Lectures

ON THE

DIAGNOSIS AND TREATMENT OF DISEASES OF WOMEN.

DELIVERED AT ST. MARY'S HOSPITAL MEDICAL SCHOOL.

BY

GRAILY HEWITT, M.D.LOND., M.R.C.P.,

PHYSICIAN TO THE BRITISH LYING-IN HOSPITAL; LECTURER ON MIDWIFERY AND DISEASES OF WOMEN AND CHILDREN AT ST. MARY'S HOSPITAL MEDICAL SCHOOL.

PAIN REFERABLE TO THE GENERATIVE ORGANS.

THE abnormal sensations attendant upon or connected with micturition and defæcation have been duly discussed. There remain for consideration the various pains referable more particularly to the generative organs, and which are usually seated in the pelvis or in its immediate vicinity.

Pains referable to the generative organs may, for the sake of convenience, be divided into two classes, viz.: 1. Those associated with the performance of the function of menstruation—*dysmenorrhœa*; and 2. Painful sensations experienced irrespective of menstruation.

A. PAINFUL SENSATIONS ASSOCIATED WITH MENSTRUATION.

The term "*dysmenorrhœa*" has been long employed for the purpose of designating the symptoms now to be considered; it has been used to designate cases in which *pain* or *difficulty*, one or both of these, attend the performance of the function of menstruation. The term itself has had an injurious effect in giving the idea of a distinct disease for what is really a collection of symptoms due to causes variable in their origin and widely different in their nature. What we have now to do is in the first place to examine and analyse the symptoms in question, and to endeavour to lay down some rules for the due discrimination of the several causes which may produce them.

The phenomenon with which we have to deal is the presence of *pain*. And it is obvious that the first object we have in view both in endeavouring to understand the thing abstractedly, and in making a diagnosis at the bedside, is to try to understand what is the essence of this pain.

I propose, then, to devote a little space to the consideration of this question:—

WHAT IS THE CAUSE OF THE PAIN IN CASES OF DYSMENORRHOEA?

In reference to the pathology and treatment of *dysmenorrhœa*, this question is of primary importance; but it is nevertheless true that hardly any attempt has been made by systematic writers on this subject to give an explanation of the actual and precise nature and seat of the painful sensations experienced by the patient. The explanations which have been offered, and which are so far generally accepted, are not so consistent either in themselves, or with the facts which come before us in practice, as might be wished.

Now what are the facts? Hardly two patients

suffer alike during menstruation; and we see a regular gradation between cases in which there is very slight suffering, and cases in which the agony is such as to be almost unendurable. The pain also varies in its position, but it is for the most part referable to the uterus; and, in the cases where there is most pain, the pain is generally identical in position with that of this organ. Pains of various degrees of intensity may be felt at other parts of the body; but they are added, so to speak, to the other—the essential pain, which is situated in or about the pelvic region of the body.

What is the relation of the pain to the flow of the menstrual fluid? This, being the vital point of the whole question, demands our earnest attention.

We find in practice several varieties in respect to the manner in which these two things, the pain and the flow of the fluid, are related one to the other.

In some cases, it will be found that the menstrual fluid escapes from the uterus from the first; while the patient has a little, but only a little, to complain of during the whole menstrual period.

In other cases, on the contrary, the appearance of the menstrual fluid is delayed for a certain time, and in the meanwhile the patient suffers more or less severely from pain; the discharge appears, and the pain thereupon quite or almost completely ceases.

We have, then, two classes of cases—1. Those in which there is pain *and* difficulty; and 2. Those in which menstruation is simply painful, the discharge being apparently free.

1. The first class of cases are those more ordinarily spoken of under the general term "*dysmenorrhœa*", and it is to this class of cases that the observations now to be made are chiefly applicable. The word "*dysmenorrhœa*" is used widely enough; but it is usually taken to mean pain as well as difficulty in the process of menstruation, as will be evident from the following quotations from two works of standard authority—those of Dr. West and Dr. Rigby—which further contain descriptions of the symptoms of *dysmenorrhœa* as usually observed.

