THE GENERAL PRACTICE SERIES

THE SYMPTOMATIC DIAGNOSIS AND TREATMENT OF GYNÆCOLOGICAL DISORDERS

MARGARET MOORE WHITE

SECOND EDITION

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THE SYMPTOMATIC DIAGNOSIS AND TREATMENT OF GYNÆCOLOGICAL DISORDERS

by

MARGARET MOORE WHITE
M.D. (LOND.), F.R.C.S. (ENG.), M.R.C.O.G.
SURGEON-SPECIALIST, THREE COUNTIES EMERGENCY HOSPITAL.
LATE FIRST ASSISTANT GYNÆCOLOGIST, ROYAL FREE HOSPITAL.

With a Foreword by

F. J. BROWNE
M.D. (ABERD.), D.Sc, F.R.C.S. (EDIN), F.R.C.O.G.
PROFESSOR OF OBSTETRICS AND GYNÆCOLOGY, UNIVERSITY OF LONDON.
DIRECTOR OF THE OBSTETRIC UNIT AND OBSTETRIC SURGEON, UNIVERSITY COLLEGE HOSPITAL, LONDON.

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FOREWORD

Of gynæcological text-books there is no dearth. Most of them are excellent, and there is no doubt that anyone who studies one or other of them systematically and is prepared to take the trouble to familiarise himself with the pathological changes that underlie and explain signs and symptoms, and who has at the same time opportunity for clinical observation and practice, can in course of time become an expert gynæcologist.

The general practitioner, however, seldom has either time or occasion for the systematic study of any speciality, for he must have a working knowledge of many. A large proportion of the gynæcological complaints encountered in his consulting room are minor ones—pain, backache, leucorrhœa, functional menstrual disturbances, etc.—troublesome enough to the patient but generally capable of being quickly relieved by simple measures easily applied.

It is the great merit of Miss Moore White's book that besides being a clinical text-book it includes a full account of such common symptoms and their treatment. It embodies an amazing amount of information that can only have been acquired from a large and varied clinical experience, sifted and arranged by a balanced and critical mind. Reference to it will resolve many a difficulty and it is therefore well deserving of a prominent place on the practitioner's bookshelf.

F. J. Browne.

London,
1943.

PREFACE TO THE SECOND EDITION

In this second edition minor alterations and additions have been made. The chapter on Vulval and Vaginal Disorders has been rearranged so that the reader's attention is drawn more to the common than the rare disorders, which are referred to in small type.

Throughout the book, symptoms and diagnosis have been enlarged upon when inadequate and treatments brought up-to-date. Reference is made to the latest technique of sulphonamide administration and to Penicillin in the treatment of Gonorrhœa, —to pethidine hydrochloride in the treatment of spasmodic dysmenorrhœa, to ammonium chloride in the treatment of premenstrual fluid retention and prostigmine methylsulphate in the treatment of amenorrhœa.

In the chapter on Irregular Vaginal Hæmorrhages differential diagnosis and treatment of threatened, missed, incomplete and septic abortion have been given in full.

Causes and treatment of habitual abortion (with especial reference to the Rh factor) and the technique of artificial insemination have been added to the chapter on Sterility. A chart showing rectal temperature curves indicating the time of ovulation is included.

Dr. Redding, in her chapter on Contraception, has given details of how to assess 'the safe period.'

Mr. I. G. Williams, in his chapter on Radiation Therapy in Gynæcology, has drawn attention to the possible danger of irradiation of the ovaries in young women, on account of chromosome change resulting in lowered fertility in subsequent generations.

Finally, in order to avoid pitfalls, a few lines have been included at the end of each chapter indicating the commonest errors in diagnosis and treatment.

M. Moore White.

London,
September, 1945.

PREFACE

THIS book has been written to help the general practitioner in treating patients who suffer from minor gynæcological ailments, and to enable him to ascertain those conditions which might benefit from methods of treatment not usually within his capacity.

My large out-patient experience has made me feel that many women suffer needlessly for years from complaints that might easily be treated by the doctor in his own consulting room with a minimum amount of apparatus and without excessive skill.

Since there are many good text-books on gynæcology, this book has been written from the point of view of symptoms and their appropriate treatment.

