Once a Cæsarean Always a Cæsarean*

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Like most epigrammatic phrases used in writings on medical subjects, the heading of this article does not cover the question. The pendulum has swung backwards and forwards in regard to the truth or fallacy of the statement that "Once a Cæsarean always a Cæsarean" so much, that I do not believe at present it would be possible to get any large number of obstetricians to agree on the subject.

The first recorded Cæsarean section upon a living person was done by Trautmann in Wittenberg in 1610. The patient lived twenty-five days. However, the operation is in all probability a much older one. Until quite recently the mortality was so extremely high that the operation was avoided at any cost. Hirst believes that the mortality at present, in the hands of skillful operators and under favorable conditions, should be below one per cent. DeLee says one per cent. to two per cent. Edgar thinks that in the operation under good surroundings the maternal mortality should be almost nil. Cragin gives his mortality as 6.66 in 150 cases; in 143 nontoxic cases his mortality was 2.09.

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The statistics given above ranging from one per cent. to two per cent. refer only to that type of case which we speak of as elective Cæsarean section. The mortality in emergency Cæsarean section is unquestionably a great deal higher. In a series of thirty-seven cases, all of which were emergency cases, my mortality was ten and eight tenths per cent.

Until recently the only indication for Cæsarean section was disproportion between the fetal body and the maternal birth canal. We now believe that there are many other possible indications, but we do not believe in the three indications accredited to one obstetrician, that is, 1, the patient must be a woman; 2, the patient must be pregnant; 3, the patient must be unable to speak English.

In spite of the low mortality asserted for the elective Cæsarean, we do not believe that it ever will be anything but a serious major abdominal operation, and we believe that it never should be resorted to except in those cases in which it gives the mother a better chance for life and future health than a delivery by the normal vaginal route. There are very few absolute indications for Cæsarean section. Pelvic measurements *per se* must be only looked on as comparative. A woman with a somewhat contracted pelvis will give birth to a small child as easily as one with a normal pelvis will deliver a large baby. Every case of placenta prævia should not necessarily be delivered by a Cæsarean section. A few of the indications for Cæsarean section may be given as follows:

1. A definite disproportion between the fetal presenting part and the maternal pelvis.
2. Central placenta prævia with no dilatation or effacement of the cervix.
3. Marginal placenta prævia where there has been hemorrhage with a not easily dilatable cervix.
4. Premature separation of a normally placed placenta with an undilated and not easily dilatable cervix.
5. Eclampsia where the convulsions are increasing in severity and when elimination has been tried and there is no evidence of labor. In other words, where the uterus can not be easily evacuated by the vaginal route.
6. In some cases of the toxemia of late pregnancy, in which active treatment seems to be of no value, and a long, tedious labor is anticipated, which probably will terminate in eclampsia.
7. In some cases of cardiac decompensation.
8. In some cases of pulmonary tuberculosis.
9. In some cases of prolapsed cord.
10. Face presentation with chin posterior, and in some impacted shoulder presentations.

Every case in which the question of delivery by Cæsarean section is considered must be looked upon as a law unto itself. I do not believe that we can unequivocally say that any case under a given condition must be Cæsareanized. The whole question resolves itself into what is best for the individual case under consideration. At present it is considered safer for the patient, both as to her immediate recovery and subsequent health, that she should be delivered by Cæsarean section rather than the use of axis traction forceps upon a high floating head. It is unquestionably so for the child. The injuries to the various parts of the birth canal, following a high forceps operation, are unquestionably the cause of invalidism occurring in the later life of many women.

It must be understood that I am speaking only of the classical Cæsarean section. I am not considering the Porro or the various types of socalled extraperitoneal section, or the vaginal Cæsarean section, which latter is a misnomer and should always be termed anterior vaginal hysterotomy.

The chief contraindication to the promiscuous use of Cæsarean section is the danger of the rupture of the uterine scar in a subsequent labor. Davis, of Philadelphia, in his discussion before the American College of Surgeons this year, said it was generally conceded that in four per cent. of cases the uterine scar was ruptured in a subsequent labor. Hirst has the record of but one case that he knows of, of a ruptured uterine scar in a subsequent labor in approximately five hundred cases of Cæsarean section done by himself. I have seen two cases within the past six months which seem to have a peculiar interest in this problem.