"The pain," says Dr. Rigby, "precedes the discharge, and rises to its acme just before the discharge appears. When this has taken place, the congestion diminishes, the pain abates, and perhaps disappears before the discharge has ceased. This, on the whole, is the most common mode of its appearance. In many cases, however, the discharge appears first; and, having lasted for a short time, it stops suddenly or diminishes considerably, and is then followed by an attack of pain which continues until the discharge returns." (P. 30.)

Let us hear Dr. West's description of the *congestive* form of *dysmenorrhœa*.

"During the first twenty-four or thirty-six hours of each menstruation, the discharge in general is but scanty, and the pain is very severe. At the end of this time, however, sometimes even sooner, the hæmorrhage often becomes abundant; and, as the blood flows, the pain abates, and then ceases altogether. . . . Sometimes, in these cases, the menstrual flux at no time becomes abundant, and consequently the relief which nature gives is very partial. When this is so, the womb continues to ache and throb during the whole of the menstrual period, and is left afterwards tender and painful." (P. 71.) Further: "In some of the cases, the discharge, having continued for a few hours, ceases, and then comes on again; while, though *scanty*, it is in-

termixed with small coagula, owing probably to the blood having been poured out so slowly as to allow of its coagulating within the uterine cavity." (P. 71.)

It is impossible to read these descriptions—and we know that they are truthfully drawn—without being struck by the evident connexion of the *pain* with the *absence of the discharge*. "The pain rises to its acme just before the discharge," says Dr. Rigby. "As the blood flows, the pain abates, and then ceases altogether," says Dr. West. In fact, it is as clear as anything can well be, that the pain is dependent, in these particular typical cases, on absence of the discharge.

But how dependent? Is the pain caused by non-secretion of the fluid? or is it caused by *retention* of the menstrual fluid, there being some impediment to its escape from the uterus? Dr. West explains the matter thus:—

"The congested womb ached till nature bled it, just as the head aches when the brain is congested, till the cupping-glasses or the leeches have relieved the overloaded cerebral vessels." (P. 71.)

This explanation of Dr. West's is the one which has been generally received and acted upon.

Dr. Simpson, a still more recent writer on the subject, says, in reference to the seat and origin of the pain in dysmenorrhœa, that it is "one of those points on which our knowledge is particularly defective"; and he refrains from dwelling on the subject. Dr. Simpson considers that there is an ovarian and an uterine form of dysmenorrhœa; and, further, that there is a neuralgic, a congestive, an inflammatory, a gouty or rheumatic dysmenorrhœa; a dysmenorrhœa caused by organic diseases or displacements; a membranous dysmenorrhœa; and, lastly, an obstructive dysmenorrhœa.

The explanation given by Dr. Simpson is to all intents and purposes the same as that of Dr. West and others, so far as cases of ordinary dysmenorrhœa are concerned; but, in reference to cases of "obstructive" dysmenorrhœa, Dr. Simpson associates the pain with the *retention* of the menstrual fluid, and with the distension of the uterus thereby produced. But it will be found, on examination, that the symptoms of ordinary dysmenorrhœa, as described by Drs. Rigby, West, and others, and the symptoms of "obstructive" dysmenorrhœa, are to all intents and purposes identical; and the arguments derivable from an attentive consideration of these symptoms lead to the conclusion—a conclusion which, I think, must be accepted—that the pain suffered by patients in ordinary cases of dysmenorrhœa, *i. e.*, where there is delay in the appearance of the discharge, is due to retention of menstrual fluid within the uterus, and to the distension thereon consequent.

Let us consider for a moment the normal condition and presumed physiological action of the parts concerned in menstruation.

