STRICT INDICATIONS FOR OBSTETRIC OPERATIONS.*

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Listening to some remarks of a Fellow at our last meeting, informing us that a well-known maternity hospital used rubber dilators in about 13 per cent. of their cases, it struck me that it would be of the utmost value to show the readers of such remarks that while it is proper in a hospital to show students the various instruments and devices and their application for relieving suffering, it must always be made clear that these operations are often performed for their benefit only, of course without hurting the patient, and the same operations are frequently contra-indicated in private practice.

Thus in small university clinics the application of forceps, for example, is often absolutely demanded to give the student some idea of their practical working from the true reasoning that such an operation under proper expert supervision, even without a strict indication, will do less harm to the individual patients in the long run than it will help humanity in general by giving so much more experience to its future benefactors.

It is perfectly proper and possible for an expert to perform dozens of Duehrsen operations for bloody dilatation with the best assistance and the best skill without infecting the patient, when a general practitioner would get better results staying many hours at the bedside and waiting for a natural dilatation. Again, an expert may make a record in symphyseotomy while the general practitioner would kill the same number of infants and mothers by following his teaching.

Now all our knowledge is either gained by experience or by being taught either by precept or *ex cathedra*. All Fellows of our society are teachers, are sowing their seed broadcast throughout the land; but very little fruit is received by congenial soil. We relate our experiences in our society and have them published. We invite people to our operations and are looked upon as great operators, or we go directly to our pupils and teach them didactically or clinically.

There is a great deal of difference in teaching an undergraduate, a

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young graduate, an older man, or a specialist, and yet we hardly ever separate our remarks; on the contrary, we try to make them fit the whole profession.

How would you, for example, consider a statement in one of our newest text-books on obstetrics for students and practitioners, where the medium degrees of pelvic contraction of the superior strait at the conjugate are put down not only at 9½ to 8 centimetres, but where the gentleman repeats in brackets for the benefit of his readers, that this corresponds in inches to 3.741 to 3.1496. If this expert may be able to measure these fractions of inches he is wecome to his knowledge, but he is wrong to burden the mind of the student with such minute details which one out of a million will ever retain. The bad results from such teaching I have unhappily too frequently seen in my professional experience. Right here in New York City at the center of medical education of the continent, there still occur and have been occurring thousands of cases of puerperal fever brought on by too frequent and injudicious operations. I see in my own consulting practice at least twenty-five septic puerperal cases a year, and in a large percentage too early interference without strict indication was primarily responsible for the disease of the patient. On the other hand, in my connection with the Post-Graduate School, I have had occasion to teach several thousand practitioners of medicine, and found those remarks on strict indications most appreciated by them.

This state of affairs ought certainly to be attended to.

First of all, by understanding that light, witty remarks in debating are frequently taken seriously by the profession in general, and theoretical precepts are occasionally carried out in good faith by unqualified followers.

Secondly, by not making general rules in a specialists' meeting for everybody, but differentiating to whom we are talking, and laying stress on this fact.

Thirdly, by giving undergraduates only the strictest general indications to arrive at a result, instead of giving them vague and devious roads which they are not prepared to appreciate.

All obstetric operations are easy of performance if done at the correct time and for a proper indication.

Now, what text-book gives the proper indication to a man without experience? A high forceps operation done by an expert with an axis traction forceps is easy of performance for him, but put this same instrument, made for an expert, into the hands of an inexperienced practitioner, and he will try to get results which the original inventor

had never thought of. A low forceps operation, on the other hand, can be performed by any individual, and will do the patient no harm barring an incidental tear, which can also be remedied by this same physician.

Again, symphyseotomy, if done with all requisite assistance, with all the caution in expert hands, gives excellent results, but performed in dirty quarters, by inexperienced operators, where time might have given the same result, is a more dangerous proceeding than performing version in a neglected shoulder case. The indications in our text-books talking, for example, of forceps, are so complicated that the young physician gets absolutely bewildered and applies his instrument a great many more times than is absolutely necessary.

Now all modern obstetricians agree that any interference, any too frequent examination, or any unnecessary operation increase the danger to mother or child. Therefore, if for no other reason, operations ought to be avoided wherever possible.

I think we can put all the indications into this single rule: *Whenever mother or child are threatened with danger, interference is necessary and indicated.*

That means, whenever the fœtal heart-sounds are either increased by twenty or reduced by twenty a minute, whenever meconium appears in head presentations, whenever a head swelling loses its tenseness, this shows that it is time for the infant to be extracted. On the other hand, the mother shows us by an increasing temperature, by a heightening pulse, by increasing respiration, or by hæmorrhage or convulsions that she needs to be delivered. Included are also non-normal proportion between the maternal passages and the fœtus, and mal-presentations and positions.

