GYNECOLOGY and GYNECOLOGIC NURSING

MILLER
and
AVERY

GYNECOLOGIC NURSING

With a Chapter on
The Gynecology Operating Room by

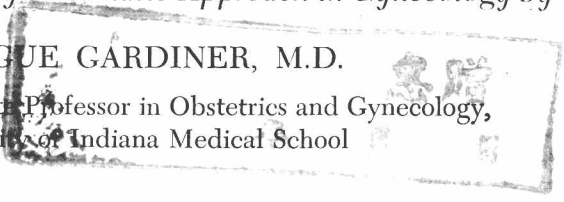
MOLLY KOWAL, R.N.

Formerly Operating Room Supervisor,
University of Michigan Hospital

And a Chapter on
The Psychosomatic Approach in Gynecology by

SPRAGUE GARDINER, M.D.

Associate Professor in Obstetrics and Gynecology,
University of Indiana Medical School



Philadelphia and London • 1954

Made in United States of America

Press of W. B. Saunders Company

Library of Congress Catalog Card Number: 54-7688

GYNECOLOGY
and
GYNECOLOGIC NURSING

GYNECOLOGY and

By NORMAN F. MILLER, M.D.

Professor of Obstetrics and Gynecology,
University of Michigan Medical School

And HAZEL AVERY, A.B., R.N.

Assistant Professor of Nursing,
University of Michigan Hospital;
Supervisor of Nursing, Women's Hospital,
University of Michigan

THIRD EDITION

Illustrated with 272 Diagrammatic Drawings

W. B. SAUNDERS COMPANY

PREFACE

In general, nurses obtain their knowledge of gynecology from three principal sources: (1) didactic lectures, (2) practical instruction, and (3) reading. All three sources are important, but their pedagogic value is extremely variable. Didactic lectures can be splendid but frequently are sketchy, hurried and incomplete. Practical education emphasizes—as it should—nursing procedure. It also leads to the acquisition of helpful impressions regarding some disorders, but fails to give the full understanding essential for comprehension of disease. Book learning completes the triad, but it can be meager or considerable, depending on required assignments, the student's desire for knowledge, and the quality of texts available. These three teaching methods complement each other.

In preparing this text we have stressed those things which make for a clearer understanding of disease. In addition to concise description we have emphasized fundamentals—basic changes which lead to dysfunction. Thus, to mention but two examples, organ physiology and normal gland function precede consideration of such common complaints as hypermenorrhea, polymenorrhea and amenorrhea. Similarly, the description of mechanical factors predisposing to uterine displacement, prolapse and pelvic floor relaxation makes for a clearer understanding of both the mode of occurrence and the logical remedy. This attempt to create understanding in addition to presenting a clear description of disease is characteristic of the entire text.

Throughout the preparation and revision of this text it has been our aim to make clear and easily understandable all diseases or procedures discussed. This effort has included the free use of carefully prepared pen and ink drawings designed to portray clearly specific conditions or procedures. The pedagogic value

of such visual aids has long been recognized. Here they are liberally used to enhance understanding so important for proper care of the sick.

Except for brief mention of generally accepted therapy, no attempt has been made to describe, in detail, the remedial measures for the various gynecologic disorders. The details of treatment and surgical procedures do not appear to be a logical inclusion in a text of this sort.

In the care of gynecologic patients, stress has been placed on nursing principles rather than on specific procedures, although the latter have been included in the Appendix for use when desired. More attention has been given to emotional and public health aspects of gynecologic disease. Self- and home care have also been given increased emphasis.

The steps in gynecologic nursing procedures are designed to make the reason as well as the procedure clearly understandable and easy to follow. Furthermore, the didactic arrangement of this material in the Appendix should permit ready adaptation to all examining rooms and hospitals.

Miss Virginia Bryant, co-author of the first edition, has retired from nursing practice, and Miss Betty Hyde, co-author of the second edition, has entered the field of Public Health. To both Miss Bryant and Miss Hyde we hereby acknowledge our debt and our thanks.

