A TEXTBOOK OF PHONOLOGY

A TEXTBOOK OF GYNECOLOGY

By

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Preface

The purpose of this book is to present in a brief and clear manner a new and modern summary of present-day gynecology.

Theories will be touched upon, but stress will be directed to the facts as known today. The object is to remove the chaff from the grain, to make perusal easy and rapid, and to invite the instructor to individualize his own methods of teaching. If textbooks covered every detail and philosophy, they would be too voluminous for practical purposes. This book may act as an outline for the teacher to elaborate and digress. In addition, it is intended to interest the practising physician who has never ceased being a student, and who may wish to follow the methods and approaches in this field today.

Everywhere in this book the basic pathology is stressed. Never has that part of this specialty been presented better than in Emil Novak's *Gynecologic and Obstetric Pathology*. Now the details presented are fewer, but they remain the basis on which gynecology is founded. After the pathology of the individual disease has been considered, the symptoms of the patient become more obvious and logically understood. Similarly, the diagnosis may be reached from the physical examination and laboratory findings more logically in the light of the understanding of the pathology. And finally, the treatment of the disease has its logical basis in combatting the pathological process. When it is difficult to understand the reason for a method of treatment, it is well that the mind of the physician be turned to the pathological findings. Frequently, as time passes, a diametrically opposite approach to treatment of a particular disease is accepted by the profession. There must be an explanation eventually available in every instance.

Certain operative techniques are described briefly, because even the general practitioner and internist may be interested in these methods. Gynecology has a strong Kellyian surgical background and includes almost half of all major surgery. The function, diagnosis and treatment of the numerous and variable gynecological malignancies make up a fascinating and complicated area of grave importance. The extra-ordinary effects of the hormones on the genital tissues, which includes even the skin of the entire body, are so striking as to cause obvious gross changes and numerous delicate variations in function.

In recent years, the effects of emotions and personality factors in women have been recognized to be of tremendous importance in genital function. The varying stimulation by the emotions of the autonomic nervous system, the vascular system in the pelvis, and finally the endocrine system, may be so profound as to cause major disability. These factors must be reckoned with daily in the understanding and treatment of gynecologic disease and studied constantly for greater understanding.

An uncommon feature of this book is its new types of illustrations. The author has foregone the use of the often-repeated cuts and offers completely new material. The new tone drawings are the work of one artist. The photomicrographs have been made by one medical photographer. It will be pleasing, perhaps, to view Kodachromes not previously published. These efforts are offered for the reader's interest.

At the end of each section in this book are listed a few choice references. Usually there are one or two historical references, one or two experimental papers, and finally, two or three modern clinical articles which may introduce the student to the literature in

gynecology. The instructor may choose to make these references required reading, or may substitute others of his own choosing. The habits formed from an early approach to the literature may be extended throughout a medical career.

If this treatise aids physicians in their understanding of the large number of diseases of women, with the dramatic hormone relations, devastating cancers, and emotional upheavals, its purpose will have been realized.

L. A. G.

Acknowledgments

This volume would be incomplete if it did not recognize again, the masterful touch and artistry of a great gentleman, Mr. Charles C Thomas, and the executive ability and co-operative attitude of his son, Mr. Payne Thomas. The editorial genius of Mr. Warren H. Green has contributed greatly to the completion of this book. Doctor William K. Keller, Professor of Psychiatry at the University of Louisville, kindly consented to write the chapter on "Gynechiatry", an original word which he has coined. For reading the manuscript and offering many suggestions, the author is indebted to Doctor Douglas Haynes, Doctor William Christopherson and Doctor Harold Gordon. Doctor Malcolm Barnes has been most helpful in the selection of material for illustrations. I am most indebted to Mrs. Jean Hellstrom for her long and patient efforts to demonstrate the pathological lesions in her tone drawings. The photomicrographs have been prepared with great care by Mr. Wendell Gillette. As always, my loyal secretary, Mrs. Phyllis Ray, has been of inestimable aid in the preparation of this book.

