A Paper

ON

THE CHRONIC PELVIC WOMAN*

BY

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At the outset I should apologize for, or explain, the title of this paper. When thinking of a true medical description of the conditions to be discussed it seemed impossible to find a sufficiently inclusive term, and resort to a colloquialism was necessary. I can, however, claim justification both by precedent and by the more important reason that it describes a well-known clinical type. Some years ago, Dr. Hutchison gave us an analysis of what he called the "chronic abdominal woman," and showed her to be a very real medical problem, with whom we were only too familiar. In this paper I am dealing with a similar condition in which genital rather than alimentary symptoms predominate. The difficulties of diagnosis and management are, in many ways, the same, but there are sufficiently important differences to justify an account of how these patients are viewed by the gynaecologist.

DISORDERS OF MENSTRUATION

The condition we are considering may comprise any or all of the common pelvic symptoms, together with others referred to any part of the body. The paramount importance of the reproductive system in women is the reason for the usual prevalence of pelvic symptoms, and of these the most marked are those of menstrual disorder. Pain for several days before the period is felt in the back, abdomen, and thighs, with headache and breast-ache, followed by pain lasting the whole time of menstruation and perhaps for a few days after it. The persistence of pain throughout the period is characteristic of the functional or non-organic type of dysmenorrhoea. True spasmodic dysmenorrhoea may be intense, but it seldom lasts more than a few hours, while the congestive dysmenorrhoea of organic pelvic lesions is pre-menstrual in time and usually disappears soon after menstruation starts. Another feature of the dysmenorrhoea of the menstrual invalid is the existence of other aches and pains all over the body, often with nausea and vomiting, and frequency and pain on micturition. Menstruation is reported by the patient to last longer than normal, sometimes for ten or twelve days, and to return in three or even two weeks. The loss is described as excessive, with large clots, though usually these patients do not appear to be as anaemic as one would expect from their description. The intermenstrual interval is a period of recovery from the debility produced by the last menstruation, followed by a few days of fear and preparation for the next. During this time she is likely to complain of fatigue, backache, and lower abdominal pain. These vague pains are commonly unrelated to the ordinary causes of discomfort, and an attempt to trace their origin fails. Backache is one of the chief complaints, but instead of conforming to what we should expect, it may, to our surprise, be worse on lying or sitting down. There is not the ordinary relation between cause and effect; in other words, the pains are capricious in their onset and behaviour.

SIGNS AND SYMPTOMS OF DYSMENORRHOEA

In an attempt to emphasize the reality of symptoms these patients describe them with a great wealth of detail. Particularly is pain minutely described—its site of origin,

to where it radiates, and how it is burning, shooting, stabbing, or aching. For the same reason the word "terrible" is commonly used, to ensure that the doctor will regard the pain as a very real trouble. Other symptoms which are frequent are leucorrhoea and dyspareunia. The latter is important, as it is often the cause of marital unhappiness, which serves further to aggravate the patient's distress. A careful consideration of the nature of the dyspareunia will sometimes give the clue to the true aetiology of the whole condition. To this I shall refer later.

An examination of the pelvis often reveals no lesion, but a general survey of the patient usually finds her anxious, tired, and thin, with abdominal laxity, toneless muscles, and flatulent dyspepsia. There may be general or local abdominal tenderness, but no muscular defence, and nothing but a spastic colon, mobile kidney, or inflated tender caecum can be discovered. The scars of surgical operations are often to be seen. Other patients (parous women) may have some prolapse of the vagina, with a soft, relaxed perineum corresponding to the similar condition of the abdominal wall. Almost inevitably there will be a torn cervix with leucorrhoeal discharge. The uterus may be a little retroverted, enlarged, and soft. It is always tender, and pain is caused by moving the cervix: this may give the impression of adnexal disease, but thickened tubes can seldom be felt. The ovaries are often low-lying, easily palpable, and always extremely tender to the gentlest touch. Indeed, a feature of the vaginal examination is the general increased sensitivity of the whole pelvis, so that the pain is out of all proportion to the pressure or thrust of the finger. This pelvic tenderness is noticeably present without the fixity, induration, or adventitious swellings which are the organic accompaniments of painful vaginal examination.

