THE RATIONAL TREATMENT OF MENORRHAGIA.

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By the term menorrhagia, it is intended to include all cases of uterine hæmorrhage occurring in the practice of the gynæcologist, whether as profuse or prolonged menstruation, or as loss of blood from the uterus other than that which occurs at or about the time of parturition.

The subject is one of much interest to every practitioner, and will, I trust, be found worthy of a brief consideration.

Uterine hæmorrhage must not in every case be regarded as a disease or entity *per se*, for which one method of treatment is universally applicable. Nor must we in every case attempt to check the hæmorrhage; for it may be merely an expression of constitutional or general vascular tension, the uterine mucous membrane acting, so to speak, as a safety-valve, a smart attack of hæmorrhage often serving to avert a still more serious effusion from the ovary, or its surrounding plexus, into the peritoneal cavity, or even preventing an attack of apoplexy at the so-called climacteric period.

Of all the organs in the body, the uterus is the only one from which blood flows as a normal physiological process, the function being influenced by many and various causes, both general and local.

A recognition of this fact is essential; for, unless we acknowledge the importance of forming a correct diagnosis in every case of hæmorrhage, our treatment will not only often be futile, but actually mischievous. Diagnosis is, in fact, the most important element of treatment, for menorrhagia is merely a symptom, not a disease. In many instances, the differentiation of the predisposing and exciting causes of any individual case under observation may be one of great difficulty, but must nevertheless be attempted. The history of the onset of the attack, whether gradual or sudden, attended or not by pain or febrile disturbance, will often give us some clue to the cause. The age of the patient often suggests the possibility of certain well defined causes, cardiac complications from rheumatic fever, hæmatocele, ovarian irritation, constipation, etc., in the young; polypi, fibroids, retroflexion, retained products of conception in the middle-aged; climacteric irregularities, cancer in its various forms, hepatic disorders, etc., between the ages of forty and fifty.

In young plethoric girls, whose sexual development is well marked, menstruation is not unfrequently profuse. In place of giving iron, which generally produces constipation, and thus aggravates the tendency to menorrhagia, the better plan is to regulate carefully the diet, avoiding alcohol and any undue amount of animal food; to give bromides, which lessen the ovarian irritation, together with some saline aperient when requisite.

In anæmic patients, iron generally proves most serviceable; but, in place of "pouring in iron", as is not unfrequently spoken of, it should be given in combination with salines in moderate doses, more as a chalybeate water than a mixture; and care must be exercised that it does not produce headache, nor spoil what little appetite may exist.

In a case recently seen in consultation, of a young lady aged 17, whose periods were very profuse, acetate of lead had been given so heroically as to produce symptoms of lead-poisoning, the gums being marked with the characteristic blue line, colic and muscular weakness being also present. This method of treatment seemed scarcely rational, considering that menorrhagia is a well marked symptom in women employed in white-lead manufactories.

In single patients, where menorrhagia is marked, and relief does not follow ordinary medicinal treatment, local investigation should be suggested, and, if necessary, insisted on. In one instance lately, a maiden lady, aged 37, who had suffered from frequent and severe losses of blood, extending over a period of several years, for which ergot and iron, kino, hæmatoxylon, and various other remedies had been prescribed in vain, was found to be suffering from a large intra-uterine fibroid polypus, of the size of a hen's egg. Dilatation of the cervix by means of tents was effected, and the growth was removed by the aid of the *écraseur*, combined with torsion and traction. Medicines had been prescribed for many years, but the cause of the hæmorrhage had not been made out until dilatation of the cervix, when the source of the hæmorrhage was at once apparent. The patient convalesced rapidly, although, before the operation, she was reduced to a very anæmic condition, and her life was despaired of.

Where a married patient suffers from menorrhagia, the cause of

which is not at all obvious at first, a careful examination should be insisted upon. In no fewer than four instances recently, I have met with cases of unsuspected pregnancy complicated by polypus uteri. A brief narration of one case may prove of interest.

