IMPLICATIONS OF THE SPECIALITY OF OBSTETRICS AND GYNAECOLOGY

Trends in Gynaecological Work

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The foregoing dissertation on the wide scope of preventive work in Obstetrics will have shown the extent to which certain gynaecological problems can be reduced.

Gynaecological work may be divided into:

1. Legacies of trauma, and relaxations (perineal, vaginal & cervical tears, fistulae, prolapse and certain displacements).
2. Inflammatory conditions.
3. Endocrinal aberrations.
4. New growths.
5. Developmental defects.

1. Taking each of these groups for deeper consideration, we will see how far one can minimise work in any of these categories. Western workers made out that about 60% of gynaecological work was the result of bad obstetrics. For our country, I feel, the percentage will be higher, and much of this, as we have seen, is preventable. Ante-natal work should go a long way towards warning the obstetrician about cases of disproportion, malpresentations, etc. Much trauma to mother and foetus results from omission to realise the degree of disproportion, and unwise attempts at vaginal delivery. Strong traction with forceps, applied on a head at a level higher than ideally permissible, and, in addition, an improper grip of the head, will drag on the attachments of the cervix and vaginal vault, traumatise the septa between bladder and vagina in front, and the rectum and vagina at the back, and cause bad cervical, vaginal and perineal lacerations. Stress incontinence is probably brought about after such forcible traction. Vesico-vaginal fistulae, as seen until a few years ago, were most often the result of neglected labour, when the head had been left too long jammed in the pelvis resulting in sloughing of parts. But since the last ten years or so, I have felt that there was a shift in the causation, and a number of cases of fistulae resulted from unwise attempts at vaginal delivery. If the work of the untrained dai is being controlled we must also see that doctors learn to tackle obstetric problems with care and consideration. Good ante-natal work will minimise the intra-natal problems; however, much vigilance has to be exercised during the labour to foresee possible aberrations, and to adopt prompt measures.

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Careful suturing of lacerations, and above all perfect asepsis, will ensure good union.

Prolapse is commonly seen in multiparous women. This incidence may possibly be reduced by proper spacing and limitation of families.

Retroversion, if acquired, is usually the result of subinvolution. We have seen that this is preventable, by proper management of the puerperium and the post-natal period. Pessary has hardly a place in the permanent cure of retroversion, but as a palliative measure it is useful and in certain cases helps towards a permanent cure. These latter are cases where the retroversion is considered responsible for repeated abortions about the third month. If knee-chest exercises are not found sufficient to keep the uterus up, a pessary may be inserted and kept in till the uterus is an abdominal organ, that is almost till the end of the fourth month. But this is not sufficient, for the uterus will fall back again during the post-natal period unless the precaution of ensuring involution in the anterior position is taken. It is best that such cases are examined earlier than the fourth week during the post-natal period, and, if the uterus is found retroverted, in spite of regular knee-chest posture, it is best to insert a pessary, of course after correcting the position, and leave it in for about a month. This will probably bring about a permanent cure of the retroversion without resorting to operation. Such a result is only possible if the woman conceives, as we then take advantage of the subsequent involution. The operation of ventri-suspension is perhaps overdone. As we have seen, retroversion and retroflexion are natural positions in nearly 25% of women and unless one can definitely ascribe the symptoms, for which the woman seeks advice, to the retrodisplacement, one is not justified in advising an operation.

2. *Inflammatory Conditions:*

The common causes under this head are:

(a) Puerperal and abortion sepsis.
(b) Neisserian infection.
(c) Tuberculous affection.

The most outstanding inflammatory affections are those of the tubes and ovaries. Results of puerperal sepsis should not be, and in fact are not, seen these days in view of strict asepsis and prompt antibiotic treatment in suspicious cases; but post-abortal infection is still common, largely because there is still a tendency to unwise attempts at abortion. This incidence, we hope, will go down with the propagation and proper understanding of the scope of contraception. With the popularisation of the ideas on family planning, induction of abortion is being demanded by the public, but the medical profession must beware of acceding to this request. The public must be made to realise that the idea of family planning is based on prevention of conception and not on interruption of pregnancy. We medicals are permitted to induce abortions only on medical grounds, and that too when two consultants agree on the procedure. Social aspects, although often deserving consideration, cannot be permitted to influence our judgment. You will recollect the case made out by Aleck

Bourne a few years ago, with a view to enlist public opinion, but one must get legal sanction for interrupting pregnancy even under such extenuating circumstances.

