Golden rules of gynæcology / S. Jervois Aarons.

11 Golden Rules of Gynæcology.

GOLDEN RULES OF GYNÆCOLOGY.

BY

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TO MY FRIEND AND TEACHER,

SIR HALLIDAY CROOM.

4TH EDITION.
Revised, June, 1902.

PREFACE TO FOURTH EDITION.

The gratifying manner in which the former editions of this little book have been received, has encouraged me to make a number of additions, and at the same time to thoroughly revise and bring up to date the original work.

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PREFACE TO FIRST EDITION.

The following pages are the result mainly of my work in the Gynæcological Wards of the Edinburgh Royal Infirmary. I trust that the hints here thrown together may prove as valuable to the busy Practitioner and to Students as they have been to me.

London, *December*, 1898.

INDEX OF HEADINGS.

Golden Rules of Gynæcology.

ABDOMEN.

Always examine the abdomen systematically, thus:—

1.—By Inspection.

(a) *Shape.* Whether swelling or swellings (if any), are regular or irregular in outline.

(b) *Skin.* Lineæ Albicantes, scars, pigmentation, cutaneous eruption. Whether tense.

(c) *Size.*

(d) *Movements.*

(e) *Umbilicus.* Whether prominent or retracted.

2.—By Palpation.

Examine the different abdominal regions, note any enlargement of organs, presence of tumours, whether hard or soft, fluctuating or not. If fluid, whether encysted or free.

3 — ,, Percussion.

Note if dull or resonant in the various regions, and whether this changes by altering position of patient.

4.— ,, Auscultation.

Presence of fœtal heart sounds, uterine souffle.

5.— ,, Mensuration.

Whether symmetrical or not.

The next procedure should be the combined examination. Abdomino-vaginal (Bimanual).

Note the position, size, and mobility of uterus, tubes, and ovaries, condition of bladder and rectum, presence or absence of tumour formation.

Grave error in diagnosis will rarely be committed if the above routine is adopted.

Never diagnose an abdominal tumour without excluding :—

1.—Distended bladder.

2.—Uterine pregnancy.

Do not accept the patient's statement that "she has just passed her water." Pass a catheter yourself if you wish to make sure that the abdominal swelling is not due to a distended bladder.

If you cannot satisfy yourself, after careful examination, that the enlargement is not due to pregnancy, examine under an anæsthetic, or call in the assistance of a colleague. You "give yourself away" entirely if you diagnose

a tumour, when at the subsequent operation it proves to be an ordinary pregnancy.

Remember that fæcal masses have sometimes been mistaken for abdominal tumours. It is important, therefore, that the bowels should be thoroughly cleared out before making a diagnosis.

AMENORRHŒA.

Remember that this term does not merely mean the cessation or absence of the menstrual flow, it applies also to its diminution, that is, it may be **complete or partial**. A woman who usually menstruates for six days and gradually alters to two days, is amenorrhœic, just as one who does not menstruate at all.

You can divide amenorrhœic cases into (*a*,) Physiological, (*b*,) Pathological.

(*a*,) Physiological :—

1.—Before puberty.

2.—During pregnancy.

3.—During lactation.

4.—At and after the menopause.

(*b*,) Pathological :—

1.—Constitutional diseases, *e.g.*, Anæmia.

2.—Congenital conditions, *e.g.*, absence, or atresia of any portion of the genital tract.

3,—Some pelvic diseases, *e.g.*, Parametritis.

4.—Emotion, fear, change of climate, etc.

In cases of amenorrhœa do not forget the **possibility of pregnancy,** and beware of using the sound until you have absolutely excluded this possibility.

Remember that in girls after the age of puberty who have never menstruated, but who have the molimen and discom-

forts of menstruation, the condition is **probably due to atresia,** which must be relieved at once.

Remember that when the amenorrhœa is due to constitutional diseases, emotion, etc., no local examination or interference is necessary. Medical treatment and general management will usually effect a cure.

ANTISEPSIS AND ASEPSIS.

Remember that success in operation depends mainly on the thoroughness of your **antiseptic precautions.**

Instruments can be easily and effectually sterilized by being boiled for twenty minutes. The addition of a little carbonate of soda both hastens the process and prevents rusting. Hot water and soda can be obtained in any household.

Never put steel or plated instruments into a solution containing corrosive sublimate; you will utterly ruin them by so doing.

Remember that you have a good and reliable antiseptic in the **biniodide of mercury;** it has all the advantages of the perchloride, without its disadvantages. It can be used to sterilize the hands. Instruments placed in a solution of it do not rust.

Instead of sponges, **use gauze pads,** or Berlin wool covered with gauze. These may be conveniently sterilized with the dressings.

Never apply any dressing to a freshly-made wound unless such dressing has been previously sterilized either by steam or by boiling in soda solution.

Remember that ligatures (silk, silkworm gut, and wire) should always be

thoroughly boiled and afterwards be kept in a 5% solution of carbolic acid.

