LECTURE XI.

OVARIAN HYPERÆSTHESIA.

SUMMARY.—Local hysteria of British authors. Ovarian pain; its frequency. Historical remarks. Opinion of M. Briquet.

Characters of ovarian hyperæsthesia. Its exact position. Aura hysterica: first node; globus hystericus, or second node; cephalic phenomena or third node. The starting-point of the first node is in the ovary. Lesions of the ovary; desiderata.

Relations between ovarian hyperæsthesia and the other accidents of local hysteria.

Ovarian compression. Its influence on the attacks. Modus operandi. Ovarian compression as a means of arresting or preventing hysterical convulsions known in former times. Its application in hysterical epidemics. Epidemic of St. Médard—the remedy termed "secours." Analogies which exist between the arrest of hysterical convulsions by compression of the ovary, and the arrest of the aura epileptica by ligature of a limb.

Conclusions, from a therapeutical point of view. Clinical observations.

GENTLEMEN,—By the somewhat picturesque and certainly very practical term *local hysteria*, British authors are accustomed to designate most of the accidents which persist, in a more or less permanent manner, in the intervals between the convulsive fits of hysterical patients, and which almost always enable us, on account of the characteristics they present, to recognize the great neurosis for what it really is, even in the absence of convulsions.

Hemianæsthesia, paralysis, contracture, fixed painful points occupying different parts of the body (rachialgia, pleuralgia, clavus hystericus), according to this definition, come under the head of local hysteria.

I.

Among these symptoms there is one which, on account of the predominant part it, in my opinion, plays in the clinical history of certain forms of hysteria, seems to me to deserve your entire attention. I refer to the pain which is felt in one side of the abdomen, especially in the left, but which may occupy both sides, *at the extreme limits of the hypogastric region.* This is the *ovarian pain*, concerning which I said a few words in my last lecture; but I do not wish to make unreserved use of this term before justifying the hypothesis which it implicitly adopts—and this, I trust, will be an easy task.

This pain I shall enable you to touch, as it were, with the finger,

in a few moments, and to observe all its characteristics, by introducing to your notice five patients who constitute almost the whole of the hysterical cases, actually existing among the 160 patients who occupy the department devoted in this hospital to women affected by incurable convulsive diseases, and reputedly exempt from mental alienation.

II.

You already perceive, from this simple indication, that iliac pain is a frequent symptom in hysteria; this is a fact long recognized by the majority of observers.

Let it suffice, as regards former times, to mention the names of Lorry and Pujol, who, most particularly, noticed the existence of hypogastric and abdominal pains, in hysterical cases.

It is singular, after this statement, to find that Brodie, who was perhaps the first to recognize all the clinical interest which attaches to local hysteria, does not treat of abdominal pain in a special manner.[1]

It seems as of traditional custom that the practical spirit of English surgeons should be attracted by the clinical difficulties which the local symptoms of hysteria present. Mr. Skey, who in this respect may be regarded as continuing Brodie's work, in a very interesting series of lectures on local or surgical forms of hysteria,[2] as he calls them, expatiates on the iliac pain, or pain of the *ovarian region*, which, in his opinion, is very common, and which, according to his view, but contrary to what really occurs, is chiefly met with in the right side.

You are aware that, in France, Schutzenberger, Piorry, and Négrier, have laid special stress on this symptom, which they unhesitatingly attribute to the abnormal sensibility of the ovary.

In Germany, Romberg has followed Schutzenberger on this topic; however, it is to be remarked that, as regards our contemporaries, most of the German authors pass in almost complete silence over all that relates to this hypogastric pain. This is the case, for instance, with respect to Hasse and Valentiner. Hence, it is clear that this symptom, after having enjoyed a certain degree of favour, doubtless on account of the theoretical considerations connected with it, has gone somewhat out of fashion, at present.

Symptoms, also, as you see, have their destiny: *Habent sua fata.* I should not be surprised if the otherwise very legitimate influence of M. Briquet's work counted for a good deal in the production of this result. It now becomes our duty to examine how far we ought to follow this eminent author in the path which he has marked out for us.

[1] Brodie, 'Lecture illustrative of certain nervous affections,' 1837.

[2] F. C. Skey, 'Hysteria—Local or Surgical forms of Hysteria,' six lectures, London, 1870.

III.

