

# SKEEL (R. E.)

[Reprinted from THE MEDICAL NEWS, February 25, 1893.]

## THE USE OF THE CURETTE IN ABORTION.

BY R. E. SKEEL, M.D.,  
OF CLEVELAND, OHIO.

No one who forms the habit of examining the pelvic organs of all married women applying to him for relief from general nervous symptoms, as well as local evidence of intra-pelvic disease, can fail to be struck by the great number of cases of endometritis, salpingitis, and old pelvic exudates, dating from a miscarriage or abortion. In many of these cases the patient either did not employ a physician, or did not summon him until serious symptoms, such as profuse hemorrhage, foul discharge, or severe pain, had occurred. In other cases the physician was called, but resorted to the old temporizing measures, because the patient objected to active treatment, or because he did not believe it indicated. Nearly all, if not all, of these serious sequelæ might be avoided by proper treatment with aseptic or antiseptic precautions. Too often the medical attendant is inclined to relieve the mind of his patient by assuring her that she will be all right, trusting to luck to avoid any immediately serious consequences, and hoping that the remote ones will not be properly traced.

The ignorance of the laity is often a bar to proper



treatment, and we should do all in our power to educate them to recognize that an abortion is not a simple matter, but that, owing to frequent retention of secundines and, before the third month, the decidua vera, it is extremely likely to be followed by serious disorders.

The use of the curette is sometimes condemned in all cases in which membranes or placentæ are retained, unless serious symptoms supervene, and this objection is based on the theory that there is danger of infection, and that all shreds of decidua cannot be removed in this manner. Theoretically this does not appear to me to be true, and practical results prove that the immediate removal of all retained products of conception, and, before the third month, curetting to remove the decidua vera, is followed by results as nearly perfect as can be asked for. If we can fearlessly enter the uterine cavity and curette for endometritis, we can as safely do so for the removal of foreign matter retained there, and with as little danger of infection. Further, it has been proved that the cervical canal contains microbes that under ordinary circumstances are harmless, but which readily become virulent in the presence of dead animal matter. That all shreds of decidua can be removed I am certain, from an experience in a considerable number of cases.

Clinically, three classes of cases present themselves to us, leaving out of consideration those in which prophylactic measures may prove successful :

1. Cases of inevitable abortion.
2. Those in which the ovum, in whole or in part, has recently come away.

3. Cases in which, after the lapse of some time, hemorrhage, or decomposition, or pelvic peritonitis, has occurred.

In the first class of cases we meet with a few in which the hemorrhage is very profuse before dilatation has occurred, and here the great majority of authorities agree that immediate dilatation is required; with a careful scooping out of the ovum either with the finger or ovum-forceps. In addition to this, as we are obliged to enter the uterine cavity, it would seem advisable to use the curette in all cases occurring before the third month, for the purpose of removing the hypertrophied mucous membrane forming the decidua vera. If this is not curetted it will generally come away in shreds, and from the entrance of air it has abundant opportunity to putrefy and set up septic trouble.

In cases with only moderate bleeding the *anti-septic* tampon, properly used, will control the hemorrhage, and at the same time secure rapid dilatation and frequently expulsion of the ovum. If this comes away entirely, it may be debatable as to what is the best course to pursue. The vast majority of cases have no further trouble, but the thickened decidua is certainly a foreign body, and it would seem best to proceed with a thorough scraping. If the ovum is not expelled after a few hours, it should then be removed by the finger and curette, as nothing is to be gained by further delay.

In the second class of cases, unless we have seen the ovum and are positive that it is entire, it is far better to thoroughly but gently scrape over the surface with the Récamier curette, the danger from

this procedure being much less than that of retention of matter that so readily becomes septic.

The cessation of pain and hemorrhage is not positive evidence of the complete expulsion of the uterine contents, although the converse is undoubtedly true. In those cases in which hemorrhage persists or the lochia are offensive, no one will object to the removal of the retained matter, and here again the curette is the only instrument at all effective, removing, as it does, all shreds and attached portions of membrane, and leaving no nidus to favor the development of bacteria, to result in the production of a purulent or hemorrhagic inflammation of the endometrium in later years. When pelvic peritonitis has occurred, the same principles should apply, but the treatment, advocated by Polk, of subsequent drainage certainly looks feasible. In this class of cases there is not the immediate improvement which follows when a pure sapremia exists, but the primary infecting center should none the less be removed.

This operation can be safely performed with lay assistance only, if professional help is not obtainable. An anesthetic is rarely necessary.

A vaginal douche should first be given of 1 : 3000 hot bichlorid solution. The Kelly rubber pan or some similar receptacle is of great assistance. If the physician is obliged to do the operation unaided, the patient is placed in the lithotomy position, and the bivalve speculum, well sterilized, is introduced. The cervix is steadied with a tenaculum or tenaculum-forceps, and the sterilized sound is introduced

to ascertain the size, depth, and position of the uterus.

A Récamier curette, the large end of which is dulled by rubbing on a whetstone, or by filing, is introduced and the entire uterine cavity is thoroughly gone over without any great amount of force. Sterilized hot water or hot bichlorid solution, 1 : 10,000, is now used to wash out the débris, and, when no more comes away by washing, the uterine wall is again gently scraped, to ascertain whether anything still remains attached to it. If nothing more is removed, the uterus is again thoroughly washed out, a final vaginal douche is given, and the antiseptic pad applied over the vulva. Of course, perforation of the uterus is possible; but this ought never to happen if the curette is handled gently and no undue force is used.

I am aware that the principles urged in the foregoing are in the main those advocated by Hirst; but it is the writer's object to emphasize the connection existing between the retained products of conception and infection followed by acute or chronic endometritis, and to urge the use of the curette more generally to avoid these disastrous after-effects.

Like the uterine sound, the curette is capable in careless hands of doing great damage, but properly used it is also, like that instrument, invaluable.