Never boil catgut ligatures in water. Remember that water gelatinizes the gut. Catgut may be boiled in xylol, but the following process sterilizes the gut quite as effectually. It should be wound on flat glass plates, thoroughly scrubbed with soap and water, rinsed in sterilized cold water, then immersed in a glass jar containing ether. It is left in this for twenty-four hours; if at the end of this period the ether is cloudy in appearance, the gut should be placed in a fresh solution of ether and left for a further period of twenty-four hours; it is then transferred to a clean glass vessel containing an alcoholic solution of biniodide of mercury 1-200, it is left in this for three days, and is then placed in the same solution, but of weaker strength (1-2000), when it is ready for use.

Remember above all that personal cleanliness is absolutely essential.

ATRESIA.

This may be either congenital or acquired.

Acquired is caused by—

1.—Injuries received during parturition.

2.—The use of caustics.

3.—Operations on the cervix.

4.—Vaginitis, etc.

Do not forget that this condition, either of hymen, vagina, or cervix, is one of the causes of amenorrhœa, and one which requires immediate attention. (See "Amenorrhœa.")

In operating on cases for atresia the **strictest antiseptic precautions** must be observed.

Never fail to examine the condition of the **Fallopian tubes** in cases of atresia. Do this by rectal examination.

Always allow the retained fluid to escape very slowly.

Remember that **re-union may take place,** and, therefore, means must be adopted to keep the tract patent.

BARTHOLINIAN GLANDS.

Do not forget that in abscess of these glands the incision must be a large one, the abscess cavity thoroughly scraped, packed with iodoform gauze, and allowed to heal gradually from the bottom.

Remember that bi-lateral abscesses are usually gonorrhœal.

Always try to dissect out a Bartholinian cyst. If this is impossible, the cyst wall, or the portions of it which have been left behind, should be destroyed by a thermo-cautery, and the cavity treated as above.

Be careful to **secure all bleeding points** after dissecting out the cyst, as subsequent hæmorrhage is not uncommon.

BLADDER AND URETHRA.

Remember that the prominent symptoms of urethral caruncle are:

1.—Painful micturition.

2.—Pain on coitus.

Remember that in the removal of urethral caruncles the cautery should be at a dull red heat, and that the caruncle should be removed deeply.

Remember that when the caruncle is distinctly localized, it is better to dissect it out and then to stitch the mucous membrane with fine catgut.

Remember that stricture of the urethra is very uncommon in women, but that when it does occur, dilatation with Hegar's dilators is the best method of treatment.

Never pass a catheter without:—

1.—First sterilizing the catheter.

2.—Thoroughly cleaning the external genitals.

Never, if you can possibly avoid doing so, expose your patient in order to pass a catheter.

Remember that the cleanest catheter is one made of glass. Such a catheter is sufficiently strong, and is very easily sterilized.

Remember that retention of urine in the female is not common from any cause in the urinary tract itself, but that it occurs in retroflexion of the gravid uterus, and very frequently reflexly after operations in the region of the perinæum.

Remember that amongst other causes of retention are: (1,) Pressure from foreign bodies, *e.g.*, fibroid tumours, or any foreign body in the vagina; (2,) Hysteria. Be wary of passing a catheter in cases due to hysteria. Try all other plans first.

Remember that retention of urine can often be relieved (except in retroflexion of the gravid uterus and in

pressure by fibroid tumours) by squeezing a hot sponge over the external genitals, or by placing the patient in a hot bath. Do not immediately have recourse to the catheter without first trying the above plans.

Remember that incontinence of urine is often the sign of an over-distended bladder, *e.g.*, the retention of urine in a case of retroflexion of the gravid uterus is often accompanied by a slight dribbling (called Stillicidium) from the over-distended bladder.

Do not forget that incontinence of urine may proceed from a fistulous opening from the bladder into the cervix uteri or into the vaginal canal.

Remember that frequency of micturition is a common cause of complaint amongst female patients. An idea as to the frequency may be gained by asking the patient how often she has to rise

from her bed during the night in order to make water.

Remember that the commonest cause of frequent micturition is **cystitis.**

Remember that the best drugs for cystitis are hyoscyamus, salicylate of soda, benzoate of ammonia, and atropine.

When there is pus in the urine, urotropin often acts like a charm.

Always, when washing out a bladder, which is the best treatment in chronic cystitis, inject a sufficient quantity of fluid to stretch out the folds of mucous membrane; if this is not done, the furrows between the folds of the mucous membrane, which may contain mucus or pus, do not come in contact with the fluid.

Always inject the fluid slowly, and introduce as much as the patient can endure without undue suffering.

Always allow the injected fluid to remain in contact with the bladder wall for several seconds.

Never absolutely empty the bladder, lest the mucosa may prolapse into the eye of the catheter.

Repeat the process of irrigation two or three times, until the solution returns almost as clear as when it was injected.

Do not forget that when all other remedies have failed in the treatment of chronic cystitis, **dilatation of the urethra,** sufficient to give the bladder complete rest, will often effect a cure.

Remember that the dilatation should be gradual, and effected by means of Hegar's bougies.

Never dilate rapidly by an instrument that may tear the muscular fibres.

Never dilate the neck of a tuberculous bladder; if you do, permanent incontinence will result.

