PROBLEMS OF THE CLIMACTERIC*

BY

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Of the vagaries of the ovaries there is no end, while the symptoms of the menopause present problems to every practitioner of medicine, whether orthodox or heterodox. This twilight of femininity is treated in the majority of textbooks with a respectful silence; the average teacher, be he physician or gynaecologist, hints to the waiting student that it is a nuisance that has to be tolerated, and sums up its treatment with the text of mist. pot. brom. et valer.

The physiologists tell us that the cyclic activity of the ovaries is controlled to some extent by the anterior lobe of the pituitary gland, which also provides a thyrotropic hormone to stimulate thyroid secretion. It is so far unknown to what extent, if at all, the normal menopausal changes in the ovary are due to pituitary failure. The adrenal cortex has also some association with ovarian function: it is well known that certain tumours of the adrenal cortex manifest themselves in female children by the precocious onset of menstruation and the development of secondary feminine characteristics. At the other end of the scale certain of the climacteric characteristics—notably hyperpiesia, cutaneous vaso-dilatation, and cardiac acceleration—are probably caused by overactivity of the sympathetic system and the adrenal glands.

The climacteric may be described as the smouldering fire of the endocrines, in which, from time to time, certain embers flare up, emit sparks, and subside into cold ashes. The age of onset of the menopause varies considerably, but seems to bear some relation to that of the onset of puberty: a patient who has arrived early at puberty may meet the menopause at 40; one who has been late in developing may not be able to say good-bye to the plague until her sixtieth birthday. The result of this irregularity is inevitable: the practitioner consulted by a woman patient between the ages of 40 and 60 is apt to discount symptoms of which she may complain as being due to "change of life." Whereas there is no doubt that all symptoms stand out more sharply against the gloomy background of the climacteric, there is no excuse for those who do not set to work conscientiously to eliminate possible organic causes for these symptoms.

Every day women come to all of us with voluminous complaints of strange and remarkable feelings, which mean so much to them that they are prepared to talk for hours to a sympathetic listener, but, if rebuffed, are apt to take their revenge by writing reams of heavily underlined, badly punctuated, and somewhat incoherent detail. Let us try, if we can, to carry out a systematic physical examination, in order that we may assure ourselves that the various systems of the organism are not sharing the degeneration of the genital tract.

Need for Systematic Examination

Many of these patients are the subjects of chronic infection, particularly of the paranasal sinuses, teeth, gastro-intestinal tract, and urinary tract. It is necessary to stress the importance of the first and last of these systems. We have all heard how careful investigation of chronic mental cases has revealed the relatively high incidence of sinus infections, while the treatment of these foci has resulted in the restoration of mental health. Similarly, many women who feel tired and depressed, perhaps with occasional bouts of fever, are found to harbour *B. coli*

and pus in their urinary tracts. The teeth are usually suspect, and the presence of rheumatism, neuritis, or halitosis is sufficient evidence to transfer the patient to a competent dentist who does not despise the help of a radiologist.

As for the gastro-intestinal tract, woman has been described as a constipated mammal with a pain in the right side. We need not necessarily install a colon station in our garages or back kitchens, but, by means of increased fluid input, psyllium seeds, and lactic-acid-bacillus emulsions, we can do something to help their sagging, bulging colons and clear their fallow skins. Our physical examination will also aid us to eliminate the ordinary chronic diseases, such as pulmonary tuberculosis, Addison's anaemia, Bright's disease, and diabetes mellitus, which may give rise to symptoms of fatigue, dyspepsia, sweating, and similar menopausal complaints.

Two Common Types

When we have cleared the air in this way we may be able to recognize a clinical type. One of the most common types among the well-to-do is that presenting the triad of obesity, hyperpiesia, and arthritis of the knee-joints. These cases are particularly amenable to treatment by diet and thyroid administration, and need not detain us.

Another common type is that of the small, thin worrier—the woman whose children have gone out into the world and whose husband has been nagged by excessive mother love into the public-house, the club, or the dog-track. This is the woman who cannot sleep, suffers from noisy belchings, palpitations, and strange feelings that commence in the pit of the stomach and go to the top of her head, where she experiences a sensation of weight and oppression. She commonly complains that she has curious sinking feelings, and would like to fly away. She lives on strong tea, aspirin, cigarettes, or brandy. It is reasonable to suppose that she suffers from excessive adrenal activity, disturbance of the solar plexuses of the sympathetic, and hyperglycaemia, due to excessive mobilization of glycogen. This type is benefited by bromides, sumbul, and valerian to depress the sympatheticotonia, while her nips of brandy or cups of tea should be replaced by administration of boiled sweets or glucose.

These two examples of clinical types are distinctive, and should be treated quite differently—the first by starvation, the second by feeding.

Development of a Neurosis

Finally, we may consider quite briefly the psychological manifestations. As has been hinted above, the woman at the menopause is often lonely, either unmarried and brought to bitter realization that the male has passed her by, or else, having been married and brought up her family, these have left the home to fend for themselves and she no longer has an outlet for her natural maternal devotion; her husband, if at all active, will tire of her solicitude and fly; if passive, will meekly acquiesce in her tirades and indulge her curious fancies. The result is, in some cases, the development of a definite neurosis, most commonly melancholic, sometimes manic-depressive, and almost always an obsession that the patient is the victim of some obscure or malignant disease.

