

Technical Data

... on an
Approved Method
of Contraception

Series One ... from the Laboratories
of DUREX PRODUCTS, Incorporated

Fitting Rings

Diaphragm Pessaries

Mayer Pessary Director

Distributed to members of the medical
profession or at their direction

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Durex Products, Inc.
New York, N. Y.

AN effective and harmless means of preventing conception is a matter of vital importance to every physician at one time or another during his practice.

In general, a physician who is treating a patient for almost any disease recognizes the frequent necessity of relieving that patient of the additional strain which pregnancy would involve. Viewed from this standpoint, *contraception is a purely medical matter.*

There are two essential steps in the proper application of the contraceptive method herein discussed.

1. The use of a carefully fitted diaphragm which prevents the immediate entrance of the spermatozoa into the cervical canal.
2. The use of an effective jelly to immobilize or kill the sperm since it is difficult, if not impossible, to secure a fitting so accurate that the possibility of motile sperm passing around the outside rim is entirely precluded.

This method is efficient and does not induce sterility. The physician realizes the absurdity of claiming any one method to be 100 per cent effective. He does not expect it in other branches of medicine and this field is not an exception.

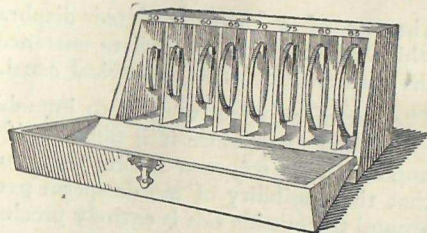
However, this is the most scientifically established method now used by gynecological and contraceptive clinics and by leading private practicing physicians.

In general, clinics extend a cordial invitation to the physician who is just becoming interested in the subject of contraception to visit them and observe their procedure.

MEASURING OR FITTING RINGS

These rings are the regular coiled springs of one type of Durex Diaphragms covered with a heavy red rubber (suitable for frequent sterilizing) and are made to correspond exactly with the size of the diaphragms.

The physician realizes of course that all patients cannot be fitted with the same size diaphragm. These rings are intended to serve as a guide in determining the proper size diaphragm with which to make the subsequent fitting. In view of the variation in the structure of the vagina no measuring device in itself can replace the skill of the experienced physician.



(Actual size, $10\frac{1}{2} \times 4\frac{3}{4} \times 4\frac{3}{4}$ inches)

DUREX MEASURING RINGS

The use of the rings has

1. Encouraged many more physicians to enter the field themselves instead of referring their patients elsewhere.
2. Served to supplement those sizes kept on hand wherever the complete assortment is not stocked.
3. Obviated the necessity of soiling several diaphragms in making the fitting rather than a few.

VAGINAL DIAPHRAGMS of DUREX

To supply the need of American physicians for a satisfactory coiled spring diaphragm, Durex Laboratories first experimented with and produced a coiled spring type. For the first time in the history of the coiled spring pessary, it was found possible to produce one without the use of any rubber solvent, thus avoiding the injurious effects that these solvents invariably have on the finished product.

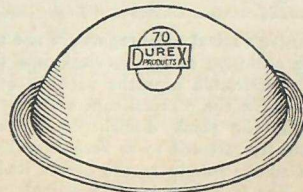
Later, in response to numerous requests from physicians and clinics, the flat spring type was developed for the first time in America in Durex Laboratories. (These have been distributed by us since September, 1928.)

Durex diaphragms are made, in so far as is possible, in compliance with the specifications outlined for the perfect pessary. A program of research and experimental work is provided for by the Durex budget. This program is always in progress in our Laboratories and enables us to carry on our search for means of improving our present products and developing new ones.

TYPES of VAGINAL DIAPHRAGMS

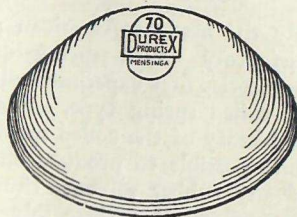
The three types of occlusive vaginal diaphragms are:

1. A coiled circular steel spring of finest piano wire with an arched rubber dome.



(Approx. $\frac{1}{2}$ actual size)
THE "DUREX"

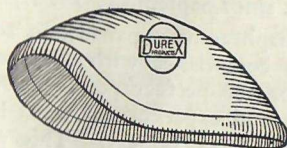
2. A circular steel watch spring with an arched rubber dome.