Remember that the chief causes of vesico-vaginal fistula are:—

1.—Tedious and instrumental labours.

2.—Malignant disease.

3.—Ulceration of tissues from retention of foreign bodies, *e.g.*, retained pessaries.

Do not forget that, if you cannot detect a fistula on inspection, a little milk and water or coloured fluid injected into the bladder will, by the aid of a speculum, be seen to escape through the fistulous opening.

Remember that it is of no use attempting to operate for the repair of vesico-vaginal fistula following labour until at least two months after the labour.

Remember that strong catgut or fine silkworm-gut are the best sutures for fistulæ; the latter should be removed on the tenth day.

Remember that the catheter which is left in the bladder at the time of operation, should be changed daily and thoroughly cleaned.

Remember that stone in the female bladder is comparatively rare; the condition is easily diagnosed by means of the sound, or, after dilatation, by the exploring finger.

Remember that calculi, if of any size, should be crushed before removal; the larger pieces may be removed by forceps and the smaller by washing out the bladder.

Remember that, occasionally, when the stone is very large, removal by an incision through the anterior vaginal

wall is the best method. The incision should be sewn up with silkworm-gut immediately after the removal of the calculus.

BOWELS.

Remember that a large percentage of pelvic disorders is due to constipation, and, therefore, attention to that condition is of the first importance.

Do not forget that in pelvic inflammation saline purges are useful to deplete the pelvic organs.

Remember that, although it is important in all operations to have the bowels thoroughly cleared out beforehand, it is doubly so in gynæcological operations.

Never omit to ask the patient how often the bowels are moved. Do not be satisfied with the answer "Quite regular," but ascertain whether they are moved at least once in the twenty-four hours.

CŒLIOTOMY.

(Syn. Laparotomy. Abdominal Section.)

The abdomen, except the actual field of operation, should be covered, by warm sterilized towels.

Never make the abdominal incision longer than is absolutely necessary; the bigger the wound, the greater the risk of sepsis and of ventral hernia.

Never open the peritoneal cavity until all bleeding points have been secured.

Remember that if there is hæmorrhage, or if pus or tumour contents have escaped into the abdominal cavity, it is advisable to wash out with weak antiseptic (boracic acid or formalin) or normal saline solution (sodium chloride ℥j to sterilized water Oj at 100° F.).

Never close the wound until you are sure that all hæmorrhage has ceased.

If there is any capillary oozing, or if pus be present, it is safer to use a drain. Many a life has been saved by drainage.

Never close the wound until all instruments and sponges have been accounted for. To leave a sponge, a swab, or any instrument iu the abdomen is almost criminal. Close the wound in three layers, the peritoneum with a continuous layer of fine silk, the fascia and muscles with catgut, and use silkworm-gut (interrupted suture) for the skin.

The dressing for the wound should consist of sterilized gauze, or cyanide gauze, over this a thick layer of sterilized wool, and the whole secured by a many-tailed bandage.

CURETTING.

Remember, when curetting a uterus, the curette should be used in a systematic manner, thus:—First scrape the anterior wall; next the posterior wall; and then the lateral walls.

Remember the following rules in curetting:—

1.—Boil instruments.

2.—Antiseptic douche to vagina.

3.—Dilate cervix with graduated bougies (up to No. 17).

4.—Introduce curette and scrape as above.

5.—Wash out débris by double channelled catheter.

6.—Apply an escharotic to the cavity of the uterus (pure carbolic acid, iodized phenol, or chromic acid solution.)

Always, where the uterus is soft and heavy, or where there is an undue amount of hæmorrhage place a tampon of iodoform or cyanide gauze in the uterus; this acts both as a drain and in stimulating the uterus to contract. It can be removed after the lapse of twenty-four hours.

Use an antiseptic douche, biniodide of mercury 1-4000, morning and evening for a week.

Remember that the patient should **remain in bed** for at least ten days after the operation.

DILATATION.

(Of Cervix and Uterus.)

Dilatation is performed for—

1.—Stenosis of cervical canal.
2.—Anteflexion and retroflexion.
3.—Preceding curettage.
4.—Applying medicaments to the interior of the uterus.
5.—Exploration of the uterus.

Always, before attempting to dilate the uterus, eliminate the possibility of pregnancy.

Never dilate immediately before the menstrual period.

Never dilate if there is any symptom of inflammation present.

Remember when dilating the uterus always to pass the sound first in order to ascertain the size of the cavity and the direction of the canal.

Remember that graduated dilators, such as Hegar's, are, as a rule, preferable to rapid dilators.

Never use force in passing dilators. If, after having passed a small dilator, you find that you cannot pass the next in size, return immediately to the smaller one; leave that *in situ* for a few seconds, and then again try the larger one.

Always after dilatation is completed, swab the canal with an antiseptic.

Remember that **the strictest antiseptic precautions** must be observed when dilating the uterus.

DISPLACEMENTS OF UTERUS.

Remember that the most common displacements are *forwards*, and *backwards*, and *downwards*.

Always correct a displacement before inserting a pessary.

Do not attempt replacement until you are certain that there are no complications present, *e.g.*, inflammatory conditions, adhesions, etc If these are present, reduce inflammatory conditions of uterus, or tubes, etc., first.

