SURGICAL INTERVENTION IN OBSTETRICAL PRACTICE

INDICATIONS FOR AND AGAINST*

BY

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In the time at my disposal I can only mention the outstanding indications for and against surgical intervention in obstetrical practice. I shall endeavour to discuss the subject from the standpoint of the general practitioner. It is true that major operations, such as Caesarean section, have eventually to be referred to the specialist for their performance, although the family doctor in many cases is the first to give advice as to the procedure to be adopted. It is generally agreed that the wider the experience one has gained in the management of obstetrical cases the more conservative one becomes in their treatment. Maternal mortality statistics published from all parts of the world prove that the practice of conservative methods in midwifery gives the most favourable results. Not infrequently it has happened with all of us at some time or other that more courage is required to leave well alone than to terminate the pregnancy or labour by some method of operation. My general rule is "when in doubt do nothing." The old political quotation "wait and see" is not a bad rule to follow in obstetrical practice. I might, however, qualify this by stating that once a decision has been made for operative intervention it should be carried out promptly with the best possible surgical and aseptic technique obtainable.

It must be remembered that obstetrics is not a branch of surgery; it stands alone, and has its own methods of procedure. It is the exercise of wise judgement that really gives good results.

Ante-natal Complications

These comprise mainly the indications for (a) induction of abortion, (b) induction of premature labour, (c) version, (d) operations for tumours complicating pregnancy, and (e) haemorrhages.

(a) INDUCTION OF ABORTION

With our modern methods of medical treatment induction of abortion is not resorted to so frequently as was the case in former years, when often the sole method of treatment was the termination of the pregnancy. An example of this may be found in diabetes, where the administration of insulin has proved so effective. In vomiting of pregnancy isolation of the patient and treatment of the symptoms of starvation by dieting have reduced the incidence of induction to a remarkable extent. I now practically never terminate an early pregnancy on account of vomiting. The three main conditions calling for the consideration of induction are cardiac disease, pulmonary tuberculosis, and nephritis.

In cardiac disease no definite rules can be laid down. Each case must be judged on its merits, with due regard to the condition of the heart and its reaction to exertion and prolonged rest. It is advisable to have in consultation a colleague with special experience in this disease. The use of the electrocardiograph and x rays has helped very much in making a more exact prognosis than was formerly possible. I have again and again had experience of the improvement which takes place in a damaged heart by careful ante-natal supervision and treatment.

* Address given to the Huddersfield Division of the British Medical Association, February 3, 1937.

It not infrequently happens that in those cases in which there had been no treatment previously, the heart is in better condition at the end of pregnancy than at the beginning. The strain of late pregnancy and labour, however, must necessarily be considered when one is forming an opinion as to the advisability of the continuation of pregnancy. In 200 cases of heart disease treated in the Royal Free Hospital, a number of whom were sent in for the purpose of induction, only 6 per cent. had their pregnancies terminated. The mortality of these patients when followed up for a considerable period was 2 per cent.

In pulmonary tuberculosis the indications for induction in patients with early active lesions are more evident than in chronic cases. Treatment by artificial pneumothorax and other methods should be tried before resorting to induction. It must be remembered that any forcible surgical interference in these conditions is not advisable; I have seen serious haemoptysis follow a straightforward induction of abortion. The slow method of emptying the uterus by laminaria tents is to be preferred. I feel convinced that the termination of an early pregnancy will not be necessary once we have established proper medical treatment for these patients. They should have residence in a sanatorium without any break in the continuity of the treatment during the confinement and post-natal period. It is the present method of turning these patients out of a sanatorium a few weeks before labour is due that is so detrimental to a possible cure. Sanatoria make no provision for maternity cases and are anxious to avoid all risk of the confinement taking place. The maternity hospitals avoid the admission of tuberculous patients as far as possible owing to the fear of infection.