(Approx. $\frac{1}{2}$ actual size)

THE "MENSINGA"

3. The Matrisalus, a combination of the two, shaped like a humped ellipse or a Smith pessary reversed, with a rubber dome.



(Approx. $\frac{1}{2}$ actual size)

THE MATRISALUS

THE MAYER PESSARY DIRECTOR

FOR THE PHYSICIAN AND HIS PATIENT

The busy physician can save both time and effort by employing the pessary director, which facilitates the insertion and removal of all types of spring rim and hard rubber pessaries. *If the vaginal vault* is too long for the short

The occlusive vaginal diaphragms are not to be identified with the occlusive rubber cervical caps (such as the mizpah, with removable cap; the varieties of commonly called French caps; the cervical caps known as the Stopes or Prorace; or the thick disc-shaped Stewart, another variety commonly referred to as French or Dumas). The cervical caps adhere snugly to the cervix itself, generally by suction. The technique is more difficult to teach and the caps can only be readily used when the cervix is conical, low, pointing forward or unturned.

fingered patient to know when the pessary is properly placed, the length and curve of the director offers a simple and effective remedy.

The cervix which is located high in the vagina also presents the difficulty of the patient's not knowing when the pessary is properly placed. The correct introduction of the curved director and its insertion as far as it can go removes this doubt.

The length of the director makes it possible for the obese patient, who cannot otherwise reach into the vaginal vault, to insert and remove the pessary.

The curve of the pessary director makes it impossible for the patient to lodge the pessary against the anterior fornix of the cervix.

The more intelligent type of patient who lives at a distance from the physician's office and is unable to make the necessary return visits to him for removing, cleansing and reinserting the hard rubber pessary, can quite readily insert and remove the Smith or Hodge with the aid of the director. Naturally, this does not apply to those cases where the removal would displace or dislodge the reposit uterus.



THE MAYER PESSARY DIRECTOR

The patient who has no difficulty in inserting the pessary correctly occasionally experiences some difficulty in removing it. (This is, more often than not, caused by the fear in her mind that the pessary can get beyond her reach.) The hook on the end of the director makes the removal of the pessary simple and quick.

The director is not harmful in the hands of the patient since it has no sharp edges.

THE USE OF THE VAGINAL DIAPHRAGM

Too much stress cannot be placed on the fact that the use of a vaginal diaphragm should be under the supervision of the physician in order to insure intelligent usage and to maintain ethical and effective standards. Each case should be considered as thoroughly as possible; patients' habits inquired into fully; and instructions given carefully to suit each type. These points should always be kept in mind and diaphragms dispensed or prescribed *only* after careful examination and fittings.

FITTING PROCEDURE

To insure proper fitting a careful gynecological examination should be made. The approximate size of the vaginal vault and its general condition may be ascertained by digital examination and the use of the speculum.

Even though the physician is not a gynecologist nor an obstetrician — such an examination should not be omitted, for as a result of the findings of this examination the physician must decide what method of contraception is most likely to prove effective in a given case, as well as decide whether there are conditions present which demand treatment by himself or a specialist before contraceptive advice can be given.

In general, (physiologically) the diaphragm pessary can be used in vaginal tracts free from cystocele, prolapse or extreme relaxation of the vaginal walls.

Following examination and the decision of the physician to fit a diaphragm pessary — the ring or pessary is selected that most nearly

approaches the digital measurement. The ring or pessary is then lubricated with a lubricating or contraceptive jelly* (never with vaseline or like substances which attack rubber).

There are four outstanding methods of actually inserting the ring or pessary, from which to choose.

(The following methods have been based on the premise that the correctly fitted pessary should lie at an angle to the cervix and extend from the posterior fornix to a position just behind the symphysis pubis. Since this necessitates adapting the pessary more to the *length* of the vaginal vault than to its width, the sizes fitted are larger.

There is, however, another group of clinical physicians who believe in fitting smaller pessaries snugly *across* the vaginal vault over the cervix and extending from the posterior fornix to the anterior fornix.)

