A METHOD OF DRAINING THE SEPTIC UTERUS.

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To those who are much engaged in the treatment of puerperal sepsis there is one form of treatment, at any rate, which is rapidly passing out of favour, and that is leaving the septic uterus to take care of itself. This opinion was definitely reached in this hospital when it was found that in over half the cases of puerperal sepsis admitted there was pent-up pus.

Since there still seems to be a diversity of opinion as to the best method of draining the uterus it is thought that a short account of that we have found most successful might be helpful to those engaged in the task.

The first point which always arises when we have to deal with pent-up secretions, naturally, from our surgical teaching, is the question of placing a drainage tube in the parts concerned. For some time a drainage tube was left in the uterus either as a continuous method or only for some hours. After considerable experience it became apparent that this was not the best form of treatment, as even after twelve hours the tube became offensive. It was thought that a tube left in the uterus acted as a sort of plug, or as a cork in a bottle, and retarded the flow of lymph from the tissues. In many cases it excited uterine contractions and caused pain, because the organ is always trying to expel foreign bodies. Such a procedure exhausts the uterine muscle, rendering it toneless, and doing away with the very function it is essential to retain. In some cases we were of opinion that leaving in a tube promoted haemorrhage rather than lessened it, and dammed back the secretions in the uterus.

In order to arrive at the best method of draining the uterus two things have to be borne in mind. In acute cases the oedematous tissues of the uterus have to be drained, and in chronic cases the secretions in the over-distended tortuous glands have to have an exit. Further, the cervical canal must be kept clear of all foreign bodies and retained products, such as pieces of placenta, membrane, and blood clot. The swollen cervical canal has to be reduced in size by a drug which diminishes the inflammation and so widens the canal.

In our experience the presence of a tube constantly in contact with the cervical canal does not obviously tend to reduce the swollen tissues. The whole art, therefore, of draining the tissues, as well as regaining the patency of the cervical canal and the contractile power of the uterus, is to use a suitable drug without leaving in a tube.

In choosing a drug the question has to be asked: Is there a method which can be applied again and again without being followed by an increase in the fever or disease, so that each application fulfils the purpose of an aid to the draining of the tissues which are in a state of stasis, which in no way injures the living cells of the tissues with which it comes in contact, which promotes a flow of lymph from the infected tissues—a method which, if properly applied, alleviates pain, relieves congestion, and by so doing stops secondary haemorrhage, mildly stimulates the uterine muscle to contract, and finally restores the function of the uterus? There is a method, and that method involves the use of glycerin (undiluted).

The Method.

The instruments required are: (1) a catheter introducer; (2) terminal-eyed soft rubber catheters; (3) an anterior vaginal wall retractor; (4) a modification of Sims's speculum; (5) 2 c.cm. and 10 c.cm. Record syringes.

No anaesthetic, general or local, is necessary. The patient is placed in the lithotomy position. The external parts are washed with ether soap and water, and then with saline. The vagina is treated in the same way. A Sims's speculum is introduced into the posterior fornix, and an anterior vaginal wall retractor into the anterior vaginal fornix, and by a series of gentle movements the cervix is manipulated into a central position. The

speculum must not be pushed too far back, and the anterior vaginal wall retractor must be held horizontally and obliquely in the same plane. By this means a good view is obtained of the cervix, which becomes readily accessible for the purpose of passing a catheter. A terminal-eyed catheter is lubricated with glycerin, and gently inserted into the os, syringing the glycerin in front of the catheter so as to make a bed for its easy upward progress through the cervical canal to the fundus of the uterus. The syringing is still continued as the catheter is withdrawn. This is repeated if the uterus contains much pus.

Modifications of Treatment for the Type of Uterus.

After Labour or Miscarriage.—The patients here are relatively insensitive, and the best time for treatment is certainly during the first few weeks following labour or abortion, and quicker results are obtained.

Cases Following Labour.—In these cases we have certainly found the undermentioned method the best in all our experience. Patients are prepared in the usual way, but after the insertion of the catheter into the uterus the anterior vaginal wall retractor and Sims's speculum are removed, leaving the catheter *in situ*. The legs are then lowered on to the table, and the syringe, with the catheter still fixed on the end, is placed on a sterile pad on the symphysis pubis. A pillow is placed under the knees to add to the patient's comfort. The assistant, standing by the side of the patient, injects the glycerin slowly through the catheter, giving a slow irrigation treatment to the uterus. This may be continued for from twenty minutes to half an hour. In that time 60 to 100 c.cm., or even more, glycerin may be injected without causing the slightest discomfort to the patient. This may be done twice a day. Undoubtedly a more thorough washing of the uterus is obtained, and in many cases after one or two irrigations the temperature has fallen by crisis, whereas the short intermittent remedy which is used in the majority of cases has had no effect on the temperature.

Chronic Cases.—Many patients received into the gynaecological wards have suffered from intermittent attacks of temperature, recurrent attacks of pelvic peritonitis, and, which have been so distressing to the patient, prolonged uterine haemorrhages. Many of our recent cases have been dealt with very successfully in the following way. Small quantities of glycerin have been injected into the uterus daily until the temperature has come down, and if there is still much discharge and erosion which is not cleared up the uterus is washed out occasionally with industrial methylated spirit under morphine gr. 1/4. In cases of chronic haemorrhage, as in chronic metritis and fibrosis uteri, patients are given an anaesthetic and the uterus is washed out alternately with methylated spirit and glycerin. This is repeated for about a dozen times. Subsequently in all cases the uterus is drained for the succeeding few days.

By these treatments many cases which have seemed quite hopeless have cleared up.

I wish to thank Dr. Mary R. Levack for her help in carrying out the treatments.

CONGENITAL DEXTROCARDIA WITHOUT TRANSPOSITION OF OTHER VISCERA:

ACQUIRED VALVULAR DISEASE AND AURICULAR FIBRILLATION.

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COMPLETE transposition of the viscera, *situs inversus totalis*, is too well known as a clinical condition to merit any special description. The following case, however, presents several features of unusual interest.

Description of Case.

The patient, a female, aged 30, first came under the care of Dr. Theodore Thompson in October, 1926.

History.—For ten years she has had a troublesome cough, shortness of breath on exertion, and attacks of palpitation