Lectures

ON THE

DIAGNOSIS AND TREATMENT OF DISEASES OF WOMEN.

DELIVERED AT ST. MARY'S HOSPITAL MEDICAL SCHOOL.

BY

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PAIN REFERABLE TO THE GENERATIVE ORGANS (continued).

GENTLEMEN,—The next class of cases to be considered are those in which there is

B. PAIN EXPERIENCED IRRESPECTIVE OF MENSTRUATION.

Although it is not possible to state much as to the diagnostic value of mere "pain" of the kind now under consideration, a few remarks on the subject appear to be called for.

PAIN IN THE BACK is one of the most common symptoms present in women labouring under uterine or allied disorders; it is also the one to which attention is directed, and of which special complaint is made by the patient. The pain here alluded to affects the lower lumbar region and the parts adjacent; it is not usually an acute pain, but an ill-circumscribed, aching sensation, very wearying, and often extremely distressing to the patient. The intensity of this pain is not by any means proportionate to the severity of the disease present. Women suffering from uterine disorder, combined with constitutional derangement, are most liable to this pain in its most troublesome form, as in the often long continued menorrhagia, and consequent anæmia due to cancer of the uterus, etc.

With reference to the diagnostic value of this pain, there is not much to be said. It is so common an attendant on disorders of the uterus or its appendages, that usually it can serve only to direct attention to the probable existence of such disorders. The fact that a patient has for a considerable period suffered from pain of this description should induce the practitioner to consider whether disease of the internal generative organs, up to that time possibly overlooked and unrecognised, be not present, and to take measures for satisfying himself on this point.

The connection between the pain in question and the presence of internal uterine or other disorder is often substantiated by the fact that before, during, or immediately after the menstrual periods, it is most troublesome; sometimes, indeed, it is only present at such times. The pain of ordinary lumbago is the most likely to be confounded with it. Attacks of lumbago are, however, more acute in their character, and they occur irrespective of the menstrual periods.

PAIN IN THE HYPOGASTRIC REGION. The hypogastric region is very frequently the seat of pain in women; and, consequently, the diagnosis of the various conditions capable of giving rise to

pain in this part of the body is most important. For diagnostic purposes, we may consider: *a.* Intermittent pains; *b.* Pains more or less constant; *c.* Pain of inflammatory character; *d.* Pains with symptoms like those of perforation; *e.* Some other varieties.

a. Intermittent pains. Of all the pains which women experience in this part of the body, the most characteristic and most interesting, in a diagnostic point of view, are those pains which may expressively be termed *labour-like pains*. The pains in question are peculiar in their nature; they come on in paroxysms, lasting a certain time, and leaving the patient pretty free during the intervals; and they are due to the contraction of the uterus, generally excited by the presence of some body, substance, or fluid, within this organ. When, therefore, a woman is found to be suffering from pain in the hypogastric region, which possesses the characteristics pointed out, we generally set it down to presence of uterine contractions. The contractions in question may be due to a very considerable number of causes, between which we have to discriminate.

The typical "labour-pain" is that observed during parturition at full term. Here the uterine contractions are most severe and most powerful, owing to the great size the organ has then attained. In the case of a woman in labour at full term, it is not generally a question as to whether she is pregnant or not; the diagnosis has usually been made previously, and in other ways. It is necessary, however, to regard attentively the phenomena then observed, in order to detect and recognise the presence of pains of the same nature when they are less severe and intense in degree, and consequently more liable to be confounded with other kinds of pain.

The principal conditions under which labour-like pain may be observed will now be mentioned.

In young women who have never menstruated, the presence of hypogastric pain of the kind in question would make us suspect closure of the hymen or vagina or os uteri, and that the menstrual fluid, although secreted, could not be expelled. In cases of this kind, the pains at first felt are slight in degree; but as month after month passes without relief, they become more severe, and are finally of the most intense character. The enlarged uterus is usually to be felt above the pubis.

In young women who have menstruated, the presence of hypogastric pain, recurring at intervals, sharp while it lasts, and leaving the patient free from pain in the intervals of the paroxysms, would give the idea of the presence of *abortion*. This idea would be substantiated, or the reverse, by the collateral evidence obtainable. If the patient had passed over one or more periods without menstruating as usual, and if the pains above described were accompanied by a discharge of blood from the vagina, this would render the suspicion of abortion so strong as to necessitate not only an examination *per vaginam*, but also a careful inspection of the matters discharged. Great caution should be exercised in expressing any conclusion on such a question, and a conclusion can only be come to after a careful scrutiny of the facts elicited.

