

nephritis. There is no acceleration of pulse. These phenomena recur at every ovarian rupture.

† Iliac pain has long been recognized as a frequent attendant on hysteria. There is some divergence of opinion as to the actual seat of this pain. Schutzenberger, Piorry, Négrier, and Romberg insist that it lies in the ovary. Briquet says it is only a muscular pain, a "myodome." The pain of the pyramidal portion of the inferior extremity of the rectus muscle has been mistaken for a uterine pain; and the pain of the lower portion of the oblique muscle answers to the pretended ovarian pain. Such is Briquet's opinion. That muscular pain often enters as an element in these cases, I do not doubt, but that this explains the whole case appears to me untenable. Sometimes the pain is very intense; the patient cannot bear to be touched by the bed-clothes. It is obvious that in these cases the muscles and skin play a part. There is general hyperæsthesia. But in many of these cases, emotion plays a part too; the patient shrinks and cries out before she is touched; and this shrinking, and this superficial pain are commonly only indications of an instinctive effort to protect the deeper structures, really the seat of pain, from injury. This is only one illustration of a general law, that suffering internal organs are protected by the muscles over them contracting in such a manner as to screen them from outward disturbance.

At other times, however, the pain in the iliac region is not complained of spontaneously, and there is little or no superficial muscular pain. The muscles, when relaxed, may be pinched without evoking pain. We must feel deeper. The pain is nearly fixed in one spot, that spot being the seat of the ovary. Pressure here will, as Charcot says, when brought to bear upon the ovary, cause a characteristic pain inducing painful radiations towards the epigastrium, complicated sometimes with nausea and vomiting; next, if pressure be continued, palpitation, with extreme frequency of pulse, soon follows; and lastly, the sensation of globus hystericus is developed in the neck. Charcot goes on to say that various cephalic phenomena succeed; such, for instance, as when the left ovary is compressed, intense wheezing noises in the left ear, and loss of sight of the left eye. If the right ovary be compressed, the head-symptoms are noticed on the right side. If pressure be pushed beyond this point, convulsions would break out.

The following case related by Négrier is so apposite as a typical illustration, that I cite it in detail.

A lady, aged twenty-one, of ovarian temperament, had hysteria from fourteen to eighteen; married at nineteen; had abortion at fifth month of pregnancy, after riding on horseback at a menstrual epoch; free hemorrhage two months later. Suddenly violent muscular contractions, with throwing back of the spine set in; sharp involuntary cries, suffocating sensations attended. Energetic *pelvic projection* as often as the hand is applied to the hypogastrium. She had not menstruated since abortion. Pressure in the right iliac region reproduced a nervous irradiation towards the diaphragm. This sensation, said the patient, was exactly like that which precedes the nervous attacks. She recovered after dry cupping and cupping blood in the iliac fossa.

The "pelvic projection" mentioned by Négrier consists in the throw-

ing forward of the pelvis. It is a frequent and remarkable symptom of oophoria.

In several cases Charcot demonstrated that the convulsions of hysteria could be controlled, resolved by firm pressure upon the ovary. Willis, it appears, in the seventeenth century, was aware of the power of firm pressure by the two hands on the abdomen in stopping a fit of convulsions.

Charcot says he knows a young person in whom an hysterical fit can be produced by compression of the left ovary; and Dr. Tilt says he knows a patient in whom similar pressure is followed by unconsciousness. I have myself on several occasions witnessed similar sequences of nervous phenomena.

I feel a strong conviction that close observation will tend more and more to establish the fact, that iliac pain is the most constant and the primary feature in hysterical attacks. Opponents of the ovarian theory have too much insisted upon what seemed to them the unanswerable fact, that there is no relation between hysteria and indubitable disease of the ovary. It is true that severe organic disease of the ovary is not often attended by hysteria. It is even probable, that since severe disease commonly tends to suppress the function of ovulation, it would thereby tend to suppress hysteria. It is not organic disease of the ovary that causes hysteria, but that disorder, that difficulty in the performance of its function, which is so common in young persons.