TYPES OF PATIENTS

The chronic pelvic woman is found among the married and the single, parous and nulliparous, and at any age between 20 and the menopause. They are represented in all social grades: hospital out-patients provide nearly as many examples as the private consulting room, though the types are different. Of the hospital class a moment's thought will recall the tired middle-aged woman with the lax abdomen and perineum after many confinements. Poverty forces her to work away from home, where, again, she will find no rest with a large family of young children. Prolapse, pain, menstrual excess and frequency, visceroprosis, flatulence, and constipation all reduce her to a state of physical and mental misery.

On the other hand, we have the young woman who, largely because of foolish upbringing and little real occupation, has become a menstrual invalid. Or again, the unmarried woman in the thirties or early forties who has been disappointed in love and starved of sex, and who lives a life of wearisome monotony as a household drudge to tedious and exacting parents. These are some of the types. We can think of others, but they all have the chief features in common, though they may emphasize different groups of symptoms.

SIGNIFICANCE OF PAIN AND TENDERNES

The underlying cause of the chronic pelvic condition may be obvious or obscure, but in no other disease is it more important to arrive at the truth, for on a knowledge of the cause will hang the decision of alternative and diametrically opposite treatments. In spite of the diversity of complaints and social types there are two main groups. In the first no physical signs can be found; in the second there is a sufficient organic cause to explain adequately all the symptoms. If all patients were so sharply divided as this there would be no difficulty in

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diagnosis, but the practical clinical difficulty is to assess the value of what may be a trifling lesion as a possible cause of pain. Or sometimes there is the uncertainty lest some deeper trouble in the pelvis or abdomen should be missed, even though a careful examination has been made. The emphasis of a trivial condition, often known and exaggerated by the patient, is the commonest mistake made. Examples are the incrimination of a harmless retroversion of a normal uterus, or invention of the hypothetical "ovaritis." In forming a judgement on this important matter it is necessary to keep a sense of proportion and to stop and ask oneself if it is likely, or even possible, that so profound a disturbance as has been described, with so much physical and mental misery and pain, can conceivably be caused by a lesion so unimportant. The presence of tenderness on examination is regarded too seriously. Tenderness so often means nothing, and should seldom be considered if there are no other physical signs. For example, tenderness means nothing if it is universal, or if the organs are otherwise normal on vaginal examination. Tenderness is not sufficient for diagnosis of chronic salpingitis and "ovaritis." There must be swelling, induration, or fixity. A misinterpretation of tenderness is a fruitful source of error.

PSYCHOLOGY OF THE PELVIC WOMAN

There will probably be clear localization of pain and well-defined menstrual complaints. This is the type of patient who is so often labelled "ovaritis" or "retroversion," because consideration goes no further than her pelvic organs. We so easily assume that a pelvic pain means a pelvic disease, and we find it so difficult to realize that symptoms so strongly expressive of organic disease may be entirely explained on a nervous basis. It is only after a long touch with practical medicine that we appreciate the reality of the neuroses as causes of physical ill-health. The great physiological importance of the reproductive system in women offers an explanation of why neuroses in women so often manifest themselves through functional disorders of the pelvic organs. We must be alert, therefore, to suspect a neurotic basis in all those cases in which there are detailed complaints but no definite physical signs to support them. The remainder of the consultation should be devoted to an attempt to find the mental stress or emotional blow which has shaken the woman's mental stability and undermined her confidence. In many simple cases it is easy to discover quickly an obvious emotional cause of the trouble.

