SURGICAL TENDENCIES IN MODERN MIDWIFERY.

BY

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THE art and science of midwifery is in our days developing in a manner which seems to be as important as it is interesting. By physiological research one tries to investigate the biology of pregnancy in normal and pathological conditions. By *x* rays, pelvic measurements, examinations of the urine, and so on, one tries in time to detect various anomalies and apply a prophylactic treatment of them which may lessen the risks for the mother and her child. Finally, one aims at the same purpose by substituting with increasing frequency surgical intervention for the older obstetrical methods, in the hope of serving the interests of both. It is about this last-named feature of modern obstetrics that I want to say a few words.

The difference between past obstetrical methods and those at present employed is very striking; this is apparent if we consider for a moment the risks of a difficult labour in old times. If the foetus could not pass through a narrow brim one at first had nothing else to do than patiently wait for the accommodation of the foetal head. If that hope failed, there was no other resource than a version, an accouchement forcé, a Caesarean section, or an embryotomy, perhaps on a living child. In cases of placenta praevia, the only resource was the tamponade until version could be performed; in eclampsia venesection and chloroform were the only means to avoid new fits. Prophylactic treatment was wellnigh unheard of; from the natural forces one expected the utmost possible, which in many cases was the same as the impossible.

On the other hand, we should do a great injustice if we denied the merits of the old midwifery. The careful observation of the labour increased the knowledge of the mechanism of labour. The diagnostic ability of the obstetricians, their power of prognosis and appreciation of intervening anomalies advanced midwifery practice to a remarkable degree, and their patience—which is called the first virtue of the obstetrician—was tried to an extent which in our days is rather rare. Smellies, Boërs, and Baudelocques are bred only in such times, not in ours.

But their great merits stand out against a dark background. I only mention infections, lesions of the pelvis or the soft parts of the mother, asphyxia, cranial infractions, and so on, which, if they did not kill the mother or child, perhaps made them invalids for the rest of their lives. The number of such cases cannot be appreciated in statistics, but is easily understood.

The great advancement did not come at once, but as isolated flashlights. Among those who should be remembered with the deepest gratitude I cannot refrain from mentioning such British names as Macaulay, Smellie, Denman, and Lister.

The most important advancement from our point of view dates from the end of the last century, and is combined with the revival of the classical Caesarean section and the invention of the vaginal one. By the former we got the means of avoiding a great deal of the dangers of a narrow pelvis; by the latter we learnt to open the uterus and empty it at any time during the pregnancy or labour without risking the incalculable accidents of accouchement forcé. This epoch is not so far away but that we all remember it. We all of us remember, too, the hopes it aroused. No one who lived through that time can wonder at it, nor at the exaggerations that necessarily followed upon it.

Personally, if I may be permitted to say so, I was educated in the principles of the old obstetrical school. The

circumstances then were such that at a very young age I was entrusted with the directorship of the University Hospital for Women, and that exactly at the time I have alluded to. It was thus quite natural that a young man, who on many occasions had the opportunity of witnessing the insufficiency of the older methods, should begin to try if the new ways could give better results than the older ones. Thus it came about that I became a convinced partisan of the new surgical aspect of obstetrical therapy, and have done what I could to propagate it in Sweden.

But now there appears to me to be a tendency to go so far that even to a convinced partisan it seems difficult to keep pace. Let me state in as few words as possible my outlook upon the question, which seems to me important for the near future of obstetrics. To begin with the credit side of the surgical interventions, nobody denies that it is now possible to open and empty the uterus at any time during pregnancy or labour. What that signifies in eclampsia, in placenta praevia, in accidental haemorrhage, or in acute cases in which the life of the mother is threatened I need not insist upon. Neither can it be denied that the operations in question are so far technically perfect that the primary risk is very small.