1. Compress the rim of the ring or pessary (either the concave or convex side of the pessary dome uppermost**) between the thumb and fingers quite firmly (so that the lubricated instrument will not slip) until the ring or pessary becomes elliptical enough to introduce into the vaginal orifice. When it has been introduced as far past the orifice as this method of holding permits, the thumb and fingers can be released and the ring or pessary will not slip

* NOTE: Methods of using contraceptive jellies with pessaries are discussed on page 18.

Lubricating jelly should always be used on these instruments in the physician's office.

**NOTE: This is a matter of preference or personal experience and the physician should be somewhat influenced by the greater ease with which it can be inserted and removed by the individual patient. Advocates of both schools may be ardent supporters of one or the other method but the underlying principle remains unaltered and the matter is therefore here presented impartially.

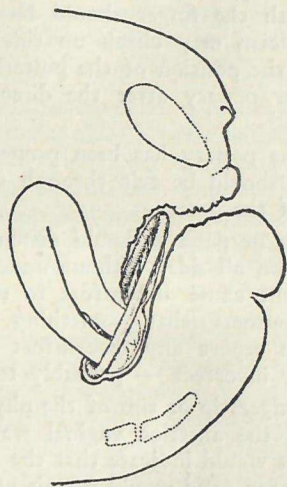
out of this temporary position. With the tip of the index or middle finger against the rim of the partially introduced portion of the instrument, guide the rim along the *posterior* vaginal wall until this anterior rim is lodged in the posterior fornix. As the guiding finger is withdrawn from the vaginal vault, press the posterior rim of the ring or pessary up in the ledge formed by the symphysis pubis.

2. The Janvier method consists of introducing the compressed ring or diaphragm pessary into the vaginal orifice as above noted (or entirely with the thumb). Instead of using the finger tip however, the tip of the thumb is used to direct the anterior rim of the instrument along the posterior vaginal wall into the posterior fornix. The posterior rim of the ring or pessary is then lifted up by the finger in place behind the symphysis pubis.

3. Again, the ring or pessary may be introduced by securing the rim between the thumb and the middle finger with the index finger placed against the opposite side of the rim. By squeezing the sides of the rim held by the thumb and middle finger the ring or pessary assumes an elliptical shape which makes introduction in and beyond the vaginal orifice possible. The index or middle finger again is employed to continue guiding the now anterior rim along the posterior vaginal vault to the posterior fornix. Lifting up the posterior rim by the fingers is resorted to, in order to secure the position of the ring or pessary, in back of the symphysis pubis.

4. The use of the Mayer pessary director, a mechanical, specially shaped finger is both quick and reliable. Adjust a portion of the rim of the ring or pessary in the grooved end of the director. The ring or pessary (again with either the concave or convex side uppermost as preferred) rests on the rounded curve

of the director at the grooved end. The hook side of the director is at the bottom. With the thumb, engage the opposite rim of the ring or pessary and slowly stretch it until the rim assumes an elliptical shape, at the same time allowing the index finger to grip the hooked end. The middle fingers support the director on the under side.



(Cut showing pessary properly placed)

If the distance on the director, between the thumb and index finger is of too great compass for the physician, the thumb may be used to engage the rim in the same manner as above indicated, letting the fingers encircle the director and the little finger grip the hooked end of the director. The ring, or pessary, thus in place on the director, is then introduced into the vaginal orifice and guided along the posterior wall of the vagina until blocked by the thumb. The thumb is then withdrawn and the director continues to guide the ring or pessary along the posterior wall to the posterior fornix. (Actually, the shape of the Mayer

director automatically directs the ring or pessary to its proper position, skillfully avoiding possible contact or lodging against the anterior fornix of the cervix.)

The director is then withdrawn slowly and unless the fit is not accurate the ring or pessary will spring into its proper position behind the symphysis pubis. It is claimed that no lifting up with the finger should be necessary. (The physician may check up this point by examining the position of the posterior rim of the ring or pessary after the director is removed.)

After the pessary has been properly placed the cervix should be felt through the rubber covering of the dome.

The ring or pessary should distend the vaginal wall on all sides without undue pressure which might cause discomfort to the patient or consciousness that something is there. Should she report any discomfort the fit is most likely incorrect — probably too large.

