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# GONORRHŒA IN GYNÆCOLOGICAL PRACTICE

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THE very title of this paper contains the implication that female gonorrhœa does not belong to "gynæcological practice," and hence to the gynæcologist. To the uninitiated this must seem curious; for gonorrhœa may be said to be the commonest and in many ways the most important infection of the female generative organs. Why then, since gynæcology is that branch of medicine which deals with the diseases of the female generative tract, does not gonorrhœa belong strictly to gynæcology and the gynæcologist? This is the first point to which I propose this evening to refer.

My own attitude can be best defined by a brief history of what has happened in this respect at my own hospital. Following the Report of the Royal Commission on Venereal Disease, the L.C.C., as is well known, approached the London hospitals with a view to establishing venereal clinics. There was already in existence at the London Hospital a department, and a very efficient one too, for dealing with male gonorrhœa, organised by Mr. Frank Kidd, and when the L.C.C. approached the London Hospital Mr. Kidd prepared a scheme for organising a venereal clinic for both males and females. The proposal then was that the male section should be under the charge of the genito-urinary department of the hospital, and that the female section should be under the charge of the gynæcological department, both to be linked up into a composite venereal department.

When I was approached, I felt I could not bring myself to agree to the scheme as far as the co-operation of my own department was concerned, and I came in for a good deal of adverse criticism in consequence.

My view then was that there should be a single department, as opposed to a combined department, under the charge of one man for the treatment of gonorrhœa, both in the female and in the male.

I felt strongly that gonorrhœa was such an important disease that it should have a status and dignity of its own as a clearly defined special branch, rather than be made a subordinate branch or appendage of other departments of medicine—of the gynæcological department on the one hand and of the genito-urinary department on the other. Further, I strongly felt that venereal disease was such a big subject, offering so many problems both medical and social, presenting so many difficulties in diagnosis and treatment, both on the part of the doctor and of the patient, that it should be in the hands of medical practitioners who specialised in the subject—*i.e.*, of those members of our profession who are now recognised as venereologists. This view has now, I think, become firmly established.

It is universally admitted that this specialisation in dealing with gonorrhœa has led to immense improvements in diagnosis and treatment, and has been an immense boon to sufferers from the disease.

The view was once put forward that the general handling and diagnosis of gonorrhœa should be left to gynæcologists and urologists respectively, and that the *treatment only* of the disease should be left to venereologists. The absurdity of such a suggestion is manifest. Quite apart from the disadvantages of such a division of duties to the patient and to progress, no self-respecting man would consent to place himself in such a subordinate and unsatisfactory position. He would become a sort of medical helot.

I know no gynæcologists, except those who still occupy very junior positions, and are in charge of venereal clinics (as they are at some hospitals), who undertake the treatment of gonorrhœa. I know of no gynæcologist who regrets it. (I should mention that I mean the word "gonorrhœa" here to mean the infection of the vulva, urethra, and cervix—and do not include pelvic inflammatory disease and its sequels.)

Though I do not treat gonorrhœa personally, I may be permitted to pass a few general remarks about its treatment nowadays. I suppose that much progress has been made since the War in the methods of treatment. But the complete eradication of the disease in the female seems still to be a matter of many weeks and even months. I would like to ask this somewhat provocative question. If

gonorrhœa were treated by rest and ordinary cleanliness only, would it ever undergo a natural cure? If so, to what extent does modern intensive treatment hasten the cure?

Having cleared the ground, so to speak, I can now discuss the various ways in which I find gonorrhœa enters into my gynæcological practice.

## Diagnosis

Although the gynæcologist does not *treat* gonorrhœa he must most emphatically be on the look out for it, and be an adept at its *diagnosis*.

One of the disadvantages inherent in the separation of gonorrhœa from gynæcological practice is that the gynæcologist, unless he is extremely alert, is liable to overlook cases. This often occurs.

A chronically inflamed or an eroded cervix, whether lacerated or intact, looks very much the same, whether the infecting agent is the gonococcus, the streptococcus, the colon bacillus or other bacteria. One of the out-patient officers in the gynæcological department at the London Hospital was told by one of the workers in the Whitechapel Clinic that most cervical erosions were gonococcal. This statement made a great impression on him and, to test it, he sent a series of cases over to the clinic for bacteriological and serological diagnosis. Nearly all came back negative for the gonococcus. This is only hearsay, and it is probably only a half-truth.*

Still, it illustrates the very different attitude taken by the gynæcologist and the venereologist respectively towards chronic infections of the cervix. The one tends to under-emphasise and sometimes to be insufficiently alert; whereas the tendency of the other is to over-emphasise and to be what may be called over-alert.

