

DUREX • NOTES

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Volume I

DECEMBER, 1933

Number 4

The Measures or Methods of Contraception as outlined in previous Durex Notes included in Group I.—Methods acceptable to prescribe or recommend. (Largely based on the fact that intra-mural and extra-mural clinics everywhere endorse them.)

1. Diaphragm pessary with contraceptive jelly, described in *Technical Data*.
2. Cervical pessary with contraceptive jelly, described in *Durex Notes No. 2*.
3. Sheath (Condom) with contraceptive jelly, described in *Durex Notes No. 3*.
4. Chemicals alone—in selected cases, (preferably jellies) discussed herein.

Physicians, pharmacists and the laity are for the most part in a state of confusion because of the avalanche of marriage or feminine hygiene preparations flooding the market. The total absence of standardization of any sort or any control of the situation from a recognized medical or pharmaceutical group makes this kind of situation possible.

Among the many products on the market there are probably not more than a dozen that are worth being sold. The formulae vary but slightly in most instances. Generally speaking "the more ingredients, the better the product" seems to be the slogan. The descriptions vary in accordance with the ignorance or aggressiveness of the manufacturer. The prices for the most part fluctuate to meet or lower the quotation of the man who was detailing the physician the "other day". Free goods, consignment, etc. deluge the physician and the pharmacist.

Since contraception is distinctly a medical matter, the resultant chaotic state is, naturally, a cause for concern to the physician. Both physician and pharmacist should cooperate with the reputable manufacturer in an effort to protect a gullible laity.

It has only recently been possible (and manufacturers do not yet have the means at their disposal) to reproduce the condition existing in the vaginal vault during or after coitus. Without a simple and effective method of determining the acidity of the vaginal vault of a given patient, the manufacturer cannot supply a product which can be guaranteed under all conditions to kill spermatozoa in the vault, even though the ingredients kill instantaneously on the slides or in the test tubes in the laboratory. The normal acidity of the vaginal canal is approximately pH 4.1. What the conscientious manufacturer has done and can do is to accept what bio-chemistry states to be the norm and develop his product accordingly.

The Use of the Chemical Contraceptive

The use of chemicals alone as a contraceptive measure is a most controversial matter among physicians.

It is logical that laboratory results with live sperm are an excellent indication of the efficacy of a chemical but clinical findings (and experiments) are the final test.

This fact granted, the next consideration is whether

1. The blocking (by an impenetrable film) of the cervix is more important than
2. The immediate or almost immediate immobilization of the sperm.

The combination of the two is not only possible in most instances, but also proportionately more effective. (This is possible where the viscosity of the base is sufficiently high to have some barrier action and to avoid the tendency to liquefy unpleasantly at body temperature and at the same

The type or form of chemical to be employed is important. The following table has been prepared to indicate the properties, advantages and disadvantages of each of the five forms of contraceptive material which depend for their efficacy upon the action of chemical substances.

Type of Chemical	1. Suppository a) cocoa butter b) boro glycerin	2. Foam or effervescent tablet	3. Powder (sprayed into vault)	4. Foam jelly	5. Jelly
Form	Conical or spherical masses packed in boxes	Large round pellets in cylindrical glass tube	Powder packed in jars	Two solutions in double tube (one inside the other)	Solution in collapsible tube (sometimes in jars)
How inserted	By hand	By hand	With use of atomizer or blower	With use of nozzle	With use of nozzle or plunger device

ADVANTAGES

Suppository	Foam Tablet	Powder	Foam Jelly	Jelly
Easily carried.	Easily carried.	If evenly dispersed and dissolved in vagina will serve as barrier.	Independent of time Independent of moisture Independent of temperature.	Independent of time Independent of moisture Independent of temperature
Easily placed by anatomically informed person.	Easily placed by anatomically informed person.		When properly compounded will serve as barrier. (Proper viscosity).	When properly compounded will serve as barrier. (Proper viscosity).
Type (a) simple to compound.		Can be water soluble.	Possibility of double spermicidal action.	Possibility of double spermicidal action.
Simple to purchase.			Can be used as lubricant with other methods.	Can be used as lubricant with other methods.
Lacks appurtenances.	Lacks appurtenances.		If properly compounded will not disintegrate.	If properly compounded will not disintegrate.
If properly compounded melts at body temperature.	Odorless.	Odorless.	Can be water soluble.	Can be water soluble.
If properly compounded will not deteriorate.	If properly compounded will not deteriorate.	If sealed well, will not deteriorate.	Can be stainless.	Can be stainless.
	Does not cause dripping.		Nozzle or plunger provides easier and deeper injection most necessary for patient with short fingers and long vault. Also assures proper spreading of substance despite lack of anatomical knowledge.	Nozzle or plunger provides easier and deeper injection most necessary for patient with short fingers and long vault. Also assures proper spreading of substance despite lack of anatomical knowledge.
			Can possess advantages of low surface tension.	Can possess advantages of low surface tension.

