

### THE INTRAUTERINE DOUCHE

Uterine douches are employed in the treatment of septic conditions affecting the uterus, to control hemorrhage, and for cleansing the uterus after curettage and other intrauterine operations. They are more dangerous than vaginal douches, and certain precautions in their use are necessary. They should always be given by the physician himself and in their use the same care and attention to cleanliness should be observed as in any operative procedure. It is absolutely essential that a free and unimpeded return of the solution be provided by having the cervix well dilated or by employing a return-flow irrigating nozzle, otherwise there is danger of overdistention of the uterus with resulting shock or of the fluid being forced into the uterus through the tubes. Furthermore, *the use of poisonous drugs, such as carbolic acid or bichlorid of mercury, should always be followed by an intrauterine irrigation of sterile water or of normal salt solution.*

**Apparatus.**—There will be required a glass irrigating jar or a large douche bag, a thermometer, 6 feet (180 cm.) of rubber tubing, 1/4

inch (6 mm.) in diameter, connecting the reservoir and the douche nozzle, a douche pan with a spout to which is attached a piece of rubber tubing sufficiently long to convey the returning fluid to a waste pail (see Fig. 804).

There are several forms of intrauterine douche nozzles. When the cervix is widely dilated, as in postpartum cases, a curved glass nozzle



FIG. 812.—Glass intrauterine douche nozzle.

with the openings upon the sides, such as the Chamberlain tube (Fig. 812), is sufficient.

In other cases it is necessary to employ some form of return-flow nozzle. The Fritsch-Bozeman nozzle (Fig. 813) is the safest of these.



FIG. 813.—Fritsch-Bozeman return-flow uterine douche nozzle. (Bandler.)

It consists of an outer tube fenestrated near the tip, with a second opening upon the under surface of the instrument near its lower end for the return flow. Inside this outer tube is a smaller inflow tube. This instrument requires some dilatation of the cervix, however.

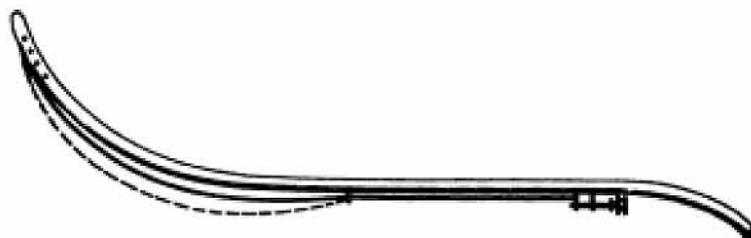


FIG. 814.—Return-flow dilating catheter. (Ashton.)

before it can be introduced and where this is lacking a smaller instrument, such as Talley's intrauterine catheter (Fig. 814), may be employed. The latter consists of a curved metal catheter with two heavy wires on its under surface, which may be expanded or closed by turning a small thumb-screw. The catheter is introduced into the uterus with the wires lying close to the catheter and, when in the

uterus, the wires are expanded, thereby dilating the cervix sufficiently to permit a return of the injected solution.

**Instruments.**—In addition to the above apparatus a vaginal speculum, a sponge holder, and a pair of bullet forceps are required (Fig. 815).

**Asepsis.**—The apparatus and instruments should be sterilized by boiling and the thermometer by immersion in a 1 to 500 bichlorid of mercury solution followed by rinsing in sterile water. The external genitals are first washed with soap and water and then with a 1 to 2000 bichlorid of mercury solution. The vagina is cleansed by means

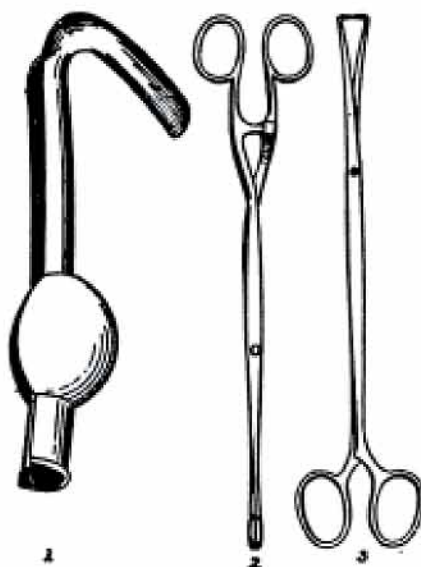


FIG. 815.—Instruments for intrauterine douching. 1, Garrigues' weighted speculum; 2, sponge holder; 3, tenaculum.

of a 1 to 5000 bichlorid of mercury douche, followed by sterile water. The operator's hands are sterilized in the usual way.