A chapter is given to birth control, and another to pre- and post-operative treatments, since it is assumed that many doctors are expected to undertake the care of their patients before and after operation by the visiting surgeon.

The different hormone preparations and their makers are enumerated in an appendix.

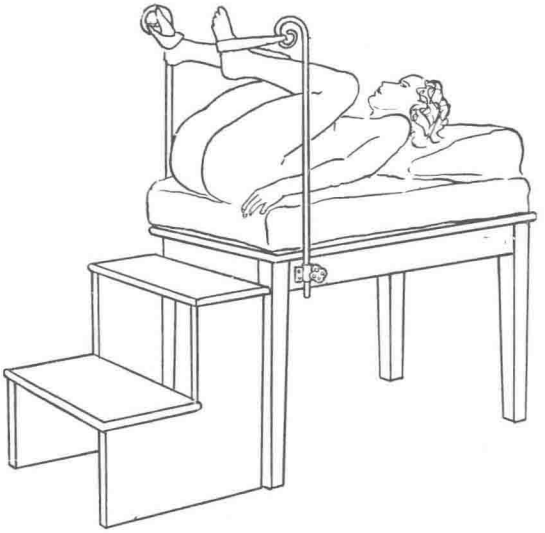
It is a pleasure to acknowledge my indebtedness to all those who have helped me in the preparation of this book—to Dr. Mary Redding for the chapter on birth control; to Mr. I. G. Williams for his explanatory chapter on radiotherapeutics; to Professor F. J. Browne for the honour he has done me in writing an introduction to this book, and for his encouragement; to Mr. B. Hogben and Squadron-Leader J. Howkins for their advice and criticism of my literary effort; to Dr. Kathleen Kitchin for valuable aid in preparing the manuscript for the press; to Mr. E. A. Fairburn and my husband for reading the proofs; to those who have taken the photographs for me; to Messrs. John Wyeth & Brother, Ltd., for permission to reproduce photographs; to the Editors of the *Nursing Mirror* and the *Proceedings of the Royal Society of Medicine* for permission to reproduce illustrations from their publications; and to Miss Gertrude Dearnley, from whom I have learnt much during the many years I have worked with her.

My great thanks are due to Miss Gwynne Jones, one of my students, who has so ably and originally executed the illustrations.

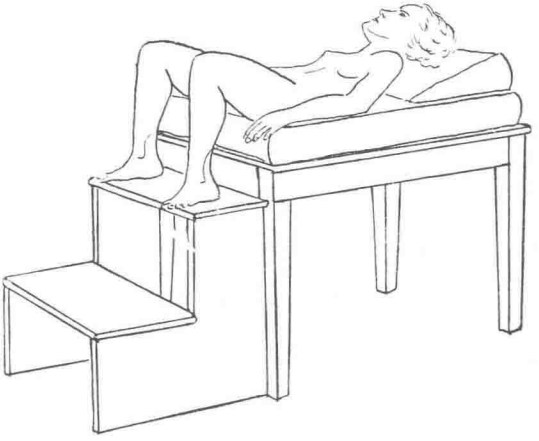
Finally, I gratefully acknowledge the help of Mr. H. L. Jackson and Mr. F. Boothby, directors of H. K. Lewis & Co. Ltd., for seeing the manuscript through the press.

M. MOORE WHITE.

LONDON,
April, 1943.



Couch with leg-rests, for treatment in lithotomy position.



