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Technique of Emptying the Uterus in Inevitable Abortion.

BY

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Technique of Emptying the Uterus in Inevitable Abortion.*

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WHEN abortion is inevitable, and it has been determined to empty the uterus artificially, the question is what is the best method of accomplishing this result. Prior to the eighth week of pregnancy, this problem seldom presents itself. In fact so far, as I can recall, I have been obliged to empty the uterus only twice at this early period. In both cases the indication was recurring hemorrhages. The method employed was dilatation with steel dilators, and the use of the curette forceps and the curette. At this early period the uterus is small, and it appears to me to be unwise to dilate it sufficiently to introduce the finger, without special indications, such as continued bleeding, foul discharge, or septic symptoms following the initial curetting. When the pregnancy has advanced beyond this period, the best method of emptying the uterus is by the use of the *finger* as a curette. The reasons why this is the best method are that less traumatism will be produced by the finger than by any instrument, and that by it we are able definitely to know when the uterus is empty. Indeed, the statement can be safely made, that in no other way can the practitioner be assured that the uterus has been emptied. Gynecologists of experience have supposedly emptied the uterus with the curette, when, much to their surprise, a considerable portion, or perhaps all of the ovum, has been subsequently expelled. The combined use of the curette forceps and curette is more likely to empty the uterus, but unfortunately, especially in inexperienced hands, the dangers of traumatism to the uterus are at the same time greatly increased.

It is unnecessary to adduce arguments in favor of performing this operation under rigid asepsis. Whatever is to be brought in contact with the patient's birth canal, and this canal itself, must be thoroughly disinfected. The prolonged washing and scrubbing of the hands, with soap, water and nail brush, followed by their immersion in corrosive sublimate solution, (1-1000,) for three minutes, is the most available method of hand disinfection for use in private practice. The vulvar region and the vagina should likewise be scrubbed with soap and water, this washed away with plain water, and the parts then thoroughly douched with sublimate solution. If instruments are to be employed, they should be boiled. When this is pos-

*Read before the Northwest Medical Society, of Philadelphia, at the November meeting.

sible, boiled water only should be used for douching, but in emergency cases the cold water may be disinfected by the addition of corrosive sublimate.

The employment of anesthesia is essential for thoroughness and certainty in emptying the uterus. First, It permits a more thorough scrubbing and disinfection of the birth canal. Second, The patient becomes passive, and the practitioner is enabled to carry out the technique, guided only by his judgment, instead of the caprice or the endurance of his patient. Third, He is enabled to carefully palpate the walls of the uterine cavity, and to determine definitely whether or not it is empty.

When disinfection has been fully carried out and the patient has been anesthetized, she should be placed in the lithotomy position, preferably on a table. The legs may be conveniently held by the Robb leg-holder, or by one or more assistants. Two fingers, or the half hand, should be introduced into the vagina, and one or more fingers into the cervical canal. If this is undilated, with patience and persistence, under anesthesia, it is possible in almost every case to dilate the cervix with the finger, sufficiently to introduce one or more fingers into the cavity of the uterus. In the rare cases in which this is not possible, the cervix should be dilated with steel dilators.

In introducing the finger into the cavity of the uterus, it is best to use the two hands conjointly ; one hand grasping the fundus of the uterus through the abdominal wall, steadying it and making counter pressure, while with the intra-vaginal finger the cervix is dilated. The ovum should be separated by the conjoint use of the two hands. Sometimes the external hand merely exercises counter pressure, while the intra-uterine finger or fingers peel off the placenta. At other times better results can be obtained by pressing the uterus down upon the intra-uterine finger, by the external hand. Should the left hand be employed (intra-uterine) it is best to begin upon the right lateral wall of the womb, separating the placenta from below upward, then across the fundus and down upon the left lateral wall, so that when the separation is completed, the ovum can be promptly removed on withdrawing the fingers. The reverse is true if the right hand is employed within the uterus.

In non-infected cases the operation should be completed by carefully washing out the uterus with boiled water, or sublimate solution, 1-5000. For this purpose a syringe with an ordinary nozzle is all that is essential, although the two-way catheter of Bozeman, or one of its modifications, is very convenient. It is wise to introduce a pencil of iodoform,* containing twenty-five or fifty grains, into the cavity of the uterus, and to tampon the uterus and vagina lightly with iodoform gauze.
This can be removed at the end of twenty-four or forty-eight hours, and thereafter vaginal douches of sublimate solution, (1-4000) should be employed

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*℞ Iodoformi, grs. C
Pulv. Amyli,
Pulv. Acaciae, aa grs. x.
Glycerini, q. s , (gtta. viii-ix)
M. Ft. Bacill. no. ii
S. Iodoform Pencils, 50 grains.

daily. In simple non-infected cases the use of the iodoform pencil and the gauze is a matter of precaution rather than of necessity.

When infection of the endometrium has already occurred, after the removal of all portions of the ovum and clots by the finger, the uterus should be carefully curetted, in order to take away as much of the maternal decidua as possible. This at once disposes of a large number of germs, and likewise of the culture medium in which they are growing, and unless the infection has spread to the deeper structures of the uterus, it cuts short the infective process. The uterus should be curetted at once, after removing the ovum. It is best done by retracting the perineum with the Edebohls or other speculum, grasping the anterior lip of the cervix with a bullet forceps, upon which gentle traction is made, to steady the uterus. The broad cutting curette is then introduced, and the cavity of the uterus systematically gone over, curetting one lateral wall, then the anterior wall, the other lateral wall, the posterior wall, and finally the fundus. A useful manoeuvre is to use one or two fingers of the left hand for counter pressure, by introducing them well up against the uterus, and changing their location as the curette is used in one or other part of the uterus. In order to do this it is necessary that the bullet forceps be held by an assistant. When the curettage is completed, the uterus should be douched with sublimate solution, and a 50 grain pencil of iodoform, and also iodoform gauze, should be introduced.

In using the curette it must never be forgotten that the soft puerperal uterus can readily be punctured. This has happened in the hands of the most experienced men, even in the non-puerperal uterus, so that the risks of this accident in the hands of the novice, or the practitioner of small surgical experience, are considerable. This accident is best avoided by using a broad curette, and by systematically and gently going over the surface of the uterine walls. Force, either in introducing the curette, or in scraping the walls, must never be employed. The real nature of this danger is the reason why the curette should not be employed, except in septic cases. The maternal decidua is thrown off by the natural processes in non-septic cases, and this is an integral part of the normal puerperal processes. To remove the maternal decidua under these circumstances is a work of supererogation. The argument in its favor, that the nidus for septic germs is thus removed, is not convincing, as if the case is not infected at the time the uterus is emptied, the probabilities of subsequent infection are slight. When contrasted with the real danger of puncturing the uterus, I believe that judicious men will advise that the practitioner avoid the use of the curette, except in infected cases.

As this paper deals only with the technique of emptying the uterus in inevitable abortion, a discussion of the cases in which this method should be employed, as distinguished from those which can be left to the unaided forces of nature, is not in order. Suffice it to say, that abortion occurring before the third month, and non-infected cases in which the ovum is intact and the hemorrhage trifling, can usually be left to the natural forces. Artificial interference is urgently demanded when infection has occurred, (which includes almost all cases of criminal abortion), in cases in which hemorrhage is free, and broadly speaking, cases in which the pregnancy has advanced beyond the twelfth week, more especially if the ovum be ruptured.