Inflammatory affections of the uterine adnexa often involve the uterus, which is drawn back and is adherent. There are no two opinions as to the need for operative treatment of such a retroversion. Inflammatory mischief of the tube may either involve the whole thickness of the tube, in which case it may not be possible to save much or any of it, or, on the other hand, there may be adhesions round the tubes and ovaries, embedding them, the tubal lumina being patulous. These latter cases are more hopeful of treatment by operation.

The incidence of tuberculosis of the genital tract should go down with the general reduction of tuberculosis in the population, if effective anti-tuberculous measures are brought into force. This, of course, is part of the general public health propaganda.

3. *Endocrine Disorders*:

Endocrine disorders seem rather inexplicable, and at the same time prove refractory to treatment. This is partly due to an improper and imperfect conception of the normal play of endocrines and consequent tendency to empiric treatment, based on prominently proclaimed advertisement. We must take a rational view of this important problem. Time will not allow of going into details of endocrinology in gynaecological practice, but I would like to remind you that action of endocrines is largely dependent on a properly balanced diet, providing an adequate supply of, and a proper proportion of, the various vitamins and salts, as also on emotional factors. There is thus a suggestion for the prevention of endocrine disturbances by properly ordered living, comprising hygienic, dietetic and psychic adjustments.

Many a menstrual disorder seems to have as its aetiology an endocrine aberration. Cases of prolonged amenorrhoea or the so-called dysfunctional bleeding are common instances. Careful evaluation of the accompanying signs and symptoms will prove helpful, and, if one has excluded organic causes, and carried out endometrial biopsy and hormone assay, endocrine therapy may be found useful; but for this to be effective, one must chalk out the treatment in a methodical manner, following the cyclic pattern laid down by nature. The treatment will have to be spread over some months to allow of the initiation of the natural endocrines into regular activity. Here again endocrine therapy should not be overdone. Dosage must be adequate but not drastic, as we would only start a train of symptoms which may be difficult to control. Cases of amenorrhoea and dysfunctional bleeding, if not benefitted by endocrine therapy, may often respond to low-dosage X-Ray therapy to the ovaries and the pituitary, or to resection of ovaries, the capsule of the ovaries being extra thick leading to retention cysts.

4. *New Growths:*

Our limited knowledge has not yet given us an explanation for the deve-

lopment of neoplasms. We have but to recognise their presence and treat them.

The treatment of non-malignant tumours is fairly straight-forward and ensures a good span of life in most cases, but the problem of malignancy is intriguing. The present aim is to detect the onset of malignancy at the earliest stage, treatment of which will mean minimum trauma and good prospects of permanent cure. The problem is being tackled from various angles. Perhaps the most important procedure is what is known as regular prophylactic examination. In some of the advanced countries women in the cancer age are advised to come up for periodic overhaul (say, every six months) and also advised against neglect of the suspicious symptoms in the intervening period. *The two commonest sites of malignancy in women are the mammary glands and the cervix.* Every gynaecological centre should definitely organise clinics for the periodic check-up of women in the cancer age, but it will take long for even the enlightened public to realise the significance of these and thus the attendance will be poor. We must, therefore, make a practice of doing prophylactic examinations of these two regions (the mammary glands and the cervix) in women of 30 and over, coming up to the gynaecological out-patients, even if their symptoms do not point to the need for an examination of these regions. Routine palpation of the mammary glands to exclude the presence of even an early nodule and routine vaginal examination in every married woman of 30 and over, will occasionally reveal an early case. An additional investigation advised of late is vaginal cytology, followed, if suspected, by cervical biopsy. This my be preceded by Schiller's iodine test.

Prophylaxis of cervical carcinoma lies in adequate treatment of *chronic cervicitis,* a very common gynaecological affection, giving rise to chronic discharge and backache, and keeping up irritation. Chronic cervicitis is often the result of labour, and should be looked for and treated during the post-natal examination. Electrocoagulation has been of great help in bringing about healing of the lesion and subsidence of the distressing symptoms. Statistics have been compiled to show the reduction in the incidence of carcinoma in cases treated by electrocoagulation. Later writers advocate conisation by preference. *Endocervicitis* is a condition little understood as an entity. On the analogy of chronic cervicitis of the portio vaginalis being a precursor of carcinoma of the vaginal portion of the cervix, endocervicitis may be considered a precursor of endocervical carcinoma. There is usually a thick muco-purulent discharge seen oozing from the canal, the portio vaginalis appearing quite healthy. Palpation will reveal an undue patulousness of the canal. In some cases the canal is patulous enough to allow of radial electrocoagulation, but otherwise a full dilatation of the canal to about No. 14 Hagar's dilator followed by radial electrocoagulation would be the right treatment. Apart from vaginal cytology, in suspected cases endocervical cells may be aspirated for cytological examination.

