The Sympto-thermal Method

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This work in Melbourne, Australia, began in 1953 in response to the request for help in postponing pregnancy by couples who were seeking to achieve this by a natural technique. At that time the only natural method known was that of calendar Rhythm (Ogino-Knaus) which was soon demonstrated to lack the necessary reliability in some circumstances, or to impose inordinately long periods of abstinence. A review of the scientific literature resulted in attention being focussed upon the fact that the occurrence of fertility in a woman is accompanied by the secretion of a particular kind of mucus by the cervix of the uterus [1, 2]. From the 1930s this mucus was the subject of intensive laboratory study in both animals and humans. Remarkably little attention had been paid to the fact that the occurrence of this mucus secretion is often observed, as a vaginal discharge, by healthy, fertile women.

A number of people in different parts of the world were turning to the temperature method, based on the fact that the raised level of circulating progesterone following ovulation tends to elevate the body temperature. For more than 10 years therefore I taught a sympto-thermal method, similar to but not identical with, other sympto-thermal techniques which were being developed concurrently in other countries. Reference was included to other natural indicators of different phases of the cycle, including lower abdominal pain, bleeding, and breast tenderness. Our sympto-thermal method was different in that the primary emphasis was upon vulval observations of the cervical mucus pattern.

In 1962 James B. Brown took up an appointment in the Melbourne University Department of Obstetrics and Gynecology. He had previously been working with the Medical Research Council of the United Kingdom in Edinburgh where he had been assigned to the development of techniques for measuring oestrogen levels in blood and urine; Brown’s method had already become known internationally. He willingly consented to submit my conclusions to laboratory evaluation, by measurement of the total oestrogens and progesterone (as pregnanediol) in 24-h specimens of urine. These were collected at first weekly and then daily throughout a menstrual cycle or a succession of cycles, sometimes for many months, in women who were breast-feeding or approaching menopause. It is impossible to exaggerate the debt of gratitude owed to the hundreds of women who have participated as volunteers in this collaborative clinical and laboratory research and continue to do so. Included in the study were young girls approaching menarche, women beyond menopause and women in all the different physiological stages of reproductive life and in the presence of many pathological disorders as well. Through
this, the teaching of mucus pattern observation, which was called the ovulation method, was refined and simplified.

In the 1970s I became aware of the studies of Erik Odeblad, Professor of Medical Biophysics at the University of Umeå, Sweden. From the late 1950s he had been studying the physical properties of mucus taken from the cervix, using sophisticated modern techniques which had enabled him to identify different types of mucus in the cervix, varying in proportion in the different phases of the cycle. His observations offered independent confirmation of the conclusions reached from my clinical studies and laboratory analyses [3].

The various natural indicators of fertility and infertility were assessed with the following results.

1. Abdominal Pain

About 50% of women notice lower abdominal pain close to the time of ovulation. This is often described as an uncomfortable sensation in the lower abdomen extending towards the groin on either side. It may be brief, stabbing and confined to one side but even then cannot be reliably taken to mark the time of follicular rupture. In most cases the pain lasts for a day or so and is then probably an expression of the effect of the high level of oestrogens in the blood upon the uterine or tubal musculature. Hormonal monitoring has demonstrated a variable time relationship to ovulation, and most commonly the pain occurs in the few days before ovulation, less commonly shortly afterwards. Some women also notice that in the days just before ovulation, some degree of tenderness exists within the pelvis so that a momentary, deeply situated pain may be experienced immediately on sitting down on a firm seat; this tenderness may be an indication of distension of the follicle ahead of its rupture.

2. Intermenstrual Bleeding

It is common for a small amount of bleeding from the uterus to occur at about the time of ovulation and sometimes this may be more profuse, even sufficient to resemble the woman's menstrual flow. These studies have indicated that the bleeding is most often of a "break-through" character, occurring close to the time when there is a peak level of circulating oestrogen.

3. Sexual Inclination

It is only recently, particularly through knowledge of her cervical mucus pattern, that a woman has had any degree of certainty regarding the time of ovulation in her cycle. It was probably the existence of a sexual season in animals that gave rise to the idea that women experience sexual inclination maximally, or perhaps only, during times of fertility. However, this would mean that during the suppression of ovulation during breast-feeding for example, which may continue for 1–2 years, libido would be diminished or absent, which is not the case. Many