It is far from my intention to proclaim them harmless; no surgical intervention is that. But considering the lesions which unfortunately sometimes occur, it is only fair to compare them with the quite incalculable and sometimes irreparable ones that so often follow upon accouchement forcé or a difficult labour in cases of narrow pelvis. Furthermore, there is no doubt that, as the surgical procedures are performed only in well-equipped hospitals, at the right time, by skilful and experienced hands, they are combined with lesser risks of infection and primary lesions. I do not think it possible to deny this. In that case it stands to reason that the surgical aspect of obstetrics has earned results for mother and child which could not have been obtained in any other way. As far as I can judge, nobody nowadays wishes for a return to the midwifery of older times.

But the medal has a reverse. The risk or value of an operation should not be appreciated only after the primary results, such as infection, embolism, and so on. The secondary ones are just as important. I will only mention two of them. One is the risk of thinning or rupturing of the scar after Caesarean section, the frequency of which in Britain has been thoroughly investigated by Herbert Spencer, Eardley Holland, and others. The other is of a kind which has not been seriously dealt with as yet—namely, the fear of the mother after Caesarean section that she may become pregnant again, and the significance such a state of mind may possibly have for the population. The effort by Caesarean section to get a living child may thus be in some degree neutralized by the mother who wishes to avoid further intervention of the same kind, and the operation thus has consequences which perhaps one has not thought of earlier.

Of course, I think it is fair to admit that the extension of the indications is in itself the natural consequence of the remarkable primary results, but the question arises whether, in these days, intervention has not sometimes been carried too far. It is difficult to discuss indications. A man who applies forceps in 3 per cent. of his cases probably considers a frequency of 6 per cent. or 10 per cent. exaggerated. Those who perform version only on certain fixed indications will certainly be considered behind the times by Dr. Potter of Buffalo, who seems to consider version to be a normal procedure in ordinary labours. And I know of a clinic where the frequency of interventions amounts to 90 per cent., against 10 per cent. of spontaneous labours.

I will give two special examples of what I consider unnecessary and therefore regrettable exaggerations.

Dr. Hirsch of Berlin is very keen on the extension of surgical methods in obstetrics, especially abdominal Caesarean section, to all abnormal labours, and he claims that this will bring about a new orientation in midwifery. He argues that the puerperal mortality has been stationary for a rather long time, and that mothers and children die who would have been saved if the mothers

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had been sent to a hospital without previous vaginal examination and operated upon in time.

To my understanding the efforts of Dr. Hirsch are creditable in so far that the early removal of complicated cases to hospitals and the omitting of unnecessary vaginal examinations would certainly bring about a decreasing puerperal morbidity and mortality. But to me it seems exaggerated to go so far as Hirsch wants to do. The new orientation that he so strongly advocates and wishes to introduce is already partly realized, and the surgical tendencies in obstetrics are nothing new. I myself have performed Caesarean section in 20 out of 200 patients with placenta praevia. I believe that no experienced obstetrician would hesitate about Caesarean section if he was really convinced that this operation would confer a better prognosis without increasing the risks for mother or child. Neither do I believe in the necessity or possibility of transferring all cases to hospitals, as Hirsch insists upon. The majority of labours go well by means of natural forces alone, and there is indeed no branch of medicine that in ordinary circumstances can be performed so efficiently and safely in the patient's home as obstetrics.

Furthermore, Dr. Hirsch's handling of the statistical figures does not quite appeal to me. Generally speaking, it is difficult to get reliable statistics on this special point. I particularly wish to draw attention to the very thorough and excellent investigation of the Caesarean sections performed in Germany in 1928 which has been recently published by Winter. It really does not point in the same direction as Hirsch, but quite the contrary. For the present I am therefore of the opinion that Hirsch overrates the possibilities of Caesarean section, while he at the same time underrates what can be done by simpler methods without surgical intervention.

Another example of misjudging the Caesarean section has been given recently in Sweden, when a colleague put

the question: "Why does not one perform that operation more frequently in order to shorten the labour and alleviate the pains of the mother?" I need not here go into a detailed criticism of such a proposal, which seems to indicate that the desire for more speed, which is such a characteristic feature of our days, threatens to extend into the domain of obstetrics.