Carcinoma of the body of the uterus is proportionately commoner in nulliparous women, at an age higher than that of women commonly liable to carcinoma of the cervix. There is a higher incidence of associated fibroids. An interesting article on the relative incidence of carcinoma of the uterus by Magner and Kearney shows that the relative incidence of carcinoma of the body as against that of the cervix depends on socio-economic factors. They examined 1,612 specimens, either by sections of uterine curettage, uterine or cervical biopsy, and found "a disproportionately high incidence of carcinoma of the body in their cases which were drawn from higher socio-economic groups. Carcinoma of the cervix was more common in the lower classes, who married early and bore a number of children before the age of 25. Unrepaired lacerations and syphilis seemed to form definite factors in influencing the higher incidence of carcinoma of the cervix in these classes." Early diagnosis of carcinoma of the body can be made by cytology of fluid aspirated from the uterine cavity. Endometrial biopsy may also be considered necessary. In this connection I would like to remind you that, in cases being investigated for early malignancy the whole area of the endometrium will need to be scraped and sent for histological examination, as otherwise an early localised focus will be missed. A suction biopsy curette, used in the consulting rooms, is suitable only in cases where the endometrium is known to be of uniform quality, as in cases of the various phases of the menstrual cycle, dysfunctional bleeding, and quite often tuberculosis of the endometrium.

The possibility of chorion-epithelioma after vesicular mole should constantly be kept in mind and Friedman's test done at frequent intervals, at least for two years. Again, cases of irregular bleeding, following after a full-term labour or an abortion, should also be investigated to exclude chorion-epithelioma.

The rare functional tumours of the ovary also make the endometrium more prone to malignancy. In this connection one must bear in mind the marked hyperplasia of the endometrium in response to the continuous stimulus from an ovary, which is probably the seat of a granulosa cell tumour or a luteoma, which hyperplasic condition is very difficult to differentiate from an early malignancy. It requires an expert pathologist to give the right verdict.

The treatment of malignant conditions is drastic, whether it be operative or radiological. Both these procedures are specialisations in the strictest sense, for much harm (apart from mortality) can result by the slighest deviation from prescribed rules. Urinary fistulae, vesical or ureteral, have been reported after operative as well as radium treatment. Such morbidity should be preventable. Extensive exenterations of pelvic viscera are being practised of late for advanced cases of carcinoma of the cervix, and reports of cases, treated on such lines and surviving with non-recurrence for years, have been published. How far these are justified can only be proved after

a follow-up of a good number of cases.

5. Developmental defects form an intriguing subject, and require much ingenuity for detecting some of the intricate types, and resourcefulness in treating these. Some of the defects have a bearing on conception and on pregnancy and labour. The worst defect, perhaps, is absence of development of the Mullerian ducts. How far one may be justified in subjecting the woman to operative procedures for giving her an artificial vagina is a moot question, but it is best to put the facts squarely to the party concerned before undertaking the treatment.

Conservative Gynaecology

Victor Bonney would be looked up to as the father of conservatism. He has shown by his extended operation of myomectomy that it is possible to save a large number of uteri in the child-bearing period. He has also shown that it is possible to save functioning ovarian tissue even in cases where apparently there is hardly any visible tissue to conserve. By the operation of cystectomy the so-called thin capsule at the base may be conserved and sewn up and thus the ovarian function kept up. The problem of conservatism was perhaps most intriguing in cases of chronic salpingo-ophoritis. The type of cases where the tubes are either thickened and occluded throughout their course, have pockets of pus, or are papery thin due to distending hydrosalpinx, are the least hopeful ones for conservatism. Ovaries may also be completely damaged by pus pockets. However, with the advent of chemotherapy and antibiotics one is glad to note that such cases are few and far between. Early exhibition of anti-infective therapy has definitely prevented the cases going on to such gross pathology.

Endometriosis of the ovaries, however, is still a problem. In the rapidly developing and spreading type it may not be possible to relieve the symptoms short of castration, either by operation or radiation.

The operation of hysterectomy is perhaps, done too frequently and one would like to warn young gynaecologists against such a practice. It may be a justifiable procedure near the menopause, but during the child-bearing period every effort should be made to preserve the uterus and its function. Some may argue that the uterus with its cervix is the commonest site of cancer in women and therefore it is best removed. Such an argument can not stand ground. Cases need careful evaluation ere drastic treatment is carried out. I have seen cases almost mental after removal of the uterus at the age of about 25. Mayo Ward's operation for prolapse is very popular with the majority of gynaecologists, but here again the risk of vault prolapse at a future date has to be bourne in mind.

