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ORIGINAL.

ENDOMETRITIS.

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IN asking your attention for the few moments that I shall occupy in considering the above subject, it is not my expectation to be so fortunate as to be in the least an *instructor* to any member of this Society. But I know no better reason why I should ask you to review a subject with me, than that it is common, and distressing, and though rarely fatal, is grave in its character.

The oldest of us may never have been called upon to even diagnos an ovarian tumor or a tubal pregnacy, much less to treat it, but the youngest M. D. will hardly have made the acquaintance of a dozen female patrons before he is consulted about some female weakness, and it will not be an unreasonable guess, to say that he will find that case an endometritis of some type, either acute or chronic cervical or corporeal, either as the trouble or consequent upon some other trouble. Hence you will be tolerant with me if I have dared to recall through this subject, the care-worn and distressed face of many a lady patient, that you have doctored and doctored until the sight of her coming into your office has made you regret that any woman should have so much faith in her physician.

Before considering my subject in detail to any extent let me say, that while my text is Endometritis, it is almost wholly of the chronic type that I shall speak, feeling justified in only making passing and necessary mention of the acute type for the good reasons: 1st. That you are all thoroughly informed students of the pathological changes consequent upon acute inflammation, not less when it involves the organs under consid-

eration than in other tissues and locations, also that you have well in mind the peculiar situation, texture, functions and exposures of the uterus and its appendages. 2nd. The the applicants for treatment of the chronic type are so much in excess of all others, that it is of more practical importance to us as practitioners to review it as nearly as possible, to the exclusion of all others, and I now forewarn you that I shall pay little regard to that system observed by authors upon this subject, remembering that our papers are only written expressions of opinions for practical purposes and texts for discussion.

Endometritis is defined as an inflammation of the lining membrane of the uterus. It has its synonim in uterine catarrh and uterine leucorrhœa. Endometritis and endocervicitis are terms employed to designate an inflammatory condition of the mucus membrane of either the cervix or body of the uterus. Both are hollow, both have a mucus surface and muscular and glandular substance, and are almost wholly covered by peritoneum; thus it is anatomically divided and designated, but when acted upon by inflammation gives us perimetritis, metritis and endometritis. Practically, and in fact, I can hardly conceive of a single one of these anatomical divisions involved to the complete exclusion of all others, when *acute* inflammation exists in the organ at all, but that we may have a chronic endometritis or cervicitis as a sequence of the *acute* condition needs no mention except among *causes*. But the chronic type may obtain with no history of any acute inflammation of the uterus or its appendages. But the clinical fact is patent to all practitioners that the vast majority of applicants for treatment are sufferers of more pain, a greater amount of discharge, and upon examination are found with more marked textural change than our text book delineated as typical cases of endometritis. Neither are they such as will admit of being placed and classed among typical cases of metritis. This is very natural and unavoidable, but very confusing in making a differential diagnosis. It is of this class of cases that I would specially speak, not forgetting that I am taking a liberty only by your permission, for a better understanding of each other in our further consideration of this subject. This *intermediate* condition, that is more than a chronic endometritis and less than a chronic metritis, is worthy of special study and, if I may be allowed, I will drop my text book names, endometrits and metritis, and

call our cases CHRONIC INFLAMMATION OF THE UTERUS AND ENDOMETRIUM, which is almost a distinction without a difference, yet will perhaps serve to absolve our minds from thinking of that intractible and incurable condition conveyed by the word chronic metritis, or areolia hyperplassia of Thomas.

If we now understand each other we will proceed to consider the causes and symptoms of this class of cases. *Causes:* Interrupted menstruation by sudden shock or cold, obstruction to the menstrual flow, acute inflammation, gonorrhœa, direct or traumatic injuries or irritations, especially from within by the incautious use of instruments or ill-fitting pessaries, adventitious growths within the wall or cavity of the uterus or cervix, retained positions of placental tissue for long periods, laceration of cervix, abortions, parturition, distortion and displacements of the uterus. Abortions and parturition seem most frequently to date the beginning of the history of the majority of this class of cases. Among the marked symptoms may be mentioned a profuse leucorrhœa in the majority of cases, but may not be constant, more or less pain low down in pelvis, and decidedly increased by much standing or walking, and of a dragging character; pain in back almost always, and generally so in one or both groins; frequently painful defacation, and not rarely painful micturition; more or less nervousness in all cases and distressingly so in very many; occipital cephalalgia is very common, periods of melancholia very noticeable and often complained of; nervous dyspepsia and constipation common.