It is not really within my province to deal in detail with the clinical aspects of neurasthenia, but all of us, especially those who have much to do with women's diseases, should have a sufficient knowledge to enable us to recognize a neurosis and treat the simple cases. Perhaps in no other branch of medicine are the baleful effects of specialism more plainly seen than in the attitude of mind of the gynaecologist who regards his work as primarily a branch of surgery. Whatever may be his surgical dexterity, no man should practise gynaecology unless he is alive to the reality and importance of its association with the neuroses. Only by this wide outlook can he regard the diseases of women as a whole, involving not only a knowledge of surgical technique, but also a sympathetic familiarity with the emotional structure of a woman's mind and temperament. I make no apology, therefore, for asking you to think of the psychological aspect of our subject, even though I am not a psychologist.

Let us first consider some of the common forms of mental stress met with in the gynaecological consulting room. It is well to remember, first, that resistance to emotional stresses varies according to the mental constitution. Some are made of poor material and will bend easily,

while others are so tough as to yield only under utmost provocation. It is important, therefore, to estimate how far the patient's mental and nervous make-up and upbringing are weaker than normal, and, thus, her liability to suffer strain. We find in our consulting rooms either the feeble woman reacting excessively to the ordinary stresses of life or, what is a rare event, the normal woman who has broken down under intensity of stress. It is not difficult to find out the type of patient we are dealing with. A little conversation and knowledge of their past and family life will be sufficient to estimate the character.

UPBRINGING AND FAMILY RELATIONSHIPS

Not only may the raw material be poor and weak, or strong and resistant, but the upbringing throughout childhood may have implanted a wrong view of life. The child may have been spoilt and pampered, and thus have grown up egocentric, with a mental gaze turned inwards on itself. If, in addition to a childhood and adolescence of excessive mother-care, the individual becomes a pampered adult shielded from life's normal stresses, and without any great mental ability and resource which will provide external interests, the stage is indeed set for a succession of functional symptoms which may well defy all attempts at treatment. If, therefore, we can trace pains and other symptoms to the operation of emotional stresses, let us consider for a moment what such stresses may be, particularly those which may produce the "chronic pelvic woman." As I have already said, human, family, and sex relationships play a predominating part in the life of a woman, and just as there is a tendency for the symptom-reaction to be pelvic, so the emotional stresses spring chiefly from family relationships. Perhaps the commonest is the distress arising not only from marital infidelity, but from the ordinary conjugal coolness which will follow after a few years of humdrum domestic monotony. Even the lack of demonstrative affection which, obvious during the first months of married life, naturally diminishes in intensity as the years pass, may, to some women, be a source of constant daily unhappiness. They feel that love and romance are buried under a weight of daily routine, with its petty cares and worries, and therefore that life now holds little or nothing of what they hoped for during the opening months of married life. Those women who suffer from the effects of this form of sex monotony are often childless. The normal hunger for affection is satisfied by the demands made by the helplessness of young children entirely dependent on her. The care of children will also help to save her by providing a work which will afford little opportunity for dwelling too much on her own imagined misfortunes.

Childlessness can also act alone as a severe stress by the acute disappointment and constantly recurring dashing of hope. It is only a few women who, after the excitement of early marriage has passed, are content to be childless; to most it is the source of the bitterest private grief. From being a mere disappointment it becomes a reason for a critical self-examination, and inarticulate assumption that she cannot be as other women. It is natural that a result of this self-accusation must often be a series of symptoms arising in the pelvic organs. A further example is the emotional stress set up by lack of love, or by active dislike of her husband, especially if the affections are placed elsewhere. Here we often find the chief complaint is dyspareunia, which is an unconscious defence against sexual attentions which are unattractive or even resented.

Unmarried women who have either no work, or perhaps the uncongenial monotony of their aged mother's household, suffer a sex starvation which is a common cause of pelvic disorders. As in the childless married woman we have here the long-continued action of a bitter disappoint-

ment, both in the lack of normal sexual life and sometimes in the absence of children which she fears may never be hers. There are other examples of the nature of emotional stresses, but I have given enough to illustrate my purpose.