In abortion occurring before the third month, the collateral facts do not so unmistakably point out the nature of the case as in instances of abortion occurring later. Respecting an abortion taking place at

four, five, or six weeks, for instance, it would be exceedingly difficult for the practitioner to affirm positively that the case was one of abortion, unless he were fortunate enough to secure the ovum itself.

Menstrual Retention occurring subsequently to more or less regular performance of the menstrual function. In these somewhat rare cases, labour-like pains may be present. These cases only differ from those alluded to in the previous section (on dysmenorrhœa) in that the secretion escapes with difficulty in the one instance and does not escape at all in the other. The pain is alike in both, and the other attendant phenomena are almost identical.

Presence of Blood clots, Fibrous Polypi, retained portions of Placenta or Fœtal Membrane, Degenerated (e.g., Hydatidiform) Ova, within the uterus, may give rise to labour-like pains, consequent on the attempt of the uterus to expel the bodies in question. In these cases, the pains are more or less irregular, in regard to the time of their occurrence, and they do not affect different individuals equally. The uterus appears, indeed, to be very capricious in regard to tolerance of the presence of bodies within it; large polypi are sometimes found in the uterus, which have given rise to comparatively little pain; while, in other cases, the patient may have been tormented almost daily by severe colic-like pains in the hypogastric region from a comparatively small growth of the same nature.

Tumours growing in the substance of the Uterus. Of these, the fibroid tumour, which is the most common, is a frequent source of pains of the kind now under consideration.

Collections of Puriform or other Fluid in the Uterine Cavity. In women suffering from chronic disease of the cervix uteri, when the canal of the cervix is not so large as to allow a free passage of the fluid secreted; in women advanced in life, and in whom the atrophied condition of the uterus produces also contraction of the canal, the uterus sometimes becomes distended with serous or puriform fluid, and labour-like pains supervene.

In cases of *Flexion of the uterus*, when the uterus is so twisted as to interfere with escape of its contents, also in cases where the uterus is *dislocated* from its normal position by presence of tumours in ovaries, etc., these labour-like pains are frequently noticed.

Cases of *difficult menstruation*, in which we have hypogastric pains of this character, have been already considered. It will generally be found that, in cases where labour-like pains are present at irregular times and periods, there is also disturbance of the function of menstruation.

b. Pains more or less constant. These may occur in all degrees of intensity, and the causes of the same are so numerous as almost to defy classification.

Pain in the hypogastric region may be due to some abnormal condition of the uterus or the bladder, or of some other of the pelvic viscera. The pain due to abdominal disease is usually situated higher up about the umbilicus. And, although these limits are not always observed, although pelvic disease may occasion pain even higher than the umbilicus, and, *vice versâ*, although abdominal disease may occasion pain in the hypogastric region, yet the rule just stated generally holds good.

Some of the more salient points as to the diagno-

sis of the causes of the pain experienced may now be mentioned. The cases in which the pain is of a more or less chronic character, and unattended with those symptoms ordinarily indicative of inflammatory conditions, are those now to be considered.

In *cancer of the uterus*, severe hypogastric pain, often described as of stabbing or burning character, accompanies almost constantly the more advanced stage of the disease; whereas, at an earlier period in the history of the affection, the pain is not so severe, and is, at the time in question, more generally situated in the back. The "lancinating" kind of pain is present usually in cases where the disease is advanced. Hæmorrhage, offensive discharges, and pain in the region of the uterus, indicate, as a rule, cancer. In cases of corroding ulcer of the os uteri, these symptoms are also present; emaciation and fever are also common to both. The pain in cancer is usually more acute than in that of corroding ulcer. An observation which applies to both is, that hæmorrhage and pain are sometimes entirely absent. The pain due to cancer frequently arises from local attacks of peritonitis.

In *fibrous tumour of the uterus*, severe hypogastric pain may be present. The foul discharge is not present as in cancer, although this rule is open to rare exceptions; but there may be profuse occasional loss of blood. The pain due to fibrous tumour may be quite as severe as that in cases of cancer; but, in the latter affection, the expulsive labour-like pains, so often associated with presence of fibrous tumour, are generally wanting.