DISADVANTAGES

Suppository	Foam Tablet	Powder	Foam Jelly	Jelly
Dependent on time.	Dependent on time.	Dependent on time.	More bulky to carry.	More bulky to carry.
Dependent on temperature.	Dependent on temperature.			
Not water soluble.	Not always water soluble.			
Annoyance from subsequent dripping.	Dependent on moisture.	Dependent on moisture.		
Fats or oils contained therein soil clothing.	Dependent on pressure.	Prone to cake or lump.		
Odor in type (a) objectionable.		Even dispersion not likely unless air disintegrates vaginal walls.		
Low temperature necessary to keep when not in use.		More bulky to carry.	Appurtenances necessary.	Appurtenances necessary.
Psychological uncertainty (no way of determining if suppository has melted).	Psychological uncertainty (no way of determining if tablet has effervesced).	Psychological uncertainty (no way of determining if powder has dissolved or dispersed).		
Psychological deterrent in necessary delay.	Psychological deterrent in necessary delay.	Psychological deterrent in necessary delay.		
Type (b) if sufficiently stable to handle, melts slowly; otherwise, melts easily, but becomes sticky, making insertion difficult.				
Injures and eventually rots rubber.				
Dependent on occlusive properties principally, since chemical action is interfered with by presence of fats and oils.				
Cannot be used as lubricant with other methods.	Cannot be used as lubricant with other methods.	Cannot be used as lubricant with other methods.		

time, the surface tension is sufficiently low to cause thorough penetration of the active ingredients into the minute interstices of the surfaces of the vaginal tissue.) The base is a most important and often overlooked factor.

As in the case of other methods of contraception, no physician should employ a chemical method without first

- a) making a thorough pelvic examination preliminary to prescribing or recommending the given method,
- b) giving careful, detailed anatomical instruction to the patient,
- c) supplying precise directions for each case.

If the physician does not adhere to the procedure outlined above he cannot conscientiously prescribe or recommend the method (without any other contraceptive aid) unless he *subscribes to the following general considerations*:

1. The case in which fertility is below average.
2. The case of a nullipara (with uterus in position).
3. The case of a patient unable to use any other accepted method.

It is fair to emphasize one fact which physicians and the laity are prone to lose sight of—namely, that unless scientifically and prudently *prescribed and used*, the best possible product will not prove effective. In short, the “failure” cases are not as likely to be caused by faulty products as they are to be caused by incomplete examination, information and followed-out instructions.

In summary of the table on the foregoing page may we point out these facts:

- a. The merits of the suppository are vitiated to a great extent because they are so dependent upon the temperature of the body.
- b. The merits of the foam tablets are vitiated to a great extent because they are so dependent on sufficient moisture* being present in the vagina.

*The small amount of moisture present in the vagina ($\frac{1}{2}$ to 1 c.c.) has to be depended upon to start action of foaming. (Manufacturers themselves suggest the addition of 2 c.c. of water to a tablet in a test tube for demonstration purposes.) After coitus, the fluid content of the vagina is approximately 4.0 c.c.. To be successful the moisture present in the vagina should be sufficient to cause reaction so that a barrier is formed *before* the ejaculate of the male takes place.

c. The merits of the powder are likewise vitiated because they are dependent on sufficient moisture.

d. The disadvantage of apparatus in the foam jelly is a negligible consideration since its possibilities of success are so many. The fact that the American foam jelly is not satisfactory** does not mean that the principle is wrong.

e. The disadvantage of essential apparatus in the use of the jelly does not negate the decided advantages of its ability to act both as barrier and spermicide.

Certain types of cases are especially adapted to the use of one or more of these chemical substances. The decision rests with the physician himself as to the best type to recommend.

The progressive manufacturer is prepared to experiment and work with clinics and physicians to obtain the preparation best suited to the majority of cases. It is well for medical groups to recognize the fact that there are some manufacturers who have standards and ethics and are not looking upon this field as one to be exploited.