To be perfectly frank, this is the opinion some of these respective specialists hold about each other. The venereologist is apt to pity the poor gynæcologist because, from lack of knowledge, or lack of observation, he fails to discover gonorrhœa when it is there. The gynæcologist is apt to taunt the venereologist with the opposite error;

* Since reading this paper Dr. Anwyl Davies has been kind enough to send me the figures for the cases referred to him for diagnosis from gynæcological out-patients: out of 21 patients, 4 had gonorrhœa, 2 syphilis and 15 were free from venereal disease (for last three months of 1933).

and suspects that he sometimes diagnoses gonorrhœa when it is *not* there.

I know that this soft impeachment directed against the gynæcologist is true. And of the two types of error, the consequences of failing to diagnose an existing gonorrhœa are much graver than the opposite ; though the opposite mistake may be also, in many ways, an extremely grave one. I wish to ask venereologists if, when they are in doubt about the diagnosis of a case, they make a positive diagnosis on principle. If they do, I am in complete sympathy ; for they are specialists and recognised experts, and are not forgiven if they make a mistake which may have such tragic consequences.

There seems to me (though I am open to correction) to be very little difficulty in making the correct bacteriological diagnosis by films or cultures in the acute stage of gonorrhœa, provided the elementary rule of avoiding the vaginal pus-pool and taking material only from the urethral and cervical canals is followed. No one would neglect making a precise bacteriological investigation in all cases of acute vulvo-vaginitis and cervicitis. Acute cases of this sort, with severe burning and irritation sensations and dysuria are not commonly seen by me, the reason being no doubt that most of them are gonorrhœal, and patients go direct to the venereologist, or their doctors send them. I very seldom see cases of acute gonorrhœa—only on an average about two a year during the last few years.

It is quite different with cases of long-standing vaginal discharge. These are common. About 10 per cent. of all the new patients who come to consult me complain of vaginal discharge, although it may not be the chief or presenting symptom.

Cases of chronic or long-standing vaginal discharge may be usefully divided into two broad classes : (1) those with what I call the " chronic cervix " ; and (2) those in which the cervix is of more or less healthy appearance. The class of case in which the cervix appears healthy is the less common. Many are cases of trichonomas infection. In others there seems to be a superficial vaginitis, in which the vagina presents the well-known granular appearance. In others there seems to be nothing more than a sort of saprophytic decomposition of the normal vaginal secretions.

By the " chronic cervix " I mean a cervix which appears obviously infected and which often presents an " erosion." The chronic cervix is also usually lacerated, with extroversion or pouting of the mucous membrane, which is thick and vascular, and bleeds easily when probed.

The cases of " chronic cervix " are much the more common of the two classes of patients with vaginal discharge. I find that out of the last 2,000 new patients seen in my consulting room, in about 6 per cent. a " chronic cervix " was the principal lesion. It is indeed the commonest gynæcological condition. This is not to be wondered at when it is realised that nearly every woman who bears a child suffers an injury of the cervix. Few, if any, of these obstetrical lacerations heal in the sense that the torn surfaces come together and unite completely. The majority heal in the sense that the torn surfaces become covered over with healthy squamous epithelium and present a surface similar in appearance to that of the healthy cervix.

In many cases, however, the torn surfaces become covered with the glandular type of epithelium continuous with that lining the cervical canal, which spreads further outwards upon the surface of the cervix. There results the well-known type of " chronic cervix "—lacerated, extroverted and eroded. This sort of cervix always secretes abundant mucus. But it is also especially liable to infection with many varieties of pyogenic bacteria.

Any of these chronically inflamed cervices may be due to gonococcal infection. Is it then advisable to investigate for the gonococcus in every case ? I take it that every chronic cervix seen by a venereologist is handled in this way. I confess this is not my practice. Perhaps I miss many cases of chronic gonorrhœa.

I always keep before me the ever-present possibility of gonococcal infection : but I do not have a special investigation made unless there is something in the appearance of the genital tract, or in the history of the patient, which leads me to suspect gonorrhœa. It is difficult to describe what this is. So far this practice seems to have worked well ; for, on the one hand, I have not heard subsequently of cases I have overlooked and, on the other hand, in a very high proportion of cases in which I have suspected the presence of gonorrhœa, the gonococcus has been found by the bacteriologist or the venereologist.

As regards the bacteriological investigation of these cases, I never do it myself. My procedure is to take the patient to the bacteriologist and let him make his films and cultures on the spot, so that he can transfer his warm special-medium tubes or plates straight to his incubator. This direct collaboration with the bacteriologist I find very useful; for a bacteriologist who is experienced in this sort of work develops a keen sense of clinical diagnosis also.

Sometimes I send the patient direct to a venereologist and ask him to make a diagnosis and to take over the entire charge of the patient if the disease is present.

