CLINICAL LECTURE

ON

THE TREATMENT OF CHRONIC
ENDOMETRITIS.

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I PROPOSE to call your attention to-day, gentlemen, to the subject of chronic endometritis, a disease of very frequent occurrence. It is quite common in married women who are sterile, and is far from being rare even in virgins. It also occurs frequently as a result of imperfect involution of the uterus; and in aggravated cases may terminate in complete disorganisation of the intra-uterine mucous membrane. Such extreme cases are, however, rare.

All cases of chronic endometritis naturally divide themselves into two classes; namely, those which occur in women who have borne children, and those who have never been pregnant. The course, symptoms, and treatment of these two classes are essentially different. I shall first briefly allude to the affection as it occurs in those who have borne children.

In the great majority of such cases, the patient's attention will be attracted to her condition by the occurrence of derangement of the menstrual function, which generally, in the first instance at least, becomes profuse, and often painful; leucorrhœa, too, is generally present. On proceeding to examine the patient, the cervix will be found to be thickened, the os patulous, the lips perhaps everted, and possibly in a state of granular erosion, while a copious discharge, thick, opaque, and tenacious, issues from it; the cervical canal also is patulous, and the sound will pass with ease through the relaxed os internum. Nevertheless, its introduction often causes pain, either at the os internum or when its point reaches the fundus. If the sound cause pain as it passes through the os internum, menstruation is, I believe, always painful; but if the extreme sensitiveness be confined to the fundus, this may not be so. Dr. Routh is of opinion that in some instances that portion of the endometrium situated between the openings of the Fallopian tubes may alone be diseased, and he terms this "fundal endometritis". I much doubt, however, if the affection be ever limited to so circumscribed an area. As the disease progresses, the mucous membrane lining the body of the uterus becomes disorganised. This is manifested, as already pointed out, by derangement of the menstrual function, which becomes painful, or profuse, or both, and it is not till this stage is reached that, as a rule, the patient seeks medical aid; true, she will in general complain of pain in the back, of a feeling of weight in the pelvis, and perhaps of a bearing-down sensation; but when contrasted with the disease as it occurs in the unmarried or sterile woman, endometritis in the woman who has borne children produces comparatively little discomfort, and, except when the patient is run down by profuse or constantly recurring hæmorrhages, comparatively little constitutional disturbance.

Here is a typical case. Mrs. —, aged 25, gave birth to her first and only child three years ago. She nursed but a few months, and then, menstruation recurring normally, she weaned the child. Shortly afterwards, her husband became ill, and for many months she tended him by day and night; notwithstanding which, her general health continued tolerably good, and it was not till after the lapse of quite a year that the occurrence of repeated attacks of profuse menstruation, latterly accompanied by acute pain, compelled her to seek relief. In her case, the os uteri was very patulous, and the cervical canal blocked up by a mass of thick semipurulent mucus. When the point of the sound reached the os internum, she complained of sharp pain. I treated this patient by the application of carbolic acid to the fundus, applying it twice a week for about two months. The first menstrual period after the commencement of this treatment was perfectly painless, but was very profuse, and lasted for seven days; the next was equally painless, and was over in four days. Since then, the function has been perfectly normal, and the uterine catarrh has disappeared.

The treatment just mentioned will often prove efficacious, provided the case be of recent origin; but if it be of long standing, and if copious uterine catarrh or menorrhagia be present, more active treatment is called for, that which I usually adopt being, as you are all aware, the application of nitric acid to the whole of the cavity of the uterus.

In all cases where much tenderness on pressure exists, local blood-letting should first be practised; this is a rule from which I make few

exceptions. Local blood-letting relieves the pain to a considerable degree, and certainly favours the action of other treatment, whether that consist of medicines administered by the mouth or applications made directly to the diseased surface.

