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# Dysmenorrhea and Stilbestrol

by JOHN J. LYNCH, S.J.

AMONG generally accepted procedures in the management of primary dysmenorrhea, the administration of estrogen receives rather frequent mention in medical literature.<sup>1</sup> The calculated effect of this hormone, commonly prescribed in the form of diethylstilbestrol tablets, is to achieve painless menstruation through temporary suspension of the ovarian function, since usually "primary dysmenorrhea does not occur in the absence of ovulation."<sup>2</sup> If it is true that one effect of the medication is to inhibit ovulation, and that it is only through the attainment of this first result that painless flow is achieved, then immediately a question can arise regarding the lawfulness of the temporary sterility which necessarily occurs. It may in fact appear at first sight that the use of stilbestrol would have to be condemned for the very reasons which have been adduced against hesperidin as an antifertility factor.<sup>3</sup>

There is, however, a distinct and important difference between fertility control as previously discussed and estrogen therapy in the

present instance. First of all, it is clear that the natural function of the ovaries is at least two-fold, generative and endocrine. Hence whenever ovarian activity is suspended, two immediate results are necessarily produced: the subject is rendered sterile, temporarily at least; and the system is deprived of certain glandular secretions which are usually beneficial, but sometimes harmful, to bodily health. Now it is entirely conceivable that either one of those results could be desired and intended without the other. One might, for example, intend sterility while disclaiming completely any deliberate intent to affect secondary sex characteristics. Or, by the same token, one might be intent on preventing metastasis of breast carcinoma and repudiate all direct intention to bring about sterility. Of those two examples involving the same morally indifferent act (suspension of ovarian activity), we recognize the first as illicit and the second as potentially permissible, since in the one case the *direct intention* is illicit, whereas in the other all *direct intent* is legitimate.

And that is why we condemn fertility control as commonly understood. There the directly intended object of medication is sterility itself, and any other possible consequences are incidental by-products as far as subjective intention is concerned. Since the

<sup>1</sup> Greenhill, J. P., *Year Book of Obstetrics & Gynecology*, 1953-1954 Series, 512-515.

<sup>2</sup> *Ibid.*, 513 f.

<sup>3</sup> Cf. *Linacre Quarterly*, Aug. 1953, 83-88, and Nov. 1953, 118-122. In these articles fertility control is shown to be morally objectionable on two counts: (a) as an unjustified mutilation of the human generative function, and (b) as a species of contraception.

natural law prohibition against direct sterilization of this kind is universal, there can be no dispute about the immorality of deliberate fertility control.

But in the management of dysmenorrhea, it is relief from pain which is sought—pain which can be controlled, it seems, by controlling the endocrine activity of the ovaries. Subsequent temporary sterility can now be considered as the incidental by-product of ovarian suppression, whose only directly intended effect is to achieve painless menstruation. And hence we have here a possible application of the principle of double effect.

Before concluding, however, that stilbestrol is morally permissible medication for dysmenorrhea, a certain number of medical questions would have to be answered in such a way as to establish some real necessity for using this procedure in preference to others which do not affect fertility. One of the postulates of the principle of double effect is that there be proportionately grave reason for even permitting an evil result. And such a reason would be lacking if it could be shown, for instance, that painless menstruation could be just as conveniently and just as effectively be achieved by a method which would not involve temporary sterility, or if it could be established that relief from pain is not of itself important enough to compensate for the extent of the evil permitted. Since the ultimate decision requires medical experience combined with moral judgment, both physician and theologian have a share of responsibility

in determining proper procedure.

### VARIOUS MEDICAL PROCEDURES

Judging from available literature on the subject of dysmenorrhea and from the testimony of physicians consulted personally, there would appear to be no universal medical rule either recommending or discouraging stilbestrol for all cases indiscriminately. Although consideration is given to a number of possible treatments, general consensus seems to be that none is entirely without its disadvantages.

