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SOME OBSTETRIC EXPERIENCES IN CHINA.

W. H. VENABLE, M.D.
Formerly of the Sloane Maternity Hospital, New York City.
KASHING, CHINA.

There is no way of estimating the mortality from childbirth in China, but it must be very large. Ignorant midwives attend most of the cases. A physician is rarely sent for, and when he comes, so far as I can learn, he is not supposed to examine the patient, but merely feels her pulse and writes a prescription for the particular complication from which she is suffering. A woman in labor is considered unclean, and ordinarily a Chinese doctor would not be willing to pollute himself by coming in contact with the discharges from a labor case. Among the higher classes, especially, the relatives of a puerperal woman will not come into her room until a month after her delivery. She is taken care of by midwives and female servants. The result of such neglect can easily be imagined.

PLACENTA PRÆVIA.

One of the first obstetric cases I saw after coming to China was a case of placenta prævia at about the sixth month. The patient had been having pains for several days, and on examination I found the os dilated to two inches in diameter and the placenta presenting. Miscarriage was apparently inevitable. At that time I had no hospital or room of any kind in which I could put an in-patient. As the woman had come from a distance, I advised her to rent a room near by and let me attend her. As she was suffering a good deal of pain, I gave her a hypodermic injection of morphin, and then she and her husband got on their boat, he promising to come for me as soon as he succeeded in renting a room. I did not see them again for two days, when they both appeared at the dispensary and informed me that the miscarriage had taken place shortly after she got on the boat. The woman said she was feeling all right, and they insisted on going back home. They were loud in their praises of my skill (?), as the morphin had relieved her pain almost immediately, and, as she thought, had brought on labor, which was painless. At the time I saw her there was very little hemorrhage, though, as I recollect, she gave the history of having had severe hemorrhage some time before I saw her. This woman made a good recovery, though after she returned home she had an attack of fever, which they said was malaria.

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TRANSVERSE PRESENTATION.

Another one of my earliest cases was a transverse presentation with prolapse of the arm. After a good deal of manipulation I succeeded in pushing up the arm and changing the position to a vertex. Then I applied the ordinary McLane forceps at the superior strait and delivered without any particular difficulty. The child was a large, healthy boy. The woman appeared to have an irregularly shaped, though not contracted pelvis. She gave the history of having borne one child previously, which also presented transversely; the attending midwife had delivered the child in sections, probably beginning by pulling off the arm. The woman has not borne any children since.

ECLAMPSIA.

One morning early I was called to see a patient who had been brought to the door on a boat. She was in a deep stupor and could not be aroused. It was evidently a case of eclampsia. Labor pains had ceased and the os was dilated enough to admit two fingers. The patient's friends and family were extremely anxious for her to be delivered as quickly as possible, even if the child had to be mutilated. That is, they insisted that I act in the interest of the woman, without regard to the child. The patient was a primipara and the child seemed to be large, so I felt that haste was necessary if the woman's life was to be saved. After dilating the cervix as much as I could with my fingers, I reluctantly proceeded to do a craniotomy. As soon as the child was delivered, the people said that they had to go. I urged them to stay and let me do what I could for the woman, who was still in a stupor, but they insisted on leaving, as they had hired out their boat for a trip that day and would lose the money if they did not appear on time. I managed to pour a large dose of magnesium sulphate down the woman's throat at the imminent risk of strangling her, and then they left. Some days afterward they came back and reported that the woman was entirely well, and they seemed very grateful for what I had done.

Some months after this I was called to see another case of eclampsia, this time in a multipara. This woman also was in a deep stupor. Labor had not begun, but as she had a roomy vagina and pelvis, I found no particular difficulty in performing manual dilatation of the os and delivering immediately with forceps. The child was alive and healthy, but, in spite of all I could do, the mother continued in her unconscious condition and finally died.

CRANIOTOMY.

