

New York Medical Journal

INCORPORATING THE

Philadelphia Medical Journal ^{and} _{the} Medical News

A Weekly Review of Medicine, Established 1843.

VOL. CIV, No. 1.

NEW YORK, SATURDAY, JULY 1, 1916.

WHOLE No. 1961.

Original Communications

CONSERVATISM IN OBSTETRICS.*

By EDWIN B. CRAGIN, M. D.,
New York.

The last few years have witnessed the development of radical surgical obstetrics and brilliant the results have been. Long lists of Cæsarean sections have been published with little if any mortality, and the indications for the operation have been extended by some to include placenta prævia, eclampsia, accidental hemorrhage, etc. The question before us is: Are we in our enthusiasm over radical obstetric surgery neglecting the fundamentals of obstetrics; the routine precautionary methods which may make the resort to radical obstetric surgery unnecessary? The consultant still sees cases of puerperal infection; of ruptured uteri; of undiagnosed posterior positions of the occiput. He sees cases in which forceps have been applied too early, cases in which version has been attempted too late. We can only conclude that, in spite of brilliant results along certain lines, the fundamentals of every day obstetrics are still neglected. It is freely admitted that pelvimetry does not always tell whether a child can be born through the natural passages or not. The angle of junction of lumbar spine and sacrum may be such as to prevent the entrance of the fetal head into the pelvis in spite of large pelvic measurements. The writer has several times been obliged to perform a Cæsarean section upon a woman whose pelvic measurements were just major, and whose dystocia came as a surprise, demonstrated only by hours of test labor. On the other hand, careful pelvimetry tells a great deal, and if a careful pelvimetry of the inlet and the outlet of the pelvis is practised during pregnancy and especially if coupled with it there is a careful comparison of the size of the presenting part and the brim of the pelvis, the surprises will be few and the possibility of dystocia can usually be foretold and provided for. The mouldability of the head and the strength of the uterine contractions are always uncertain factors in the problem, but pelvimetry will usually tell us at least one factor in the problem and should never be neglected. Pelvimetry is a part of conservative obstetrics, as it will disclose a large percentage of cases in which delivery through the natural passages

is impossible, and these are in the women who should not be allowed to lower their vitality or the vitality of the child by labor. Furthermore, it will disclose a certain percentage of cases in which, if premature labor is induced, delivery may be accomplished without resort to radical obstetric surgery, even if forceps or version is necessary.

The importance of uranalysis in the care of an obstetric case has long been recognized, but the importance of regular and frequent examinations seems to have been neglected by many. It is freely admitted that a fulminating case of eclampsia in which the urine was normal on ordinary examination a week before, will occasionally occur. This is exceptional, however, and the rule is that if the urine is examined every two weeks, danger signals will be disclosed long before the eclamptic seizure.

The value of taking the blood pressure of a pregnant patient has only recently been recognized, yet it is one of the best criteria of the condition of the woman and her avenues of elimination, and the obstetrician who omits it from his routine procedures in the care of his obstetric cases is not doing his duty. With the portable, relatively inexpensive sphygmomanometers on the market, there is little excuse for the neglect of the blood pressure, and the more we study results the more we become impressed with the fact that a pregnant patient with a blood pressure of 140 or over is usually suffering from a serious toxemia. The importance of taking the blood pressure at short intervals during pregnancy and the valuable information to be gained by seeing the patient, noting the presence or absence of edema, makes it necessary that she should visit her obstetrician frequently during pregnancy and that simply sending the urine is not sufficient.

Now let us come to the delivery itself. I am writing for general practitioners. What precautions are you taking against puerperal infection, still the nightmare of the lying-in chamber? Do you provide yourselves with a sterile gown and with sterile rubber gloves? The time has passed when it is safe for a man to deliver a woman without all the precautions which the laity recognize as important in safeguarding a woman against infection. The use of rubber gloves is one of the safeguards known to the laity, and if a physician has not worn sterile rubber gloves and happens to have a case of puerperal infection, his lot is certainly not a happy one,

*Read before the Eastern Medical Society of the City of New York, Friday evening, May 12, 1916.

as he has the support of neither the laity nor the profession. On the other hand, it is known to the profession, at least, that in spite of every precaution puerperal infection will occasionally occur, even in the best of hands. This means that if a physician has used every precaution known to science as essential in preventing infection and yet happens to have a case of it, the profession will stand by him, but without such precautions he deserves and receives support from neither the laity nor the profession. Let me say, that it pays to be charitable toward any careful man who is unfortunate enough to have in his practice a case of puerperal infection. To criticize is easy, but alas! the tables may soon be turned and we may be the next unfortunate to spend anxious days and sleepless nights over a case of puerperal infection which came we know not how. There is only one redeeming light on the horizon of darkness. If we have used every precaution known to science, our conscience is clear, even if we are criticised by our fellow practitioners and by the laity. With any important precaution omitted even our conscience upbraids us, and this may be harder to bear than all other criticism.