CONTRACEPTIVE JELLIES have in general percentage ratings from 85 up to 100 per cent—when used alone. These percentages vary with the actual type of jelly used and the care with which examination, instruction and followed-out instruction are adhered to. The percentage of success may be extremely high when all conditions are favorable. Dr. Robert L. Dickinson, in his work “Control of Conception” states—“Irving Stein, in the Mandel Clinic in Chicago followed up over a hundred patients using a jelly with chinosol and lactic acid and reports complete protection for over one year for all patients who persisted in following directions exactly.”

More recently (June 1, 1933) Dr. Stein has unofficially advised: “I wish to state that we have been using —, both in the clinic and in my private practice since we completed the investigative work a few years ago.

“I am not sure of the number of patients on whom it has been used but I would estimate some-

**Re-American Foam Jelly—“The viscosity of this would appear to be, however, too high and the foaming capacity is in my opinion, low and insufficient since it only occurs after considerable mixing of the constituents.” — *Vogel*—The Chemistry & Physics of Contraceptives.—p. 192.

where between 500 to 1000 patients, the majority of these being in private practice. The jelly is used routinely as a method of choice and only in special cases is combined method with either condom or pessary advised. The latter are patients who express some doubt in their own minds concerning the efficacy of a single method. To such patients I give instructions concerning additional apparatus.

"I do not believe that the efficacy can be rated 100%, altho we have had only one private patient who claimed to use the method regularly and failed. Most of our patients are using the jelly method alone with complete satisfaction. The technique of application does not differ in any way from the directions used in any jelly, namely to place about 1 dram¹ of the jelly in front of the cervix just before intercourse. A douche the following morning is optional. Naturally a pelvic examination should precede the recommendation to use any contraceptive and the directions given the patient must be in accord with the findings, with particular reference to position of the cervix."

Still another clinic, in Philadelphia, has just

undertaken a like experiment under the leadership of a very competent research man.

It is to be hoped that other clinics will follow the lead of these two groups and that physicians in their private practices will employ like means whenever and wherever it is practical.

Certain it is, that the use of a jelly alone always be more desirable than more complicated or combined methods and at least where financial considerations have to be taken into account, the inexpensiveness of the chemical alone is decidedly a factor in its favor.

The most vital point with regard to clinical tests of jellies now available is the fact that they *do not induce sterility and are in themselves harmless and non-poisonous* as opposed to strongly irritating materials such as chlorine solutions, creosol solutions and suppositories containing mercury compounds.

NOTE:¹ 1 dram (1 teaspoon) or 4 c.c.—as recommended for use with pessary by clinics. (A half turn of the tube attached to the bottom of the tube expels approximately ½ teaspoon of jelly.)

REFERENCE BOOKS

Any of these standard works may be secured through Book Division, Durex Products, Inc., 156 Fifth Ave., New York.

Title	Author	Publisher	Yr. Pub.	
The Chemistry & Physics of Contraceptives	Dr. Cecil I. B. Voge	Jonathan Cape 30 Bedford Square, London, England.	1933	12s
Contraception	Dr. Marie C. Stopes	G. P. Putnam's Sons.	1931	
Control of Conception	Drs. Dickinson & Bryant	Williams & Wilkins Co.	1931	
Fertility and Sterility in Marriage	Dr. T. H. Van de Velde	Covici Friede	1929	
Parenthood	Michael Fielding	Noel Douglas	1930	3s
Physicians' Manual of Birth Control	Dr. Antoinette F. Konikow	Buchholz Publishing Co.	1931	
The Practice of Contraception	Mrs. Margaret Sanger & Dr. Hannah M. Stone	Williams & Wilkins Co.	1931	
Prevenception	Dr. Wm. J. Robinson	American Biological Society	1929	
Technique of Contraception	Dr. James F. Cooper	Day-Nichols, Inc.	1930	

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SEPTEMBER - 1932

Number 2

field of contraception no startling developments have been made in the past few months. On the other hand however, many more physicians are becoming convinced of the necessity for an adequate knowledge of the subject and more than adequate methods of contraception. Reasonably to follow an awakened interest of the medical and the science of contraception will be sure and steadily toward the goal of a contraceptive method. Too much emphasis cannot be placed on the fact that in the future, physicians should be familiar with the accepted methods.

Group III.

Methods to be investigated before prescribing or recommending (until further experimental and developmental research has been done.)

