EROSIONS OF CERVIX

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In an attempt to review non-malignant conditions of the cervix, information on these cases was obtained from three large hospitals in Bombay, and a total of 242 cases were collected. Of these 224 had erosions of the cervix, 5 had tuberculosis of the cervix, 10 had mucous and fibroid polypi, one had a large cervical fibroid and two had retention cysts.

It was difficult to work out the actual incidence of erosions of the cervix among the total number of gynaecological patients attending the out-patients' department, as the cervix is not inspected as a routine in every case, and so a number of erosions with no symptoms are missed. Ross gives an incidence of 36%, while Fulkerson gives an incidence of 33%.

Age Incidence. Erosions of the cervix are seen to affect all ages. The incidence in different age groups is given in Table I.

In 48 cases, the age of the patient was not noted down. The commonest age group is from 21 to 30 years, but this is not of much significance, as that is the commonest age period during which the majority of deliveries take place, and therefore, the consequent susceptibility to trauma and infection.

The two oldest patients were 70 years of age.

Parity. That erosions commonly occur in parous women is well known, as is shown in Table II.

There were 28 nulliparous women with erosions, the latter being congenital in origin in most cases, as no history of chronic infection was obtained in any of them.

TABLE I

Age Group	15-20	21-25	26-30	31-35	36-40	41-45	46-50	51 & over
	21	70	50	17	12	2	2	2

TABLE II

Number of children.	Nil	1	2	3	4	5	6	7	8	9	10	Not noted
	28	52	44	25	28	11	14	6	4	5	4	3

Symptoms. The clinical manifestations of cervical erosions are

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diverse. These symptoms were analysed in order to see with what frequency they occurred. The main symptom or the symptom which worried the patient most, even though she may have had other symptoms, is given below in their order of frequency. Some of these symptoms are due to other co-existing conditions.

Symptom	Number of cases.
Leucurrhoea ..	68
Pain in the lower abdomen	32
Sterility	32
Backache	12
General debility	8
Polymenorrhoea and irregular periods	17
Profuse periods	6
Blood stained discharge ..	5
Prolapse	4
Dysmenorrhoea	4
Scanty periods	3
Pruritis	2
Incontinence of faeces (due to complete tear) ..	2
Dyspareunia	1
Bleeding after amenorrhoea of 2 months	1
Dysuria	1
Bleeding with micturition	1
No symptoms	3
Symptoms not noted down	22

Leucorrhoea was the main symptom in 30.3% of cases, although it was from a total of 164 cases. That means it was a secondary symptom in 96 patients. In 60 patients, or 26.8% of cases there was no leucorrhoea, which shows that erosions need not necessarily be accompanied by leucorrhoea.

Sterility of more than 4 years' duration was present in 86 cases, though it was the main complaint in 32 patients. Of the 86 cases, 19 were cases of primary sterility and 67 of secondary sterility. Although there are other more important causes of sterility, there have been a few incidents in which conception occurred after the erosion had been successfully treated. In the series of cases presented in this paper, the patients were not followed long enough to see how many of them conceived after treatment. All the same, it is very important that the cervix be inspected as a routine in every sterile woman before investigations for other causes of sterility are taken up, keeping in mind the large part the cervical factor plays in the causation of sterility.

Backache was complained of in 75 cases. Although other causes of backache must be remembered, a chronic cervicitis must not be ignored as one of the causes of low backache. This cause can be ruled out if the backache still persists after the erosion has healed.

Pain in the lower abdomen was present in 57 patients. The pain may be localised in one of the iliac fossae, or be generalised over the whole of the lower abdomen.

Dysmenorrhoea was complained of by 60 patients, in the majority of whom it was of the congestive type.

Twenty-one patients complained of dyspareunia. In only four of these, other obvious clinical causes were also present. Where cervical erosion is the cause of dyspareunia, tenderness is often elicited on moving

the cervix during a vaginal examination.

There were 15 patients who complained of profuse menstrual periods. Though other pathological lesions are more often the causes of menorrhagia, cervical erosion is associated with it in a few instances, as has been noted by Young and Ross.

In 10 patients, blood-stained discharge was present, in only one of which there was bleeding on touch, the biopsy report in this case showed evidence of chronic endocervicitis.

General debility was complained of in 22 patients who otherwise appeared quite normal. This fairly common complaint can be attributed to the layman's idea that any vaginal discharge tends to weaken the patient. Urinary symptoms were present in 15 cases. This is due to an associated trigonitis in some cases, but is usually the result of a reflex nerve irritation, as is explained by Young. Of the 15 patients, 7 had dysuria, 5 had burning micturition and 3 had frequency of micturition.

Pruritis vulvae was present in 5 cases. No other demonstrable cause, other than a cervical erosion was found in these cases.

Prolapse of the vaginal walls was present in 10 cases, and a complete perineal tear in 2 cases. These were associated conditions. In none of the cases of prolapse was the cervix lying outside the vulva and therefore the erosion was not caused by the constant trauma of rubbing against the thighs and clothes.

Five patients complained of joint pains.

With all these symptoms mentioned above, besides remembering other causative factors, one must not fail to look for a cervical erosion, which if untreated may condemn a patient to chronic ill-health as the result of these symptoms. Cases have been reported where patients have been subjected to unnecessary operations on a mistaken diagnosis, the persisting symptoms being subsequently relieved by treatment of the erosion.

Investigations.