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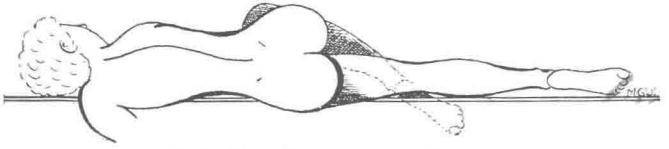
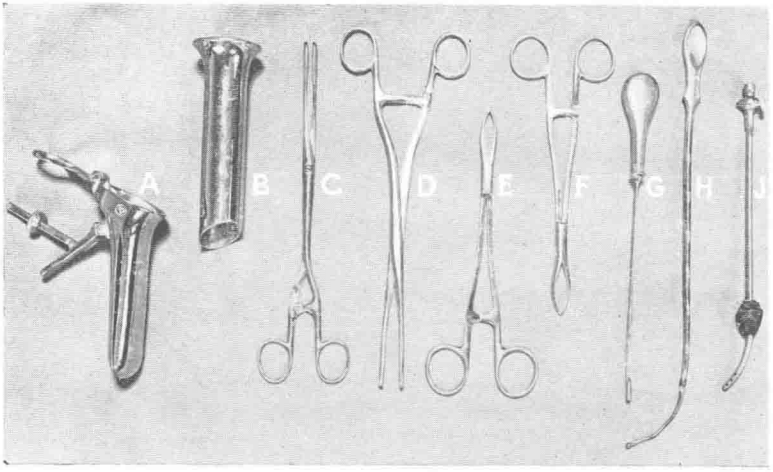


Left-lateral, or Sims', position.



Instruments necessary for out-patient and consulting-room operations.

A, Duckbill speculum; B, Ferguson's speculum; C and D, Sponge holders; E and F, Tenaculum forceps; G, Biopsy curette; H, Uterine sound; J, Insufflator nozzle.

CONTENTS

GYNAECOLOGICAL DISORDERS

CHAPTER I

VULVAL AND VAGINAL DISORDERS

VULVAL DISORDERS

A. DIFFUSE SWELLINGS: Hypertrophy, Œdema, Varicose Veins, Chronic Hypertrophic Ulcerative Vulvitis, *Elephantiasis*, *Tuberculosis*, *Rodent Ulcer*, *Granuloma Inguinale*.

B. ULCERS: Malignant: Epithelioma, Adeno-carcinoma, *Rodent Ulcer*, *Melanoma*, *Sarcoma*, *Secondary Growth*.
Benign: Primary Chancre, Soft Chancre, Pyogenic Ulcers, *Tuberculous Ulceration*, *Diphtheritic Ulceration*, *Noma*, *Lymphogranuloma Inguinale*.

C. CYSTIC SWELLINGS: Bartholin's Cyst, Bartholin's Abscess, Sebaceous Cysts, Hæmatoma (recent), Inclusion Dermoids, *Embryonic Cysts*, *Inguinal Hernia*.

D. SOLID SWELLINGS: Malignant: Epithelioma, Carcinoma of Bartholin's Duct or Gland, *Melanoma*, *Sarcoma*, *Secondary Growths in the pre-ulcerative stage*.
Benign: Hæmatoma (late stage), *Lipoma*, *Fibroma*, *Angioma*. *Neuroma*, *Endometrioma*, *Gumma*.

E. SKIN DISORDERS: Intertrigo, Eczema, Warts and Condylomata, Thrush, Pediculosis, Scabies, Psoriasis, Lichen Planus, Ringworm.

VAGINAL CONDITIONS: Cysts, Benign Tumours, Malignant Tumours, Epitheliomata, Sarcomata, Secondary Growths, Ulcers.

A. DIFFUSE SWELLINGS OF THE VULVA

Hypertrophy of the Labia Majora.—This may be a congenital condition but is usually acquired. It may be unilateral. Usually no treatment is required. Hypertrophy may accompany chronic infective lesions, the treatment being that of the provoking condition.

Hypertrophy of the Labia Minora.—This can occur at puberty as part of a rather excessive development of secondary sex characteristics, probably related to pituitary activity; it more often follows masturbation.

Treatment.—The redundant portion of the labium is excised if it is causing distress.

Œdema of the Vulva.—The vulva may become enlarged in any of the conditions in which generalised œdema occurs, e.g. cardio-renal disease, cirrhosis of the liver. Such œdema is usually bilateral. Œdema may also occur in angio-neurotic disorders or

filarial infections. Intrapelvic pressure may produce vulval œdema which, according to the pelvic cause, may be either uni- or bi-lateral. For instance, the œdema caused by pressure of the fœtal head firmly lodged in the pelvis is bilateral, but that due to a fibroid or pelvic inflammatory mass on one side of the pelvis is unilateral. Carcinomatous infiltrations in the pelvis may cause lymphatic œdema of the vulva. Œdema, which may at first be unilateral, can occur sometimes as quite an early feature in toxæmia of pregnancy. Œdema frequently accompanies a primary chancre of the labium. In an acute gonococcal infection it may be bilateral. It is distinguished from hypertrophy by the consistency on palpation. Hypertrophied labia feel normal, œdematous labia pit on pressure. Treatment is that of the cause.