If the finger tip or tips of the physician can pass along the anterior vaginal wall without difficulty it would indicate that the size selected is too large (and would permit of the phallus passing in front of, and displacing the pessary) or too small (so that the action of the glans penis could thrust the pessary to one side).

If the patient has a loaded lower bowel or the bladder is too full an improper size might be fitted. Therefore, the physician should make certain that reasonable evacuations have occurred before trying to fit the pessary.

The ring or diaphragm is removed by inserting the index or middle finger under the rim and slowly withdrawing. If the Mayer pessary director is used, the hook is inserted just under the front rim and pressed upward toward the bladder until it surely engages the rim of the

pessary. Continuing the upward pressure the pessary is slowly withdrawn.

If the rings have been used in applying one of these methods and the fit seems good, the diaphragm pessary corresponding to the size of the ring should be lubricated and made ready for insertion.

The above described process should be repeated until the physician is satisfied that the fitting is as perfect as it is possible to make.

It is well to have the patient get up and walk about the office a little with the pessary in place. If it hurts her the size is most probably wrong. When she resumes the gynecological position it is well to further examine the patient and determine that the size is correct by observing whether or not it has remained in position.

It is not deemed advisable for the physician to teach a patient the technique of inserting and removing the diaphragm by means of the fitting rings, since it is essential that the patient learn to feel her cervix through the rubber in the dome of the pessary.

TIME OF REMOVAL

Eminent physicians vary in their opinion regarding the proper time to remove the pessary. Some advocate the immediate removal, accompanied by douching with a reliable antiseptic. Others recommend removal from six to twelve hours after insertion, at which time the douching is sometimes believed advisable. The physician who recommends immediate removal and douching concedes that circumstances do not always permit of immediate douching. The physician also concedes that it is a further burden for the woman, who *should* at this par-

ticular time, be able to relax as well as her partner. More and more the physician is realizing that he must consider such matters, as much as possible, from the woman's as well as from the man's point of view.

When the immediate removal of the pessary is desired it is suggested that an immediate application be made of a reliable contraceptive jelly, properly applied with the glass nozzle against the cervical os (after the pessary has been removed). The patient can do this without getting up, thus omitting the douche. (This stand seems well taken since the jelly thus injected is allowed to continue the work of immobilizing the spermatazoa whereas improper douching may serve to direct the spermatazoa toward the cervical os and even into the cervical canal, at the same time washing out a goodly portion (at least) of the spermicidal jelly.)

If the pessary is removed several hours after coitus, as is more generally advocated, douching is becoming less and less regarded as a necessity. Especially is this so if a reliable contraceptive jelly is employed with the pessary. It is probable that soon physicians in general will advocate douching for aesthetic and hygienic purposes solely — rather than as an essential step in contraceptive procedure.

SIZES

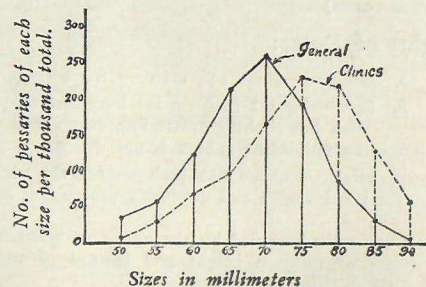
In order to make possible the most accurate fittings on the part of the physician, the following sizes of Durex diaphragms and fitting rings are placed at his disposal. (The most casual glance at this array of sizes indicates, of course, the absolute necessity of a fitting and prescribing on the part of the physician and the absurdity of making diaphragms available to the patient via drug stores that will not conform rigidly to a prescription basis.)

Following are the sizes in which Durex diaphragms and fitting rings are made:

<i>Mensingas</i> (Watch Springs)	<i>Durex</i> (Coiled Springs)	<i>Fitting Rings</i> (Coiled Springs)
60mm	50mm	50mm
62½mm	55mm	55mm
65mm	60mm	60mm
67½mm	65mm	65mm
70mm	70mm	70mm
72½mm	75mm	75mm
75mm	80mm	80mm
77½mm	85mm	85mm
80mm	90mm	
82½mm	95mm	
85mm	100mm	
90mm		
95mm		
100mm		

The following are statistical curves showing the number of coiled spring pessaries per thousand of each size prescribed, both in clinics and by private physicians.

