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CURETTAGE FOR UTERINE HEMORRHAGE DURING PREGNANCY

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The purpose of this article is to consider the place of uterine curettage in the treatment of hemorrhage during pregnancy prior to the attainment of fetal viability. Because this is of interest to theologians as well as physicians, the terms used to describe the scope of this paper will be defined for the orientation of the former.

Uterine curettage is an operative procedure the essence of which is the introduction of a curettage into the cavity of the uterus for exploratory or therapeutic manipulative purposes. It is usually preceded by dilatation of the cervical canal to facilitate access to the uterine cavity.

Curette instruments are either open loops or spoonlike scrapers attached to long handles. They may be sharp or blunted edged. They are intended to scrape out the lining mucous membrane of the uterus for either diagnostic study or therapeutic benefit. The scrapings will therefore include anything adhering to, arising from, or contained within the lining membrane. The entire procedure is commonly referred to as simply "curettage." It should be noted that any intrusion upon the confines of the uterine cavity by a curette or any other instrument is liable to cause a pregnancy, one to present, to be interrupted or aborted.

Hemorrhage during pregnancy prior to the attainment of fetal viability very often arises from an area of the uterus of variable size where the placenta has become detached from its implantation site on the uterine wall. Such hemorrhage is said to be contingent upon the pregnant state to distinguish it from other causes such as cancer which are definitely unrelated to a concurrent pregnancy.

Fetal viability outside the uterine environment becomes a reasonable possibility after about 16-23 weeks gestation depending upon the facilities available for the care of prematurely delivered infants.

The problem for solution

Is the use of uterine curettage morally licit in the presence of pregnancy prior to fetal viability for the treatment of uterine hemorrhage which is contingent only upon the existence of the pregnant state?

The approach to a solution of the problem

The use of curettage during pregnancy is specifically prohibited by Article 23 of the Catholic Hierarchy Moral Code 1 because the physician has no sure reason for believing the fetus already or detached.

Its use is also interdicted by n. 27 of Ethical and Religious Directives for Catholic Hospitals 2 in all cases in which the presence of pregnancy would render some procedure illicit (e.g., curettage), the physician must make use of such pregnancy tests and consultation as may be needed in order to be reasonably certain that the patient is not pregnant.

A further prohibition of curettage is implied by n. 17 of Ethical and Religious Directives because in the treatment of hemorrhage before the fetus viability, "Procedures that are primarily designed to empty the uterus of a living fetus still attached to the mother are not permitted."

From a practical point of view, solution of the problem presented obviously depends largely on the degree of precision with which the physician might be expected to be able to diagnose fetal death or the extent of detachment.

There is at present no infallible or convenient object method by which the suspected occurrence of either of these phenomena may be quickly confirmed in utero. The manner by which one reaches a decision regarding these crucial points is open to some debate and in practice usually resolves itself into a matter of opinion based on clinical judgment.

That there are tangible difficulties involved in the solution of the problem is borne out in the writings of various competent authors on medical ethics who have directed their attention to the matter.

Some theological opinions

Father Gerald Kelly makes no pertinent reference to uterine curettage in any of his five separate booklets of Medical-Moral Problems 3 which where published up to 1956 or in any of his contributions to The Linacre Quarterly to date.

In his new single volume edition (1958) of Medical-Moral Problems there are two pertinent references.

On page 53 Father Kelly expresses his view that there is ambiguity in the requirement of consultation "for all curetages and other procedures by which a known or suspected pregnancy may be interrupted" in a short criticism of the Standard of Medical Consultation formulated by the Joint Commission on Accreditation of Hospitals. He states that if this means that even the direct interruption of pregnancy before viability...
ity is permissible on medical grounds if agreed to by consultation it is morally unacceptable. However it means that these procedures might indirectly interrupt a pregnancy before viability it is then morally acceptable.

Because of the existence of this doubt the specific recommendation of consultation prior to curettage has been intentionally omitted from the Guide for Preparation of Medical Staff By-Laws prepared by the Council on Hospital Administration of the Catholic Hospital Association. Father Kelly concedes that individual hospitals may make more stringent rules but care must be observed to have no rules for consultation which even by implication might allow immoral procedures if consultants approve of them.

The second pertinent reference is chapter III, "Ergot and Abortion." In discussing the use of the oxytocic drug ergot in the treatment of hemorrhage prior to viability Father Kelly reaffirms the conclusion he arrived at some time previously in the old Part II of Medico-Moral Problems. He believes that the use of ergot is morally acceptable in serious hemorrhage. This is because the physician intends it to initiate a "living ligature" mechanism whereby the uterine muscle fibres, by contracting in response to the stimulus of this drug, constrict the open maternal blood vessels and thus stem the flow of blood from these bleeding points. In other words the use of ergot is a direct treatment of a dangerous pathological condition in the mother. A by-passing him via the hemorrhagic flood.

