PREMARITAL MEDICAL EXAMINATION

Nadina R. Kavinoky, M.D., Los Angeles

The premarital medical examination can not only prevent the transmission of venereal disease, as the physician complies with the state laws, but with the addition of a few simple procedures and explanations by the physician at this time, the examination can also prevent many marital maladjustments. The physician can prevent misunderstandings from becoming deep-seated problems. He can give the couple such information about their own sexual organs that they can consummate their marriage without undue trauma. The physician can recognize and treat potential medical threats to marriage. Fortunately, many parents, religious leaders, and educators are turning to the physician for medical help in preventing annulments and divorces. The premarital examination plays a large part in this education.

STATE LAWS

The premarital laws in 34 states, and the marriage courses given by church and college, bring the bride and groom to a physician. The premarital laws require a health certificate before the couple is granted a license to marry; however, the laws vary from state to state. Some only require serologic testing of the male partner; other states require serologic tests and medical examination of both partners. The medical examination is designed to detect syphilitic lesions that have not as yet shown a positive reaction in the blood.

EXAMINATION REVEALS "TROUBLE SPOTS"

A premarital examination as comprehensive as that advised by the American Medical Association for periodic check-ups can relieve anxieties and help a couple consider the health aspect of their plans and important decisions. A medical, personal, and family history may reveal traumatic experiences. A sex inventory questionnaire may reveal ignorance of simple facts or interest in psychosexual pathology. The couple's ability to ask or answer questions, their need to confess, or their reticence to discuss past indiscretions are significant. The systemic examination may reveal diabetes, obesity, endocrine imbalance, malnutrition, or an unstable nervous system. These may affect libido, energy for sexual activity, or may be the cause of nervous exhaustion, instability, and tensions. Hyperthyroidism, for instance, affects temperament and reaction time. Respiratory or cardiorenal disease may complicate pregnancy. The pelvic examination may reveal immature sex organs or pelvic abnormality that may limit sexual desire and capacity, complicate the first coitus, and lead the couple to conclude that they are sexually incompatible. Even moderate pain or bleeding in the emotionally immature bride may be so traumatic that dyspareunia may be followed by vaginismus and eventually by an annulment.

Psychological Threats.—Psychological threats lie in inaccurate concepts of sex based on superstitions, hearsay, and gossip, on sordid newspaper accounts of divorce and sex crime, unrealistic expectations of sex performance based on romantic literature and films, and on statements made in some of the older books on marriage. Such inaccurate concepts are: (1) that the hymen is a completely intact membrane that must be painfully broken and bleed at the first coitus to prove virginity, (2) that sexual compatibility is proved by a simultaneous orgasm, and (3) that the husband is responsible for his wife's orgasm regardless of her sexual capacity. As a result of these misconceptions brides are disappointed and grooms frustrated; they feel sexually inadequate if the bride fails to have one or more orgasms even before the bruises in the hymen are healed. These concepts put such emphasis on the orgasm that other joys and satisfactions are overlooked.

Affective Threats.—Affective threats lie in emotional immaturity, which causes unhealthy sexual and personal adjustment. This may cause frigidity, premature ejaculation, and impotence, which may be transitory incidents or may become deep-rooted maladjustments. Guilt, remorse, or fear—that a previous venereal infection will recur and be transmitted to the loved one, fear of pain, fear of unwanted pregnancies, fear of sexual inadequacy due to masturbation or to previous unsatisfactory performance with a prostitute—are the cause of much tension. Fear of sexual incompatibility due to size of their respective organs also occurs. A girl may have heard of brides who were too small, or the bride herself may have been told by her physician that she is small. She becomes conscious of the size of the erect male organ without any consciousness of how adequately her own sex organs are prepared to receive the erect penis.

One finds fear of the physician, of instrumentation, of unknown procedure, and fear that the examination will reveal past indiscretions or evidence of masturbation. A deep-seated fear of the bride and of her mother is that the examination, or fitting of a diaphragm, will break the "intact hymen" and remove evidence of virginity. Embarrassment at having the vulva exposed, looked at, or touched is a normal reaction, more deeply instilled in some racial groups than others. The use of a model of the pelvic organs helps the bride visualize her own organs and can make the examination more objective. This will put a woman at ease.

As a result of many interrelated factors, brides and grooms vary in their readiness for marriage. It is not their chronological age, but the kind of preparation at home and school, that helps them make mature adjustments.

