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F. G. Stuart

CURETTAGE FOR UTERINE HEMORRHAGE DURING PREGNANCY

F. G. Stuart, M.D.
Director, Department of Radiology
St. Joseph's Hospital, Victoria, British Columbia

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 curetting instrument 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.

Curetting instruments are either open loops or spoonlike scrapers attached to long handles. They may be sharp or blunt 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, if one is present, to be interrupted, i.e., 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 26-28 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 Canadian Hierarchy *Moral Code*[1] "unless the physician has sure reason for believing the fetus already dead or detached."

Its use is also interdicted in 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 objective 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 *Medico-Moral Problems*[4] there are two pertinent references.

On page 53 Father Kelly expresses his view that there is ambiguity in the requirement of consultation "for all curettages 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 viabil-

[1] *Moral Code*, Approved by Canadian Hierarchy, October, 1954. The Catholic Hospital Association of Canada, 1 Stewart St., Ottawa.

[2] *Ethical and Religious Directives for Catholic Hospitals*. The Catholic Hospital Association of the United States and Canada., St. Louis 4, Mo., U. S. A.

[3] *Medico-Moral Problems*, Parts I-V, Gerald Kelly, S.J. Catholic Hospital Association, St. Louis 4, Mo., U. S. A.

[4] *Medico-Moral Problems*, 1958, Gerald Kelly, S.J. Catholic Hospital Association, St. Louis 4, Mo., U. S. A.

ity is permissible on medical grounds if agreed to by consultation it is morally unacceptable. However, if 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 11, "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 secondary unintended and undesired consequence of this treatment may be the expulsion of the fetus from the uterus, i.e., an indirect abortion.

At the conclusion of this chapter on page 89, Father Kelly shows that he is well aware of the problem confronting the physician who must decide if a fetus is dead or detached while the mother is hemorrhaging seriously. In this crisis he asks only that the physician be able to say with a certain conscience that "most likely the fetus is dead or already detached" or "in all likelihood the fetus is dead" because in such situations the weight of odds favoring this probability is heavy enough to be tantamount to certainty. He gives one the impression that it would be an over-scrupulous demand to require the physician to make a precise irrefutable diagnosis because it is well nigh humanly impossible to do so.

To look at the matter in another way it would seem that Father Kelly's line of thought very aptly resolves a difficult dilemma for the doctor who may be fearful of doing evil whether curettage is withheld or performed. By withholding action the physician may be giving the benefit of doubt to a fetus who is already dead. To allow the mother to die under such circumstances would be undesirable. On the other hand, by taking positive action, i.e., performing curettage, there is a remote likelihood of hastening the death of a fetus who is already virtually detached and dying from want of sustenance which is irretrievably by-passing him via the hemorrhagic flood.

Fathers E. Godin and J. P. O'Hanley[5] may be considered to be in close accord with Father Kelly's view when they state: "If hemorrhage is so severe as to endanger the life of the mother curettage of the uterus, in practice is morally permissible, even if the 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 resorting 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

[5] *Hospital Ethics*, Rev. Edgar Godin and Rev. J. P. E. O'Hanley, 1st Ed., 1957, Hotel Dieu Hospital, Bathurst, N. B., Canada.

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 ten 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.

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 own 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 entertained a diagnosis of incomplete abortion. She was accordingly admitted to 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 decidua. The patient was then discharged.

During the ensuing ten days at home intermittent vaginal bleeding persisted and the patient developed elevation of temperature and general malaise. The present admission to hospital was therefore required.

Progress Notes during Current Admission. Antibiotic therapy was immediately instituted following admission. She was kept under observation for a couple of days during which it was noted that vaginal bleeding was quite persistent. Her condition was not however considered precarious. A consulting gynecologist found the uterus on external examination to be rather larger than one would expect after an abortion and described it as "bulky." The possibilities considered in the differential diagnosis were sub-involution, chronic endometritis and incomplete septic abortion. He elected to defer vaginal examination until it could be done under anesthesia in a day or two.

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 disclosed 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 couple 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.

Possibly the most interesting facet of the case is the phenomenon of the fetus surviving "curettage" of the uterus only to succumb some days later. Had curettage completely evacuated the uterine contents in the first instance it would have been tantamount to direct abortion because hemorrhage had not been alarming enough to reasonably presume that the fetus was in all likelihood dead and therefore removable. This is an example of what may inadvertently occur in actual practice if the fine distinction between direct illicit abortion and licit removal of a dead fetus is not clearly understood and recognized.

It is of some interest also to note the comment of the surgeon in his operative report that the placenta was quite firmly adherent to the uterus. This should remind physicians to be on the alert against assuming too soon that placental detachment is complete in the absence of profuse hemorrhage. Supportive and other hemostatic measures such as transfusion, oxytocics and packing must be pushed to the limit of their effectiveness even

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 on 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 hemostatic 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 questionable morality of direct extraction.

CONCLUSION

Uterine curettage for the treatment of serious hemorrhage consistent 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 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 ideal 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.