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The First American Symphyseotomy.[1]

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UNTIL late in October last we were under the impression that the first symphyseotomy on this side of the Atlantic was performed by Professor Charles Jewett, of Brooklyn, on September 30, 1892, but it was then discovered that the credit belonged to Dr. William Thomas Coggin, now of Athens, Georgia, who operated in Freedman, Northeast Alabama, on March 12, 1892, more than six months before, with entire success; his residence at that time being in Keener, in the same mining region. Learning of Dr. Coggin's case at the time indicated, I opened a correspondence with him at once; have had ten letters from him since November 1, 1893; have secured a report of his operation for the *American Journal of Obstetrics*, for which it is now in press; and am here prepared to do him credit for the initial operation in this hemisphere. I should feel inclined to censure him for withholding his case from the profession for so long a period, but for the fact, shown in his first letter to me (November 2, 1893), that he was under an impression that as many as five operations had antedated his in this country. Had he known, as he does now, that he was the pioneer operator, we should, no doubt, have had an early report, and he would have been of influence in introducing the scheme to the favorable acceptance of American obstetricians.

The record of Dr. Coggin's case shows that Drs. Pinard and Varnier, of Paris, had nothing whatever to do

[1] Read before the Philadelphia Obstetrical Society, January 4, 1894.

with inducing him to perform the operation, thirty-six days after the initial trial of the former, as he had not heard of Pinard's case, or of their advocacy of the method. He was in Heidelberg in 1890, where he heard, from an Italian physician, an account of the remarkable successes under the operation in Naples, and received one of Professor Morisani's papers on the subject. He then decided to prefer symphyseotomy to craniotomy, whenever a case should come under his care in which one or the other should be presented as the alternative; and it was thus that he became the second to perform the operation after its exit from Italy. Had he been in a large city, he might have met with a proper subject much sooner, and have antedated Professor Pinard in his work, as he had in his acceptance of the applicability of the method. Dr. Coggin was a graduate in medicine of eight years' standing when he went to Germany, and prepared by experience to value a plan of obstetrics that opened to him a way of avoiding the objectionable one of craniotomy.

It is well known that no one in Europe, except in Italy, performed a symphyseotomy from 1865 to 1892, although from 1886 to 1892 there was enough in the measure of success attained to warrant its introduction into other countries. A mortality of 5½ per cent., we should suppose, would have secured imitators at a much earlier period, but for the fact that the Italians made but little boast of their work, and appeared to be indifferent upon the question of breaking up the old and deep-seated prejudice against the operation. Although aseptic and antiseptic measures had effected a revolution in results, it was not until a long record of successful cases had been collectively reported that the opposition of a century was made to give way. Having been in correspondence with the active advocates of symphyseotomy since the year 1882, I can understand the effect of the revelation of results that was made to certain Parisian obstetrical writers and observers, in Naples and Paris, during the winter of 1891–92. By that time there was such an array of facts in favor of the operation that it was only requisite to make them known, to excite attention; for up to January 1, 1892, there had been in the preceding seven years thirty-seven Italian operations, with two women and three children lost. These cases were in order Nos. 11 and 24; the first of which had been in labor ninety-six hours, and the second, several days; Case 11 died of septicæmia, and Case 24 of metroperitonitis.

Dr. Coggin operated upon the wife of a miner, a tall and apparently well-made primipara, 23 years old, and five feet and seven inches high, who had been fifteen and a half hours in labor when he was called in. He tried to deliver by the forceps, but found the pelvis too much contracted to admit the passage of the instrument, being of the *justo-minor* type, and computed to be one-third smaller than the average. He opened the symphysis after sixteen hours' labor; applied the forceps; and in delivering the fœtus, which proved to be a male of eleven and three-quarters pounds' weight, noted that the pubic bones became separated two and three-quarters inches. There was no injury produced by the extraction of the

child, either to the sacro-iliac synchondrosis or to the soft parts.

Under a proper restraining apparatus the pubes readily united: there was no lameness, and the boy did well, as his unusually large size now indicates. There have now been thirty-five operations in the United States, and this woman was among the earliest to be operated upon, and bore the heaviest child but one of the thirty-five, the highest in weight being one of twelve pounds. Of the children, twenty-four were males and eleven females, and the average weight of thirty-three of them was eight pounds. This average is the best possible indication that, in our country at least, the minimum conjugate should be fixed for fœtal safety at two and three-quarters inches, or seventy millimetres.

As promptness in action is a very important element of success in symphyseotomy, we are surprised that there have been only four women lost out of the thirty-five cases, when we consider the fact that short labors have been the exception. As we have secured a record in hours of the duration of labor in the thirty-five cases, we are enabled to present the following analysis: Labor induced in 2 cases; labor before operation, of 6 hours or less, 1; 7 to 12 hours, 5; 13 to 24 hours, 15; 25 to 36 hours, 2; 37 to 50 hours, 6; 51 to 62 hours, 1; 63 to 76 hours, 2; and 89 hours, 1. The four fatal cases were in labor respectively 16, 20, 25, and 72 hours. Of the last 19 cases, 1 woman and 5 children were lost.

It is of interest to note the order and date of introduction of the operation into the several countries since its exit from Italy.

