VERSION, WITH A REPORT OF TWO HUNDRED ADDITIONAL CASES SINCE SEPTEMBER, 1916.*

BY

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In 1914 I became a member of this Association when it held its annual meeting in Buffalo. At the meeting in Pittsburgh, it seemed to me that there was a lack of papers upon obstetric subjects, and a great surplus of papers on surgery, for a society known principally as an obstetrical and gynecological association. When the Secretary sent out his requests for contributions to the Indianapolis meeting, the idea occurred to me that a paper on "Version" would not be out of place. Accordingly, I gave him the title of my paper, "Version, with a report of 500 cases." What happened to that paper many of those present here to-day know, and, doubtless, all have heard something of it. After a lively discussion by the members present, the Executive Committee decided to withhold its publication. The paper was returned to me with the statement, "that in due course of time I should see the error of my ways, and should be sorry ever to have written such a paper; and furthermore, that I should be exceedingly grateful to the men who had discussed the paper adversely."

To those who discussed the paper, I am grateful; but to the Executive Committee who suppressed its publication, I cannot help confessing to a sense of disappointment and disagreeable surprise.

A paper is always of value when it brings out the individuality of the writer's method of practice. My contribution was a plain report of cases of version performed by me and the results obtained with it for both mother and child. The mere fact that gentlemen were present who do not endorse my practice of version, does not make my procedure reprehensible, nor should it have been sufficient cause to bar the publication of that paper.

I did not come before the Association with text-book methods of practice, nor the methods of procedure advocated by many professors of obstetrics; I simply reported my own work, performed in the manner I deemed best because of my experience with over 6000

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personally conducted confinements; and, since the presentation of my paper, instead of resorting to version less frequently, I have felt justified in expanding its sphere of usefulness. Every intelligent man finds his best teacher in his own experience.

In the discussion of my paper of last year, it was claimed that the introduction of the hand into the uterine cavity was fraught with danger, and that it was impossible to deliver, by version, a great number of women without serious injuries to the pelvic soft parts; that the child's life was endangered when the aftercoming head could not be delivered quickly, and that the child could not be brought down by two feet as well as by one foot. These were considered the great objections in the decision against version.

I am willing to admit that, under certain circumstances, it would be dangerous to introduce the hand into the uterus, that sometimes it is impossible to deliver without tearing the pelvic soft parts, and that the aftercoming head, occasionally, causes difficulty in its delivery. But granting all of these objections, I still maintain that a properly performed version, in the hands of a competent obstetrician, is to be preferred to a difficult forceps operation. Version lessens shock by shortening the labor, it conserves the patient's strength, and does away with the injuries to the baby's head. We cannot disregard the fact that prolonged application of the forceps is followed by injurious results which are immediate, to the mother and remote to the child. Epilepsy and idiocy, etc., in the infant may be attributed to a difficult forceps delivery.

It is also claimed that chloroform anesthesia is dangerous to women in labor. Ninety per cent. of my labor cases have been chloroformed to the surgical degree without any accident or apparent danger either to mother or to child.

Some of the salient points in my paper of last year were overlooked in the discussion that followed its presentation. Permit me to call your attention to their importance once more. In the first place, the cervix must be completely dilated, or easily dilatable, before version is attempted. Deep anesthesia is best at all times. The operator should wear rubber gloves reaching to his elbow. No patient should be delivered unless the bladder is empty. Every antiseptic and aseptic precaution should be taken to render the vulva and vagina thoroughly sterile before version is attempted. Primiparity is no bar to version. Both feet should be brought down at once. No attempt should be made to deliver the arms until the scapula is outside the vulva and the anterior arm should be delivered first. The operator must remember that, in delivering the head, extreme flexion is necessary, and can be best produced

