OUT-PATIENT GYNAECOLOGY

BY

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Patients are referred to a gynaecologist for many reasons. Usually they have symptoms at least partly associated with the genital tract. Often these symptoms, however, are not entirely accounted for by the presence of a physical abnormality.

This report is based on a combined study of a small random series of women referred to a gynaecology clinic. The bodily and the mental state of these patients have been carefully analysed, and from this an attempt has been made to assess the relationship between physical and emotional factors in the development of symptoms.

Method

The study was carried out in the out-patient department of the Obstetric Hospital, University College Hospital, from June 1, 1953, to May 31, 1954. A sample was drawn from the total number of patients applying for consultations at the hospital during the year. The reception staff took two patients from those telephoning for an appointment in each week of the year, except for holidays, and entered their names for the clinic held on Wednesday afternoons. At the time of entry the receptionist knew nothing of the patient except her name, and the only selective factor here was the patient's willingness to attend on a Wednesday afternoon.

At the clinic, the two observers sat in adjoining rooms; each saw one patient, and the patients were then changed over. It was explained to each of them that she would see two doctors, one of whom would perform a gynaecological examination. The patients accepted this arrangement without dismay. Only one of the whole series inquired into the reason for it. One of us (N. M.) took a history and made a physical examination. The other made an appraisal of the woman's medical and psychiatric state. The two examinations were made separately and there was no consultation until both were concluded. Most patients were seen more than once by each observer, and some attended subsequently for gynaecological or psychiatric care. Observations made at these later attendances were used to confirm or refute the diagnostic impressions of the first interview.

In our view, the series as a whole may reasonably be regarded as representative of the "out-patient population" of this clinic.

Characteristics of the Test Series

The total number of cases seen was 64. The age range was 16 to 57, with a mean age of 33. The period of observation ranged from a single interview to 13 months. Eighteen patients attended only once. The mean period of observation in the rest was 6.4 months. Four patients came to inquire whether or not they were pregnant or to arrange antenatal care. The series under consideration therefore comprises 60 patients. The list of leading symptoms is given below, the leading symptom being here defined as the one first mentioned by the patient.

Symptom	No.	Symptom	No.
Pain, apart from period pain	22	Morning sickness	1
Discharge	14	Fatigue	1
Menorrhagia	7	Frigidity	1
Period pain	5	Headache	2
Amenorrhoea	2	Bad nerves	1
Irregular periods	2	Depression	2

When a detailed history had been taken and a full clinical appraisal made it was found that only seven of these 60 patients complained of one symptom only. In the remaining 53 the clinical picture included two or more symptoms. The largest number was in Case 1 ("Discharge, irregular periods, loss of weight, fatigue, breasts smaller, funny heads, go hot and cold, can't sleep, don't eat").

Thirty-six patients complained of one or more of the following symptoms: fatigue, tension, depression, irritability, faintness, lack of energy, being run down, shakiness, insomnia, malaise, giddiness, bad dreams, going hot and cold, and other symptoms indicative of a state of emotional tension.

Pain

Twenty-two patients gave pain (apart from period pain) as a leading symptom. Of the other 38, 12 described pain as one part of their complaint. Period pain is dealt with separately. Pain of other types formed part of the clinical picture in 34 patients, or more than half of the whole series. The most common site of pain was the abdomen (11), and the next in order were back (7), head (6), shoulders (3), groin (2), neck (2), chest (1), buttocks (1), and armpits (1). In only three cases was the pain as described by the patient fully accounted for by the demonstration of a physical disorder. These were: (1) an inevitable abortion, (2) uterine enlargement due to fibromyomata, and (3) endometriosis of the ovary. In a few cases there was some minor disorder, such as a cervical erosion or laceration. However, this could not be regarded as of such an extent as to account fully for the patient's symptoms. Therefore, in the majority of patients complaining of pain no physical abnormality was discovered, but in nearly every instance emotional tension was clearly evident. The following case illustrates this picture.

Case 3.—A woman of 21 complained of a dragging pain in the right iliac fossa, a rash "all over the body," and period pain. Her home, in Liverpool, was an unhappy one: "I was always fed-up and depressed. Mother was too strict." She ran away at 20, and came to London. The year previously she had married a coloured man after an acquaintance of two weeks. "Life is very bad. I want to go home. Can't get on with my husband. He doesn't like my girl friends. Beats me up if I try to go." After a fight with him she purposely drank part of a bottle of "dettol." She was taken to hospital and given a stomach wash-out. The abdominal pain began after drinking the dettol, and lasted about 10 days. The psychiatric diagnosis here was depression in an immature, dull, and backward person, and the emotional component in the illness was assessed at 100%.

In many of these patients the character of the pain, its time relation and site, and its response to therapy were consistent with a diagnosis of tension pain (O'Neill, 1955). An underlying fear of cancer, in our experience, was a common association in many women with pain of "non-organic" distribution.

The pain sites in these patients differ from those in patients with tension pain who attend a department of physical medicine, in that there is a greater frequency of pain in the abdomen and lower part of the body, and less in the neck, shoulders, and back. In other respects, however, the two groups resemble each other closely. Patients with tension pain who find their way to physical medicine departments are mostly women, and in them too the onset and course of the illness are related to stress. A higher incidence of abdominal pain in our series is to be expected, since it is the pain in this region which determines the woman's referral to a gynaecological clinic.