(Based on the last ten thousand pessaries distributed by us in each case.)



The Diaphragm Pessaries developed and supplied by Durex have

1. Well and evenly covered RIMS, which are completely sealed and not bulky.

2. SPRINGS that are thin in outside diameter of coil; well joined; and will not form lateral figure eights.
3. Soft, smooth and elastic RUBBER free from air bubbles; neither too heavy nor too light in texture and with good tensile strength; and containing no solvent, being made of pure sheet rubber.
4. DOMES that do not bulge about the rims because of excess rubber; and are properly vulcanized into the rim so that they will not pull or wear away in use.

The following special features are offered (without any additional charge):

Color of Rubber in Pessary:

- a. Dark, Para Rubber
- Or b. Light, Ceylon Rubber

Tensions of Springs:

- a. Medium (for the average case)
- b. Strong (for mild cases of cystocele and rectocele)
- Or c. Weak (as sometimes required for nulliparous cases)

Heights of Dome:

- a. Medium—about $1\frac{1}{4}$ inch — for average cases
- b. Low—about 1 inch — for long, narrow vault with but slightly protruding cervix and when the redundant rubber is not desired.
- c. High — about $1\frac{1}{2}$ inch — for the very relaxed vagina and unusually protruding cervix.

(Unless otherwise specified by the physician when ordering, domes of medium height and springs of medium tension are supplied.)



The Coiled Spring of the
Diaphragm Pessary



The Flat Spring of the
Diaphragm Pessary

To the physician who has studied or observed in clinics the need for both types of pessaries (flat and coiled) is obvious. The coiled spring diaphragm is applicable in most cases. However, the following points in favor of the Mensinga should be taken into consideration before the physician dogmatically restricts his choice to the coiled spring:

1. Because the flat spring is flexible in one plane only*, it cannot be twisted out of its plane and it is impossible for the patient to lodge the pessary between the anterior fornix and the symphysis pubis.
2. Because the flat spring rim is thinner it will fit more snugly in the pubic arch.
3. Because the flat spring is made in two and one-half millimeter gradations it is possible to insure more accurate fittings.

The *Matrisalus type* is for the case presenting a moderate cystocele. In clinics and in the practice of the gynecologist occasions arise which require this type. Since each case requires a different size and a variation in form, they are being made to order only by Durex Laboratories and in so far as possible in accordance with specifications or sample forwarded by the physician. For the more advanced case of cystocele a hard rubber pessary with a condom stretched over it and tied, will prove effective.

The *matrisalus* lifts the anterior vaginal wall and thus prevents the phallus from passing anteriorly.

* The physician must remember that the flat spring will tend to become elliptical if pressed together too firmly — too far from the center or severely crushed together with all of the fingers.

PHYSICIAN AND PATIENT

Just as contraceptive information and technique were omitted from the physician's medical education, so was any knowledge of sexual anatomy omitted from the patient's education.

It is well, therefore, to be most tolerant of this kind of ignorance and gain the confidence of the patient by explaining in a general way at least her anatomy (and probably something about that of the male as well) — where the important organs are — and last, but not least, something of the physiology of coitus. Given these pertinent facts, she will be enabled to respond intelligently to directions. The busy physician can further add to her limited store of knowledge by recommending one of the standard works on marriage relations.* (In general, these answer most of the questions she wants to ask.)

Anatomical discussions with patients, of course, depend upon the intelligence of the particular patient. The physician, as a judge of human nature, knows when it is unnecessary or even unwise to go into detail.

Whatever else may be impossible to impart to the less intelligent patient, the physician can relieve her fears about the pessary ever getting lost or out of reach in her vagina and can teach her to recognize the knob-like projection of the cervix in the vagina.

The physician should bear in mind that the insertion of the pessary by the patient is not difficult and in exceptionally few cases have patients failed to acquire the technique.**

* We are prepared to submit such a list and to supply any of the books named.

** NOTE: Information concerning this point may be obtained by the physician from any clinic in America specializing in this field — where hundreds of cases are being treated and patients of varying intelligence use this method.