1. Heat applied to testes.
2. Hormones.
3. Intra-uterine stems and rings.
(Gräfenberg — silver rings) — (silkworm).
4. Irradiation.
X-ray, radium
to ovary (uterus)
to testicle.
5. Reversible operations.
6. Spermatoxins.

Methods or Methods of Contraception

is acceptable to prescribe or recommend.
based on the fact that intra-mural and
clinical clinics everywhere endorse them.)
Diaphragm pessary with contraceptive jelly.
Cervical pessary with contraceptive jelly.
Condom (condom) with contraceptive jelly.
Chemicals alone — in selected cases.
(preferably jellies.)

to avoid prescribing or recommending,
being too uncertain or impractical for gen-
(see.)

abstinence.

Coitus (with continence).

Coitus Interruptus (withdrawal) . . . alone.

Coitus Reservatus.

Coitus or lathering (alone).

Coitus.

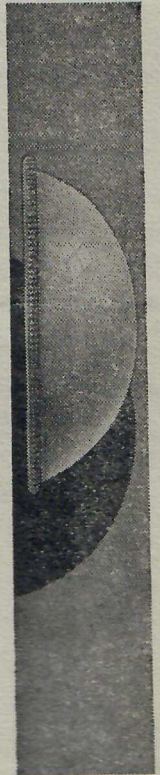
Safe period.

Coitus pessaries — (cervical stems).



Diaphragm pessary
with contraceptive
jelly.

Refer to *Technical
Data* — series One —
from the Laboratories
of DUREX Products,
Inc.



The Flexible Cervical Cap

Abroad there are snug-fitting cervical caps made of metal and celluloid as well as those made of rubber. So far as we know there have not been calls for the metal or celluloid types in America and we do not know that any are made here. This being the case, the flexible type only is being discussed.

In general principle, the Dumas, French and Mizpah are practically the same.

In appearance the Dumas or Stewart (also sometimes called French in America) is shaped like a shallow saucer, the thick rim of rubber gradually thinning toward the center of the dome. The rubber in the Dumas is thick and when boiled or washed repeatedly in warm to hot water, it is inclined to lose its shape which, in the first place, depends only on the thickness of the rubber. It is made in three sizes but it is difficult to procure in any but the medium size.



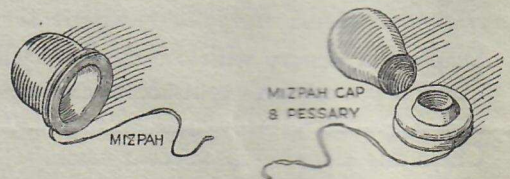
The French pessaries are made by various firms and have not been standardized. Hence, some are made with sponge rubber rims; others with air-inflated rims; some have rims about one-quarter of an inch in diameter; some one-half of an inch in diameter; some have dark rubber rims and a light weight translucent rubber dome; some have translucent rims and domes and still others are made of all black rubber. The height from bottom to



top as the pessary rests on a flat surface is about one and one-quarter inches. They are made in sizes generally termed medium, small and large.

The Mizpah is composed of an air-inflated or sponge-filled thick rubber rim containing a groove into which the adjustable thin rubber cap (which forms the dome) is slipped. (A string is also placed in this groove to facilitate removal but this is superfluous). A flange of the rubber on the inside of the rim helps to keep the pessary in place on the cervix. Quite often, in cases of moderate cystocele or rectocele, the Mizpah will serve well.

This type is made in small, medium and large sizes — the outside diameters being $42\frac{1}{2}$, $52\frac{1}{2}$ and $62\frac{1}{2}$ millimeters respectively. The inside diameters are, respectively, 30, 35 and 40 millimeters. The caps which form the domes can be replaced without purchasing the rims each time. The fact that the cap may pull off when the patient grasps it instead of the rim in removing the Mizpah has created the impression that the cap can come off the rim easily. If the cap has been inserted in the groove securely, this is most improbable.



Indications for Use of the Cervical Pessary

1. When the cervix uteri projects sufficiently into the vagina and uniformly enough to retain the cap properly in position.
2. When the cervix is pointing forward so as to be within reach of the patient's fingers, thus enabling her to adjust and remove it.

(Indicated in this connection in cases of cervical antifixion or retroversion.)

3. When the cervix is not lacerated or deformed.
4. When the cervix is not at such a decided angle that the thrust of the phallus can displace the pessary.

Under these conditions, the cervical pessary may be used to good advantage.

