THE POST-PARTUM DOUCHE.

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With Presentation of a New Instrument.

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My experience with the care of women during parturition has caused me to be a firm believer in the practice of thorough asepsis and even of antisepsis. With certain modifications hereinafter noted I have practically adopted the methods advised by Garrigues. Shortly before the expected delivery I direct the patient to take a warm plunge bath and follow the same by a copious rectal enema and an antiseptic vaginal douche of bichloride, one in two thousand. When practical, a flushing of the colon is far better than simply the rectal enema. Succeeding the delivery my practice has been to remove the secundines by Credé's method, and if there is cause to believe that any material portion has been retained I approve of the introduction

of the aseptic hand into the uterus in order to detach and remove the same, or learn if such condition exists. The next indication is to secure the expulsion of any remaining small and detached particles or coagula of blood which may be either in the uterine cavity or vaginal folds, and to thoroughly cleanse the same of all débris which would otherwise remain to be dissolved and carried away by the lochial discharge. The only practical way of securing such result is by means of irrigation.

Could we always have our patients upon an invalid bed with opening in the center, it would not be so troublesome to administer a proper douche, but with the limited facilities usually encountered and with the desire to wet and soil the bed as little as possible the task assumes more troublesome proportions, particularly if the customary method of turning the patient crosswise the bed with buttocks resting upon the side board and feet supported by chairs be adopted. To me it seems reasonable that no thorough cleansing can be secured unless the cavity to be washed is filled to a degree of moderate distention so as to separate all apposing surfaces and permit the irrigating fluid to freely touch every portion of the surface to be cleansed, and in order to attain a thorough cleansing such filling and distention should be repeated several times at each seance or until the escaping fluid contains no more débris and is only tinged with blood. This means the necessity for the use of a considerable quantity of the cleansing fluid, generally a gallon at least. Owing to the large quantity employed the maximum strength need not exceed one in four thousand, and after the first post-partum douche, one in six thousand or eight thousand is preferable, unless in event of septicæmic manifestations the stronger solution may be again used.

I claim that with the ordinary vaginal or intra-uterine tube, be it made of either hard rubber or glass and used as is commonly done, a perfect cleansing cannot be given. W. Gill Wylie says: "Imperfect syringing has frequently resulted in leaving a fœtid upper segment of the vagina entirely unwashed, while the antiseptic stream has been limited to the lower third of the canal."[1] Dr. T. Gailliard Thomas also recognizes the inefficiency of a too weakly applied douche, and says: "A syringe with intermitting jet should be used which will wash away with gentle force all blood-clots, and reliance should not be placed upon the feeble drip of the fountain syringe, the advantages of which are, I think, entirely theoretical."[2] This latter writer advises the employment of a douche every four to eight hours for at least ten days succeeding delivery. More enthusiastic disciples of obstetric

[1] N. Y. Med. Jour., June 23, 1883.

[2] N. Y. Med. Jour., Dec. 15, 1883.

antisepsis have even recommended continuous irrigation for a similar period of time (Schücking).

In order to not soil the bedding it is desirable that the cleansing solution shall be carried from the vagina outside of the bed into a proper receptacle. Feeling the need of a device whereby such irrigation as described could be obtained, I devised and had constructed the apparatus I here show (see Fig. 1), which has proven to be both simple

FIG. 1.

and efficient in the superlative degree. It consists of three parts: First, a short, hard rubber Ferguson speculum of large diameter; second, a soft rubber discharge pipe about thirty inches in length and of sufficiently large calibre to slip over the flared end of the speculum employed; and third, an ordinary hard rubber vaginal tip passing through a small hole on the upper side of the soft rubber discharge pipe near its attachment to the speculum and connected by a suitable hose with a fountain syringe of large size containing the irrigating fluid, which should be suspended not more than from eighteen to twenty-four inches above the fundus of the uterus. The specula are of three sizes, nested, the largest being suitable for use immediately after delivery at full term. The smaller sizes will answer for douches administered when indicated upon any day succeeding the delivery or after a premature birth or miscarriage.