I cannot make up my mind about the gonorrhœa fixation test. It is highly commended by some; whilst by others it is not regarded very highly. I have read with great interest the recent paper by Dr. Orpwood Price, from which I gather that the test, though extraordinarily useful in certain types of case, is unreliable in others. Is it as reliable for the diagnosis of gonorrhœa as is the Wassermann reaction for the diagnosis of syphilis? If it is, or if it promises to become so, it will indeed be of untold value.

If I thought I ought to make bacteriological investigations much more often than I do, I should keep an incubator and culture-media in my examining-room, and hand the material over to a bacteriologist for examination. Surely there can be, in the technique of making films and cultures, nothing which is beyond the capacity of any well-trained man.

## Pelvic Inflammatory Disease

We commonly use the metaphor "dividing line" to express separation between people and things. But venereologists and gynæcologists may be said to be separated not by a line but by two small openings, namely, the uterine *ostia* of the Fallopian tubes. As soon as the gonococcus attacks the Fallopian tubes, gonorrhœa becomes gynæcological. But I believe that even this is only a partial truth. I am inclined to think that pelvic inflammatory disease is seen less frequently than it used to be. I like to believe that this is so, and to ascribe it to the more efficient diagnosis and treatment of gonorrhœa which has certainly come about of late years.

In the gynæcological department of the London Hospital, only fifty cases of pyo- and hydro-salpinx have been operated on during the last three years, whereas nearly twice as many were operated on ten years ago. This fall in number is no doubt contributed to by the fact that the gonococcal cases—which, of course, form far the commonest group—are sent from the Whitechapel Venereal Clinic, not into the London Hospital, but into St. Peter's Hospital, which is the local L.C.C. hospital. It would be interesting to know if the figures at the latter hospital show a rise proportionate to the London Hospital's fall.

The separation of gonorrhœa from gynæcology carries with it the disadvantage that the gynæcologist loses touch with the natural history of the disease—*i.e.*, at what stage in the life of the disease salpingitis is most likely to arise ; and in what proportion of cases salpingitis occurs during the course of skilful treatment.

In the treatment of pelvic infections, three great principles must be adhered to : (1) the bacteriological diagnosis must be made with the greatest possible precision, bearing in mind the common knowledge that at least 60 per cent. are gonorrhœal in origin ; (2) the utmost conservatism must be preserved, a radical operation being resorted to only under well-defined indications, and the time for intervention must be carefully chosen ; (3) if the abdomen is opened under a mistaken diagnosis (*e.g.*, of acute appendicitis or ectopic pregnancy, which are the two chief conditions which enter into the differential diagnosis of salpingitis), and inflamed tubes are unexpectedly found, the tubes must *not* be removed, but the abdomen closed and drainage only be employed.

Neglect to follow the first principle (that of making a bacteriological diagnosis) is common among general surgeons and even among gynæcologists. I have seen several cases in which a vaginal discharge persisted after radical operations for pelvic inflammatory disease. In a certain proportion of these the gonococcus was at once found, and efficient local treatment resulted in cure. I teach my students that when they have to deal with a case of pelvic inflammatory disease, a careful inspection of the vulva and, if time permits, a bacteriological investigation, is of equal importance to vaginal examination in the diagnostic scheme.

The persistence of an infected uterus or cervix uteri leads me to mention the surgical conundrums associated with the radical operation.

One of the great principles in modern gynæcological surgery is conservatism. A useful organ is not to be removed if it can be safely preserved.

In many cases of bilateral inflammatory disease it is possible to separate comparatively healthy ovaries from the inflammatory masses. The tubes can then be removed by themselves, and the ovaries, or one ovary or even a portion of one ovary, and the uterus left behind. I believe it is quite useless, from the point of view of preserving ovarian function to leave an ovary without also leaving the uterus. For if the uterus is removed the blood-supply of the ovary is so interfered with that sooner or later atrophic changes occur in the ovary, and it may undergo degenerative changes, with the formation of follicular cysts. An operation has sometimes to be undertaken later on for the removal of such a remnant ovary.

If then an ovary can be dissected free from the inflammatory mass, and is found to be in a sufficiently healthy state, it can be preserved so long as the uterus also is preserved. If this is done, the uterus should be attached to the abdominal wall, as otherwise it may fall back into the pouch of Douglas and become adherent there, carrying the ovary with it, and leading to dyspareunia and other local troubles.

In selected cases in young women, this is certainly worth doing, despite the fact that an infected cervix is almost inevitably left behind and will require treatment subsequently.

But I should certainly never attempt to preserve ovarian function if I thought that by so doing the success of the operation might be imperilled. With the tubes gone and the reproductive function at an end, the ovaries have little value beyond maintaining the function of menstruation, and it is a big mistake to overvalue the importance of this function.

If both ovaries have to be removed, the *whole* uterus should be removed also. It is bad surgery to remove the body of the uterus only, leaving behind an infected cervix, as is often done.