REMARKS

ON

THE USE OF THE INTRAUTERINE DOUCHE AFTER LABOUR, WHERE OFFENSIVE LOCHIA EXIST, AS A RULE OF PRACTICE.*

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I NEED scarcely apologise for occupying your attention for a few moments, because the subject I am anxious to allude to is one of deep anxiety to us all; namely, the diminishing of the frequency of puerperal fever.

Amongst the many advances made in obstetric knowledge of late years, there are none more important than the recognition of the contagious nature of some, if not of all, kinds of puerperal fever. I think, also, we have sufficient evidence before us to assume the certainty that some zymotic diseases, as scarlatina, diphtheria, typhus and typhoid, measles, erysipelas, will, if imbibed by the pregnant or puerperal woman, produce symptoms so exactly like the so-called puerperal fever, that, having no means of distinguishing them, we are justified in concluding that an animal poison, whether one or many, is concerned in the production of the symptoms of all the different forms, whether introduced from without or engendered within.

We may divide cases of puerperal fever into three great classes:

1. Those derived, mediately or immediately, from the above named diseases; or *exogenetic*.
2. Those arising from poisonous discharges within the passages; or *endogenetic*.
3. Those in which sudden mental impressions or exposure have affected the blood by check of secretions.

Any two of these may coexist, and increase the severity of the case.

Now, the first class is the most frequent. Probably, in private practice, it forms three-fourths of the cases. In private practice, the most frequent origin is scarlatina; in hospital, erysipelas. But, as we increase our care in not exposing the pregnant and puerperal woman to these diseases, and avoid the herding together of a large number of lying-in women, the less will this class become, and the more prominently will the second class appear—namely, that form which is derived from the decomposition of blood, placenta, etc., within the uterine cavity; and it is to this class that I wish to draw your attention.

We all know that a clot is apt to be retained within the uterus after delivery. Sometimes it gives rise to flooding, and then is generally removed. But perhaps it may not be so large as to cause hæmorrhage; but, the uterus being active, it causes irritation to it, and after-pains are produced (indeed, it is probably the usual cause of this painful affection); or sometimes it remains within, attention not being called to it at first. Sometimes the clot is an old one, formed during pregnancy, adhering firmly to the uterus, so that it cannot be expelled; or it may have been formed during labour, and become adherent; or it may have been formed in the uterus, after the expulsion of placenta, and the uterus have failed to expel it from inertia, though without bleeding occurring. In placenta prævia, peculiarly liable to be succeeded by toxæmia, we find that there are clots adhering about the lower part of the uterus, preventing the free escape of the lochia. By either of these means, a clot may remain *in utero*, and, after a few days, generally the second or third, give rise to offensive discharge. A piece of placenta or membranes may also produce the same result, as is well known. In low states of the system, also, the discharges alone may decompose and cause offensive lochia. However, from whatever source we may find decomposition going on in the uterus, the patient is liable to have some form of blood-poisoning, with or without symptoms of local inflammation.

The case need not go on to a fatal termination, but we may have toxæmic symptoms in varying proportions. I can hardly call to mind a case in which, where puerperal trouble existed which could not be traced to the causes of the first class, but that there has been offensive lochia.

The first symptom, besides the rise of pulse and hot skin, is the short cough and peculiar hepatic breath, restlessness, and perhaps delirium; and then all the well known symptoms. The head possibly may sym-

pathise, producing sometimes, in the excitable brain, the so-called acute puerperal mania. It is a curious fact, that, in all the cases of acute puerperal mania which I have seen, only two have been free from offensive lochia.

But it is very important that we should recognise under the head of this second class not only those cases which rapidly prove fatal, but a variety of conditions, more or less intense, which are all fairly referable to absorption of poisonous matter. Many of those cases which are called *debility* are referable to this cause, where there is a quickened pulse, slight cough, sallow hot skin. You will almost invariably find that there has been offensive discharge from the vagina.

When we consider the large area of the internal surface of the uterus, and recollect the amount of bruising and abrasions of the os uteri, and also of the vagina, which occur during labour, it is not difficult to see that the absorption of deleterious matter would take place with great freedom upon the decomposition of a clot or of the secretions. It is not necessary that there should be large open sinuses (though this would be difficult to occur without hæmorrhage, if they were open enough to absorb); it is merely sufficient that there should be contact with a highly vascular surface, whose absorbents and capillaries are scarcely protected. The effect of absorption of decomposing matter is clearly seen in those cases where suppuration occurs, with decomposition, within an ovarian cyst, where no abrasion has taken place. The symptoms are precisely similar, but seldom so intense. Absorption from an adventitious cyst is also well observed, as in some cases of extrauterine foetation.

Therefore I think it will be admitted that decomposition of clots, etc., and secretions, not infrequently take place; and that, when they do, serious and even fatal symptoms are to be apprehended. If this be so, then it follows that their removal would be the proper thing to do. This would seem a self-evident conclusion; but, if we look to the generality of practice, we find that either this inference for practical purposes has not been drawn; or that, if it have, something has intervened to prevent its being employed. I do not here mean to say that many practitioners have not from time to time done so as a rule; but from the works on midwifery I gather no such recommendation; nor in general have I found medical men considering it a useful or necessary procedure. I shall, however, assume that you will all agree as to the truth of the inference.