INSTRUCTIONS TO PATIENTS

Every physician, after a period of time, develops his own technique for instructing the patient. The following notes, therefore, are intended as a guide to the beginner rather than as a dogmatic statement of practice — because here, as elsewhere, the physician revises or adapts his technique to the patient he is fitting. The simplest explanation is always preferable. The patient may be nervous during the examination, fitting and instructing procedures. It is advisable therefore to exercise patience in order that she may get the gist of the subject in spite of her nervous condition.

The necessity of cleanliness of instruments, hands and parts should be stressed. The pessary should be washed in warm to hot water before insertion and after removal. (A lather of good laundry or toilet soap is sufficiently antiseptic for such a personal instrument.)

After the correct size has been adjusted by the physician, the patient should examine herself as a preliminary step in learning the technique. Especially must the patient note how the cervix projects through the center of the dome and be impressed with the importance of covering this projection each time she inserts the diaphragm. It should be explained to her that the part of the rim entering first must go as high and as far back as possible past this projection and that the part of the rim last entering must be lifted up strongly behind the bone which can be felt in front.

Generally following the recommendation or suggestion of her physician the patient inserts the pessary in any one of three ways — In a reclining position; in a squatting position or semi-squatting position (one knee on the floor and the other one bent and bearing most of her weight); or in a position with one foot

(bearing her weight) on the floor and the other one placed on a chair or something that approximate height, with the upper part of the body bending forward.

If the pessary is inserted convex side up, the patient should place a fairly liberal quantity of jelly ($\frac{1}{2}$ to 1 teaspoonful) on the upper side of the dome or vice versa, in order that the jelly will be smeared over the external os of the uterus. Some physicians have found it simpler to instruct their patients to inject the jelly with the nozzle before placing the diaphragm. (The patient quite often wants to know whether it is necessary to make further injections of jelly when coitus occurs more than once. The policy of making an injection each time before coitus certainly does no harm and is a wise additional precaution.)

The physician will find it quicker for himself and less complicated for his patient however, if he suggests that she smear the jelly all over the diaphragm. In this manner perforce some jelly is deposited on the cervix.

Direct the patient to squeeze the rim of the lubricated pessary between the fingers of one hand, securely, but without undue harshness and in one of the positions as recommended, gently introduce it into the vaginal opening until the sides of the pessary are held in place by the entrance walls of the vagina, or about half way in the opening. The hold on the rim of the pessary may be released at this time. Then have her insert her index or middle finger under the rim of the part of the pessary that is already inside the vault. With the finger thus engaging the rim just inside, direct her to push the pessary into position by guiding it along the side of the vault nearest the backbone, parallel to the backbone and in the general direction of the shoulder-blades, until she can-

not insert the pessary any higher. Next, have her withdraw her finger slowly until it is almost at the opening of the vagina again, at which time she should lift up the portion of the pessary that entered the vault last and push it in the little ledge formed by the pubic or frontal bone. If she is sure to follow this procedure and remembers to check on herself to make certain that she feels a rubber covering over the knob-like cervix — she should experience no difficulty whatever.

Invariably, the patient, (if in a gynecological or reclining position and if left to her own devices), will reverse the holding of the pessary to the more natural one of holding the arm against (rather than away from) the body, grip the pessary between the thumb and fingers and start to make the insertion with the thumb and index finger farthest from her vagina. If the physician deems it a satisfactory method of insertion (which it is) he should guard against her tendency to introduce it along the *anterior* wall and lodge it in the anterior fornix so that the front rim becomes blocked by the cervix. For the physician, this technique is not obstructive since he can dislodge it with his finger and push it past and beyond the cervix but the patient is naturally not so skilled and might be careless or ignorant of the fact that it was not properly placed. (This shows the advantages of using the pessary director.)

To obviate this possibility the physician should stress the fact that as the patient inserts the diaphragm she should direct and guide the diaphragm along the wall of the vagina that is farthest from her abdomen.

In the Janvier method the right or left thumb of the patient may be used to direct the pessary. If her thumb is too short (and provided she has been instructed to start introduc-

ing the diaphragm with her thumb), the longest finger may be reverted to in order to continue guiding the pessary into the posterior fornix.

