

SOME EXCEPTIONS TO "THE GOLDEN RULES" OF OBSTETRICS.

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In presenting this paper it is not the intention of the author to attempt to undermine the "golden rules" of the obstetric art, but rather to call attention to the exceptions and limitations which hedge them in and which, unless borne in mind, are certain to result disastrously to both patient and physician. Theory, 'tis well said, may be likened to the chaff which is blown hither and thither by every passing breeze, while practice is the golden grain that springs into life wherever it falls. Yet, let us not discard as worthless these husks, for they serve a good purpose in protecting the unripe fruit stored up within them, and besides are useful in feeding the flame of scientific research. The one rule upon which, perhaps, more stress has been laid in the department of obstetrics than any other is: "In cases of labor attended with severe hæmorrhage during the latter part of the second and the whole of the third stage, promptly empty the uterus, and at the same time stimulate uterine contractions." Few there are, perhaps, who cannot recall the force and earnestness with which such a practice was advocated. "Turn out the infernal clots," still rings in many old student's ears, though the author of them has long since passed away. But is this rule, though a good one, to be rigidly carried out under all circumstances? Theory boldly makes answer, without hesitation, "Yes!" while Practice, on the other hand, says, "No!" Hence, we must turn to Experience as being a higher court, and submit the whole matter to her for a final decision.

Before, however, asking for an opinion, I would offer in evidence the history of the following case, which has, I think, a direct bearing upon the subject: Mrs. F., aged 30 years, white; American; mother of two children, both now deceased, I was called upon to attend in 1889. There was no history of miscarriages, nor tendency to hæmorrhage in previous confinements. She last menstruated on September 16; duration, five days; in every respect normal. Some weeks after its disappearance there occurred slight morning sickness, but at no time did it seem likely to undermine the patient's health. The usual bladder and respiratory disturbances were present; likewise, anæmia, which tended to become aggravated as gestation advanced toward completion. Calculating by the Duncan method, her confinement might be expected about the last week in June or the first in July.

On the 28th day of May, however, I was called to attend Mrs. F. She had been, I was informed, in labor all night. Deeming a digital vaginal examination necessary, I proceeded at once to place my patient in proper position. On exploration of the utero-vaginal canal, I found the uterus settled low down in the pelvis, with the cephalic end of the foetus presenting. The os was already somewhat dilated, and each pain caused its further increase and bulging of the membranes, indicating, beyond contradiction, that whatever had been the duration of the period of gestation the woman was in the first stage of labor. The fetal heart-sounds were audible, and the uterine contractions, though not very strong,

were of ordinary length and frequency. The abdomen was not unduly distended, and there seemed no cause for anxiety as to the ultimate result. Leaving my patient to the care of a neighbor, who was to act as nurse, I did not see her again for some hours. On my return I found, on inquiry, that the pains were rather weak, and that, though the os was sufficiently dilated, the head had not engaged satisfactorily.

My patient was much exhausted, and gave evidence of a lack of nervous tone, which warned me that to delay longer the delivery of the foetus would endanger its life as well as that of the mother. Why the prostration should have been so rapid and extreme, since it developed in a few hours, I was at a loss to understand, until subsequent investigation acquainted me with the fact that my patient had taken large and frequent draughts of whisky in my absence, in direct violation of instructions.

Deeming the case to be one suited to the immediate application of the forceps, I applied them to the sides of the foetal head and delivered, without undue haste or difficulty, under chloroform. No laceration of cervix or vagina was discoverable, though hæmorrhage quickly followed extraction, and was of an acute character, which had its origin in the uterine cavity.

Hastily grasping the fundus of the uterus, I found the organ was not contracting properly, and that I had to treat a grave case of post-partum hæmorrhage without adequate assistance. By external manipulation over the abdomen I endeavored to secure firm uterine contractions, but though the muscular fibers responded slightly to strong irritation, yet in a few seconds relaxation followed, and the blood poured forth in a stream from the vulva.

Like a flash of lightning the golden rule—"turn out the clots, separate and remove the retained placenta"—came into my mind, and I proceeded to do so. Introducing one hand into the vagina and carrying it up into the uterine cavity, while the other grasped the body of the organ through the abdominal wall, I strove to detach the placenta which I found adherent to the internal coat. The difficulty attending separation was due to a failure of the chorionic villi to undergo atrophic changes as the gestation approached full term. At last the villus attachments were broken up and the placenta withdrawn by the examining hand. During the time expended in attempting to remove the afterbirth my patient was given one drachm doses of the fluid extract of ergot every fifteen minutes, part of which was, however, vomited. No sooner had I emptied the uterus than the flow of blood, instead of lessening, greatly increased, until it fairly welled out of the birth canal, and running through the mattress formed a pool on the floor.