**Solutions Used.**—Plain sterile water, normal salt solution—salt 3i (4 gm.) to the pint (500 c.c.) of water, 1 to 10,000 to 1 to 5000 bichlorid of mercury, 50 per cent. alcohol, 0.5 per cent. solution of lysol, 0.5 per cent. solution of creolin, silver nitrate 1 to 1000, etc., etc., are among the solutions employed.

**Temperature.**—Ordinarily the temperature of the solution is about 105° F. (41° C.). Where the stimulating and constricting effect of heat is desired the temperature of the solution should be 115° to 120° F. (46° to 49° C.).

**Quantity.**—About 1 quart (1 liter) of solution is used at a time.

**Rapidity of Flow.**—The fluid should not be allowed to enter the uterus more rapidly than it can escape, otherwise there is danger of its

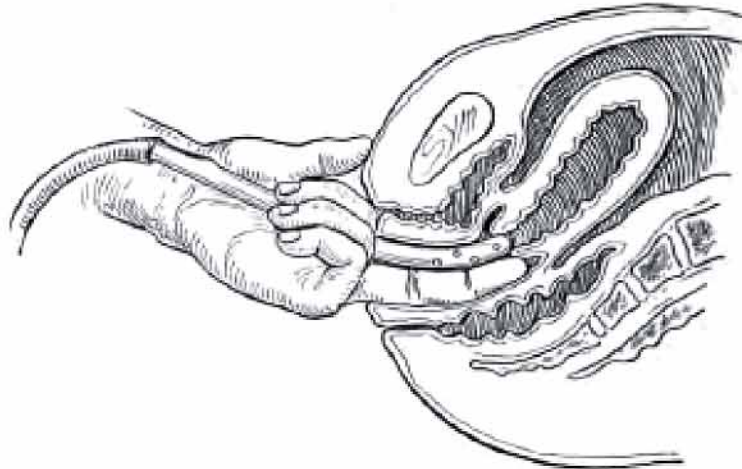


FIG. 816.—Inserting the douche nozzle when the cervix is well dilated.

being forced into the tubes. Therefore, the reservoir should not be elevated more than 2 feet (60 cm.).

**Position of Patient.**—The patient should be in the dorsal position.

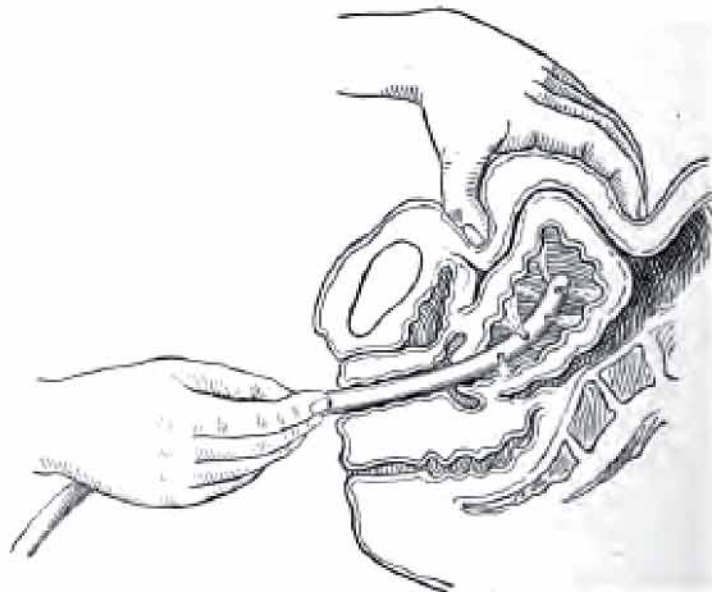


FIG. 817.—Method of giving an intrauterine douche in a postpartum case.