In the employment of this device the soft rubber discharge pipe is first stretched over the flared end of the appropriate speculum, care being taken that the end of the discharge pipe is selected which is provided with the small opening and through which is next passed the hard rubber vaginal tip which is in turn connected with the fountain syringe already filled with the irrigating fluid. The speculum is next entered into the vagina and sufficient pressure is exerted so that its flared end will press against the vulva and prevent the escape of the

fluid employed, which is allowed to flow until it begins to escape through the discharge pipe in order to expel the air. Now by compressing the soft rubber discharge pipe the solution flowing from the fountain syringe into the vagina is retained, causing it to enter the uterus through the dilated os, thoroughly filling all portions of the combined cavities and producing some distention which at the proper time is recognized by a swelling of the discharge pipe between the point compressed and its attachment to the speculum. By now removing pressure from the discharge pipe the retained fluid will escape with a gush, carrying with it post-partum débris. This process should be repeated until the irrigating fluid comes away quite clear, and is, I believe, a method of administering a vaginal and intra-uterine douche to the parturient patient which gives less disturbance than any other known means of accomplishing this result with the patient in the recumbent posture. The fountain syringe has certainly a great advantage in points of simplicity and cleanliness over any bulb syringe, and even though its stream ordinarily may be a "feeble drip", when employed with the device described with the intermitting overflow, the maximum of flushing power is obtained, causing a mechanical as well as a chemical antiseptic action while the larger quantity of the weaker solution employed gives equally as good results as can a smaller quantity of a stronger solution. Even "pure water, while not destructive to, at least weakens the vitality of many of the bacteria which infest the post-parturient cavity."

After the delivery and use of the douche I apply the protective pad of absorbent cotton moistened in the 1 to 2000 bichloride solution, covered with oiled silk, retained in place by suitable bandages and renewed from four to six times daily, as suggested by Garrigues.

If the occasional employment of a vaginal douche is advisable at other than parturient times, and I think it is, then why should not appropriately administered douches be indicated daily, or even more often, after a delivery? I have frequently advised such a practice, and have never known the patient to make other than favorable criticism thereupon, always acknowledging that after the use of the douche there was a sense of relief—a sensation of increased comfort.

For use during the first few days after delivery, I recommend the flushing apparatus which I have described, though as soon as the patient can get up and sit upon the commode I advise her so to do, as by such exercise a natural drainage is secured, and owing to the more vertical position of the uterus a free escape of the antiseptic fluid employed is assured. As soon as the patient can thus sit up I advise the use of a more simple device, consisting of an ordinary hard rubber vaginal tip suitably curved and provided with what is known as a

"nozzle bulb" (see Fig. 2), an article manufactured by G. W. Lutz & Co., of Indianapolis, Ind. This bulb is made of soft, white rubber and so shaped as to serve as a convenient plug for the external vaginal opening. By use of this nozzle bulb tip the same results are attained as with the previously described device, to-wit: filling and distention of the vagina, and possibly of the uterus, in combination with alternating retention and free discharge, and it would seem that in no other way can the entire surface of the vagina be satisfactorily cleansed. With this "nozzle-bulb" tip no air can possibly be introduced if the precaution is taken of allowing the fluid to flow through the tip prior to its introduction. A small point in this connection worthy of

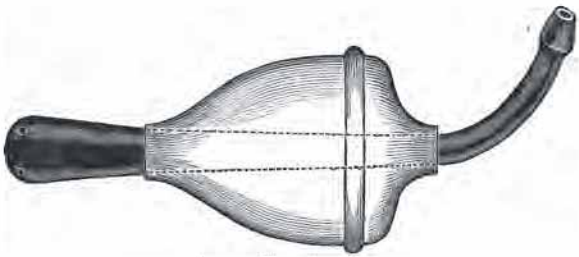

FIG. 2.

notice is that the most desirable style of fountain syringe is one, the several tips accompanying which, simply slip into the rubber hose, and all those more elaborate, complicated and expensive kinds, wherein the tips are attached by screw or soft rubber cork, should be avoided.

One possible point of objection might be raised against the devices I have described when used particularly with the post-parturient patient, and that is that, through the forced retention of the irrigating fluid and the distention coincident therewith, some of this fluid might be forced through the Fallopian tubes into the peritoneal cavity. When employed in the method described and with the slight fall of fluid not exceeding twenty-four inches as recommended, I cannot consider such objection admissible.

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[*For Discussion see Society Proceedings.*]