The drawings illustrating vaginal hysterectomy are from the first edition of the author's book "Vaginal Hysterectomy." The drawings illustrating abdominal total hysterectomy by the author are presented by permission of the editor of the American Journal of Obstetrics and Gynecology.

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CHAPTER I

The Patient Presents Herself

Every woman should have regular, periodic pelvic examinations. For that matter, every person, man or woman, should have regular physical examinations. But such a goal, while most desirable, must await the millenium. On the other hand, there is a definite increase in interest in these routine procedures in the examination of women, stimulated greatly by the newspapers and magazines, and by various lay-medical organizations, such as the American Cancer Society, and the many other groups, which are banded together for their own particular medical interests. As the value of the Papanicolaou cytology test becomes more obvious, and the medical profession becomes more keenly aware of its accuracy, another great stimulus will have been added for regular pelvic examination. Lay knowledge and interest will progress and continue, and undoubtedly more and more women will present themselves for routine examinations.

The majority of women who present themselves to the gynecologist, or general practitioner, or internist, for pelvic examination are married, have children, and have developed some pelvic complaint, whether related to minor functional disturbances or to serious disease. These mothers may bring in their small daughters with pre-pubertal vaginitis, their children at puberty with delayed menses or abnormal bleeding, their adolescent daughters with dysmenorrhea, or the young women who sincerely desire, or have been advised to seek, premarital advice. Similarly, these active and mature women may bring in their elders, their mothers, aunts and grandmothers, who complain of nervousness, vaginal irritations, pruritus, abnormal bleeding, prolapse, or abdominal enlargements. A certain proportion of patients is made up of divorcees, who realize the importance of their femininity and sex, because this has been brought home to them after their dramatic separations from their mates, and who are more cognizant of the necessity of maintaining their health. The busy mother may neglect herself, caring not only for her brood, but for her sometimes tense, egocentric and demanding husband. As knowledge of the Papanicolaou test is more widely disseminated, more and more women of all ages request this examination. Many of these patients must have the explanation that the cytology test is essentially only a test for the cervix uteri and that it does not replace careful pelvic examination. The information obtained from cytology, while accurate, largely relates to neoplasia of the cervix alone.

As the patient presents herself, there is always a sense of some reluctance, modesty, and nervousness, combined with some anxiety as to the verdict of the examination. Similar tensions undoubtedly affect the majority of men when they have physical examinations, but it appears that the emotions of the woman are more sensitive, more near the surface, and more intense. It is important that the receptionist, the secretary and the nurse, be courteous and friendly. They should exhibit a professionally interested manner. These contacts aid much in maintaining a woman's confidence, understanding and emotional ability to accept a

diagnosis, carry out directions, and have performed necessary procedures without emotional upheavals.

When the patient meets her physician, she responds to a genuine warmth of human interest, and is given confidence by a maintained courteous professional manner. While friendliness is to be developed, familiarity often leads to loss of confidence or lack of appreciation of serious opinions.

THE HISTORY

In the practice of gynecology, it is important to obtain a concise, accurate and encompassing history of the patient's background and her illness. This should be standardized, so as to expedite the method of obtaining the record, and in order not to miss important points. Ordinarily, the gynecologist takes his history form from that which he has learned in the study of internal medicine, but he shortens and abbreviates his form and method, so as to touch on the high points, to explore each system briefly, and to determine if any area should be investigated more thoroughly. Some clinicians have preferred to use small cards on which the systems and complaints are printed. A positive or negative finding may be checked. Others use a printed form, enumerating the systems and some points under each which may prompt queries. Details are supplied in each individual case. It is important to elicit those symptoms that may be related to any positive findings in the examination, in order to evaluate the patient properly. Listing all symptoms originally is important in retrospect after treatment, to clarify non-related and pre-existing complaints. This latter point may seem unimportant, but time reiterates its usefulness. The patient may misunderstand what is to be expected, regardless of repeated previous explanations.