N. S., aged 36, married nine years, sterile, began to have irregular losses of blood *per vaginam*, in addition to the periods being profuse. Ergot was given freely, but no examination was made. When I first saw her, she was looking very anæmic, from a rather smart attack of hæmorrhage. On examining her, I found that the uterus was enlarged above the umbilicus, the cervix soft and full; it was evidently a case of uterogestation. Protruding from the cervix was a polypus of the size of a walnut. Torsion was employed, and the growth removed, pregnancy advancing to full term.

Where the slightest irregularity in the appearance of the catamenia leads to the suggestion of the possibility of utero-gestation being present, any attack of menorrhagia, especially if it recur, should be regarded as a threatened miscarriage, and treated accordingly. Should only the foetal portion of the ovum be expelled, hæmorrhage recurring so soon as the patient leaves the recumbent position, in place of contenting ourselves with giving ergot, an examination should be made, and the remainder of the ovum extracted. Where the cervix has closed up so much as to prevent the expulsion of the placenta, though this is rare, a sponge-tent should be inserted, the cervix dilated, and means taken to clear out any *débris* remaining in the uterus. The following case may serve as an illustration of many others.

Menorrhagia: Attempted Miscarriage: Removal of Ovum: Recovery.
—A. B., aged 18, single, mother of twins, one only living, aged twelve months. After the first few months, during which time the patient suckled her child, she had rather a copious sanguineous discharge, lasting four or five days, and recurring every fortnight. There was then an interval of five weeks without any sanguineous discharge; but after this she had irregular losses, brighter in character than usual. In June, about three months after the cessation of any sanguineous discharge, severe flooding came on during the night, lasting an hour and a half. She was much exhausted after this, and was compelled to remain quiet. An interval of three weeks elapsed, and then a second flooding occurred, the loss being very severe—estimated at three or four quarts. The practitioner administered ergot, but failed to ascertain the cause of the flooding.

When seen by me in July, on examination the uterus was found to be excessively bulky, mobile, the cervix enlarged, the os patulous. Protruding from this latter was a dense mass, about the size of a thumb. The history pointing to the probability of its being a case of miscarriage, an ovum-forceps was inserted gently within the cervix, and the mass gripped firmly. Torsion and traction were then employed, and what proved to be the maternal portion of the ovum was removed. Ergot with bark and acid were given, rest enjoined, and appropriate nourishment administered. No further hæmorrhage occurred, and the patient made a good recovery.

In this case, the absence of any sanguineous discharge in a patient who had been losing blood every fortnight should at least have suggested the possibility of utero-gestation. The sudden hæmorrhage three months subsequently was accounted for by an attempted expulsion of the ovum. Even the second flooding three weeks later, which jeopardised the patient's life, led to no local investigation, and therefore to no explanation of the cause of the hæmorrhage, without a knowledge of which treatment could but be ineffectual.

Where two or three periods have been missed, and the question of pregnancy is tolerably certain, should hæmorrhage occur, accompanied by pain, the fact of a miscarriage having taken place may generally be assumed. If hæmorrhage persist or recur at intervals, an examination should be made. In one instance, in which I was recently consulted, the patient was allowed to go on losing blood continuously for over three months. The history of the miscarriage at once suggested the expediency of exploring the uterus. Nearly a teacupful of placenta, perfectly fresh, was removed, and the hæmorrhage at once arrested. An action was commenced by the husband of the patient against the practitioner for improper treatment, and the latter was advised to compromise the matter and stay further proceedings, by foregoing his claim for over three months' attendance, day and night, and giving the patient a substantial recompense.

Where uterine hæmorrhage is severe, whether from imperfect expulsion of an early ovum, intra-uterine polypus, submucous fibroid tumour, or other similar condition, in place of attempting to restrain the flow by pieces of linen or cotton-wool packed in the vagina, which practically have no influence in controlling the loss in the majority of cases, a far more scientific and rational method is to insert a sponge-tent into the cervix uteri. This has the double effect of plugging the os uteri, thus checking or arresting the flow, and at the same time dilating the

cervix, so as to facilitate subsequent exploration of the interior of the uterus.

Where the practitioner does not possess the requisite skill, or has not the instruments at hand, packing the vagina with pieces of sponge is far more likely to arrest the hæmorrhage than pledgets of cotton-wool, which, in place of expanding like sponge when moistened, become compressed and lessened in bulk.