The usual mistake in the beginning of labor is the too early artificial dilatation; unless labor has fully set in and membranes are ruptured we ought to wait for the obliteration of the cervix and for the dilatation of the os (a thing, by the way, that is not generally separated in the remarks which are made about dilatation).

Emptying the bladder will frequently help to obliterate the cervix and dilate the os where an artificial dilatation would be absolutely out of place. The subjective symptoms of the hysterical patient, or the pleadings of the family, or the impatience of the physician ought never to be taken into consideration. A dilatation is only necessary if the delivery made necessary by the condition of mother or child is to follow immediately.

Forceps ought never to be employed except by an expert unless

the head is engaged in the pelvis. This will exclude all those cases of deformed pelvis on account of which the head cannot descend, as well as all those cases of monstrosities on part of the infant, where the head cannot pass through. It will also exclude any mal-presentation.

Version is either performed to correct a malposition of the fœtus or as a preliminary to extraction. This indication will again exclude such cases of contracted pelvis which make it impossible for the infant to pass.

Craniotomy nowadays is only performed on a dead child, and certainly is preferable to an attempted version late in labor or to a symphyseotomy in unfavorable surroundings.

Elective Cæsarian section is only to be performed by expert laparotomists in the very best of surroundings. Just as much as the indication for a symphyseotomy can only be drawn by the expert obstetrician and the operation ought never to be performed except by an aseptic operator will a full staff of trained assistants. The absolute indication for Cæsarian section will be best appreciated if we keep in mind that a medium-sized hand ought not to be able to pass through the superior strait. The indication of abortion or premature delivery ought to be much more strictly observed. No vomiting in pregnancy ought to be called uncontrollable until after the usual remedies having failed, rectal feeding has not stopped this symptom.

One of the finest points in choosing the operation is a medium-sized pelvis of three and a half to three inches conjugate diameter, where premature delivery, version and extraction, symphyseotomy, or elective Cæsarian section have to be compared. The same with placenta prævia.

Permit me, for illustration, to cite three cases happening to me sometime ago in succession, where three different ways led to the same result, but where each road was indicated by the correct marks.

Case I.—I. para, fainting, husband left, nurse had not arrived, head not engaged. I delivered her at once by quick version and extraction.

Case II.—III. para; roomy pelvis, membranes not ruptured, cervix obliterated, os dilated, pains good, strong and regular; head presenting well, not engaged, quite an amount of hæmorrhage. Membranes were ruptured and patient was delivered spontaneously within ten minutes.

Case III.—II. para. Cervix not quite obliterated, but dilatable; head presentation; head not engaged; very little hæmorrhage; good surroundings, good assistants. Bimanual version and easy extraction an hour afterwards. I think if I had reversed this order of proceedings I would not have succeeded in saving mothers and children.

Gentlemen, if I have succeeded in calling your attention to the fact that it is not the operation, but the indication, the condition of the patient, the surroundings, which are the difficult factors that save or kill our mothers and children; if I have succeeded in calling your attention to the fact that a series of brilliant successful operations against the rules, or experiments to devise new rules are followed by a crowd of imitators without your brilliant skill or power of initiative, whose result will prove the very opposite of your intentions; if I have succeeded in convincing you that a sharp repartee in debate at a specialists' meeting may work immeasurable harm to some readers of the report; if I have called the attention of the obstetric teachers, not only members of this society, but of the country, to the fact that the teaching of strict indications lies at the bottom of the whole teaching of obstetric operations, I have not pleaded in vain.

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(See page 112.)

Discussion.

Dr. J. Clifton Edgar: I have been much interested in the paper. The problem which the author brings before us this evening is not one easy of solution. So far as the teaching goes, the difficulty lies in the fact that the time is too short and the student sees too many operative cases. He takes a four years' college course, attends a few lectures on the physiology of pregnancy and labor, takes a course in a maternity hospital where, unfortunately, he sees a number of obstetric operations—perhaps three or four out of twelve cases observed—and enters practice with the idea that the tendency in obstetrics is toward interference, although in each of the cases in which he saw an operation performed interference was demanded by some positive and special indication.

I agree with the author that in debating we are apt to speak hastily and thus convey a wrong impression; but I do not agree with him that low forceps is a simple operation or that it can be performed by anybody who has not had the requisite experience. There are cases on record in which the forceps have been applied in the median and even in the low position, and in which the child's head has been drawn through the rectum. Personally I know of one instance in which a physician, in the excitement of the moment, made traction in the wrong direction, pulled the head up against the pubis, and ruptured the urethra. In another case the head was pulled through the rectum. Immediate operation was performed, but it was at night, the light was poor, and the result was bad. A second operation was performed later, but in the meantime the patient was an object of disgust to herself and to her family.

Nor do I quite agree with the author that the tendency of the day is toward interference; to my mind it is toward conservatism. During the last four or five years the tendency has been to let well enough alone and to interfere only when there is a positive indication. When a man reports six or seven cases of symphysiotomy, we must bear in mind that he has had several hundred cases of confinement under observation each year. This also applies to cases of Cæsarean section.

