gens, whereas levator spasm may respond to counselling of the patient (and possibly her partner) on sexual technique.

Physical signs should not, however, always be taken at face value. Levator spasm may be a protective mechanism in a patient with a tender pelvic lesion, while an intact hymen should not necessarily be accepted as the cause of superficial dyspareunia—it may simply be the effect of non-consummation, the cause of which must be sought elsewhere.

Deep dyspareunia may be primary, when it is classically associated with retroversion of the uterus, or secondary, when it is associated with pelvic disease. Pain on deeper pelvic examination, reproducing the pain of intercourse, may arise with pelvic inflammatory disease, endometriosis, or uterine enlargement due to adenomyosis or fibroids. Examination will be highly informative in these circumstances, but it will be valueless if the patient is not at her ease. Endometriosis is generally suggested by other features such as dysmenorrhoea, especially during the menstrual flow, midcycle pain, and the classic pelvic finding of numerous small tender nodules on the uterosacral ligaments, but the absence of these features does not necessarily exclude the diagnosis. Indeed, in this condition, frequently found in low parity women of the higher social classes, the severity of symptoms may be out of proportion to the degree of disease, and only direct visualisation of the pelvis by laparoscopy may give a final verdict. This procedure is often performed for deep dyspareunia in the absence of other physical signs, but like all surgical procedures it has a risk: the death rate is one in 12 500 laparoscopies.¹

The presence of a retroverted uterus may bring the ovaries into a vulnerable position in the pouch of Douglas resulting in dyspareunia. Retroversion itself, however, is not indicative of disease provided that the uterus is mobile, and the once widespread surgical panacea of ventrosuspension to place the uterus in anteversion has lost popularity because the results have been disappointing. With careful clinical assessment, however, some patients may be identified who would benefit from this procedure, and in such cases the results may be gratifying. Before surgery is tried the patient should be advised to experiment with different positions of intercourse as she may well find one which is free from pain.

Dyspareunia should not be labelled as psychogenic purely because no physical cause has been found. Further evidence is required such as the patient's opinion of coitus, her sexual history, the state of her marriage, and her mental state. Depression is a potent cause of dyspareunia, as is marital disharmony, fear of pregnancy, or even memory of an unpleasant vaginal examination or sexual experience. One rapid interview at a busy gynaecological clinic may well be inadequate to elicit this background, whereas the investment of time and patience by the clinician should reap rewards. If no answers are forthcoming the next step is for psychosexual counsellors to interview both the patient and the partner, separately and together, the interview itself possibly providing the treatment necessary for a successful outcome. Patients remain singularly unconvinced by techniques such as vaginal dilatation under general anaesthesia, and in fact such procedures focus the patient's attention on the physical rather than the psychological aspect of her problem with resultant reinforcement of her view that "she is small down there." A gentle vaginal examination, preferably augmented by the patient learning to explore herself using either fingers or vaginal dilators, may help to satisfy her about the normality of her vaginal dimensions. Behavioural therapy, where appropriate, requires a gradual relearning of sexual behaviour in which anxiety is alleviated by forbidding intercourse and

advising the couple on a series of "exercises," starting with kissing and touching fully dressed, gradually advancing through various types of stimulation and ultimately to intercourse—the so called "sensate focus" technique.²

Recently a "new" cause of secondary introital dyspareunia has been described at the Johns Hopkins Hospital associated with the appearance of punctate erythematous foci immediately lateral to the hymenal ring.³ Woodruff and Parmley believe that this is due to chronic inflammation of minor mucus secreting glands at the junction of the labial and vaginal skin. They claim good results from excision of this skin in a Y shaped area with the arms extending bilaterally almost to the urethral meatus and the stem down on to the perineum with primary resuture using chromic catgut; 15 such patients, aged 22 to 39 years, were treated and 14 apparently cured on short term follow up. I believe that I have seen only one such case, but again treatment along similar lines was apparently curative. As with any new procedure caution is needed in selecting patients, and long term results will need to be assessed before too many willing patients undergo possibly unnecessary surgery just because there is nothing else to offer. Sadly, there will remain, as in so many branches of medicine, a hard core of patients for whom we have nothing to offer but sympathy and support.

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² Masters WH, Johnson VE. *Human sexual inadequacy*. London: Churchill Livingstone, 1970.

³ Woodruff JD, Parmley TH. Infection of the minor vestibular gland. *Obstet Gynecol* 1983;**62**:609-12.

Life changes

We do not always know what really brings a patient to the doctor. But whatever the complaint, behind it often lies some disturbance in the normally smooth pattern of day to day existence that reduces the patient's tolerance of symptoms and his capacity to cope.¹ Paying attention to this background disturbance sometimes makes better sense of the consultation for both doctor and patient (and may offer more rewards) than concentrating on foreground symptoms. Of the many possible influences, one of the most powerful is a life change—a psychosocial step or transition which alters a person's relation to the world about him and demands new responses.