Hæmatocœle, or effusion of blood into the pelvis, is a frequently overlooked cause of menorrhagia. If careful inquiry be made, there will usually be found to be some history of exposure to cold, undue exertion, over-fatigue, violent straining, or injury of some sort at or near a menstrual period. Extra-uterine gestation at an early stage, although not often suspected, will often explain these cases.

In place of applying hot fomentations to the abdomen, and pouring in brandy, a more rational method of attempting to restrain hæmorrhage is to get the patient rapidly under the influence of opium, so as to allay pain and prevent restlessness, and apply cold or pressure to the abdomen by means of ice or small pads of cotton-wool and a firm binder.

If hæmorrhage be severe and continuous, and the probability of extra-uterine gestation exist, the patient's life being evidently jeopardised by the amount of effused blood withdrawn from the circulatory system, the only hope of saving the patient is to make an exploratory abdominal incision, secure if possible the bleeding vessel, or remove the ruptured cyst, as may be found advisable.

Retroflexion, accompanied by congestion of the uterus, in patients who have borne children, is not an unfrequent cause of menorrhagia. A correct diagnosis is here essential, before treatment is likely to prove of service. The two conditions are often so intimately associated, that, unless both of them be dealt with simultaneously, permanent relief is not obtained. The misplacement serves to keep up the congestion, and the latter equally tends to prevent the uterus from assuming its normal position. Puncturing, scarification, or the application of leeches, followed up by hot water injection and glycerine plugs, may first be tried to lessen the congestion; a ring pessary, or other appropriate support, being then inserted to keep the uterus in its normal position, and thus lessen the tendency to a recurrence of the congestion.

The management of hæmorrhage, due to large intramural or sub-mucoid fibroids, is one often of much difficulty. Where ergot, bromides, cannabis Indica, gallic acid, digitalis, and other similar remedies, fail to arrest the flow, and the patient's health is markedly affected by the repeated or severe losses, the question of spaying, division of the cervix uteri, or removal either of the fibroid or of the entire uterus should certainly be entertained. The results obtained during the last few years by operative interference in these cases are most encouraging, and the operation well deserves more extended trial. No patient, the subject of uterine fibroid, where the symptoms are so severe as to impair her usefulness or threaten her life, should be allowed to die unrelieved without having the option of operative interference.

The following case illustrates well the importance of forming a correct diagnosis, as also the value of treatment.

Menorrhagia: Intramural Fibroid: Removal: Recovery.—M. N., aged 24, married three years, mother of one child, aged two years. Since her confinement, but especially during the last few months, the patient had suffered from frequent and severe losses of blood *per vaginam*. She was supposed to have had several miscarriages, but the subsequent history of the case rendered this more than doubtful. On examination, the uterus was found to be somewhat retroverted, excessively bulky, mobile. The cervix was large, the os patulous, admitting the finger. Protruding from the posterior wall a fibroid tumour, of the size of a very large hen's egg, was detected, almost sessile, the lower end presenting at about the level of the internal os uteri.

As the patient was exceedingly weak, and very much exhausted from the profuse hæmorrhage which had occurred, it was deemed expedient to plug the cervix uteri, administer ergot, and rally the patient's powers by means of strong beef-tea, jellies, milk, and other forms of nourishment, before attempting any operative procedures.

Later on, the patient was placed in the lithotomy position; chloroform and then ether was administered; the cervix incised bilaterally by means of Simpson's metrotome; the capsule of the tumour was divided by the aid of a curved blunt-pointed bistoury, the finger inserted in the aperture, and the tumour shelled out. Some difficulty was experienced in reaching the upper portion of the growth; a large ovum-forceps was therefore employed to grasp the tumour, and the removal was accomplished by a judicious combination of torsion and traction. It was as large as a goose's egg, and composed of dense fibrous tissue, almost as hard as cartilage. But little hæmorrhage occurred during the operation. A plug of cotton-wool, moistened with the tincture of perchloride of iron, was inserted in the cervix to restrain

hæmorrhage, a morphia suppository inserted, and nourishment administered in small quantities at short intervals. The patient was much exhausted after the operation, but ultimately made a good recovery.