Varicose Veins of the Vulva.—These usually occur in the cavernous tissue of the labia majora, but may be found over the symphysis or in the vagina. Increase of intrapelvic pressure from pregnancy or tumours, pelvic congestion accompanying a pelvic inflammatory mass, or uterine prolapse with kinking of the veins, are all predisposing causes in those who exhibit a tendency to this vascular weakness. It is more likely to occur in women who do much walking or standing, or who become constipated. Varicose veins give rise to a feeling of weight, and may cause irritation and often intense discomfort. They present as knotty blue swellings of the vulva which, on palpation, may be found to contain harder areas, due to thrombo-phlebitis. A vein may rupture, especially during pregnancy, and give rise to severe hæmorrhage.

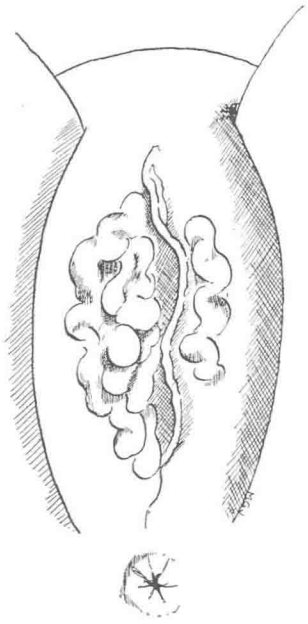


FIG. 1.—Varicose veins of the vulva.

Varicose veins may be treated by injection of one of the sclerosing fluids, quinine-urethane or sodium morrhuate, 2 c.c. into each vein at not more than one site on the first injection, and up to three on subsequent injections. If the dilatations are so large that they would make the overlying skin redundant after the sclerosis of the vein, then operative removal would be preferable.

Chronic Hypertrophic Ulcerative Vulvitis.—This name is

given to a condition of the vulva produced by more than one cause, including elephantiasis, genital tuberculosis, rodent ulcer, granuloma inguinale, and esthiomène (a term used to describe an ulcerated condition due to syphilitic or tuberculous infection). The entire vulva is grossly enlarged from inflammatory exudation combined with œdema from lymphatic obstruction. Uncleanliness predisposes to secondary infection. Ulceration may set in. Common symptoms are local discomfort, irritating discharge, dyspareunia and, if urethra or anus are involved, disturbance of urination and defæcation. The practitioner is advised to send any patient with such a condition to hospital for investigation and diagnosis, which, as stated above, may be one of the following:

Elephantiasis.—True elephantiasis is caused by the filarial parasite, and is rarely seen outside the tropics. Treatment is that of the disease. In this country it is usually due to lymphatic block in syphilis, or after deep X-ray or radium therapy for malignant glands of the groin.

In the former case improvement follows specific treatment; in the latter, little can be done.

Tuberculosis.—Tuberculosis of the vulva is rare, and usually occurs in association with tuberculous disease elsewhere. There is ulceration of the labia, which may be covered with irregular, ragged, undermined ulcers that coalesce, break down, and leave fistulous communications. In some cases there is less destruction and more proliferation, with formation of tuberculous nodules. Examination of a vulval smear or biopsy gives the diagnosis.

Treatment is by X-ray or excision.

Rodent Ulcer.—This condition is rare, but is diagnosed by biopsy from the spreading edge, which is firm and rolled over. In an advanced condition the lesions are diffuse.

The ulcer is treated by radium if the site or extent of ulceration precludes excision.

Granuloma Inguinale (Granuloma Vulvæ).—Though not a true venereal disease, this is usually associated with unclean habits and seen most commonly in the tropics. It is characterised by granulation tissue which assumes the appearance of a slowly progressing, non-healing ulcer with serpiginous edges. It occurs in the perineal region, vulva, or groin. Scrapings of the ulcer reveal the "Donovan bodies" characteristic of the disease. This has not been proved to be the causative agent, but distinguishes it from syphilitic, tuberculous, or carcinomatous conditions.