In cases of nephritis with hypertension, albuminuria, etc., I have little hesitation in terminating a pregnancy when treatment by ordinary methods has failed. There is a risk not only of permanent damage to the kidneys, but as is shown by the history of these patients when followed up, death occurs within a few years of the confinement in quite a number of instances. The ovum frequently dies and may be extruded in a macerated condition, which goes to show that Nature herself has her own methods of treatment. A marked amount of albumin and persistence of a high diastolic blood pressure are indications for removal of the ovum. I have found that hysterotomy with or without sterilization has given very good results. The ophthalmological examination is often the deciding factor in the consideration of induction. Haemorrhages or destructive changes in the retina are an indication for intervention in most instances. I hope in the future that in these cases of nephritis some method of treatment will be found to obviate the necessity for termination of the pregnancy.

(b) INDUCTION OF PREMATURE LABOUR

The indications for and against this are much the same as for abortion. The problem in the case of premature labour is not an ethical one, as the operation is performed in most instances to save the life of the infant—for example, in cases of habitual death of the foetus at a given week of pregnancy. I have been trying the effect of medication by vitamin E—wheat-germ oil—in a few cases with encouraging results.

In cases of marked pelvic contraction or disproportion where, for example, the head cannot be pushed into the brim at the thirty-sixth week, it is obvious that Caesarean section is indicated; but we all have experience of the head which stubbornly refuses to enter the brim of the

pelvis until the last moment, when it passes through without any injury to itself or the maternal structures. Trial labour, therefore, is essential in all doubtful cases. Hot sitz baths, sedatives, and anaesthetics during labour render its progress much easier. In cases where there is a doubt as to the possible necessity of a Caesarean section no vaginal manipulation should be carried out. For this reason surgical induction causes more risk if a subsequent Caesarean section has to be performed.

Labour is rendered easier in doubtful cases if careful dieting and walking exercises during pregnancy are advised. If fifteen grains of chloral hydrate are given every night for a week or ten days before labour is due rigidity of the cervix may be prevented.

(c) VERSION

Version is not necessary in the majority of cases of breech presentations, as most foetuses turn spontaneously before the thirty-sixth week. In my experience of antenatal examinations about 25 per cent. of all cases have a breech position before the thirty-second or thirty-fourth week.

Version should be attempted only after a radiograph has been taken of the position of the foetus, and the patient should be admitted to hospital or have the manipulation carried out in her own home. It may be necessary to give an anaesthetic. If version is easy the probability is that spontaneous version would have taken place if the case had been left alone. Version fails in most cases because of extension of the back and legs. It is a dangerous procedure in cases of toxæmia or nephritis, as it may cause separation of the placenta and death of the foetus, or even of the patient from haemorrhage.

(d) TUMOURS

Tumours of the ovary tend to twist during pregnancy and in most cases should be removed.

Fibroids give little trouble unless they cause pressure symptoms. If they occur in the pelvis Caesarean section and enucleation is the operation of choice. If the patient is young the uterus should not be removed if it can possibly be saved. I have performed Caesarean section in a young patient with a uterus studded with fibroids and have not removed them. They involuted, and the patient had no subsequent symptoms of pressure or haemorrhage. In the case of degenerating fibroids associated with toxic symptoms I treat the patient for toxæmia, and if necessary perform Caesarean section at term. Fibroids should not be interfered with during pregnancy unless there are symptoms of pressure or evidences of acute infection.

In some cases I have enucleated a degenerated fibroid from the uterine wall several weeks after delivery, with successful results and without recourse to hysterectomy.

(e) HAEMORRHAGE

In toxic haemorrhage the less interference the better. If the haemorrhage occurs in the late weeks of pregnancy absolute rest in bed and the administration of morphine will be sufficient; this should be followed by treatment for the toxæmia. Rupture of the membranes may be necessary in some cases. I have given up packing the vagina and all manipulation. It is remarkable how well these cases do compared with those treated by surgical methods. One must always remember in these cases that the danger of any interference is shock, increased haemorrhage from lacerations, and sepsis. In toxic conditions of the liver pressure by an abdominal binder is dangerous.