A not unfrequent cause of hypogastric pain is that condition of the uterus known as *irritable uterus*—a neuralgic or inflammatory condition of the organ.

Pain in the hypogastric region, perhaps more frequently extending also to one or both ovarian regions, is almost always a most troublesome accompaniment of long standing *disease of the cervix of the uterus*, where hypertrophy, hypersecretion, and chronic inflammatory conditions are conjoined. Pain due to either of these two latter causes is often very severe; it is much increased by motion, and there is great tenderness on pressure.

An *ovarian pain* has been recognised by most modern writers, which is referable to the ovaries, and situated deep down behind the inguinal region. It is not by any means clear, however, that the presence of pain in this region is to be considered as diagnostic of any one condition in particular.

It is undoubtedly the fact that inflammatory action circumscribed and limited to the peritoneum covering the ovaries and adjacent parts, the fimbriated extremities of the Fallopian tubes, etc., is frequently present. This is proved by the results of examination of the parts after death. The inflammatory action in question can hardly go on without producing more or less pain; and it is reasonable to presume that a pain or a sense of uneasiness chronically experienced in the ovarian regions, more especially if associated with menstrual disorder or with sterility, is connected with existence of the sub-inflammatory action alluded to.

Like the lumbar pain, or the hypogastric pain, however, pain in this situation may proceed from a vast number of causes. For some excellent remarks on this subject, I would refer to the work of Dr. West, p. 55, Part II.

c. *Pain of Inflammatory character.* Under this head are included all cases in which the ordinary signs of inflammation are present—pain, more or less acute in character; heat and throbbing; tenderness to the touch (which is to be distinguished from that very extreme tenderness met with in hysteria); feverishness; quickness of pulse; etc. These symptoms are often preceded by the occurrence of a rigor. They indicate inflammation of the uterus or its peritoneal covering, or of some of the adjacent viscera, or their coverings; and they are most commonly the consequence of labour, of abortion, and of operations about the genital organs. Rarely do we observe instances of the affection of idiopathic origin.

It seems hardly possible to fail to recognise the inflammatory element in cases presenting the foregoing symptoms. The error most liable to be committed is that of taking for inflammation what is only a hysterical condition. As a rule, hysterical pain is marked by its severity, by its variability, by the suddenness with which it appears and disappears, and by the circumstance that the patient is known to be hysterical, or to have been the subject of hysteria. The condition of the pulse is the best criterion. In cases otherwise closely simulating actual peritonitis, the frequency of the pulse present in the latter affection is wanting.

d. An important class of cases are those in which *pain of an acute and intense character is suddenly felt in the hypogastric region*, accompanied by great prostration, and depression and shock to the system generally. Fainting, great pallidity of surface, weakness or almost complete absence of pulsation at the wrist, a feeling of sickness, with or without vomiting, are symptoms often witnessed in this class of cases.

The symptoms in question are such as to excite suspicion of perforation, or rupture of some of the abdominal or pelvic viscera, with consequent escape of blood or contents of the ruptured viscera into the peritoneal cavity. It is very necessary to distinguish these really alarming cases from a class of cases already alluded to, and which in certain respects may simulate them—those of hysterical origin. The severity of the pain is, by itself, of not much value in a diagnostic point of view. In hysterical cases, there is an absence of symptoms of depression and prostration; and there is, moreover, generally evidence of previous hysterical attacks, or, accompanying the severe hypogastric pain, there are other unmistakable signs pointing to hysteria, feeling of fulness and rising in the throat, slight convulsions, etc. On the other hand, in the really serious cases, the patient has been previously in a state of good health, or at all events free from attacks of hysterical character, and the positive signs of great perturbation of the system only require to be looked for to be detected.

Further, examination of the abdomen gives valuable information. In hysteria there is, together with the pain, great sensibility of the surface, the slightest touch giving rise to complaint, whereas deep slowly increased pressure is not painful; the reverse is true of the class of cases now under discussion. It is only at the onset of the attack that there is any possibility of confounding the perforation symptoms with hysteria.

The conditions which may give rise to the alarming symptoms above described will now be enumerated.

