THE USE AND ABUSE OF THE UTERINE CURETTE.

BY
R. P. McREYNOLDS, M.D.,
Philadelphia, Pa.

THE uterine curétte was first introduced by Récamier in 1846. It seems strange that previous to this time no one had conceived the idea of using a sharp instrument within the uterine cavity for the purpose of removing diseased tissue. The new instrument did not at first receive a flattering reception, and although it was condemned by surgeons from all parts of the world, the most intense opposition came from Récamier's own countrymen—Dubois, Velpeau, Avan, Becquerel, Gallard, Chassignac, Crede and others opposed it. Scanzoni was very severe in his denunciation of it; he claimed that it was based on erroneous theories and was void of all utility. Hildebrandt thought the curette would injure the healthy part of the uterus and allow the diseased part to remain intact. In our own country Parvin, A. Simpson, Barnes, and later on Marion Sims, Taylor, Howard, Barker, Byrne, Goodell, Palmer and others came out in favor of the

curette. Marion Sims, as we all know, modified and improved Récamier's curette, and to-day we have no better instrument than the one he has given to us. It seems strange that a progressive man like Emmett should have been so severe in his denunciation of the curette; in the 2d edit. of his book, Emmet's Princ. and Practice of Gynecology, page 617, we find this statement: "As regards the instrument of Sims, I honestly believe that the ingenuity of man has never devised one capable of doing more injury." He claimed to have seen peritonitis, cellulitis, pelvic abscess and even death follow the use of the instrument. Munde in his Minor Surgical Gynecology, expressed a decided preference for the dull curette, he claimed that it was safer, while quite as efficient; an opinion held by a good many of the older men. Notwithstanding all the adverse criticism, the curette gradually increased in popularity and came more and more into general use—in fact there seems to have developed a mania for curetting the uterus, and the operation was resorted to for all or nearly all of the ills of womankind. Vulliett in referring to the craze very aptly described it as "Curomania." It might perhaps be compared to the "Ovariomania" of a few years ago. I think I can truthfully say that these diseases do not exist to-day, and that the indiscriminate curetting of the uterus and removal of ovaries and tubes is no longer fashionable. The more accurate and scientific knowledge of the uterine conditions requiring the use of the curette has in no way lessened its popularity or restricted its usefullness. The curette is to-day in the hands of not only every gynecologist and obstetrician, but of nearly every general practitioner throughout the country. A distinguished New York gynecologist says, "If I had to have one instrument to treat a woman I would beg that one to be a sharp curette." When we consider how extensively and universally the curette is used we would naturally expect to find some cases where harm rather than good has resulted from its use. I have operated upon women suffering from the effects of sepsis caused, I suspected, from the too zealous use of the curette in the hands of the family physician.

This article is based upon the study of 170 cases of curettement and is prompted by a desire to point out in a general way some of the conditions in which I have found it to be beneficial, and others in which it is liable to be followed by serious and perhaps fatal complications. I use the sharp curette almost exclusively, but do not agree with those who claim that the dull curette should be

forgotten. I occasionally find use for a large dull curette, and should hate to see it taken from my instrument case.

Endometritis hyperplastica chronica or polyposa (Olshausen); subinvolution of the uterus; puerperal conditions of the endometrium caused by the retention in utero of some of the products of conception, yield promptly, as a rule, to a thorough and careful curettement of the uterus, unless there is already present disease of the adnexa, or a general septic infection. I scarcely even find it necessary to leave a packing of gauze in the uterine cavity, and when I do I make it an invariable rule to remove it within twelve hours. I can conceive of no condition requiring gauze packing or drainage to be left in the uterus for from five to seven days as advocated by Burrage, or from two to five days as advocated by Vanderveer and others.

A great many of these cases, especially those following abortions and miscarriage, have suffered severely from pain and hemorrhages before we see them, and when they come to us they are profoundly anemic and often septic; a curettement is accompanied by more than the usual amount of danger; they take the anesthetic badly and we must always bear in mind the possibility of shock, perforation of the uterus, pulmonary embolism, and septic pneumonia. We make it a rule to give them the minimum amount of ether (no other anesthetic should ever be used), and to finish the operation, if possible, during the primary stage of anesthesia, all the preliminary part of the operation, the washing up, etc., being done before the anesthetic is started. We use for the curetting, the finger (if the cervical canal is dilated sufficiently to admit it), followed by a large, moderately sharp curette, or sometimes a large dull curette; the uterine cavity is irrigated with hot (110° or 115°) water, or normal salt solution. We have given up all antiseptic solutions for this purpose and think safer and better results are obtained by using the hot water or normal salt solution. If the uterus does not contract as it should, we can nearly always bring this about by packing the uterine cavity with gauze and then minipulating the uterus between the finger in the vagina and the hand on the abdominal wall; the gauze is then removed, and if it is reapplied only a small strip is left in the uterine cavity.