I am not prepared to say that there never has been a time when there has been too much interference, for at the beginning of the present decade forceps were used much more frequently than they should have been, and in many cases entirely too high. I believe, however, that the records of the last International Congresses of Obstetrics will show that there is gradually creeping into midwifery an element of conservatism.

Dr. BACHE MCE. EMMET: The evils to which the author alludes are difficult to cure, for they are due to a lack of thorough obstetric training along practical lines. The practitioner who has been well trained in obstetric diagnosis should not make the mistakes to which allusion has been made. A fruitful source of error is the fact that the general practitioner feels himself competent to take charge of almost any case of delivery, and often attempts to do a capital obstetric operation where he would hesitate to perform a much less serious surgical operation. If he were taught to recognize difficult cases and the necessity for calling in an experienced obstetrician such mistakes would occur less frequently.

Dr. ROBERT A. MURRAY: The author has touched upon a number of points this evening, but a primary point and one upon which he did not touch is the fact that a knowledge of midwifery is not gained by intuition. The physician takes it for granted that a case is going to do all right, and does not examine to find out what conditions are present. Many cases are not examined at all before labor, and some are in the hands of midwives. The trouble is that the person in charge relies upon the normal character of labor and forgets that the only normal labor that we see is that in which we know all the conditions which exist in the patient.

I, also, would like to enter a plea for strict indications for operative interference and for teaching the practitioner to differentiate ordinary cases from those in which there should be interference. When the student is taught by examinations on the manikin and on the subject how to determine the normal conformation of the pelvis and the abnormal variations; when he is taught what are positive indications for serious obstetric operations, and that, when he finds these positive indications he must send for a man who is competent to do obstetric surgery, then and then only will we have better midwifery.

I agree with Dr. Edgar that during the last few years there has been a strong tendency toward conservatism in midwifery. I think it has been carried too far. In some colleges students are taught to make the diagnosis of presentation and position in labor by outside

examination. This is always difficult, and in some cases impossible to be done even by an expert. I maintain that if a practitioner knows anything about surgery and asepsis he can examine a pregnant woman vaginally without any more risk than he would incur by making an application to her throat, no matter whether she is in a tenement-house or in a palace. To make this clear, when I had charge of the obstetric department in the university, two students were allowed to see and examine each case, and in but a single instance in many years was I obliged to send a patient to the hospital for sepsis. In that case the woman had been examined by a physician who had been handling a case of erysipelas.

A large proportion of the deaths which occur during the puerperium occur in the practice of midwives, and here we have no primary teaching—the cases are allowed to go too far. Almost every accident and every difficulty in midwifery can and should be prevented—and this is successful midwifery. The pregnant woman should be examined carefully before labor. This should be taught, but in most obstetrical hospitals, objection is made to students examining cases for fear of infection.

Dr. E. A. TUCKER: I think we all agree with the author that obstetrical operations should be very strictly indicated before being performed. I think that if he will look into the manner in which these matters are conducted in the hospital to which he refers he will find that they are governed by rules as strict as are to be found anywhere in the city. If he asserts that operations are done there simply for the benefit of the students, I deny it.

The main point is this: The statistics of a hospital differs from that outside, no matter what it is. The hospital which has the most operations to show students is the most valuable for teaching purposes, but it does not necessarily follow that because a student sees several obstetric operations in one day at the hospital he is going to see the same kind of cases outside. There have been times at the Sloane Maternity—and I know something about the work there during the past years—when 40 per cent. of the cases required some obstetric operation—not major operations in every case, but operative interference, such as forceps, version, or breech extraction. It may not be supposed that outside one is going to meet so many cases requiring operative treatment, for private cases are usually watched during pregnancy. Moreover, many cases are brought to the hospital because something is wrong. Therefore, hospital statistics is no index of outside statistics. I make this explanation because the author criti-

cised the statement which was made at our last meeting to the effect that dilators were used in 2 per cent. of the cases at the Sloane Maternity during the past year.

In reference to the text-books, I agree with him that most of them in use at the present time give some teaching which cannot be carried out. In the same book to which he has alluded the statement is made that a patient in labor should be examined every hour during the first stage and every fifteen minutes during the second stage. This is not good teaching for the student.

In a word, it all depends upon the training a man has had In an obstetric hospital many difficult cases will always be seen, whereas in private practice such cases are comparatively rare. The gist of the whole matter has been touched upon by the preceding speakers, who have said that a longer obstetric training is necessary. The experience that a man gets in a week, two weeks, or four weeks, is simply the starting-point of his obstetric career, and he should then learn more for he is scarcely capable of conducting a normal labor after such a short training. The men who are doing obstetric operations when they should not are men of this type, with little experience, who attempt to deliver too soon, or too late, as the case may be.

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