GYNAECOLOGICAL DISEASE IN THE MIDDLE-AGED WOMAN

A study from general practice

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GYNAECOLOGICAL disease accounts for a substantial part of the work of an average practice. So much so that others like myself must have wondered whether any woman ever gets through middle age without suffering from some complaint falling within the field of this speciality. It is a commonly held belief in all classes of society that unpleasant symptoms of one sort or another are the inevitable lot of every woman who survives to the age of 45 and that the calm of old age can only be reached by weathering the storms of the middle years. This study is an attempt to see how far this is true and, if so, in what ways the inevitable suffering can best be alleviated.

The practice is situated in a seaside town and the women belong to all social classes with relatively few in classes I and V. It is single-handed and, except during short holiday periods, all patients are seen by the principal who has held the practice since January 1946. Detailed notes are kept of all cases seen so that the practice records provide a comprehensive picture of the clinical findings and treatment in each case. Patients with gynaecological conditions requiring specialist advice are sent to the local general hospital where there is a well-qualified consultant staff who have, however, always been hampered in their work by shortage of beds and by a long waiting list for operations.

Method

For the purpose of this study a list was made of all women aged 50 to 64 inclusive on 1 January 1965 who had been patients of the practice since the age of 45. The records of these patients were then examined and the necessary information extracted. It was appreciated from the start that these would not give a complete picture of the incidence of gynaecological disease in this age group since many of the women had not yet completed that part of their lives which was

being studied. If, however, the investigations had been limited to those of over the age of 55 or 60, there would not have been a sufficient number available for study; furthermore, it soon became evident that there was far more gynaecological disease between the ages of 45 and 50 than in the later years of middle age and that useful conclusions could be drawn despite the statistical inexactitudes inherent in the method.

Results

The total number of women in the survey was exactly 200. Of these nine were known to have had hysterectomy before reaching the age of 45 and were therefore only partially at risk for gynaecological disease. It is known that there was only one woman who would otherwise have been included in the survey who had died from a gynaecological complaint, a carcinoma of the ovary. Altogether 82 of these women sought advice for gynaecological symptoms subsequent to their forty-fifth birthday. If it is allowed that some of the remaining 118 will suffer from a gynaecological complaint before reaching the age of 65, it is reasonable to conclude that one woman in two consults her doctor for trouble of this sort between the ages of 45 and 65 and that there is an unknown number additional to this who suffer symptoms but do not seek advice. Although this is not the suspected 100 per cent it is still a formidable number and makes one wonder why the functions of the genital system and its hormonal controls should be so much more liable to break down than those of other systems.

The varying complaints will now be dealt with in greater detail.

Haemorrhage

No attempt has been made to differentiate between menorrhagia and metrorrhagia; prolonged and heavy menstrual bleeding and irregular bleeding may occur in the same patient at different times during the same illness and the definitions become blurred. 'Haemorrhage' was deemed to exist when the patient found the menstrual or intermenstrual loss heavy enough to make her seek treatment from the doctor. A 'cure' was defined as freedom from these symptoms for a minimum period of one year, after which further symptoms were considered to constitute a new illness.

By these criteria there were 45 patients who suffered 55 episodes of illness. In only nine cases could any definite underlying cause be determined. In four of these fibroids were found at hysterectomy and in one other case this diagnosis was almost certain, a very large irregular mass being present in the uterine body. The patient refused to have hysterectomy performed but fortunately her menopause followed soon afterwards and she had no further trouble. It is highly probable that fibroids were present in a number of the other

cases but they were not large enough to diagnose with certainty and the symptoms subsided without the need for hysterectomy so that the diagnosis remained in doubt. In three patients definite fibroid polypi were demonstrated and removed and in one the symptoms were considered to be due to thyrotoxicosis as they subsided when that condition was brought under control. Even allowing for missed diagnoses there is no doubt that the great bulk of the cases were of sex-hormonal origin.