OVER-REACTION AND FATIGUE

One clinical feature of all these patients is fatigue. Whatever may be their other symptoms they are all tired. Weariness is, perhaps, a better term, as it conveys in addition to fatigue the idea of mental tiredness and even hopelessness. They are nervously tired, partly by effort to withstand their anxieties and partly by the physical over-action which is a feature of neurasthenia, and of which their symptoms are the obvious manifestation. In his book *The Common Neuroses*, Ross gives as an illustration of excessive reaction the vomiting which may be induced by a foul smell. Here is a sufficiently positive and obvious symptom, but nobody would deduce from it that the victim must necessarily have some organic disease of the stomach. In a similar way the physical accompaniments of anger and fear are the symptomatic reactions to these emotions. So we have, particularly in women, a series of functional symptoms referred to the pelvis and its organs which are a response to an excessive emotional stimulus. Of all patients we are called upon to treat, other than the fatal organic diseases, there is no more difficult group to cure; but with care, sympathy, and great trouble much can be done to bring them back to normal life. At the beginning of any treatment the first essential, without which nothing can be done, is to be able, after the most careful physical examination, to reassure the woman that she has no organic disease of the pelvic organs. I am assuming that we are dealing with the neurasthenic group which have either a normal pelvis or one which cannot possibly be a source of trouble. Unlike the hysterical patients, most of our present group want to be well, and therefore if they can be reassured as to the physical integrity of their pelvic organs the basis of a successful treatment has been laid.

In this connexion it is well to add that a vaginal examination, especially if aided by a simple speculum, will give the impression that a real exploration has been made. Additional examination, such as of the urine and blood pressure, will serve to increase the feeling of confidence. It is impossible to emphasize too much the importance of giving the patient real assurance that great care and thoroughness have been used to exclude every possible mistake.

ANXIETY AND ASSURANCE

After having emphatically reassured the patient on the condition of her pelvis and physical state generally, the decks are cleared for a simple explanation of how local symptoms and fatigue can be the result of anxiety and emotional stress. Common illustrations of reactions to great emotion, such as the flushing in anger, the palpitation and pallor of fear, and the collapse of grief, will assist in bringing home the idea of the intimate connexion of emotional states with physical symptoms. Another good illustration which has been the experience of most people at some time or other in their lives is the atonic flatulent indigestion which accompanies worry, and no less its sudden and complete disappearance when the anxiety has been lifted. We all know the sense of physical well-being which follows the exaltation of good news or relief from deep anxiety. If these common illustrations of everyday experiences are set before an intelligent patient after reassurance of her pelvic state, there will begin to dawn on her mind that here is probably a true explanation of her own condition, and from this moment another step in recovery has been taken. The next advance is a consideration of the nature of her anxiety and the encouragement to face it and examine it. Here we are almost led

to a dissertation on the philosophy of living, and I believe that it is not a small part of a doctor's duty to inculcate, both by example and by precept, the right way of life. Anxiety is one of the most pernicious of all the influences which act upon ourselves, not excluding alcohol, food, and overwork. It is useless, and generally proved baseless by the outcome of future events, but while it lasts it depresses and inhibits all vitality. Its continued action will even so alter metabolism that the subject will lose weight to the point of emaciation, while its influence on the mind is such that the springs of energy are drained. It is scarcely possible to make this indictment of any other of the evil influences which surround the modern individual, and it is no exaggeration to say that anxiety is the most insidious foe which each of us has to face.

CHANGE OF ATTITUDE NECESSARY

The debilitated subject of whom we are speaking cannot be expected either to realize the effects of her worries or to make any successful attack on them without the help of confidential talk with some understanding guide and mentor, in whom complete confidence is found. It is possible, however, to show the way by teaching the patient to realize that nothing matters very much. The care-free attitude of laughing at life, so difficult for some to attain, is the end in view, and we lose nothing by adopting it. Most anxiety is about the possibility of future events of terror which seldom materialize, and in any case the realization is never so bad as its anxious anticipation.