**Drug therapy** may prove satisfactory, especially in milder cases; but my impression is that it is frequently useless, always labors under the handicap of obliterating only the symptom without correcting the cause, and cannot completely escape the risk of addiction if recourse must be had to the more powerful but habit-forming drugs such as codeine. (Even though the prescribed monthly dosage of codeine should create no more than a negligible danger of habituation, doctors are instinctively reluctant to prescribe a regimen of such drugs if it can be reasonably avoided.)

**Hormones**, of which stilbestrol is but one species, represent another possible solution. On the theory that menstrual pain is sometimes caused by uterine spasms, progesterone is employed at times since it tends to relax the uterus. Greenhill, however, alleges that it is seldom successful and is comparatively costly. Methyltestosterone, a male hormone, is likewise rated as relatively expensive, and

may also in some cases affect secondary sex characteristics, though it does apparently have the advantage of not suppressing ovulation. And regarding less costly stilbestrol, which occasioned this whole discussion, it is said that pain is relieved in a large proportion of cases, but that relief is by no means permanent and that often either the menstrual cycle is upset or profuse menstruation results. Its chief disadvantage, even medically, is the sterility which it induces—and in proportion to the frequency with which treatment must be repeated, sterility becomes progressively less a temporary state of affairs and verges on permanency.

**Surgery** appears to be considered a procedure of last resort. Presacral neurectomy is rather commonly mentioned as sometimes successful and as recommended in selected cases after other means of effective relief have been excluded.<sup>4</sup> Dilatation and curettage is another possibility. Doyle favors paracervical denervation through culdotomy, and proposes this method as highly effective in affording permanent relief when surgery is indicated.<sup>5</sup>

It is not my purpose, nor is it within my competence, to judge the relative medical merits of these various procedures. That remains the prerogative of doctors, and

even they may have legitimate grounds for disagreement to some extent on that question. But in choosing a procedure which involves temporary sterility, indirectly intended though it be, a physician would have to satisfy himself that there is legitimate medical reason for rejecting other methods which do not affect fertility. It may well be that other treatments are recognized as useless in a given case, or at least considerably less effective than stilbestrol. Comparative expense is another item to be considered, as would be surgical risk or inconvenience to whatever extent they may be envisioned. In general, any serious disadvantage to the patient, which would result either from failure to treat or from the choice of an alternate therapy, will contribute towards establishing reason sufficient for permitting the mutilating effect of temporary sterility as produced by estrogen treatment.

### PAIN RELIEF AS A JUSTIFYING CAUSE

Let us suppose that in the considered judgment of a capable physician there is good medical reason (in the sense just explained) for preferring estrogens to other possible treatments. Does pain relief alone constitute reason sufficiently serious to justify temporary sterility as the indirect but inevitable result of inducing anovulatory menstruation via stilbestrol?

First of all it should be conceded—and physicians would doubtlessly be the last to disagree—that pain of itself is not to be dismissed lightly as something necessarily inconsiderable in the order of phy-

<sup>4</sup> For some comments on the moral aspects of presacral neurectomy, cf. Gerald Kelly, S.J., *Medico-Moral Problems*, V, 40. The same article also appeared in *Hospital Progress*, Feb. 1954, 66.

<sup>5</sup> Doyle, J. B., "Uterine Denervation By Culdotomy," *Irish J. Med. Sc.*, Feb. 1953, 73-76; "Use of the Pelviscope in Culdotomy," *J. A. M. A.*, 151: 605-608 (Feb. 21) 1953.

sical inconvenience or hardship. Pain relief can be the moral justification for the medical use of narcotics, sometimes even at the risk of possible addiction or at least to the point of temporary privation of one's rational faculties. Some theologians have also admitted the lawfulness of prefrontal lobotomy in certain cases, exclusively for the purpose of relieving otherwise intractable pain, and they do so with full realization of the other possible effects of that species of mutilation.<sup>6</sup> The immediate point I wish to make is that moralists do allow, for the sole purpose of pain relief, procedures which have very serious mutilating effects on the very highest of human faculties.