Perfect coincidence as to time in the occurrence of ootocia, and of the development of hysterical symptoms, is not wanted to establish the truth of the ovarian theory. Clinical observation, however, proves conclusively that the iliac pain, which is the expression of dysootocia, in an immense number of instances, is the first condition. When once the hysterical temperament has been thoroughly established by several attacks, the excitability of the nervous centres induced is so great, that it will respond to the slightest peripheral or emotional irritation. The attacks then occur at other than the menstrual periods. It must, moreover, be remembered that menstruation, that is, the flow of blood, does not always coincide exactly with ootocia. This process certainly often begins several days before the uterus pours forth blood; and in very susceptible persons, the proclivity to excito-motory disturbance is so great, that even the trouble of the early stages of dysootocia is enough to bring forth the hysterical fit.

When the hysterical habit has once gained force, any physical or mental fatigue, or ordinary emotion, may induce such exhaustion of the nerve-force that the balance is disturbed, and the control of the will, which undoubtedly is often sufficient to keep down a fit, is lost. It is, however, a serious error, because, if acted upon, it may lead to cruel treatment, to look upon hysteria, as some do, as essentially a mental disorder, characterized by moral perversion. Some such element certainly, in some instances, enters into the field; and a certain degree of counteracting moral force from without must be exerted in the treatment. But intimate knowledge of the constitution and character of many sufferers from hysteria leaves a settled conviction on my mind, that the attack is utterly beyond their voluntary control; that they look upon it with a sense of pain and degradation; that they would willingly conceal their infirmity

from others. In persons of feeble character, of little self-reliance, eager for sympathy, especially where the ovarian excitement gives rise to an erotic feeling, no doubt the attack is often promoted and encouraged by a perverted will. It is difficult when witnessing a case of this kind to repress the feeling that a decided treatment of coercion would be the most appropriate. But it would be neither true in science, nor morally justifiable, to carry this feeling into the treatment of the numerous other cases in which the patient can no more suppress her illness than can the subject of puerperal convulsions. Lately it has been proposed to employ terror—the terror of being strangled by violent compression of the vessels of the neck—as a means of dealing with these cases. I cannot look upon this revolting practice—for I believe it has been practised—without shame and humiliation that such ignorance and brutality should be so far recognized as to be discussed.

Tracing the nervous phenomena usually summed up as “hysteria” to ovarian influences, Négrier proposes to substitute the word “ovaric” for “hystéric.” Agreeing in great measure with Négrier’s views, I see practical objection to the particular word he has selected. I therefore propose the word “oophoria,” which is more correct etymologically, and convenient in relation to oophoritis or inflammation of the ovary.

Négrier says the ovaries perform alternately.

1. He finds in one ovary a recently ruptured follicle, and in the opposite, one coming forward.
2. In cases of dysmenorrhœa the suffering is sometimes at every other epoch, the pain being one-sided, and in that side which at other times has evinced local disease.
3. In women having double uterus and vagina, the menses have come from each side alternately.

The *diagnosis* of ovarian dysmenorrhœa is made out by the history, the subjective signs, and the objective signs. Pain occurs in one or both iliac regions, limited to a small space, before the menstrual flow appears; if the region which is the seat of pain be touched externally, the abdominal muscles become tense, so as to screen the deep structures beneath; if pressure be made on the opposite side, although often the patient shrinks, either from dread or from a generally diffused hyperæsthesia, the pressure is borne with comparative ease; if examination be made by the vagina very tenderly, so as to touch the os uteri without exerting pressure on either side of the uterus, no marked pain is elicited; but if the uterus be pressed upwards or towards the side where the affected organ is situated, acute pain is produced; if the finger be pressed deeply in the vaginal roof towards the affected ovary, avoiding the uterus, pain is also elicited; if the abdominal muscles can be relaxed, and sometimes an opportunity is found on deep expiration with the thighs well flexed, the hand outside can be pressed down towards the finger inside, so as to grasp the tender ovary between them; if the like manœuvre be repeated with one finger in the rectum, the ovary may often be felt enlarged, tumid, tender, a little lower than its usual position, and a little more central.