One day I was called to see a case of difficult labor several miles out in the country. As the messenger who came for me said that the child's head was visible, I did not take my craniotomy instruments with me. When I reached the patient I found a case of contracted pelvis with the child's head above the brim. The fetal heart was very slow and barely audible. What they had taken to be the child's head I do not know, unless it was the swollen and discolored external genitals, or possibly a blood clot. I was in a quandary. However, after soaking my penknife in a carbolic solution for a while, I succeeded in perforating the head with it. Then by using my McLane forceps as a cranioclast, I reduced the size of the head enough to accomplish the delivery. The patient made an uneventful recovery, and I have seen her a number of times since.

PODALIC VERSION.

A little over two years ago I was called to see the most difficult obstetric case that it has ever been my lot to attend. The patient lived about 5 miles out in the country. I was called at night and my Chinese assistant and I went in a boat. We found the patient in a straw-thatched hovel with a dirt floor, lying in a dark corner on a pile of straw. It was a transverse presentation, and the child's arm had been broken by the midwife's efforts at delivery. The patient was in an exhausted condition, her lips were parched and dry and her pulse was 120. The doubled-up chest of the child was jammed down into the pelvis and the arm was prolapsed; the uterus was contracted so firmly on the rest of the child's body that it was impossible to push the prolapsed arm or the chest up above the brim. I had no bone forceps with which to cut the ribs and cause the chest to collapse, so the alternatives left to me seemed to be decapitation and podalic version, both of them about as difficult and dangerous under the circumstances as one could well imagine. I have never had any leaning toward decapitation. The thought of a trunkless head inside of a firmly contracted uterus is not, to my mind, a particularly enviable condition to treat. Podalic version, if it were possible, seemed to offer the best chances of a quick delivery, which was the great desideratum, considering the condition of the patient. I decided that the danger of rupturing the uterus or otherwise injuring the soft parts by manipulation was more than overbalanced by the greater danger of leaving the woman undelivered, so I determined to use a good deal of force, if necessary. To get my hand and arm past the child's doubled-up chest as it lay in the pelvis seemed a physical impossibility, and so I thought it was going to be when I first tried it. Gradually, however, I worked my arm up in spite of the great pressure until my fingers came in contact with the child's feet. When I tried to grasp a foot, I found that I could not, as my fingers were numb from the pressure. I tried again and again without the slightest success. As the numbness was increasing, there was nothing to do but to withdraw my arm. After waiting a while, I tried again. About this time my assistant informed me that the patient's pulse had increased to 140, so feeling that I must not lose any time, I made a desperate effort and succeeded in grasping a foot firmly enough to exert a little traction. Then I got a better hold and exerted more traction, and as a result the mass that had seemed hopelessly wedged in the pelvis began to move upward. It was not long before I had a foot out, and of course the rest was easy. I was surprised at the marked effect of moderate traction on the foot in making the impacted chest go back into the uterus, in spite of the fact that the uterus was in a state of tonic contraction. This patient also made an uneventful recovery.

DELIVERY OF MORIBUND PATIENT.

A little more than a year ago I saw a case of twins that illustrates the influence of Chinese superstition on foreign medical practice. One child had been born the day before I was called and was living. The second child, much the larger of the two, was still in the uterus. It was evident from the degree of maceration and the odor that the child had been dead for some time. As the mother was almost moribund, I told them that I did not care to undertake the case. I told them that the patient would probably die during delivery or soon after. They replied that they realized the woman's desperate condition, but that they wanted her delivered, living or dead. Their extreme anxiety to have her delivered was due to a belief of the Chinese that a pregnant woman who dies undelivered is doomed to continue carrying the child in the next world. After receiving their assurance that I would be free from responsibility for the death of the woman, I proceeded to remove the putrid fetus. Labor pains had ceased entirely and the breech was presenting. On account of the large size of the fetal head and the rigidity of the maternal tissues, I had to apply forceps to the after-coming head. The patient died a few hours after delivery.

UTERINE INERTIA.

Chinese women seem to be subject to uterine inertia. It is not surprising that this should be the case in women of the higher classes, who have bound feet and who take practically no exercise, but I have been struck with its frequency even in hard-working women with natural feet. Often after the os is half dilated the pains become feeble and ineffectual and the labor drags on hour after hour, making scarcely any progress. Making these patients walk around or giving them quinin seems to have very little effect. In a great many cases, however, rupturing the membranes early (i. e., when the os is about half dilated) seems to have a remarkable effect in stimulating the pains. I have done this so often lately and with such uniformly good results, that the conviction is constantly being strengthened in my mind that, after the os is dilated to about two inches in diameter, the "bag of waters" rarely serves any useful purpose and often makes the pains ineffectual.

