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**A Consideration of Certain
Doubtful Points in the
Management of Abortion**

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*A CONSIDERATION OF CERTAIN DOUBTFUL POINTS IN THE MANAGEMENT OF ABORTION.**

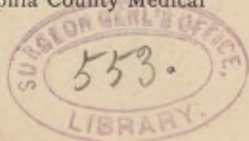
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There are many problems which come up for solution in the management of cases of threatened abortion, for the proper determination of which all of the resources of the practitioner are requisite. Few cases in clinical medicine make greater demands upon his tact, knowledge, experience, and judgment, for their proper treatment, than cases of threatened abortion. As a contribution to the study of the subject, I shall offer my own views concerning four of the problems which frequently present themselves. 1. When is abortion inevitable? 2. When is abortion complete? 3. After septic abortions, when shall irrigation of the uterus be discontinued? 4. After septic abortions, when shall operation *per vaginam* or by abdominal section be done?

When is abortion inevitable? Every practitioner of experience is aware of the delicate nature of the question as to when abortion is inevitable. Upon its proper solution depends,

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upon the one hand the chances for existence of a human being yet unborn, and upon the other hand the well-being, the health, and it may be the life, of the pregnant woman. Unfortunately it is difficult, if not impossible, to lay down hard-and-fast rules to determine when abortion is inevitable. It is currently believed that when hemorrhage occurs from a pregnant uterus, and contractions of the uterus have come on, abortion is inevitable; but I have seen these symptoms subside under appropriate treatment, and the pregnancy go on to full term, with the delivery of a living child and with no ill-result to the woman. In this connection reference may be made to a case reported by Scanzoni, of a woman who was seized with profuse metrorrhagia in the third month of pregnancy. Great numbers of clots were discharged, and, as all hopes of saving the ovum were abandoned, ergot was used in large doses, and tampons were placed in the vagina. After thirty-six hours, a sound was employed to explore the uterus; and finally, as the bleeding continued for three weeks, an intra-uterine injection of a weak solution of perchloride of iron was resorted to. Eight weeks later the patient quickened, and presented the distinctive evidences of a pregnancy advanced to the sixth month.* I, myself, was consulted in a case in which the pregnancy had contin-

* Lusk, *The Science and Art of Midwifery*, 1892, p. 319.

ued in spite of systematic application to the endometrium of pure carbolic acid, continued over some weeks.

When, in addition to hemorrhage of the uterus, there is a dilatation of the cervix and descent of the ovum, abortion may be considered inevitable. If a portion of the ovum has been discharged, or the liquor amnii has come away, or if septic inflammation has taken place, there is no question that the abortion is inevitable, and under these circumstances attempts to prevent the expulsion of the ovum should not be employed. Especially is it reprehensible to make use of such attempts if the discharges are foul-smelling and the patient is febrile.

The most puzzling cases are those in which moderate hemorrhage takes place from the uterus, unaccompanied by uterine contractions, and when the general condition of the patient continues good. Under these circumstances it is wise to keep the patient in bed for at least some weeks, before employing measures to empty the uterus. I recall very vividly the case of a lady about three months pregnant, who, on her way from church, was taken with a hemorrhage very considerable in amount; indeed, she was fearful that a sensation would be created on the street, and so had her husband walk behind her, lest the flow should be so great as to leave a trail of blood upon the pavement. This patient was kept in bed for some weeks, the hemorrhage persisting in slight amount

without other symptoms, and finally ceasing. She was delivered, at full term, of a living child. There can be no objection to temporizing under these circumstances, except that the time of the patient may be wasted through the lack of success of the method employed in preventing abortion. At the same time, too great care cannot be employed lest the persistence of bleeding, slight in amount on any one day, should eventually produce a grave anemia. Also, the temperature should be regularly taken, and other signs of infection looked for, lest an insidious infection should progress sufficiently to become serious before its recognition.

When is abortion complete? The classical maxim that the uterus should be emptied of all portions of placenta and membranes, and also of clots, both after labor and after abortion, is just as true now as when first enunciated. In abortions after the fourth month, there is usually little difficulty in determining whether or not the uterus has emptied itself, because both the fetus and the placenta have attained such size that an examination of them is of value, and besides, an exploration of the interior of the uterus, in case this should be necessary, can, as a rule, be carried out without special difficulty. During the first three months of pregnancy it is not so easy to determine whether or not abortion is complete. During the first two months, as a rule, the question is not of great importance, because nature usually takes care of the

abortion without much aid from the practitioner. In certain criminal abortions, when virulent infection of the endometrium has taken place, this is not true; but in these cases other problems present themselves, and the uterus should undoubtedly be explored and thoroughly curetted to remove the infected decidua, so that the mere question of whether or not a piece of the ovum remains behind assumes a relative rather than an absolute importance. It is during the third and fourth months that the practitioner is most often in doubt as to whether abortion is complete or incomplete. Spontaneous abortions, in which the ovum is delivered entire, present little difficulty, as the intact ovum is ample evidence that the uterus is empty. When the fetus and the chorion (or the placenta and membranes) are delivered separately, it is not so easy to determine the question, but an examination of the mass delivered will frequently settle it. If the practitioner only sees the patient after the abortion is supposed to have taken place, if hemorrhage has ceased, and if the cervix has contracted, it is a fair inference that the abortion is complete. Persistence of the bleeding, and a patulous uterine canal, are very reliable evidences that a portion of the ovum is retained.