It is highly probable that many cases of uterine haemorrhage will remit spontaneously if left untreated, but in the absence of a control series it has to be assumed that, where cessation of symptoms took place while treatment was being given, it was that treatment that brought about the remission. The exception to this rule is where the menses finally ceased whilst medical treatment was still being given, in which case it was assumed that the cure was attributable to the menopause. Twenty out of 55 episodes ceased in this way but in a number of these the symptoms were already tending to improve before the final cessation of the menses. It is impossible to assess accurately the influence of the therapy in these cases. In the remaining 35 episodes remission or final cure of symptoms was brought about by the following forms of treatment:

Hysterectomy	8
Dilatation and curettage	3
Polypectomy	1
Thyroidectomy	1
Methyltestosterone	16
Ethinyloestradiol	4
Progesterone	1
Oral iron	1

In 17 patients this successful treatment had been preceded by other unsuccessful forms of treatment as follows:

Dilatation and curettage	3
Methyltestosterone	8
Ultandran	1
Ethinyloestradiol	10
Stilboestrol	2
Anovlar	1
Ethisterone	1
Ergot	4
Oral iron	3

The discrepancy in numbers is due to the fact that in some cases more than one form of treatment had been used unsuccessfully. These 17 patients were eventually cured in one of the following ways:

Hysterectomy	5
Dilatation and curettage	3
Polypectomy	1
Methyltestosterone	4
Onset of menopause	4

When treatment with methyltestosterone failed, eventual cure was effected by hysterectomy in three cases and dilatation and curettage in three, whilst in two the menopause intervened before further treatment had been given.

Thus it will be seen that treatment with methyltestosterone, given either as a first choice or after the failure of other treatment, was successful in almost one-third of all the cases and almost a half of those where the menopause did not intervene. It was being given to several others at the time of the menopause and it is reasonable to suppose that it might have induced remission of symptoms of some of these if menstruation had not ceased. It was given in doses of 5 mg twice daily for two months, followed by an intermission of one month and then a further course if necessary. In these doses the side-effects of virilism and acne did not constitute a problem. It was therefore a very successful form of treatment and it would seem worth trying in every case where the heaviness of the bleeding or the presence of large fibroids does not constitute an indication for early hysterectomy. If it fails it is unlikely that any other form of medical treatment will be successful.

Treatment with other sex hormones was not used extensively in this series, apart from ethinyloestradiol which was given generally in doses of 0.03 mg to 0.1 mg daily from the fifth to the 24th day of the cycle. As already indicated, this drug, as well as stilboestrol in a few instances, was only successful in a quarter of the cases in which it was used. During the past two or three years mixtures of oestrogens and progesterones, available as proprietary preparations, have been used in the practice to treat a number of patients who are still too young to be included in the present series. Insufficient data are available to see how this treatment compares with androgens but the first impression is that, whereas symptoms are often controlled by this form of therapy, they tend to recur more rapidly after treatment is stopped.

Vaginal discharge

Eight patients presented with vaginal discharge. The underlying cause was considered to be as follows:

Senile vaginitis	3
Trichomonas infection	4
Moniliasis	1

All except one case of trichomonas infection were postmenopausal and all responded rapidly to standard treatment. Discharges therefore present no great problem in this age group.

Dysmenorrhoea

Only two cases were seen, one in a highly neurotic woman and the other associated with menorrhagia. The first subsided after little

more than token treatment with oestrogens and the other was cured by hysterectomy. A diagnosis of adenomyosis was made although the pathological findings were equivocal.

Dyspareunia

Two cases were seen. One was associated with senile vaginitis and was eased by the use of oestroform ointment. The other patient was found to have a very small introitus and had suffered from the symptom for many years before seeking advice. She was offered surgical treatment but preferred to leave things as they were.

Hot flushes

As might be expected, as many as 39 patients complained of hot flushes sufficiently severe to justify treatment. There were nine cases among the 23 patients on whom hysterectomy had been performed. Most of these had also had their ovaries removed but the records are not clear on this point in certain cases. There remained 30 women out of the 177 who had certainly retained their ovaries, thus confirming the commonly accepted opinion that hot flushes are much more troublesome after oophorectomy than after the natural menopause. Standard treatment was with ethinyloestradiol 0.01 mg three times daily to be taken only on days when the patient had suffered at least three flushes during the previous 24 hours. The symptoms thus act as an automatic control for the therapy and overdosage is avoided. Most patients require only a few weeks treatment along these lines but there remain a few who continue to complain of recurring flushes many years after the menopause and have to take the oestrogens at varying intervals. It is accepted that a hysterical element may be present in these cases and that the tablets may be exerting only a placebo effect. Only one case of oestrogen withdrawal bleeding has occurred and there would therefore seem to be little risk in properly controlled prolonged oestrogen therapy, even if the indications are doubtful.