**Technic.**—If the cervix is well dilated so that the entrance of the douche nozzle is not interfered with, the latter may be inserted by touch alone, as follows: One or two fingers of the left hand are passed

into the vagina and the external os is thus located. The douche nozzle, with the solution flowing so as to avoid injecting any air, is then inserted into the uterus by the right hand, being guided through the cervix by the fingers of the left hand (Fig. 816). The nozzle is then gently passed to the fundus of the uterus and the cavity is thoroughly irrigated. The return flow must be carefully watched to see that it is not obstructed. It is well to place the left hand externally over the fundus uteri in puerperal cases to prevent any possible overdistention of the uterus and opening up of the sinuses (Fig. 817).

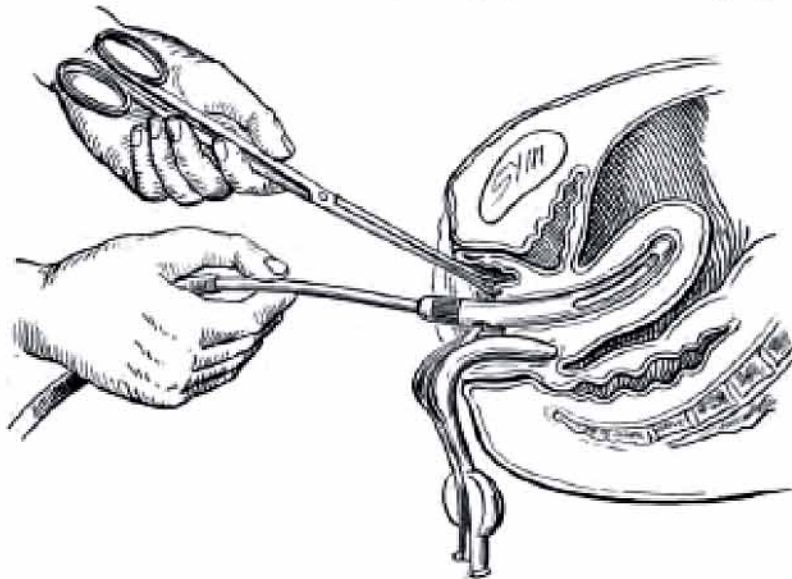


FIG. 818.—Shows the method of giving an intrauterine douche with a return-flow nozzle.

To introduce the douche nozzle by sight, the posterior vaginal wall is retracted by means of a speculum, and, if the cervix is not readily accessible, it is drawn down into the vagina by means of bullet forceps caught in its anterior lip. The cervix is then wiped off by means of a swab on a sponge holder wet with a 1 to 2000 bichlorid of mercury solution, and a return-flow nozzle is inserted by direct sight, taking care to have the solution first flowing (Fig. 818). In inserting the nozzle extreme gentleness should be used to avoid injuring the tissues or possibly perforating the uterus. The latter accident has happened frequently enough to warrant this caution.

### INTRAUTERINE APPLICATIONS

The application of drugs with an astringent or caustic action to the mucous membrane of the uterus is employed in the treatment of endo-

metritis alone or in conjunction with curettage. The best results are obtained, however, when intrauterine applications are used after a preliminary curettage.

The indiscriminate employment of intrauterine applications should be condemned, as they often do more harm than good. They should only be employed in cases where thorough asepsis can be obtained, and then only with the cervix sufficiently dilated to allow thorough subsequent drainage. The procedure, therefore, is one that rises to the dignity of an operation and should never be attempted as a part of the office treatment.