Always attempt replacement with the fingers and "posturing the patient," before having recourse to the sound and the volsella.

Remember, as a rule, that as soon as replacement is effected it is necessary to insert a pessary to keep the uterus in position.

Remember that patients who are suffering from displacement are often sterile.

Remember that all anteflexions in unmarried women are congenital.

Remember that all anteflexions and anteversions in parous women are due to inflammatory conditions outside the uterus, and are best treated by hot douching and plugging with icthyol tampons.

Remember that anteflexions in young women due to non-development, if causing dysmenorrhœa, are best treated by dilatation.

Remember that retroflexions in single or sterile women are **congenital deformities**, and are best treated by dilatation and suitable pessaries.

Remember that retroflexions and retroversions in parous women are due to conditions **consequent on pregnancy**, subinvolution, etc., and are best treated by reducing congestion, replacement, and pessaries, but on every subsequent pregnancy are apt to recur.

Remember that the most suitable pessary for a retroversion is the Hodge or Albert Smith pessary, but that those are not always the best for retroflexions, where a soft rubber ring more often affords relief.

Remember, when replacing the uterus in cases of complete prolapse, to reduce, firstly the posterior vaginal wall; next, the uterus; and lastly, the anterior vaginal wall.

Remember that in mild cases of prolapse, rest in bed, hot douching, and lightly plugging with glycerine tampons often effects relief.

In the majority of cases of prolapse there will be found a **torn perinæum.** Repair this.

Bear in mind that if pessaries do not keep the uterus in position, and the patient is in great distress, operative measures may be resorted to, *e.g.* (1,)

Repair of the perinæum; (2,) Anterior and posterior colporraphy; (3,) Shortening the round ligaments (Alexander-Adams operation); (4,) Stitching the fundus uteri to the abdominal wall (Hysteropexy); (5,) Stitching the uterus to the anterior vaginal wall (Vaginal fixation); (6,) Stitching the round ligaments to the abdominal wall (Ventrosuspension).

DOUCHING

Never order a Higginson syringe for douching purposes. It is worse than useless. The best appliance consists of a can, a long rubber tube and a glass nozzle.

Always instruct the patient to use the douche lying **flat on her back,** and to place a large bed-pan under her hips; to use water at a temperature of 110° to 120° Fahr., according to the requirement of the case. The douching should last for at least twenty minutes.

Never order cold douches.

Remember that in douching a case of hæmorrhage the temperature of the fluid should be from 118° to 120° Fahr.

The following medicaments may be added to the douche, according to the nature of the disease:—

1.—Alum (℥j—Oj of warm water).
2.—Copper sulphate (℥ss—Oj of warm water).
3.—Zinc sulphate (℥ss—Oj of warm water).
4.—Biniodide of mercury (1 in 4000).
5.—Carbolic acid (1 in 40 to 60).
6.—Tinct. opii (℥j—Oj of warm water).

Boracic acid, thymol, permanganate of potash, creolin, lysol, etc.

DYSMENORRHŒA.

Never prescribe any form of alcohol whatsoever. It *may* give relief, but is

liable to be a starting-point for alcoholism.

Never give opium; it *will* give relief, but the opium habit may be induced.

Do not locally examine young, unmarried women. Try drugs first.

Remember the varieties of dysmenorrhœa:—

1.—Constitutional { Gouty, Rheumatic, Neuralgic

2.—Local { Uterine { Spasmodic, Congestive, Membranous; Extra-Uterine { Ovarian, Tubal

Remember that displacements of the uterus are a frequent cause of dysmenorrhœa. Narrowing of the canal causes a certain amount of obstruction and consequent congestion. This is particularly so in anteflexion and retroflexion.

Remember that in membranous dysmenorrhœa the mucous lining of the uterus is discharged either whole or in fragments.

It is important **not to mistake** membranous dysmenorrhœa for an abortion. To avoid this, examine the "cast" microscopically. Note in a membranous cast the presence of utricular glands and decidual cells, and the absence of chorionic villi.

Remember that ovarian dysmenorrhœa is associated with prolapsed and congested ovaries.

Always attend to the local condition (except in specified cases) in order to effect a cure.

Remember that most cases of dysmenorrhœa due to inflammatory conditions are benefited by the use of the hot douche and of medicated tampons.

Remember that, occasionally, cases occur of intermenstrual dysmenorrhœa (Mittelschmerz).

ECTOPIC GESTATION.

Bear in mind that ectopic gestation is generally preceded by a period of sterility.

Remember that in those who are the subjects of ectopic gestation you will generally find a history of some previous pelvic inflammation, *e.g.*, salpingitis.

Do not forget that there are the usual signs of pregnancy.

Remember that the periods may be suppressed only once, or even not at all, after which come irregular hæmorrhages.

Remember that for the first three months the uterus enlarges *pari passu*

with the ectopic gestation. Growth of the uterus then ceases.

Remember that there is the formation of a decidual membrane in the uterus. This is expelled either in part or whole during one of the irregular hæmorrhages referred to.