This case illustrates well the absolute importance of forming a correct diagnosis. It was assumed that the hæmorrhage depended upon miscarriages, and ergot was administered. Pain, due to expulsive efforts on the part of the uterus, seemed to support this view; but it is more than probable that the ovum, even had conception occurred, would have been washed away by the profuse loss of blood, before becoming sufficiently attached to permit its becoming developed.

Vascular disturbances at the climacteric, or change of life, as it is popularly spoken of, should never be treated lightly, but always carefully investigated.

In some instances, regulation of the bowels, restriction as to diet, especially the amount of alcohol, and a proper amount of outdoor exercise, will be all that is requisite. In others, the hæmorrhage persists, in spite of all treatment; and, on a careful investigation, epithelioma of the cervix uteri is at once detected, probably too late for any operative interference. In no case should hæmorrhage at this period be diagnosed as change of life, without a careful examination being made, and a correct diagnosis formed. Numerous cases could be cited illustrating this. The following may suffice at present.

Menorrhagia due to Cardiac Mischief.—C. M., aged 42, single, consulted me for profuse menstruation. The period generally lasted a full week, and recurred at an interval of from two to three weeks. During the last few months, the patient had lost far more than usual, and her general health was beginning to suffer. She had been taking medicine for the hæmorrhage for some time past, but without obtaining relief.

On examining the chest, a loud systolic murmur was detected over the apex of the heart. The pulse was small, weak, irregular, and the appearance of the patient was extremely anæmic.

As the patient herself feared that some uterine tumour was present, a vaginal examination was made. The uterus was found to be fairly normal in size and position, and there was nothing in the condition of the pelvic organs to throw any light upon the uterine hæmorrhage. A mixture of iron, magnesia, and nux vomica was prescribed, and subsequently digitalis. This had the effect of improving the heart's action. Appropriate rest and diet were enjoined, the bowels carefully regulated, and the general health attended to in every possible way. Marked improvement ensued as regards the uterine hæmorrhage.

Menorrhagia: Abuse of Alcohol: Constipation.—Mrs. G., aged 40, mother of three children, the youngest nine years old, had suffered from menorrhagia the last year or two, the periods recurring too frequently, and the loss being excessive.

She was rather stout, the complexion ruddy, the conjunctivæ yellowish, the abdomen distended. The bowels were very confined, the appetite indifferent. She slept badly, and suffered much from languor and debility, spasms in the chest, and tickling in the throat.

On examination, the uterus was found to be bulky and mobile; the os patulous; the cervical canal rather granular. On inquiry, the patient acknowledged that she had been very worried and anxious of late, and had been advised to take port wine and brandy to keep her strength up.

Complete abstinence from alcohol was enjoined. A combination of rhubarb and blue pill, to act upon the liver and to secure regular action of the bowels, was given; and a mixture of bromide of potassium, ergot, nux vomica, and cinchona was prescribed. The patient improved rapidly, and the periods soon became normal.

Cirrhosis of Liver: Menorrhagia: Death.—B. T., aged 48, married, sterile, had been fairly regular as to her periods until the last three years, since which time they had been too profuse and too frequent. She was much troubled by flatulence, constipation, anorexia, nervousness, inability to sleep, great depression, and irritability of temper. Various remedies had been tried to check the menorrhagia, but failed. I was asked to see her, with a view to determining whether any fibroid or other tumour of the uterus existed. The uterus was found to be normal in size and position, and there seemed to be nothing in the condition of the pelvic organs to explain the hæmorrhage. On examining the abdomen, it was found to be very full and distended, the walls excessively fat. The liver could be detected enlarged, hard, and nodular at the edge. The heart's action was weak, but otherwise normal, no murmur of any kind being present. The lungs were fairly healthy.

In this case, the uterine hæmorrhage was clearly due to alcoholism—enlarged liver and obstructed portal circulation. It was subsequently discovered that she sometimes took as much as a bottle of brandy in the day. She died suddenly a few months later, being found dead in her bed.