In placenta praevia intervention in most cases must be prompt if haemorrhage takes place. I have kept cases of slight haemorrhage under observation with good results, but there is always anxiety, as sudden and fatal haemorrhage may take place. Version, performed in order to control the placental bleeding by means of the foetal buttock, has its uses. Willett's clamp is useful if the head is down and the foetus not too premature. In central placenta praevia Caesarean section should always be considered if there is a living foetus.

Intervention During Labour

Forceps.—The application of forceps is more of a problem in practice than one at first realizes. In most cases of domiciliary midwifery the practitioner is influenced to some extent by a desire to terminate the labour on account of the suffering of the patient and the risks to the foetus attendant upon delay. The anxiety of the relatives may tend to precipitate matters. The forceps rate in such practice is higher, therefore, than in hospital cases. The urgency for instrumental delivery can be avoided by the administration of sedatives in the first stage; and anaesthetics, such as gas and oxygen or gas and air, during the second stage. Forcible muscular exertion on the part of the patient should be avoided as it causes uterine fatigue. The lithotomy position gives more room for the head to come down to the outlet, and simulates the Eastern method of delivery by means of the squatting position. I do not apply forceps when the head is high in the pelvis, and I consider the administration of pituitrin a danger, except after the termination of the third stage of labour.

If the perineum is preventing the expulsion of the head or is showing signs of laceration a median episiotomy is of value. The lateral incision may prevent extension of the tear, but I have found it difficult sometimes to get primary union. Undue stretching of the perineum is just as frequent a cause of rectocele as a lacerated perineum. Careful suturing of the perineum in layers will prevent subsequent prolapse. If primary union does not take place I make it a rule to have the wound thoroughly cleansed by swabbing with an antiseptic (dettol for choice) and in about ten days to freshen the edges and unite them by secondary suturing. As a rule the results are excellent and no repair is needed at a later date. It is a mistake to deliver a head rapidly by forceps; slow traction during the pains causes little injury. If the head lies for a prolonged period on the perineum without any progress forceps should be applied. In cases of foetal distress or prolapse of the cord forceps may have to be applied earlier than would be the case under normal conditions. If a patient is having few pains and the foetal heart is regular there is no necessity for terminating the labour, even though the second stage may have lasted for some hours.

Caesarean section is advised for cases of extreme disproportion, for central placenta praevia, and where undue strain would be dangerous for the patient. In patients who have had previous stillbirths during labour, or in the case of a breech with extended legs where the pelvis is rather small, Caesarean section may be indicated. I always operate after labour has started, as not infrequently the operation has been found to be unnecessary. The more experienced the obstetrician the fewer cases of Caesarean section he has to his credit.

The Third Stage of Labour

Uterine fatigue is the most frequent cause of retained placenta. Patience and time will effect its delivery.

Passing a catheter is often of advantage; and expulsion from the vagina may be effected if a light anaesthetic is given. In normal cases it is not necessary to massage the abdomen in the third stage. Massage often causes irregular contractions and retention. It is unnecessary to explore the uterus for retained membranes; they will probably come away as involution proceeds. If the membranes do not come away naturally in a day or two and give rise to local sepsis a glycerin drain may be advisable. When the placenta reaches the vulva the hand should not touch the abdomen, as it may produce constriction of the cervix, which would prevent expulsion of the membranes. Injection of saline solution into the umbilicus in some cases effects delivery of the placenta.

Manual removal of the placenta should be avoided, except for haemorrhage or complete retention, as it is not infrequently followed by some degree of pyrexia.

Puerperal Sepsis

There is no time to do more than mention this subject. With improved methods of treatment, as, for example, with prontosil in cases of acute blood infections, surgical intervention has been much diminished. Hysterectomy has always seemed to me a mistaken method of treatment, and has been responsible no doubt for the loss of some lives. Drainage of the abdominal cavity does not seem to me a rational method in these cases, as the infection is not comparable with that of appendicular abscess or pyosalpinx. I have found serum of value in some cases; and of course fresh air, colon lavage, and blood transfusion all help towards a cure.

In local or uterine sepsis glycerin drainage is the best method of treatment.