The patient should then insert and remove the diaphragm two or three times under the supervision of the physician and he should check her technique carefully.

DOUCHING

If douching is advocated by the physician the patient should be instructed to use a one or two quart antiseptic or cleansing solution.

One-half of the water should be used immediately before, the other half immediately after removal of the diaphragm. Every fold or crevice of the passage is flattened out and cleansed, if the external parts are held closed around the nozzle for a moment and then released so that the water gushes out. In using a fountain syringe the top of the water should be no higher than two feet above the nozzle. Too great a force is then impossible.

With a bulb type of syringe having a shoulder on the nozzle to close the external parts and properly distend the vagina, care must be taken to use no excessive force such as a grasp by the whole hand. Squeezing with the thumb and one finger cannot drive the fluid too forcibly or too high.

RETURN VISITS

At the end of a week the patient should return and have a further check made upon the size and her technique. Semi-annually or at least annually the patient should be instructed to return for a still further check-up. This is a necessary part of the method and is essential

in the case of a newly married patient or one who has borne a child in the interim. In the majority of such cases a change in the size of the diaphragm is required.

PROPER CARE of the DIAPHRAGM

Properly cared for, a Durex vaginal diaphragm will last over a year. It is difficult as a rule to guarantee rubber goods because rubber solvents, such as vaseline, are often used by well-intentioned persons for purposes of lubrication and sterilization. A Durex pessary is guaranteed for one year, if cared for in the prescribed manner.

Durex Laboratories have made a careful study of the effects of the various sterilizing materials to find a product which would have no effect on the strength or life of rubber, and at the same time be a good sterilizing agent. As a result of this study the laboratory is convinced that at present the most satisfactory results can be obtained by boiling the diaphragm in water. The diaphragms are sealed so completely that this can be done. *Under no circumstances however, should the diaphragm be subjected to more than a three-minute boiling.*

The patient should wash the diaphragm with warm water and soap, rinse in clear, warm water and dry thoroughly. (Medicated talcum powder, cornstarch or any patented form of these items do not preserve the rubber and are unnecessary if the diaphragm is thoroughly dried.)

The diaphragm should be tested occasionally by filling the inside with water to the brim and holding for a minute. The diaphragm is whole if no water passes through it. Be certain that the outside is dry before filling with water.

The suggested original order includes:

- 1 set—Durex Measuring Rings
- 1 62½—Mensinga Flat spring diaphragm
- 1 67½—Mensinga Flat spring diaphragm
- 1 72½—Mensinga Flat spring diaphragm
- 1 65mm—Durex Coiled spring diaphragm
- 1 70mm—Durex Coiled spring diaphragm
- 1 75mm—Durex Coiled spring diaphragm
- 1 pessary director—at least
- 6 tubes jelly—Lactikol Formulae
- 1 tube Durex Lubricating Jelly

In general, the physician who has a clientele largely composed of multiparous patients will find that he will require larger sizes and that smaller sizes will be necessary if his clientele is largely composed of nulliparous patients.

Lactikol formulae were prepared for proper lubrication of the diaphragm as well as to afford additional protection.

Lactikol A contains ½ of 1% lactic acid, 4% boric acid and base.

Lactikol B contains 2% lactic acid, 1 two thousandth part oxyquinoline sulphate and base.

As a further service to the physician interested in this field, Durex Products, Inc. will supply (at cost) photostatic copies of articles or excerpts from articles on the general subject which are otherwise impossible to procure.

Re: DISTRIBUTION

If you are interested in having us appoint an ethical distributor of our contraceptive materials in your city, will you please return to us the detachable slip below in the enclosed order blank envelope.

We shall approach the concern whose name appears most often on the returned slips.

Name of pharmacy or surgical house

.....
(first choice)

Address

Name of pharmacy or surgical house

.....
(second choice)

Address

May we use your name in communicating with the firm recommended by you?

Signed, M.D.

The

Physician's Patient
using
a Jelly Formula
from
Durex Laboratories
should

(over)

of course realize that a vaginal jelly will not prove effective unless used conscientiously. This jelly which your physician has prescribed or recommended has been clinically tested, is harmless and has proved its superiority in the field of vaginal jellies and is used in the majority of Maternal Health Clinics in the United States.