In malignant growths not permitting a radical operation, a careful curettement and the free use of the cautery, followed by chloride of zinc gives surprisingly good results; the pain, foul discharge and hemorrhage are relieved, life is rendered much

more comfortable and materially lengthened. In fact it is an open question if this procedure does not in the majority of cases we see suffering from cancer of the cervix, give as good, if not better, results than a vaginal hysterectomy. In curettement for diagnostic purposes, I regret to say that my results have not been entirely satisfactory; we cannot always get a scraping from the diseased foci and besides the personal equation of the pathologist enters into it very largely. A man may be a good general pathologist and yet very inaccurate when he attempts to make a diagnosis from uterine scrapings; the pathological report should be only a contributing factor in the diagnosis, and the clinical history and examination should never be neglected, or its importance underestimated.

In septic conditions when the infection has passed through the endometrium into the muscle of the uterus, to the Fallopian tube or to the cellular tissue around the uterus, or has been carried by the lymphatics to the ovaries or elsewhere over the body, no appreciable benefit comes from the curettement, except to establish the diagnosis and to prove that the uterine cavity is free from all decomposing and septic material. This is the only way oftentimes, to distinguish between a sapraemia and septicaemia. It has been claimed by some that they have gotten good results from curetting the uterus in acute salpingitis. Pryor, among others, advocated it. I cannot agree with them and should much prefer not to curette in such cases, if I knew the uterine cavity was clean.

In endometritis, accompanying submucus fibroids, I have failed to see a curettement do any permanent good. It has been advocated as a method of stopping the hemorrhage (from which these cases often suffer profusely), and it has been claimed to have caused the fibroid to disappear. Dr. Noble's recent work upon fibroid tumors shows so conclusively and clearly the dangers from malignant degeneration in these tumors, that it would seem foolish to waste time upon a curettement, provided the woman's condition will permit a radical operation, and the size, position, rapidity of growth, etc., of the tumor demands it.

In gonorrheal endometritis I have gotten anything but satisfactory results from curetting the uterus and swabbing out the cavity with pure carbolic acid, tr. iodine, etc. I have now and then had a case which I though was benefited by it, but they have been the rare exception and not the rule. Yet I continue to advocate this treatment, for I know of nothing better to do in those cases where the woman refuses a radical operation, and where

the symptoms and the apparent disease of the adnexa do not seem to be sufficiently grave to warrant a radical operation. I wish someone would tell us what is the best treatment for gonorrheal endometritis.

Chronic Endometritis.—Sims of New York has advocated a curettement and drainage of the uterus for such cases; he reports a number of successful cases so treated. I have never, I think, seen but one case benefited by this treatment, and shall, in the future, advocate a radical operation from the start. I have often seen a woman suffering from salpingitis, wonderfully improved temporarily, by rest in bed, hot douches, etc. However, when these patients get up and resume their usual occupation, the symptoms return and sooner or later they have to have a radical operation. In dysmenorrhea from pathological flexions, the result from a dilatation and curettement are good. Sterility may be cured and many of the symptoms from which the woman seeks relief are permanently alleviated. In dysmenorrhea from neurotic conditions, infantile uteri, uterine adhesions, disease of the adnexa, etc., and from general conditions, as pulmonary tuberculosis; cachexia, from malignant diseases; anemia; chlorosis, etc., harm, rather than good, follows the curettement; the less tinkering with the womb the better it is for the woman. Major operations upon the adnexa should be preceded by curettement of the uterus (unless there is some contra-indication). I am thoroughly convinced that both from a theoretical and a practical standpoint this is the proper surgical procedure and should be routinely carried out. We often find a unilateral salpingitis, and the tube and ovary of the opposite side apparently normal. We operate on the diseased side and allow the other to remain; later on we are called on (generally another surgeon is called on), to operate the second time for disease of the remaining tube and ovary. It seems to me that this can be prevented to a certain extent by the preliminary curettement; it may not cure the endometritis, but it may prevent the infection from going into the other tube. I agree fully with the statement made by the late Dr. Pryor, who says that the preliminary curettement lessens the leucorrhea, hemorrhage, backache, etc., which too often are the aftermath of major operations upon the pelvic organs. It certainly increases the time of the operation and adds to a certain extent to the dangers of infection, but it seems to me that by the use of rubber gloves we can minimize the danger of infection, and

that no stone should be left unturned at the time of operation which will add to the future comfort of our patients.

3722 Walnut Street.

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