(The normal, healthy cervix is about one inch in width. It projects about one-half an inch into the vagina, varying from one-quarter of an inch on the upper or top side to three-quarters of an inch on the under or bottom side.)

Fitting Procedure for The Flexible Cervical Pessary

The physician should first proceed as in the examination for the fitting of the diaphragm pessary. (See *Technical Data*, page 6.) Palpation of the cervix will afford a fairly accurate idea of the size required for trial fitting.

After sterilizing the pessary, it should be lubricated with a lubricating or contraceptive jelly — *never* with vaseline or like substances which are rubber solvents. The lubricated pessary is folded together between the fingers, the concave side with the rim uppermost. It is introduced and guided past the vaginal orifice along the posterior vaginal wall. It is then allowed to open up (keeping the concave side facing the anterior vaginal wall), until it is in a position directly opposite but actually touching the cervix. A gentle pressure of the fingers is all that should be necessary to adjust the rim in place around the cervix if the size is correct.

Correctly fitted, the flexible pessary secures purchase from the contact of the rim with the vaginal walls, some suction and some friction. Care should be taken not to have it fit so snugly that the patient experiences discomfort (which may give rise to inflammation). On the other hand, it must not be so large that the penis can readily displace it.

The flexible pessary is withdrawn by hooking

the finger (which should be introduced sidewise) under the front rim and drawing downward.

The technique of instructing the patient does not differ greatly from that of the diaphragm pessary. A squatting position with trunk bent forward is a very satisfactory one for the introduction of the cervical pessary because, in this position the uterus and cervix are thrust downward and forward.

If the cervical pessary has been fitted in accordance with the indications for its use stated, the likelihood of lubrication causing it to be displaced is minimized. The patient should be instructed to use contraceptive jelly in one of the ways indicated on page eighteen of *Technical Data*. She should then be instructed to press the rim of the cap between the thumb and forefinger, holding it so that the dome is pointing *downward*.

She should introduce it into the vaginal orifice and guide it upwards and backwards until the cervix is reached. If her fingers are long enough, she should feel round the rim to make certain that the pessary has been guided into its proper position, encircling the cervix. She should always feel the cervix through the rubber covering of the dome.

She should assume the same position for removing the pessary which she found easiest for inserting it — probably the squatting one.

The Durex Forum

The absence of any, or inadequate instruction to physicians in medical school on matters pertaining to contraception, and especially applied contraception, has placed innumerable physicians at a disadvantage. Many physicians are not in a position to leave busy practices and visit mural or extra-mural contraceptive clinics for observation or instructions. Other physicians there are, who frankly do not like to admit there has been such an omission in their medical training. Still others believe and sincerely, that the methods handed down to them by senior physicians are "just as good" as any others and are not aware of the practices and methods prescribed in clinics.

To assist and inform is the mission of Durex Notes. The Durex Forum is one place where the physician may feel free to request or give information on this subject. The Forum will answer all serious questions which are sent in on the signed letterhead or prescription blank of a member of

the medical profession duly listed in medical directories. No names or initials will be published. Durex Notes are sent only to members of the medical profession. Durex files are and will be as inviolate as case records in the physician's office.

Medical men and women of unquestioned integrity will be consulted in answering any questions submitted or questions involving ethical procedure.

Interchange of correspondence is invited and of course, as are informative letters.

Durex Notes has a wide circulation and possibilities are unlimited. This is the physician's Forum and we sincerely trust the response will be immediate so that thought may be stimulated among physicians whether they be interested or indifferent to the science of contraception.

All communications should be addressed to

DUREX Notes (Forum)
DUREX PRODUCTS, Inc.
156 Fifth Avenue,
New York, N. Y.



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Number 1

Volume I

JULY - 1932

DUREX products have been developed either entirely originally or for the first time in America in our Laboratories.

Durex Laboratories were the first commercial ones established in America to do developmental and research work *solely* in the field of contraception.

Since the establishment of Durex Laboratories, physicians and clinics have had

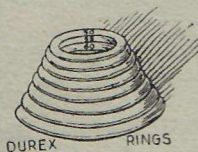
1. A dependable source of supplies for materials pertaining to this field.
2. A Laboratory which has consistently improved standards on all such materials.
3. A Laboratory which develops new products in accordance with the needs of physicians.