by gentle traction with the finger in the child's mouth. If the head remains extended, complications always arise. After the chin and mouth are delivered, mucous will flow from the child's mouth; this should be promptly removed, because many children will breathe before the complete delivery of the head. Excessive pressure upon the mother's abdomen is not necessary and should be avoided because of injuries that may be done to the bladder and lower anterior uterine wall. The aftercoming head may be delivered by the use of the forceps if necessary. The operator should, in every instance, have a perfect knowledge of the attitude of the child in the uterus before version is attempted. Version can be accomplished only by introducing the hand into the fundus and by exploring the uterus and the fetal parts carefully. If the membranes have not ruptured, it is well to separate them from the uterine wall, as high up as possible, before rupture is undertaken. In this way much of the amniotic fluid is retained within the uterus, and version is more easily accomplished. When the knees of the child have been born, version is complete. Version is a procedure which should never be hurried; the operator should at all times be master of the situation. The extreme lithotomy position is not always the best for the patient when a version is performed, but it is convenient, and requires less assistance. The Walcher position gives better results because it relaxes the soft parts of the mother; but the obstetrician can obtain this relaxation only by having two assistants, or by allowing the feet of the patient to rest upon chairs. When the child is born, it is placed upon the mother's abdomen upon its right side, and is kept there until the cord is cut. I should like, at this point, to enter a protest against the too common practice of spanking or beating the child to make it breathe. This is wholly unnecessary, for all we do is to hold the baby up, with its head down to allow the mucous to run out of its mouth, and then breathe a few times upon its chest. Respiration invariably takes place. The third stage of labor can be completed by delivering the placenta manually; but I have had two experiences in which I was obliged to deliver the placenta first, and then bring down the child. In each instance the child lived.

It makes no difference whether this method is termed a premeditated version or an elective version, since the results secured are preferable to those obtained by an even moderately difficult forceps delivery.

The maternal mortality, in properly selected cases, should be *nil*. The maternal morbidity is no greater than that in normal cases, as my charts will show. In my experience the mutilation of the soft

parts of the mother is less than that resulting from the use of the forceps, and the patients leave in good condition.

The principal dangers to the child are due, first, to a prolapsed cord, partial, complete, or concealed, the last being more common than is generally supposed; and secondly, to prolonged pressure of the uterus upon the child, as in cases of faulty presentation, and in the border-line cases of contracted pelvis. The intelligent application of the forceps to the aftercoming head has greatly reduced the fetal mortality and morbidity.

Version is easier of performance where the amniotic fluid has not entirely escaped, but the operation may be readily performed in any case in which the uterus is not too firmly contracted around the child. Wherever there is still some of the liquor amnii in the uterus, it is best to introduce the forearm as far as possible, using the arm as a plug to prevent the entire escape of the fluid, until the version is accomplished. Green sterilized liquid soap I regard as the best lubricant.

From September 1, 1916, to August 31, 1917, I have delivered 515 cases, a series in which version was performed, for various reasons, 200 times. Adding these cases to the 500 cases reported last year, I now have 700 versions to my credit. Approximately 50 per cent. of the last 200 versions were hospital cases. There was no maternal mortality in this last series; and, if you remember, none in my first 500 cases of version.

Of the series of 200 versions eighty-five were performed in primipara, and 115 in multipara. Forty of these were seen in consultation with physicians, and thirteen were in the care of midwives. One hundred and twenty-six cases were left occipitoposterior positions of the vertex. Forty were of the right occipitoposterior variety. Three times version was performed when the occiput was to the left and anterior, and five times when it was to the right and anterior. Version was performed in these cases in preference to the use of forceps. Of face presentation, mentoposterior position, there were three cases; shoulder presentation, one case; transverse presentation, one case; mentoanterior position, one case; central placenta previa, four cases in multipara with the os dilated or dilatable; lateral placenta, one case; prolapsed cord, fifteen cases, of which six were complete, and nine were of the concealed variety. In fifteen cases the cord was around the child's neck once; in six cases, twice; in one case, five times, and the child lived. In two cases the cord was tightly stretched between the legs, and had to be cut before delivery could be accomplished. Both children lived. The cord was around the neck, and between the legs, in two cases; twice

around the neck and right arm, in one case; three times around the neck and between the legs, in one case, and short cord occurred once.

