GONORRHŒAL VAGINITIS; ITS COMPLICATIONS AND TREATMENT.[1]

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The progress of pathology has in many instances explained why certain methods of treatment demonstrated clinically to be the best, should be the best, because of its antiseptic or germ-destroying power, and, as a logical deduction, has suggested many remedial agents and measures which have been found beneficial.

[1] Read at a meeting of The New York Obstetrical Society, held February 2, 1892.

Pathology has also shown us that the complications of many diseases are not irregular and inexplicable results, relapses as they were formerly expressed, but that they are direct extensions of the original disease either by continuity of tissue or by absorption of the germs, or the products of disease by the lymphatics and blood-vessels. These propositions, which are almost axiomatic at the present stage of medicine, need but a third, which is, that septic conditions do not ordinarily arise in the organism, but are due to morbific agents from without, producing changes either by themselves or by lowering the power of resistance to other agents, or germs, in the tissues. The acceptance of these propositions has been the basis of most of the advances of surgery of the last fifty years.

Hence the necessity of constantly reviewing the time-honored methods of treatment of disease.

I do not think that the success which has followed the use of cleanliness and antisepsis in midwifery and abdominal surgery has been attained in the treatment of the disease which is the title of this paper, and that laparotomy is so frequently demanded to remove pus tubes is the best argument that it has not.

In discussing gonorrhœal vaginitis and its complications I shall not go into its symptomatology further than to follow out the ordinary sequences of its course.

The poison being introduced at the vulva, a vulvitis and inflammation of the ostium vaginæ, Bartholin's glands, and urethritis results.

Bumm has claimed that in some cases the virus is first introduced in the upper vagina and cervix, but this apparently is exceptional, though it may explain some cases where very slight vulvitis and vaginitis result, but there is rapid involvement of the endometrium and Fallopian-tubes.

In the course of from a few days to a week the whole vagina, to the cervix, is involved with all the symptoms of acute catarrhal vaginitis; if left without proper treatment there is endometritis next, extending to the Fallopian-tubes, causing catarrhal or purulent salpingitis, with more or less peritonitis, limited mostly to the pelvis, though sometimes becoming general, with resulting adhesions from pelvic exudations. It has been my experience that the involvement of the endometrium, cervical and corporeal, has been most frequent and most rapid when the vaginitis was acquired shortly before or after menstruation; also I have observed that usually the attacks were more severe.

In many cases the involvement of the uterine mucous membrane, and also the tubes, was not evidenced by the ordinary symptoms of pain and abdominal tenderness until the next menstrual period. The late Dr. Charles E. Budd called my attention to a point which I have since observed many times. that where pelvic peritonitis, with salpingitis, caused by gonorrhœal vaginitis, existed on one side of the pelvis before menstruation, that following the period the other side would become involved, thus prolonging the disease. Why general peritonitis does not more frequently result from the extension of the disease can only be explained by the protective influence of the peritonitic adhesions in the pelvis.

This disease is very apt to become chronic, and this is explained by its frequent relapses, a new vaginitis of more or less virulency and contagiousness resulting from discharges from Bartholin's glands, the uterus, cervix, or body, or the tubes, caused by coition, exercise, or straining.

The remote results in sterility, displacements of the uterus, ovaries and tubes, pelvic abscess from pyosalpinx, depreciation of health and strength from recurrent attacks of pelvic peritonitis, are familiar to every gynæcologist, though the cause may not be obvious or determinable from any history the patient can give us.

With this merely outlined picture before us, it is apparent that while the vaginal discharge, heat and tenderness of the vulva, vagina, and urethra are the symptoms which cause distress to the patient, and for which she is grateful if relieved, yet, while prescribing rest and soothing applications we must remember the gravity of the case, and seek as earnestly to prevent extension of the disease as we would the entrance of sepsis to a wound, or into a puerperal patient.

In the male urethra many of the germicides cannot be used on account of the frequency of resulting stricture, but on the vulva and vagina there can be no objection, either as regards pain or resulting impairment of function, to the use of solutions of 1-5000 or 1-10,000 of mercury bichloride, carbolic acid 1-100 in saturated solution of boric acid, or other astringents which are germicidal.

