

Kime (R. R.,)

The drainage tube xxx





THE DRAINAGE-TUBE IN PUERPERAL INFECTION.

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To the Editor of the American Gynæcological and Obstetrical Journal :

SIR : At this opportune time while surgical measures in puerperal infection are being so freely discussed I desire to present a plea in behalf of the use of the soft-rubber drainage-tube in these conditions. Having tried its efficacy in a number of cases extending over a period of several years I am fully convinced that its use coupled with cleansing and disinfection of the uterine cavity is the most efficient plan of treatment and method of drainage in cases of infection occurring after labor. I am also fully convinced that its timely, persistent, systematic, proper use will save more lives than abdominal section or vaginal hysterectomy.

In making this statement I do not wish to decry or obstruct the advances of surgery in this line of work—far from it—for treatment and surgery each has its field of usefulness in these cases.

While I advocate heroic surgical measures in these cases, when the conditions and circumstances demand it, yet I feel it is our duty to save life by the simplest means possible and with least risk to our patient. Not only should life be saved but every organ of the body should be so preserved as to perform its functions afterward if possible. For this reason I strongly urge the proper use of the drainage-tube.

In cases of abortion or infection afterward I use and advise thorough emptying of the uterus, irrigation, disinfection and the gauze tampon. Here the gauze tampon is most efficient and meets all the requirements because the uterus is small, readily contracts and is easily drained of liquid contents, there being little if any solid elements to be thrown off. By the use of the gauze drainage and hot vaginal douches involution takes place rapidly.

Infection after labor at or near full term presents different conditions to deal with, the uterus is large, flabby, relaxed and will not drain itself although the os be patulous, does not contract readily

leaving a large placental site, and large venous channels open favoring absorption and preventing involution. In all these cases whether it be putrid, septic or mixed infection the uterus contains material which should be eliminated. As to the method of getting rid of this material eminent authorities differ. (See April issue of this JOURNAL.)

In these cases it is important we keep in view the variety and severity of the infection as well as investigate the contents of the uterine cavity. I can not conceive how any physician can object to the removal of putrid placental tissue from the uterine cavity when we know that it is the ptomaines or putrefactive alkaloids that are absorbed and not the germs.

While this putrefactive material remains in the uterine cavity it is constantly adding fuel to the fire. To remove it is to get rid of the cause and the only rational method of procedure whether it be by irrigation, finger, curette forceps or curette, adapting the method best suited to the individual case and dexterity of the operator.

In septic infection the conditions are different—the entrance, development and absorption of germs with their alkaloidal developments are the cause and the curette should be used with extreme caution. Yet if the uterus contains placental tissue or blood-clots they form hotbeds for germ development and should be removed by the simplest method possible, avoiding injury to the endometrium which forms in many cases a barrier to the entrance of germs. To empty the uterus in all forms of infection, first dilate the cervix and hold it open with dilators then wash out all material possible with a disinfectant solution, after which remove the contents of the uterus by the method best adapted to the individual case irrigating again and follow by disinfection and drainage.

Drainage is the most essential factor in these cases and should be so conducted as to carry off fluids, germs, pus cells and small particles of degenerated endometrium, blood-clots or other *débris*.

Gauze drain can meet but one of these requirements—draining off fluid—while the drainage-tube properly used meets all and drains off the fluid more readily than gauze. It is to these solid elements as well as the fluids we wish to give free exit and even the drainage of fluids is obstructed by the gauze if it be packed tightly in the cervical canal or near its entrance. A practical test of the drainage-tube properly used will certainly convince the most skeptical. I have a case of infection now convalescing which I saw ten days after confinement with a temperature of 106.5° F., the drainage-tube having

saved her life. The uterus was large, flabby, relaxed, over six inches in depth with a patulous os yet filled with a purulent material that filled the vagina and speculum, running down into the tub by the side of the bed when the cervix was held open with dilators. On three different occasions this patient was so improved the tube was removed, but each time within twelve to twenty-four hours the patient grew rapidly worse with elevation of pulse and temperature reaching as high as 104° F.

The other treatment was not changed, the use of the drainage-tube resumed and the patient gradually improved each time.

Gauze drainage was also tried in this case but failed to accomplish the desired result. As to the method of using the drainage-tube, including other treatment and the surgical measures in puerperal infection, see an article in last issue of *Medical Progress* of Louisville, Ky.

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