LECTURES ON GYNÆCOLOGY.

BY MISS GERTRUDE DEARNLEY, M.D.

A course of six Lectures on Gynæcology have been given by Miss Gertrude Dearnley, M.D., Gynæcologist to the Royal Free Hospital, London, W.C., at 39, Portland Place, W., on Thursday evenings, beginning on Thursday, October 18th, and have been well attended by an attentive and interested audience of Fellows and Members. The Chair was taken by Miss M. Breay, Vice-President, or Miss M. G. Allbutt, Member of Council.

The first lecture was on the Anatomy of the Pelvis, and Miss Dearnley has kindly sent us the following synopsis of the succeeding lectures.

Menstruation.

DYSMENORRHŒA.

This term signifies pain at the period sufficient to interfere with the woman's work or pleasure.

Classification is difficult.

Spasmodic Type.—This is the commonest variety. It generally begins in young adult life. The pain starts just before the onset of the flow or at the same time. It is felt in the mid-line of the lower abdomen and there are often acute spasms of pain. Vomiting, fainting, headache and frequent motions may occur. It is often cured by labour, but women who have a bad type of this form of Dysmenorrhœa are often sterile.

Cause of the pain.—Often no abnormality of the genital organs can be found. In some cases some slight abnormality of the uterus is found, such as infantile type, acute anteversion. It is probable that the chief cause is to be found in faulty development of uterine muscle and in spasmodic contractions in the neighbourhood of the internal os. Abnormalities in the endometrium are undoubtedly the cause in some cases.

Treatment.—Endochrine therapy; uterine tonics; treatment of general health; dilatation and curetting in some cases.

Congestive Type.—This is essentially an acquired symptom. The pain is specially pre-menstrual and is relieved by the onset of the flow. It is a dull, wearing pain often improved by lying down.

Cause of the Pain.—Constipation, sedentary occupation, lack of exercise; often associated with retroversion and retroflexion following labour, endometritis, fibroids, pelvic inflammation.

Treatment.—Treatment of the underlying cause; regulation of the action of the bowels; exercise; uterine tonics. Curetting if endometritis is present.

Membranous Dysmenorrhœa.—A rare condition in which a large part of the endometrium is cast off each month and passed as a cast of the uterine cavity. This condition is usually of infective origin.

Treatment.—Dilatation and curetting and thorough disinfection of the uterine cavity.

Displacements.

DISPLACEMENT OF THE PELVIC ORGANS.

To understand the causation of uterine displacements it is essential to have a clear idea as to the structures which normally maintain the uterus in position.

The normal position of the uterus is in the mid-line of the pelvis, lying nearly horizontally; it is slightly bent anteriorly, and it rests on the bladder. The cervix points backwards.

The factors which are concerned in maintaining the normal position are:—

1. The muscular pelvic floor, particularly the levator ani muscle.
2. Connective tissue sheaths of the vessels of the uterus, vagina and bladder.
3. Intra-abdominal pressure acting on the posterior surface of the uterus.
4. The size and consistency of the uterus.
5. The ligaments of the uterus.

The above are given in the order of their efficiency.

DESCENT OF THE UTERUS (PROLAPSE OF THE UTERUS).

This condition is always associated with descent of the bladder, anterior vaginal wall (cystocele); and often with descent of posterior vaginal wall (rectocele).

Causation.—In the majority of cases, pregnancy and labour.

Damage to the pelvic floor during labour predisposes to prolapse.

This damage may be by tearing of the muscle, or long stretching of the muscle without an actual tear.

As the result of the labour, there may be a heavy, subinvoluted uterus.

If this uterus is retroverted, there is an added risk of descent.

Chronic constipation is an important factor.

Hard work, too soon after a confinement, adds to the risk of prolapse.

Degrees of Prolapse.—1st, Retroversion, some descent of bladder; 2nd, cervix reaches the vaginal orifice, cystocele and rectocele; 3rd, vaginal walls completely everted, uterus outside vulva.

Symptoms.—Sense of bearing down and backache. There is in many cases a visible protruberance. Disturbance of micturition. Invalidism owing to the difficulty in standing for long, backache, etc. These patients become very "nervy."

Prevention.—Ante-natal supervision so as to prevent long and difficult labour.

Avoidance of the wrong use of obstetric forceps.

Pelvic examination of all patients four weeks after delivery to ascertain that the uterus is in normal position, and, if not, to rectify a mal-position.

Adequate rest for the patient after delivery, associated with massage and exercises if possible.

Treatment (1) *Palliative.*—Correction of position of uterus and improvement of its tone. Rest is often beneficial. Improvement of the general health, particularly massage exercises and electrical treatment (general and local). Pessaries: These are useful in patients who are unsuitable for operation—(1) Simple rubber ring; (2) all-rubber cup and stem pessary for complete procidentia, or in cases where there is a patulous outlet. (2) *Curative*—Operation is the only reliable method of cure. The modern operation aims at reconstruction of the pelvic floor and of the replacement of the bladder to its normal position; also the replacement of the uterus to its normal position.

The operation is that of Anterior and Posterior Colporrhaphy, Perineorrhaphy; and it is very dependent for its success on highly skilled nursing. In addition, it is sometimes necessary to add some form of abdominal fixation of the uterus.

BENIGN NEW GROWTHS OF THE UTERUS.

Mucous polypus of the Cervix.—This is the commonest simple growth. It is due to over-growth of the mucous membrane of the cervical canal and is always the result of some chronic infection. The symptoms are backache and blood-stained vaginal discharge.

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