Gynaecology in General Practice

Backache—I

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British Medical Journal, 1971, 2, 99-100

Some symptoms, such as bleeding and shortage of breath, bring the patient dramatically to the family doctor; other problems have to be dragged out as part of a history taken for other reasons, and backache often comes into this group. People expect to get lumbago and they put up with several variations of this pain, visiting their medical advisers only when folk remedies and the other homegrown therapeutics have failed.

Most backaches are in the lumbar or sacral regions, and of these only those below the level of the fifth lumbar vertebra may be referable to the pelvic organs. Backache at a higher level is rarely due to gynaecological causes, these usually being some orthopaedic or degenerative reason. Not every woman who presents with backache has an organic disease. Like other non-specific symptoms, it may often cover psychological upset, being a distress sign or a call for sympathy. Backache may be part of a post-trauma compensation syndrome, and it is sometimes an expression of self-assertion. Moreover, it may be both an expression of psychiatric tension or the source of this trouble; the general practitioner has to analyse this kind of problem and help the patient solve it. If he does not, the hospital specialist is unlikely to be any more successful in detecting or treating the emotional part of this psychosomatic condition. The family doctor knows his patient and her background best, and he is in the position to assess the meaning of her symptoms.

History and Examination

A woman complaining of backache should be asked about the timing, site, and radiations of the pain. Often a definite relationship may be elicited to movements, menses, or time of day. Her backache may range from the renal angle to deep in the buttock and she may be able to localize it with a fingertip. If the doctor knows the areas to which the pain radiates he can identify which nerve roots are concerned and so the site of the triggering lesion. The backache may be wrongly identified owing to a faulty description of the pain. The patient will use the words of her own choice, which may not be precise enough to define adequately the quality or site of the ache. Further, she may find it difficult to remember what she felt

some time ago—the longer ago the ache occurred the poorer and more diffuse the localization. The best description comes at the time the backache is present, and the best localizer is the patient's own hand.

Any examination of a woman with backache must include a check of the abdomen, the pelvis, and the back. There may be masses or areas of tenderness and guarding detected in the abdomen. Disorders of the kidney or gut may cause high backache and they may be discovered by abdominal palpation. Pelvic problems, on the other hand, will not usually be identified by such palpation unless the organ concerned has risen out of the bony bowl.

Vaginal examination may trouble many women who have no obvious problems in the pelvis. It is wiser therefore to "talk your way in" with the introduction of the examining finger or fingers. Any attempt forcibly to overcome the guarding that some women show will only diminish the usefulness of the later examination. When the cervix is reached the examiner should pause and talk to his patient to allow her time to relax. Then slow and careful bimanual stimulation, in turn, of either ovary, tube, uterosacral area, uterus, and cervix may reproduce the backache. Sometimes a little time elapses between stimulation and sensation (because of what Sir Thomas Lewis would have called temporal summation of pain). If the backache can be reproduced by this test it is the best indication that the pain is of gynaecological origin.

Should one organ only be implicated, both the diagnosis and treatment may be obvious. Often, however, the test produces backache when any part of an adnexum is palpated or the whole uterus is moved in any direction. The backache is still probably of gynaecological origin, but the patient is going to need a further opinion before therapy can be brought to bear, and so, while referral to the specialist unit must be made without precise diagnosis, it is with the assurance that the gynaecologist is the right man to be seeing her. A vaginal examination in any woman with backache is important not just for diagnosing disease but as a guide to which specialist the general practitioner should refer her.

EXAMINATION OF THE BACK

Examination of the back and of the hips can start with the patient on the couch. She should be asked to roll on to her face and the ease with which she turns, the mobility of her trunk, and any pain involved can tell a lot about the tension of the muscles guarding the joints of the back. The examiner should then press over each sacroiliac joint and work his way up the lumbar spine in the midline seeking for areas of tenderness. He should also try to reproduce the pain; and, while the patient is still in this position, should test the

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passive extension of each hip and of the lumbar spine. After excluding the hip itself as a source of disease he should increase the pressure on the fully extended joint and so rotate the half pelvis.

