REFRESHER COURSE FOR GENERAL PRACTITIONERS

IRREGULAR VAGINAL BLEEDING

BY

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Lady Macbeth disliked blood in the wrong place, gynaecologists dislike bleeding at the wrong time, but the patient seems often to be quite apathetic about the matter until her haemoglobin has dropped to 30 to 40% or her body is infiltrated with secondary deposits. This apathy, of course, is due to ignorance, and once more disproves the old adage that "where ignorance is bliss, 'tis folly to be wise." This, however, is not the responsibility of the practitioner, but it makes it very much more difficult for him to cure the patient.

When the patient complains of irregular bleeding—and the complaint may be couched in a variety of ways—the first problem for the practitioner is to decide whether the condition is an abnormality of menstruation—that is, an upset of the endocrine functions—or whether it is truly an "irregular bleeding." This can generally be decided by taking a careful history. The endocrinological aspects of menstruation and the menopause have been dealt with already in the Refresher Course in two articles by Dr. P. M. F. Bishop (*British Medical Journal*, 1950, **2**, 1214, 1268).

Students learn to classify the causes of symptoms in order to pass examinations, but even for qualified people there is value in such classification, although to the experienced practitioner it becomes more an orderly sequence of thoughts and mental questions rather than a conscious classification. Thus, if the history suggests that the condition is irregular bleeding, the next question arises, Is this in connexion with pregnancy?—for example, threatened or incomplete miscarriage, antepartum haemorrhage, retained products, or even chorion-epithelioma. The diagnosis of these conditions will be considered in another article in this series. This leaves the other causes to be dealt with here, and they can be divided into general causes and local causes. Although this division may seem very obvious, general conditions in which the vaginal bleeding is merely a symptom of a disease not connected with gynaecology are not infrequently overlooked. Examples of these are acute leukaemia, pernicious anaemia, and, more rarely, diabetes, typhoid fever, etc.

It is at this stage that the patient must be examined not only locally—that is, examination of the pelvis—but completely, with the idea of excluding the general diseases already enumerated. For this purpose a blood count and other tests may be necessary. An abdominal examination is essentially a part of the pelvic examinations, as a pelvic tumour—for example, a fibroid or an ovarian cyst—may rise up into the abdomen, and the inguinal glands must also be palpated. A vaginal examination should be carried out with a speculum under a good light or, better still, with an illuminated speculum. The vaginal wall can best be examined with Sims's speculum, but the cervix often needs a Fergusson type of instrument. The next step is a bimanual palpation, and, lastly, a rectal palpation often combined with a bimanual examination. In some conditions this rectal bimanual examination will give much more information than bimanual vaginal examination alone.

Likely Findings

Now what are the conditions which are likely to be discovered? A large mass of *fibroids* may be felt through the abdominal wall, or smaller ones may be felt on bimanual examination. It is true that fibroids more often give rise to menorrhagia—that is, increase in the amount and length of menstruation—rather than to irregular bleeding, but when one of the fibroids becomes polypoid in the cavity of the uterus the latter symptom is not uncommon. At one time, when the risk of hysterectomy was much greater than under modern conditions, the patient was treated symptomatically in the hope that once the menopause had taken place both uterus and fibroids would regress. Such a procedure often resulted in the patient being an invalid for several years, and is never justified in these days.

There is another danger that must not be forgotten—namely, that, although the diagnosis of fibroids is obvious, a carcinoma of the body of the uterus *may coexist*, or a fibroid may have undergone a sarcomatous change. The right procedure, therefore, when a fibroid gives rise to this symptom is to carry out a diagnostic curettage to exclude malignancy, followed by a myomectomy or a total hysterectomy. The indication for myomectomy is when the uterus after the operation will be of value for child-bearing. In the event of hysterectomy after the age of 40 the problem arises whether the total hysterectomy should be combined with a bilateral salpingo-oophorectomy, to prevent trouble developing later in the ovaries. There can be no definite ruling on this point, as so much depends on the psychological condition of the patient. There is much more reason for extending the operation in this way if the patient has passed the menopause, but fibroids seldom give rise to symptoms after the climacteric unless undergoing malignant changes.

Endometriosis, particularly when situated in the ovary, is another condition which may give rise to irregular bleeding, generally accompanied by pain. This as a rule is best treated by bilateral oophorectomy or a more limited operation, although in certain cases the condition can be satisfactorily treated by radiotherapy, thus causing an artificial menopause.

A simple polypus can be seen and palpated in the vagina. Although it is perhaps justifiable for a practitioner to remove a polypus by twisting it off with a sponge-holder forceps, it is essential that it should be sent to a laboratory for section, as a small proportion of these growths prove to be malignant.

The Normal Climacteric

Before discussing malignant tumours, the most important of all causes of haemorrhage, it is necessary to say a few words about irregular bleeding at the time of the menopause. Since the cause of such bleeding is often endocrinal in origin, it belongs to Dr. Bishop's articles, but the importance of irregular bleeding at this time in the patient's life is so great that it justifies a further discussion at the risk of a little overlap.

So many generations of women have suffered from irregular losses during the climacteric that it is now regarded as a normal thing and one that should be borne patiently without complaint. By some means or other women must learn that such symptoms are *abnormal*. In this the practitioner's

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help is essential. Women should think of the menopause as taking place normally in one of the following ways :

(1) The periods get less and less, but the interval remains the same.