Endometritis occurring in virgins, or in women who have never been pregnant, runs a very different course. In the great majority of cases, these will seek medical aid either for the cure of sterility, or, more generally, with the view of procuring relief from the sufferings which they experience at each menstrual period. I will first trace a case as it occurs in a married woman. On being questioned, she will, as a rule, tell you that prior to marriage menstruation had been normal, or at least attended with but little suffering; that, after marriage, the function gradually became more painful, and that this increased in intensity till she was compelled to seek relief. On making a vaginal examination, you will find the cervix uteri to be elongated, probably swollen and congested; frequently too, indeed I think in the majority of cases, antelexion of the fundus will be found to exist, the os uteri is small and annular, and frequently we shall be able to see a clear and slightly viscid discharge to exude from it.

Now, the pathology and causation of these cases is, I think, this. They always occur in women in whom either the cervical canal is contracted and the cervix conical, or in whom some congenital flexion of the uterus exists; the canal, narrow though it be, sufficed before marriage to permit without difficulty the exit of the menstrual discharge, but under the influence of the excitement caused by sexual intercourse, a greater quantity of blood flows towards the uterus and ovaries; the mucous membrane lining the cavity and cervix becomes unduly swollen and vascular, and, as a result, an increased amount of blood is, at the menstrual period, poured out into the cavity of the uterus; the swollen condition of the mucous membrane at the os internum and in the cervical canal renders the originally narrow passage almost impermeable, the menstrual flow is retarded, and, as a result, the blood coagulates in the distended cavity, and thus becomes virtually a foreign body. It excites the uterus to contract; and after much suffering, it is expelled; relief then for a time is obtained, but the same process recurs over and over again, and in time, permanent irritation of the intra-uterine mucous membrane is excited. And now the patient's sufferings are not confined to the menstrual period alone; for, in consequence of the unhealthy condition of the intra-uterine mucous membrane, its secretion is increased in quantity and altered in character; it becomes viscid, and exudes slowly from the uterus. Often its exit is impeded to such a degree that it distends the cavity, inducing permanent dilatation, and often hypertrophy, of the whole organ, aggravating the previously existing irritation of the lining membrane, and causing great distress and pain to the patient.

If these cases be neglected, the whole system suffers; the ovaries are specially liable to be implicated; the irritation set up in the uterus seems to be propagated to them; they become enlarged, painful to the touch, and the source of great suffering; the bladder often sympathises, and the patient suffers from irritability of that viscus; then reflex irritations manifest themselves; the breasts become painful, the appetite fails, and often there is nausea and even vomiting; in a word, chronic endometritis in a nulliparous woman is a most serious affection, causing great suffering and undermining health, not rapidly indeed, but surely, while sterility is an invariable result. Unfortunately, too, it is a most obstinate affection. If the case be of old standing, the hope of doing much for the patient is but small; if, however, it have not gone on too long, the prospect of effecting a cure is good; but to do this, it is essential to bear in mind the pathology of the disease, the basis of which is that the conical cervix and contracted canal, coupled with antelexion when it exists, prevent the menstrual discharges and viscid secretions of the diseased lining membrane from obtaining easy exit. The first step, then, towards effecting a cure is to ensure the free escape of the contents of the uterus. There is but one means of effecting this—the cervical canal must be divided. I lay this down as an axiom from which there are few exceptions, that it is almost impossible to cure chronic endometritis in the nulliparous female in whom a conical cervix and contracted cervical exists, unless the cervix be divided. I have tried every other possible method, including the free use of nitric acid after dilatation of the cervical canal, to find my patient, after the lapse of a few months, in no way improved. The following affords a striking example of this. It is interesting, too, from the fact of its being the first case in which I divided the cervix for the cure of endometritis, my previous operations having always been for the relief of painful menstruation.