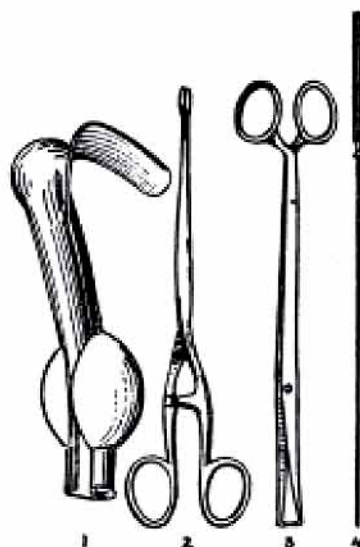


FIG. 819.—Instruments for making intrauterine applications. 1, Garrigue weighted speculum; 2, sponge holder; 3, tenaculum; 4, applicator.

The position and size of the uterus and the condition of the other pelvic organs must be determined by bimanual examination beforehand. In the presence of adnexal involvement or other complications intrauterine applications are contraindicated.

**Instruments.**—There should be provided a vaginal speculum, sponge holders, bullet forceps, and two uterine applicators (Fig. 819).

**Asepsis.**—The instruments are boiled for five minutes in a 1 per cent. soda solution. The external genitals are washed with soap and water followed by a 1 to 2000 bichlorid solution. The vagina is douched with a 1 to 5000 bichlorid of mercury solution followed by sterile water. The operator's hands are likewise sterilized as for any operation.

**Solutions Used.**—Sulphate of zinc 5 to 10 per cent., chlorid of zinc 5 to 10 per cent., silver nitrate 5 to 10 per cent., perchlorid of iron 5 per cent., ichthyol 5 to 10 per cent., tincture of iodin 50 per cent., Churchill's solution of iodin, pure carbolic acid, etc., etc., may be employed.

**Position of Patient.**—The patient is placed in the dorsal position.

**Technic.**—The vaginal speculum is inserted and the cervix is drawn down into view by means of bullet forceps which seize the anterior lip. Any secretion or collection of mucus is then wiped away

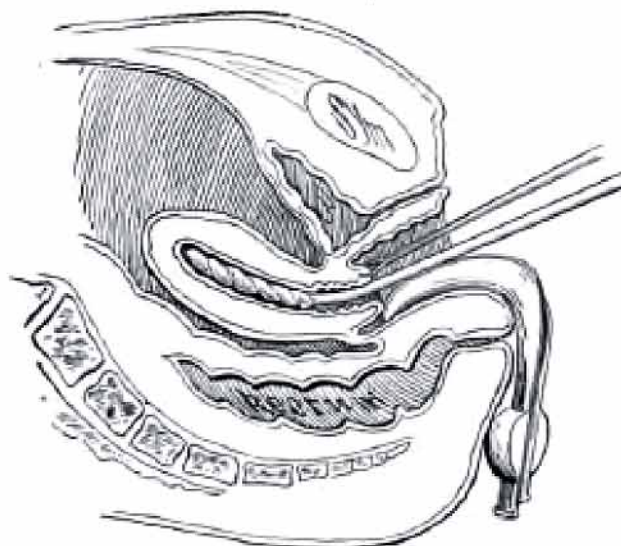


FIG. 820.—Shows the method of making an intrauterine application.

from the external os by means of a swab soaked in a 1 to 2000 bichlorid solution, and the cervix is dilated if necessary (see page 803). A small thin layer of dry cotton is then securely wound round an applicator, taking care that the tip of the instrument is well covered. The swab thus fashioned is to be of such size that it will readily pass the cervix. The applicator is curved to the shape of the canal and is passed into the uterus for the purpose of removing any secretions and thus allow the solution to come in contact with all portions of the mucous membrane. A second applicator, similarly wrapped with cotton, is dipped in the solution. Any excess of fluid is squeezed from the cotton and the application is then made to the interior of the uterus, carrying the cotton-tipped applicator well up to the fundus and moving the instrument about in the cavity (Fig. 820). A vaginal tampon is finally inserted, which is removed in twenty-four hours. The patient should remain quiet for a day or two, and if a strong

caustic has been employed she should be warned that at first there will be an increased discharge.