Unless the ovum be delivered intact, the only absolute evidence that the uterus is empty is that afforded by the finger when introduced into the uterine cavity. When there is any reasonable doubt upon this point, in

abortions taking place about the fourth month, especially if the patient is not under absolute observation, it is best to settle the question by exploring the uterus under full antiseptic precautions. This can be done, as a rule, without anesthesia, and always with its aid. Two fingers or the half-hand should be introduced into the vagina, and one finger into the cavity of the uterus—the uterus itself being steadied through the abdominal wall by conjoined manipulation.

After septic abortions, when shall irrigation of the uterus be discontinued? It is universally recognized that in the treatment of abortion when infection has taken place, the uterus must be emptied of all portions of the ovum; and almost all authorities go further and advocate that the maternal decidua should be removed with a sharp curette. Following this thorough curetting of the uterus, douching of its cavity with an antiseptic solution is essential. When this method of treatment is instituted promptly, in a very large percentage of the cases it is followed by the best results. In some cases, however, and especially those in which the treatment has been instituted after considerable delay, the septic processes are not arrested before the infection extends either along the Fallopian tubes to the peritoneum, or through the lymphatics or the veins to the broad ligaments, giving rise either to localized inflammatory conditions in the pelvis, or to general peritonitis, or to septicemia. In this class of cases it is

of the utmost importance that too much reliance should not be placed upon the influence of uterine irrigation. Manifestly this can do no good unless it remove septic material from the cavity of the uterus, or assist in disinfecting the endometrium. When the infectious processes have extended into the deeper portions of the uterus or entirely beyond this organ, they are no longer influenced for good by uterine irrigation. I am heartily in accord with those who believe that uterine irrigations are distinctly harmful in all cases in which inflammation has extended beyond the uterus—the manipulation necessary to irrigate the uterus having a distinctly bad effect. My own experience leads me to believe that, if the uterus has been properly cleaned out and douched in the beginning, irrigations are seldom necessary for more than one or two days, and that if continued longer than this they are a source of harm rather than of good.

After septic abortions, when shall operation per vaginam or by abdominal section be done?
It is assumed that the abortion itself has been properly treated—by thoroughly emptying the uterus, by carefully curetting the endometrium and removing as much of the maternal decidua as possible with a sharp curette—and that then the uterus has been properly douched, and a pencil of iodoform, containing fifty grains, introduced. If this treatment and subsequent irrigations of the uterus with an antiseptic solution, continued

over one or more days, have failed to arrest the septic inflammation, the latter, as a rule, spreads rapidly either along the Fallopian tubes or into the broad ligaments.

The proper management of this class of cases is one of the burning questions of the day; indeed, conditions have not been ripe until the immediate present to properly study this question. Clinical experience has taught what can be expected under these circumstances when the cases are left to nature assisted by non-surgical measures of treatment. A considerable percentage of the milder cases, especially in patients having a vigorous vitality, will recover either perfectly or partially. In a larger percentage, septicemia, pelvic or general peritonitis, acute purulent salpingitis, and acute cellulitis and pelvic abscess, are among the usual results.

In localized pelvic inflammation, either in the Fallopian tubes, the ovaries, the pelvic peritoneum, or the broad ligaments, the methods of treatment proper in the individual cases have been pretty well agreed upon by authorities. Proper regulation of the diet, mild purgation, the use of ice or very hot applications over the hypogastrium, the exhibition of quinine and strychnine, and the use of baths, are methods of treatment applicable in all cases. Should evidences of pus-formation present themselves, or should indications appear that the localized pelvic inflammation tends to become a general peritonitis or to give rise to septicemia, operation

is indicated. Up to the immediate present, abdominal section and the removal of diseased structures, followed by irrigation and drainage, has been the accepted mode of treatment. At the present time the advocates of operation *per vaginam* will insist that this is a proper field for vaginal hysterectomy.

The class of cases concerning the treatment of which there is the most dispute just now, is that in which a septic abortion has been treated in the most approved way, including curetting and douching, and in which, in spite of this treatment and the continuance of douching for one or more days, together with the use of proper general treatment, the patient continues to go from bad to worse. The infection spreads from the uterus to the broad ligaments, or perhaps along the tubes, and the evidences of general septicemia are apparent and growing more decided. In the class of cases in question there is no attempt at the formation of an abscess, but the case tends to become one of general septicemia. It has been proposed to treat these cases by hysterectomy, either abdominal or vaginal, with drainage of the pelvis. Under the conditions laid down, I believe this practice to be eminently proper, and that it promises to save the lives of many who under the let-alone practice of the past would die. It is urged that if this doctrine receives approval, many women with septicemia after abortion will be subjected to hysterectomy without

warrant. I doubt this very much, as these patients are so ill that no surgeon will desire to operate upon them, except under the conviction that in so doing the patients' chances for life are increased. The cases coming under this category are those in which the women have been violently ill from the beginning, and who either improve or die within a week after the septic symptoms appear. If operated upon at all, it must be within a few days after the onset of the symptoms.

The milder cases—those in which the type of the septic invasion is less marked and the process tends to localize itself in the pelvis—seldom require operation until the later weeks of the puerperal month. It has been proposed, however, of late, in such cases to open up the broad ligaments from the vagina, and, in cases of localized pelvic peritonitis due to salpingitis, to open up Douglas's pouch from the vagina, and to pack gauze into the region of the tubes, so as to give free drainage for the products of inflammation. This procedure is so new that experience must determine its value. If, as its advocates claim, it will lessen the necessity of sacrificing the sexual organs because of the ultimate results of inflammation, it will be a great addition to the surgery of the diseases of women.

The proper treatment of localized pus-collections in the pelvis, whether of puerperal or non-puerperal origin, is so well recognized that it is unnecessary at this time to discuss

the question. The diseased structures must be removed; and in case of broad-ligament abscess, drainage must be employed.

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