The record of the year 1892 has been carefully collected by Dr. Franz L. Neugebauer, of Warsaw; Professor Charpentier, of Paris; Dr. Francesco Caruso, of Naples; and the writer,

No.	Country.	Locality.	Operator.	Date of Introduction.	Result to Woman.	Result to Child.
1	France.	Paris.	Prof. Adolphe Pinard.	February 4, 1892.	Recovered.	Died.
2	United States.	Freedman, Ala.	Dr. Wm. Thos. Coggin.	March 12, 1892.	"	Lived.
3	Germany.	Strassburg.	Prof. Wilhelm A. Freund.	April 29, 1892.	"	"
4	Austria.	Cracow.	Dr. W. Harajiewicz.	August 4, 1892.	"	Dead.
5	Russia.	Helsingfors.	Dr. Adolphe Törngren.	September 5, 1892.	Died.	Lived.
6	Brazil.	Rio de Janeiro.	Dr. Rodrigues dos Santos.	November 11, 1892.	Recovered.	"
7	Ireland.	Dublin.	Dr. William J. Smyly.	November 23, 1892.	"	"
8	Switzerland.	Basle.	Prof. H. J. Fehling.	November 25, 1892.	"	"
9	Holland.	Leyden.	Prof. Hector Treub.	December 2, 1892.	Died.	"
10	Canada.	Montreal.	Dr. J. A. Springle.	December 5, 1892.	Recovered.	"
11	India.	Bombay.	Surg. Maj. H. P. Dimmock.	December 22, 1892.	"	Dead.
12	England.	London.	Dr. Arthur H. N. Lewers.	February 12, 1893.	"	Lived.

under a reciprocal arrangement, whereby both published and unpublished cases have been recorded, and we have found 81, with 10 deaths and 24 children lost: France had 37 operations, with 6 deaths; Germany 11, with 2 deaths; Austria 6, with 1 death; Italy 9 and the United States 8, with no death; Russia 4, with 1 death; and there was 1 each in Brazil, Ireland, Switzerland, Holland, Canada, and India, with 1 death, in the Holland case. Under the first thirty-one operations of the year, there were three women lost. In the first six months of 1893, there were more operations than in the whole of 1892,

and the record of the year will probably reach two hundred, or more than the Cæsarean and Porro-Cæsarean cases of the world together.

It is worthy of note that France had forty-three operations and had tested antiseptic symphyseotomy during a year before England, the twelfth country to follow the teaching of Italy, had her first operation; and, although this was entirely successful, others do not appear inclined to repeat it. Old obstetrical writers in England are afraid of the Cæsarean operation, and do not appear to realize how much its mortality has been reduced, are strongly wedded to craniotomy, and cannot overcome their educated prejudices against symphyseotomy, the result of a century of training. Her younger obstetricians may in time learn, as we are doing, the value of the operation, and give it a fair, honest trial; but the medical profession is very slow in England in making advances; much more so than in her provinces, Canada, India, and Australia.

There is much of a fallacy in calculating the risks of symphyseotomy by an average of results, taking all the cases together, good and bad. France lost three women out of her first twenty-five, and six out of her second twenty-five, a change from 12 to 24 per cent. Experience should have secured better results; but experience is largely individual, and properly refers to a repetition of the same operation by the same surgeon, as is very well demonstrated by the tables of ovarian exsection. In symphyseotomy the object should be to deliver the woman of a living child, and to save the lives of both; and anything that comes short of this is to that degree a failure. Another object to be considered is the avoidance of injuries to the woman in the opening of her pubes and the forcible delivery of her child. Haste has in it more of an element of risk of injury in the delivery than wisely-considered delay has.

Each case must be considered by itself in making a prognosis; the woman may have been a long time in labor; she may have a minimum conjugate, a small vagina, and a large fœtus; the child may be barely alive or possibly dead, and the woman in a state of much exhaustion. What we call *good* cases generally recover; some *bad* ones, and even *very bad* ones, may do this, but they are to be regarded as exceptional; *extremely* bad ones rarely belie the prognosis.

Symphyseotomy in too many cases belongs to the surgery of emergency, and has to be classified as such. Where the subject is under observation before labor, and the size of the pelvis is tested by pelvimetry, rather than by a trial under the forceps, she will almost always make a recovery, provided she is not injured by a hurried delivery and has not had a hæmorrhage produced by incision or laceration.

There is also a fallacy in calculating the proportion of fœtal deaths by the number lost in a hundred cases under all operators. Where the pelvis is a fraction too small for the passage of the fœtal head, and the woman is operated upon early, she and the child should be saved; but where the disproportion of size between head and pelvic calibre is very marked, there is danger that the child may be lost. Under the eighty-one operations of 1892 there were twenty-four

children lost, as follows: Still-born, ten; delivered in a dying state, three; premature and lived three days, one; and died within three days after delivery, ten. An early delivery should have reduced the deaths one-half.

The question is often asked me in letters, What is the death-rate under symphyseotomy for the women and the children? We cannot estimate what should be the prospective risk under the operation, as we have already shown, for so much depends upon varying conditions which may be favorable or the reverse.

Recent experience has shown conclusively that some of the old objections to the operation have been removed under antiseptic surgery. Failure of the pubic symphysis to unite, and lameness produced thereby, are no longer tenable objections. Injuries to the sacro-iliac synchondroses are not recorded in connection with any recent sections in Europe or America, and lacerations of the soft parts, which should seldom occur, can be treated so as to restore them to their integrity and avoid septic infection. The symphyseotomy of to-day is a much more innocent operation than that of a century ago; and we see no objection to using it as a substitute for craniotomy when the case is in skilled hands.

As far as ascertained, there were twenty-seven symphyseotomies in the United States in 1893, and there have been forty operations in North and South America, with four women and nine children lost, a maternal mortality of 10 per cent. There have been twelve operations in Philadelphia, or one-third of those in the United States, all performed by members of this Society. The operation has been performed in ten States and by twenty-six operators. Twenty-eight of the cases were in our large cities.