The essential part of menstruation, so far as the uterus is concerned, appears to be, growth, thickening and increase of vascularity in the mucous membrane lining the body of the uterus, the tissue of the uterus itself being also congested, and the venous plexuses situated around the uterus being filled and gorged with blood. The menstrual blood is poured out, as is generally believed, by the mucous membrane of the body of the uterus. Now, where the body of the uterus and the cervical canal join, the canal is much

narrowed; and, in cases where there has been no reason to suppose any morbid narrowing to have occurred, it has frequently been found so small as to admit with some degree of difficulty the bulbous termination of the uterine sound. Hence it follows that, in a by no means insignificant proportion of cases, the internal os uteri, as it is termed, is so narrow that very little is needed to close it altogether, or at all events to so close it that the escape of fluid from the uterine cavity is rendered difficult.

It has been said that we find that "such a contraction of the os and cervix uteri as to impede the discharge of the menses *guttatim* is very unusual" (Dr. West). But I would remark, that a canal which may be a very sufficient outlet in one individual, or under one set of circumstances, may be inadequate in another individual and under different circumstances. There are many things to be considered, in respect to each of which considerable variations are observed; there is the state of vascularity of the uterus itself; there is the state of vascularity or fullness of the surrounding organs; there is the quantity of blood poured out into the uterine cavity; etc. In reference to the variations in the quantity of blood poured out, Dr. Simpson (*Med. Times and Gaz.*, March 12th, 1859) makes some remarks which are entirely in unison with my own ideas on this part of the subject.

"When the amount of fluid secreted is too great to allow of its easy escape, it becomes accumulated in the cavity, and causes pain by distending and exciting the uterus. . . . In this way, retention and obstruction may even occur with a comparatively wide os, provided the menstrual fluid be very rapidly secreted, and especially if it be mixed up with solid masses of coagula or fibrine; and, on the other hand, in cases where the uterus gives out only and always a very small and scanty, or rather a very slow secretion, no pain may be experienced, although the os may be of the smallest calibre."

These observations, which are made by the author in question in relation to obstructive dysmenorrhœa only, I would apply more generally to those cases of dysmenorrhœa in which pain and delay in the appearance of the discharge are associated.

But, further, the uterus is liable to certain morbid alterations in position and texture which may still more materially affect the patency of the canal of exit. Thus it may be bent on itself like a retort, by which the canal is necessarily somewhat constricted, or the axis of the canal so altered as to affect sensibly its patency. Within the tissue of the uterus frequently grow fibrous tumours, which may, and do frequently, encroach on the canal, and may thus constrict it. The same result may be produced by polypi growing within the uterine cavity itself; and occasionally we find the whole cervix uteri congenitally narrow, from an apparently defective development of this part of the generative organs. And a very important class of cases are those in which the lower segment of the uterus—the cervix, has become hypertrophied, indurated, and otherwise diseased: here the canal may be contorted and twisted in such a way that the extra amount of congestion which occurs at menstruation so swells out the cervical tissues as to seriously affect the patency of the canal.

All these considerations are sufficient to show that we have not far to go in order to find a number of

conditions capable of producing constriction of that canal by which the menstrual fluid is evacuated from the uterus. Conditions of the kind alluded to are known to be associated with severe dysmenorrhœa; and the pain in such cases is completely accounted for by the retention, temporary or partial, which we may suppose to be present under these circumstances.

Further, it is probable that the congestion of the uterus which is present during menstruation, involving as it does a certain "erection" of the organ, may impede the escape of the secreted fluid by producing constriction of the excretory canal, and thus lead to menstrual retention. This would be more likely to be observed in cases where the canal itself was of less than the average calibre. The category of cases here alluded to may, in one sense of the word, be considered as cases of "spasmodic" dysmenorrhœa; and they are doubtless those with which we are familiar in practice as particularly amenable to an antispasmodic treatment.

Another argument for the truth of the explanations now offered may be drawn from the facts, that, in the first place, dysmenorrhœa of the kind now under consideration is generally associated with sterility; that, in the second place, it is not observed in women who have had children, unless in connexion with that actual recognised obliteration of the canal which is sometimes the result of the parturient process; and, in the third place, from the results obtained by what may be termed the mechanical treatment, consisting in dilatation of the utero-cervical canal, or incision of the same. It is incontestable that, in many cases of severe dysmenorrhœa, the pain has been removed by the treatment in question, which would, of course, have the effect of preventing the occurrence of menstrual retention by widening the canal of exit.

