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[Reprinted from the AMERICAN GYNÆCOLOGICAL AND OBSTETRICAL JOURNAL
for April, 1896.]

CIRRHOISIS OF THE OVARIES.*

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The gynæcologist meets with other diseases in the female genital organs than pyosalpinx, ovarian abscess, and uterine fibroids that require surgical intervention, one of the comparatively infrequent, most protracted, and painful diseases of the ovaries being cirrhosis—the title of this article.

The literature on the subject I find to be very meager and unsatisfactory. While the pathology in this condition, in the great majority of instances, has its origin in a chronic ovaritis (some claiming the exanthematic hardening of the ovaries to be of a non-inflammatory origin), its permanency justifies an individuality, and its clinical history and pathology a separate chapter in our works on gynæcic diseases.

I have within the last year operated for the relief of this, the most painful of ovarian diseases, in five subjects. They have all recovered from the operation, and four of them have been permanently relieved of their sufferings, restored to comfort, and made happy, useful wives and mothers. The fifth, operated on a few weeks ago, is convalescent, and I feel safe in predicting that the ultimate results in her case will be equally as satisfactory.

The ovaries are sometimes affected with an interstitial sclerosis as a result of numerous small follicular dropsies, which are, of course, of a non-inflammatory nature. In the post-inflammatory sclerosis or interstitial ovaritis, like pathological processes in other organs, the fibrous tissue predominates and the ovules are either compressed and strangled, so to speak, in their normal location, are choked on their way to the surface, or perchance, after a painful effort, find their way to the surface and rupture.

Where the ovules fail to reach the surface, owing to the denseness

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and unyielding character of the fibrous tissue, the condition is one of sclero-cystic ovaritis. One of the specimens I have here should be so classified.

Early in the history of this process the ovary looks much like a normal organ; but as the process progresses, as is usual, the organs contract at the expense of the vascular stroma or medullary substance. The true gland structure atrophies, yet the ovary in some instances is larger than normal, owing to the increase of the fibrous elements.

Battey, of Georgia, in 1872, performed for the first time in the history of abdominal surgery what was and is yet called a normal oöphorectomy. Many of his cases operated on for the relief of pain, and supposed to be the removal of normal organs, have, in the light of more modern and advanced pathological knowledge, been demonstrated as belonging to this classification of ovarian diseases. The compression of the delicate and painful nerve filaments in the ovary, by the disappearance of at least the greater part of the ovarian structure, save the dense, fibrous trabeculæ, accounts for the sickening, compressing, and almost constant pain in many of these cases, and from the same source the reflexes so often manifested where there exists a constant irritation to branches of the ganglionic nervous system.

I would not have my hearers misunderstand me in this matter, for I am dealing with diseased and not sound organs. I am not advising the removal of any organ where it is not a constant source of trouble and a menace to the health and comfort of the patient. Dysmenorrhœa is a term that should be banished from the nomenclature of gynæcic diseases, as jaundice has been left out of the classification of hepatic diseases, since its source has been definitely traced to well-marked pathological processes; they are both only symptoms. In women who cease to menstruate prematurely, often the cessation may be traced to cirrhosis (atrophy), the result of a chronic ovaritis or an acute exanthematic disease affecting the ovaries, as smallpox, measles, or mumps. To this same source may often be traced the irregular, scanty, or painful menstrual periods of young girls.

As a result of the fibrous contractions in a cirrhotic ovary, the surface of the organ is made to resemble the convolutions of the brain. The majority of women suffering from cirrhotic ovaries are sterile, or will give a history of a long interval between or since the last birth. In many of these cases the Fallopian tubes are also affected, not by a suppurative process, but by a form of inflammation that results in an obliteration of the tubal caliber—an atrophic salpingitis—the same process taking place in the vermiform appendix, as described by Senn

and others, as appendicitis obliterans. A few of these cases cease to menstruate altogether, and thus Nature cures the case, unless there exists firm surrounding adhesions, the remains of old inflammatory processes; these, of course, are to be dealt with in the usual surgical manner if there exist indications for a surgical procedure.