The abdominal or the pelvic viscera may be affected, and there are no marked signs by which it can be absolutely determined at the moment whether the seat of the accident be in the abdomen or in the pelvis proper. The concomitant circumstances generally enable us to decide this point, or the course of the case determines the diagnosis in this particular.

In *perforation of the intestine*, as from typhoid fever, from tuberculous ulceration, or connected with organic disease of the abdominal viscera, etc., the previous history would generally suggest the proper interpretation of the symptoms; and the pain is more usually, perhaps, referred to the umbilicus, or a point above it, than to the hypogastric region.

Certain conditions of the pelvic viscera, especially, are capable of giving rise to the symptoms in question. The following are the most important of these:—

Hæmorrhage causing Peri-uterine Hæmatocele. Effusion of blood here takes place in the pelvis from the ovary or from the Fallopian tubes. The accident mostly occurs during or immediately after the occurrence of a menstrual period. It may happen in women previously healthy, but is more generally, perhaps, observed in women who are anæmic, and in whom there have been menstrual irregularities, profuse menstruation particularly. Walking a long distance, the act of straining, or sudden muscular effort, may precede the attack; the attack may occur without such apparent exciting cause. The symptoms observed in such cases vary in degree of intensity; there are reasons for believing that the accident happens not very rarely, the symptoms being less severe, and the accident escaping recognition. The diagnosis is established by recognising the presence of a semi-solid tumour above the pubis, or pressing on the vaginal walls—the effused blood—such tumour having been before wanting.

Extra-uterine Pregnancy and Rupture. Cases in which the ovum is situated in one of the Fallopian tubes, frequently occasion symptoms having the character of those described. Here the patient is usually known or suspected to be pregnant. There may have been nothing about the case to excite particular attention; but more generally the woman has experienced unusual pains, or more discomfort than in ordinary pregnancy. The rupture occurs in the third or fourth month, or earlier, in the majority of cases, when the ovum is in the Fallopian tube; it is rare that it is postponed much later than this. On the other hand, the time of rupture may be considerably later than this if the ovum be attached just without the tubes, or in the abdominal cavity itself; and there may be no rupture at all, the pregnancy going to full term, with further results, which need not be particularly alluded to in this place. More or less profuse hæmorrhage attends the escape of the embryo from its containing cyst, often so profuse, indeed, as to kill the patient.

Rupture of the Gravid Uterus itself. There are a few very rare cases on record, in which this accident has happened without any very obvious cause. The third, fourth, or fifth months, are the periods during which this has been observed. The symptoms would not essentially differ from those present in rupture of an extra-uterine pregnancy.

Rupture of Ovarian Cysts, and escape of their contents into the peritoneal cavity, does not usually give rise to marked disturbance; in some cases, however,

when concurrently with the rupture there is hæmorrhage, severe symptoms may be produced, more or less identical with those described.

e. A few remarks are necessary concerning some other varieties of pain which may be referred to the hypogastrium or pelvic region. Thus in hysterical women, presence of pain in the hypogastric region is frequently associated with distension of the bladder and retention of urine. These pains are of frequent occurrence. In women suffering from chronic disease of the uterus, the patient often complains of what are called *bearing-down pains*. They more frequently occur in women who have lost flesh and who are in a bad state of health, and in whom the uterus is diseased. Diseases of the uterus involving enlargement of the organ more particularly cause it. So also hypertrophy of the cervix with prolapsus of this part of the uterus, an affection the maximum intensity of which is witnessed in washerwomen. In most cases, where bearing-down pains are present, there is partial or complete prolapsus of the uterus or of its cervix. The bearing-down sensation is also present in cases where tumours of the uterus, pregnancy, polypi, or fibroid tumours, cancer, etc., exist. It may be due to prolapsus of the bladder. The presence of pains of the latter variety generally points out the necessity for exploration of the uterus from the vagina.

Illustrations OF HOSPITAL PRACTICE: METROPOLITAN AND PROVINCIAL.

ST. GEORGE'S HOSPITAL.

CASE OF COMPOUND FRACTURE OF THE SKULL, WITH
DEPRESSED BONE: RECOVERY.

Under the care of PRESIDENT G. HEWETT, Esq.