THE BRIDE AND GROOM

Brides can be divided into two major groups; between 50 and 65% are virgins; the others have had sexual experience in a previous marriage, premarital experience with their fiancés, or promiscuous sexual contacts. Some virgins have become familiar with the feeling of an or-
gasm through erotic dreams, masturbation, and petting without complete sexual contact. Others only begin to develop sensory perception through petting and engagement familiarities. Such experiences sensitize the genital nerve endings in the clitoris. Some brides need several months of manual stimulation of the clitoris for a spontaneous orgasm to develop. Some virgins are familiar with the structure of the hymen and the presence of a vaginal canal through the use of inserts for menstrual protection; others have learned the scientific nomenclature in their biology classes but cannot visualize their own sex organs. Many know nothing about the “facts of life” or how to cooperate to achieve their first sexual union.

Grooms also vary in their background, concepts, sexual experience, and understanding. Sexual experience may not help the groom understand how to consummate sexual union with a virgin or how to obtain and give sexual and emotional satisfaction. Grooms vary in their ability to maintain an erection and control their orgasm. This may be due to anxieties, to long periods of continence, or to long periods of release through masturbation or petting. Most grooms are more sexually mature, familiar with their sex organs and function, and have a more physical concept of the sexual relationship than brides have. Some appreciate the value of tenderness, patience, and affectionate, sexually stimulating caresses of the erogenous zones as means of developing a spontaneous response. Others are conscientious, literal, even mechanical in their sexual approach.

PELVIC EXAMINATION

The first step in the pelvic examination of a virgin is inspection of the vulva. The physician should record the appearance of the hymen and the size of the opening before he begins the bimanual examination. After palpation, he should record the texture of the hymen, whether thin and elastic, thick and fibrous, or whether it bleeds easily. The first procedure that helps the bride understand and cooperate is teaching her how to relax and contract the vaginal sphincter and pubococcygeus muscles.

Even the fearful virgin with a hypertrophied sphincter muscle soon learns how to cooperate and develop a more spontaneous rhythm. This exercise prevents “honeymoon cystitis” in the bride who has a mild degree of stress incontinence. The second procedure consists in helping her insert a well-lubricated Pyrex centrifuge tube. This helps the virgin realize that there is a normal opening in the hymen that leads into a deep vaginal canal.

After the patency of the vaginal canal is determined, the tip of the tube is placed within the introitus and tilted to follow the natural axis of her vaginal canal. She is then asked to bear down as she inserts the tube. The rate at which she introduces the tube and her facial expression reveal her anxiety. The return of color to her face and her relief, as she discovers no bleeding and no pain, convinces the physician of the therapeutic value of this simple procedure. The bride learns more about her “mysterious” sex organs in these few minutes than she could have learned in hours of talking and studying. The bimanual examination, using a vaginal speculum, and fitting a diaphragm can usually be done at this time. If the girl is tense and fearful these can be postponed until the second visit.

THERAPY

Therapy begins with the interview, history, and examination. In fact, it begins when the couple realize that their physician is interested in helping them make their dreams of “living happily ever after” come true. Explanations, assurance, and peace of mind have psychotherapeutic value. This is enhanced by rapport with the physician and his staff, their kindly, patient, and sympathetic interest and understanding of the couple's needs and even their mistakes. The physician who is brusque, forbidding, cynical, or who sits in judgment cannot put a couple at ease or make them receptive; he only strengthens their defense. These are intangible but influential aspects of the physician-patient relationship.

Some medical problems should be treated before the wedding, others postponed. Malformations of the hymen and vaginal canal and hypertrophy of the vaginal sphincters can obstruct the consummation of the marriage by making the first coitus a painful and psychologically traumatic experience. A small opening, less than 1 cm., can be stretched, first in the office, then at home. This should be done only after consultation with the bride and groom, referring to the condition as one found in the “super-virgin.” The word “small” has too many inaccurate implications. Stretching is accomplished by one or two 15-minute sessions, in which the bride herself inserts several graduated vaginal or rectal dilators. These should be well lubricated with an anesthetic ointment. When she learns to relax the vaginal sphincter and painlessly introduce a dilator that is ¾ in. in diameter, she continues the stretching at home, following Dickinson’s suggestions. Long, warm douches soften the rigid hymen and reduce the hypersensitivity of the membrane.

Hymenectomy or hymenotomy is surgically expedient but psychologically traumatic; vaginismus is not relieved but aggravated. Leaving the malformed hymen to nature, even with an anesthetic cream, is a good way to prepare the couple for an annulment. Septums in the vaginal tract must be treated surgically. Immature or atrophic vaginal canals can be treated with estrogens and warm douches. The juvenile or senile vaginal tract shows the same characteristics. The vagina is short and inelastic, the mucosa thin, bruises easily, and has only poorly developed rugae. It is gratifying to see the development of the immature canal and the retardation of the atrophic process in the older bride when the pattern of frequent gentle sex contacts is established.