The operation of pre-sacral sympathectomy for primary dysmenorrhoea seemed very popular a few years ago. In all my practice of over forty years, I have had very few occasions when I felt the necessity for this operation. The majority of dysmenorrhoeas are of functional origin and respond to general management and suggestive treatment. An investigation was carried out by the Medical Women's

Federation in England into the incidence of dysmenorrhoea in girls' schools and their relation to active outdoor exercises. It was found that those girls who led an active life hardly suffered from dysmenorrhoea. A girl with sedentary habits, subject to constipation and of an introspective nature, is most liable to spasmodic dysmenorrhoea, and such a girl should be given the right guidance rather than subjected to neurectomy.

Thus I am inclined to think that there is a good scope for reducing operative gynaecology in a large number of cases. The patient coming to us must be looked upon as a person with complicated psychological and social problems, and unless some definite pathological lesions are discovered, operative therapy should be the last to be considered.

Two sociological problems are common in gynaecological practice, those of sterility and overfertility. Here again, I feel, the need to warn against over-zealousness.

Sterility: Certain routine procedures have been laid down for investigating these cases. Tubal insufflation, hystero-salpingography and even a dilatation and curettage seem to be overdone. Ventrisuspensions are too frequently resorted to. Time and again one sees cases where all these procedures have been carried out only to find that the other partner is sterile. Retroversion is not necessarily an abnormal condition, which needs to be corrected. It is a normal position in about 25% of women and numbers of women can be shown to have conceived quite easily in spite of retroversion. I do not think one should subject a woman to tubal insufflation until the husband is pronounced to be normal, and then only after confirming that the ovarian and uterine functions are normal, which may be verified by endometrial biopsy. And I would certainly not consider any of these investigations in a very young person. Only recently a note was brought to me written by a general surgeon, suggesting endometrial biopsy and tubal insufflation in a girl of 17! He was kind enough to put down names of four gynaecologists, and mine was at the top! I wonder if the girl was eventually subjected to any of these procedures.

Recent reports on routine endometrial biopsy, done during investigation of sterility, show a high incidence of tuberculous affection of the endometrium, although there have been no other symptoms except sterility. It would be futile to subject such women to further investigation and treatment until the tuberculous focus is cured. Antibiotic therapy has been shown to cure some cases, so that they have conceived.

I am constrained to think that tubal blockage is not as common as is made out. Hystero-salpingography may show blocking at the uterine ends, but this is probably due, in the majority of cases, to spasms. A second skiagram should invariably be taken 12-24 hours later to see if there has been peritoneal spill. I had seen a case some years ago of a woman of 38 on whom tubal insufflation gave a negative result, after which she came to me. I had a hystero-salpingography done, which showed blocking at the uterine ends. I advised her to come back for operation after the next

period, but this did not come on and the woman was later delivered of a full-term child. A few years later a young gynaecologist, in her enthusiasm, investigated a young woman married only a year, and brought me the plates of hystero-salpingography with a similar picture. I advised her to be patient, and fortunately the woman conceived without any treatment. The tubal openings at the uterine ends are very fine, and may give a fallacious impression of being blocked. I would suggest that if any of you do decide on transplanting the tube, a section of the cornu be taken for microscopic examination.

I was interested to read a paper by Jeffcoate, in which he mentions that negative findings at tubal insufflation test were found to be fallacious in 37% cases, and a positive result misleading in 8.6% cases. Evidence of bilateral tubal occlusion on salpingography was proved to be fallacious in 15.1% cases, but only 1% of cases, reported as normal, proved incorrect. He goes on to say that 60% of women who show spasm, enough to give a false negative insufflation test, will conceive subsequently without any treatment at all.

The cervical factor in keeping up infertility is being studied. Cervical secretion undergoes cyclic changes in response to hormone cycles. Thick cervical mucus at the ovulatory stage is a bar to permeation by spermatozoa. Infections of the cervical canal are common and are probably responsible for many more cases of sterility than realised.

A good number of cases of sterility need general advice and guidance, rather than a multiplicity of investigations and operations. A type of case I have felt needed operative treatment is one in which the tunica albuginia is thickened and the follicles fail to rupture. There is usually oligomenorrhoea or hypomenorrhoea. There may be a retroversion; a ventrisuspension is done, but this may be incidental, the main treatment being resection or extroversion of the ovaries.

