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THE DOCTOR and OVULATION DETERMINATION

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THE CURRENT emphasis on "population explosion" has added new impetus to the willingness of Catholic couples to want to space their pregnancies. The modern urban housewife turns to her gynecologist, often without discussing the matter with her spiritual adviser. More often than not she is rebuffed by discouragement, laughter, and trite remarks. If her gynecologist happens to be non-Catholic, his attitude is likely to be one of impatience and unwillingness to instruct her in any method that does not involve contraceptive greases and gadgets. Even the Catholic doctor may instruct her with the impression that rhythm is not trustworthy. If she does not succumb to sin, she goes to the priest, who sends her back to the doctor.

The obsolete "rhythm calendars" were never truly reliable and for good reasons: first, they used a technique of *guessing* at a body function as opposed to *measuring* a body function. It can be compared to older methods of determining anemia. Doctors trained in former times were known to hold down the patient's lower eyelid, peer into the mucous membrane and diagnose the presence or absence of anemia. Fortunately, this method has been replaced by measuring the blood count. A second reason for the failure of rhythm calendars was the inability of a woman to collect a significant amount of data to average out her cycles. For most women, it did not seem important for them to know the length of their cycles until marriage approached. More often than not, pregnancy occurred soon after marriage and subsequent pregnancies came in such succession that they failed to have enough menses to find out what their "average" was. As a result of this series of circumstances, this group of women maintain that rhythm does not work.

There have been a number of methods devised to measure the body function of ovulation. These were recently reviewed by Speck[1]. Of the now known methods, there are two that are practicable and adaptable to home use. They are basal temperature determinations and detection of cervical glucose. The value of basal temperatures is well established. Its chief popularity with gynecologists is its valuable use with the infertile couple. It has been used as an index of ovulation since Van de Velde[2]

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[1]Speck, George. *Obst. & Gyn. Survey*, 14:798, 1959

[2]Van de Velde. *Monograph*. 1904

first described it in 1904. Techniques of measuring and interpreting basal body temperatures have been published many times. This method is in disrepute with many people, but only because of a lack of understanding on the part of the patient and the doctor. The commonest errors lie in using an inaccurate thermometer and the recording of temperatures that are not truly basal. The most efficient thermometers are graduated only to 100 degrees. These allow a more accurate reading and can be used orally. More often than not, the fertile woman who is anxious not to be pregnant is up and down several times a night to attend waking children. If such a mother cannot prevail upon her husband to attend these occasions, she should practice taking her temperature upon the first waking. Under most circumstances, the child will not truly suffer for a drink of water for three minutes while she measures her temperature. Body rest is more profound after the first few hours of sleep than it is at 6:00 a.m. after having been up several times since 2:00 a.m. Temperature graphs large enough to clearly show the thermal shift are also important in interpreting the readings.

The detection of glucose at the cervical os has been described by Birnberg et al.[3], modified by Doyle[4] and confirmed by Cohen[5]. Only one investigator, Siegler[6], has failed to confirm the findings of the others. There are explanations for Siegler's conforming results. The most important reason for his failure was faulty use of the test material. Tes-Tape. He allowed the Tes-Tape to remain in the vaginal canal for 5 minutes and observed it an additional 5 minutes prior to recording the finding. The manufacturers of this material caution against inaccuracy under these circumstances. They commend "dipping" the tape long enough to become thoroughly wet and observation of no longer than one minute. The other reason for his failure to confirm is the fact that he was testing infertile women.

We have been interested in still a different technique of eliciting the presence of cervical glucose. The techniques of other investigators utilized the random testing at approximately 24 hour intervals. We have been collecting 24 hour samples of cervical secretions and testing the 24 hour aggregate. This is done by having the patient wear the Tassette or menstrual cup described by Liswood[7]. These patients have also kept basal temperatures and we have done endometrial biopsies on the first day of menstruation. These data are being collected for publication elsewhere. Whether or not this more troublesome technique will prove to be even more accurate must await the publication of our data. At any rate, it is certain that the appearance of cervical glucose is related to ovulation in an important way.

[3]Birnberg, C. H., Kurzrok, R., & Laufer, A., *J.A.M.A.*, 166:1174, 1958
[4]Doyle, J. B., Ewers, F. J., & Sapit, D., *J.A.M.A.*, 172:1744, 1960
[5]Cohen, M., *Fertility & Sterility*, 10:340, 1959
[6]Siegler, A. M., *Am. J. Obst. & Gynec.*, 79:1169. 1960
[7]Liswood, R., *Obst. & Gynec.*, 13:539, 1959

When a woman turns to the gynecologist, it behooves him to instruct her carefully in the use of basal body temperatures and cervical glucose determinations. She should also make notes of symptoms such as abdominal pain, breast tenderness and mucorrhea. Each of these can serve as a recheck on the other. Again, we can use the analogy of anemia — most laboratories simultaneously perform red cell count, hemoglobin and hematocrit determinations, each as a check on the other.

