OBSTETRICAL SOCIETY OF PHILADELPHIA

STATED MEETING, OCTOBER 12TH, 1922

THE PRESIDENT, DR. STEPHEN E. TRACY, IN THE CHAIR

DR. NORMAN L. KNIPE read a paper entitled **Version in the Manner Suggested by Potter, as a Safe, Routine Procedure in Delivery; with a Report of over a Hundred Consecutive Cases without the Death of a Child.**

My purpose in reporting this series of over one hundred cases of version without the death of a child, is simply to add the result of my experience to that obtained by others who have given modern version a fair and unbiased trial.

Version is not a new procedure; neither are most of the many surgical operations we do today without thought of failure. But in the last twenty years these operations, due to our increasing skill in technic and asepsis, have given us favorable results which we were never sure of before.

Is there any reason, therefore, in our refusing to accept the possibility that even such an ancient obstetrical operation as version may be so improved as to give us end results decidedly superior to those of Nature at her best?

If we allowed Nature to have her way, few of us perhaps, would be here tonight. We should certainly not have to worry about the overpopulation of the world a hundred years hence and that always interesting, much-discussed and excitement-producing subject of birth control would cease to have any interest whatever.

I believe that version, modern version, is a safe routine procedure to follow by the skilled obstetrician in nearly all cases of labor. You will not agree with me if you are thinking of version in the clumsy way it was formerly managed. Neither will you agree with me if, putting yourself in a previously antagonistic attitude, you read Potter's book and don't practice the operation.

I might say here that I do not agree with Potter in thinking it is a safe procedure for the physician doing occasional obstetrics to follow, unless he has been carefully taught the method on a large series of cases and then follows it routinely. I say this because although I visited Buffalo and saw Dr. Potter deliver a number of cases, I often found myself in the beginning, forgetting occasionally some of the steps which should be remembered to get good results. Gradually however, I became more confident and expert as the number of cases increased.

Remember that one of the satisfactory things about version is that it does not make the slightest difference what the cephalic presentation may be, the version is always done in the same way and the after coming head may be guided through the desired oblique diameter of the pelvic inlet. The only presentation that is not desirable is that of the breech.

A brief outline of my first hundred cases may be of interest. Left presentations about 60 per cent; right presentations about 30 per cent; one case of twin birth. The presentation of a few of the cases seen in consultation, has been forgotten.

Two cases of shoulder presentation which during pregnancy had been diagnosed as transverse.

Two cases of placenta previa, neither case central in type but both cases bleeding at the onset of labor.

Two cases associated with gonorrhea contracted with the pregnancy, i.e., newly married women becoming pregnant by infected husbands. These two cases had a very satisfactory afebrile convalescence.

There were several cases in which previous labors had been very difficult. One of these cases I delivered safely of the third child. The first two babies had been lost by difficult forceps deliveries.

Another case gave a history of a very difficult forceps delivery with first child. She received a complete tear through the sphincter and was referred to me for a repair. Naturally she looked forward to her second pregnancy with fear and trepidation. Notwithstanding the fact that she was two weeks' overdue and required the insertion of a bag to start labor, her delivery was not difficult. A tear of only three-quarters of an inch in length occurred through the inelastic perineal scar tissue.

In the next series of 100 or even of 50 cases, I might misjudge the relative proportion between the size of the pelvic inlet and the fetal head and attempt version on cases that should have had cesarean sections. But certainly I should make the same mistake by applying forceps; and any case that may be delivered safely by forceps may be delivered by version.

So far I have been fortunate and have had no cases of abnormally large heads or excessively flat pelves to cause trouble.

I have done the Potter version on every case that I could get to in time. If I have found the head so far advanced that the usual damage caused by the hard head digging into and tearing the levator muscle and pelvic floor, had already occurred, I have allowed the head to keep on coming and have tried to preserve, so far as possible, the more unimportant perineum.

I agree most emphatically with Potter, that less damage is caused to the pelvic floor by version than by a head presentation. This I have proved by repeated examinations.

After thoroughly stretching and enlarging the vaginal canal by the proper kind of manipulation, the feet, the legs, the thighs and then the buttocks and body are brought down, dilating the vaginal canal in the same cone-like way that the Voorhees bag dilates the cervix. One does get quite often small tears of the perineum, but I have always thought that these were caused by too much anxiety and haste to end the labor and could have been generally prevented by a calmer and less hasty delivery. But such tears are unimportant compared to the more severe and complicating injuries to the pelvic floor.

In any delivery of a pregnant woman: 1. We wish to deliver the mother safely and leave the birth canal in good condition. 2. We wish to deliver a living and uninjured child. 3. We wish to save the mother as much suffering as possible, and the most logical way to do this is to shorten the time of her labor.

