**SELECTED ABSTRACTS**


The authors report upon 83 patients who underwent microsurgical procedures for the repair of an obstruction of the fallopian tube. Isthmouterine anastomoses in 46 patients resulted in 34 per cent success rate at 14 months, and the success rate of 33 isthmointerstitial anastomoses was 48 per cent. Of 108 obstructions analyzed, 85 were from endometriosis; 17 were from inflammation, and six were from different causes, including placental residues and muscle hypertrophy. The postinflammatory lesions showed better postsurgical results, a 48 per cent actual success rate. Pregnancy results were better when one tube was repaired than when the repair was bilateral. It is noted that there are two types of lesions, one of which is localized and more easily treated. The more generalized disorder did not respond well to local excision. The total success rate was 44 per cent.

**Paul D. Urnes**


A potential role for laparoscopy in the management of patients with suspected salpingo-oophoritis is proposed. It would be helpful for establishing the diagnosis of many patients who are admitted with the clinical diagnosis of salpingo-oophoritis. Long term evaluation of patients with salpingo-oophoritis and subsequent fertility could be enhanced by the use of laparoscopy. Microbiologic details of endosalpingitis could be specifically identified in affected patients using this method. Further prospective studies must be performed, however, before it can be determined how frequently laparoscopy should be used.

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The value of combined cytologic and colposcopic findings in predicting the final diagnosis of lesions of the uterine cervix is assessed. Involved in this study are 170 consecutive patients who were referred to the Dysplasia Clinic at Nassau Hospital in Mineola, New York, between July 1978 and October 1979. The referring cytologic diagnoses were: moderate dysplasia in 74 patients, mild dysplasia in 33, class 2 dysplasia or inflammatory atypia in 20, severe dysplasia or suspicion of carcinoma in situ in 18, carcinoma in situ in ten, invasive carcinoma in two, suspicion for adenocarcinoma in one patient and other abnormal cytologic results in 11 patients. Standard colposcopic procedures were carried out upon all patients, with examination of the uterine cervix following a thorough cleansing with 3 per cent acetic acid solution to enhance the visibility of vascular and epithelial changes. Punch biopsy and endocervical curettage were performed upon all the patients except for 13 who were excluded from the analysis. Colposcopic findings included inflammatory changes in 15 patients, mild dysplasia in 35, moderate dysplasia in 61, severe dysplasia in 22, carcinoma in situ in 17 and a recurrence of carcinoma in one patient. Final histologic diagnoses included chronic cervicitis in 39 patients, moderate squamous dysplasia in 38, carcinoma in situ in 31, mild squamous dysplasia in 29, severe squamous dysplasia in 18, adenocarcinoma of the endocervix in one patient and recurrence adenocarcinoma in one. Over-all, 7 per
cent of those referred for moderate dysplasia showed carcinoma in situ at histologic examination. While 74 patients were referred with an initial cytologic diagnosis of moderate dysplasia, only 38 of all 157 patients who underwent biopsy proved to have moderate dysplasia. When both cytologic and colposcopic results were combined, the accuracy rate for predicting the severity of a lesion was approximately 85 per cent. No false-negative reports were found at any level of severity of preclinical lesions when the more significant finding, cytologic or colposcopic, was tabulated. When the less severe diagnosis of the two findings was used, however, false-negative reports were present at every level of severity in precancerous lesions. A few false-positive reports were present, regardless of whether the more or the less severe of the combined findings was considered.

Judith S. de Nuno


THE RESULTS of this study demonstrated that, when cytopathologic findings predicted disease of the uterine cervix more severe than carcinoma in situ in a grossly normal uterine cervix, the prediction was confirmed by histotumerine cervix, the prediction was confirmed by histopathologic findings in 22 of 28 patients, 79 per cent. Cytopathologic findings predicted histologically proved microinvasive or occult invasive carcinoma in 27 of 31 patients, 87 per cent. From the results of this study, therefore, it is apparent that good cytopathologic findings are potentially useful when used in conjunction with colposcopy, directed biopsy and endocervical curettage to aid in deciding upon the treatment of patients with possible early carcinoma of the uterine cervix. A persistent cytopathologic diagnosis of a lesion more severe than carcinoma in situ that is not borne out by colposcopically directed biopsy findings requires cone biopsy of the uterine cervix so that therapeutic error can be avoided.

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FOR A FRENCH SYMPOSIUM, Doctor Allen recounted how he diagnosed and treated the syndrome bearing his name. He operated upon only 28 patients with the Allen-Masters syndrome in his career. The syndrome consists of postpartum dysmenorrhea, metrorrhagia, backache and dyspareunia. Results of physical examination reveal uterine retroversion and tenderness to movement of the uterine cervix. Laparotomy results reveal increased amounts of yellowish brown fluid; the utems lying in the hollow of the sacrum; uterosacral ligaments severed at their attachments to the uterine cervix, and retracted, unilateral and bilateral rents of the peritoneum of the broad ligaments and side walls of the pelvis, with retraction of the peritoneal surfaces exposing the course of both ureters and dilated pelvic veins. Surgical repair consists of reattachment of the uterosacral ligaments and reconstruction of the peritoneal surface. Results of dye injection studies have confirmed that the dilated varicosities of the pelvis are accompanied by dilation of the myometrial veins as well. According to the author, the Allen-Masters syndrome is poorly understood todly-largely because virtually no practicing gynecologist has an accurate conception of the syndrome. Thus, even when fully in view, the syndrome escapes detection.