We agree that to ascertain and record the suggested data becomes a lot of trouble. However, the woman who is anxious not to fall pregnant is often willing to go to such trouble. If she has asked for help, this is the best help that the Catholic doctor can offer her.

There is another important facet to this problem and it is more mysterious than the rest. We refer to the psychological aspects. The entire idea of techniques of determining the body function of ovulation is repulsive to some women. Intelligent women may have a mental block on recording and interpreting the data. Others find that their emotional strength in the middle of the night overpowers the intellect which is reminding them that this is their fertile time. It is a natural feminine phenomenon to be more interested in sexual activity at the time of ovulation. How else would God have arranged this! Surely, such women who subconsciously ignore or knowingly do not care, have a very strong maternal instinct and reproductive urge. Such an urge would most likely be subconscious. It has long been recognized that woman has a basic conflict between the urge to reproduce and pregnophobia. All females require courting: the hen runs from the rooster. It is only logical then, that some women who come for advice are intellectually capable of performing the necessary tests, but are overcome by their basic urges. On the other hand there are women who can determine their fertile period and are prepared and willing to abide by proper abstinence. In either case, the doctor has the obligation, when asked, to instruct properly.

There are other pitfalls. It has been estimated that only 60% of women who menstruate 12 times a year will have 12 ovulations. In other words, 40% of fertile women have varying numbers of anovulatory cycles. Since the temperature and glucose methods only measure ovulation, one readily sees that during anovulatory months, there will be no sign and no security. Many women have become discouraged and given up these methods because they failed to show ovulation the first month. They should be encouraged by the doctor to continue, and he should carefully explain anovulatory cycles to her. If a girl is anxious to remain unpregnant, she is better off to have 6 months of security by knowing her time of ovulation than she is to have no security at all.

The woman who is particularly prone to have trouble in interpretation is the very irregular menstruator. She is an irregular menstruator because she is an irregular

ovulator. The relationship between ovulation and the following menstrual period is consistent. The relationship between the ovulation and the previous menstrual period is consistent only when the cycles occur at regular intervals.

Nearly everyone believes that the stimulus of sexual activity may precipitate ovulation, particularly in the irregular menstruator. On the other hand, these girls will eventually ovulate spontaneously. One of our records to be published, is that of a para VI who feels desperate about another pregnancy. Her menses are irregular, often as far apart as 50 and 60 days. Recently she brought in her record that showed a flat temperature curve the first 50 days. On day 49 she showed the first positive glucose reaction, had abdominal pain, and on day 50 had a thermal shift in the temperature curve. Only until day 53 did she consider herself safe and her restraint was rewarded by menstruation on day 63. Such prolonged absence of sexual functions has its disadvantages, but so does an unwanted pregnancy. These couples must decide which price they are willing to pay. The amount of security a woman receives from measuring and knowing when she ovulates is very valuable to her. Nobody has ever been able to demonstrate that lack of sexual activity is harmful to physical or emotional health.

In summary, it is reasonable that women can measure the time of their ovulation and thereby space their pregnancies at a desired interval. It requires help from the physician and motivation from the patient. No one claims that these methods are completely accurate. No "method" is. Doctors are often not well enough informed to realize that it is reasonable practice and consistently find it difficult to "sell" the patient. The patient is often discouraged to begin with and needs all the help and encouragement the doctor can muster.

It is interesting that many otherwise well-informed Catholics have said that the Church will yield to the pressures and sanction artificial contraceptives. Theologians have repeatedly stressed that the rules governing procreation are those of the natural law. Since this is true the Church does not have the authority to change them regardless of pressure. The Church has been known to lose the British Empire in one fell swoop because She refused to sanction divorce. Neither will She change the stand on contraception.

Furthermore, everyone knows that contraceptive gadgets are not nearly 100% effective. Neither do we claim that temperature and glucose methods are 100% effective. It would seem clear that gadgets are more convenient. Likewise, there are many times in every person's schedule when it is inconvenient to hear Mass. Because of the convenience factor, no one can accurately compare the different methods. If the temperature and glucose methods are used *properly*, it is reasonable to believe that their accuracy would equal that of artificial contraceptives. It behooves the doctor to be professionally equipped to instruct in this matter.