TRANSACTIONS OF THE SOCIETY OF THE ALUMNI OF THE SLOANE HOSPITAL FOR WOMEN.

Meeting of October 27, 1916.

The President, DR. JOHN DOUGLAS, *in the Chair.*

DR. GEORGE L. BRODHEAD reported the following cases:

I. NORMAL LABOR FOLLOWING CESAREAN SECTION.

The patient came to me on May 18, 1916, giving the following history: the first labor, some years before, had been at full term, and resulted in the extraction of a large stillborn child by the breech. The second labor had been terminated by Cesarean section, after a three-hour labor, the child again being of large size, but the exact weight of which, was unknown. The patient gave the date of the last menstruation in the present pregnancy, as December 5–9, 1915, and life had been felt on March 31. The spines measured

26 cm., the crests 28 cm., and the external conjugate 20.75 cm. The diagonal conjugate was 10 cm., and the estimated true conjugate 8.50 cm.

The patient was advised either to have labor induced at the end of the eighth month, or to have Cesarean section at term. The woman refused to have labor induced, and said she wished to see if she could not have a normal labor at term. I consented to this, provided she would come to the hospital when labor set in. It seemed to me that in all probability, she would again require section. On September 19, the first stage began at 9 P. M. and when first seen by Doctor Ingraham, resident obstetrician at the Woman's Hospital, at 1.30 A. M. September 20, the patient was having slight pains at infrequent intervals. The second stage began about 3 A. M. and rectal examination at 3.45 A. M. revealed the fact that the head was low in the pelvic cavity. It was deemed safest to apply forceps, and at 4.10 A. M. with the head in normal position, low in the pelvis, a few very easy tractions were made, and at 4.20 A. M. the woman was delivered of a 9¾-pound male child in good condition. The biparietal diameter of the head measured 10 cm. The rest of the labor was normal, and after an uneventful puerperium, the mother left the hospital with her child, both in excellent condition.

I confess that I was amazed with the outcome of the easy labor, as the head was unusually large, and the pelvis was markedly contracted. Notwithstanding the excellent result obtained here, we are of the opinion, that when a Cesarean section has been previously performed and with factors present such as we have mentioned, large child, and small pelvis, it would be better as a rule, to perform an elective section, rather than to wait for possible normal delivery, with the possibility of rupture of the Cesarean cicatrix constantly in mind.

2. CESAREAN SECTION FOR CONTRACTED PELVIS, WITH TWIN PREGNANCY.

The patient came to me on August 8, 1916, stating that she had been pregnant twice before. The first pregnancy went to full term and she had been delivered of a dead child, after a difficult forceps operation. In her second pregnancy, labor had been induced, because of the difficulty in the first confinement, and also because of the fact that she had apparently progressed beyond term. Again the forceps was used, and a dead child extracted. Both children were large, but the weight was unknown. In the present pregnancy, the last menstruation, was December 23–28, 1915. Life had been felt on May 11, 1916, at about four and one-half months, and the patient was estimated for October 1, 1916. The spines measured 27 cm., the crests 29 cm., and the external conjugate 19 cm. The transverse, at the outlet measured 8 cm. Internal examination revealed a marked inlet contraction, especially on the right side, and the patient was advised to have Cesarean section at full term. On September 22, 1916, the membranes ruptured, and the patient started

at once for the hospital. Examination of the large abdomen showed twin pregnancy, the large head of one child resting under the abdominal wall, in the region of the umbilicus. Inasmuch as the children were of large size, and the pelvis markedly contracted, it was decided that the Cesarean section should be performed, as the patient was very anxious to have a living child. The classic operation was done, the first child being extracted by the head, which was lying directly under the incision. The second child was then removed, with no complications, the placenta was removed, and the uterine and abdominal wounds were closed in the usual manner. The children were females, weighing 7¼ and 6¼ pounds. The mother made an uneventful recovery, and left the hospital at the end of two weeks. with both children in good condition.

DISCUSSION.