Do not forget that the occurrence of intense pain, sickness (sometimes accompanied by vomiting) with fainting (symptoms of collapse) indicate rupture of the sac.

Remember in early extra-uterine pregnancy it is advisable to remove the whole sac. In later cases remove embryo and placenta and leave the sac.

In most cases it is preferable to **leave the placenta** *in situ*, and to pack the cavity with gauze. The placenta can then be removed after a few days.

Remember that as soon as ectopic gestation is diagnosed, its removal is immediately called for.

EXAMINATION OF PATIENT.

Abdominal (see page 11).

A routine examination of the various systems should always be made.

The urine should be carefully examined, more especially before resorting to operative interference.

Remember that the four cardinal symptoms which must be looked for in every woman examined are:—

1.—Bearing down.
2.—Pain in back.
3.—Vaginal discharge.
4.—Menstrual irregularity.

Never examine *per vaginam* without the consent of the patient, and always in the presence of a witness.

Never expose the patient more than is absolutely necessary.

Remember that in the first instance, at least, the left lateral is the best position in which to examine a patient. She ought to be on her left side with her buttocks near the edge of the bed or couch and the knees well drawn up.

Examine the vagina for:—

1.—Patency.
2.—Condition of walls.
3.—Presence of foreign bodies.
4.—Tumour formation.

Next the os uteri, its shape, size, position, if fissured, soft, hard, or eroded; then the cervix, its position, length and shape, if lacerated, hard or soft; finally, examine all the vaginal fornices.

Remember that the lithotomy position should be used as seldom as possible, unless under an anæsthetic.

Remember that your examination is impeded if the bladder and rectum are full. Those should be emptied before the examination takes place.

Always wash the hands thoroughly before examining. Anoint the first two fingers with carbolised vaseline or soap. Flex the fingers into the palm of the hand to avoid soiling the patient's clothes.

Always begin the examination as near the region of the anus as possible, passing the fingers forward until they reach the anterior edge of the perinæum. The fingers (one finger in nullipara) should be inserted into the vagina, keeping them as far away as possible from the anterior and more sensitive parts.

Remember that in order to make your examination complete, the bimanual (abdomino-vaginal) should be always next adopted.

Remember that in young girls it is preferable to conduct the examination **under an anæsthetic.**

Do not forget that in certain conditions a rectal examination is indicated, *e.g.*, in virgins, in malformations, in tumours blocking the vagina, etc.

FIBROID TUMOURS.

Remember that fibroid tumours are most frequently met with in women over thirty years of age.

Do not forget that fibroids sometimes disappear after pregnancy has terminated; (they involute with the uterus).

Fibroids **sometimes atrophy** after the menopause.

Remember that sub-peritoneal fibroids, if of small size, may never give rise to symptoms.

Remember that the most pronounced symptom in interstitial and sub-mucous fibroids is hæmorrhage (menorrhagia and metrorrhagia).

In the sub-mucous variety, on the other hand, there is generally dysmenorrhœa and leucorrhæa.

Remember that the removal of a tumour is called for only if it is giving rise to urgent symptoms:—hæmorrhage from sub-mucous and interstitial fibroids, pressure in the interstitial and sub-peritoneal, pain, or if it shows signs of undergoing degenerative changes.

Remember that in small fibroids curetting gives temporary relief.

GONORRHŒA.

Remember that gonorrhœa is a much more serious disease in females than in males.

Remember that ovaritis and salpingitis are often the result of gonorrhœa.

Remember that the *only certain proof* of gonorrhœa is the demonstration of the gonococcus in the discharge.

Very active treatment is necessary to effect a cure. Simple douching is not sufficient, the affected parts must be swabbed with strong antiseptics.

HANDS.

To Make Aseptic.

The finger-nails should be kept closely pared.

The hands and arms, as far as the elbows, should be thoroughly scrubbed with soap and hot water, either with a sterilized nail-brush or, better, sterilized wood shavings, which can be thrown away after use; this scrubbing should

last for five minutes, next they should be rinsed with sterilized hot water, and scrubbed again with an alcoholic solution of biniodide of mercury (1 in 2000).

It is better not to dry the hands unless with sterilized gauze pads.

HÆMATOCELE.

This word means hæmorrhage into the peritoneal cavity, whereas hæmorrhage into the broad ligament is spoken of as hæmatoma.

Remember the symptoms—sudden pain in the pelvis, followed by pallor and collapse. If the hæmorrhage is large in amount you will get all the indications of it, *e.g.*, fall of temperature, rapid and weak pulse, blanching of the skin, etc.

A blow or a fall may cause hæmatocele, also excessive coitus, or coitus during or near the menstrual epoch.

Hæmatocele is commonly believed to be due to extra-uterine gestation.

Remember that in the majority of cases (especially in the extra peritoneal form) surgical interference is *not* called for.

Absolute rest, the application of ice to the abdomen, and the administration of opium or morphia, are the first essentials.

Remember that the indications for operating are: large and continuous hæmorrhage, and when you have reason to believe it due to rupture of an extra-uterine gestation.

HISTORY OF PATIENT.

Begin with :—

The complaint.

The duration of the complaint.