These three things we are able to do by version: 1. We are able to deliver a

to do the major gynecological operations, he does feel that his experience in obstetrics has made him perfectly competent to deliver a normal case. If therefore this Society goes on record as advocating version in normal labor to prevent the suffering of the second stage we shall assume a responsibility from which I for one most certainly shrink. Can we honestly say to our fellow practitioners that it is right for them, forsaking the well established means of control of pain and nullifying Nature's mechanism, to routinely convert normal head presentations into those of the breech?

This operation of version is a major obstetrical procedure and for its safe performance, good judgment, aseptic technic and deep anesthesia are prerequisites. I am frankly of the opinion that if this Society should set its seal of approval upon this procedure there will be much time saved in the practice of obstetrics in this locality together with a perfectly unjustifiable loss of fetal and maternal lives.

DR. COLLIN FOULKROD.—If we are discussing the introduction of version in place of normal delivery, and I take it this paper has been presented with this end in view; it seems to me that more than one voice should be raised in this Society to stamp its disapproval upon such an action. If 60 per cent of Dr. Knipe's cases were left sided children the majority of that 60 per cent were L. O. A. and in my experience my L.O.A. deliveries are normal, with perhaps a slight cutting of perineal body. It has been my experience, just as Dr. Potter expressed it, that the record in textbooks regarding right sided babies making only 5 to 10 per cent of the total is inaccurate, that there is a growing increase of right sided children; these make up the biggest bulk of the obstetric operations today and are perhaps the major field for forceps delivery and version. Neither Dr. Knipe nor Dr. Potter have demonstrated to me that they can stretch the vagina with their fingers as well as it can be stretched by the bag of waters, or by the head, nor do I believe that when I stretch the vagina for version none of the muscle fibers give way; the muscle may break even if the mucous membrane is intact. It is far better for us, as pointed out, if we have need for such stretching, to cut. Certainly 60 per cent being first position children would have given good dilatation, but if any one attempts to do a version he must take into consideration the laceration of the upper pelvic canal as well as the lower and it is impossible for them to convince us in eight to ten pound babies, of which we see a certain proportion, that they can do version as well as head presentation. I rather hoped that commendations would be placed upon the improvement Dr. Potter has instituted. Several things are new which have come out, so I believe much can be learned by studying his book and method and much can be learned by way of relieving women of pain.

DR. DANIEL LONGAKER.—I want to say that I agree very fully practically with everything that has been said and I want to congratulate Dr. Knipe particularly upon his brilliant results. He has certainly shown very remarkably good judgment. There is one point, however, in which I cannot agree with Dr. Knipe. If I did not misunderstand him, I think he said that any baby that could be delivered by forceps could also be delivered by version. I must say, if this be true certainly Potter would substantiate it, but he does not. In June, 1921, I spent three days and two nights with Potter. I saw him deliver eleven babies. The last case I saw was certainly worth a trip to Buffalo; more about it later. I would say to Dr. Nicholson, while I agree with what he says and while I would second the word of caution in regard to the general adoption of this method, I believe if he went to Buffalo he would see that there is something totally new there, something of which written accounts give an inadequate idea, an amount of team work and consistency of operating which is new. I have never seen anything, or read anything like it and I am sure Dr. Nicholson will sound a different note after he comes back. To come back to my

result is thorough stretching of the levator ani muscle. Dr. Foulkrod said I spoke continually of the more unimportant perineum and vaginal floor; when the head comes down it digs into the pelvic floor and it dilates by tearing. The pelvic structures above I continually emphasized as being the most important in the whole vagina. Now as to advising routine version for the general practitioner, I state in my paper I do not. I said that modern version ought to be taught in our medical schools to students so they will have a chance to use it. I believe it is just as logical to do version routinely as it is to do anything else routinely where we think it is an improvement on what we have had before. We do cesarean section on certain cases. I think we have just as much right to emphasize this version as cesarean section. Now we do section with impunity and we have a right to do it. Dr. Tallant mentioned the length of the first stage and the shortness of second stage. What is the first stage of labor? The first stage of labor is up to complete dilatation of the os. What is the period of labor between complete dilatation of the os and time it begins to come from pelvic outlet? It has no name. I have seen and you have seen a head being pounded for hours, long after the os dilated. Then is the time to do version at full dilatation of the os and save the woman a great deal of pain. In answer to Dr. Cogill: I have always used chloroform, as a rule Potter does. I have never had bad results with chloroform anesthesia in confinement. It takes about ten minutes to iron out the pelvic floor. I do not remember what Dr. Potter said about maternal mortality. I had one case of maternal mortality and I think Dr. Cogill is right, if I had noted the odor I possibly would not have done a version for fear of contaminating, but it was not until I started to manipulate that this material was squeezed out and then I went ahead with the version.