The vague, wild claims made for various products in this field are patently absurd to the intelligent individual but when cleverly presented are sufficient to confuse most anyone. Your physician has been making a study of developments in this field and has prescribed what he feels to be the best product.

* * *

Do not neglect to consult your physician on all medical matters.

About This Jelly

This jelly does not flow too freely and therefore does not prove annoying after use; still it spreads readily in the vaginal vault and will dissolve in water.

It is not poisonous.

It has no objectionable odor.

It will not stain clothing.

It will not spoil.

It will *not* induce sterility.

Sanitation and convenience have been considered in the container. Tube, key, nozzle for application and caps for the ends of the nozzle are packed in an attractive box.

The nozzle employed is non-breakable and may be easily sterilized by boiling. The key on the bottom of the tube regulates the quantity to be used. The two and one-half ounce tubes used by us, (and in general by manufacturers of similar products) contain about

nc.

eight full turns of the key or sixteen half turns.

The large tubes from Durex Laboratories contain about 16 half turns of the key or 32 quarter turns.

Specific Directions for Use

1. Remove the nozzle from the box and wash it thoroughly inside and out.
2. Unscrew the metal cap of tube and remove little cork disc which may adhere to top opening of the tube.
3. Screw the one end of the cleansed nozzle onto the top of the metal tube.
4. Slip key on the bottom of the tube and turn the key until the nozzle is filled to the tip.
5. Be certain the hands are clean before making the injection of jelly.

6. (a) Insert the nozzle slowly and carefully as far or high up as it will go in the vaginal vault. Give the key about a one-half turn and then slowly withdraw the nozzle, continuing to turn the key slightly while doing so.

(For large tubes about a quarter turn.)

6. (b) Or — if any difficulty is experienced in so injecting the jelly — a full turn of the key (or 1 teaspoonful) may be placed on the finger tip or tips and spread along the vaginal walls.

(For large tubes a one-half turn.)

In this method of introducing the jelly it should be remembered that a generous quantity should be deposited against the knob-like cervix (or opening into the uterus or womb).

7. One application of this jelly is sufficient in the average case and its prophylactic effect does not diminish for several hours. However, an application should be made whenever exposure is repeated.
8. After each application the caps should be placed on the ends of the nozzle and the nozzle rinsed off in warm water. (The jelly inside does not have to be washed out, and therefore, this quantity is not wasted each time.)
9. Replace the cap on the tin tube. Then place the filled nozzle and tin tube of jelly away in the container provided.
10. When the metal tube is empty, the old nozzle, which will still contain some jelly, should be attached to the new tube.

Pertinent Notes

The jelly should NOT be removed by douching, for approximately eight hours after injection.

The consensus of medical opinion today is that the douche is unnecessary except as a cleansing agent.

We believe we have here presented in compact form the directions you have already received from your physician. By all means be guided by his specific instructions.

* * *

DUREX PRODUCTS, Inc.
New York, N. Y.

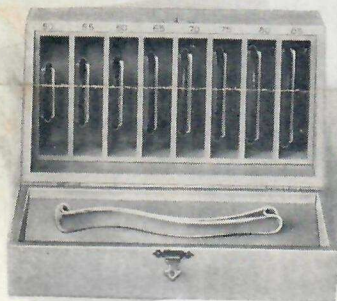
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Group Price		Regular Price
\$8.50	4 Durex Diaphragms (65-70-75-80 mm.) (or assorted as to type and size)	\$ 7.20
	1 Mayer Pessary Director	2.75
	2 Tubes Lactikol B	1.80
		<u>\$11.75</u>
	(A saving of \$3.25)	

OR



GROUP II

\$7.50	8 Measuring Rings (Sizes 50-55-60-65-70-75-80-85 mm.) (Permanently boxed)	5.00
	1 Mayer Pessary Director	2.75
	2 Tubes Lactikol B	1.80
		<u>\$9.55</u>
	(A saving of \$2.05)	

To the physician returning the detachable slip with check covering the initial order of his selection, we shall include without charge — one copy of a compact working office manual, "The Technique of Contraception" by Eric M. Matsner, M.D.
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