In cases of septic abortion it is advisable not to remove the ovum or placenta when first seen, but to delay until the patient's resistance has been improved with prontosil, etc. A glycerin drain may effect the spontaneous expulsion of the ovum. If not, removal of the uterine contents by the finger or forceps is not accompanied by much risk of disseminating the organisms by breaking down the barrier in the uterine wall. A mole which gives rise to haemorrhage should, of course, be removed as soon as possible.

In conclusion, we must remember that although we are often tempted to use surgical methods in obstetrical practice time and patience will do much to banish the possible complications which we apprehend. The results of operation at the moment may be dramatic, but the dice are loaded sometimes against us in the form of shock to the patient, haemorrhage, and sepsis. Masterly inactivity may seem to many to be poor treatment, but the results will often be infinitely better than those attained by surgical intervention.

A. Alfano (*Rinasc. med.*, January 31, 1937, p. 47) states that recent studies of the extra-articular manifestations of acute articular rheumatism have induced him to record the following case. The patient was a girl aged 13, who was suddenly seized with abdominal pain, chiefly localized in the right side, constipation, vomiting, and fever. The pain in the lumbar region which subsequently developed made it doubtful as to whether the condition was a retro-colic appendicitis or suppurative peritonitis. The subsequent course of the disease made the last diagnosis appear the most probable at first, but later the occurrence of pain in the typical situation showed the true nature of the disease.

AN UNUSUAL CASE OF HERMAPHRODITISM

BY

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I put forward the details of this case as of considerable importance in having a direct bearing on the problems of sex, its origin, and manifestations.

Case Report

The patient consulted me when she was 18 years of age because she had never menstruated, though she had had frequent manifestations of sexual excitement at irregular intervals, and had become anxious as to their exact significance. Her general bearing was that of an attractive female, aware of her beauty, both of face and figure. Her voice was pitched in the female register.

On examination she was found to be a beautiful woman, remarkably well developed as far as her typically female body was concerned. The face was free from hair. Her breasts were large and full, her pubis covered with a mat of hair. Her pelvis was rounded and well developed. Her clitoris, which bore to the naked eye a strong resemblance to a small penis not fused on its ventral aspect, was conspicuous between her labia, which were fully developed and definitely larger than the average. The vagina was about one and a half inches in length and terminated in a smooth, rounded extremity, but on removal of the examining finger it collapsed so as not to seem so long as the finger had indicated. She was very active sexually, and had a lover who had frequent connexions with her, and during these she became very excited. This man, an experienced bachelor, had assured her that he was able to complete the act with great satisfaction in spite of the shortness of her vagina, and that he had never had relations with such a passionate woman. These facts are mentioned to show that she was very highly sexed. Her sexual desires were invariably directed to males; indeed, she said she had rather an antipathy to females.

Desiring to settle in life and to cease her irregular friendships with her various lovers, she consulted me again in 1921 with the object of having her "passage" elongated, and asked if it were possible to make an artificial uterus so that she might have children. On examination I could not detect any sign of the presence of a uterus. I found in each inguinal canal a smooth, rounded lump which was readily returned into the abdominal cavity by slight pressure, but appeared again when the pressure was removed. She complained that squeezing the lump caused a pain, which she herself described as sickening. I explained to her that it was possible to make an artificial "passage" for the sake of intercourse, but that it was not possible to construct a uterus from which she could bear children. I added that there was a definite risk to her life in the former procedure if carried out by the abdominal route, and she wisely decided not to undergo it. Noting the elasticity of the perineal tissue, an elastic T-bandage was devised which kept up a constant pressure on a metal dilator. This was worn during sleep and for as long a part of the day as possible. Rapidly it became possible to increase the size and length of the dilator, and the patient's persistence was rewarded by the development of a passage three inches in length which on superficial examination bore a strong resemblance to the lower end of a normal vagina.

OPERATIONS

Three years later she came to see me again because the lump in the right groin had become painful and had increased in size, and an operation for the cure of an inguinal hernia was undertaken. The lump was exposed and was manifestly a small testicle, complete in every detail, except that no vas could be found. It was replaced in the abdominal cavity and the canal closed. Two years later a similar operation