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CONTENTS.

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GYNÆCOLOGICAL REPORT—MONTHLY.

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DYSMENORRHŒA.

The fact that the majority of women suffer more or less from dysmenorrhœa makes it a subject of deep interest to the profession. In an able paper read before the Obstetrical Society of London, last year, Dr. John Williams points out that its most serious form is met with chiefly in the unmarried, which renders a complete investigation difficult. He divides dysmenorrhœa into two classes: primary and acquired. The latter are few, only about 1 to 40 of the former. Dr. W. thinks ovarian pain or inflammation rarely cause dysmenorrhœa, but rather consequences of it.

The doctor is not in favor of the mechanical theory of causation, as in his investigations he has found there was stricture of the canal, though the rarely round cervical ossæ were present. Imperfect development of the uterus was frequently found to exist, and accounts for the frequency of dysmenorrhœa among delicate ill-developed girls. The prospect of the paper favors constitutional rather than mechanical treatment.

The following are Dr. Williams' conclusions:

1. Dysmenorrhœa should be studied first under the least complex conditions—in single women.

2. Dysmenorrhœa in single women is rarely acquired; it is almost invariably primary, viz., it appears with the menstrual function.

3. Dysmenorrhœa in a few, but rare, cases spontaneously a few years after puberty.

4. Marriage, if sterile, aggravates the disorder in many cases; it is only very seldom that it relieves the pain.

5. Child-bearing cures a large number of cases, and it is not impossible that were all puerperal complications excluded it would cure every case.

6. The proportion of sterile to fertile women, subjects of primary dysmenorrhœa, is one to twelve.

7. Menstruation begins in women who become sufferers from primary dysmenorrhœa at about the estimated average age for the appearance of the function in London.

8. Menstruation is regular in about two-thirds of the cases; irregular in about one-third.

9. The menstrual fluid is profuse in about two-fifths of the cases, and scanty in about one-half. It contains clots or shreds in about three-fourths.

10. The changes which take place in the fluid in the course of dysmenorrhœa are various, and cannot at present be classified.

11. The uterus is imperfectly developed. It may be too short, or too small in volume, or it may be defective in both respects. The cervix may be conical, and the os small and round, but stricture of the canal in any part of its course is infinitely rare.

12. The changes in the uterus due to dysmenorrhœa are slight hypertrophy, erosion and eversion of the mucous membrane of the cervix, and catarrh. The cavity increases but little in length, for after