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PROLONGED PREGNANCY

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THIS short article is intended as a sequel to a paper on "Induction of Labour at Term as a Matter of Routine," published in the *American Journal of Obstetrics* two years ago. Since that time observation of cases, consultations, and conversations with fellow-practitioners, have given me more definite opinions as to the evils of prolonged pregnancy.

The following recommendations were made in the paper referred to: "Induce labour in all cases within two or three days after the expected date of confinement without waiting for any signs of labour. First plug the vagina according to the Schauta method, making a special effort to pack the vault tightly. After packing allow the patient to get up and go about if she wishes. Remove the tampon in twenty-four hours, introduce a new plug, and again allow the patient to get up and go about if she chooses. Remove the second tampon in twenty-four hours after its introduction. If by this time labour has not commenced, it is generally advisable to pass a bougie into the uterine cavity before introducing the third tampon."

A few remarks will now be made in reply to criticisms and certain questions which have been asked. For the purposes of present argument a pregnancy prolonged one month after term will be considered. First, as to child. The growth of the child in utero after it becomes viable is very rapid. At the end of seven months the average weight is 1,400 gm.; at the end of eight months, 2,200 gm.; at the end of nine months, 3,470 gm., the increase in the latter month being nearly 58 per cent. The probable increase in the tenth month is 2,000 gm. In other words a child weighing seven pounds at term will weigh eleven at the end of another month. A child weighing nine pounds will weigh thirteen or fourteen pounds. In addition, the child loses, to some extent, its flexibility; "universal flexion" is not so marked; worse still, the head becomes hard because of ossification.

We cannot speak so definitely as to the effects on the mother. We may say, however, that her nervous system is more or less

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seriously affected, she is frequently much depressed, and her general health is impaired in many ways. The difficulties we meet in conducting the labour are always great, sometimes tremendous. The large ossified head neither moulds nor flexes properly. In an unduly large proportion of cases the occiput turns to the rear. The uterine contractions are very painful, and unsatisfactory in many ways. They commonly become weaker, or cease altogether just at the time when the expulsive forces are required. Interference is generally necessary, and the results are frequently, if not mostly, disastrous for both mother and child.

Such evils are generally recognized, but many think that it is not right to subject the patient to the risk involved in the induction of labour unless grave dangers arise. The gravest danger is really the growth of the child in the uterus; and this we should not fail to appreciate, although we cannot see it. If the induction of labour is done in an aseptic way it is practically devoid of danger. In any case, it involves much less danger than a labour when a pregnancy has been prolonged to ten months.

One of the objections raised is that we cannot always tell when the patient has reached "term." For instance, there may be evidence to show that conception has occurred, not shortly after the last menstrual period, but a little before the next period should have commenced. In such a case, or in any case of doubt, the accoucheur may obtain evidence by both external and internal examination which may assist him in arriving at a correct conclusion. If the matter still remains doubtful, it may be well to wait for one week before inducing labour. It is safer, however, to induce labour one or two weeks before "term," than two weeks after.

Many questions have been asked about methods of procedure. The Schuta method of vaginal tamponade is not effectual in a large proportion of cases. This being so, it seems better in the majority of cases to introduce a tube or bougie into the uterine cavity as the first step. The parts should be prepared as for vaginal hysterectomy. The patient is usually placed in the lithotomy position, "across the bed," in private practice. A "weight" speculum is introduced, and the cervix is fixed with a tenaculum forceps. A sterilized gum elastic bougie (No. 12 English) is introduced gently within the uterus up to the fundus if possible, care being taken not to rupture the membranes. If membranes are accidentally ruptured immediate vaginal tampinade will usually prevent evil results. Little, of Montreal, uses a medium-sized rectal tube with a flexible metal director; and finds this sufficient in

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all cases, while the smaller gum elastic bougie alone sometimes fails.

In my own practice I always use the vaginal tampon after the bougie is introduced. There is generally about an inch of the bougie in the vagina below the cervix. The patient is turned from the back to the Sims' position, and the Sims' speculum is introduced in such a way that the vagina is "ballooned." The gauze, medicated generally with iodiform, is introduced, and packed tightly over or round the small portion of the bougie projecting into the vagina. The bougie is quite flexible, and the portion below the cervix is generally turned at a right angle while the gauze is being introduced. The aim is to pack very tightly the vault and upper two-thirds of the distended vagina. If the lower third is tightly packed it causes great pain, and frequently retention of urine. During the last few years I have used ordinary cheese cloth instead of the gauze, for reasons which do not apply to our present argument. The material is cut into strips, 4 in. wide and 4·5 yds. long. One of these strips is usually sufficient for one packing; but occasionally a little less or a little more is used. This strip represents one-half square yard, that is, a piece of cheese cloth one yard long and half a yard wide.

In some cases, as before mentioned, the vaginal tamponade is sufficient to induce uterine contractions, and bring on labour. In all cases, it appears to have a good effect in dilating and softening the vagina, the pelvic floor and the perineum. I may say incidentally that in dry labours my custom now is to introduce the tampon as soon as possible after the rupture of the membranes. For such a purpose the cheese cloth is also better than gauze, because it is more likely to keep the liquor amnii, or a portion of it, within the uterine cavity.

Another question frequently asked is this: Do you often find that introduction of the bougie, and especially of the tampon, produces pain? Yes, it frequently does, and I often desist, and get an assistant to administer an anæsthetic,—preferably ether. In such a case I always introduce both the bougie and the tampon.

Does protracted pregnancy frequently occur? So far as we can judge from the statistics of those who have investigated the matter, it would appear that it occurs in about 15 per cent. of all pregnancies. Protraction to the extent of four weeks, or one month after term, probably occurs in 6 per cent. of the cases when there is no interference.

Is it still deemed advisable in all cases to induce labour at, or shortly after, full term? As to this question I shall speak on this

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occasion for myself alone. Careful observation and increased experience have fully confirmed my opinions expressed two years ago. I think, therefore, that it would be well for both mother and child to make it an ordinary matter of routine to induce labour in all cases within a few days after term.

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