Age. This is important in relation to puberty, the child-bearing period, and the menopause.

Occupation. Disease is aggravated by certain occupations, and in some cases by the lack of occupation.

Menstruation :—

a.—Normal.
b.—Amenorrhœa.
c.—Menorrhagia.
d.—Metrorrhagia.
e.—Dysmenorrhœa.

Intermenstrual discharge, *e.g.*, leucorrhœa.

Coitus, whether painful or not.

Pregnancy. Dates of first and last; abortions, dates of occurrence and at what period of pregnancy; labours, whether normal, difficult or instrumental.

Post partum conditions.

State of the bowels (*see* page 28).

State of the bladder.

ICHTHYOL.

Remember that this is one of the most useful drugs in the treatment of pelvic inflammation. It is best applied either in the form of pessaries, 10%, or as tampons saturated in a solution of ichthyol and glycerine, 10%.

LEUCORRHŒA.

Remember that this is only a symptom of many diseases.

Always find the cause before attempting treatment.

Leucorrhœa is very often associated with **anæmia.**

Chronic cervical catarrh is one of the chief local causes.

Remember that the use of hot douches with some astringent and antiseptic, such as sulphate of zinc, sulphate

of copper, and permanganate of potash, will often effect a cure.

When the leucorrhœa is uterine in origin, **curetting** or the application of an escharotic to the mucous membrane is the best treatment.

Remember that, in children, leucorrhœa is often vulvar in origin, and is due to dirt, to thread-worms, or to general debility.

MENORRHAGIA AND METRORRHAGIA.

Always examine a patient suffering from the above, more especially if she is at or near the menopause.

Never attempt to treat a patient for hæmorrhage until you have **found the cause.** If on vaginal examination no information is obtained, the uterus should be dilated and explored.

Remember, however, that there are constitutional causes associated with this condition, *e.g.*, plethora, hæmophilia, etc.

The most frequent causes are :—

1.—Retained products of conception.
2.—Subinvolution.
3.—Fibroid tumours.
4.—Endometritis.
5.—Polypi.
6.—Malignant disease, etc.

Do not forget that the best local application is hot water at a temperature of 120° Fahr.

Remember that in severe hæmorrhages, packing of the uterine cavity and of the vagina gives the best temporary relief.

The best drugs are ergot, hydrastis, hamamelis, chloride of calcium, stypticin, and locally, supra-renal extract.

OVARIAN CYSTS.

Remember that ovarian cysts are usually multilocular.

Never aspirate an ovarian cyst unless to relieve urgent symptoms (such as dyspnœa), or when the patient is not at the moment fit for immediate operation.

Remember that after aspiration of cyst, adhesions may form, which tend to complicate subsequent operation.

Never, if possible, allow the contents of an ovarian cyst to escape into the peritoneal cavity.

Bear in mind that pregnancy may be present, and that it is better to remove the cyst in the early stage of the pregnancy.

OVARY.

Remember that hernia of the ovary, though not common, may occur.

The distinctive points are, the **sensitiveness** of the swelling and its **increase in size** at the menstrual period.

If the uterus be pulled down with the aid of a volsellum, it will be noticed that the swelling alters its position.

Remember that prolapse of the ovary is common, and, if left untreated for any length of time, its replacement may be extremely difficult, if not impossible.

Ovaritis is best treated by hot douches, counter-irritation by means of small blisters over the region of the ovary, and by the application of vaginal ichthyol tampons.

Never use fly blisters on a patient who may be suffering from any kidney affection.

Remember that only when salpingo-ovaritis has resisted all medical treatment should operative interference be adopted.

PARAMETRITIS.

The exudation in parametritis, before it has gone on to abscess formation or resolution, has the three following well-marked signs:—

1.—It is hard.
2.—It is irregular.
3.—It is immobile.

Remember that the exudation is so hard and boardy that it feels as if plaster of Paris had been poured into the pelvis.

The uterus, at first is pushed aside by the exudation, and feels as if buried in it (when of large amount); later, when absorption takes place, the viscus is drawn over toward the exudation, due to shortening of the affected ligaments.

Remember that the most frequent cause of parametritis is **septic infection** after labour or abortion.

If abscess formation takes place you should open *per vaginam*.

Never wait for the abscess to point. Once you have made your diagnosis, open freely and drain.

Do not forget that the abscess, if left to itself, may burrow into the rectum or bladder, and the condition becomes practically incurable.

PAROVARIAN CYST.

Remember that a parovarian cyst is always unilocular; that its contents, unlike those of an ovarian cyst, contain as a rule a bland, non-irritating fluid. Rupture is, therefore, not so serious as in the case of ovarian cysts.

PERINÆUM.

Remember that after operations about the perinæum retention of urine is a frequent symptom.

In most cases of perineal operations it is advisable to **pass the catheter** every

six hours for the first two or three days.

The **bowels may be opened** on the second day by an enema of olive oil, this should be given daily.

Be careful to prevent infection of the wound from the rectum.

PESSARIES.

Never insert pessaries while the parts are in a state of inflammation.

Always, after a pessary has been inserted, let your patient bear down, cough, and walk, in order to ascertain if the pessary fits and is comfortable.

