

SOME REMARKS ON THE INTERRELATION OF GYNECOLOGICAL AND GASTRO INTESTINAL SYMPTOMS*

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THE trite saying that one should treat not the organ or the disease but the patient applies perhaps nowhere more succinctly than in the field of gynecology. Symptoms involving other organic systems are very frequently present in gynecological cases. I remind the reader here only of the various symptoms involving many different organs which are seen so frequently with menstruation and pregnancy. Thus the gynecologist should know at least sufficient general medicine to be able to interpret correctly symptoms and signs of nongenital origin, so as to be able to advise and treat his patients intelligently. To pass up the responsibility by immediately and uncritically referring all such patients to the respective specialists may easily result in a wrong perspective in which each man sees but a small part of the entire clinical picture, reminding one of the three blind men who examined the elephant. An example of such overspecialization is a case I saw at my office where the woman had been treated for several months for gastritis and indigestion because of nausea and vomiting, and the main fact that she was pregnant had been entirely overlooked.

As in pregnancy, so in many other gynecological lesions and disturbances, gastrointestinal symptoms are especially common, and I shall limit myself here to this interrelation of gynecological and gastrointestinal symptoms, and even here stress only some more or less common associations.

Considering the close proximity of the genital organs to all others found in the abdominal cavity and the interrelation of the blood supply, general, and autonomic nervous innervation, it would indeed be

strange if disturbances in the genital system did not affect the gastrointestinal system, and vice versa. That the correct interpretation of the mechanism of the influence of one of the systems on the other is, however, not always easy is shown by the fact that the vomiting of pregnancy, for example, has been explained on a purely mechanical basis, due to the enlarging uterus, on the physical basis of changed blood supply, on a nervous basis, due to the stretching of the peritoneum, on a chemical basis, as the result of absorption of fetal toxins by the intestines or general system, and on a psychic basis, as a repugnance and revolt of the woman against carrying in her body a part of a consciously or subconsciously disliked male partner.

There are, of course, many lesions where the interrelation of genital and gastrointestinal symptoms is at once evident. That markedly relaxed abdominal walls and relaxation of the pelvic floor may cause gastrointestinal symptoms goes without saying, and I have cured many such cases by perineal repair and a proper belt. In the same way, large fibromyomata, ovarian and other pelvic tumors may cause gastrointestinal symptoms by causing changes in abdominal pressure. Appendicitis may lead to perisalpingitis and actual salpingitis and the other way round. At the same time every case of pain in the right lower quadrant, especially if the pain comes and goes, or lasts only minutes or an hour or so, and is not accompanied by fever, is not appendicitis, though often diagnosed as such and uselessly operated for. Spasms of the intestines, cramps, or dilatation of the cecum due to gas from intestinal fermentation or air swallowing must always

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be excluded. Again, adnexitis often leads to adhesions to the intestines, sigmoid and rectum, and so results in disturbances of intestinal function of various types, such as spasms and even intestinal obstruction. Even where no adhesions to the intestines or to the rectum are present, pelvic inflammation may cause spastic contractions of the intestines and tenesmus. Again, intestinal disturbances may lead to pelvic congestion. Constipation alone is often an important factor in pelvic congestion and some cases of pelvic pain can be cured readily by overcoming such constipation. The relation of mucous colitis to the genital system is also very close and may lead to a multitude of symptoms referred to the genital tract.

Personally I feel that mucous colitis is regarded too much as a clinical entity. Perhaps there is here an hereditary or congenital irritability and supersensitiveness, but I feel that genital inflammation can produce exactly the same symptoms, and following such inflammation there often remains an irritability of the colon which only long-continued diet can overcome. There are, however, undoubtedly also nervous factors involved. One of my patients who came to me with bilateral masses has been entirely relieved of her pelvic inflammation by conservative measures, but gets low abdominal distress and pains in the adnexal regions following indiscretions in diet, or as the result of emotional upsets. At times her menstrual cycle is also affected by these upsets and it is well known that disturbances of the abdominal blood supply may cause menstrual abnormalities as well as abortions and even premature labor.

Being a firm believer in the importance of psychic factors in the production of some peptic ulcers, I think that even in such cases at times a relationship between genital and gastrointestinal systems will be discoverable.