Durex Products, Inc., conforms to the policy of

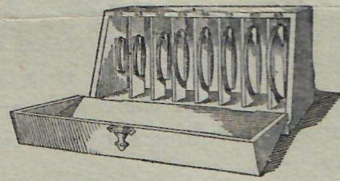
1. Ethical selling by restricting its sales to physicians only or upon their prescriptions.
2. Rendering efficient sales service.
3. Establishing and maintaining equitable prices.

Physicians are hesitant to change from an established, reputable source of supplies. Naturally, the progress made by Durex has encouraged imitation. Therefore, physicians are advised that Durex Products, Inc., has no affiliation with any other concern of similar name or supplying similar materials. Distributors, selected by physicians themselves, are located throughout the United States and elsewhere. Such distributors agree to sell in the same manner that Durex does.

March 1928. Measuring or fitting rings were first developed in Durex Laboratories. Eight sizes, ranging from 50 to 85 millimeters inclusive, are made.



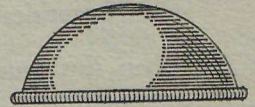
The regular Durex coiled spring is covered with a heavy red rubber which can be sterilized frequently. The rings correspond with the even sizes of Durex diaphragms.



Rings of larger size are now made upon request. Any set of eight is furnished at the regular price. They are sent to the physician boxed in a permanent container.

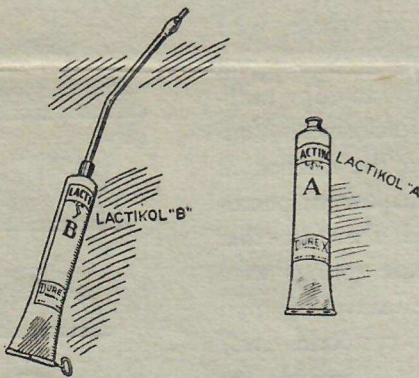
March 1928. The first diaphragm, made without the use of any rubber solvent, was placed on the market for physicians.

At first these were made in sizes ranging from 50 to 85 millimeters, inclusive. Variations in the method of fitting diaphragm pessaries (and the fact that more tense springs were found effective in mild cases of cystocele, etc.) caused a demand for larger sizes. At the present time therefore, Durex regularly makes 11 sizes, from 50 to 100 millimeters inclusive. All are priced the same.



March, 1928. It has been the consistent policy of Durex Laboratories, in introducing contraceptive jellies to physicians, to adhere rigidly to the following routine procedure:

1. The formula is always frankly stated. (Durex Products, Inc., feels it is the physician's undisputed right to know this, since he never prescribes other medicines without such knowledge.)
2. Carefully selected chemicals are subjected to careful analysis to make certain that they have the properties claimed for them. The substances are then tested on fertile, motile spermatozoa. It is a matter of months before all the details are worked out and the resulting substance is ready for clinical tests.
3. Three or more contraceptive clinics then give the jelly a trial and advise Durex Laboratories of their findings. In addition, physicians with large practices, who are especially interested and cooperative, are given quantities for testing purposes.
4. When this routine has been successfully completed, the jelly is made ready for marketing. Packaging of all Durex products is most conservative.



Several formulae have been made up in Durex Laboratories but only two of these, Lactikol A and Lactikol B, marketed — the others being private formulae for physicians and clinics. Numerous other jellies are in various stages of developmental routine and will be announced soon.

September 1928. As a result of a questionnaire sent out by Durex Products, Inc., in May 1928, and requests from clinics, the Mensinga (flat spring diaphragm pessary) was developed for the first time in America in Durex Laboratories.

Since less than 60 millimeter pessaries were rarely used, the flat spring type was made in sizes ranging from 60 millimeters to 85 millimeters in gradations of $2\frac{1}{2}$ millimeters each. At present, Durex Laboratories are supplying these regularly in fifteen sizes from 60 millimeters to 100 millimeters. Smaller and larger sizes can be made to order at no extra charge.

With judicious handling, the flat spring will not deform. For the benefit of those physicians who did have patients malform them by not following their instructions, Durex Laboratories have still further developed the flat spring. The new Mensinga will not deform under ordinary treatment. Since a flat band of flexible steel, whether straight or rounded, can always be bent, it is not *impossible* to bend this Mensinga too — but Durex Laboratories have progressed far in making it much more difficult to do so.



The Mensinga was first marketed by Durex Products, Inc., in September, 1928.

June 1930. The Mayer Pessary Director (patent pending) was developed in Durex Laboratories during 1929 and 1930, and first placed on sale in August of 1930.