Vaginal injections of hot water proved ineffectual, seeming rather to increase than to control the hæmorrhage. To keep the uterine cavity free from accumulated blood and secure contractions was impossible. The blood had lost the power to coagulate, and could not respond to the means employed to bring about such a desired condition. It remained, even on the floor, in a perfectly fluid state, though exposed to atmospheric influences. A strong solution of the subsulphate of iron in hot water was thrown by a Davidson syringe into the uterine cavity, but failed to reach the bleeding point owing to the amount of blood already in the organ. The uterine

walls were as limp as a wet piece of tissue paper, perfectly devoid of their normal tonic. Ergot had not the slightest effect; in fact, it was doubtful if it was even absorbed.

Stimulants, whether introduced by hypodermic or stomachic methods, were unavailing. What was to be done? By this time my patient was almost exsanguine and in a state verging on collapse. Consciousness was lost, though her head had been lowered and her feet elevated at the very first sign of dangerous hæmorrhage. Intense thirst was present, and it was evident unless the bleeding was speedily controlled death would inevitably result.

A binder was now drawn tightly about the abdomen with the hope of preventing further relaxation of the organ, but it, like the other means, failed.

Still the flow continued in spite of drugs, external and internal manipulations, and efforts directed to compress the abdominal aorta. To stop the hæmorrhage seemed beyond the powers of science. In about fifteen minutes after the completion of the third stage of labor life was extinct. Not less than two quarts of blood had been lost; besides, the cavity of the uterus was distended with, perhaps, half as much more. Thus terminated fatally one of the saddest and most trying cases of post-partum hæmorrhage I have been called upon to treat.

In meditating upon the management of this case, I now see, which experience, not a blind adherence to theory, has demonstrated, that the result was due indirectly, if not directly, to three causes: First, excessive imbibition of whisky, taken by the patient contrary to orders, which tended still further to depress the already anæmic nerve centers at a time when life depended upon their activity; second, persistent efforts to separate an adherent placenta in a case complicated by threatened uterine inertia with the idea of removing all substances likely to retard or prevent uterine contractions; in other words, following out literally that golden rule—"turn out all clots from the uterus and remove the placenta as early as possible in cases of labor complicated by hæmorrhage"; third, the mistake made in not packing the whole uterine cavity at once with any clean fibrous material at hand, saturated with a powerful styptic, as soon as it was evident the uterus would not, or could not contract. This latter procedure, which at present has so many advocates, and has given such satisfactory results—Dührssen, of Berlin, having treated seventy-nine cases successfully—in addition to the other means employed, would, I firmly believe, have saved my patient. But I hesitated to tamponade the cavity of the organ, fearing subsequent infection, and relied upon other measures, which I pushed to the limit of safety, believing every moment they would excite the uterus to contract and close the open-mouthed uterine sinuses. Having failed, through an error of judgment, to employ the comparatively new method of tamponing the uterine cavity, I feel justified in bringing this subject to the attention of the medical profession, that the exception to this golden rule may be laid down as strongly as the rule itself. The case I have reported only too clearly proves how important is our duty in this respect. Let us take warning, lest we are over-anxious to tear off a placenta and clear the uterus of its contents; for if the organ fails to contract, we will only drain off more blood and further jeopardize the life of our patient. That one cannot rely solely

upon ergot in such an emergency would appear evident from cases reported by Oui, of Bordeaux, who, in order to save his patients, was obliged to tampon the uterus. Should we be obliged to resort to packing the uterine cavity, let us not delay doing so, lest our patient expire while we stand idly by making up our mind. Direct and equitable pressure, which can thus be brought to bear upon the bleeding points, is the safest and surest method of treating grave cases of post-partum hæmorrhage. That there is an element of danger from subsequent infection, is very true; but what is the risk of septicæmia in competent hands compared to instant death? Under such circumstances the demand is for immediate action, or our patient will be a corpse. In conclusion, then, it would appear that the exceptions to these golden rules are no whit less important than the rules themselves. Practice must govern theory; not theory, practice. Therefore let us express, without fear of contradiction, these exceptions: First, do not tear off an adherent placenta from the uterine wall, in cases of labor complicated by hæmorrhage, unless the uterus gives promise of speedily contracting.

Second, emptying the uterus of fluid blood is useless when coagulation cannot be secured, and when uterine inertia persists.

Third, do not delay packing the whole utero-vaginal canal firmly, in post-partum hæmorrhage, if the organ will not contract and close the uterine sinuses.