Thus in every female patient with gynecological or gastrointestinal symptoms or both, we must determine first if an organic lesion is present, and second, where

it is situated. A careful general and pelvic examination, and, if necessary, gastric analyses, gastrointestinal x-ray pictures, laboratory examinations of blood, urine, etc., will usually determine this. At times a basal metabolism test will show a hyperthyroidism which may be responsible for the gastrointestinal disturbances, and an electrocardiogram may discover a heart lesion which has been hiding behind gastrointestinal symptoms. The gastric crises of locomotor ataxia must also be mentioned here. Sometimes a cystoscopy revealing a markedly trabeculated bladder may be the first sign-post leading to a correct diagnosis; once again showing the interrelation of various symptoms and signs in different organ systems. One must, however, always remember that finding a gynecological lesion does not preclude the presence of gastrointestinal disease and vice versa.

After an organic lesion has been found, we must carefully evaluate whether it can explain *all* the symptoms the patient complains of, and if the symptoms referred to one organ system can be explained by the organic change present in the other. Here it must not be forgotten that the gynecological lesion, for instance, may obscure or hide gastrointestinal symptoms or contrarily cause only gastrointestinal disturbances, or that the gastrointestinal lesion may produce only gynecological symptoms. Finally, if organic changes are found in both gynecological and gastrointestinal systems, it must be determined whether or not the two lesions are separate entities or whether they are interrelated and if the latter, in what way.

Despite experience and careful examinations, mistaken diagnoses are not uncommon. Perhaps a few illustrative cases from my own practice may be of interest here.

CASE I. A white female, thirty-six years old, complained of backache, a feeling of "losing insides," "indigestion" and gastrointestinal cramps. Examination revealed relaxed abdominal walls and vaginal prolapse. No gastrointestinal lesions were found. Operative repair

and a belt helped the patient, but her intestinal cramps and "indigestion" persisted. I then thought of the possibility of ureteral stricture and one was found on the right side. Dilatation of the ureter immediately relieved the patient of all gastrointestinal symptoms. After three months a recurrence of the gastrointestinal symptoms was again cured by ureteral dilatation. The rôle of a ureteral stricture in producing gastrointestinal symptoms is perhaps not so well known, but should always be thought of. After all, Dietl's crises, resulting in abdominal pain and vomiting, have practically the same etiology except that the sudden obstruction of the ureter causes more acute and correspondingly more severe symptoms and signs.

CASE II. White female, forty years old. The diagnosis was fibromyomata uteri with right-sided ovarian cyst. Operation showed uterine fibromyomata and normal ovaries, but an enlarged and markedly dilated cecum. (Aside from a dilated cecum, a dilated sigmoid may also lead to misinterpretation on vaginal palpation.)

CASE III. White woman, forty-five years old, with menorrhagia. The cervix was small, leading directly into a hard nodular mass which moved freely with the cervix. The adnexal regions were negative. Diagnosis: Fibromyoma uteri. Operation showed a carcinoma of the sigmoid attached firmly to the atrophic uterine fundus. A two-stage Mikulicz operation was done.

CASE IV. A thirty year old white woman complaining of pains in the left lower quadrant. On palpation a nodular, doughy tumor was felt in this region. Diagnosis: dermoid cyst. Operation showed only enlarged appendices epiploicae closely packed together in the left adnexal region.

CASE V. Same symptoms, palpatory findings and diagnosis as in Case IV. Operation showed slight adnexitis and adhesions to a thick omentum lying low down in the pelvis.

CASE VI. The last case is one in which gynecological findings were apparently associated with severe gastrointestinal disease. The diagnosis was fibromyomata of the uterus. The patient refused operation and was later taken to another hospital with very severe abdominal pains, distention, fever and leucocytosis. A diagnosis of acute pancreatitis was made, but at operation nothing was found, except the uterine fibromyomata. The patient died the next day. An autopsy showed a valve-like

occlusion of the right coronary artery by a calcified arteriosclerotic plaque.

So much for cases in which organic lesions are found. At times, however, no organic lesions are discoverable on the most careful examination, or the lesions actually present cannot possibly explain the patient's gastrointestinal or gynecological complaints. What is to be our method of procedure in such cases? Shall we without further ado send such patients to the gastroenterologist or call them neurotic and hysterical and throw up our hands and pass them on to the neurologist? I think not. After all, there must be a cause for such symptoms and the gynecologist, first because he has already been in contact with the patient and secondly because of the peculiarly intimate nature of the relations between him and the patient, seems to me to be eminently fitted to obtain such accurate and detailed confidential knowledge as may assist in clearing up the condition.