What, then, has intervened to prevent us from freeing the uterus from these offensive contents? I can hardly tell, but I fancy it has been for two reasons—first, because of the trouble and annoyance it might cause the patient; second, the fear lest some injury might be produced by washing out the uterus.

Now the first may be reduced to a minimum by care and management. If the patient lie on her side, you need not disturb her; but, placing some small basin or tray (a tooth-tray answers very well) against the lower buttock, you can catch nearly every drop of injected fluid: a towel beneath will save the rest. The clothes should only be turned back to enable us to work properly. The tube best suited is the long elastic one of an enema-syringe, with the opening at the end. After attaching it to the syringe, and carefully expelling the air, pass two fingers gently up to the os uteri; then, guiding the tube by these, pass it into the os, gently onwards to the fundus; as soon as it meets with a check, stop; and then gently throw up the fluid, allowing it to escape as fast as it is injected. This is important, to prevent any accumulation in the uterus; but the os is always so open in these cases, that no apprehension need occur, unless we pass in the fluid too rapidly. The vulva sometimes retains the fluid. I therefore see that there is no retention in the vagina. If all this be done gently, no pain need be caused; and no excitement need arise in the patient's mind if it be considered only an ordinary vaginal cleansing.

Now, as to the fear of injury, I am able to say this much, that I have never seen or heard of a case in which it has done anything of the sort. I have used it extensively myself for some years; and we use it in the Lying-in Charity of Guy's Hospital very frequently, but without any untoward result.

There may be a third cause why, as a rule in practice, the procedure has not become recognised; namely, that it is considered that, when the serious symptoms have fairly commenced, so much mischief has ensued, that the time is past for any chance of benefit; the poison acting as a ferment, increasing as it passes through the system. This is quite erroneous. In the cases in which it has been tried before the typhoid symptoms have set in, the subsidence of all the irritative symptoms has been very marked. Immediately after, the patient expresses herself much more comfortable; and in twenty-four hours the whole character of symptoms has changed for the better; the uterine tenderness and enlargement have diminished; and in another day the principal anxiety has subsided. From what I have noticed, I think that the poison is elimi-

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nated from the blood in about twenty-four hours; so that in the first few days, in the generality of cases, it requires a constant supply of poison to keep the system under its influence to the same point.

The injection which I use generally is warm water at blood-heat, to every half-pint of which is added one drachm of solution of permanganate of potass. I prepare at least a quart, and use it till the lotion returns of its proper colour. Any other disinfectant may be employed; but this acts very nicely, without any risk, and tells when it has completed its work. In any case, it is better to use a weak solution, making up in the quantity of fluid used.

The ordinary syphon-syringe is very convenient, as is also the French enema-apparatus. Both these are worked by one hand.

From what has been remarked above, it may be gathered that I would have it established as a rule of practice, that, whenever offensive discharges occur, which are not removed by ordinary vaginal injections, we should at once wash out the interior of the uterus once or twice a day. But I would further add that I believe, if this were systematically done early in every such case, then we should in a large measure do away with the endogenous form of puerperal fever; and here I would remark, that even a very offensive state of the interior of the uterus may exist without manifesting itself very noticeably in the room. Upon two occasions I have seen very offensive fragments of placenta removed, and scarcely a suspicion of any putridity existed. Thus, provided we could keep the exogenous cause from the pregnant and parturient woman, and then remove the endogenous source from the puerperal one, we should reduce puerperal fever to its lowest point; at which point I should not despair of arriving, if every one would assist to this desirable end.

I shall not detain you with recitation of a number of cases, but shall instance a few which exemplified the benefit of the treatment.

Mrs. B. was taken into Guy's Hospital for induction of premature labour for a small pelvis. It was begun by dilating the os uteri with the elastic bags. The placenta was found presenting. However, upon its being dilated a sufficient size to admit two fingers, the placenta was detached from the cervix; the child turned by the combined external and internal version, and in due time delivered. An hour after delivery of the placenta, the uterus relaxed, and considerable hæmorrhage ensued. This much reduced her. On the third day, the uterus became enlarged and tender, the lochia offensive. She had rapid pulse; furred tongue; and anxiety of countenance. The day following, these symptoms increased; upon which I ordered the uterus to be syringed out with warm water, introduced through a gum catheter. This was done, with very considerable immediate relief to the patient; but the next day the change was very rapidly for the better. The uterus had become markedly reduced in size, and the tenderness nearly gone. Nearly all the irritative fever had subsided, and by next day was quite gone. She rapidly lost every untoward symptom, though the loss of blood and free leucorrhœa from chronic endometritis kept her weak some time. I may add, that the uterine douche was continued for some days.