The simpler cases can be treated by sympathetic assistance in overcoming anxiety by reassurance, and an effort to put the cause of anxiety in its true place. It is astonishing how many of these women are helped by encouragement afforded by sympathetic conversation with their trusted doctor. Where no real cause of anxiety or distress exists, they can be restored to a normal view of life, especially if opportunity is taken of a confidential interview with her husband or grown-up daughter. Indeed, it is in this latter direction that tension in family life, so often the underlying cause of trouble, can be eased, and a new harmony created. More than one interview with the patient is needed, in fact repeated consultations may be necessary to ensure that no relapse back into the anxiety-state should happen. The influence of the first conversational treatment is unlikely to last long unless further moral support is given at frequent intervals. But sooner or later the patient is able to stand on her own legs, to take a healthier view of life, and to lose her pelvic consciousness.

In those cases where there is distress beyond our control, some of which I have already referred to, our possibilities of treatment are limited. Something can be done, however, by encouragement and creation of new interests to divert the mind from its obsession and to enable the patient to gain some measure of happiness.

In describing to you these so-called functional cases, I have tried to emphasize the mental and human aspects of the problem. So often we find that they are ignored or overlooked by thinking too much in terms of viscera and not enough in terms of the mind and nervous system. It is difficult even for us, who are doctors, to be aware that pelvic symptoms can be forcibly prominent in the entire absence of pelvic disease; and where we find no pelvic physical signs beyond tenderness we must be ready to consider the patient from an entirely different angle.

PATIENTS WITH ORGANIC DISEASE

The second group of patients we are discussing present quite a different problem. Here there is definite organic disease which, by causing long-standing pain, disability, and constantly recurring menstrual distress, produces a

nervous exhaustion or reaction which is not unlike that of the first group. It is essential, however, to realize by physical examination that there are real lesions present which are an obvious and sufficient cause of symptoms.

The majority are women whose troubles date from child-bearing, in which the essential event was injury of uterine or vaginal supports, with infection. The end-result is some variety of prolapse, perhaps not severe, together with chronic cervicitis and intractable leucorrhoea. The uterus is usually bulky, due to subinvolution, and is often lying back in the pouch of Douglas. The perineum is deficient and relaxed, allowing protrusion of the vagina on straining. The symptoms are familiar—constant pelvic discomfort and backache, relieved on lying down, worse on standing and for a few days before menstruation. There may be a sensation of prolapse or perineal weakness with weight and aching after any physical effort. Menstruation is excessive, prolonged, and too frequent. Congestive pain may trouble the woman for several days before the period, and at the end of it she will be left in an exhausted condition. There will be scarcely time to recover from one menstruation before the beginning of the pre-menstrual discomfort of the next. The abdomen is loose, tumid, and toneless, sagging forwards and downwards on standing. Flatulent dyspepsia and constipation are the constant associated conditions. The woman is tired and depressed, and unable to respond to external interests, but she differs essentially from the first type we have considered inasmuch as her nervous state is secondary to the organic trouble, and, unless it has been of too long standing, it will clear up rapidly after successful treatment of the organic lesion.

TREATMENT BY RADIUM

The treatment usually offers little difficulty. It is seldom possible to cure these patients except by operation, and in most cases the operation must be radical. The large group of patients suffering from long-standing menstrual malaise, pain, excess, and frequency, must have menstruation finally arrested if they are to improve. Drugs, rest, douches, and tampons are of little, if any, real use. The constant application of one treatment or another produces a kind of devotion to the pelvic organs which serves only to fix the attention thereon. The patients cannot be well so long as the pelvis attracts any attention whatever, and therefore if the menstrual trouble cannot be entirely cured the function must be arrested. Where there is nothing more than a bulky, probably subinvolved, uterus, without prolapse or salpingitis, and the patient is over 40, a good treatment is by radium; but I am opposed to radium in younger women, and if there are the associated conditions of prolapse, old tubal adhesions, or fibroids.