Since its advent copies and modifications have been made of it but none thus far can compare with the simplicity and effectiveness of the original instrument.

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Volume I

JANUARY - 1933

Number 3

THE accepted measures or methods of Contraception endorsed by intramural and extramural clinics everywhere include:

1. Diaphragm pessary with contraceptive jelly. (Described in "Technical Data" Series 1).
2. Cervical pessary with contraceptive jelly. (Described in "Durex Notes" vol. 1, No. 2).
3. Sheath (condom) with contraceptive jelly. (Discussed herein).
4. Chemicals alone — in selected cases. (To be discussed in next number of "Durex Notes").

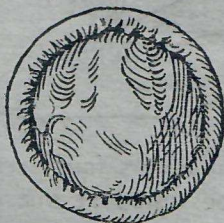
The Sheath or Condom

Physicians and lay people alike have known and used sheaths for years. Until quite recently, physicians recommended them without giving the matter very serious consideration. This was very simple and a good many times the patient found the use of the sheath satisfactory or nearly so. However, the fact that so many patients have not found it satisfactory has made physicians realize that there is a definite technique for its proper use.

To our knowledge, in no instance are directions for the correct employment of the sheath provided with the article itself.

Since the use of the sheath does constitute a sound method to employ in certain cases, the physician should be able to supply directions for its proper use when he prescribes it.

The sheath is, as its name indicates, a covering of rubber or skin, placed over the penis. Following ejaculation, the semen is retained in the sheath and so prevented from entering the vagina and subsequently the uterus.



A ROLLED RUBBER SHEATH

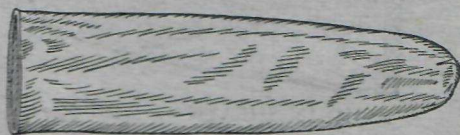
Indications for the Use of the Sheath

1. If the male erection is strong, that is, in the case of the virile male.
2. If the interruption in the continuity of the sexual act, involved in the placement of the sheath, does not disturb either partner.
3. If neither partner experiences noticeable lack of pleasure sensation as a result of the covering.
4. If either partner actually has venereal disease or has been exposed to venereal disease.
5. If the couple is newly married and other methods cannot be prescribed.
6. If the couple is traveling and other methods might prove annoying or embarrassing.
7. If the male is willing to assume the responsibility and will not delay the placement of the sheath at the proper time.
8. If a contraceptive jelly is used in conjunction therewith.
9. If the male can be depended upon to test the sheath each time before and after use.
10. If the male can be depended upon to buy the standard, preferably dated brand of condom which the physician recommends or prescribes.
11. If the male has too quick an emission then the sheath may dull the feeling sufficiently to defer the climax.

These are, perhaps, disconcerting and bothersome *ifs* but they are the factors which account for many of the proven failures in the use of the sheath.

The Rubber Sheath

1. The rubber sheath possesses elasticity; it is usually softer to the touch at first.
2. It is cheaper . . . than the skin sheath.



RUBBER SHEATH — UNROLLED

3. It is attacked by vaseline, cold cream or like substances more readily than the skin sheath.

4. The rubber sheath is not as strong or durable as the skin, although strong enough for ordinary (limited) service.

The Fishskin Sheath

1. The skin sheath is generally made from the peritoneal covering of the bowels of sheep or goats.

2. The skin sheath is thin (like parchment paper) but durable.

3. The skin sheath is not hurt by greasy lubricants.

4. The skin is not elastic and cannot be rolled up, making placement more difficult.

5. The skin is more expensive than the rubber (in original cost).



FISHSKIN SHEATH — *Average Size*

Sheaths vary little in size according to comparison of leading makers.

The rubber sheath averages:

7½" long

1½" diameter

2" diameter when lying flat

The skin sheath averages:

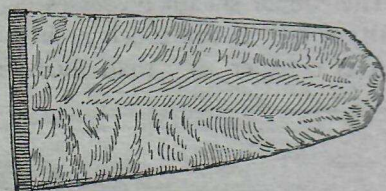
Between 8¼" to 10" in length

Between 2" to 2¼" diameter

Between 2½" to 3⅜" flat

The average penis is 6" long.

For maximum security, two sheaths, one drawn over the other, are sometimes recommended.



