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ON THE USE OF

THE CURETTE

AS A THERAPEUTIC AGENT IN GYNECOLOGICAL PRACTICE.

BY

B. BERNARD BROWNE, M. D.

PROFESSOR OF DISEASES OF WOMEN, IN THE WOMAN'S
MEDICAL COLLEGE OF BALTIMORE; FELLOW OF THE
AMERICAN GYNECOLOGICAL SOCIETY, ETC.

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ON THE USE OF THE CURETTE AS A THERAPEUTIC AGENT IN GYNECOLOGICAL PRACTICE.

Read before the Clinical Society of Baltimore, June 2d, 1882.

By B. BERNARD BROWNE, M.D.,

Professor of Diseases of Women in the Woman's Medical College of Baltimore;
Fellow of the American Gynecological Society, &c.

In a paper which I had the honor of reading before this Society in February, 1880,¹ I spoke of the use of the curette in removing fragments of placental tissue which were retained after abortions and miscarriages. For this purpose I had made a double curette of two sizes which also may be used as a uterine depressor, its cutting edge may be made sharp or blunt at will by using a small file.



CURETTE WITH CUTTING EDGE.

Since that time I have had occasion to use the curette in quite a number of such cases, my later experience having been as satisfactory and successful as at that time reported. In this paper, however, I will confine my remarks to its use in gynecological practice only, and wish to contrast the beneficial results of its use with the application of the stronger intra-uterine remedies as being more certain and less dangerous in its effects.

In 1850 Récamier first recognized intra-uterine fungosities as a cause of metrorrhagia, and recommended the curette, known by his name, for their removal; he advised and practiced scraping them off with this sharp instrument, which, however, was not devoid of danger, for he reported three cases of perforation of the uterus and death from its use. Like many other powerful therapeutic agents it was violently condemned by many who considered it barbarous, dangerous and unnecessary, and for a time it was cast into comparative oblivion. But it was not altogether discarded, for Sims and Simon both saw in it an agent of great value and modified it to suit their respective views of its appropriate application.

In chronic hyperplastic endometritis, which is frequently accompanied by a fungous degeneration and intra-uterine vegetations, we have the cause of many cases of uterine hemorrhage.

The flooding is frequently due to peculiar morbid changes in the mucous membrane and utricular glands of the uterus.

Aran, following Récamier, described these fungosities as small tumors, ordinarily sessile, continuous with the mucous membrane, by a base

¹ Maryland Medical Journal, April, 1880.

sometimes as large as themselves, and varying in size from a grain of wheat to that of a pea or small strawberry, and sometimes pediculated. Cases are related where profuse and constant flow resulted from very small vegetations.

Klob relates the case of a woman who died from menorrhagia, the uterus was examined post-mortem and nothing was found, except a peculiar flat vascular elevation of the mucous membrane of the uterus about one inch thick and one and one-half inches in diameter.

Thomas relates a case in which the patient suffered for years from menorrhagia and occasionally from metrorrhagia; on many occasions the tampon was resorted to and several times the cervix had to be forcibly plugged to prevent death from excessive flow. Upon post mortem examination nothing was found to account for the condition but three fungous projections, which were situated just above the os internum.

Sometimes this menorrhagic condition comes on quite suddenly in previously healthy women, but generally it is gradual, as increased menstruation, until it becomes continuous, lasting for months or years. In some cases it stops for a time, this being due probably to the great anemia which has been induced; sometimes when the discharge is continuous it assumes the character of a bloody serous fluid rather than a true hemorrhage.

There is seldom any pain, the principal suffering being due to the anemia, with loss of appetite, weakness, sleeplessness, etc.

By palpation of the uterus nothing is discovered for the position is frequently normal, except sometimes a slight prolapse, although versions and flexions do occur.

The cervix is generally soft and the lower portion of the canal and os gaping; the introduction of the sound causes little pain and its withdrawal is generally followed by hemorrhage. The uterus is easily dilated by tents; upon the introduction of the finger the cervical canal is found normal, the folds being smoothed out by the pressure of the tent.

Frequently nothing is felt until the fundus is reached where the endometrium is found thickened, softened and uneven. Irregularities are not generally felt on the sides because they have been smoothed out by the pressure of the tents, and this is one reason why the disease so frequently escapes detection. The diseased mucous membrane can be taken off with a curette, in most cases the dull wire curette of Thomas will be entirely successful in its removal. In most cases previous dilatation is not necessary, for the curette will convey to the operator's mind a full knowledge of the character and location of the disease.

Light cauterization of the mucous membrane is not sufficient to destroy the disease, and if we use powerful cauterizing agents the danger is much greater than in using the curette, which has been condemned by many who have never tried it. The continuous and frequent use of alterative

astringents, such as Churchill's strong tincture of iodine, will often set up acute cellulitis in the periuterine connective tissue.