I am far from saying that M. Briquet did not recognize the very frequent existence of fixed abdominal pains in hysterical cases. He has even coined a new word to designate these pains *cœlialgia* (from κοιλία, the belly), and a word, even though it be merely a word, is still something that arrests the mind. In 200, out of 430 cases of hysteria, M. Briquet met with cœlialgia. However, I should point out to you that, under this name, he includes alike the pains of the upper part of the abdomen and those of the iliac and hypogastric regions, but the latter are confessedly the most common.

At first glance, therefore, it seems as if the difference between M. Briquet and his predecessors were merely an apparent one. Now, it is nothing of the kind, and here is the chasm which divides them.

Whilst MM. Schutzenberger, Piorry, and Négrier place in the ovary the chief seat—the focus, so to speak—of the iliac pain, M. Briquet only admits the existence of a simple muscular pain, an *hysterical myodynia.* According to his view: 1st, pain of the pyramidalis or of the lower extremity of the rectus abdominis has been mistaken for *uterine pain;* 2d, pain of the lower extremity of the obliquus abdominis takes the place of the so-called *ovarian pain.* Such is the thesis of M. Briquet.

IV.

Let us investigate together, gentlemen, the basis on which this opinion rests. In order to arrive at our object, I am about to refer to the observations which I have been enabled to collect upon a large scale in this hospital. I shall, therefore, proceed to describe this pain, such as I have learned to know it.

1st. Sometimes it is an acute, nay, a very acute pain; the patients cannot tolerate the slightest touch, nor suffer the weight of the bedclothes, etc.; they shrink suddenly, and as if instinctively, from the finger of the investigator. Add to this a certain degree of tumefaction of the abdomen, and you have the clinical appearance of *false peritonitis*—the *spurious peritonitis* of British authors. It is manifest that the muscles and the skin itself share in the suffering here. The pain then occupies a considerable extent of the surface of the body, and, consequently, is not easily localized. However, Todd[1] remarks, and I have frequently verified the accuracy of his statement, that in certain cases, a circumscribed cutaneous hyperæsthesia occupies a rounded dermal space of from two to three inches in diameter. This hyperæsthesia has its seat partly

[1] Todd, 'Clinical Lectures on the Nervous System.' Lecture xx, p. 448, London, 1856.

in the hypogastrium, partly in the iliac fossa, and corresponds, according to this author, to the region of the ovary.

2d. In other cases, the pain does not spontaneously show itself; it requires pressure to discover it, and, under such circumstances, we note the following phenomena: *a*, there is a general anæsthesia of the *skin; b*, the *muscles*, if relaxed, may be pinched and raised without causing pain; *c*, this preliminary exploration proves that the seat of the pain is neither in the skin nor in the muscles. It is consequently necessary to push the investigation further, and by penetrating, as it were, into the abdominal cavity by pressure of the fingers we reach the real focus of the pain.

This operation allows us to make certain that the seat of the pain in question is usually fixed, that it is always nearly the same; and indeed, it is not uncommon to find that patients point it out, with perfect unanimity. From a line uniting the anterior superior spines of the ilia, let fall the perpendicular lines which form the lateral limits of the epigastrium, and at the intersection of these vertical and horizontal lines will be found the focus of pain, as indicated by the patient, and which becomes further manifest on pressure being applied by the finger.

Deep exploration of this region allows us readily to recognize part of the superior inlet which describes an inwardly concave curve; this is our guiding point. Towards the middle part of this rigid crest, the hand will usually meet with an ovoid body, elongated transversely, which, when pressed against the bony wall, slips under the fingers. When this body is swollen, as often happens, it may attain the size of an olive, or of a small egg, but with a little experience its presence can be easily ascertained, even when it is of much smaller dimensions.

It is at this, the period of exploration, that the pain is chiefly determined; it then manifests itself with characters which may be called *specific.* This is no common pain we have to do with, but a complex sensation which is accompanied by all, or some, of the phenomena of the *aura hysterica;* such as they spontaneously show themselves before an attack. When the sensation is thus determined, the patients recognize it as familiar—as having felt it scores of times.

In short, gentlemen, we have succeeded in circumscribing the initial focus of the aura, and, by the same act, we have provoked irradiations in the direction of the epigastrium (the *first node* of the aura, to use M. Piorry's terminology) sometimes complicated with nausea and vomiting, then, if the pressure be continued, there soon supervene palpitations of the heart, with extreme frequency of the pulse, and finally, the sensation of the globus hystericus is developed in the throat (*second node*).