Vaginal examinations will almost invariably reveal not only a large and congested cervix, but a patulous external os, pouring fourth a copious muco-purulent discharge, and generally, but not always, an excoriated or ulcerated cervix, uterus large and heavy and almost invariably with more or less displacement, and generally of the type of either retroversion or retroflexion—most often the latter. Tender to touch; so much so that conjoined manipulation produces more distress than patients can well or willingly bear without complaint. A ridge of cord-like hardness and quite tender to the touch can almost always be felt at the junction of the body and neck, or at the internal os. The sound is generally passed without much trouble if carefully insinuated and coaxed along between the congested mucus folds of the ceroix, providing its curviture

corresponds to the flexion of the cervix and body. The cavity of the uterus is generally elongated from one-half to a full inch, and enlarged in all of its dimension. Probably before the sound is withdrawn a little blood will ooze from the os, and is quite certain to do so after the sound is withdrawn. The touching of the fundus and sides of the uterus will give more or less pain—sometimes very acute and severe—but generally it is more of an ache than a pain, and quite as often complaint is made of a faint, sick sensation being produced in the stomach as distress locally; but a careful use of the sound or uterine probe rarely gives that amount of pain that causes the most timid or sensitive any fears of its use, after the first examination. The position of the cervix relative to the outlet of the vagina will depend of course upon the position of the body, which, I repeat, is almost always displaced; if not flexed, at least is lower than natural in the pelvis.

To recur to the enumerated *causes*, it is noticeable that *all* are most prolific of *congestion*, and that the conditions found most favorable for persistent and constant congestion exist markedly in a great number of the cases that apply for treatment; cases of *displacement*, and especially of the *type of flexions*. A perfectly healthy uterus subjected to a marked flexion of any kind, I think I can safely say, will almost invariably take on a condition of acute congestion and inflammation and *certainly will*, if allowed to remain unreduced, result in some kind of uterine catarrh, perhaps no more than an endometritis. The history of the patients girlhood will be monthly dysmenorrheas and irregularities of all kinds, and her nervous system a wreck with which to commence that more trying and perilous period of her existence—womanhood.

I need not detail how the flexion brings this about. The word flexion conveys to your mind in a moment constricted and obstructed circulation, as well as retained menstrual flow, all conspiring and cöoperating to produce persistent and constant engorgement of its natural sequences.

Again, a uterus normal in position, but with a constriction or stricture of any portion of cervical canal, *through* rentention of fluids, soon must suffer engorgement and weight. Or, a uterus containing polypus or any kind of tumor, or the retention of portions of placental tissue, or a lacerated cervix, or subinvolution, in short, anything that will keep up irritation

and congestion, will very soon give sufficient weight, not only to make the uterus sink lower in the pelvis, but from the very shape of the organ, being large of body and small of base, so to speak, will certainly, sooner or later, if not relieved, give a version, and once bent, a flexion will soon follow; for it is no physiological enlargement as in gestation, but rather all the changes are pathological and irregular. *Once flexed*, upon mechanical principals alone, we have but a natural result: That of *chronic inflammation* and all of its distressing *sequelæ*.

Hence, from a therapeutic standpoint, this question of *relieving congestion* is all important, especially so, as it applies to its early stage. This should be ever remembered in advising and treating menstruating girls, who, from accident, are so unfortunate as to suffer a displacement, or from shock or cold have suppression of menstruation, for it relieves promptly; there will be no chronic condition of which we are speaking. The heretofore mentioned symptoms have not told half the effects, for there is no doubt that the great majority of the various uterine and ovarine tumors, homologous and heterologous growths, menorrhagias, amenorrheas, dysmenorrheas, sterility and the long and distressing neuroses, which we see and of which we hear, grow out of what were, *at one time*, curable conditions of acute congestion. It is not my purpose to prolong this paper by a long review of treatment, for I recognize the fact that I need but suggest a reasonable *cause* for any trouble, but your mature judgment and experience will need no hint upon therapeutics from me. Yet it would be shifting, if not shirking, a responsibility were I to drop this consultation without suggesting my plan of treatment in this class of cases; therefore, I will, as briefly as I can, state the course I pursue.

This you can but anticipate from my theory of *cause—congestion*. It is *always present* and *almost* always depends, in chronic cases, upon obstruction *somewhere, generally* in the *circulation*, owing to a well marked flexion. The indications then are certainly to reduce it. Do so if you can, but it cannot always be done at once, for it may have been of many months or years standing. It is chronic in the full sense of the term. Then let us do the next best thing. If we are called during some acute exacerbation, when there is acute pain, marked tenderness and perhaps a little abdominal tympanites and fever, and