Grooms may be sexually immature or inadequate in function, not necessarily in size, but need treatment for their endocrine, nutritional, and metabolic problems as well as assurance, understanding, and encouragement to relieve their anxieties. Temporary impotence often occurs from the groom’s inability to inflict pain on his bride. This reaction is normal in an intelligent, sensitive man. Helping the bride understand and cooperate can prevent the groom’s anxiety about this problem. Other anxieties are created by fear of pregnancy, coitus interruptus, or condoms.


Pregnancy must be discussed. Some couples are ready; others must be encouraged to start their family to prevent sterility. Brides who are already pregnant need the physician’s help to accept their unplanned child without transferring guilt to the innocent infant.

**CONTRACEPTIVES**

Many couples need and request contraceptive advice. The vaginal diaphragm and jelly is the most effective contraceptive for the virginal bride. She can be fitted and instructed in its accurate use several weeks before the wedding. Most brides learn to place it accurately and remove it in two 15-minute practice sessions with the nurse. Prior to the third visit, the bride is instructed to place the diaphragm the evening before the appointment and leave it in place. The physician checks her technique, the fit and comfort of the diaphragm, and inspects the lateral walls of the vaginal canal for any signs of pressure or irritation. After the bride returns from her honeymoon she often needs a larger size, as the rugae and vaginal musculature have relaxed. The condom and jelly is less efficient in the virgin, as it slips or breaks from the friction of a spastic vaginal sphincter. The rhythm, safe period method reinforced by a temperature chart is best adapted for the couple who feel guilty using a mechanical contraceptive. Guilt could create new tensions, block their psychological adjustment, and thus prevent the development of emotional values in the marriage.

**NERVOUS EXHAUSTION**

Nervous exhaustion in the acute form called “premarital jitters,” should be treated by supportive treatment—additional sleep and food. A bride on the verge of tears is hardly able to create happy sexual contacts. Nervous exhaustion also responds to the satisfaction of normal emotional needs for love, affection, and security; for understanding, encouragement, attention, recognition, and status. Family life is enriched by sharing work and responsibilities, success and failure. Such cooperation and comradeship is reflected in the couple’s interpersonal and sexual relationships. These constitute the psychic background of their psychosexual pattern and release the dynamic and creative forces that enrich living as well as create new life.

**PSYCHOSEXUAL PATTERN**

Psychic satisfactions in the couple’s intimate relationship are many and varied. Pleasure, adventure, and excitement in the sexually stimulating preliminaries result from the tender caresses of any and all erogenous zones and from spontaneous changes of position during sexual intercourse. Pleasure in the sexual contact and activity, with the added satisfaction of the orgasm, is biologically essential in the male. The orgasm has psychological value in the female, even though pregnancy does not depend on her orgasm. The physician must sanction caresses of all parts of the body as well as give greater appreciation of the relaxation, comfort, nearness, and unity that follows the orgasm. To be wanted, to give as well as receive pleasure, kindness, and consideration, although intangible, are important psychic aspects of the sexual relationship. These help the couple accept each other’s individual differences in sexual need and capacity. These psychic aspects satisfy the bride’s greater need for affection, especially during the time that she is developing her orgasm response.

The psychosexual pattern is a complex, delicately balanced physiological and psychological reaction stimulated by the physiological need for sexual activity. Libido can also be aroused, accentuated, repressed, or inhibited by any and all other sensory perceptions.

Healthy personal relationships based on mutual respect, for one’s own sex and the opposite sex, and appreciation of the equal social value of the feminine and masculine contribution to the family all affect the attitude toward sex. The economic background also affects the ability to fulfill the masculine or feminine destiny as parents. Cultural backgrounds determine the pattern of the couple’s relationship.

**COMMENT**

The amount of counseling skill and time that the physician must give to help the couple understand and harmonize their differences and create their own unique psychosexual pattern depends on the individual needs of each couple. Their questions and requests help the physician evaluate their specific needs, understanding, interests, attitudes, fears, aversions, and sense of values.

Brides and grooms can be classified into several categories, according to their readiness for marriage. Group 1 are enlightened, healthy, and both sexually and emotionally mature young persons. They have been so well prepared for marriage that the physician only needs to examine them, explain, and assure them. Their specific needs are easily met. Group 2 primarily have physical problems that the physician can treat. Group 3 are emotionally immature or unstable young men and women, even though they may be mature in years. They may have a good education or may have had much sexual experience. These need more time and wise counsel to help them establish new attitudes. Group 4 are seriously neurotic or psychotic men and women. Some are addicted to alcohol or drugs; others have a record of antisocial or criminal behavior or a history of psychotic episodes. These need highly skilled care before they will be able to make the necessary marital adjustments and carry the responsibilities of parenthood. The physician must be on guard to recognize these conditions. The parents of psychotic or mentally deficient sons and daughters go to great lengths to arrange a marriage for them.