At this point terminates the description, given by authors, of the ascending irradiations which constitute the aura hysterica. But,

judging from my own observations, the enumeration of symptoms, if thus limited, would be incomplete; for an attentive analysis allows us to ascertain the presence, in most cases, of certain cephalic disorders which are evidently the continuation of the same series of phenomena. Such are, for instance (in case of compression of the left ovary), the intense sibilant sounds in the left ear, which the patients compare to the strident noise produced by the whistle of a railway engine—a sensation as of blows from a hammer falling on the left temporal region—and, lastly, a marked obnubilation of sight in the left eye.

The same phenomena show themselves in the corresponding parts of the right side, when pressure is applied on exploration of the right ovary.

The analysis cannot be carried further, for when matters have arrived at this point, consciousness becomes profoundly affected, and, in their confusion, the patients no longer retain the faculty of describing what they feel. Besides, the convulsive fit soon supervenes, if the experiment be persisted with.

Leaving out of the question the phenomena which relate to the last phase of the aura hysterica (the *cephalic symptoms*), I have just been describing to you, gentlemen, the whole series of phenomena obtained in the experiment of Schutzenberger, and we are thus led to acknowledge, with this eminent observer, that compression of the ovarian region, simply reproduces artificially the series of symptoms that spontaneously present themselves in the natural course of the disorder.

I am well aware that, according to M. Briquet, the aura hysterica starts, in the immense majority of cases, from the epigastric *node;* neither do I forget that, in support of his assertion, this author quotes an imposing array of figures. But we must not always bow to statistics, and it may be fairly asked whether M. Briquet, who has shown himself somewhat severe upon the "ovarists," has not in his turn allowed himself to be carried away by some preoccupation which made him neglect to inscribe the initial iliac pain in the series of phenomena of the aura.

If I am to judge from my own observations, this *iliac pain* always precedes in point of time, however small the interval may be, the epigastric pain, in the development of the aura, and consequently it constitutes the first link of the chain.

V.

It remains for me, gentlemen, to establish that this particular point, where the iliac pain of hysterical patients resides, corresponds exactly with the position of the ovary, then I shall have rendered it highly probable, if not absolutely demonstrated, that

the painful oval body, whence the irradiations of spontaneous or provoked hysteria start, is really the ovary itself.

Generally, I believe, an imperfect idea is formed of the precise position which the ovary occupies during life. When, the abdomen being laid open, and the intestines raised, we find in the pelvis behind the uterus, in front of the rectum, the appendages of the uterus flabby, shrunken, and as it were shrivelled, it is plain that we are in presence of appearances not at all answering to vital conditions. It is evident that, after death, the arterial network of the Fallopian tubes and of the ovaries (the vascular wealth and erectile properties of which have been so well illustrated by my friend Professor Rouget, of Montpelier), has long ceased to fulfil its functions. Again, it must not be forgotten that the laying open of the abdomen most certainly alters the true relations of the appendages of the uterus to other parts. This is proved by the fact that, in frozen corpses[1], the ovaries occupy a more elevated position,—one which recalls to some extent their admitted position in the newborn infant. In the diagram before you, which is copied from the 'Atlas' of M. Legendre, you see a horizontal transverse section of the body of a woman, aged 20; its plane passes three-quarters of an inch (2 centimètres) above the pubis, and divides one of the ovaries in twain, whilst the other, lying superior to it, escapes. From this it appears that, in the adult female, the ovary should be situated on a level with or even a little above the superior inlet, (or brim of the pelvis) jutting over into the iliac fossa along with the Fallopian tube. This result accords in every particular with that given by palpation applied to the living body. I will add that if you pass a long needle perpendicularly through a corpse laid on the dissecting table, at a spot corresponding with that where hysterical patients complain of iliac pain, you have every chance—as I have frequently found—of transfixing the ovary.

This position of the ovary appears, in fact, to have been implicitly recognized by Dr. Chéreau in his excellent treatise on diseases of the ovary,[2] when he remarks that, in women, where the abdominal wall does not offer too great a resistance the tumefaction, or even the sensibility only, of the ovary may be ascertained. The introduction of the finger into the rectum would not be a superior mode of exploration, according to our author, except in cases where the abdominal parietes present an invincible obstacle.

Gentlemen, after all these explanations which I have just discussed, I believe I have a right to draw the conclusion that it is to the *ovary*, and the *ovary alone*, we must attribute the *fixed iliac pain of hysterical patients*. It is true, that at certain epochs, and in severe cases, the pain, by a mechanism which I need not at present indi-

[1] E. Q. Legendre, 'Anatomie Chirurgicale homolographique,' etc., pl. X, Paris, 1858.