A plan of treatment which has given much satisfaction to me, and in which I endeavor to fulfill the indications before presented, has been in the cases as they ordinarily present themselves in the acute stage.

To order, if possible, that the patient remain in bed, to give internally salol and an alkali to relieve the pain in micturition, which at the same time aids in destroying the urethral trouble.

A lotion is given of a 1-5000 solution of hydrarg. bichlorid., made by the patient dissolving a one-grain tablet of corrosive sublimate to each ten ounces or two-thirds of a pint of hot water; to bathe the outside parts thoroughly afterwards; to inject in the vagina three or four times a day for the first two days; then reduced to 1 10,000, or if much tenderness, 1-20,000; replaced if much pain by a 1-100 solution of carbolic acid.

This injection should always be taken when recumbent, as the folds of the vagina will be distended and the cervix also will be cleansed.

By the third day the speculum can be used, the cervix is observed, and after thoroughly cleansing the canal, a small cotton swab on the applicator can be carried in with strong carbolic acid or a solution of the bichloride, followed by the application of iodoform in powder.

As soon as the swelling subsides so that the use of the speculum is not painful, a five-per-cent. solution of nitrate of silver is painted over the cervix and vagina, and the vagina is tamponed with iodoform or weak bichloride-gauze, to separate the walls of the vagina, the ends being brought down to the vulva; if the tampon is changed every two days generally, in a week, or at most ten days, the discharge has ceased.

Before pronouncing a case cured the condition of the glands of Bartholin should be observed. If any pus can be made to extrude by pressure, the disease has certainly not been eradicated, and would relapse; the gland is opened by a small incision over the duct, and cauterized with carbolic acid, cocaine being used to prevent pain, the parts being dressed with iodoform-gauze. The cervix is also inspected, and if a purulent discharge is present, the Nabothian glands distended, they are curetted and strong carbolic acid applied to them, a tampon of iodoform-gauze being packed around the cervix so that the vagina may not be inflamed again.

This has been my course in dispensary, and in private cases where possible; the results have been gratifying in making the duration of the disease shorter than under any other plan I have followed, and in preventing relapses.

Where the disease is subacute from the beginning, as in cases where apparently due to a gonorrhœa in a chronic form, as is seen many times in married women whose husbands have whipped up a neglected gleety discharge by free stimulation, the disease will have affected the cervix, and produced less inflammation of the vagina and vulva.

Here the speculum can be used immediately, the cervix thoroughly cleaned, as it is usually pustulous, and a strong carbolic or silver solution applied, followed by the application of the silver solution to the vagina, and the carbolized or weak bichloride injections.

Corporeal endometric involvement is usually shown by the muco-purulent acrid discharge from the cervix, the patulousness of the cervix, and free bleeding on touching the os internum with the applicator, also by the weight and tenderness of the womb.

After cleansing the cavity, except when marked parametric trouble was present, I have applied the strong carbolic acid to the endometrium, sometimes preceding the application by passing the blunt-curette over the membrane, if slight tenderness were present in the broad ligaments and tubes before the application; it will frequently quickly disappear under the use of hot-water injections.

My belief is strengthened that gonorrhœa is more frequently the cause of sterility than is generally stated; from finding that the husbands of many of the sterile patients whom I have treated have had attacks of the disease, and without complicating epididymitis, according to their history, or from an examination of the testicles for hardness or tenderness. It may be remarked by some that this may seem excessive care to be bestowed on such a common disease as gonorrhœal vaginitis; that a catarrhal vaginitis, caused by a badly applied dirty pessary or by cold, by chemical irritants, will be as severe apparently, and will get well without any more than an astringent injection. I do not deny that any septic matter may cause purulent vaginal discharges which may set up by its contagiousness endometritis, salpingitis, etc., and may even affect the male with a urethritis, but it must also be admitted that these results are infrequent, compared to those that have a gonorrhœal origin, and, if it proves anything, demonstrates the same antiseptic plan should be followed as in the specific cases.