Remember that a pessary, if it produces pain or discomfort, should be at once removed.

If a pessary fits properly the patient is **not conscious** that she is wearing one, unless by the relief of symptoms.

Always make a careful examination in order to find out what kind and size of pessary is required for each individual case.

Remember that the following pessaries will meet the requirements of most cases:—Ring, Hodge, Albert Smith, Zwaencke, and Cutter.

Never let a pessary project beyond the vulva, nor should it impinge on the symphysis. Its upper end should not press unduly against the fornix.

Always give careful instructions to your patient to return for the removal and cleansing of the pessary. If she douches daily, the pessary may then remain *in situ* for two months at a time.

PREPARATION OF PATIENT.

1.—For Abdominal Operations:—

Where possible begin your preparations at least four days beforehand.

The bowels should be thoroughly regulated.

The night before operation, a warm bath should be given, and the patient thoroughly washed.

After the patient is back in bed, the abdomen is well lathered, preferably with liquid soap, (as this can be sterilized), and sterilized water and shaved; after this the skin should be thoroughly rubbed with a sterilized gauze pad, special attention being paid to the umbilicus, first with alcohol, then with ether, and next with a 1-2000 solution of biniodide of mercury.

Finally a large sterilized gauze pad is securely fastened over the abdomen and left on until the operation.

Castor oil, or any other suitable purgative should be given, and early next morning an enema.

When the patient is on the operating table and under the influence of the anæsthetic, the protecting gauze pad is

removed, the abdomen is again rubbed with alcohol, ether, and biniodide of mercury, and then covered (except the actual field of operation) with warm sterilized towels.

2.—For Vaginal Operations :—

Preliminary preparation as regards baths and bowels as for abdomen.

The external genitals should be shaved, washed with soap and hot water, and scrubbed in the same way as described for the abdomen ; the vagina is douched gently with a warm solution of biniodide of mercury (1-4000), and the night before operation is packed with sterilized gauze.

The vulva is protected by a large pad of sterilized gauze kept in position by means of a T bandage.

After the patient has been anæsthetised and placed in the lithotomy position, the sterilized gauze pad and packing are removed, the external genitals are again thoroughly cleansed, the vagina thor-

oughly washed with sterilized soap and water, a douche of 1-2000 biniodide of mercury, and finally plain sterilized warm water.

All the above should only be carried out by the surgeon or nurse after their own hands have been made thoroughly aseptic (*see* Hands, page 48).

PRURITUS.

Remember that this condition may be due to causes either:—

1.—Constitutional, e.g., *Diabetes.*
2.—Local, e.g., *Leucorrhœal or Gonorrhœal discharges.*

Before attempting treatment determine the cause.

REST.

Remember that in gynæcological practice both physical and sexual rest are essential.

SHOCK.

Ether or brandy ℥ss, should be at once administered hypodermically, to be followed by strychnine gr. $\frac{1}{30}$.

An enema should be given, composed as follows: —

℞ Brandy ℥ij
Ammonium carbonate gr. xxx
Distilled water to ℥viij, at a temperature of 100° F.

The strychnine should be repeated every hour, and suspended if muscular twitching be noted.

Subcutaneous injection (under the mammary gland) of normal saline solution (sodium chloride ℥j, distilled water Oj), should also be given at a temperature of 100° F.

Hot-water bags should be placed in the bed, care being taken that they are protected and not in immediate contact with the patient's body.

The foot of the bed should be raised five or six inches.

SOUND.

Never introduce a uterine sound :—

1.—Until it is sterilized.
2.—During menstruation.
3.—During inflammatory attacks.
4.—During amenorrhœa (unless you can absolutely exclude the possibility of pregnancy).

Remember the information which can be obtained by using the sound : —

1.—The length of the uterine cavity.
2.—The patency of the canal.
3.—The direction of the axis of the canal.
4.—The presence of a foreign body or tumour growth.
5.—The mobility of the uterus.

It may also be used :—

1.—To restore a displaced uterus to the normal position.
2.—To apply medicaments to the interior of the uterus.

SPECULUM.

Always warm the speculum before introducing it.

Remember that the best form of speculum to use in making applications to the cervix is that known as the tubular.

In all other cases when the speculum has to be used the spatular is the best form, *e.g.*, Sims'.

STERILITY.

Few women are primarily sterile, but the following are some of the causes :—

Absence of ovaries, tubes, uterus or vagina.

Atresia of ovaries, tubes, uterus or vagina.

Stenosis of os uteri.

Displacements.

Inflammatory conditions, etc.

In most cases, however, sterility is due to hyperæmia and hyperæsthesia of the uterine mucosa, and is best treated by the curette.

Remember that if, after careful examination, you can discover no cause in the woman, the husband may be at fault.

SYPHILIS.

Do not forget the possibility of syphilis when a patient complains of recurrent abortions.

Remember, if your patient is a married woman, that it is advisable to put both husband and wife under the influence of mercury.

TUBERCULOUS PERITONITIS.

Remember that encysted tuberculous peritonitis is **difficult to diagnose** from parovarian tumours. Be guided by the

general condition if the vagino-abdominal examination does not help you.