David B. Redwine


IN THIS ARTICLE, observations of the uterine cervix using the acetic acid test and the naked eye are compared with those using acetic acid and the colposcope. The cervixes are evaluated independently by the two authors and, when appropriate, were then compared with the cytologic and histologic results. A total of 2,400 patients were examined. No selection of patients was done according to normal
or abnormal cytologic findings. As expected, there was little difference between evaluations of the cervix with the colposcope and those with the naked eye. Sixteen instances were rated as atypical with the naked eye and were thought to be a physiologic transformation zone with the colposcope. With the naked eye, five patients were classified as being suspect because of a very flat, white epithelium that required the colposcope for it to be clearly identifiable; an insignificant histologic appearance was found in all five of these patients. Of those patients diagnosed with the colposcope and the naked eye as having an atypical transformation zone, 54 per cent had findings of normal benign lesions at histologic examination. One hundred and thirty-seven patients had intraepithelial neoplasia of the uterine cervix, and six had preclinical invasive carcinoma; no invasive carcinoma was included in the study.

The results of this study seem to answer the question of whether or not careful observation with the naked eye, a good light and acetic acid is an accurate way of assessing the transformation zone of the uterine cervix. There seemed to be a slight increase in the diagnosis of atypical or suspected transformation epithelial changes with the naked eye that could be delineated more accurately by an experienced colposcopist.

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This study was undertaken to determine whether or not the extent of estrogen deficiency influences the occurrence of hot flashes. Hormonal levels were measured in women who experienced frequent hot flashes and an equal number who had never experienced the symptom. Estrodial, E2, estrogen, E1, sex hormone binding globulin, SHBG, and the percent and total non-SHBG bound E2 were measured. Postmenopausal women with severe hot flashes were found to have significantly lower mean body weight, per cent ideal weight and levels of E1 and E2. Body size has previously been found to be the most important factor influencing the degree of estrogen deficiency. Through its dual effects upon peripheral aromatization and circulating SHBG concentration, the significantly lower per cent ideal body weight in the symptomatic women was most likely the primary factor responsible for the differences in estrogen levels.

David W. Cromer


Danazol has been used effectively as a medical form of therapy for endometriosis. Thirty-two patients with pelvic endometriosis confirmed by laparoscopic findings were included in a double-blind study of the immediate short term and long term effectiveness of daily doses of danazol upon the disease itself. Surgical findings and symptomatic changes after treatment were studied utilizing the American Fertility Society point system for classification. The daily doses of danazol varied and were 100, 200, 400 or 600 mgm. Clinical improvement rates varied from 75 to 85 per cent, while the surgical improvement rate was 50 to 70 per cent. Ovarian endometriomas of even 1 cm. in size generally do not respond to danazol, and the over-all pregnancy rate was 45 per cent. Lower than maximum doses of danazol produce similarly beneficial effects upon the treatment. Freedom from side-effects was not seen with low doses. With a mean follow-up period of 19 months, the average symptomatic recurrence rate was 36 per cent and was also dependent upon the dose.

It is concluded that a regimen of 200 mgm./day for six months should be the lowest treatment dosage of danazol, while only occasionally will a patient, require the maximum dosage of 600 mgm./day. The best candidates for danazol therapy are infertile women with mild to moderate endometriosis. If the disease is extensive and pelvic organs are distorted, however, danazol may be a good preoperative or postoperative agent.
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A STUDY was designed to assess the effectiveness of and tolerance to orally administered acyclovir in the treatment of patients with initial and recurrent genital herpes. Seventeen patients with initial disease and 42 patients with recurrent disease were treated with 200 mgm. of acyclovir orally five times per day for five days, and 14 patients with initial disease and 43 patients with recurrent disease received matching placebo. This was a double blind, randomized study. In patients with initial genital herpes shedding virus, acyclovir significantly reduced the duration of viral shedding, itching and pain, the time to crusting and complete healing and the formation of new lesions, as compared with control patients. In patients with recurrent herpes, acyclovir significantly reduced the duration of viral shedding, time to complete healing and new lesion formation. The incidence of adverse events was not significantly different between those receiving acyclovir and those receiving placebo. It is concluded that acyclovir given orally is effective and well-tolerated in patients with initial and recurrent genital herpes.

**Morteza M Dini**


The CLASSIFICATION, cause and treatment of chronic dystrophies of the vulva are discussed in this article. Recently, members of the International Society for the Study of Vulvar Dystrophy suggested that instances of chronic vulvar dystrophy be classified into: hyperplastic dystrophy with or without atypia, lichen sclerosus and mixed dystrophy or lichen sclerosus with epithelial hyperplastic foci with or without cell atypia. The cause of vulvar dystrophy is still unclear; therefore, treatment must be dictated by the clinical signs and symptoms. Surgical intervention is recommended in instances of cell atypia, after the failure of repeated medical therapy, and in instances of anatomofunctional changes preventing normal sexual activity.

One history of a patient with mixed vulvar dystrophy is discussed. After the repeated failure of topical testosteronocortisone treatment, a simple vulvectomy and plastic correction were performed with good results.

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