Artificial Insemination

This has been practised freely in animal husbandry with a view to ensure a good stock. Gynaecologists in western countries started applying the practice to human beings, and there seems to be a definite demand in this direction from the public. This subject requires most profound consideration, for legal as well as psychological factors are involved. Artificial insemination should be looked upon and treated as an operation and the strictest asepsis observed, as otherwise the very object with which the procedure is carried out will be defeated. Insemination from the husband is a straight-forward procedure, but if the semen has to be obtained from a donor the strictest secrecy has to be preserved, and the written consent of both husband and wife taken. In spite of this precaution, psychological complications may arise at some future date, if the husband realises that after all it is not his child, and this may even involve succession rights. It is, therefore, best for the gynaecologist to desist from such a practice and discourage prospective patients as far as possible.

The subject of *over-fertility* has received much prominence of late.

Economists and politicians look at it from the angle of over-population and work out meticulously the percentage increase of population as the years go by. To us obstetricians and gynaecologists the subject has quite a different significance. We look at it from the point of view of the effects of over-fertility on the mother and her offspring. The effects of frequent childbearing are noticeable in the higher incidence of abortions (nature's attempt at limitation), greater frequency of premature and immature births, tendency to various obstetric complications, of which inertia, persistent occipito-posterior, placenta praevia, atonic post-partum haemorrhage are common, bringing in their deleterious effects on the foetus as well. The susceptibility to chronic lesions of the cervix and uterus (known formerly as chronic metritis) and particularly increased liability to developement of carcinoma of the cervix, and tendency to tuberculosis are definitely increased. We are interested in ensuring good health in mother and infant, which object can be achieved largely by proper spacing and limitation of the family. In young couples, under 30, some reliable contraceptive method should be advocated. The question of sterilisation, apart from indications on account of some organic disease of the woman, should come into consideration only after the age of 30. In a country teeming with infectious diseases, which are almost endemic, one should think twice ere one deprives a young woman of the chance of bearing more children, if she happens to lose all hers. And again the psychological approach to the problem by the couple should be carefully studied. It must not be forgotten that it is an easier operation to sterilise a man, but even then age factors of both parties should be carefully considered.

Gynaecology is tending more towards operative treatment, but a proper evaluation of facts and conditions can minimise the need for operations. Senior gynaecologists have a good opportunity to direct the rational study of each case coming to the out-patients' department. A large number of patients have a psychological background, perhaps the result of marital or family maladjustment; a certain proportion will need general advice on proper dietary, regulation of the excretory functions, and arrangement of daily routine. Only a small percentage will need consideration from the operative point of view. It is high time that the approach to gynaecological problems is re-orientated to bring in prophylaxis, which will reduce the operative incidence.

I found a very pertinent quotation in an article by Sir Bernard Dawson on "Conservative Gynaecological Surgery" in Modern Trends in Obstetrics and Gynaecology, which I would like to quote:—

> "To remember that Gynaecology does not consist solely of pelvic surgery. The word "gynaecology" conveys no conception of disease, thereby differing from the older term "diseases of women". The word "logos" has many shades of interpretation, and in this connection the better word is "lore". Gynaecology is the "lore of women", an understanding, so far as is possible, of their psychological,

physical and functional phenomena from the cradle to the grave, but especially of the delicately balanced epochs of puberty, pregnancy and the menopause. To this must, unfortunately be added their pathology, but this should not be permitted to dominate the problem picture of women's whole life and being".

To sum up the series, we have seen how far obstetrics, practised in the right perspective, will ensure a healthy state to the woman and child. This is the responsibility of our speciality. We must, therefore, see to it that we have the right preparation for shouldering this responsiblity.

The first essential is the training of the student, the future general practitioner. He should be given a thorough training in the basic knowledge of obstetrics and gynaecology. Secondly, the preparation for the speciality—Anyone, aspiring to this speciality, should first of all ensure a good understanding of general medicine and general surgery, for many an obstetric complication requires a thorough knowledge of medicine, and for gynaecological surgery, particularly, a good grounding in abdominal surgery is essential.

Specialists in every subject must needs keep abreast of the latest advances in bio-chemical and other laboratory investigations which have a bearing on the problems presented.

It is only after such a back-ground of study and practice that one who aspires to the speciality can settle down to its study. He must be prepared to put in at least three years in very wide reading, so as to be well informed.

Above all, we must realise that no speciality, least of all ours, can work in a watertight compartment. We must work in co-operation with, and welcome the suggestions and advice of, general physicians and surgeons, pathologists, radiologists and pediatricians on relevent subjects. It is only thus that we can give of our best to the service of humanity.

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