Dr. William H. W. Knipe, in opening the discussion, said: "I think that most of us feel that Cesarean section is not indicated in twin pregnancy and I imagine that most of us off hand would say so; still, every now and then we meet with a case where it seems that in that particular patient a Cesarean section is indicated. I had one about a year ago where we did a Cesarean section in a twin pregnancy, where a diagnosis was made beforehand; in our case there was a moderate contraction of the pelvis, a true conjugate of 8.5 cm. with a transverse presentation of one child and a prolapse of the cord; in other words, we felt that while we could probably deliver either one of those twin babies through that woman's pelvis, under the conditions present with a prolapsed cord and a transverse presentation, we felt that the safest thing for the woman was to do a Cesarean section. Still I think, as a general proposition, that twin pregnancy and Cesarean section do not go together. In other words, if you have a twin pregnancy it means that the children, as a rule, are undersized, and undersized children, as you know, go through contracted pelves rather easily. I think that Dr. Brodhead did not mention the true conjugate in his case. (By Dr. Brodhead: "It was 8.50 cm.") Of course, no one can tell except the man who examines the patient whether a head will go through or not. I understood Dr. Brodhead to say the weight of the babies in his case was 6½ pounds for one and 7¼ pounds for the other. Those are fair-sized children and while one would perhaps consider taking a child of that size through that pelvis, still with the fact that in this case it was complicated by a twin pregnancy and considering further the difficulty of manipulation, etc., I think that Dr. Brodhead was justified in doing a Cesarean section, as I felt we were justified in doing a Cesarean section in a case of similar character.

"The second case which Dr. Brodhead reports was one of normal labor following Cesarean section. Unfortunately, we have had the same thing happen to us. We have done Cesarean sections and then we have learned afterward that the second baby was delivered by some one else—or perhaps by ourselves—normally and easily

and a third baby the same way. Still I do not believe that we should censure ourselves on that account. Perhaps Dr. Brodhead will remember a certain case which we both saw with a contracted pelvis —a moderate contraction. The true conjugate was about 8½. Dr. Brodhead thought that a Cesarean section was indicated. I saw the case and thought we could get the head through without doing a Cesarean section, and I argued rather strongly with Dr. Brodhead and he said, 'Well, go ahead.' I did an internal podalic version with a breech extraction, but could not deliver, and did a craniotomy on the after-coming head. In other words, my judgment was at fault. That baby had a very large head and the mother had hydramnios. We could not very well make out the size of the head before rupturing the membranes on account of the hydramnios, in fact, we were very much surprised to see the size of the head after doing the craniotomy. That same patient in her next pregnancy came along spontaneously without any induction of labor and had a perfectly normal delivery, and the third pregnancy went the same way. Our version and breech extraction and craniotomy proved that Dr. Brodhead's judgment was correct and that a Cesarean was indicated, and mine was wrong; still she went into labor spontaneously with the second and third child, delivering herself rather easily of normal-sized children.

"It comes down to a question between that particular baby and that particular pelvis. I have a case under observation at the present time with a true conjugate of 8 cm. that I saw a month ago and I felt that the woman would probably require a Cesarean section. The baby at that time seemed reasonably large and I felt that in a month it would be a good-sized head. Recently a practitioner in the lower part of the city, for the sum of twenty-five dollars, promised her a normal delivery in, I think he said, three or four hours. He had never examined her previous to his promise. I understand the patient has also visited one of our obstetrical institutions in this city and there she has also been told that she will not require Cesarean section, and I recognize that she may not. But with a generally contracted pelvis, now that I recall it, and a true conjugate of 8 cm., I do not believe with a normal-sized head that delivery will take place naturally, still she has the right to have a test of labor applied. Were we to do a Cesarean section in a case like this I think we would be perfectly justified. At the same time some one else is justified in giving her a test of labor. After all, those of us doing much obstetrics are very much surprised with the ease with which some heads go through certain pelves, and it is not the size of the head altogether but the moldability of the head which determines whether labor will proceed normally in a contracted pelvis."

Dr. Frederic O. Virgin said: "I just want to ask a question. Statistics are always faulty. However, the essential fact to be determined is not whether a child will go through a pelvis of so many centimeters diameter, but whether a relative head will fit a relative pelvis. I would like to know if the *x*-ray has been used to

determine the relative size of the head and of the pelvis and if so, is it of any value?"

Dr. William H. W. Knipe said: "I think I can answer that question. Dr. Isaac S. Hirsch, of Bellevue Hospital, took an *x*-ray about a week ago of the last case I mentioned and his diagnosis was that the patient required Cesarean section. I saw the *x*-ray plates and from my limited knowledge I do not think it is possible to tell whether the patient requires a Cesarean section or not. Although I believe that Dr. Hirsch, who is a very expert *x*-ray man, feels he can tell by taking an *x*-ray whether Cesarean section is indicated or not, I have not very much faith in its accuracy."

Dr. Walter M. Brickner.—"If the *x*-ray is to be of any value I think that a single radiograph would hardly be sufficient because you are apt not to see just the diameter that you want to measure, but it may be that a couple of stereoscopic radiographs would give a very good presentation of the relative diameters of the head and of the pelvis."

Dr. Brodhead closing the discussion said: "The fetal head diameters, in an *x*-ray picture taken before labor starts, would not be of any value at all, because you should take into account the tremendous overlapping of the bones and the molding after uterine contractions have started."

Dr. Robert T. Frank presented a lantern demonstration and a series of plastic models illustrating the