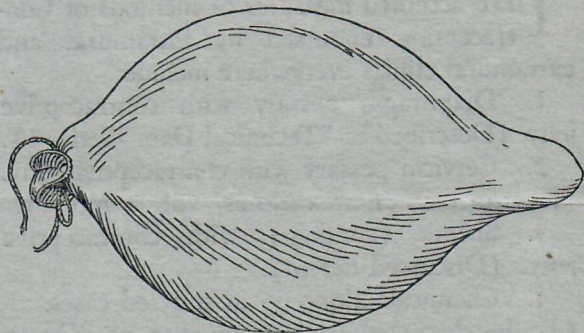
FISHSKIN SHEATH — *Small Size*

Length—6½"

Width (flat)—3" (at top)

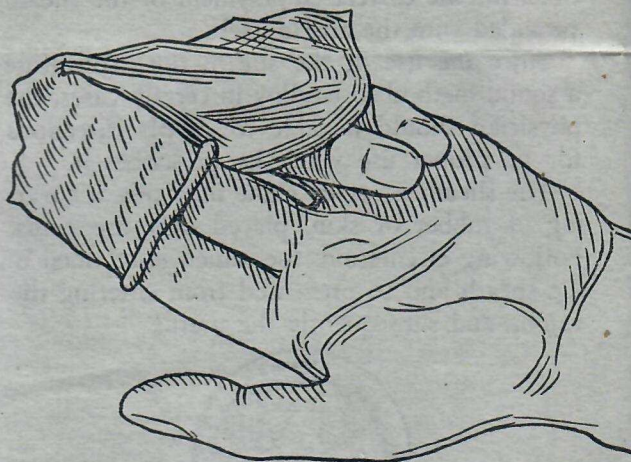
Testing of the Sheath

The sheath should be tested first by blowing it up (with the mouth) until all surfaces except the very top are distended. Then the top or open end is gripped and twisted so the air cannot escape readily and the sides and tip are examined for any small perforations through which the air may be escaping.



If there is any doubt whatever, and in any case as an additional precaution, it is well to fill the sheath to the top with water—being careful not to wet the outside. If little beads of water appear on the surface of the sheath, it is not whole and should be rejected.

If it is a rubber sheath which has been so tested, it should be thoroughly dried and then rolled by drawing it over the first and second fingers of the left hand, spreading them apart slightly to secure the necessary pressure, and then with the right hand rolling the rubber up to the end, snugly. If the sheath is a fishskin it can only be dried thoroughly and left flat.



When coitus occurs fairly regularly, several sheaths can be tested at one time and kept ready for use.

extend beyond the tip of the penis to receive the semen and somewhat relieve the strain at that point.

The skin sheath cannot be rolled on but its larger size facilitates drawing it on.

A rubber band may be slipped over the top of the skin sheath to help hold it in place.

Too much lubrication of the sheath may detract from the pleasure of the sexual act. The exercise of common sense plus experience will go a long way toward the proper adjustment of such a detail for each couple concerned.

Repeat testing each time before and after. If, after use, a tear is discovered, the user should douche immediately (within a day or two). The tear is rarely minute.

In contraceptive clinics 50% failure with use of the sheath is reported. This percentage, however, does not take into account the estimated number of people who find it a satisfactory method and so do not report to a clinic.

Like any article to be applied to a part of the body, the sheath must, of course, be sterilized before use.

The Durex Forum

It has been gratifying to note the response of physicians to the Durex Forum. Over a period of time, we shall print all material as it comes to hand. Because of limited space, however, all data cannot be printed at once. We have, therefore, planned to handle all correspondence chronologically.

* * *

Since several physicians have asked about lists of books on contraceptive matters and allied fields, we wish to advise that the Book Division of Durex Products, Inc., has been at work compiling as complete a list as possible of books which will include among others:—

Technical works for physicians on fertility and sterility.

Works of interest to sociologists and professional lay people.

All communications should be addressed to

DUREX Notes (Forum)

DUREX PRODUCTS, Inc.

156 Fifth Avenue,

New York, N. Y.

Works for parents and married couples
Works for the adolescent.

As soon as completed, this list will be sent to any physician desiring it.

* * *

The matter of fees to be charged for contraceptive advice has been brought to our attention on numerous occasions. Quite naturally no dogmatic statement can be made. It is a physician's personal province to make a charge he deems equitable. In general, the following may serve as a helpful guide.

From numerous discussions we have learned that the physician most frequently makes a charge of from \$10 to \$15 for examination, instruction and materials

or

makes a charge of from \$5 to \$10 for instruction and materials on a prescription basis.