There is another sign characteristic of ovarian congestion which I have almost constantly observed. It is this: the body of the uterus is

drawn towards the affected ovary in lateriversion, so that the vaginal roof on that side is more tense and full than on the other. This drawing together of the uterus and affected ovary is no doubt due to the greater tumefaction of the intervening tissues, caused by the more active vascular process.

It is curious to remember that Galen says lateral displacement of the womb is often associated with hysteria.

A frequent, if not constant, phenomenon in ovarian dysmenorrhœa is a swelling of the lower abdomen, which takes place about the time of the menstrual effort. It is due to distension of the intestines, and is the result of a disturbance or metastasis of nerve-force, by which the intestines for a time lose their tone or contractile energy.

The symptoms above described will, in many cases, be found almost alone, that is, as far as pelvic symptoms are concerned. They will in almost every case be attended with nervous phenomena, generally of the so-called hysterical order, sometimes by vomiting, occasionally even by convulsions, generally by headache. The pulse is seldom much accelerated; there is no marked heat of skin.

But in a considerable number of cases the symptoms of ovarian distress are accompanied by those of uterine distress. Uterine obstructive dysmenorrhœa, as it is commonly called, but to which I prefer the term, dysmenorrhœa from retention, complicates the ovarian dysmenorrhœa. But even in these cases the ovarian symptoms take precedence in time.

The *treatment* of ovarian dysmenorrhœa.

The indications are, to allay general and centric hyperæsthesia, and to moderate the local ovarian pain. The two indications are carried out at the same time. It is important to clear out the bowels, so as to take off any pressure upon the ovaries which a loaded rectum may cause. When the pain is very great, and especially if the pulse rise, and the skin be hot, ten or twelve leeches to the iliac region will give great relief. Two or three leeches applied directly to the fundus of the vagina are more effectual; but this treatment is open to serious practical objections. Indeed, when we consider that the affection is one that tends to return every month, the remedy may be found as distressing as the disease; and if often repeated, the consequent anæmia and debility will increase the hyperæsthesia by lowering the general strength. Now and then, however, the affection has been cured in a comparatively short time by the application of leeches outside. Fomentations, to which turpentine is added, or slight vesications by chloroform, may always be used with advantage. Warm water enemata, acting like fomentations, will sometimes give relief. Their efficacy may be increased by adding a drachm of laudanum to the water used.

The general remedies consist chiefly in sedatives. Hoffman’s anodyne, acetate of ammonia, chloride of ammonium, bromide of potassium, chloral hydrate, and opiates give valuable aid. Opiate suppositories, or vaginal pessaries, are often serviceable. If convulsions appear, the inhalation of chloroform should be resorted to, with great discretion, however, lest we engender a desire for its frequent use. Here, again, as generally in the diseases of women characterized by marked nervous

phenomena, alcoholic stimulants should be allowed only in the most rigorous moderation, or even absolutely cut off.

DYSMENORRHOEA FROM OBSTRUCTION OF FALLOPIAN TUBES.

Bernutz relates a case which seemed to be of this nature. A lady at twenty-eight enjoyed good health till some months before death; she then had metrorrhagia, and was thought to have a miscarriage. During a time of severe mental trial she was seized suddenly with violent pains in the abdomen, fainting and vomiting. There was then no discharge. She soon sank with symptoms of internal hemorrhage. Much blood was found in the abdomen and pelvis. The left tube presented a tumor the size of a pigeon's egg; on its surface was a small transparent cyst, covered with filaments of the tube. At its junction with the uterus the tube was rendered impervious by a small fibrous tumor.

INFLAMMATORY DYSMENORRHOEA: DYSMENORRHOEA MEMBRANACEA;
(ENDOMETRITIS EXFOLIATIVA).