JOHN C., aged 10, admitted into Fitzwilliam Ward, under Mr. Hewett, on April 28th, 1862.

History. A short time before admission, he was knocked down by a water-cart; his head being jammed between the wheel of the cart and the kerb-stone. He was stunned to a certain extent by the accident; but, he says, he was not rendered perfectly insensible.

On admission, the boy was not insensible, but he was somewhat stupid, as if rallying from concussion. There were three wounds on the left side of the scalp, extending one behind the other in a semicircular direction from the external angular process of the frontal bone to the occiput. There was a fracture of the skull, running through the frontal, parietal, and occipital bones, and corresponding to the external wounds. The lower fragment was completely driven in so as to be overlapped by the upper fragment; the bone could be felt through the wounds to be denuded of periosteum to a considerable extent. There was bleeding from the right ear; none from the left. The pupils were natural, and acted freely. Pulse 90, soft, and compressible; skin warm; respiration quiet.

1 P.M. (three hours after admission). After admission, he became much more sensible, answering questions rationally. He vomited up a quantity of black, coagulated blood. There was slight bleeding from the nose, considerable ecchymosis around the left eye, with effusion of blood under the ocular conjunctiva. The pulse was quiet, 90. The pupils acted. The tongue was dry.

A consultation was held; but it was determined that no operative measures were justifiable. He was ordered three grains of calomel immediately.

April 29th. He was reported to have passed a quiet night, sleeping at intervals. He was quite sensible, answered questions rationally, and gave an account of the accident. He stated that he suffered pain in the head. The tongue was dry; pulse quiet, 84; skin warm and moist. The respiration was quiet and natural, 17 in a minute. The bowels had not acted. The pupils were natural. There was a quantity of coagulated blood about the wound. All bleeding from the ear and nose had ceased, and he had not again vomited.

April 30th. He had passed a very restless night, and was throwing himself about, and continually moving his position. He was, however, perfectly sensible; but said that he suffered considerable pain in the head. There was a little pus oozing out from under the dried scab, and a little erysipelatous blush around the wounds. The tongue was dry and furred; the face flushed. Pulse 96. The powder was repeated.

May 1st. There was much less pain in the head, and he was much quieter. There had been a copious evacuation from the bowels. The tongue was clean and moist; pulse 78, soft.

May 3rd. He had not passed such a good night. There were considerable swelling and puffiness behind the left ear. An incision was made, and a quantity of bloody pus and brain-like substance evacuated.

May 6th. He was still without any head-symptoms. The wound was quiet, and discharged a small quantity of healthy pus. He suffered no pain. The pulse was quiet, 78. The tongue was clean. The bowels had not been open for three days. The ecchymosis around the eye was fast disappearing.

May 8th. There was noticed to be slight facial paralysis of the left side. He suffered no pain, and, to use his own expression, "felt quite well".

From this date he went on well. The wound granulated freely, requiring the free application of lunar caustic. The facial paralysis gradually disappeared, and the blood effused under the conjunctiva was absorbed. After a time he was allowed to get up; but he was kept under observation till June 18th—without, however, manifesting a single bad symptom—when he was discharged. At this time there was still considerable depression of bone; the skull having a generally flattened appearance on the left side. The wounds, however, were quite healed up; and the boy looked in perfect health.

REMARKS. The amount of injury to the head which children will sustain, as compared to adults, is so great, that the surgeon is justified in giving a much more favourable prognosis in a case resembling the preceding, than when the same amount of injury occurs in a man. It is seldom, however, that we see a case, even in children, in which the injury is so extensive as it was in this, recover; for, superadded to the depressed bone, this boy had undoubtedly fracture of the base of the skull—an injury in itself almost fatal.

The great point in regard to all such cases as these is the question as to whether the depressed bone ought to be elevated or not. If there be symptoms of compression, of course no one would hesitate a moment about the advisability of the operation. The patient cannot be put in a worse condition than he is, and most probably his death will not be hastened by the operation; and, on the other hand, there is just the possible chance of benefiting your patient, though, unfortunately, it is very rarely that any benefit does accrue from this operation. But in those rare cases in which there is depression of the bone, without symptoms of compression, the line of practice is somewhat unsettled, as to whether an operation for elevating the depressed bone should be performed or not. Sir Astley Cooper, in his *Lectures*,