OPERATIVE TREATMENT.

For these latter patients, and they are the common group showing the brunt of child-bearing, I believe that only hysterectomy, combined if necessary with repair of prolapse, will effect a certain cure. Where the patient is past 40 years a radical operation is not objectionable, but there is a certain amount of reluctance to perform hysterectomy between 30 and 40, especially if the woman still has a desire for children. Nevertheless, should the symptoms be sufficiently distressing to force the patient to be willing to have the uterus removed, and should there be accompanying objective signs of anaemia and loss of weight and muscle tone to support the story of subjective symptoms, I believe the surgeon is entirely justified in doing a radical operation. I do not remember regretting having been too radical in the treatment of these patients, but I have more than once regretted time wasted on ineffective medical treatment, or an operation

not sufficiently extensive to cure all pelvic symptoms. Such an operation must include at least a total hysterectomy, for leucorrhoea is a constant feature of chronic pelvic symptoms, and if the cervix is left *in situ*, maintaining the discharge which has been so obvious a source of discomfort, the patient will still complain that she is not cured.

Gynaecological surgeons have a considerable advantage over those operating in other parts of the body, inasmuch as their field is not a vital essential to life. We can be radical in our methods without causing a disabling mutilation. The results of the post-operative menopause after 40 years have been greatly exaggerated, and are not comparable to the previous symptomatic distress for which the operation was done. Retention of some ovarian tissue is usually possible, and though it may not persist for long as a useful organ, yet it often affords the patient a certain sense of satisfaction that she has not entirely lost her essential sex organs.

In conclusion, I would repeat that diagnosis of the cause of chronic pelvic symptoms is of so great importance because the treatments are opposite. Where the origin lies in the nervous or temperamental system, operation is likely to be a disaster, but where the trouble springs from actual pelvic lesions then the only hope lies in radical surgery.

OLEOTHORAX, WITH OBSERVATIONS ON TWENTY CASES

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Ever since Bernou,¹ using large quantities of medicated oil for intrapleural injection, reported in 1922 on his first successful application of oleothorax, this treatment has been gaining prominence, and now claims a definite place in pneumothorax therapy. Following on the recognition of various difficulties and complications of artificial pneumothorax (associated chiefly with pulmonary tuberculosis) the list of indications for oleothorax has increased and the technique has been modified and improved upon. Convincing results from this treatment have been reported on the Continent, chiefly by Kuss,² Weil,³ and Burnand,⁴ and more recently in this country by Chandler,⁵ Gloyne,⁶ and Burrell.⁷ In 1929 Fontaine⁸ published a treatise on oleothorax, with reports on one hundred cases collected from various Continental sanatoriums. For fuller information the reader is referred to this publication and the above-mentioned reports. This paper is only a brief outline of the treatment based on personal observations from a series of twenty cases.

OILS USED AND THEIR PROPERTIES

The choice rests between olive oil and liquid paraffin. Both were employed in the early cases of the series, but on account of the invariable reaction after liquid paraffin I abandoned it in favour of olive oil. Less frequent oil refills are necessary with liquid paraffin because of its slow absorption from the pleural cavity, but this advantage holds only at the beginning of treatment. Both are found to be absorbed at an almost equal rate once the pleural surfaces have become saturated. It is usually advised that for all cases a small quantity of gomenol should be added for its antiseptic properties. Having discovered that gomenol acted as an irritant to a "virgin pleura"—that is, where no effusion has existed—I used it only where antiseptic oil was to replace an effusion. The strength varied according to the degree of purulence of the effusion, with 5 per cent. as the maximum.