In the present state of society the treatment of these cases is almost impossible. Early treatment is offered at the out-patient clinics of optimistic mental hospitals, but the name is in itself sufficient to prevent most of these patients from going near the physicians who are best qualified to help them. It would appear that the underlying factor in these psychopathological cases is lack of

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education: the woman is deprived of her family cares and does not know how to fill the gap. We offer the doctrine of sublimation, gardening, literature, the fine arts, the Church, but she has not the mental capacity or training to enjoy them. The most successful navigators of the menopausal rapids are those women who have been adequately educated and can direct their maternal instincts to social welfare, their physical activities to gardening or "Guiding," their fantasies to literature or Anglo-Catholicism.

Clinical Memoranda

Severe Dyspituitarism in a Child

A case of dyspituitarism of Fröhlich's type in a child has recently come under my care. The condition is so severe that I think the particulars would interest your readers. The child is now 2 years and 9 months, and weighs 7 st. 2½ lb. Below is a photograph of the child with his mother and also brother of 4½, who is quite normal.

At birth the child weighed 7 lb., and his mother tells me she had a normal labour. The baby, however, immediately began to put on weight at an abnormal rate. The following figures will give some idea of his progress: at 1 month, 9 lb. 8½ oz.; 3 months, 16 lb. 6 oz.; 6 months, 29 lb. 8 oz.; 10 months, 46 lb.; 1½ years, 63 lb. 12 oz.; 2 years, 76 lb. 4 oz.; 2½ years, 91 lb. 8 oz.; 2¾ years, 100 lb. 8 oz.

That this increase in weight is due to increase in adipose tissue and not to skeletal over-development is shown by the fact that the child's height is only 36½ inches, his skull circumference is 21½ inches, and he has small feet, and hands with tapering fingers. His skin is soft and his hair fine. At this age, of course, it is impossible to gather much information from the condition of the sexual organs, but so far they appear normal; both testicles are descended.

The condition would appear to be one of hypopituitarism, a true case of Fröhlich's syndrome. Whether it is caused by a tumour I have not yet been able to satisfy myself. There are no signs of tumour, no optic atrophy, no oculomotor palsies or epilepsy, but I have not yet been able to obtain a satisfactory x-ray as the child is so restless. The urine is sugar-free. Moreover, the mentality of the child seems to be normal; he is clean, talks, sings hymns, feeds himself (he is left-handed), and has a good memory. The teeth are normally developed and good. He is not able to walk or stand, but this is scarcely to be wondered at with his enormous bulk; he can crawl and kneel, and is very active. I hope to be able to get this child into a London hospital for investigation and treatment, as I think his condition could be greatly improved, but at present his parents are very unwilling to let him go.

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Gastric Carcinoma with Duodenal Ulcer

The combination of gastric carcinoma and duodenal ulcer seems sufficiently rare to warrant record.

A woman, aged 59 years, was admitted to the Salford Royal Hospital for gastrectomy, a diagnosis of carcinoma of the lower extremity of the oesophagus having been made. Two hours after admission, whilst in the bath, she complained of sudden and very severe abdominal pain. On inspection she indicated the epigastrium as the site of intense pain; respiration was shallow and the abdomen motionless. On palpation rigidity and tenderness were marked, more especially in the epigastric region.

There was no doubt that a perforation had occurred, but it was suggested by those who had seen her shortly after the onset of the pain that its position indicated the pyloric rather than the cardiac end of the stomach as the site of perforation. This opinion proved to be quite correct, for at operation, although there was a large and fixed carcinoma of the cardia, the perforation was of the anterior wall of the duodenum immediately beyond the pylorus. The opening was utilized for a duodenostomy by Witzel's technique, and recovery from the operation was uneventful.

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Use of an Omental Plug in Perforation of Stomach

Recently I had a call to Clydach War Hospital to operate on a man, aged 43, who had "perforated" about an hour previously. His doctor, Dr. Morgan, who gave the anaesthetic, had great difficulty in overcoming the rigidity. The perforation was high, near the oesophagus, and, added to these difficulties, I was without an assistant.

A curved intestinal needle on a holder snapped on attempting to suture the perforation. I took a stronger, round-bodied needle, but it tore up the friable stomach wall. An omental tag was then fixed on to a chromic ligature on a curved needle. This needle was passed through the perforation, into the stomach, and forced through a healthy portion of stomach a little distance away. The ligature was then pulled sufficiently to cause the omentum to plug the hole. It was then hitched to the stomach wall. One further stitch was put in the neighbourhood of the plug as it entered the perforation.

The following day the temperature rose to 100° F., and remained up for forty-eight hours. There was some hiccup, which was relieved by atropine and morphine; otherwise the patient made a satisfactory recovery and caused no anxiety.

I have always felt that the usual graft placed over a suturing would readily be floated up if there was a gush of fluid, unless it were well sutured, whereas the plug readily blocks the opening without the need of elaborate suturing. Some years ago, at the same hospital, I had to deal with a pyloric perforation, where the difficulties of friability and lack of elasticity rendered suturing impossible, and for the first time I adopted this method. The result was most gratifying. I only felt justified in using this unorthodox method as a last resource, and have therefore avoided it when the more usual measures have been possible. I have never heard of the method being used before, and I now wonder whether perhaps this simple procedure might be all that is needed for the closure of a perforation. It has the advantage of simplicity and the absence of puckering. It would be interesting to know if others have tried this method and would follow the suggestion that it might be tried in cases where the ordinary procedures are impracticable.

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