It is here that a painstaking and tactful anamnesis is of inestimable value.

The onset and duration of the complaint, the amount of pain, its location, etc., the continued or periodical appearance of the symptoms, are all important. But further than this we must know of the patient's habits, her diet, bowel movements, her occupation, domestic and sexual life and mental state to be able to treat intelligently.

So-called indigestion with flatulence, belching, gastric distress or even marked pain are too often labeled gastritis, hyperacidity or hypoacidity, with or without gastric analysis, and treated with all sorts of medication when the root of the whole trouble lies in domestic difficulties. Nostalgia or grief may cause gastrointestinal upsets as well as gynecological symptoms. Excitement of any kind may lead to constipation or diarrhea, and air-swallowing may be the sole cause for the eructations which are sometimes almost continuous. Even if determination of the gastric acidity reveals values above or below normal, this does not necessarily

mean that organic disease is present. Emotional disturbances alone suffice to produce such conditions. I have a patient who from time to time has all the signs of peptic ulcer, but only when domestic or other difficulties occur. Otherwise she has no complaints of any kind and can eat and drink whatever she pleases with no unpleasant effects. Such psychic effects are not at all uncommon. The secretions and excretions of the body: saliva, gastric juice, sweat, urine, feces, etc., are all to a much larger degree than is often realized under the control of the psyche. Everyone will remember numerous examples which prove this. Again nausea and vomiting may appear only around the menstrual period, perhaps due to pelvic congestion. In other cases the reaction is a psychic revolt against menstruation because of a desire for offspring. After coitus also sometimes gastrointestinal symptoms may come on. Disgust or even religious principles may be the underlying factors in such cases. In contradistinction to such emotional causes irregular hours, overeating, or the opposite, wrong diet, peculiar allergic sensitivity to certain foods, such as shell fish, various berries, pineapple, etc., alcoholic excess or overindulgence in tobacco, may be responsible. A change to a sedentary occupation may be the sole factor underlying constipation. Roentgen-ray treatment for uterine fibromyomata may cause diarrhea, as in a patient of mine who was treated by her family physician for this complaint, since the patient had not told him about her x-ray treatments, not connecting these in any way with her gastrointestinal symptoms. Asthenic conditions and even gonadal insufficiency coupled as it always is with other hormonal defects may cause symptoms simulating gastrointestinal disease. At the same time, we must not forget that chronic gall-bladder disease or appendicitis, even if mild, may be the root of the trouble. Intestinal parasites also must be thought of, though I believe the presence of a small number of parasites does not immediately explain the whole problem. Often such parasites are purely

coincidental.

With such a galaxy of causes for gastrointestinal distress in gynecological disease, it is evident that routine treatment is impossible. It is useless to medicate for gastrointestinal distress which is based on domestic, financial or other difficulties which the physician can only alleviate if he will take the time really to get at the source of the patient's troubles. Sometimes a mild sedative such as bromural will alleviate gynecological and gastrointestinal symptoms quicker than any complicated specialistic treatment. Again a sympathetic attitude and reassurance of the patient in regard to her gynecological troubles will with one stroke cure all gastrointestinal distress.

In some cases diet, of course, is important, but I feel we must be most individualistic here too. Diets and dieting to my mind play far too great a rôle in the daily life of the average American citizen. If marked constipation is present, regulation of diet, roughage, etc., is important, but with such roughage again we must avoid gastrointestinal irritation. Sometimes cathartics are necessary. Often they work well when combined, especially in the obese, with a choleagogue. Even in constipation, however, it must be remembered that patients differ, some naturally move their bowels twice a day, some once a day or once in two days, or even less often, without therefore really suffering from constipation. Rash interference in such cases can only lead to harm.

SUMMARY

I have reviewed here briefly some of the organic and psychic causes of the interrelationship of gynecological and gastrointestinal lesions and stressed the need of accurate diagnosis as a prerequisite for intelligent treatment. No attempt has been made to cover the entire field. My more or less random remarks simply record some of my personal experiences and my opinions based thereon. I hope that a full discussion will enable me to pick up many valuable points.