Recently I attended a multipara with marked uterine inertia. The os was dilated to about two inches and she seemed

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to be making no progress. The pains were very feeble and seemed to have scarcely any effect on the dilatation. I ruptured the membranes, and the pains increased enough to dilate the os to about three inches, and then there was no further progress. The pelvis was roomy, the child's head was small and there was no rigidity of the cervix, but still the head refused to descend. I applied the forceps and, though the traction used was very slight, the head came down without the least difficulty and delivery was soon accomplished. I think I have never used such a small amount of traction in a forceps delivery.

Though my obstetric practice is not large, there is a steady increase, which shows that the Chinese here are beginning to realize the value of foreign methods in this branch of medicine. In looking over my records I find that in about ten years of hospital work here there have been 14 forceps deliveries, 4 craniotomies, 2 transverse presentations, 1 cephalic version, 1 podalic version and 1 premature labor for hyperemesis gravidarum.

During 1906 I had 12 cases, more than in any previous year. Several were in wealthy, influential families.

China is making rapid strides toward civilization, and Western medical science is destined to be an important factor in the process. A large number of medical books have been translated into Chinese by medical missionaries and more are constantly being translated. There are several medical schools in China, and we hope to see a medical magazine in Chinese established at no very distant date.

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AN IMPROVED TRACTION SHOE.

JOHN JOSEPH NUTT, B.L., M.D.
Clinical Instructor in Orthopedic Surgery, Cornell University Medical College; Assistant Surgeon to the New York State Hospital for Crippled and Deformed Children.
NEW YORK CITY.

The successful treatment of Shaffer's foot, invariably, and of flatfoot, frequently, depends on the elongation of the gastrocnemius muscle. Compensation in the former condition, by means of a higher heeled shoe, and splinting the deformed foot with steel arches, in the latter condition, are measures which generally give relief, but of themselves are not curative.

An active foot, with limitation of dorsal flexion, must suffer from the alteration of its mechanics. The changed disposition of the superincumbent weight and the abnormal points of resistance due to the restricted movements of the lever-arms, must, inevitably, cause such disturbances as result from pressure, i. e., corns, bunions, callosities, "ingrowing toe-nails" and Morton's toe and an alteration, or a tendency to an alteration, in the relations of the tarsal bones. Whether the foot becomes what is known as flat, or presents a higher arch than formerly, depends on the amount of limitation of dorsal flexion and on the strength of the plantar tissues which serve to maintain the normal medio-tarsal joint.

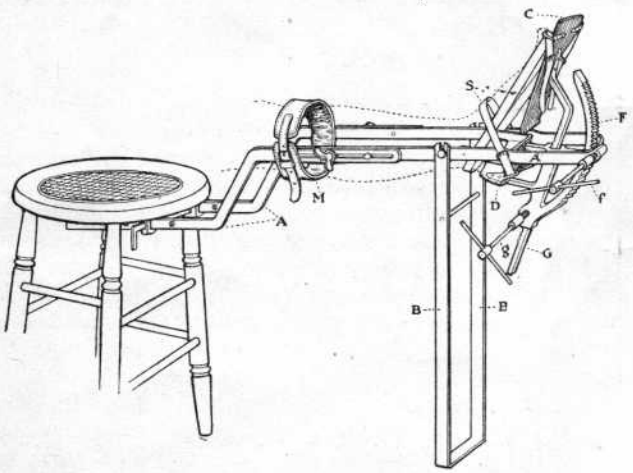


Figure 1.