Case I.—I delivered this patient by Cæsarean section two years ago, the indication being obstructed labor. There was a stormy puerperium with signs of local peritonitis. On or about ten days after operation, the patient passed from the vagina a long mass of tissue, the length of the uterine scar, with the deep layer of continuous catgut stitch unabsorbed. The patient made a final recovery and I warned her that she was never to allow herself to fall in labor as she would undoubtedly rupture her uterus. Some months ago she presented herself to the outpatient department and was given the usual prenatal care and ordered to come to the hospital two weeks before term. This she failed to do and was admitted sometime later in active labor with signs of shock and internal hemorrhage. She was operated upon and the uterine scar had ruptured completely. Hysterectomy was done and the patient eventually recovered.

Case II.—The patient had been previously delivered three years before in Boston. I was asked to take charge of her by her family physician, who showed me a letter from her doctor in Boston stating that in his judgment the woman should be delivered by Cæsarean section and that the indication for the previous Cæsarean was toxemia of pregnancy and a faulty pelvic inclination. My examination two months before term disclosed no pelvic contraction and there were no symptoms of toxemia. The patient had a slight goitre. It was determined to give this patient a test of labor. Later on the doctor in charge of the case, which was in a city at some little distance, notified me by telephone that the head had not come in the pelvis. Before we could arrange for an elective section the patient was in labor. With the membranes unruptured she was given morphine until I could arrive. Examination gave every indication that labor could be successfully terminated by the vaginal route so the patient was allowed four hours of sharp labor. At the end of that time, as she had made no progress, I became fearful of the uterine scar and opened her abdomen. We delivered a living child and found the scar of the previous Cæsarean had thinned out until it was less than a half inch thick. One of the indications in this case that decided us to do section was a high abdominal incision, which made us suspect that there had been a high uterine incision, and this proved to be the case. A few more hours of hard labor

would in all likelihood have caused a rupture of the uterus.

I have seen other cases of rupture of the scar of a previous Cæsarean operation, but the two cases cited are the only ones of which I have an intimate, personal knowledge. It would seem that any statistics on this subject must of necessity be rather inaccurate, as in order to give real statistics of rupture in a subsequent labor in a hundred cases, we must know that each of these patients is delivered by the vaginal route if they became pregnant at all, and in many cases, similar to Case I, cited above, it would unquestionably be the worst kind of obstetrics to allow the patient to fall into labor at all.

The question of repeating a Cæsarean section, I believe, depends upon two things: namely, the indication for the first section and the character of the patient's postoperative convalescence, following the first operation. Taking a hypothetical case for an example, if I were called to attend a woman in confinement, and she gave a history of having had two children normally, and in her third pregnancy she was delivered by section on account of central placenta prævia, following which she had an uneventful, afebrile convalescence, I should certainly allow her a test of labor under careful observation. If, on the other hand, a woman were delivered of her first child by Cæsarean section on account of a definitely contracted pelvis, I should doubt the advisability of allowing her to fall in labor in any other of her subsequent pregnancies, unless she should accidentally fall in labor at least four weeks before term, when she might be allowed a moderate test of labor.

This problem is one which is open to a difference of opinion, and one should not be too didactic in the matter, but I believe that any woman that has been delivered twice by Cæsarean section should never be delivered in any other way. This statement naturally brings up the question of how many times this operation may be done on any one woman. Davis, of New York, has delivered one woman six times and Hirst, of Philadelphia, has delivered one four times by Cæsarean section. It would seem that any woman that had undergone four abdominal operations to give birth to children has done her fair share along that line, and that she should be sterilized, if she expresses such a wish.

CONCLUSIONS.

1. A Cæsarean section at all times is a serious major operation.

2. The indications for a first Cæsarean section is the most important factor in determining whether it should be repeated in the next parturition.

3. A stormy puerperium is a contraindication to a normal vaginal delivery at the next confinement.

4. The advisability of elective Cæsarean section should always be carefully considered in any subsequent pregnancy.

5. Once a Cæsarean, almost always a Cæsarean.

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