Instruments were applied to the aftercoming head, ten times. In the last series, there were three cases in which it was necessary to repair the perineum; each case required two silkworm sutures, and in each of these three cases the forceps were used on the aftercoming head. In one of these cases, a primipara, thirty-one years of age, the baby weighed 9¾ pounds; in another, a primipara, twenty-eight years old, the child weighed 9 pounds; in the third, a primipara, thirty years old, the child weighed 11 pounds. All the children were born alive.

There were sixteen stillborn children, of whom one was a hydrocephalus, requiring craniotomy on the aftercoming head. In two cases the fetus was macerated, having been dead for some time. The cause of the death was unknown. There were two stillborn children in the placenta previa cases, and one stillborn in the mento-posterior position. In this case no fetal heart sounds could be heard before the version. One stillbirth was due to short cord, and one was the result of disproportion between the child and the pelvis. This was really a case for abdominal Cesarean section. The remaining eight stillbirths were due to prolapsed cord, two of which belonged to the complete and six to the concealed variety. Ten of these sixteen stillbirths were consultation cases, six of them in the hands of midwives, and four in the care of physicians.

To safeguard maternity by reducing the maternal mortality due to pregnancy, labor, and puerperal complications, is most desirable, and any procedure tending in this direction commends itself without question. According to "American Medicine," July, 1917, a bulletin issued recently by the Children's Bureau of the Department of Labor shows that more women between the ages of fifteen and forty-five years die of puerperal causes than of any other diseases except tuberculosis. About 15,000 maternal deaths, the results of pregnancy and labor, occur annually in the United States, and these figures have shown no decrease since 1900.

I feel, therefore, that my paper has a direct bearing upon this very point and that the proper management of faulty presentations and positions, as described above, must lower the maternal mortality and morbidity. I have shown that, in my practice, I employ version more frequently than any other method of delivery, that my maternal mortality has been *nil*, my maternal morbidity less, and my fetal mortality not greater than that of other obstetricians.

In my paper of last year I recommended and reported twelve cases of version for pendulous abdomen. I also advocate version in cases of large varicose veins of the vulva, vagina, and thighs, because I fear hematomata in these regions, as the veins are apt to cause serious trouble when they break down and become infected.

You may think I find L. O. P. position more frequently than is usual, but this is, probably, because I make an earlier examination and a more careful one. I pay no attention to the sutures or fontanelles, as an accurate diagnosis, based upon these landmarks, is impossible because of the overlapping that always takes place. I depend upon the ear entirely, because the ear is always on the side of the head; but I am always careful in making my diagnosis, as the ear may be folded upon itself.

It is evident that I am advocating version more frequently than the present teaching of obstetrics would seem to justify, but I feel that my procedure is not more dangerous than the practice of waiting for a spontaneous labor, and I am certain that the dangers of a properly performed version have been much exaggerated in the past. Give version a wider field of application, and you shorten the duration of labor and thus lessen the dread and horrors of childbirth so universal among the mothers everywhere.

CONCLUSIONS.

Version lessens the shock of labor.

It lessens the dangers due to pressure from and on the head of the child.

Version should never be undertaken until the os is fully dilated or easily dilatable.

The majority of occipitoposterior positions are best treated by version.

Version is as readily performed in the primiparæ as in multiparæ.

The fetal mortality of version should not be as great as that of prolonged labor and instrumental delivery.

Injuries to the child's head are reduced by a properly performed version.

Face presentations are better treated by version.

Prolapsus funis, when the cervix is dilated or dilatable, and the cord is still pulsating, is best treated by version.

Placenta previa, in multiparæ with cervix dilated or dilatable, is best treated by version.

A moderately contracted pelvis, when the child is small, is best treated by version.

42. FRANKLIN STREET.