The following list of books and pamphlets help the couple learn:

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<tr>
<th>Title</th>
<th>Authors</th>
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<tbody>
<tr>
<td>When You Marry—Evelyn Duvall</td>
<td>Reuben Hill</td>
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<tr>
<td>Building a Successful Marriage—J. T. Landis</td>
<td>and M. G. Landis</td>
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<tr>
<td>Before You Marry—Sylvanus Duvall</td>
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<td>Facts of Life and Love—Evelyn Duvall</td>
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<tr>
<td>Personal Adjustment, Marriage, and Family</td>
<td>J. T. Landis and M. G. Landis</td>
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<td>Living—Evelyn Duvall</td>
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<td>Family Living—Evelyn Duvall</td>
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<td>Marriage and Family Relationship—Robert</td>
<td>Foster</td>
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<td>Modern Pattern for Marriage—Walter Stokes</td>
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<td>Marriage—Robert Harper</td>
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<td>Marriage Manual—Abraham Stone</td>
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<td>Marriage and Sexual Harmony—Oliver</td>
<td>Butterfield</td>
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<tr>
<td>A Handbook for Husbands and Wives—Theodore</td>
<td>Arden</td>
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Time, love, and patience are necessary to absorb these new concepts of right and wrong, of normal or ab-
normal, of values and objectives into their own feeling. Knowledge can be sterile without motivation of the emotions. The physician can recognize, evaluate, and treat problems. He can make the examination a constructive experience. He can give the couple new concepts of sex, new appreciation of the emotional values. He can help them develop healthier attitudes and personal relationships that create the spiritual values in everyday life.

2400 Beverly Blvd. (57).

TREATMENT OF JUVENILE MELANOMAS AND MALIGNANT MELANOMAS IN CHILDREN

Henry E. McWhorter, M.D., Frederick A. Figi, M.D.
and
Lewis B. Woolner, M.D., Rochester, Minn.

The concept originally proposed by Pack 1 that malignant melanomas of childhood tend to follow a benign course has been cited repeatedly in medical writing. Theories of Pack 2 and of Spitz 3 that some as yet unknown hormonal influences inhibit malignant melanomas during childhood and stimulate them after puberty to become highly malignant also find frequent mention. Opposing this view have been reports of a small number of childhood lesions that appeared to be malignant melanomas histologically and clinically. 4 Reflecting this background, the treatment of pigmented tumors in childhood is subject to contradictions and confusion. Conservative treatment of childhood malignant melanomas advised by Pack 5 is at variance with suggestions for radical excision and dissection of lymph nodes. 6 Such formidable ideas as the prophylactic removal of all childhood pigmented nevi have been offered. 7 Largely resolving these problems, Allen and Spitz 8 recently presented a new and logical concept of these pigmented tumors in childhood. Studies at the Mayo Clinic have provided additional confirmatory evidence. 9 We trust that a review of our studies and a presentation of the principles of treatment of these lesions will be of value not only to surgeons concerned with operative decisions but to all physicians, as these lesions first must be understood, properly diagnosed, and classified before treatment is undertaken.

REVIEW OF LITERATURE

As already mentioned, Pack, 10 in 1939, reported that malignant melanomas in childhood tended to be of low-grade malignancy and seldom metastasized. Series of cases presented as malignant melanomas in this age group by Sylven 7 and by Webster and associates 8 gave further weight to this concept, as did additional cases reported by Pack and co-workers. 11 The histological appearance of these tumors was said to be indistinguishable from adult malignant melanomas, yet they all followed a benign course. In 1948, Pack 10 suggested that these lesions be termed “prepubertal melanomas” and be considered as clinically separate from adult malignant melanomas because of their benign behavior. In 1949, Sylven 7 reported 11 cases with a 100% survival rate and also made a proposal for a separate clinical classification.

Shortly after Pack’s suggestion, Spitz 8 gave evidence that in at least half of these cases there might be some histological, as well as clinical, difference between what she called “juvenile melanomas” and adult malignant melanomas. She included in her series of juvenile melanomas one clinically malignant tumor, however. In the aforementioned recent comprehensive study of malignant melanoma, Allen and Spitz concluded that the lesions with a benign course, long referred to as childhood malignant melanomas and described histologically by Spitz as juvenile melanomas, often could be differentiated as specific histological entities distinct from adult malignant melanomas. Lesions of this specific histological appearance were also seen in adults and followed a benign course. These authors presented five true malignant melanomas in children, all of which had a highly anaplastic histological picture and three of which caused death.

At this point it was becoming increasingly clear that there was a lesion occurring characteristically in children that had a microscopic picture easily mistaken for that of malignant melanoma but that followed a benign course. This lesion, referred to as the juvenile melanoma, was gradually taking its place as a subheading under the classification of benign pigmented nevi. Yet the reported cases of true malignant melanoma with metastasis and death 11 provided documented evidence that malignant...