Conservatism, as the writer uses the word, does not mean opposition to progress. It is used more in the sense of favoring progress which is not too rapid, progress which conserves the well being of both mother and child. We may well ask ourselves the question, Am I doing my obstetric work in the way that will best conserve the life and health of my two patients, the mother and the child? Thus far we have considered chiefly the mother, but the child certainly deserves consideration. Are we watching the fetal heart as we should? or are we taking it for granted that because we heard it once it will still be beating when the child is born? I know of no criterion of the well being of the child which compares to the rapidity and character of the fetal heart sounds, and no obstetrician seems to me to be doing his duty to the incoming member of society who does not keep posted as to the fetal condition by listening frequently to the fetal heart during labor. It may be argued that after the obstetrician has put on his rubber gloves, he cannot listen to the fetal heart without unsterilizing them. This argument does not hold, as for years the writer has been in the habit of lifting with his gloved hands the sterile towel from the patient's abdomen and having the nurse pull down the night dress so that through it he could listen to the fetal heart; the night dress is then drawn up by the nurse, the towel which has been held with sterile hands is then replaced on the abdomen, and this process is repeated as often as may be necessary.

A few months ago the writer was summoned in the afternoon to one of the suburbs of the city to deliver a woman by forceps. One of my first questions was, Is the case ready for forceps delivery? The answer was, Oh, yes. It is time she was delivered. I made a hurried twenty-five mile run to the place in an automobile and on arriving and examining the patient found a cervical dilatation about the size of a silver quarter. I was obliged to tell the attending physician that I thought by next morning the cervix would be sufficiently dilated and the head

sufficiently descended to make the forceps justifiable. I then returned to the city.

My object in mentioning this case is to call attention to the fact well known in most maternity hospitals in the city, that many cases are brought to our hospitals with the history that the doctor had applied the forceps and after several attempts had failed to deliver the woman. Many of these cases have shown, even on arriving at the hospital, a cervix without sufficient dilatation to make the use of the forceps justifiable.

There is a Scylla and a Charybdis in the use of the forceps in obstetrics. We might call the Scylla the too early application of the instrument, before the cervix is sufficiently dilated, and the Charybdis the too late application, after the fetal head has rested so long on the pelvic floor as to cause cerebral injury on the one hand and loss of vitality in the maternal soft parts on the other. Conservative obstetrics steers midway between the two, and this middle course is usually charted by a vaginal examination of the cervix and by careful and frequent listening to the fetal heart. The difference in the ease of delivery in an anterior and a posterior position of the occiput is so marked that the conservation of both mother and child depends largely upon the accurate diagnosis of the position of a vertex presentation. The consultant is not infrequently called to a case of persistent occiput posterior which undiagnosed has been left in ineffectual labor for twenty-four hours with perhaps repeated attempts to deliver with forceps, under the supposition that the posterior fontanelle was anterior. A correct diagnosis many hours before, with a manual rotation of the head till the occiput lay in front of the transverse diameter of the pelvis, and then the proper application of the forceps would have saved the mother many hours of exhausting labor and the child many hours of dangerous cerebral compression. The writer's plea is for early diagnosis of occipitoposterior positions, and as elements in this diagnosis he would emphasize:

1. The absence of the smooth broad fetal back from the front of the mother's abdomen.
2. The location of the greatest intensity of the fetal heart sounds outside of the line joining umbilicus and either anterior superior iliac spine.
3. The character of the labor pains.

This characteristic of labor in a persistent occiput posterior should be well known by all. The absence of flexion prevents ready descent of the vertex into the cervical canal with its associated stimulus to uterine contractions. This means that the uterine contractions are often feeble, far apart, and ineffectual. This type of labor—long, tedious, with little advance of the presenting part—is so often found associated with a persistent occiput posterior that this diagnosis should at least be suggested and should be either verified or excluded by careful examination.

