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The Function of the Internist

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endometrial biopsies should be done, preferably on day one of the cycle. A prettier microscopic picture will be obtained in the premenstrual phase, but unless the patient has been instructed not to attempt pregnancy that month it is best to wait until the first day of the cycle to avoid interruption of a pregnancy. The endometrium offers an easy organ picture of the response of the tissues to both the pituitary and ovarian hormones, and is simpler and less expensive than extensive hormone assays. The microscopic picture can be improved by the use of estrogen and progesterone. We prefer 0.1 mg. stilbestrol daily throughout the cycle. When these agents fail, we must suspect failure of delivery of these hormones to the endometrium.

Since the excellent work of the Smiths with stilbestrol in the prevention of repeat abortion has been seriously challenged by Davis and Dieckmann’s recent large series, we feel that there is a place for a more physiologic approach. We have proposed the maximal delivery and utilization of the patient’s own hormones by the surgical elimination of autonomic imbalance and vaso-spasm. A more stable blood flow will deliver more hormones to the tissues. We feel, however, that the procedure should be reserved for patients who abort normal fetuses and have evidence of autonomic imbalance by kymographic demonstration of utero-tubal pressures of high degree. To utilize the endogenous hormones of the patient in maximal amount by eliminating vasospasm and improving endometrial circulation we suggest the simple procedure of paracervical uterine denervation, which can be done either per vaginam or at laparotomy. A series of seventeen patients who had this type of denervation while under fertility studies conceived fourteen times and delivered thirteen live children during a two year study. (Jour. Fertility & Sterility, Mar. 1954)

These are the simple standard procedures which constitute the study of the female partner. If we will only till the barren ground, it will be easier for the Author of life to plant the seed.

The Function of the Internist

Francis W. Drinan, M.D.

The function of the medical staff in the operation of an Infertility Clinic is primarily to evaluate patients in order to exclude all systemic disorders that may have a bearing on fertility. At times, a relatively simple examination may reveal abnormalities that are significant, but equally as likely is that exhaustive studies will fail to supply any explanation of infertility.

The causes and factors are many and varied. The internist’s interest will be directed towards extra pelvic disorders of an organic nature. In general, the search entails an evaluation of the general state of health, endocrine systems, toxic or traumatic factors and metabolic disorders.

The relationship between general health and ovarian and testicular function has not been clearly defined, and is a source of considerable physiological speculation. General debility, malnutrition, hypoproteinemia are well known factors that are associated with hypofunction of sexual organs. The mechanism of the hypofunction is not clearly understood, but most likely involves several factors, as cellular and enzyme activity, primarily hyaluronidase and glucuronidase and hormonal production. No medical disease, excluding endocrine disorders, is inevitably associated with infertility. However, spreading tuberculosis, especially involving the Fallopian tubes, and decompensated liver disease are examples of conditions in which conception is unlikely.

Endocrine dysfunctions make up the most likely medical reason for sterility. Several conditions that are almost invariably associated with decreased ovarian or testicular activity below the functioning threshold are: Froehlich syndrome, eunuchoidism, Simmond’s disease, arhenoblastoma, masculinovoblastoma, Stein-Levinthal syndrome and struma ovarii. These situations are usually suspected and diagnosed after appropriate studies. There is a vast field of glandular disorders that may be significant in sexual gland function. Correction of thyroid deficiency commonly results in a return to normal of either the general state of health or hormonal balance requisite for pregnancy. In many cases, administration of thyroid to euthyroid patients has been followed by pregnancy in a couple that may have been barren for many years. Hypoadrenalinism is not per se sufficient to depress the factors necessary for conception. However, Addison’s disease is rarely seen in pregnancy. Cessation of cortisone therapy is known to be followed by a decrease
in adrenal cortical activity, and thus may be a temporary factor in sterility. The pituitary activities are so inter-related with each other and with other glands, that almost anything causing a derangement of function will be reflected elsewhere. The Sheehan syndrome has to be considered in cases of secondary sterility. Pituitary neoplasms and non-sexual gland over-stimulation may adversely affect estrogen and androgen production.