On intra-uterine applications Dr. Gaillard Thomas says that a lymphangitis frequently arises, which commonly goes on to cellulitis and peritonitis. He says that he is sure that he is within truthful bounds when he says that there are hundreds and hundreds of women in this country alone who are suffering from this disease (cellulitis) produced by intra-uterine medications.¹

There has always been a divided opinion as to how the inflammation excited in the uterus by an irritating application extends to the cellular tissue of the pelvis, some thinking that it must make its way through the uterus and fallopian tubes. The probability, however, is that the irritation excited in the utricular glands of the uterus and cervix is conveyed to the lymphatic vessels, which are very abundant at the juncture of the cervix and body of the uterus, and thence into larger vessels which pass beneath the broad ligament, while those from the fundus pass along its uppermost part, and, according to Guerin and Lebec who have recently made the broad ligament and the cellular tissue of the pelvis objects of special study, these trunk lymphatics ultimately empty themselves either into one single gland, or else, more commonly, into a series of glands, situated on the inner aspect of the ischium. The course of these lymphatic vessels explains certain symptoms frequent in pelvic inflammation and go to prove that pelvic cellulitis begins as lymphangitis, produced by any severe irritation to the vagina or cervix; then the large lymphatic trunks below the broad ligament become involved, and the glands become enlarged, and may be detected by digital examination by the vagina. When the morbid process extends, the tissue around the lymphatics may become indefinitely involved, and abscess form at any point along the track. Hence the ill-defined extensive hardenings and the scattered collections of pus frequent in pelvic cellulitis. In short, says Lebec, the anatomy of the lymphatics of this part thoroughly explains the clinical symptoms of pelvic cellulitis.

Chronic hyperplastic endometritis is not confined to women who have had children, but frequently occurs in single women, and even after the menopause.

The existence of profuse chronic leucorrhœa will convey a suspicion of the existence of this disease.

It generally begins as chronic catarrh of the endometrium, the mucopurulent discharge having gradually become sanious or of pure blood, accompanied by profuse menstrual flow, anemia and general debility.

A short time ago I removed with the currette these fungosities from the uterus of a woman aged sixty-two, who had suffered from a mucopurulent discharge since the menopause.

Oldhausen states that chronic hyperplastic endometritis is limited strictly to the cavity of the uterus proper, stopping at the os internum, below which commences the region of enlarged Nabothian

¹ Transactions American Gynecological Society, Vol. 4, p. 80.

follicles and mucous polypi in the cervix. The difference consists in the large masses of dilated glands found in the last named affection which are absent in the former. Polypi of the uterus are distinguished from the fact that they are generally confined to a small part of the endometrium; while the chronic hyperplastic endometritis extends over a large surface.

In nearly all cases of chronic inflammation and hypertrophy of the Nabothian follicles or utricular glands of the cervix (of which, according to Tylor Smith, there are at least 10,000 in the cervical canal alone) a thick tenacious plug of mucous hangs from the cervix which it is often difficult to remove.

In these cases where the secretion is albuminous and persistent, and remains unchanged in spite of the use of all the stronger caustics; the Sims' curette with sharp cutting edge will effectually remove the hypertrophied glands down to healthy tissue, and will generally effect a permanent cure; for this purpose it is often necessary to dilate the cervix with tents before the curette is used.

In nearly all cases of supposed return of the menses occurring after the menopause and continuing for years, a pathological condition of the uterus exists, and what has been related as a wonderful prolongation of a physiological process, is in fact the result of a diseased condition not seldom malignant in character.

In the paper which I have already alluded to on "Retention of the Placenta after Abortion." I stated that there was a class of cases which we meet with one, two, or three years, or even longer, after an abortion. These cases present all the symptoms of chronic uterine disease, such as menorrhagia, leucorrhœa, backache, etc.; they are generally improved by any intelligent plan of treatment; tonics benefit them for a while, and local treatment such as vaginal douches, pessaries, applications of iodine, etc., do sometimes improve them very much, but within a month or two after leaving off treatment, they relapse and are as bad as before; this condition is frequently, I believe, a remote result of partial retention of the placenta. In these cases if the dull wire curette be used it will generally be found that the former placental site is studded over with numerous little cysts from the size of a shot to that of a pea, which when removed with the curette, will float upon water and have the appearance of small air bubbles. After they are thoroughly removed a few applications of Churchill's tincture of iodine may be made, although generally even this is unnecessary. This condition is very frequently accompanied with cellulitis and sometimes with laceration of the cervix.

In conclusion I would state that in leucorrhœa proceeding from chronic disease of the endometrium; in menorrhagia and metrorrhagia caused by intra-uterine fungosities; and in glandular disease of the cervix, the curette is a more efficient and safer therapeutic agent than the stronger caustic or irritant astringent applications within the uterus.

And that in all obscure affections of the endometrium the curette is a valuable diagnostic agent enabling us to locate the seat and character of the disease and that its usefulness in this respect is only equalled by its therapeutic value.

