Routh's observation of interest, for it is very rare to have a sensation of sexual excitement such as that described by Dr. Routh in his case; and perhaps it had some relation to the adhesions there present involving branches of the pudic nerve.

Dr. BARNES, in reply, said that most of the observations made were supplementary to his paper. Mr. Lawson's case was related in detail in the paper. The remarks of Messrs. Hulke and Langton supported the observations set forth by Cruveilhier, whose accuracy in all matters Dr. Barnes had often confirmed. Cruveilhier says that these cases are mostly congenital; more on the left than right side, and more often inguinal than otherwise. Dr. Barnes had not himself seen distinct evidence of sexual excitement, as described by Dr. Routh; as a rule, pressure produces mere pain. There is one case well known to obstetric physicians, where the ovaries swell enormously at every menstrual epoch to the size of a Tangerine orange, and then subside. Pressure on an ovary prolapsed in Douglas's pouch produces much pain. At present he has a case in hospital where the organ is probably diseased. The frequency of left-sided prolapse was probably due to the greater length and laxity of the left round ligament, and the greater depth of Douglas's pouch on the left than on the right side. This difference between the two sides accounted for other pathological phenomena—*e. g.*, hæmatocele is almost invariably left-sided—and may also explain the more frequent occurrence of adhesions in connection with the shorter right ligament. Ovarian hernia seemed to be more frequent than he had imagined, and instances come largely under the observation of surgeons, especially of those who see much of hernia generally. It was a field for physiological research, and also for surgical study. He thought that when there was pain and distress, it was better to remove the organ, which was liable to become inflamed and diseased, whilst trusses were apt to cause distress. In Mr. Lawson's case, the previous pressure of a truss had probably caused adhesions obliterating the process of peritoneum.—*Lancet*, Jan. 28, 1882.