It is unquestionably true that in the examples just cited one is dealing with pain so severe that it is commonly termed intolerable; whereas the suffering proper to dysmenorrhea may not ordinarily deserve that classification in the objective order of things. That point can be conceded, it seems, without detriment to the conclusion eventually to be offered in the present discussion. The fact is that we are now dealing with a type of pain which, though varying in intensity from one case to another, can correctly be called severe in many of the cases which find their way to a doctor's office. Even though it may not be objectively comparable to the pain alleged in justification of lobotomy or the use of dangerous narcotics, it is still not to be dismissed as trivial.

<sup>6</sup> Cf. G. Kelly, S.J., "Lobotomy for Pain Relief," *Medico-Moral Problems*, III, 29-32.

Furthermore, any attempt to appraise pain in the objective order alone would be as unreal as it is inadequate. The truth of the matter is that pain is a highly subjective phenomenon whose severity must be measured also in terms of the victim's individual perception of it and reaction to it. The common medical term "threshold of pain" recognizes that subjective and variable element as something inescapably real and essential in measuring gradations of pain. What one person can bear with equanimity may prove excruciating for another.

Besides, how great is average human capacity for tranquil suffering? Persistent pain over a notable period of time—even pain considerably less than excruciating—can be a severe test of almost anyone's powers of endurance; and measured even in terms of minutes, time can assume gigantic proportions in the mind of one who is suffering without prospect of relief. Even the common head-ache or tooth-ache, or the pangs of indigestion, can make release from pain seem the *summum bonum* of the moment for most of us, and very soon find us turning to our favorite nostrums for relief. No realist can deny that placidity in the grip of continued pain reflects either crass stoicism or virtue of more than ordinary dimensions, and is not the sort of reaction usually encountered.

And even if asceticism should prevail over physical distress, it is the rare person even among the virtuous who can long endure without betraying marked loss of

efficiency, power to concentrate, ability to do his ordinary work, capacity to cope satisfactorily with the normal routine of living. All of these disabilities, not to mention the ordinary effects of prolonged pain on one's natural disposition, can constitute a serious handicap for the average individual—serious enough, it would seem, to merit careful consideration when sufficient cause is being sought to justify certain undesirable but concomitant effects of therapy.

In trying to estimate, therefore, the gravity of pain associated with any physical affliction, one should take into account not only the objective nature and measure of the pain involved, but also the subjective and no less real element of individual susceptibility to suffering, especially of a persistent kind. Furthermore, if a patient finds that pain constitutes a real handicap in the normal routine of daily living, that measure of inconvenience cannot properly be termed slight. All things considered, it does not seem unreasonable to propose that relief from pain in many such circumstances can qualify as serious in the category of justifying causes.

Is it serious enough to warrant temporary sterility as a concomitant indirect effect? I am inclined to say that it can be. Moralists admit that even permanent sterility may be permitted when it is the necessary indirect result of therapy required to prevent metastasis, and their teaching on that score has been confirmed by Pius XII.<sup>7</sup> It is

true that they are then thinking in terms of preserving, or at least markedly prolonging, life itself, and are not primarily concerned with relief from pain which, relative to life and death, is unquestionably of less importance. But it is also true that the evil they permit in that case (*permanent sterility*) is almost immeasurably greater than the temporary effect involved here, and that a proportionately less serious cause would therefore suffice to justify the latter. Relief from pain would seem to be a serious cause in that legitimate sense of the word, i.e. *sufficiently* serious in view of the *temporary* nature of the evil permitted.

It goes without saying, of course, that stilbestrol should not be employed if some other procedure, which does not affect fertility, can be used as effectively and as conveniently in a given instance. In addition, neither patient nor doctor could legitimately intend contraception as another effect of the medication. But with these precautions stipulated, there would seem to be good reason to allow a physician to prescribe stilbestrol for dysmenorrhea if and when in his considered opinion it is indicated as a reasonably necessary medical procedure.

<sup>7</sup> Allocation to the 26th Annual Convention of the Italian Society of Urologists, Oct. 1953. For the pertinent excerpt from this address, together with comments by Fr. Kelly, S.J., cf. *Linacre Quarterly*, Nov. 1953, 106-107. Cf. also G. Kelly, S.J., *Medico-Moral Problems*, I, 21-29.