(2) The loss each time remains the same but the interval between the periods gradually increases.

(3) A combination of (1) and (2). This is perhaps the commonest course of events.

(4) A sudden complete cessation of all menstruation.

Floodings or irregular haemorrhage at the time of the climacteric, although very common, should always be spoken of as an *abnormal change of life*. In the past, practitioners, after correctly diagnosing that the symptoms are due to the menopause, have often reassured their patients by saying it is "only the change of life." When the patient's neighbour suffers from the same symptoms the patient in turn reassures her by saying, "I have had the same trouble, and the doctor said it was only the change," with the result that the neighbour neglects a visit to the doctor, often with fatal results.

Malignant Disease

It is perhaps unnecessary to remind practitioners that the peak of incidence of malignant disease is in the years 45–55, and therefore any irregular bleeding, even if accompanied by hot and cold flushings and other menopausal symptoms, must be investigated completely and immediately to exclude malignancy. It is even dangerous to tell the patient to return in two weeks' time unless a special note is made to remind her if she fails to return. In this connexion Dr. Bishop will, I am sure, forgive me for calling attention to a sentence in his article where he advises that the patient be told to return in two months "after keeping a careful record of her bleeding dates." Dr. Bishop is, of course, referring to patients in whom all possibility of malignant disease has been excluded and in whom it is a question of what type of endocrinal disturbance exists.

Of the various malignant conditions that may cause irregular bleeding, *carcinoma of the cervix* is the most common ; it is often diagnosed by seeing the growth or an ulcer on the cervix. Endocervical carcinomata, which form only a small proportion of these growths, generally show nothing abnormal, but the cervix on palpation is often slightly enlarged and barrel-shaped. The diagnosis can be proved only by biopsy.

Another help to diagnosis consists in taking cervical and vaginal smears, a technique used extensively in America but only to a small extent in this country. Carcinoma of the cervix may occur at any time of life, but is rare before 30.

Carcinoma of the body of the uterus rarely occurs before the age of 40, and is commonest after the menopause. Indeed, there are few other post-menopausal conditions to give rise to irregular bleeding except a rare granulosa-cell tumour of the ovary which also causes this symptom. Carcinoma of the body is often found in a uterus of normal size and can be diagnosed only by a diagnostic curettage.

Carcinomata of the vagina and vulva give rise to blood-stained discharges ; a tumour or ulcer may be seen on examination.

Carcinoma of the Fallopian tubes is a very rare disease which gives rise to a blood-stained discharge, but is seldom diagnosed before operation.

Conclusion

Irregular bleeding is the most important gynaecological symptom of which women complain, but, owing to the fact that very often it is due to a transient endocrinal upset, the patient is likely to ignore it. For the same reason there is an understandable temptation for a busy practitioner to give the patient a prescription for some ergot or other medicine and tell her to return again if the bleeding does not stop. The patient, reassured, may wait for several months, with occasional bouts of bleeding, before once more visiting her doctor, when an advanced growth may be obvious.

It is true that the thorough investigation of a case of irregular bleeding takes a long time, and for an overworked practitioner it is perhaps wise to send the patient at once with a note to the gynaecological department of a hospital. If, however, the practitioner has the time, the following is a summary of the steps to be taken :

(1) A careful menstrual history. If every woman could be persuaded to keep a diary in her bedroom for noting the dates, the difficulty of obtaining an accurate history would be much less.

(2) Decide if the irregular bleeding is or is not connected with pregnancy.

(3) Decide if the condition is purely an irregularity of menstruation or is true irregular bleeding.

(4) Decide if the irregular bleeding is only a symptom of some general disease or is due to a local condition in the pelvis.

(5) If it is a local condition exclude the possibility of malignant disease.

(6) In the case of irregular bleeding never adopt the Asquithian motto of "Wait and see."

Next Refresher Course Article.—"Nephritis," by Dr. Robert Platt.

A SURVEY OF OCCUPATIONAL PROBLEMS IN A NEUROSIS CENTRE

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Roffey Park provides residential treatment for 120 psychiatric cases at a time and maintains close contact with the community as an integral part of resettlement. The stay is about six to eight weeks. The patients undergo comprehensive physical and psychiatric investigation and subsequently a planned régime, including physical training, workshops, and resocializing activities. Appropriate psychotherapy is given in all cases and physical methods of treatment are used when required.

Many patients have become desocialized both in their work and in their communal activities. More and more it is becoming apparent to the psychiatrist that his function is to break the vicious circle of neurosis that isolates an individual from the community and to help him back to his right level and right field in that community. In many instances the neurosis is characterized by a situation in which immature social attitudes lead to loss of emotional rapport with the community. To reverse the spiral of neurotic adjustment, treatment must take into account as many facets of the situation as possible. Hence emphasis is placed at Roffey Park on the communal structure of the centre, the patients' committees, and the various methods of producing a co-operative atmosphere. Harris (1949) referred to these techniques as sociatry, a word that came into common usage during the war but is seldom heard to-day.

An integral part of this reversal is suitable occupational placement. Clearly, many patients have a firm

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