

THE VALUE OF GYNAECOLOGICAL EXAMINATIONS IN SPINAL CORD INJURED WOMEN

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Summary. The necessity for regular gynaecological examinations in tetraparaplegic and paraplegic women is pointed out. Outcomes of such examinations during a two and a half year period in the Rehabilitation Centre of Tobelbad illustrate this, as is shown in the tables.

Key words: Spinal paralysed women; Gynaecological investigations and findings.

AFTER discharge from the Spinal Centre, many, if not most, spinal cord injured women are faced with problems concerning gynaecological examinations. One of the problems is the long distance between her home and the place for the gynaecological examination; and also the consulting room usually has architectural obstacles.

The incomplete or complete loss of sensibility increases the morbidity rate of inflammations in the genital regions of paralysed women. Gynaecological disorders may include simple colpitis with vaginal discharge, as well as severe, acute or chronic inflammation of the fallopian tubes and the ovaries.

Menstrual disorders such as amenorrhea, dysmenorrhea and metrorrhagia demand a clinical analysis, and if necessary, treatment similar to that for non-paralysed women.

Even without any symptom, the possibility of uterine cancer demands a yearly gynaecological check up. Statistics from Europe and America show that breast cancer is the most frequent malignant tumour in women. In Germany three to four women per hundred are affected with such a malignancy. Breast and genital carcinomas together account for up to 50 per cent of all malignant growths. In the genital region cervical cancer is the commonest (50 per cent), followed by carcinoma of the corpus uteri (20 per cent). Next are the heterogeneous group of ovarian tumours with an incidence of 15 per cent. The incidence of cancer of the vulva is about 5 per cent. Primary carcinoma of the fallopian tubes and vagina are very rare.

For these reasons we began to carry out regular gynaecological studies once a year in our centres. Before these, routine check-ups; paralysed women were only examined after requesting to be seen by a gynaecologist.

The gynaecologist involved is a consultant in the University Clinic for Obstetrics and Gynaecology in Graz, and co-operates closely with the spinal rehabilitation centre. We distinguish between two kinds of gynaecological studies; the first takes place shortly after admission to the centre and is intended to obtain a gynaecological status. The second examination is a follow up, which is combined with a routine urological check-up.

The parameters of gynaecological explorations are: Inspection and palpation of the breasts, colposcopy and cytology for early uterine cancer

detection, and a bimanual vaginal and rectal study. In extremely obese patients, women with severe spasticity or patients suffering from autonomic hyper-reflexia the exploration is carried out under a general anaesthetic.

Surgical treatment can take place in the rehabilitation centre for minor operations such as removal of cervical polyps followed by a cervical canal curettage. There is no doubt that the pre- and post-operative care of the patient is best carried out at the Centre, because well trained doctors and well educated nursing staff are available. Major operations such as vaginal hysterectomy or perineal repair for stress incontinence caused by vaginal prolapse are carried out in the University Clinic of Obstetrics and Gynaecology in Graz. After operation, patients when fit enough are transferred back to the spinal unit.

The results of our gynaecological examinations, covering a period of two and a half years (1 October 1979–31 March 1982) are now given.

TABLE I
Patients' age, and frequency of gynaecological examinations

Age		Frequency of gynaecological examinations before being seen at the centre	
15–30	21	Not previously examined	17
31–50	32	Regular check-up before seen at the centre	20
51–70	43	Occasional check-up	30
over 70	6	Failure to attend for examination after the onset of paralysis	5
		No comment	30

Table I shows the distribution of age. The onset of the paralysis from an accident or from functional disease varied from 1 month to 31 years. Eight-one patients had an accident, 21 patients were suffering from a medical disease. One hundred and two patients underwent 133 explorations. The frequency of examination per patient in the centre was 1–5 times. Only six of 20 patients were paralysed for more than 1 year.

TABLE II
The incidence of gynaecological abnormalities

Number of patients: 102		Number of examinations: 133	
No pathology: no treatment necessary		65	48.8%
Treatment necessary			
Group I: Patients without complaints but with pathological findings		33	24.8%
Group II: Patients with complaints and pathological findings		15	11.4%
Group III: For consultation only		20	15.0%

Table II gives the incidence of gynaecological abnormalities in 133 examinations. Four of the 65 patients had examinations under general anaesthesia.

Table III shows the diagnosis in group one to three of Table II.

Table IV sets out the types of operations performed.

TABLE III
The diagnosis in group 1, 2 and 3

Group I		Group II		Group III	
Inflammation of the genital tract	6	Metrorrhagia	2	Vaginal discharge	4
Suspected malignant adnexal tumour	1	Prolapse of vaginal wall and uterus causing stress incontinence	1	Menstrual disorders after accident or disease	13
Cervical polyp	6	Anatomical changes in the outer genital region	4	Post partum check-up	1
Mucous polyp of urethra or bladder	3	Suspect colposcopy	1	Desire for contraceptive advice	1
Myomatous uterus	1			Menopausal complaints	1
Suspected breast pathology on palpation	5				
Suspect colposcopy findings	10				
Carcinoma in situ	1				

TABLE IV
Operations performed

At centre		At clinic		Treatment as an outpatient	
Scotts conisation	1	Mastectomy	1	Cervical biopsy	11
Electrical conisation	1	Vaginal hysterectomy with perineal repair	1	Removal of cervical polyp by cervical curettage	4
Dilation and curettage	3	Abdominal hysterectomy	1		
Exploration under general anaesthesia	4	Prenatal supervision and delivery by caesarian section	1		
Marsupialisation	1				
Plastic grafts in outer genital region	3				

Conclusions

This paper shows the value and the striking results of regular gynaecological examinations in a spinal rehabilitation centre. There should be proper arrangements for paralysed women to have a gynaecological examination at least once a year, shown by the fact that 51.2 per cent of our explored patients required treatment, and 24.8 per cent had no clinical symptoms or discomfort because of their spinal disorder. In the group with no complaints, two patients had a carcinoma, cervical in one and breast in one. Complete cure was possible by a minor operation in the case of

the patient with cervical cancer because of the early detection. The value of gynaecological examinations in paraplegic women is obvious for two reasons: Although gynaecological disorders are not significantly more common in spinal paralysed women than in non-spinal paralysed, it is the loss of sensibility which increases the risk of disregarding gynaecological disorders. The paralysed women have no complaints therefore they do not consult a gynaecologist. Another problem is that paralysed women are unable to continue with their routine gynaecological check-ups that they had before the onset of their paralysis because of the lack of adequate facilities for examining paralysed women. Therefore, spinal rehabilitation centres should be well equipped for such complex gynaecological examinations.

RÉSUMÉ

On attache beaucoup d'importance à une régulière examination gynécologiques des tétraparaplégiques. Sous forme de tableaux on démontre les explications détaillées des explorations gynécologiques durant deux années et demi au Réhabilitations-Centre Tobelbad.

ZUSAMMENFASSUNG

Auf die Wichtigkeit einer regelmässigen gynäkologischen Untersuchung bei tetra- und paraplegische Frauen wird referiert. Ergebnisse und Aufschlüsselung der gynäkologischen Explorationen über zweieinhalb Jahren im RZ Tobelbad werden an Hand von Tabellen aufgezeigt.

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