Every examination of an extremity should include an examination of all its joints. Examination of the ankle joint will often determine the cause of a thigh, leg or knee pain which, erroneously, has been considered rheumatic, neuralgic or neuritic. A painful flatfoot having a shortened gastrocnemius may often be relieved by restoring normal movement to the ankle joint, even without any further attempt at restoring the arch. When a neglected Shaffer's foot has resulted in a flatfoot an artificial arch alone can not be expected to cure. The prolonged use of steel arches is seldom necessary and must be productive of atrophy of the small muscles, ligaments and fasciæ of the foot.

The apparatus in general use for stretching the posttibial muscles is the traction shoe devised by Dr. Shaffer and presented to the profession about twenty-five years ago. With this machine any desired force can be applied. From a therapeutic standpoint it is unqualifiedly successful. The force is the resultant of two forces, one applied in an antero-posterior direction through a strap passing behind the heel and called the heel-strap, and the other a force applied through a strap passing over the neck of the astragalus and called the astragalar strap. This resultant pulls the calcaneum downward and forward in an arch whose radii are from a center passing through the astragalus just below the external malleolus; the traverse axis of the ankle joint. In very resistant cases, however, the force exerted by the astragalar strap is such as to cause considerable discomfort

In the apparatus presented herewith the astragalar strap is not brought into use until the gastrocnemius is well stretched, and then a momentary hyperextension is obtained by the use of an antero-posterior ratchet exactly similar to the one in Shaffer's shoe.

The machine consists of two lateral bars, a stand and a foot-piece. The lateral bars A, A, are joined at their distal ends in a U shape piece. Their proximal ends are bent so as to pass beneath the chair, where they are secured by a draw-pin which passes through a socket

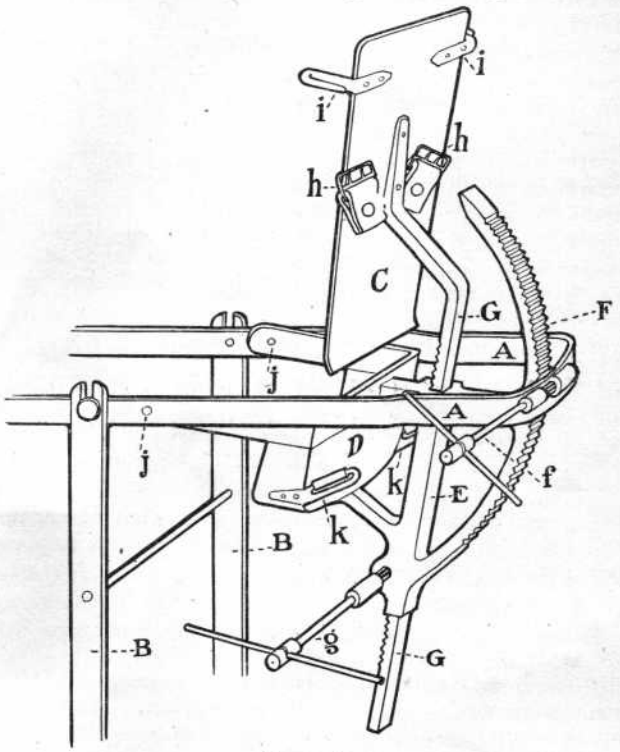


Figure 2.

screwed to the bottom of the chair-seat. The continuity of these lateral bars is interrupted just below the calf-band M, and the ends, overlapping, are held by thumb screws. Thus these bars may be shortened or lengthened as desired. The stand B, B supports the machine. It is detachable. The foot-piece consists of a foot-plate C and a heel-cup D. The foot-plate is joined to the heel-cup through the ratchet bar G, passing through the sheath E, which is secured to the bottom of the heel-cup. The entire foot-piece is riveted to the lateral bars at j, j, and by means of the ratchet F can be moved about the axis passing through j, j. The arc of the ratchet F is constructed on the radius jF.

To the bottom of the foot-plate are riveted two buckles h, h, which secure the heel-strap. This strap passes behind the heel, forward on both sides of the foot, over the hangers i, i, projecting upward from the front of the foot-plate and backward to the buckles. On each side of the heel-cup are pulleys, k, k, through which the astragalar S is roven. The strap crosses over the ankle opposite the head of the astragalus, from one pulley to the other, and is doubled back and one end passed through the buckle sewed to the other end.

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