URETERS.

Remember the danger of wounding these structures in vaginal hysterectomy.

The ureter may open directly into the vagina, and is liable to be confounded with vesico-vaginal fistula.

UTERUS (CANCER OF).

Never tell a patient that she is suffering from cancer unless really necessary. Tell her friends.

Remember that **hæmorrhage after the menopause** is suggestive of malignant disease, and that before the climacteric, **hæmorrhage after coitus** is equally suggestive of cancer.

Never omit to examine a patient who complains of metrorrhagia. Malignant

disease may be present, and the earlier you recognize it the better are the chances for removal.

Remember that in cancer of the cervix the discharge is usually foul smelling, but when the disease affects the body of the uterus it is not, as a rule, offensive until the later stages.

Remember that in cervical cancer **pain is often absent**; when present, is sharp and intermittent; in fundal cancer it is more acute and periodic.

Remember the four cardinal signs of cancer are :—

1.—Hæmorrhage.
2.—Foul discharge.
3.—Pain.
4.—Cachexia.

Remember that chronic cervical catarrh is the condition most apt to be confounded with early cervical cancer.

If in doubt, excise a small wedge-

shaped portion from the cervix and examine it microscopically.

Remember that senile endometritis closely simulates in many respects cancer of the body of the uterus. When in doubt as to diagnosis, microscopic examination of a scraping will in most cases clear up the difficulty.

Never dilate the cervix, and curette in cancer of the body of the uterus, except for diagnostic purposes, and unless you are prepared to proceed at once to the further operation of hysterectomy. Curetting only makes matters worse, and hastens the advance of the disease

Never perform hysterectomy unless you can pull the cervix down to the vulva. If this is impossible, you may be sure the broad ligaments are affected, and that operation is useless, as the disease will soon recur.

Remember that you may palliate

cervical cancer by removing with the cautery small portions of the fungating mass; this checks hæmorrhage for the time.

If **hæmorrhage** is sudden and profuse, plug the vagina tightly with iodoform gauze.

Do not forget that you add to the comfort of the patient if you can relieve her of the foul odour which accompanies cervical cancer. This is best done by plugs of cotton wool soaked in a saturated solution of potassium chlorate.

ENDOMETRITIS.

Remember that this condition is frequently due to abortion, labour, or infection from the cervix.

Remember the chief symptoms are:—

1.—Leucorrhœa.
2.—Tenderness of the uterus.
3.—Menorrhagia.
4.—Dysmenorrhœa (sometimes).

Remember to try the effects of hot douching and drugs (ergot) before resorting to operative treatment.

Do not use the curette except in cases where there has been recent abortion or where the cavity of the uterus is enlarged and roughened, or in the endometritis caused by fibroids, or where the menorrhagia has not yielded to douching and ergot.

VAGINA.

When plugging the vagina in the treatment of inflammation, the plug should be one of absorbent cotton wool in strips about twelve inches in length, three inches wide, and an eighth of an inch thick. Over this is poured glycerine, or ichthyol and glycerine. The edges of the wool are turned over to the centre and the whole is twisted into a rope.

Always have the patient in the left lateral position. Then, with the Sims' speculum separating the vaginal walls, introduce the plug, taking care to pack well round the fornices.

A convenient way of **swabbing the walls** of the vagina is by passing a Fergusson's speculum well up into the fornix. A medicated swab on a holder is introduced until it touches the cervix, the speculum is withdrawn a little, and then both speculum and swab are further slowly withdrawn, the vaginal walls closing on the swab as it projects beyond the end of the speculum.

VAGINISMUS.

Remember that this condition is most commonly due to:—

1.—Urethral caruncle.
2.—Vaginitis (acute or chronic).
3.—Hysteria.

4.—Fissure (rectal or vaginal).

5.—To spasm of the muscles of the pelvic floor.

6.—Impotence in the male, leading to ineffectual coitus, thus causing hyperæsthesia in the female.

Treatment:—

As far as possible remove the cause; *e.g.*, caruncle, fissure, etc.

Sexual rest, hot douching, dilatation of vagina, and the wearing of a vaginal bougie for a few days. If necessary the fibres surrounding the vaginal opening may be divided.

VAGINITIS.

Remember that simple vaginitis is most commonly due to want of cleanliness, or to the too long retention of pessaries or foreign bodies in the vagina.

In the acute stage, give warm vaginal douches (to which may be added Tinct.

Opii. ℥j–Oj) three or four times daily. At night a pessary containing cocaine, belladonna, and oil of theobroma.

Second stage, astringent and antiseptic douches, (sulphate of zinc ℥ss–Oj, sulphate of copper ℥ss-Oj, biniodide of mercury 1–4000).

Remember that gonorrhœal vaginitis is usually secondary to infection of the vulva and cervix. On that account, your treatment must be applied to those structures before you can hope for a cure of the vaginal condition. (*See* "Gonorhœa" page 47.)

VULVA.

In examining, note:—

The condition of the hymen (if present), urethral orifice, clitoris; if any swelling, tumour formation, hyperæmia, sores, or discharge.

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