Vaginal Discharge

Fourteen patients gave vaginal discharge as the leading symptom, while seven others mentioned discharge among their other complaints. There was a clear-cut physical explanation in only four of these patients. Two had acute trichomonal vaginitis, one a cervical polyp, and another cervicitis. In the other 10 no definite physical lesion was identified. On the other hand, all these patients had a significant degree of emotional tension. It is well established that vasomotor rhinitis is often associated with emotional tension, and it is not impossible that a similar association may be found in regard to the cervix.

Case 1.—A woman of 23 complained of a persistent vaginal discharge. She had never succeeded in bearing a live child, in spite of four pregnancies. Naturally she was extremely apprehensive about the prospect of another pregnancy, and in addition she was concerned over her physical state, complaining that she was losing weight and that her breasts were shrinking. In fact, no physical abnormality was demonstrated. She showed the signs of an acute anxiety state with considerable depression. She attended the clinic regularly and was seen by one of us (D. O'N.) on six occasions. Here she talked freely of her doubts and fears and was given reassurance. From her story it seemed possible that there might have been a stress factor associated with her repeated miscarriages, and this aspect of the disorder was fully discussed. At her last visit she felt much better and the discharge, in company with all her other symptoms, had dwindled considerably.

Menorrhagia

Menorrhagia is a relatively common gynaecological symptom, and can arise from several organic disorders, such as fibromyomata, subinvolution, adenomyosis, and certain disorders of the blood. Frequently, however, no physical cause is to be found. Blaikley (1949) called attention to the importance of menorrhagia of emotional origin.

In our series, seven patients gave menorrhagia as a leading symptom. All of these had a uterine curettage performed —three in combination with a vaginal repair operation. Histological examination of the endometrium showed no gross abnormality. In five out of the seven the bleeding was one bodily component of a response to stress, the factors concerned being: Case 26, intense domestic friction; Case 27, bad housing; Case 28, fear of pregnancy (in this patient the menorrhagia cleared after an operation for sterilization); Case 47, fear of disorderly and violent tenants in the house; Case 15, fear of cancer.

Period Pain

Five patients gave pain at the period time as a leading symptom. In each case these were quite young women, and the pain was of the type usually referred to as primary spasmodic dysmenorrhoea. No organic abnormality was found in any of these cases. In three, however, there was an obvious stress factor, which was at least causing some intensification of the pain experienced.

Case 42.—A girl of 18 had come to London to escape from her parents and was conducting an affair with a married man, over which she felt a great deal of guilt. The periods had begun at 15. She had suffered some pain with the first period, and on three later occasions, but after her arrival in London she had severe pain with every period. "I vomit, and have to lie down. Must stop work. Feel miserable."

It is of course not our view that stress is the sole cause of period pain, but from our experience there seems to be no doubt that emotional tension can stimulate pain at the period in a woman who has not suffered it before, and can intensify period pain already present. Other symptoms, such as depression, malaise, or vomiting, can also make their first appearance at a time of stress. Pain at the period was also mentioned as one symptom by seven other patients, Cases 3, 29, 39, 41, 55, 59, and 62; all these patients were manifestly anxious or depressed, or both.

Other Symptoms

Amenorrhoea.—Two patients came to hospital because they developed secondary amenorrhoea.

Case 50.—A woman of 24 came for advice because she had had amenorrhoea ever since the birth of her second child. She was very worried about a further pregnancy, which she did not want. She had little appetite, felt listless, and was very depressed. She had occasional headaches of a migrainous type. She was examined, was reassured that she was not pregnant, and was sent for advice about contraception. Four weeks later menstruation began again.

Irregular Menstruation.—Two patients complained of irregular periods, and in both the symptom was associated with a manifest emotional disturbance.

Miscellaneous Ailments.—One patient attended for advice about morning sickness and was found to have a normal pregnancy. The remainder—one case each of fatigue, frigidity, and bad nerves, two cases of headache, and two of depression—were thought to be suffering from psychiatric rather than gynaecological disorders.

Assessment of Cases

As a result of the combined assessment of all the cases seen it was decided to divide them into four categories.

Group 1 (12 cases).—Patients in whom an organic abnormality appeared to explain all the symptoms.

Group 2 (6 cases).—Patients in whom an organic abnormality accounted for most of the symptoms, but in whom there appeared to be also an emotional factor.

Group 3 (18 cases).—Patients whose symptoms appeared to arise in the main from emotional tension, but who had a minor organic abnormality.

Group 4 (24 cases).—Patients whose entire illness was a stress disorder.

Comment

The outstanding conclusion from our survey is that emotional tension outweighed physical malfunction and disease as a cause of illness.

This conclusion is surprising, and not at first sight easy to accept, yet the clinical observations seem inescapable, and the case histories speak for themselves. We tried to guard against an over-estimation of the emotional factor by careful appraisal of the whole clinical picture, by following up each case so that first impressions could be checked, and by interviewing the patient's relatives, where this was possible. Another useful check was the effect on symptoms of the brief and simple kind of psychotherapy which could be carried out in an out-patient department. Twenty patients who attended for repeated interview for this purpose reported that they had gained much benefit, or were entirely relieved. We believe that the series reported here is a representative one, and that women suffering from physical concomitants of emotional tension do in fact form a large part of the out-patient attendance at a gynaecological clinic.

Summary

A combined surgical and psychiatric survey of a random series of 60 women attending an out-patient clinic for gynaecology is reported. The largest single group was that of women who gave pain as the leading symptom; of these 22 cases, only 3 were proved to have any significant gynaecological abnormality.

The conclusion of the survey is that emotional tension outweighs physical malfunction and disease as a cause of illness in women who attend a gynaecology clinic.

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