Inflammatory dysmenorrhœa is not common in single women. The clearest examples are those in which dysmenorrhœa follows on suppressed menstruation, as from the sudden shock of cold, injury, or emotion sustained during the flow. Under this circumstance, metritis, or at least intense uterine congestion, is very likely to arise; and an inflamed organ necessarily performs its function, if it be performed, with pain. Not uncommonly in these cases, pelvic peritonitis and oophoritis complicate the metritis; and these conditions in themselves will make menstruation painful. The history of the case, the evidence of primary pelvic inflammation, and of secondary dysmenorrhœa, explain the nature of the affection. In some of these cases there is not only some degree of chronic metritis persisting, but as sequelæ of the peritonitis, adhesions may remain which impede the mobility of the uterus, and even drag it out of place. Local examination confirms the diagnosis supplied by the history.

In these cases the appropriate *treatment* is to apply six to ten leeches to the groin, or two to the cervix uteri; or to scarify the vaginal-portion; to use warm hip-baths containing Vichy salts; to administer salines and sedatives. If the peritonitic complication be severe, it is desirable to give small doses of calomel and opium for two or three days. The rectum should be cleared out by an enema of gruel and olive oil; but all purgatives which disturb parts which ought to be at rest, should be carefully avoided.

Inflammatory dysmenorrhœa is well exemplified, although not perhaps in its purest form, in those cases where metritis, with perimetritis and some degree of fixing of the uterus, spring up, and persist after labor or abortion. In many of these cases there is a clear history of freedom from dysmenorrhœa until after labor; henceforth the menstrual function is performed with pain. The pain comes on with the flow, which is often profuse, lasting for six days or more. The pain is referred to the uterus, whence it radiates to the back. The treatment resolves itself into that of the abnormal condition of the uterus, and surrounding structures. The

further history, then, of this form of dysmenorrhœa will be discussed when describing the conditions of which it is a symptom or consequence.

The *Dysmenorrhœa membranacea* may be classed under the inflammatory kinds. It is often a very obstinate affection. The pathognomonic feature is the discharge of a membrane, sometimes in shreds, sometimes representing a cast of the cavity of the body of the uterus. Denman seems to have anticipated one of the most commonly accepted theories of the dysmenorrhœal membrane. He says:¹ "Having very often observed a substance expelled with the menstrual discharge, which has hitherto escaped notice, and apprehending that the knowledge of this substance may be of use in practice, I feel it incumbent on me to describe it. . . . I constantly found that one surface had a flocky appearance, and the other a smooth one; that it had in all respects the resemblance of that membrane, which Ruysch had called the villous, of the formation of which Harvey has given a very curious description, which the late Dr. Hunter described with his usual precision, and called the decidua. To put the matter out of doubt, I requested the favor of Dr. Baillie to examine some portions of this membrane, and he agreed with me in thinking it an organized membrane similar in structure to the decidua. As the first cases in which this membrane was discharged were those of women who were married, a doubt arose in my mind whether it was not really a consequence of early conception; but I have lately had the most undoubted proofs that it is sometimes discharged by unmarried women, and may be formed previous to and without connubial communication." A case is graphically related by Morgagni. These membranes have often been regarded as casts formed by exudations of lymph, like those of croup. They are so described by Montgomery, R. Ferguson, Churchill. But Oldham² distinctly enunciated the proposition that they were formed under the ovarian stimulus; and that they were formed by the uterine glands—that they were, in short, menstrual decidua.

Oldham's observation was speedily confirmed by others. Professor Simpson³ described the membrane as resembling the decidua vera. Bernutz cites three cases from Boivin and Dugès, in which casts or cysts were expelled from the uterus, in order to prove that the affection described by Oldham had been previously known in France.

But here, as is constantly happening in the history of medicine, we have an instance of the disposition, at once and absolutely to exclude the hitherto existing theory of a disease, and to replace it as absolutely by the last new theory brought forward. It is too often forgotten that both may be true, as expressing the nature of certain cases; and that neither may be true, as expressing the character of all cases. The new fact, that the membrane expelled is the mucous membrane of the uterine cavity, is undoubtedly true, but I am in a position to affirm from my own observation that the membrane expelled in some cases of dysmenorrhœa consists essentially of fibrin and mucus, and does not contain the elements of mucous membrane.

¹ Introduction to the Practice of Midwifery.

² London Medical Gazette, April 17th, 1846.

³ Edinb. Monthly Journ. of Med. Sci., Sept. 1846.