The lumbar spine is then rechecked in full extension (lifting both thighs clear of the couch or putting several pillows under the knees). After this, the patient is turned on to each side. Passive rotation of the lumbar spine is checked in each direction and the patient then lies once again on her back. Both knees should be firmly flexed up on to the belly wall, thus giving maximum flexion to the lumbar region. Rotation at this level of the spine can now be checked in the fully flexed position by moving both knees to one side of the body. Internal rotation and abduction of the hip joints are examined with the legs extended on the couch. Finally, the patient should be asked to stand and the curves of the lumbar spine should be examined, looking for increased or decreased lordosis or scoliosis and spasm of spinal muscles. The range of forward flexion is investigated by making her touch her toes, watching particularly for a "catch" in coming up—a sign strongly suggestive of lumbar instability. Sometimes limitation of movement may be noted, but usually passive movements are more revealing.

Investigations

Few investigations help at this stage. Posteroanterior and lateral x-ray films of the lumbar spine and sacroiliac joints may exclude osteoarthritis, prolapse of an intravertebral disc, or any serious degree of spondylolisthesis which might be the seat of the trouble or might be incidental. A total and differential white cell count as well as an erythrocyte sedimentation rate may help elucidate chronic inflammation or malignancy, and, if relevant, cervical, vaginal, and urinary bacteriological investigations may be done. Culdoscopy and laparoscopy may sometimes help in diagnosing pelvic lesions, while in centres that use it frequently pelvography (radiographic examination of the soft tissues of the pelvis) may show up masses that might be missed on clinical examination. Except for occasional abnormalities found in the straight x-ray film, however, the cause of backache is usually diagnosed on clinical grounds, and one of the first things a general practitioner has to decide is whether the woman needs the further help of a gynaecologist, a psychiatrist, or an orthopaedic surgeon.

(Part II of this article will appear in next week's B.M.J.)

Therapeutic Conferences

Drug Allergy—II

FROM THE DEPARTMENTS OF THERAPEUTICS AND PHARMACOLOGY AND DERMATOLOGY, ABERDEEN UNIVERSITY

British Medical Journal, 1971, 2, 100-101

Case 3—Photoallergy

PROFESSOR MACGREGOR: Our third patient today is a 62-year-old woman who was transferred from a psychiatric ward after a haematemesis. Dr. Main, I'd be interested to hear your comments on her rash.

DR. MAIN: As you see, this patient has an erythematous, well-defined rash on the light-exposed areas of the face, V of the neck, and backs of the hands. The skin is also quite pigmented. Has she been taking a phenothiazine?

HOUSE PHYSICIAN: Yes, she's been on chlorpromazine for five years.

DR. MAIN: Chlorpromazine is not an uncommon light sensitizer and it seems that this patient has been affected. The drug produces both phototoxic and photoallergic reactions.

Phototoxicity can be produced in most people on first exposure if the concentration of the drug is sufficiently high and if there is enough light. The mechanism is not allergic.

Appointments of Speakers

- A. G. MACGREGOR, M.D., F.R.C.P., Professor of Therapeutics and Pharmacology.
R. A. MAIN, M.B., F.R.C.P.Ed., Consultant Dermatologist.
J. C. PETRIE, M.B., M.R.C.P., Lecturer in Therapeutics.
L. STANKLER, M.B., M.R.C.P.Glasg., Consultant Dermatologist.
R. A. WOOD, B.Sc., M.R.C.P.Ed., Lecturer in Therapeutics.

The wavelengths of light which precipitate the reaction are those of the absorption spectrum of the drug. The drug absorbs quanta of light and this energy in turn causes cellular damage in the skin.

STUDENT: Could this be likened to a primary irritant dermatitis?

DR. MAIN: Yes. However, photoallergy is an example of cell-mediated delayed hypersensitivity.

FIG. 1—Skin sensitization. This reaction which includes contact dermatitis and photoallergy, is a lymphocyte-mediated allergic response to the antigenic stimulus of a drug-protein complex.