In cases of epithelioma of the cervix, where hæmorrhage is a marked symptom, in place of giving ergot or iron, and plugging the vagina with cotton-wool loosely, as is too often the case, the more rational

method is to remove as much of the diseased mass as is deemed prudent, with either the *scraper* or the curette, or both combined, and then to apply either the liquor ferri perchloridi fortior, the persulphate of iron, or the actual cautery.

Much may be done in these distressing cases to postpone the evil day, and lessen the amount of suffering consequent upon the exhaustion from repeated hæmorrhages, by timely assistance. It is no reason why the patient should be left to die miserably, unrelieved by art, because the nature of the malady has been recognised to be one which at present baffles our efforts to cure it, unless complete extirpation of the uterus, by abdominal or vaginal incision, can be regarded as a cure.

Mr. MORRIS and Dr. THOMAS DUTTON (Sidlesham) remarked on the possibility of vaginal examinations in the unmarried becoming too frequent, and spoke of the difficulties that stood in the way of younger practitioners in dealing with uterine cases.

Dr. ROUTH (London) thought that perhaps country practitioners were too chary of examining their cases. Of course, promiscuous examination was wrong. But, in his experience, many ladies, married and unmarried, came to town with uterine disease, declaring that they had suffered for years, and had found their medical attendants unwilling to make an examination. He had not unfrequently met with polypus or epithelioma, which might have been prevented or cured had an earlier examination been made.

Dr. WALLACE (Liverpool) said his experience was not in accordance with Dr. Routh's. The patients who consulted him (Dr. Wallace) had almost invariably been examined, and their cases diagnosed, by their own medical attendants. He considered that, when an examination was called for, it was by no means a good plan to ask permission; permission should be taken for granted.

Dr. EDIS, in reply, stated that, practically, it would be found that very few cases of severe menorrhagia occurred in young girls, and therefore the question of submitting them to examination was seldom presented; but, where menorrhagia persisted, in spite of all ordinary remedies, the fact of a patient being single should not deter us from ascertaining the nature of the disorder. If menorrhagia were regarded, not as a disease, but as merely a symptom, and the exciting cause of this were carefully investigated, we should more frequently succeed in arresting hæmorrhage.

ON THE ETIOLOGY AND TREATMENT OF A CERTAIN FORM OF ENDOMETRITIS,

ACCOMPANIED WITH VERY TENACIOUS LEUCORRHOEA.

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THERE is a variety of dysmenorrhœa which we occasionally meet with, and which is very difficult of cure. I allude to that form where, in addition to the pains about the uterine organs, to be hereafter more fully defined, there is a thick muco-purulent discharge, so sticky, that it is often wellnigh impossible to remove it.

The general symptoms of this affection resemble in many respects those I detailed in a paper read before the Obstetrical Society of London (*Transactions*, vol. xii, 136), on Fundal Endometritis, and vary according to the part of the uterus affected. To recapitulate a few particulars. First, the pain felt varies greatly; it is sometimes trifling, general uneasiness being the chief complaint, with the knowledge of the daily passage of more or less leucorrhœal discharge, which becomes yellow on the linen. More frequently, however, there is a marked feeling of weight in the uterus with bearing down; and the symptoms are greatly aggravated at the menstrual period, when colicky uterine pains are superadded. These, beginning in the back, run downwards towards the region of the round ligaments, and outside one, generally the left, or both thighs, coming on in paroxysms more or less severe. It has been stated that in such cases there is no rise of temperature, even although the pain has been excruciating, leaving no trace when once the cause has been removed. This, I am satisfied, is an error. If the temperature be taken in the axilla, it is true there is seldom any rise of temperature. If, however, it be taken in the vagina, it will be found raised sometimes to 103°. This, however, is by no means an exceptional case. In most, if not all, women during menstruation the temperature rises in the vagina.

To what is this particular discharge due? First, I believe, in most cases, it is essentially the result of gonorrhœa communicated during

the first few days of married life, whether by a gonorrhœa proper or a gleet. At least, in questioning many women, they always referred its occurrence to marriage; and in not a few of these cases, when I have been able to examine the husband also, I have found gleet. Yet, even here, I have observed what appears to contradict this view. I have found gleet present in a husband, and no sticky discharge in the wife.