But, further, we derive important confirmation of the truth of the position here maintained—that the chief cause of the pain in these cases is obstruction to the passage of the blood through the internal os uteri—from a careful study of the symptoms and phenomena observed in cases where actual obliteration of the os uteri, permanent or temporary, has been known to be present, the menstrual product having been retained within the uterus, and unable to escape. In the recently published work of Bernutz and Goupil, we find collected a very large number of accurately observed cases in which the kind of menstrual retention now alluded to was unquestionably and demonstrably present, and means are thereby afforded for studying the subject analogically, so to speak. The resemblance is indeed very striking in the symptoms, in regard, at least, to the *kind* of the symptoms present—between these cases of complete retention of the menstrual fluid, and those more common instances which would, according to the view of the matter now maintained, be considered as cases of incomplete or partial menstrual retention.

An observation of Scanzoni's is very important in reference to the subject now under discussion. Speaking of nervous dysmenorrhœa, Scanzoni says:

"The causes of this anomaly are still imperfectly known. . . . Finally, in an etiological point of view, the following circumstance also deserves consideration, that the abnormal nervous irritation of the uterus may give rise to reflex movements of the organ, and to a convulsive contraction of the cavity of the neck. Hence the

escape of the blood which is already effused, is impeded by an obstacle which irritates in its turn the motor nerves of the body and fundus of the uterus, and thus provokes painful contractions. This is what to us appears particularly to take place in cases where, after intense expulsive pains lasting perhaps several hours, the patients suddenly eject a considerable quantity of blood, partly liquid and partly coagulated, and find instantaneous relief." (*Diseases of Females*, American Translation, p. 345.)

The tendency in Scanzoni's mind towards an "obstructive" explanation of the pain is hereby made particularly evident.

And, lastly, it is known and admitted by standard writers that, in cases of dysmenorrhœa, the tumour perceived through the abdominal walls increases in size before the discharge appears—a fact which is perfectly consistent with the explanation now offered.

I have sought carefully, but have been unable to find any clinical facts which tend to disprove the truth of the position now maintained, that in ordinary cases of dysmenorrhœa, in which there are, first pain, and, after a variable time, appearance of a discharge, what we have before us is really *partial but temporary menstrual retention*.

Naturally, the cavity of the uterus is very small, and incapable, unless dilated, of containing more than a very small quantity of fluid. It is the result of experience, that different individuals bear dilatation of the uterine cavity very variously; and hence it follows that retention of menstrual fluid within the uterus may produce different degrees of pain and very various degrees of suffering in different individuals.

There is a class of cases, not very common, in which, as a result of menstruation, there is ejected from the uterus a membranous substance, when ejected entire forming a complete cast of the interior of the uterus. The pain present in these cases of "membranous dysmenorrhœa", as they are called, is evidently connected with the difficulty experienced by the uterus in expelling this membrane through the narrow internal os uteri; and this membrane itself may perhaps, by blocking up the canal of exit, give rise to partial retention of the menstrual fluid.

But it may be said there are surely cases in which the patient complains of pain during menstruation, and in which there is no evidence of menstrual retention, in which the discharge of blood is from the first continuous. This is undoubtedly true. And, further, we have evidence to show that in certain cases, when the uterus being absent, but the ovaries present, there have been periodically observed pain and symptoms slightly resembling those attending cases of dysmenorrhœa. But neither the one nor the other statement interferes with the reasonableness of the explanation here offered of the nature of the pain in ordinary cases of dysmenorrhœa.

[To be continued.]

AN EMBALMING UNDERTAKER. The following advertisement appears in the *London Gazette* in the year 1684:—"William Russel, coffin-maker, who hath the art of preserving dead bodies without embowelling, sear-clothing, cutting or mangling any part thereof, and hath used it to the great satisfaction of those honourable persons, by whom he hath been employed, lives at the sign of the Four Coffins in Fleet Street. Coffins ready made, and the body preserved for five pounds."