The pH of the vagina and the cervical canal was done in 50 cases. In all these patients the pH of the cervical canal varied from 7.0 to 7.5. which is more or less normal. On the other hand, the pH of the vagina varied in different cases. It was 4.5 in 24 cases, 5.0 in 8 cases, 5.5 in 6 cases, 6.0 in 10 cases and 6.5 in 2 cases. So, in 50% of the cases the pH of the vagina tended towards the alkaline side.

Cervical biopsies were done in 7 cases, because of suspicious areas which bled on touch. In all these cases, the report was chronic inflammation. In 3 other patients, the biopsy was done after a total hysterectomy, this radical method of treatment being employed because of the existence of a suspicious cervix in a woman near or after the menopause.

The Kahn test was done in a few cases to exclude syphilis.

Treatment. It is imperative that all cases of cervicitis be adequately treated if that dreaded complication, carcinoma of the cervix is to be avoided. Craig found that in 2,895 cases of cervicitis treated adequately

and then followed for a period of 10 years or more, not one case of carcinoma of the cervix developed.

The majority of patients, i.e. 205, were treated by electrocoagulation, 8 had applications with tincture iodine or iodized phenol, 3 had total hysterectomy (1 vaginal and 2 abdominal) and 8 patients were not treated.

Those patients who had treatment by local applications of iodine or iodized phenol were not followed long enough to note the effectiveness of this line of treatment. This method of treatment is used by some doctors for tiny erosions or very superficial erosions.

Electrocoagulation of the cervix, using a short-wave diathermy machine, is the treatment of choice in the majority of cases. Of the 205 patients who had electrocoagulation, 17 did not return for a follow up. The erosions healed completely in 133 cases, giving a percentage of 70.7 cures. Much better results have been obtained by Ross, in whose series 99.2% were cured. Of these, in 55 patients the erosions were found to have healed after one month, in 65 patients after 2 months and in 13 patients after 3 months. From these figures one realises that a repeat electrocoagulation of the cervix should not be done if the cervix is still raw after one or two months. The majority of erosions take 6 to 8 weeks to heal, and a few erosions may heal after 3 or 4 months. The erosion should be inspected every month after electrocoagulation, and no harm is done in waiting for 3 or 4 months to see if it will heal. If, after 4 months the erosion is still raw, it should be electrocoagulated again, making quite sure by biopsy that a malignant change has not occurred. In elderly patients, other radical methods of treatment may have to be employed.

Of the remaining patients, 9 had almost healed after one month, and 4 after 2 months. In 23 cases, the cervix was still raw after 1 month, and in 9 cases it was still raw after 2 months. In all these cases, as the patients did not turn up again for re-examination, it is not possible to state in how many of them the erosion might have healed after one or two or even 3 months. In one patient, the cervix was still raw 5 months after the initial treatment. This patient was advised a second electrocoagulation, but she did not report again.

In 5 patients, the electrocoagulation was repeated after 2—3 months as the erosion had not healed. In 2 of these, the erosion had healed when seen 1 month later; in two other patients, the erosion was still raw one month later, and these cases did not report again. The fifth patient was not seen at all after the repeat electrocoagulation.

Some cases of endocervicitis, which are accompanied by thick mucopurulent discharge, require dilatation of the cervix and electrocoagulation from within the canal, the patients being given general anaesthesia. This line of treatment was given to 4 patients, two of whom already had electrocoagulation of the cervix with no relief. In 3 patients, the local condition had healed completely when seen one month later;

the fourth patient was not seen again after she had had this treatment.

In no patient in this series, were other methods of treatment, like amputation of the cervix, trachelorrhaphy, or conization done.

The results of treatment as regards symptomatology were only possible in 75 cases, and were as follows:—

Leucorrhoea was relieved in 74% cases.

Backache 50% relieved.

Pain in the abdomen—60% relieved.

Dysmenorrhoea—25% relieved.

Urinary symptoms—50% relieved.

Three patients with pruritis were all relieved. One patient was relieved of her menorrhagia. Cases of sterility were not followed up long enough in this series to see if they had conceived.

Complications.

Pelvic cellulitis occurred in one case, who reported 15 days after electrocoagulation with a history of fever and pain in the abdomen. Another patient developed bilateral salpingitis. These were the only instances in which complications developed. Haemorrhage after cauterisation was not reported in this series, although we come across this complication quite frequently among our private patients. Probably, the patients attending the out-patients' department are not sufficiently alarmed by this complication if at all it occurs and hence do not report. Stenosis of the cervix was seen in one patient, who is not included in this series. She had had cauterisation of the cervix done soon after marriage and was now worried about sterility. She was found to have stenosis of the cervix and conceived soon after a dilatation was done.

Summary.

An analysis of 224 cases of cervical erosions is presented. The symptoms varied greatly with different patients. Although leucorrhoea would be a natural consequence of this disease, it was the main symptom in 30.3% of cases and in 26.8% of the cases it was absent. The remaining patients had leucorrhoea as a secondary symptom. The other important symptoms are backache, pain in the lower abdomen, dysmenorrhoea, dyspareunia and urinary symptoms.

Stress is laid on the fact that some of these symptoms are caused by cervical erosion, and that this condition should be treated first before subjecting the patient to an unnecessary operation or condemning her to chronic ill-health.

The treatment of choice, electrocoagulation, was done in 205 cases with a percentage of 70.7% cures. Three patients had hysterectomy, 8 had local applications with iodine or iodized phenol, and 8 patients were not treated. The results of treatment as regards symptomatology were possible to be assessed in 75 cases. Relief from some of the symptoms did occur in from 25 to 74% of cases.

The complications that occurred were pelvic cellulitis in one case

and bilateral salpingitis in one case.

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