Any Questions?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Dyspareunia After Hysterectomy

Q.—*Is dyspareunia common after vaginal hysterectomy, owing to shortening of the vagina? Could this complication also arise from an abdominal hysterectomy?*

A.—Unless an unusually large cuff of vagina is removed, either unnecessarily or as part of a radical operation for malignant disease, total hysterectomy by either abdominal or the vaginal route does not materially shorten the vagina. Tenderness of the scar in the vaginal vault is also quite exceptional. Hysterectomy should not, therefore, by itself cause dyspareunia. It has to be recognized, however, that a decision to remove the uterus vaginally is often prompted by the presence of some form of prolapse. The excision of an enterocele and the strengthening of the vaginal vault may then result in narrowing of the upper vagina and thus make it functionally shorter. Added to that, many surgeons always carry out posterior colpoperineorrhaphy when vaginal hysterectomy is performed. This is a traditional procedure which is probably unnecessary in most cases and is much more likely to cause dyspareunia than the hysterectomy itself.

Many other factors enter the picture. The type of prolapse for which vaginal hysterectomy is sometimes performed is caused in part by congenital shortness of the vagina. The operation then tends to be blamed for what was pre-existent. Hysterectomy and vaginal repair operations are most often carried out on women at or approaching the menopause, at a time when climacteric atrophy is about to reduce vaginal capacity and when advancing years may be curbing the sexual appetite of either husband or wife. Sometimes the operation is used as an excuse to avoid intercourse. Often the couple are left in ignorance of the implications of the operation and they fear that coitus will cause harm. If intercourse is attempted too early after the operation anxiety and tenderness cause vaginismus. If it is attempted too late climacteric atrophy may have intervened to cause difficulty. In either case the occurrence of dyspareunia deters further attempts and the situation comes to be regarded as hopeless.

The resumption of comfortable coitus following hysterectomy therefore depends on: (i) The avoidance of unnecessary additional procedures which narrow the vagina unduly. When colporrhaphy has to be performed as well allowance should be made for subsequent senile atrophy of the vagina. (ii) Explanation of the significance of the operation to both husband and wife. (iii) Observation of the patient for several weeks after operation so that she can be specifically told when to resume coitus and how to overcome vaginismus or other difficulty which may be encountered initially.

Familial Periodic Paralysis

Q.—*What is the treatment for familial periodic paralysis? Is potassium helpful, and if so in what dose?*

A.—Attacks of familial periodic paralysis may be precipitated in some patients by a high carbohydrate intake and by excessive physical exertion, and it is obviously wise to avoid these precipitating factors. The relationship between the plasma potassium level and the development of an attack of paralysis is not thoroughly understood, but in a number of cases the plasma potassium level is reduced during an attack and normal in the intervals between attacks, while in a few cases normal plasma potassium levels have been recorded during attacks. In patients in whom an attack is accompanied by a low plasma potassium level it is reasonable to give potassium chloride 1 g. eight-hourly by the mouth with the object of preventing attacks, but in such a rare disease, in which attacks may occur at very infrequent intervals, it is difficult to assess the efficiency of this treatment.

Vitreous Haemorrhage

Q.—*Is there any new treatment for vitreous haemorrhages?*

A.—Many new forms of treatment for vitreous haemorrhages have been tried in recent years, but the results are disappointing. In most cases a small vitreous haemorrhage which is not associated with serious intra-ocular disease absorbs spontaneously.

NOTES AND COMMENTS

"H3."—Dr. H. B. WRIGHT (Mount Merrion, Co. Dublin) writes: I was very interested to read the reply about H3 ("Any Questions?" March 28, p. 872), having asked a similar question a couple of years ago with reference to Parkinsonism. Personally, from limited experience of it, I do feel this substance helps in Parkinsonism. Unfortunately, owing to the irregular receipt of generous supplies sent to me gratis from the Institute in Bucharest, I was unable to make any scientific comparisons. Delivery got held up all along the postal line for all sorts of reasons; many boxes seemed to get lost, and the mere mention of the contents being anything to do with procaine was sufficient to excite the departments of excise everywhere. Eventually I grew tired of the endless correspondence and explanations (it was not exactly rejuvenating) and I gave up my treatment. I hear the supply position is easier now, and I should be interested to hear if any of your readers have any similar impressions about its use in Parkinsonism. Its use in rejuvenation is best left to those who live to kiss the feet of Ayesha.

OUR EXPERT replies: A beneficial effect of procaine in Parkinsonism has occasionally been mentioned in the literature. The reports have occurred at two periods: about 1947–52 in America (e.g., Graubard and Peterson[1]), when intravenous procaine was in vogue for the treatment of many painful conditions, and again recently in Rumania and Germany, where H3 is being used to treat diseases of old age. The disappearance of tremor after giving H3 has also been reported.[2] Usually one or two cases have been described among a large group of patients with miscellaneous diseases receiving the same treatment, and no attempt seems to have been made to carry out a controlled assessment of its effectiveness. Doshay,[3] who does not include procaine among the many drugs which have a place in the treatment of Parkinsonism, points out that the symptoms often improve if emotional tension is reduced.

REFERENCES

1 Graubard, D. J., and Peterson, M. C., *Anesthesiology*, 1949, **10**, 175.
2 Odens, M., *Lancet*, 1959, **1**, 737.
3 Doshay, L. J., *Parkinsonism and Its Treatment*, 1954. Philadelphia.

Correction.—In the article on "Breast Abscess" by Mr. I. C. S. Knight and Mr. B. Nolan (May 9, p. 1224) the dose of stilboestrol (line 7, p. 1226) should have been given as 15 mg. three times a day (not 45 mg.).

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