Mrs. —, aged 36, married ten years, came under my care four years ago. She stated that, previously to marriage, she had always enjoyed good health, but that, some months subsequently, she suffered from a severe attack of pain in the region of the uterus. This after a

time subsided; but from that date she never was perfectly free from suffering, till of late, though naturally of very active habits, she had been compelled to give up taking exercise nearly altogether; for years, too, she had been off and on under medical treatment, without even obtaining permanent benefit. She suffered from constant headaches (these occasionally were very severe), from indigestion, flatulence, and constipation. She was unable to walk; for, on attempting to do so, she was always seized with pain, referred to a point corresponding to the fundus of the uterus. This pain lasted for some time, then she would obtain relief; and immediately after, invariably perceived a copious viscid discharge to exude from the vagina. These attacks of pain and subsequent leucorrhœal discharge occurred even when she remained quiet; though then the intervals between them were considerable. Walking, however, always brought them on. I subsequently satisfied myself that these attacks of pain were due to the efforts of the uterus to expel the copious secretion which collected in it.

On making a vaginal examination, I found that the cervix was conical, and the os so small that I could not introduce an ordinary sound, but had to use a fine probe; the fundus was large and heavy, and slightly painful to the touch; there was no abrasion; but, though pressure with the fingers on the fundus caused but little pain, sexual intercourse was always productive of suffering.

I decided on treating this case by applying nitric acid to the fundus, but as this was impossible in the contracted state of the cervical canal, I introduced a length of No. 3 sea-tangle bougie into uterus, and after the lapse of twenty-four hours was, on withdrawing it, enabled to introduce a platinum cannula, and through it apply the fuming nitric acid. The result was for the time very satisfactory. She improved wonderfully, and lost most of her distressing symptoms, and I saw no more of her for four months, when she again consulted me, saying that she was as bad as ever; and, on making a vaginal examination, I found that she had relapsed into her former condition—the os uteri was as small and the catarrh as copious as ever. On considering this case, I became convinced that till I gave free exit to the pent-up viscid discharge no permanent benefit would follow; and believing that division of the cervix would alone effect this, proposed the operation to her. She at once agreed to submit to it, and I accordingly performed it, dividing the cervix bilaterally, in the manner described in a previous lecture. The result has been most satisfactory. She recovered without any drawback, has ever since steadily improved, and now, after the lapse of several years, is quite free from suffering, is able to take long walks, and leads a most active life.

After the divided surfaces have healed, and that no danger of exciting inflammation exists, it is generally necessary to apply carbolic acid, or some other caustic, up to the fundus; in fact, I always keep the patient under observation for some weeks subsequent to the operation. The length of time during which it is necessary subsequently to continue intra-uterine medication must depend on the previous duration of the disease, as well as on the severity of the symptoms. In the case just related, I applied carbolic acid several times to the fundus subsequent to the operation.

In this case, the patient has remained sterile; indeed, I had no hope that conception would follow in her on the cure of the endometritis; the disease was of too long standing. As a rule, I object to perform the operation of dividing the cervix, simply with the view of removing sterility; conception doubtless sometimes does occur after the operation, not because the cervix is rendered patulous, but because the membrane lining the interior of the uterus being rendered healthy, conception becomes possible. The following case is an example of this.

Mrs. K., aged 26, had resided in India, and ever since her marriage, five years ago, has never become pregnant. Menstruation was normal and nearly painless. She suffers, however, constantly from backache and much discomfort in the left ovarian region; is quite unable to take exercise, as walking brings on pain. She was specially anxious to have a family, and returned from India, and sought advice, more with the view of having sterility removed than for the relief of her sufferings. On examining her, I found the cervix to be conical, and the fundus acutely anteverted; there was also a good deal of uterine catarrh. The probe passed to the depth of nearly three inches. As this case was by no means a severe one, and evidently not of long standing, I decided on endeavouring to avoid dividing the cervix, and accordingly introduced an anteversion pessary, punctured the cervix, applied carbolic acid to the fundus, gave bromide of potassium in full dose, and found the patient's condition steadily to improve. All her symptoms subsided; the flexion, however, remained unaltered. After a time, I sent her to Ems, where she remained for some weeks, and returned in a very satisfactory state. Her husband, who during this time had remained in India, now joined her, and they travelled about for a couple of months. On returning to Dublin, just a month before they were to start for India,