The chapter on Psychosomatic Aspects of Gynecology by Dr. Sprague Gardiner continues to be a welcome addition, broadening both the scope and the usefulness of the text.

The wide experience gained by Miss Molly Kowal, R.N., as former operating room supervisor and Instructor in Nursing at University of Michigan Hospital and presently at Blodget Hospital in Grand Rapids enhances the value of her chapter on the Gynecology Operating Room.

The drawings are the work of Mr. Gustav Bethke, Miss Elizabeth Schweich, Miss Janet McLaughlin and Miss Mary Lou Cummings. All new drawings added to the third edition represent an additional contribution on the part of Miss Cummings.

We wish to express our thanks and acknowledge the assistance of: Miss Mildred I. Quackenbush, B.S., R.N., Assistant Professor

of Nursing and Operating Room Supervisor at the University of Michigan Hospital, and her staff; Mrs. Julia Morris, R.N., Instructor in Nursing and Assistant Supervisor of Obstetric and Gynecologic Nursing; Mrs. Mary Rowley, R.N., present Head Nurse on the Gynecology Service, and to Mrs. Hallie Jackson, R.N. former Head Nurse in Gynecology, for their invaluable assistance and helpful suggestions.

If by means of this text we contribute to a better understanding of the gynecologic diseases and their nursing care we shall have achieved our aim, and the text, its function.

NORMAN F. MILLER, M.D.
HAZEL AVERY, R.N.

Ann Arbor, Michigan
July, 1954

INTRODUCTION

THE TERM *gynecology*—which is pronounced with either a hard (guy'ne-col'o-gy) or soft (gin'e-col'ogy) "g"—is derived from the Greek words *gynē* or *gynaikos,* meaning woman or female, and *logia,* meaning study; thus gynecology means the study of the *diseases of women.* Once comprising a limited field, gynecology has today become a specialty of vastly widened scope. Along with the general advance of medicine, concentrated study in the special fields of endocrinology, psychiatry, surgery and other branches has led to an improvement in our understanding of the human female and the diseases to which she is heir. Although human suffering from disease has been reduced and the average span of life materially lengthened, there remains much that is not known.

Knowledge regarding disease requires first of all an understanding of what constitutes the normal. To this end, therefore, we shall consider first the normal anatomy and physiology of the female reproductive tract and allied organs. With an adequate understanding of the normal person we may then pass on to consideration of the abnormal.

CONTENTS

Part I. ANATOMY AND PHYSIOLOGY

Chapter 1. ANATOMY

THE *average* normal adult woman measures 5 feet 4 to 5 feet 7 inches in height and weighs between 116 and 140 pounds. Naturally there are wide variations, the average simply serving as a model from which there are many normal deviations.

Contour. Because of the underlying skeletal structure, less localized muscular development, the presence of the breasts, and the peculiar distribution of fat, the contour of the adult female is characterized by graceful curves in contrast to the more angular body configuration noted in the male. Age, childbearing, occupation, the degree of muscular development, nourishment, and bony framework all contribute to help or alter this picture. The breasts become prominent and, when fully developed, are in sharp distinction to the undeveloped, flat male breast. The typical adult female figure shows some flaring at the hips in contradistinction to the broad shoulders and narrow hips seen in the male. The trunk length is approximately the same as the lower extremity. This ratio is subject to wide variation, and depends upon heredity, gland function and many other factors.

