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RAPID UTERINE DILATATION.*

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There are few minor operations in gynæcology which can show such good results and as widely applicable as that of rapidly dilating the cervical canal. The operation is far from being a panacea for all the ills produced by uterine disease, but in properly selected cases the benefits arising therefrom are prompt and decided. By this method, cases of stenosis can be cured more readily and with less danger than by the operation of incision, as advocated by the late Sir James Simpson, Dr. Robert Barnes and Dr. Marion Sims. Indeed, this operation has almost entirely superseded the latter on this side of the Atlantic, and this is not to be wondered at when we consider the anatomical peculiarities of the part involved, and the sources of danger in the operation of incision. Again, by this means we are frequently enabled to dispense with the tedious and somewhat dangerous method of dilating the cervix by means of tents, where it becomes necessary to make applications to the intra-uterine mucous membrane. We are all aware of the danger of intra-uterine injections, unless there is a perfect patency of the cervical canal, to allow the fluid to freely and rapidly escape, and the usual mode of accomplishing this has been by the expansion of tents. By means of rapid dilatation more perfect patency may be secured, without the tediousness and danger of dilatation by tents, and the nozzle of the syringe can be passed between the divergent blades of the dilator. I shall briefly describe the method of performing the operation and then state the various conditions to which it is applicable, and finally give the history of a few cases which I have treated by this means.

1. *The Operation.*—By far the best uterine dilator which we, as yet, possess, is Dr. William Goodell's modification of Ellinger's dilator. The great advantage of this instrument is that the blades open parallel to each other, and it is provided with a screw to retain the blades open when necessary. Dr. Sims and Dr. Atlee each devised an instrument for this purpose, but both lack the parallel expansion of the blades. To perform the operation of rapid dilatetion thoroughly, an anæsthetic should be given, although for partial or incomplete dilatation—such, for instance, as for using intra-uterine applications or injections—it is not always necessary. Having anæsthetized the patient, she is brought to the edge of the table or bed and each foot held by an assistant. A bivalve or duck-bill speculum is introduced, and the uterus steadied by a tenaculum or vulsellum. It is best now to pass a probe into the uterus for the purpose of ascertaining the size and direction of the canal. The dilator is then introduced and the handles pressed gradually together, and then held there for ten or fifteen minutes. The difficulty in the procedure is in the introduction of the dilator. To overcome this, it is recommended to use at first an Atlee dilator or a small size Goodell's Ellinger, and introduce it as far as it will go. Then, by stretching the part it occupies, the stricture or contraction above yields to a certain extent, allowing further introduction and dilatation, and so on until the entire cervical canal is dilated "or tunnelled out." That accomplished, the larger instrument should be used, inasmuch as the more perfect the dilatation the less the chances are of recurrent retraction. When the os is so small as not to permit the entrance of the point of the dilator, it is recommended by Goodell to produce enlargement by means of the closed blades of a pair of sharp-pointed scissors introduced with a boring motion. As a certain amount of pain and soreness is felt after the operation, a suppository of morphia or opium introduced into the rectum will be beneficial. While the operation of rapid cervical dilatation is, perhaps, most conveniently performed as described, with the patient in the dorsal position, yet many gynæcologists operate exclusively with the patient

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