[2] Chéreau, 'Etudes sur les maladies de l'ovaire,' Paris, 1841.

cate, extends to the muscles and to the skin itself, so as to justify the description given by M. Briquet; but I cannot too often repeat that, if limited to these external phenomena, the description would be incomplete and the true focus of the pain misapprehended.

VI.

This would be the place to investigate what is the anatomical condition of the ovary in cases where it becomes the seat of the iliac pain of hysterical patients. In the actual state of affairs, we can unfortunately only give you some rather vague information, in reference to this subject. There occasionally exists a more or less marked tumefaction of the organ, such as was found in the case of blennorrhagic ovaritis recorded in the memoir of M. Schutzenberger. But this is rather an exceptional circumstance, and it is proper to remark that common inflammation of the ovary may exist with all its characters, and yet there shall supervene no *irradiations*, as described, neither spontaneously nor under the influence of pressure. M. Briquet has not failed to set this circumstance prominently forward, and here he is perfectly right. Hence we must emphatically declare that every *ovarian inflammation* is not indifferently adapted to provoke the development of the aura hysterica. Ovarian tumefaction in hysterical patients is sometimes completely absent, at other times it is but little marked; and it seems probable enough that the tumefaction of the ovary, in such cases, is the result of a vascular turgescence analogous to what is exhibited after the occurrence of certain neuralgic affections. Pathological anatomy has not hitherto supplied us with any positive data in relation to this question; at present, therefore, you may designate the state of the ovary either by the term *hyperkinesis* (Swediaur), or *ovarialgia* (Schutzenberger), or *ovaria* (Négrier)—the name, indeed, matters little, when the fact is well established.

VII.

It being conceded that the ovary is the starting-point of the aura hysterica, at least in a group of cases, it will not be uninteresting now to show that an important and, in some sort, an intimate relation exists between the *ovarian pain* and the other phenomena of local hysteria.

You can in fact discern, gentlemen, in the patients to whom I call your attention a remarkable concord between the seat of the iliac pain and the manner in which the concomitant symptoms are localized. I will not revert to the cephalic phenomena of the aura which, as I stated a little ago, are manifested on the same side with the ovarian pain; I will confine myself to showing that the *hemi-anæsthesia*, the *paresis*, and the *contracture of extremities*, occupy the left side when the *ovaria* is situated on the left, and *vice versâ*. I will also point out to you that when the ovarian pain occupies both left and right sides, the other phenomena become *bilateral*, predominating however on the side where a greater intensity of iliac pain is felt.

On several occasions, we have noted in some of our patients an abrupt change of the seat of ovarian pain. The patient Ler— is one of these. When the ovaria, in her case, predominated in the left side, the cephalic symptoms of the aura, the contracture of extremities, etc., showed, for the time, their maximum of development on the same side—predominating afterwards on the right side, when the right ovary became again the more painful.

It must not be forgotten that ovarialgia appears to be a constant phenomenon, one eminently permanent, in the form of hysteria which engages our attention, so that, taken in connection with some other indication of the same category, it may guide your diagnosis in difficult cases.

VIII.

It remains for me now, gentlemen, to enter upon an exposition of facts which will probably be considered by you as the main feature of this study. These facts, in reality, are of a nature, if I err not, to set out in still greater prominence the truly predominant part pertaining to ovarialgia in *one of the forms of hysteria*.

You have just seen how methodical compression of the ovary can determine the production of the aura, or sometimes even a perfect hysterical seizure. I propose now to show you that a more energetic compression is capable of stopping the development of the attack when beginning, or even of cutting it short when the evolution of the convulsive accidents is more or less advanced. This, at least, is what you can very plainly discern in two of the patients whom I have placed before you. In their cases, the arrest of the convulsion, when compression has been properly applied, is total and final. In the others, the manipulation merely modifies the phenomena of the seizure in varying degrees, without, however, producing complete cessation. And be kind enough to note carefully that we have to deal in all of them, not with common vulgar convulsive hysteria, if I may so express myself, but with convulsive hysteria in what is unanimously recognized as its gravest type—I mean *hystero-epilepsy*.

Let us suppose that one of these women is taken with a seizure. The patient suddenly falls to the ground, with a shrill cry; loss of consciousness is complete. The tetanic rigidity of all her members, which generally inaugurates the scene, is carried to a high degree; the body is forcibly bent backwards, the abdomen is prominent, greatly distended, and very resisting.