Treatment is specific and consists in the intramuscular injections of a 6·3 per cent. solution of sodium antimosan. The initial dose is 1·5 c.c., gradually rising to 5 c.c., until a total of 75 c.c. has been injected. Injections are given every second day. The patient must be kept under strict observation, since some people have an intolerance to the drug, and deaths from acute poisoning have been reported.

In all the above-mentioned conditions treatment must include:

1. Strict attention to cleanliness.
2. The use of non-irritating disinfectants.
3. The use of a catheter if micturition is difficult or if the passage of urine over the ulcerated area augments discomfort.

B. ULCERS

Malignant

Epithelioma of the vulva is all too common. It may start as a small innocent-looking ulcer, but suspicions should be aroused regarding the possibility of malignancy if, with the usual treatment for a small ulcer, there is no improvement in two or three weeks, or if it bleeds readily on touch. If there is any doubt it is better to send the patient to hospital for local excision, followed by further treatment when necessary. Epithelioma may arise in a crack or fissure in an area of leucoplakia. The malignant area is then usually elongated as carcinoma sets in round the margins of the fissure. Any indurated, ulcerated area on a leukoplakic vulva should be regarded with suspicion and the patient sent for further investigation. Epithelioma may appear as a large, flat indurated ulcer on the labia (majora more commonly than minora), the clitoris or about the urethral orifice (this latter particularly in kraurosis).

There is a sero-sanguinous discharge.

The inguinal glands may or may not be enlarged, in one or both groins. If enlarged they will be discrete and hard, unless secondary infection sets in, when they soften and finally ulcerate.

Carcinoma of Bartholin's Duct or Gland.—A neoplasm of the duct is of the squamous-celled variety; that of the gland an adeno-carcinoma. The site of the swelling is in the posterior third of the labium majus, it feels hard and irregular. There may be a sero-sanguinous discharge from the duct. Secondary infection is not uncommon.

Rodent Ulcer.—In the early stages the ulcer is small and hard, with an indurated base and rolled-over edge.

Melanoma.—See Solid Vulval Swellings (p. 8).

Sarcoma.—See Solid Vulval Swellings (p. 8).

Secondary Growth.—A chorion-epithelioma may give rise to vulval metastases. A preceding history of a chorion-epithelioma should make the diagnosis obvious. These secondaries, unlike other tumours, may, after removal of the primary, disappear within a few weeks without treatment. Rarely primary malignant growths of the cervix may metastasise to the vulva and undergo ulceration.

Treatment of Malignant Vulval Growths.—This is surgical when the local extent, age, and general condition permit. It is followed by irradiation. The vulva is excised by electro-cautery or scalpel, removing most of the greater lips, lesser lips, and clitoris. Either at the time or after an interval of two weeks, block dissection of the glands in both groins is performed, removing the superficial and deep inguinal and femoral glands. Later the area is exposed to irradiation therapy. Inoperable cases are treated by irradiation. Although the chance of cure is remote, alleviation is obtained, provided the growth is not grossly infected.

For an infected growth only palliative treatment and sedatives can be employed.

BENIGN ULCERS

Primary or Hunterian Chancre.—This is most frequently located on one of the greater lips. It is usually but not always single. The ulcer, which appears three to six weeks or more after exposure to infection, is round, flat, or slightly raised in the centre, with reddish-brown base, covered with a pseudo-membrane composed of a thin layer of necrotic tissue. The induration of the base can normally be felt but may be masked on the vulva by an œdematous induration of the labium. About the time of the appearance of the chancre the inguinal glands enlarge and present discrete, hard, round, painless swellings in the groin, which do not usually suppurate.

The treatment is that of syphilis.

Soft Chancre.—Chancroid molle usually occurs on the greater or lesser lips and, since it is auto-inoculable, there is usually more than one. The causal organism is Ducrey's bacillus, which gains entrance through a vulval abrasion, usually during sexual intercourse. The incubation period is three to seven days. The lesion passes quickly through the stages of papule and pustule to a punched-out, rather undermined ulcer surrounded by an inflammatory areola. The regional lymph glands are enlarged, soft, and painful, and sometimes suppurate.

