Important Advances in Clinical Medicine

Epitomes of Progress—Obstetrics and Gynecology

The Scientific Board of the California Medical Association presents the following inventory of items of progress in Obstetrics and Gynecology. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole is generally given for those who may be unfamiliar with a particular item. The purpose is to assist the busy practitioner, student, research worker or scholar to stay abreast of these items of progress in Obstetrics and Gynecology which have recently achieved a substantial degree of authoritative acceptance, whether in his own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on Obstetrics and Gynecology of the California Medical Association and the summaries were prepared under its direction.

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The Hirsute Patient

ALTHOUGH HIRSUTISM in the majority of women has a genetic basis, any sudden change in the quantity or distribution of hair at times other than puberty, pregnancy or menopause is abnormal and should be carefully investigated. Hirsutism accompanied by signs of virilization or defeminization usually is of endocrinologic origin. Determination of urinary 17-ketosteroid (KS) excretion and serum testosterone should be performed in these patients. Only if elevated levels of 17-KS—greater than 25 mg in 24 hours—are found should an adrenal source be suspected. If 17-KS are elevated, urinary pregnaetriol should be measured to rule out adult onset of congenital adrenal hyperplasia. An overnight dexamethasone suppression test (1 mg taken orally at 11 PM followed by an 8 AM serum cortisol determination) can rule out Cushing's disease or an adrenal tumor if the cortisol is less than 5 μg per 100 ml. The most common endocrinological cause for hirsutism is polycystic sclerotic ovaries. These patients almost always have 17-KS less than 25 mg per 24 hours, elevated serum LH, normal serum FSH and only slightly or moderately elevated serum testosterone. Treatment may include clomiphene citrate, gonadotrophin suppression with oral steroid contraceptives and occasionally ovarian wedge resection. If the serum testosterone is markedly elevated and 17-KS are normal, an ovarian tumor should be suspected. If catheterization of the ovarian veins shows pronounced difference between the two testosterone levels, an androgen-producing unilateral ovarian tumor is probably present. If testosterone levels are similar, a severe form of PCO is probably the cause of the hirsutism.

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REFERENCES

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