perhaps the vaginal discharges contain a little blood, treat the condition the same as though it was an acute endometritis. Hot fomentations over hypogastrum, hot vaginal injections of water, rectal suppositories of opium, sufficient to control pain and bromides sufficient to control nervousness. Control fever as in any other case, and you have the old chronic case just as good as new, or just as bad as ever and in about such condition as you will find the majority of this class of cases when first consulted, and as represented when speaking of signs and symptoms. We will suppose it to be a case of retroflexion, which you have determined by both digatal examination and the sound, the latter especially. With the patient in the knee chest position and two fingers in the vagina it can soon be determined whether there are adhesions or not; if so, and sufficient to hold the uteras firmly down, I will cut the story short by saying: Treat the case palliatively and resort to dilatation of neck in such manner as you choose or as I may mention later on in speaking of constriction of neck, but *cure* will never be realized before the *menopause*, and perhaps not then. But, again, the uterus is not firmly bound down, though thickened cellular tissue and adhesive bands will not let it be but partially replaced. There is lots of hope in such a case. Retain the advantage you have by inserting a glycerine pledget or tampon of cotton—or wool, which is by far the best, behind the uterus, and repeat this every day, for one, two or three weeks; and my experience is that in many cases replacement becomes perfect, in others sufficient to admit of free drainage, as well as greatly improved uterine circulation. So soon as you can, supplant the cotton by a good retroflexion *pessary;* or, if replacement is possible at first trial, all the better; but it must be retained by some form of support, or else *cure* need not be looked for. Posture and digital manipulation is my choice of repositors, though the sound as a repositor works well in some cases; but nothing equals an intelligent band. Flexions do not exist in all cases. So much the better. If the cervical canal is sufficiently open to admit of free drainage and free intra-uterine treatment, then the time is propitious for commencing the regular and full treatment of your choice; but in case you can only by cautious and careful effort pass a probe or sound, there is little use of commencing the thorough intra-uterine medication until

dilatation has been first employed. The choice rests between instrumental and rapid dilatation or the use of tents. If there is no great amount of congestion or hypertrophy of the cervix and the sound conveys the idea of constriction or stricture, the dilator is all sufficient and by far the most rapid and convenient for both patient and practitioner, and if carefully and gradually used will give very little discomfort. But if the cervix is large and with a gaping external os, and giving the feel of interstitial hardening about the junction of body and cervix, by all means use tents, either of sponge or tupelo. I need not detail the manner of their use and the cautions to be observed while using them, but will say, do not stop short of dilating the internal as freely, for it will not only straighten any beginning flexion, but by this pressure will produce a more alterative and absorbent effect than any means of which I know. Now that the uterus is more or less in position, and free drainage is established, and freedom of circulation greatly improved, what medication can be employed to still farther reduce congestion and establish alterative and absorbent changes, that offer a reasonal hope of a practical *cure* of all these grave conditions, heretofore enumerated? To a very great extent I think each practitioner is a law unto himself from habit or choice of a few special means as medicaments that he learns to specially depend upon. I will mention none other than my own choice of intra-uterine applications, in the order of most frequent use: 1st. *Phenol*, which, as you remember, is a combination of acid carbolic, chloral hydrate and iodine resublimate. 2d. Tincture of iodine, from full to one-third strength. 3d. Argenta nitras, 40 gr. sol. 4th. Liq. ferri persulph, tr. iodine and glycerine. Rarely anything else. Swab the uterine cavity freely from once to twice a week, depending upon condition and medicament used. The daily use of a glycerined pledget of cotton or wool is of *inestimable* advantage in this class of cases, and is an adjunct in the treatment that no one can afford to omit, and *will* not if he employs it persistently for ten days in any well chosen case *once*. Hot *water—not* tepid, but *hot* water injections should never be omitted for a single day, except when menstruating. Twice a day is best; but at bed-time without fail, from 10 to 20 minutes. At its conclusion use a quart or pint of medicated wash, containing say one dram of tr. of iodine or one-half

dram of acid carbolic or zinc sulph.; or, if vaginal tissues are greatly relaxed, decoction of white oak bark or tr. of iron is good. And never forget to enjoin the taking of the knee-chest position, morning and evening, for from 5 to 20 minutes, especially when there is a retroflexion. Also remembering to tell the patient to open the vagina with her own hand, to secure the full force of gravity and atmospheric pressure, and also to sleep upon her face, at least not on her back at all.

Constitutional treatment is based upon the same general plan that is indicated by symptoms of disease in general, with this addition: Tonic alteratives are frequently especially useful. Such as bitter tonics with small doses of iodide of potassium and bichloride. Ergot in some cases, where there is an enlarged and flabby uterus. Nervines hold an important place in this class of cases. Always provide against habitual constipation. If married and it is possible, send the "husband west." In the main, this outlines my plan of treatment. Try and meet the indications and remove the cause.

I feel that I am making this paper by far too long and so will close, foregoing my original intention of reporting a few cases in point and results of treatment, but will, in a sentence, summarize this for your better discussion and criticism, which we earnestly and honestly solicit.

Chronic inflammation of the uterus and endometrium or chronic endometritis, plus more or less metritus, if I may so put it, in the vast majority of cases should be looked upon and treated more as an *effect* than a disease. A *result* not a *cause*.

TREATMENT.

Replacement, so far as possible, and retention by the use of pessaries so long as needed. Free *drainage always*. Alteratives and antiseptic intra-uterine medication. Body posture and hot water vaginal injections. And last, but not least, make your patient understand that you are in earnest when you tell her you will not be responsible for results except she gives you *time*, *except* she be obedient to directions and be prudent in all things.