The all-important question to the patient is what can be done for the relief of her suffering.

CASE.—Mrs. B., aged forty-two, mother; last child eleven years old. Menstruation regular in time, normal duration three to five days, and free from pain. Not a dysmenorrhœa or painful menstruation. Her best days during her menstrual month are those during and for several days following her flow. Nine or ten days before her expected menstrual period a pain of a sickening, throbbing, and compressing character developed, and lasted with unremitting severity up to the day preceding the flow, ceasing with its development, to return again at the beginning of the usual painful period. This pain has made her an invalid by its protractedness. She has not acquired the morphine habit, because she is the wife of an intelligent practitioner, who foresaw the dangers attending the prolonged occasional administration of an opiate, and used other analgesics.

This is a short history, but it is all there is to say about the case, save to assure you that all other symptoms inquired for were negative.

An examination revealed small, tender ovaries; no evidence of old, purulent tubal disease. The case was diagnosed as one of cirrhotic ovaries; the correctness of this opinion was fully established at the operation, and the justifiability of the operative procedure has been thoroughly proved by the results in the case. The pain has not returned, and I feel safe in predicting a permanent cure in the case. There are some features in this case worthy of comment.

The absence of any history of an exanthematic disease demonstrates that a cirrhotic ovaritis may take place without this cause; the absence of any evidence of old tubal disease shows that the process did not originate from this source. The left ovary had the cirrhotic process the most marked, and it must be remembered that it is the left testicle that is oftenest found atrophied, one of the most frequent causes in the male being a varicosity of the spermatic veins. It was noticed in this case that the pampiniform plexus on the left side was very greatly enlarged and tortuous. It might be claimed that this disease of the blood-vessels was the source of the pain, but the character, time, and duration of the pain would negative this deduction.

That this atrophy of the ovaries was of a post-climacteric character was disproved by the regularity of the menstrual function and by the microscopical as well as macroscopical appearance of the structure of the organ.

This woman being forty-two years of age and menstruating regularly would not warrant waiting for a natural menopause to occur, for many women continue menstruating for six years beyond this age; this would imply six years more of continued suffering and invalidism.

I know of nothing to relieve this suffering save the removal of the cause. The results of this cause, be they what they may, are of a permanent character, and in an organ not essential to comfortable existence the only remedy for the relief of suffering produced by its presence is the removal of the diseased organ.

Many of these patients will present the usual uterine syndrome, and a diagnosis is arrived at by exclusion of other conditions giving rise to these pelvic manifestations.

It is with no certainty that the patient can tell when her symptoms began, as the process is a gradual one. Arrested involution is responsible for many cases of this disease. The all-important point in these cases to the gynæcologist and the patient is the present condition and the methods of relief.

The pain in the cases I have had under my care has been of a sharp, darting, sickening, or throbbing character, in one or both ovarian regions, but most frequently and of severer character in the left ovary. This pain has its greatest intensity from a few days to two weeks prior to the menstrual period, and is usually accompanied with the usual nervous reflexes, as hysterical manifestations, backache, etc. In many of the cases, owing to the intimate nerve connection with the lumbar ganglia of the spinal nerves, the pain will be found running down the front and inner side of the thigh, genito-crural and anterior crural, and in the hip joint through the obturator nerve connections with the sympathetic. Dyspareunia is in many cases absent, owing to the fact that the ovaries are small and are not prolapsed, and may not be very tender.

Early in the history of these cases they may be treated, with some relief of the pain, by electricity, but the results from this agent have not been at all satisfactory. All cirrhotic ovaries do not require removal. It is in cases where other means have failed, and where the woman has been made an invalid or her suffering becomes almost intolerable, that the removal becomes imperative. Each case is an individual one, and should be studied and treated as such.