Search must be made into other disorders that may directly or indirectly depress sexual gland activity. Excessive radiation in x-ray workers and those exposed to radio-active substances is an accepted etiological factor in sterility. Disturbances of hormonal metabolism as seen in liver disease and the chronic congestion of organs with their inadequate arterial circulation of congestive heart failure are frequently associated with amenorrhea and inadequate sperm counts. Many other pathological conditions with deranged body physiology are at times associated with sterility—whether as a coincident or causative agent is difficult to determine.

The diagnostic studies for medical evaluation of sterility cases are multiple. However, no set of screening tests can be established. Routine laboratory procedures, as blood counts, sedimentation rate, urinalysis are a part of any complete examination. Basal metabolic studies, protein bound iodine determination, blood sugar, glucose tolerance curves, liver function tests will be required in some cases. Bio-assays of hormones, if more feasible, would add greatly to our knowledge of the subject, but from the practical point of view will seldom be mandatory tests. Enzyme determination may perhaps in future years be very important, but at the present time adds relatively little to the workup.

The internist must be aware of all factors and the inter-relationship of factors if he is to contribute to the individual's problem of sterility. A very complete and exhaustive workup may reveal no significant abnormalities, but the discovery of obscure conditions may make the time consumed a very fruitful experience.

The discovery of many of the abnormal conditions will not produce fertility but will obviate further diagnostic procedures and perhaps add to our ever-growing knowledge of sterility.

Urological Aspects

RICHARD E. STILES, M.D.

The function of the Catholic urologist in the management of apparently infertile marriages is two-fold. He is concerned primarily with the diagnosis of infertility or sterility in the male partner, and secondarily with the treatment of such abnormalities. In both these concerns, his medical enthusiasm is tempered by Catholic principles of morality. It is the purpose of this paper to describe how these objectives are achieved within the framework of a hospital out-patient clinic.

Patients are usually referred by the obstetrical clinic or family physician, after at least superficial studies of the wife have been made and no obvious cause of infertility found. At this point it is frequently desirable to investigate the male partner, in an effort to determine his role, if any, in the etiology of the problem.

When he is first seen, the husband's attitude may vary from genuine interest and enthusiasm, to polite skepticism, or ill-concealed antagonism. A little time spent in establishing rapport at this point pays dividends later, not only to the urologist and referring physician, but also to the patient's wife, whose repeated urging has frequently been necessary to get the patient to the clinic. For this reason, an effort is made to personalize each original interview at the clinic to avoid any impression of assembly-line tactics. At the same time, for consistency in record maintenance, a printed blank form is used, which has adequate space for entering the necessary historical, physical, and laboratory data.

In addition to establishing the usual details of medical history, the patient is questioned concerning previous marriages or pregnancies, episodes of genital infection, especially gonorrhea, mumps orchitis, or epididymitis. Inquiry is also made concerning previous operations for hernia, cryptorchidism, hydrocele, or varicocele, or allied conditions.

In 1970, the urologist should be aware of the possibility that the patient may be suffering from inguinal, epididymal, or seminal vesicle infection. He should also be on the lookout for the possibility of testicular injury. He should ask the patient if he has ever been treated for hernia, orchitis, or varicocele.

In addition to establishing the usual details of medical history, the patient is questioned concerning previous marriages or pregnancies, episodes of genital infection, especially gonorrhea, mumps orchitis, or epididymitis. Inquiry is also made concerning previous operations for hernia, cryptorchidism, hydrocele, or varicocele, or allied conditions.

Detailed information concerning the use of tobacco, alcohol, and other drugs is sought, as well as facts concerning the patient's occupation, with particular reference to his exposure to industrial poisons, x-ray, or other noxious agents. Finally, detailed information pertaining to the patient's marital life is worth eliciting. It is surprising how much variance there may be in the history obtained from the two partners on such fundamentals as potency and libido, frequency of intercourse, contraception, premature ejaculation, and so forth.

General physical examination is then carried out, with particular