In the history of the patient, the first question always is related to the *chief complaint*. This must be distinctly enunciated, as clearly as possible. Ordinarily, in gynecology, commonly this has some relation to menstrual dysfunction, to pelvic pain, or to discharge and irritation. A certain percentage of patients have no complaint, but wish a routine examination, particularly to exclude malignancies. Often, patients, in considerable number, complain only of nervousness, which at first is vague and indefinite, with perhaps many associated symptoms.

The family history is rarely entered into by the gynecologist. While malignancy may have some familial and congenital association, and in fact it undoubtedly does, this is of no great importance in determining the diagnosis and treatment of any individual patient. The inherited diseases in gynecology are so rare as to be of little importance. That nervousness is familial and inherited is undoubtedly correct, to a certain extent. But the exact situation with the individual patient is the important matter.

The *past history* begins with a statement regarding the *general health* of the patient. The *energy status*, whether normal, low, or excessive is an important general question, having some bearing on the thyroid activity and nervous tension of the patient. *Serious illnesses* are enumerated, because of possible relation to the general resistance and gynecologic system. *Operations* particularly must be listed specifically along with their dates. This information may indicate absence of the appendix, or the presence or absence of fallopian tubes, etc., and may influence greatly the subsequent diagnosis and operative treatment. *Cardio-respiratory* symptoms are inquired into, including chest pain, precordial pain, palpitation, dyspnea, edema, cough, breathlessness. Any positive answer is to be explored further, as indicated. *Gastro-intestinal* symptoms may include abdominal pain, nausea, vomiting, constipation, diarrhea and indigestion. The character of any of these symptoms should be elucidated

in some detail. The type of abdominal pain is accurately described as to its occurrence, severity, character (continuous, intermittent, cramp-like), localization and moveability. The physician must consider in his evaluation of the history the indication for specific tests and detailed investigations of any system. The patient is questioned as to frequency of *urination*, nocturia, pain, burning, stress incontinence, or urgency incontinence (the differentiation of the latter two being important in regard to relaxation of vesical muscles and fascias, as contrasted with irritation in the urethra and bladder).

The *menses* are described in detail, including the time of onset (menarche), the cycle with its approximate number of days and variations, the duration of flow, the amount of flow (scant, moderate, heavy), the presence of clots, and the occurrence of dysmenorrhea. The character of the pain is determined, whether it is constant, localizing in the midline or sides or rectal areas, whether it is cramp-like or continuous in character, or whether it represents some strange type of discomfort, as burning or weakness or pressure. *Intermenstrual bleeding* (I. M. B.) is a most important symptom, and its time of occurrence must be noted carefully. It may represent the dwindling of a menstrual period, the prodromal signs of menstruation, or bleeding associated with ovulation. One must not be led astray from the fact that any abnormal bleeding may represent a malignant tumor. Careful questioning is necessary in relation to the occasion when irregular bleeding occurs, its quality and relation to activities, particularly sexual intercourse. *Discharge* is one of the most frequent symptoms of which women complain. The amount of discharge and its relation to menstruation, whether occurring immediately before or immediately after, at the time of ovulation, or continuously between menses, are to be recorded, along with a description of its odor and color (clear, white, yellow, brown or green). The presence of blood in discharge is to be carefully distinguished.