Hair. The color, texture and amount of body hair vary

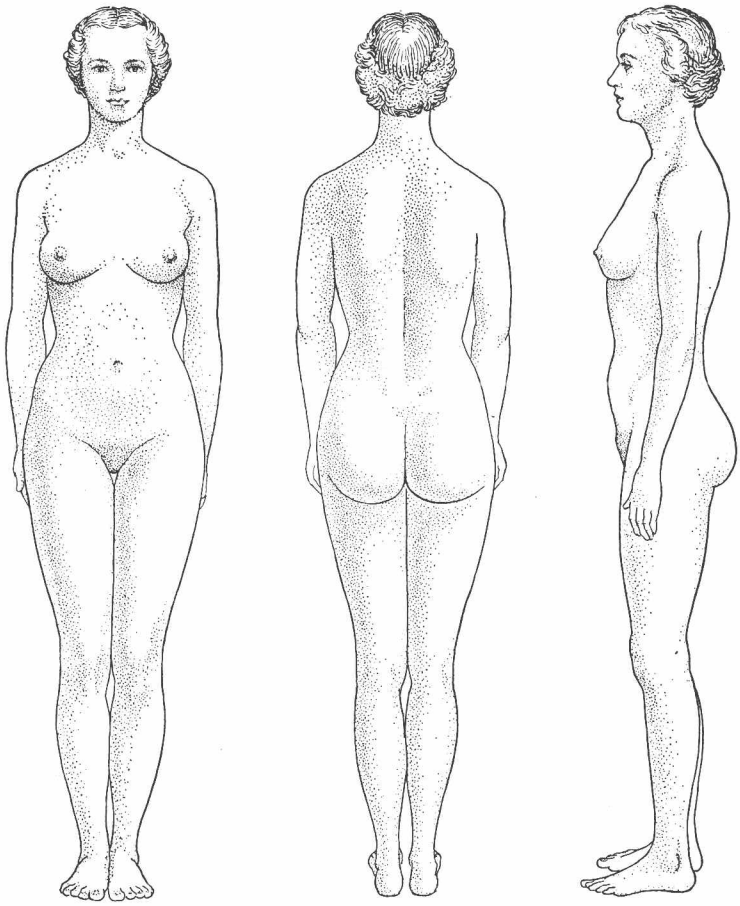


Fig. 1. Normal body configurations in the young adult woman.

considerably in the two sexes and in the same sex. Such factors as age, heredity, health, glandular dyscrasia and living habits influence its growth and development. In general, the head hair of the two sexes shows little difference except for the male tendency to baldness and such other changes as are imposed by society and civilization. The resemblance does not extend beyond the head hair, however, for there is a wide variation in the body hair. The male shows a tendency to abundant facial hair

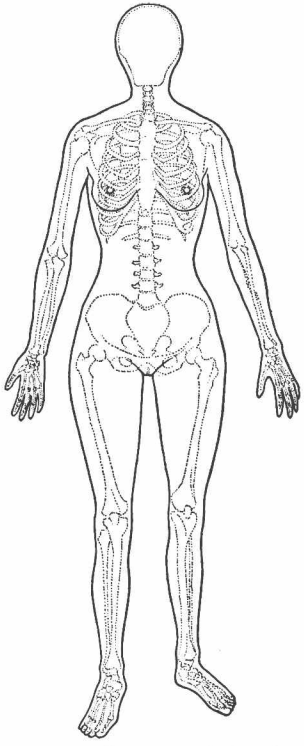


Fig. 2. Contour of the female, showing relation between the soft parts and the bony skeleton.

growth and growth particularly over the extremities and occasionally over the body. Except for a relatively small amount of hair growth over the arms and perhaps the lower extremities, the hair growth over the female body is minimal. A fine facial down and body hair do exist. In both sexes there is abundant axillary and pubic hair. The latter is arranged in a rather characteristic form and differs remarkably with the two sexes. In the female the pubic hair seldom extends beyond the mons veneris, whereas in the male the pubic hair grows in the form of a triangle, the apex of which extends upward on the abdomen toward the umbilicus. In the female, excessive hair growth (or hirsutism), especially facial hair and body hair growth, suggests a glandular imbalance, characterized by a lessening of the fem-

inine secondary sex features and a gradual increase in masculine appearance. An abnormal increase in facial and body hair growth may be one of the signs of so-called *virilism.*

Bony Framework. In the female the skeleton is inclined to be light and small, the pelvic bones showing additional variations adapting the female for childbearing. Externally, these bony changes are not apparent, but comparative osteologic studies reveal well-defined sex differences.