Treatment is with the usual antiseptic applications.

Pyogenic Ulcers.—These may occur in debilitated persons, especially in young children, and are due to infection with the staphylococcus, streptococcus, *Bacillus coli*, etc.

Treatment.—The general condition of the patient must be improved, and local treatment follows the usual lines for septic conditions.

Tuberculous Ulceration.—This condition of the vulva has been mentioned in connection with hypertrophic vulval lesions, but may appear as an irregular ulcer without much surrounding hypertrophy. There is usually obvious tuberculous disease elsewhere.

Local actino-therapy may assist healing.

Diphtheritic Ulceration.—This is usually seen in young girls, though occasionally in adults, especially parturient women. A diphtheritic membrane forms and there are accompanying constitutional symptoms. Culture confirms the diagnosis.

Treatment is with diphtheria anti-toxin and Protargol paints locally.

The *Bacillus coli*, streptococcus, or staphylococcus may be associated with vulval and vaginal ulcers, especially in debilitated persons. The predominating organisms are demonstrable on culture.

Gangrenous Vulvitis (Noma).—In very debilitated children gangrene may commence as a furuncle which rapidly spreads.

(Ulcerated gumma and ulcerated malignant disease have been described under the heading "Solid Swellings of the Vulva.")

Lymphogranuloma Inguinale (Climatic Bubo).—This is venereal in origin. The first symptom is tenderness in one or both groins, followed

by enlargement of the sub-inguinal gland. The incubation period is three to five weeks. The port of entry is a small ulcer, herpetiform vesicle, papule, or indurated nodule on the vulva or vagina, which commonly escapes notice since it is neither painful nor irritating. No organism has been isolated. Accompanying the initial glandular enlargement is low pyrexia and general malaise which increases as the glandular enlargement increases and peri-adenitis sets in. The inflamed glands become matted together, break down, and discharge. The Frei-Hoffman test (the intra-dermal injection of specially prepared material procured by needle puncture from the infected gland) gives a positive reaction.

Treatment is symptomatic at first, but usually surgical intervention becomes necessary, and incision or excision of the affected glands is required. X-ray therapy has been found of benefit in early cases.

C. CYSTIC SWELLINGS OF THE VULVA

Bartholin's Cyst.—A cystic distension of Bartholin's gland may be either a result of blocking of the mouth of the duct, or a mucous cyst formation originating in the epithelium of the gland. It appears in the posterior third of the labium majus. The size may be from that of a hazel nut to that of a turkey's egg, and may vary in the same individual from time to time. The cyst may contain colourless mucus or opaque coloured material from admixture of blood or pus.

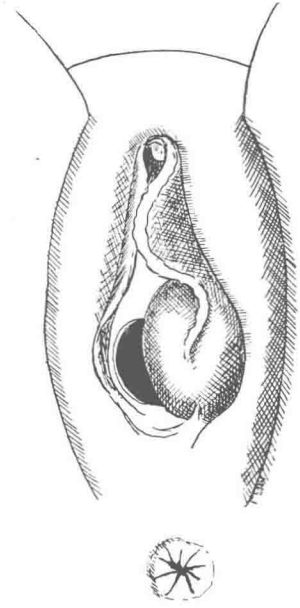


FIG. 2.—Bartholin's cyst.

It must be removed by excision. If it is large and stretches the overlying mucous membrane, it is best incised through the inner surface of the inner lip, but if small or more deeply buried, it may be easier to reach through an incision in the labium majus. Should it be impossible to enucleate, owing to adhesions from previous inflammation, as much as possible of the wall should be removed by enucleation and excision with scissors, and the site of removal swabbed with spirit. Subsequently, it should be packed, if bleeding is excessive, and allowed to heal by granulation. If bleeding can be controlled, the cyst should be closed by deep sutures, leaving a gutter drain down to its bed.

Bartholin's Abscess.—Abscess of Bartholin's gland is found in the same site as the cyst, but is accompanied by inflammation with considerable induration of the surrounding tissues. If the abscess