There is one danger which is still not sufficiently understood by the general practitioner—version in a tonic uterus. If we have tried a forceps delivery in a given case and have failed, either on account of a disproportion between the presenting part and the parturient canal, or because on account of a poor

application of the forceps blades the instrument has slipped, it is only human to be tempted to try a version. The bimastoid diameter is shorter than the biparietal, and by a podalic version the smaller end of the wedge would be made to enter the pelvis first. Under certain conditions this would be good conservative obstetrics, but it all depends upon whether version is, or is not contraindicated by a tonic uterus. Version in a tonic uterus, with uterus contracted on the child and lower uterine segment thinned out, usually means rupture of the uterus and death of the mother in over seventy-five per cent. of cases. Certainly a craniotomy is better than a ruptured uterus.

With the present popularity of Cæsarean section and its low mortality—in the writer's last seventy-three cases there was only one death and that from an embolus in the course of a complicating bronchopneumonia and in the sixty-one cases just preceding this one there had been no death—we naturally ask the question, What is a conservative position to take regarding Cæsarean section?

The writer regards Cæsarean section as a conservative procedure when delivery of a living child through the natural passage is shown to be impossible, either from a contraction of the pelvis which makes the indication positive, or as the result of a test labor, *provided that certain conditions are present*. These conditions are:

1. Labor of short duration or not begun.
2. Unruptured membranes; or membranes only recently ruptured.
3. No recent vaginal examinations, or only one or two under strictest aseptic precautions with sterile gloved hands, etc.

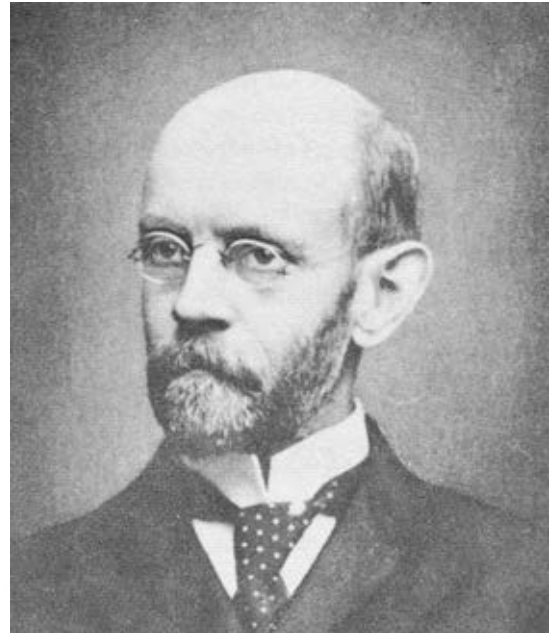
If the woman has been a long time in labor with membranes ruptured many hours, the mortality of from two to three per cent. rises to a mortality of from ten to fifteen per cent., and the operation ceases to be a conservative procedure and becomes one of considerable hazard. This emphasizes the importance of an early diagnosis in all cases with a positive indication for Cæsarean section so that the operation can be performed either just before or in the early stages of labor. Moreover, it demonstrates the importance of the greatest care during the test labor of the border line cases in primigravidae, that the labor should not be too long and that the vaginal examinations should be as few as possible and made with the strictest asepsis.

In conclusion, the writer would like to state his views of conservatism in the extension of Cæsarean section to conditions other than dystocia from pelvic contraction or tumors; for instance, placenta prævia, eclampsia, accidental hemorrhage, etc.

In the writer's judgment these conditions furnish an indication for a section only as a rare exception. In certain cases of complete placenta prævia with marked loss of blood and cervix not easily dilatable, a section offers the best prospect to mother and child. The same may be said of certain cases of accidental hemorrhage with complete premature separation of the placenta, but it is the writer's custom to deliver most of these women in some other way, usually after preliminary dilatation with the elastic bag.

One thing must always be borne in mind, viz., that no matter how carefully a uterine incision is sutured, we can never be certain that the cicatrized uterine wall will stand a subsequent pregnancy and labor without rupture. This means that the usual rule is, *once a Cæsarean always a Cæsarean*. Many exceptions occur, and recently one of my hospital patients upon whom I performed a section for an ovarian cyst, removing the cyst at the same time, came to me to report that she had since had three children without difficulty. In this case the obstruction had been removed and the labors were easy. The general rule holds, however, that we cannot depend on a sutured uterine wall, whether it is done in a Cæsarean section or a myomectomy, hence I believe that the extension of Cæsarean section to conditions other than dystocia from contracted pelvis or tumors should be exceptional and infrequent.

10 WEST FIFTIETH STREET.



Edwin Bradford Cragin (1857 - 1918)