The next and an important question is the date of the *last menstrual period*. This is of particular importance because the majority of women are susceptible to pregnancy; certainly menstruating women are. Pregnancy may occur in the most unexpected and inopportune situations, which may be dissembled as carefully as possible from the families involved and the physician. At times, a patient is completely unsuspecting herself, particularly because a pregnancy may be entirely unwanted, and even a tragic accident. The differentiation of many pelvic tumors from pregnancy is of greatest importance. While the date of the last menstrual period is never conclusive in the diagnosis, it is of importance and another link that adds to an accurate diagnosis. The author had this point indelibly impressed upon his mind many years ago. During a third year class in Gynecology under the late Doctor Thomas S. Cullen, at an operative clinic given for small groups, the author narrated the history of the anesthetized patient being prepared for abdominal operation. As the history unfolded and seemed complete, Doctor Cullen asked what item had been omitted. Since everything was thought complete, he asked the date of the last menstrual period. With consternation the written history was re-examined, and no date was recorded. Doctor Cullen then pointed out that this was a symmetrical mass in the lower abdomen, that while he thought pregnancy was not present, he considered it a serious dereliction to operate without at least having known the date of the last menstrual period. This student was instructed to return with the anesthetized and unoperated patient to the ward, and remain at her bedside until she was sufficiently coherent to give an accurate answer. Doctor Cullen made much of this incident, proclaimed a fine of twenty dollars against the student to be paid to the class (which was never collected!), and subsequently re-

moved the myomatous uterus at a later session. The number of *pregnancies, the* number of *abortions,* and *difficulties with deliveries,* including fevers, hemorrhage, the use of forceps, and previous emergency procedures, are enumerated. The *weight* of the patient, present and past, with gains and losses, is to be noted.

The *present illness* is recorded as a relatively short but accurate summary of the patient's true complaints, and includes all of the reasons which brought her to the physician. Abnormal bleeding, whether prolonged, profuse, irregular, or intermenstrual bleeding, constitutes a large percentage of primary gynecologic complaints. The frequency of occurrence and the duration of this complaint must be determined accurately. Pain is another frequent complaint that brings the woman to the physician. The type, its location, duration, moveability, and radiation to back, flank, groin, thighs or rectum, are to be carefully distinguished. A third common complaint is discharge; it is described briefly, as to its duration, severity, type, color, and association with burning, pain or pruritus. The next large group of women comes to the gynecologist with the complaint of nervousness, which may or may not be associated with hot flashes. A patient with chief complaint of nervousness, may be of menopausal age, postmenopausal, or quite young. Evidently very many women think nervousness is related to their ovaries and hormones. The occurrence of hot flashes with normal and regular menstruation is a frequent one, and yet, hot flashes can never be of menopausal origin if the patient is menstruating, because the presence of a normal amount of estrogen, necessary for menstruation, cannot possibly allow hot flashes of menopausal origin; these hot flashes are due to nervousness or anxiety. If the nervousness and hot flashes are possibly menopausal, the cessation of menses is carefully documented. Other patients complain of tumors, or prolapses, or swellings, which are caused by distinct pathological entities, or which may be caused by weight gain, or may be phantom. Still other patients have no complaints, but simply want the cancer smear test and routine examination. Others have very vague complaints, and it may seem difficult to find just why the patient did present herself. Usually after the examination of the latter has been complete, if the patient has been given another opportunity to elucidate, then her family troubles, sex difficulties, frigidity, or her husband's infidelities are poured out with tears. It is particularly important to encourage patients to ask questions, and to add to their history after the examination has been completed, and a professional opinion has been expressed. Often many emotional problems with direct relationship and previous methods of treatment now are explained by the patient.

GYNECOLOGICAL EXAMINATION

The *gynecological examination* should include an overall survey of the patient. The relation of every system to the reproductive is well known. For this reason all patients are asked to remove their clothing completely, and after voiding (and the specimen is given immediate routine analysis), the patient may be draped with sheet (half size or cot size) on the table with feet in stirrups. Shoes may remain in place for comfort and convenience. A small hand towel may be placed across the breasts.

First, a notation is made of the *general appearance,* as to whether the patient is normally nourished, obese, underweight, healthy-appearing or ill-appearing. The mucous membranes are carefully inspected, which allows one an opinion of the hemoglobin content. This evaluation is made by observing the conjunctiva and the tongue. Inspection of the nail beds is helpful, if tinted polish has not been applied. The