If we closely question the wife, however, in these cases, we often are enabled to learn that soon after marriage, indeed within the first week, some acute symptoms supervened; abdominal pain low down, over both ovaries, especially the left, and in the groin, with more or less feverish excitement. In one case, I believe, peritonitis was the immediate result, which proved rapidly fatal. In another case, the peritonitis was more limited, and recovery occurred. Now, in both these cases the wives were believed in the first instance to be healthy; but both husbands were affected with acute gonorrhœa. The opinions of Noeggerath, and his belief that catarrh of the Fallopian tubes plays a part in the occurrence of perimetritis, and even peritonitis, have been widely made known. By most gynecologists, they have been said to be extravagant. Attention has also been called lately to this etiology by Dr. Edis. I must say, for myself, that, while I cannot go quite to the length of Noeggerath's opinions, I am quite sure that the chronic form of tenacious uterine leucorrhœa with dysmenorrhœa, of which I am now speaking, is due to gonorrhœa in most cases. In a few more cases, it is due to intense vaginitis in the virgin, which acts precisely in the same way in producing tenacious uterine leucorrhœa; a vaginitis capable of producing a gonorrhœa in the male, or rather an urethritis, which cannot be distinguished from gonorrhœa.

Whatever be the cause, however, in nearly all the cases where the discharge existing is thus tenacious, I assert distinctly also that, so far as my experience goes, sterility is the constant result. The affection is, moreover, in many cases, perhaps the majority, exceedingly difficult of cure, and for this simple reason: it is not only the uterine cervical and superior cavity which is affected, but the tubes likewise. A temporary cure by local applications to the uterus may be effected in the cavity, and for a few days a practitioner may believe he has cured the patient. Perhaps, a fortnight later, he is mortified in finding his patient as bad as ever. There has been no cure of the catarrh of the Fallopian tube, and, through the continuity of surface, the uterine mucous membrane has been affected.

I believe one of the reasons why peritonitis is not more common in these cases is, that the expulsive or downward action of the cilia of the tube directs the unhealthy secretion into the cavity of the uterus rather than into the peritoneum.

I think it will facilitate the description of the points I wish to bring especially before your notice, if I speak of this disease under three varieties, although they are but stages of the same disease: namely, (1) where it is confined to the cervix; (2) where it extends to the superior cavity of the uterus; (3) where it reaches the Fallopian tubes and peritoneum.

1. Let us speak first of the cervical variety. On examining a woman affected with this form of tenacious leucorrhœa, we generally find an accumulation of muco-pus around the cervix. This is generally removed with difficulty, but even then a more or less thick cord of the same secretion projects as a piece of string from the os, and cannot be detached. Even if a piece of thick wire, or a sound, around which some medicated cotton has been wound, be introduced into the uterus, it cannot be so removed; more and more seems to have accumulated above, and the mucus is as tenacious as ever. It is rare, however, that in such cases the operation can be done without exciting pain, just as you pass the internal os, and sometimes higher up. The severity of this pain varies. In more chronic cases, it may be slight; in others, and in these generally the dysmenorrhœa is very troublesome also, it amounts to an agony, which lasts for hours afterwards. I may here state, however, as useful, not only in these cases, but in others, where the passage of the sound is attended with pain, that the injection, *per vaginam*, of water as hot as the patient can properly bear it, is the most effective way of checking or relieving it. The moment the internal os is passed, the exact pains which the patient is accustomed to have during a period are reproduced. The patient, indeed, will spontaneously exclaim, "Oh, you are bringing on all my poorly pains." The point of starting the pain is therefore probably at the internal os. I have also noticed that, in a large proportion of cases, uterine version or flexion exists, especially anteversion; but there can be no doubt that the internal os, by reason of the pain, is the seat of spasm, which, for a time at least, precludes the passage of the cervical fluid into the superior uterine cavity. This spasm, as well as the version where it exists, is in a measure a preservative action, and often prevents the development of the second stage.