The next case was somewhat similar, as far as the reason for induction of labour, and its complication with placenta prævia. It was treated in the same way; but the placenta was adherent, and the uterus very inactive, so that the hand had to be introduced to detach it; and much difficulty was experienced in getting it to contract, whereby some loss of blood ensued. However, the uterus at last contracted firmly; and, next day after, pains of much severity came on, lasting for upwards of two days, when suddenly portions of clots came away, with a little fresh blood and offensive discharge. On examining the os, I found some firm clots still adhering just inside the cervix, where the placenta had been situated; these I carefully removed. Next day, the offensive discharge filled the room with the odour. The pulse was 120; skin burning; tongue brown in the centre, with much thirst; a short cough, which had not existed before; and a peculiar odour in the breath, like the hepatic breath. In fact, the whole symptoms were indicating the rapid approach of puerperal fever. I washed out the uterus well with weak lotion of permanganate of potass. The patient felt more comfortable afterwards; but next day, on visiting her, I found her wonderfully better. The above symptoms were, however, all present; the cough was still troublesome, with much expectoration. The injection was repeated. The next day, every anxious symptom had gone, with the exception of the cough, which lasted some days. The offensive uterine discharge lasted only two days. The douche was used three days. The patient recovered fairly, being, of course kept quiet rather beyond the ordinary period.

I was asked to see, in consultation, a primipara who had been delivered a week. She had been ill three or four days. I found the room very offensive, from the discharge from the vagina. The pulse was 120 to 130; temperature 106° F.; tongue brown and dry in the middle; skin dry; respiration quick; considerable delirium; and hurry of manner.

Milk was not secreted, and the lochia was colourless and very offensive. Indeed, the case appeared one hastening rapidly to a fatal termination. I recommended the interior of the uterus to be washed out with warm and weak solution of permanganate of potash twice a day, with quina in pill, and chlorate potash and ammonia. The next day she was better, and gradually improved for five days. The injection was then omitted, and the offensive discharge recurred, with an increase of the symptoms. On repeating the injection, these improved. It was continued till the tenth day, when she objected to the disturbance it caused, and it was omitted altogether. She had for some little time after this an offensive discharge, which finally ceased, and she made a slow but steady recovery. Of course, it is difficult to say how far the douche saved the patient from a fatal termination; but, from what I have seen of the disease, I have every reason to think that it materially aided to her recovery. The cause of the offensive discharge was not apparent.

I have employed the douche in some cases of adherent placenta, after labour and in abortions, as a preventive, where a portion has been agglutinated to the uterus.

As the retention of clots in the uterus is liable to be followed by serious symptoms, our indication is, no doubt, to get the uterus to contract as firmly as we can, so as to expel the mass, which it frequently does next day, and thus saves the patient further risk.

You will, I dare say, have observed that the firm contraction of the uterus is no proof that a clot does not exist within, because it is sometimes retained by the very firmness. Its bulk often indicates its presence, especially if there be a rather obstinate trickling and a firm uterus. It is not my intention to go into this question more than to say that, if we have every reason to think there is a clot in the uterus after labour, it is well to pass one or two fingers through the os, and break it down, as far as they can readily reach. We may then, with a little grasping pressure applied outside, cause its expulsion.

An excellent instance of the advantage of clearing out the uterus in such a case occurred to me not long since. Secondary hæmorrhage occurred a week after delivery in a lady whom I had attended in consultation. She had placenta prævia, with much *post partum* hæmorrhage. The secondary loss was not very severe, but the discharges somewhat offensive. Finding the uterus bulky, I passed my finger through the os, and detected a clot, part of which I removed. It was very offensive. I therefore broke it up as far as I could reach, without passing the hand into the vagina. I then introduced the long tube to the fundus; and, as soon as it reached the fundus of the uterus, about half a pint of most offensive *gas* escaped. Water, slightly charged with tincture of perchloride of iron, was thrown within till it came away without smell. The remaining clots did not come away till next morning, after which all unpleasant odour ceased. The patient had had rigors before the washing out, but they did not recur. She had afterwards slight phlegmasia dolens and a slight cough. The leg soon recovered, but the cough remained some time. I think we may fairly assume that the evacuation of the offensive contents of the uterus saved this patient from a serious, if not fatal, illness.

FOUR YEARS' EXPERIENCE AS A HEALTH-OFFICER IN BRISTOL.*

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OWING to the prevalence of maculated typhus in Bristol, during the winter of 1864 and 1865, I was appointed without a moment's notice, by the Board of Health of that City, to the anomalous office of Medical Inspector of Health. I believe I am the only specimen of that species of health-officer in the kingdom. That appointment I have held up to the present time. No specified instructions were delivered to me on my appointment; but I was made to understand that I was to find out the cause of the existing evil, and to recommend the best measures to be taken for improving the health of the city. Having received no special training in hygiene, and having no authority to guide me, I had to tumble into my duties in the best way I could. Since then, a system of inspection and hygienic measures has been developed, which, on more than one occasion, has been most severely tried, and on each occasion has proved to be of infinite value. To trace the rise and development of our Bristol plan would unnecessarily occupy the time of this meeting. I will, in as few words as possible, describe it.

The city, for the purpose of inspection, is divided into four districts, each district being under the special superintendence of an able in-

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