AMENORRHOEA

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This term means the absence or stoppage of the menstrual flow due to causes other than physiological.

In primary amennorhoea the menstruation has never occurred and puberty is delayed. The cause must be carefully sought for. It may result from absence or under development of the internal genital organs or from some constitutional disorders like anaemia, tuberculosis, rickets, chlorosis or malnutrition.

The symptoms of primary amenorrhoea are those of delayed puberty. The patient may experience the molimen, that is, may feel as if the menstruation might start at any moment, but there is no flow. If the amenorrhoea is due to some constitutional disease, probably the symptoms of that disease will stand out and in this case the amenorrhoea is the result and not the cause of the malady. The delay in this function not infrequently causes a nervous condition; hysteria often occurs and a nervous state often results in chorea. Neuralgia is not uncommon especially if anaemia or chlorosis is present.

The diagnosis of primary amenorrhoea is not difficult but care must be used not to mistake it for the physiologieal amenorrhoea of pregnancy. In primary amenorrhoea the evidence of delayed puberty such as small size of uterus, the undeveloped mammae and figure, the absence of an abdominal tumour all argue against pregnancy.

In secondary amenorrhoea, the menstrual cycle has existed for a longer or shorter time, but owing to some cause has become suppressed. In some acute illnesses like tuberculosis, anaemia or chlorosis the suppressiou is not undesirable, as the absence of the period may aid in conserving the strength of the patient. If the anaemia is very marked it is better if the patient does not menstruate because the flow is very apt to be excessive and this in itself may be the cause of tbe anaemia and here the physician should endeavour to cause a partial or complete stoppage of the menstruation, at least until the health of the patient is brought to a higher plane.

Secondary amenorrhoea may be produced by mental shock, violent emotions or hysteria, over-study and lack of exercise, super-involution of the uterus or atrophy of the uterus, chill during menstruation, pelvic inflammation, acute febrile diseases, systemic diseases sucb as Bright's disease, diabetes, chronic malarial cachexia. It may also be a sequel to a radical change in residence, as has been noted in the examination of immigrants after a long sea voyage and climatic change. Amenorrhoea has been traced to the anaemia of syphilis, obesity and morphinism.

Symptoms of secondary amenorrhoea depend to a large degree upon the suddenness of the suppression. In acute suppression there are marked dis-

turbances of the nervous and vascular systems, as is noted in the increased arterial pressure, palpitation of the heart, headache, neuralgic pains in various parts of the body and, not infrequently, hysteria. The local distress is often great, the pain being sharp, darting or cramp-like. Occasionally the vascular excitement is preceded by a chill and the congestion induced may develop into a serious inflammation. When the amenorrhoea comes on gradually, the symptoms are less severe, though often of more serious import. Prostration, lassitude, indigestion, constipation, and cardiac oppression, either singly or all together, may appear in due time. The symptoms of the disease which has caused the amenorrhoea, be it tuberculosis, anaemia or some other disease, will often present themselves to the physician.

Diagnosis of secondary amenorrhoea is often mistaken for pregnancy. The subjective symptoms are very similar; nausea, vomiting, morning sickness, mammary pains may result from either pathological or physiological suppression. During the early stages of pregnancy the increased size of the uterus is so slight that even the most expert diagnostician may be uncertain of its contents. If the patient is untruthful and denies the possibility of pregnancy, time is the only absolute test, although x-ray may assist sometimes.

Retention of the flow may be due to some interference to the exit of the flow after it has been secreted. It may be either congenital, as in imperforate hymen or atresia of the vagina higher up, or acquired following child-birth where inflammation and sloughing has occurred or from atresia of the cervix following operation upon it. Tumours, polypi, flexures or coagula may cause temporary stoppage of the flow.

Symptoms of retention are usually accompanied by much pain. Attacks of pain recur at regular intervals with all the usual symptoms of menstruation except the flow. There is often systemic disturbance such as headache, increased arterial tension, nausea and vomiting. The patient has pains in the back, abdomen, and legs with nervous phenomena of various kinds. Hysterical convulsions are not infrequent and even epilepsy may develop. In time the uterus becomes distended with the products of menstruation giving rise to a tumour in the hypogastric region. A rectal or vaginal examination will usually differentiate this condition from pregnancy.

Prognosis depends upon the underlying cause. Anaemia is the most amenable to treatment, but tuberculosis is always of serious import.

Treatment of amenorrhoea is in many instances simply the treatment of the general disease which has brought on the amenorrhoea. I have often found the following remedies indicated.

Calcarea carb.—Scrofulous diathesis with malnutrition and indigestion; face pallid and bloated with blue rings around eyes; oppression of the chest tending toward tuberculosis. Cold hands and feet.

Ferrum—Anaemia with fiery redness of the face on the least excitement; great nervousness and debility; palpitation; diarrhoea of undigested food; dyspnoea on moving about.

Kali carb.—Swelling of the eyelids; disposed to phlebitis; stiffness and

pain in the small of the back; all symptoms are worse from 2 to 3 a.m.

Pulsatilla—Delayed puberty; suppression from getting feet wet; menstruation late, scanty and irregular; leucorrhoea and dysmenorrhoea; pallor and lassitude; hemicrania with stitching pains in the face and teeth; painful lumps in breasts extending to arms.

Sulphur—Great congestion of the pelvic organs and of the head; coldness of the feet or burning of the soles of the feet at night in bed and often extends feet out from under the covers; flushes of heat; haemorrhoids; chronic inflammation of the eyelids; general eruptive tendency.

These are only a few of the remedies oftenest indicated in amenorrhoea, but there are many others, any one of which may be just the one needed in the particular case you may be treating. Also, in some instances surgery is necessary.

In all cases of amenorrhoea we must be sure to secure a complete history of the patient and then the selection of the right remedy will be simplified.

DISCUSSION

Dr. Allan D. Sutherland: Madam Chairman, I haven't been primed to discuss this paper and, in fact, all I know about amenorrhoea is what I see in my patients, and read in *The Recorder* and other literature.

There was one thing that struck me and that is the thoroughness with which the subject was covered in so brief a paper. Another thing is the point which came up when the essayist said it is sometimes difficult to distinguish between the amenorrhoea of pregnancy and that due to other causes, and that time, in the last analysis, is the only factor which would actually determine.

I think he might have mentioned that we do get some information from the so-called A-Z test, and other tests of a similar nature, for pregnancy. These are not infallible, however, as I have reason to know, but are often positive very early in pregnancy. A negative test doesn't necessarily rule out pregnancy, but a positive test is very definite. Those are things to be borne in mind that might be helpful.

Dr. P. L. Cobianchi: I should like to make a comment on a remark Dr. Sutherland made. It is about the urine test being positive when it is really positive. We can assume, and we might assume, the patient is pregnant. It is not so in all cases when the urine is positive, because there are other factors to be considered that might bring out a positive urine, such as chorioepithelioma of the uterus. It is true that the urine has diagnostic value, but a positive test should not always be considered pathognomonic of pregnancy.

Dr. Ralph S. Faris (closing discussion): I wish to thank the gentlemen for their comments and criticisms. I believe that I will stick by my guns in saying that the final test in a pregnancy is time. The A-Z test is often of value, and x-ray will often help, but there are chances that both of them may fail sometimes but time is not going to fail.

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