Such changes may lead to better adjustment or may precipitate failure or breakdown.² They may be directly related to phases of growth and development, as at puberty or menopause; to socially ordered events, such as going to school, getting married, or losing a job; or to a mixture of both—the first lover, the first child, a serious bereavement.³ An illness may arise and itself cause further changes in lifestyle. Attendances at surgeries cluster round these moments, and they demand understanding and appropriate help. The child in care comes with abdominal pain, the divorcee with indigestion, the elderly widow with painful knees. The isolated young mother presents her child with a cold, the newlywed

arrives with vaginal discharge, and the 40 year old worries about a chest pain. If the meaning or value of these symptoms is wrongly assessed a patient may be sent away with an issue dangerously unresolved or a physical symptom distressingly and expensively investigated.

Family doctors have always recognised these associations, but they have recently been given firmer scientific basis. In general practice psychosocial factors have been shown to play a large part in many adult consultations⁴ and in up to half the encounters with children.⁵ Similar patterns are suggested by studies of adolescents.⁶

Bereavement has now been extensively researched; after an important death the survivor is more at risk, has more symptoms, and is more likely to attend at surgery in the subsequent months.⁷ A woman who loses her mother early in life may be more vulnerable to depression when later she herself becomes a mother with young children.⁸ Even positive life changes, like marriage or having a baby, may of necessity contain some loss (such as a reduction of privacy or independence). Being aware of these factors may help doctors make more sense of many of the tribulations and troubles seen in primary care, where conventional classifications of psychological disorder seem less relevant and useful than in psychiatric practice.⁹

Impressive though these research findings may seem in specialist journals, the general practitioner still depends mostly on his own intuition and experience to make sense of what he sees. Not enough attention has been given to description in practice research, for in many ways we are still like the early pathologists, trying to identify new patterns of complaint and attendance. Plays and novels may be a great stimulus to inquiry: in this context *Staying On* is more important than switching off.¹⁰ But the most important source of education available to every practising doctor remains himself and his own patients—provided that he takes the opportunity from time to time to ponder and discuss.¹¹ To help this process the *BMJ* has asked some doctors to identify life changes that they consider important to their practice of medicine; each will start the article with a personal account of the problem under discussion. This series begins today (p 1584).

Whether the patient's basic complaint is physical or emotional the doctor's work starts with imaginative listening, so that the patient feels that his condition is being taken seriously. The timing of attendance or symptoms may give valuable clues. The doctor may notice an anniversary, a significant birthday, or an important association for the symptom.^{12 13}

Reactions may be delayed after an important life event because the patient is coping in some senses too well. Something small then comes as the last straw, or strength ebbs when the patient has stopped being so active or responsible. What the patient himself makes of the complaints and how they fit the context of his life may help to unravel the meaning for all concerned. With attention being paid, and appropriate physical checks made, the task in general practice is often one of excluding and explaining, anticipating, and preventing. The doctor should discuss the range of normal experience, how things may develop or change further, what can be expected, and what should be avoided.¹⁴ With experience much of this can be fitted into usual practice time limits, since the patient may consolidate his thoughts between consultations. What more remains to be done depends on the individual and the severity of the disturbance.

Counselling or similar intervention has been shown to be

effective for those particularly at risk, such as vulnerable widows or widowers.¹⁵ A planned programme of support from members of the primary care team should always be offered. The impact of a disturbing event may be minimised, and anxiety and fear may even be turned into contentment by good planning and family support—for instance, when a baby is to be born or a death expected. Relief from responsibility may be provided, and time given for the patient or the family to talk through the events and express their emotions. The doctor must always be on the alert for reactions that are distorted and offer help before a pathological or destructive pattern is established. The skills of specialists, trained therapists, peer support groups, or voluntary helping agencies should be considered. The doctor should not forget the needs of caring relatives and practice staff. Life changes affect us all. They should be milestones, not millstones.

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Prognosis in sarcoidosis

Sarcoidosis usually affects young people and may be symptomless and discovered by chance. The natural questions are "What is it?" and "Will it get better?" We still cannot answer the former, but a recent study of over 800 patients attending a special sarcoidosis clinic in London has provided a useful summary of the clinical course and prognostic factors in sarcoidosis¹ and has largely reaffirmed the experience of previous, smaller series.²⁻⁴

Nearly all patients with sarcoidosis have abnormal chest radiographs when first seen. These changes will eventually disappear in just over half, but the chances of resolution and remission of disease depend on both the radiological appearances at presentation and their subsequent behaviour.