Fathers E. Godin and J. P. E. O'Hanley5 may be considered to be in close accord with Father Kelly's view when they state hemorrhage is so severe as to place danger the life of the mother by the curettage of the uterus, in practice, is morally permissible, even if fetus is not yet viable.

Taken literally there is some possibility of an indiscriminating reader's concluding that this statement condones direct abortion and is contradictory to Article 16 of the Canadian Moral Code and n. 15 of Ethical and Religious Directives, each of which states "Direct abortion is never permitted." This however is not the case because the words "in practice" included in their statement may be presumed to imply the same line of reasoning suggested by Father Kelly, namely, that there is a reasonable presumption that the fetus is dead or detached. Therefore, curettage serves simply to remove the dead fetus.

**CONSENSUS OF OPINION**

The views of the authors just cited seem to come to this: in emergency situations which make it impossible to form a perfectly clear estimate of the condition of the fetus, a sound presumption that it is already dead or already detached is sufficient to justify the emptying of the uterus in order to stop the dangerous hemorrhage.

One basis for such presumption is profuse and dangerous hemorrhage. A doctor who is working against time in order to save a mother's life may follow this presumption in order to justify a curettage which is simply for the removal of the contents of the uterus, including a fetus that is presumptively dead or detached, as part of the procedure for the control of the hemorrhage.

This conclusion however is not one that can be conveniently formulated into an easily applicable general rule because it presupposes the recognition in every instance of the very fine distinction between illicit direct abortion on the one hand and morally lawful removal of a dead fetus on the other.

Theoretically the person best qualified to make this distinction in any given individual case would be an experienced obstetrician of mature judgment who also has a thorough knowledge and understanding of the principles of medical morality. This is, of course, an unrealistic standard to expect from all physicians. There will therefore exist a potential danger of inexperienced or incompletely informed physicians reporting to curettage a little too soon in cases of only questionably severe uterine hemorrhage. Obviously, in the absence of an emergency, medical or moral consultation should be obtained when there exists doubt or uncertainty.

That this potential danger may actually materialize is attested to by the following case summary which is cited to illustrate some of the pitfalls to be avoided in the
management of hemorrhage during pregnancy prior to fetal viability.

**CASE SUMMARY**

This is a brief summary of the case of a thirty-year-old married woman.

**Entrance Complaint.** Elevation of temperature and persistent vaginal bleeding following uterine curettage three days ago.

**Past History.** Gravida 7: Para 4: Patient had been treated at various times during the past ten years for chronic pelvic inflammatory disease. She had a record of having definitely aborted twice in the past and possibly once again recently. She was in a precarious condition when admitted to the hospital. After her physician entered the hospital. After

**History of Present Illness.** Patient became pregnant about three months ago for the seventh time. During the current pregnancy she had been treated on two or three occasions by bed rest because of threatened abortion. She claimed that two weeks ago she had spontaneously aborted. There was no other confirmation of this beyond her statement of having passed "tissue" which she flushed away not realizing it should have been retrieved for examination by a physician.

Following this event she continued to bleed intermittently. For this reason her physician entered the hospital. After confirmation of the diagnosis by a qualified gynecological specialist through mandatory consultation, curettage of the uterus was performed by her attending physician. This yielded only a few fragments of tissue, identified on microscopic examination as degenerated placenta. The patient was therefore discharged.

**Operative Findings.** Visual examination of the vagina after induction of anesthesia revealed prolapse of a short loop of umbilical cord through a partly open cervix. Digital exploration of the uterus confirmed the presence of a fetus. Although hemorrhage had never been severe enough to place the patient in a precarious condition the fetus was nevertheless extracted with the aid of an ovum forceps. It was partially dismembered during the procedure. The placenta was found to be very adherent to the uterus but as much of it as possible was removed by digital efforts and gentle traction with an ovum forceps. Curettage was not done because of the symptoms of infection. Treatment was completed by the administration of ergometrine and pitocin which was followed by packing of the uterine cavity.

**Pathological Findings.** Detailed gross and microscopic examination of the dismembered fetus showed no evidence to indicate beyond a reasonable doubt whether death had occurred sometime prior to or during the manipulation of extraction. The fetus was estimated to have reached about the twenty-first week of gestation.

The patient was discharged a number of days later in improved condition.