she called on me and said she had again of late begun to suffer as much as ever, and on examining her I found her to be in exactly the same condition as when I had first seen her five months before. I at once told her that all she had done had been useless, and that there was no chance of a cure except she submitted to have the cervix divided. She readily consented. I divided the posterior wall of the cervix only, this being the operation I always perform in cases of anteversion. She sailed for India in four weeks from the date of the operation, soon after became pregnant, went to the full term of utero-gestation, and gave birth to a healthy child.

I have given these two cases in detail, because they show how useless any attempt to cure endometritis in sterile women is, unless, as a preliminary step, free exit be afforded to the discharge which invariably collects to a greater or less extent in the cavity of the uterus. And if I have succeeded in impressing this fact on your minds, your failures in your future practice will be lessened very considerably.

ON THE CURE OF DYSMENORRHOEA, STERILITY, AND CERTAIN AFFECTIONS OF THE UTERUS, BY A NEW FORM OF ELASTIC INTRA-UTERINE STEM.

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THERE is great difference of opinion among gynecologists as to the utility and safety of intra-uterine stems—a difference made manifest in a recent discussion at the Obstetrical Society. Notwithstanding the very adverse opinions as to the use of these stems expressed at this discussion, I am convinced that there is an increasing tendency to employ them, as exemplified in the many modifications which have been made in their construction since the year 1844, when they were first introduced to the notice of the profession by Sir James Simpson, and by the large number of these instruments sold by the instrument-makers to practitioners specially engaged in the treatment of the diseases of women. For my own part, being at a loss to imagine how certain mechanical affections of the uterus can be otherwise satisfactorily treated, I am constrained to assume the necessity of some such contrivance.

Before I describe my thoroughly efficient intra-uterine stem, the outcome of many failures and partial successes, it may be interesting to many little conversant with this subject to take a cursory glance at some of the steps which led to the adoption of intra-uterine stems. It is recorded that Aëtius recognised a contracted os uteri as a cause of sterility, and he is supposed to have treated this strictured condition with sponge-tents; but, passing over the dim records of ancient surgery, we come in recent times to the late Dr. Mackintosh of Edinburgh. This acute observer, in the second volume of his work on the *Practice of Medicine*, gives a graphic account of the sufferings wrought by persistent dysmenorrhœa, sets forth the insufficiency of all methods hitherto devised for its cure, and then makes the remarkable suggestion that many cases of painful menstruation might be due to some obstruction, for which condition "mechanical dilatation appeared to be the only remedy". For some years he hesitated to carry this conception into execution. At length, in the year 1826, he put his idea to the test, with such success that he was emboldened to repeat the experiment in numerous cases. In the year 1836, he thus records his experience: "In twenty-seven women, twenty-four cures have taken place, and of these eleven have since had children": an amount of success never since exceeded, if equalled. "The instruments employed to produce the dilatation were the common metallic bougies, of different sizes, from that of the ordinary small silver probe to No. 14." During the year 1844, Sir James Simpson published in the *Edinburgh Medical Journal* (page 734) an account of his permanent metallic stems of various sizes, which, he stated, "gave much less pain to the patients, and less trouble to the practitioner; were more certain and expeditious in their effects". He further stated "that he found the stricture occasionally at the os internum or opening between the cavities of the cervix and body, and not at the os tincæ": a statement the correctness of which I, in common with other observers, have since fully verified. In fact, the obstruction in the majority of cases is situated nearer the os internum. In cases where the external os uteri is small, particularly where the neck is conical and elongated, with a canal scarcely admitting the introduction of an ordinary sound, the menstrual flow scanty and of short duration, mostly indicative of