Amenorrhoea

Only one patient sought advice for amenorrhoea and no cause was found. Menstruation was re-established spontaneously but the symptoms recurred on several occasions over a period of five years until the menopause finally intervened. Amenorrhoea is probably a common symptom in this age group but women accept it as natural and do not seek advice for it.

Prolapse

Five cases of prolapse were seen. All were dealt with by operation, four having colporrhaphy performed and one, which was associated with a cervical fibroid, having vaginal hysterectomy.

Premenstrual tension

Two women complained of this symptom. Both were given

ethisterone in the second half of the menstrual cycle and both ceased to attend after two or three months of this treatment. It is unlikely that they were permanently cured and it is more probable that their symptoms, normally tolerable and accepted, had temporarily become unbearable owing to coincidental social problems.

Ovarian cyst

One patient had a large ovarian cyst which presented as abdominal enlargement. The cyst was removed successfully and proved to be non-malignant.

Delayed bleeding after the menopause

Three cases occurred. One was associated with senile vaginitis, one was the oestrogen withdrawal bleeding already mentioned and the third case cleared up undiagnosed.

Other conditions

There was one case of Bartholin's abscess and one of acute salpingitis. Both responded to standard treatment.

As already stated, it is known that there was one patient who would probably have come within the purview of this survey and who had died from malignant disease of the genital organs. This patient had a carcinoma of the ovary and developed generalized abdominal secondaries. This almost complete absence of malignant disease emphasizes again how infrequently any one general practitioner will encounter these conditions. However, the National Morbidity Survey carried out by the College of General Practitioners and the General Register Office indicates that in any one year approximately two out of every thousand female patients in the 45 to 65 age group will be suffering from malignant disease of the genital organs. On this assumption it is calculated that there should have been about eight cases in the present series, which suggests that we have been particularly fortunate during the period under review.

Fourteen patients in the age groups covered by the survey had hysterectomy in addition to the nine whose uteri had been removed before the age of 45. All were operated upon between the ages of 45 and 51 and, as already indicated, all were suffering from non-malignant conditions. The average time between reference to the gynaecologist and operation was two months but eight cases were operated on within one month or less.

Discussion

A few definite conclusions can be drawn from this survey.

1. Any woman has no more than a 50 per cent chance of getting through her middle years without needing to consult her doctor for some gynaecological complaint. She has about a one in eight

chance that she will lose her uterus before she is in her middle fifties.

2. Gynaecology is therefore an important part of general practice and recent suggestions that it should be taught almost entirely as a postgraduate subject would seem to be out of touch with the facts. Although many young women need to be referred to hospital for minor surgical procedures, the great majority of middle-aged women with gynaecological complaints can be dealt with entirely by their general practitioners.

3. Androgens are probably the most satisfactory form of hormone therapy for excessive uterine bleeding in women of the middle-aged groups.

4. Oestrogen therapy can be given with almost complete safety to postmenopausal women if the dosage is regulated from day to day by the symptoms.

Summary

An account is given of gynaecological disease in women aged 45 to 60 as occurring in a general practice.

The suspected high incidence of such disease in this age group is confirmed.

The treatment of the various diseases is discussed and conclusions drawn from its success or failure.

VOCATIONAL TRAINING FOR GENERAL PRACTITIONERS

The trainee scheme

General-practitioner trainers having a trainee desirous of obtaining a better and broader view of general practice by transferring to another type of practice for a short period of say, one week during his traineeship, should contact the **Administrative Secretary, The Royal College of General Practitioners, 14 Princes Gate, London, S.W.7,** for the names of those general practitioners who would be willing to co-operate in such a scheme.