**DISCUSSION OF CASE**

The truth of the oft-repeated observation that the Moral Code attracts serious attention only on those occasions when an apparent contravention occurs is once again borne out by this case.

Because these misadventures are usually due to a lack of knowledge of the Code, one wonders whether it might not be advisable to discuss various aspects of the latter from time to time at medical staff or departmental meetings.

One point that now stands out prominently in retrospect is that the whole chain of unfortunate events which ensued followed the acceptance of information from the patient which in the light of subsequent happenings proved to have been of a misleading nature. Skepticism of statements from unqualified observers is fully justified in cases such as this. Of course when the patient is in hospital restriction of bathroom privileges retention of all "clots" and "tissue" passed for pathological examination pretty well precludes the occurrence of this type of error.
in serious hemorrhage before one resorts to curettage. Had curettage not been performed during the admission prior to the present hospitalization, the pregnancy might have continued to full term. This possibility is postulated on the fact that the patient went through an uneventful full-term pregnancy the year before in spite of her long history of chronic pelvic inflammatory disease.

There is possibly room for some debate as to whether or not extraction of the fetus was actually justified when it was unexpectedly discovered at the time of examination under anesthesia. Although one might argue that the pregnancy appeared to be doomed (there is no doubt that it was certainly prejudiced by the preceding curettage) it must be admitted that death of the fetus was by no means certain at the time and the placenta was subsequently found to have been firmly attached. In the absence of severe enough bleeding liable to be an immediate threat to the life of the mother it would have been ethically more prudent to use conservative hematonic measures such as oxytocics and packing in this case. Then even if indirect abortion occurred it would have been a natural event in contrast to the question of direct extraction.

**CONCLUSION**

Uterine curettage for the treatment of serious hemorrhage contingent upon pregnancy prior to the attainment of fetal viability is morally licit only after the fetus has died or becomes detached.

There is a high probability that at least one of these conditions is fulfilled when hemorrhage is so severe that it constitutes an immediate and serious threat to the life of the mother. In such circumstances it is unlikely that the fetus is obtaining sufficient metabolic support from the mother via the placental circulation to sustain life. This justifies the assumption that it is dead or detached.

Application of this criterion presupposes that the physician recognizes the distinction between direct abortion and licit removal of a dead fetus. The theoretical test of absolute certainty is not always attainable by all physicians. Therefore, a reasonable margin of honest error in making judgments in severe hemorrhagic emergencies is tolerable as a realistic calculated risk until greater precision becomes possible in the diagnosis of fetal death or detachment.

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The Impediment of Impotency and The Condition of Male Impotence

A Cannibal Medical Study


To present the problems involved in the matter of male impotence as related to the validity of marriage, the medical considerations, as prepared by Rev. Paul V. Harrington, J.C.L., were published in the August and November 1958 issues of The Linacre Quarterly. The medical study as set forth by Dr. Charles J. E. Kickham appears in this issue. Dr. Kickham is a graduate of Holy Cross College and Harvard Medical School. He is Associate Professor of Urology at Tufts Medical School and Harrison-in-Chief, Department of Urology, St. Elizabeth's Hospital, Brighton, Carney Hospital, Boston, and Providence Cancer Hospital at Norfolk, Mass. He is a diplomate of the American Board of Urology.

**MEDICAL CONSIDERATIONS**

**HAVING** set forth the historical evolution and present understanding of the impediment of impotency and the condition of male impotency, it remains now to consider this canonical definition in the light of present-day medical knowledge and determine what diseases, anomalies or abnormalities would or might constitute an impotent condition. The possibilities of cure or remedy of such a condition will also be discussed in an attempt to discover which might be judged to be permanent. As mentioned previously, the antecedents of each condition can be determined by the fact of its congenital nature or by the date of the surgery or accident which accounts for it.

The etiological background of impotence may, in many instances, tax the diagnostic acumen of the most meticulous and painstaking investigator. A detailed present and past history with particular emphasis on those features, pertaining to the sex apparatus, must be elicited. An evaluation of the person's attitude towards the other sex is necessary. A careful physical examination should be carried out and an impression obtained as to the gonadal type involved. Inspection of the genital organs will reveal the existence of any anomalies or gross defects. Palpation of the scrotal contents is of importance as any abnormal findings may be of real significance. The testicle should be followed to the inguinal canal and the size, consistency and location of the testes should be noted. The status of the epididymis must likewise be recorded. The normalcy of the penis must be confirmed. These relatively simple procedures may provide a clue to the solution of the entire problem in an individual case.

A complete neuropsychiatric evaluation may, at times, be indicated. Neurogenic factors may