THE PELVIS

The *pelvic bones* are the two *ilia,* the two *ischia* and the two *pubic bones,* in addition to the *sacrum* and the *coccyx.* Since the ilium, the ischium and the pubis on each side fuse early to form what is essentially one large bone, the *innominate bone,* it is only necessary to consider the two innominate bones, the sacrum and the coccyx. Similarly, the sacrum and coccyx develop from several segments, but later become more or less fused, and for our purpose may be considered as one. The two innominate bones are joined anteriorly by a firm fibrocartilaginous band spoken of as the *symphysis pubis.* Posteriorly they articulate with the sacrum, forming the *sacroiliac joints,* which are reinforced by dense fibrous bands or ligaments. The sacroiliac joints are true joints, and permit a certain amount of movement. This movement is of clinical importance, especially during pregnancy. The bones making up the pelvic girdle are so constructed as to give support as well as great strength. The general appearance of these bones and the way they unite to form the pelvic girdle are shown in Figures 3, 4 and 5.

The pelvis is divided into two parts, the *true* and the *false pelvis.* The false pelvis is that part above the *pelvic inlet,* or opening into the true pelvis. It is bounded laterally by the upper portions or wings of the innominate bones, posteriorly by the lumbar vertebrae and anteriorly by the abdominal wall. Its primary purpose is support. Secondarily, it aids in guiding the fetus into the parturient canal during labor. The true pelvis, or the part below the pelvic inlet, is roughly cylindrical in shape. At the inlet the pelvis represents a kidney- or heart-shaped opening, the indentation being due to the promontory of the sacrum.

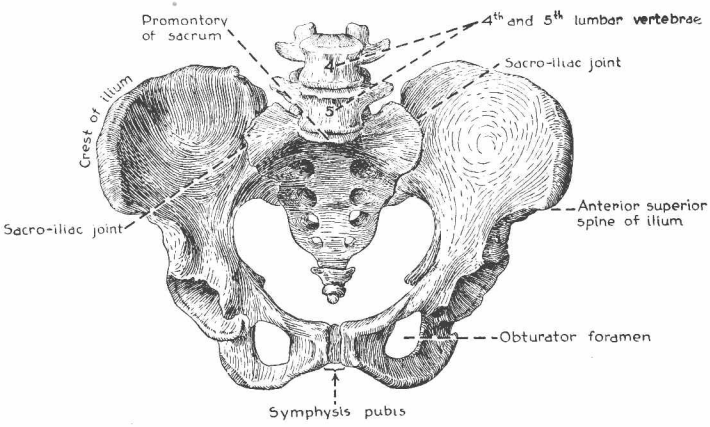


Fig. 3. The bony pelvis or pelvic girdle.

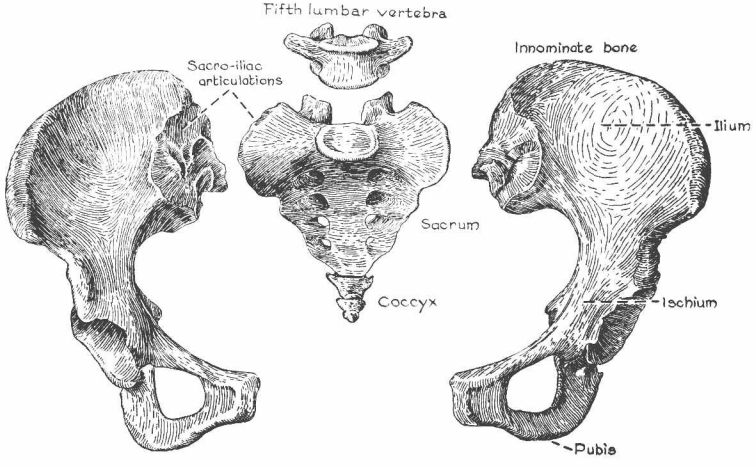


Fig. 4. Disarticulated bones of the pelvic girdle.

Below, the pelvis acquires a more cylindrical contour. It is bounded by the sacrum and coccyx posteriorly, the pubic bones anteriorly, and the ischia, ilia and the sacrosciatic ligaments laterally. The true pelvis contains some of the reproductive organs, the bladder and the rectum. Normally, the pelvis is tilted forward so that the plane of the pelvic inlet forms an angle of approximately 50 to 60 degrees with the horizon; that is, a