I should venture to go farther and say that these and other efforts to extend surgical intervention in obstetrics are indicative of a too superficial understanding of childbirth. Labour is decidedly a physiological process, the most difficult and strenuous that the human organism is able to perform. Who knows the deeper effects of such an enormous effort on the body of the mother herself? The coming into life of new individuals is associated not only with risks, but also with means of safety which may be considered as wellnigh perfect. When trying to follow and understand them we are reminded of the words of our great Linnaeus: "Deum omnipotentem a tergo transeuntem vidi." And we ought to remember, too, that nothing great and dear in life is attained without struggle and suffering. If we try to reach the goal by easy byways, we may perhaps find that we have lost more than we have gained.

No; surgical intervention is not intended to shorten a physiological process, nor merely to alleviate it. It is permissible only after thorough consideration of the pros and cons. It requires of the obstetrician a patient observation and infallible recognition of commencing complications, the power of choosing the way of the greatest safety, and, not least, a sufficient surgical training. These qualities can be demonstrated by choosing a surgical procedure which is considered advisable or necessary, but they can also be just as well shown by abstaining from interfering in a physiological process if the interference is unnecessary or risky.

THE TREATMENT OF HYPERPIESIA.*

BY

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BEFORE dealing with the details of treatment of this prevalent disease I propose bringing to your notice a medley of symptoms, any one or more of which may be indicative of its existence. In the first place, we find that cases of hyperpiesia may be divided into three types:

1. *Menopausal*, in which the common vasomotor disturbances are only too apt to divert attention from the possibility of associated hyperpiesis. The subjects present increasing obesity and other signs suggestive of hypothyroidism—for example, loss of hair, waxy colour of the skin, and subnormal temperature.

2. *Plethoric*, preponderating in males of 40 years or more, who are fat with florid facies and short, thick neck. Often this type has for years taken freely of food and alcohol, but sparingly of exercise; this, however, is by no means always the case. The majority suffer but little from symptoms of the disease, and form the greater part of those dying suddenly and unexpectedly.

3. *Sallow*, found chiefly in females, the disease commencing generally at an earlier age than that of the first two types. The picture presented is that of the patient with visceroptosis and intestinal toxæmia. The skin is muddy in appearance, dark rings are present beneath the eyes, the tongue is thickly furred, and constipation is the rule. These people are thin, "wiry," energetic workers, seldom given to alimentary indiscretions, but over-conscientious in the performance of their tasks. This is the type which actually suffers so greatly from the disease which afflicts it, and which responds the least readily to treatment. I lay stress on its description, because the lean patient is prone to pass through our hands incorrectly diagnosed, the possibility of a raised blood pressure never having been considered.

We must recognize, also, that hyperpiesia is by no means a disease whose onset is peculiar to middle life. Genuine cases are met with in young adults and in adolescence—a fact which those of you whose work includes the routine examination of school children will confirm.

Lastly, in this connexion, should be mentioned the type of patient whose blood pressure reading may lead to the diagnosis of hyperpiesia, yet in whom the hyperpiesis is transitory and the result of apprehension only. It is a matter of common knowledge that the first estimation of blood pressure in a strange patient is unreliable, but in some cases nervousness may produce truly surprising results. Thus a male patient whom I saw recently had blood pressures of 220/130. Suspecting this as a case of "fictitious" hyperpiesia, I took a series of readings during the next half-hour. They were 180/125, 160/120, 145/100. Actually he was suffering from peripheral neuritis, but he thought that the pains in his arm were due to angina pectoris, a disease of which a near relative had died. Whether this form represents a potential hyperpiesia, a hyperpietic in embryo, is, I think, a point worthy of consideration.

SYMPTOMS.

The variety of symptoms of hyperpiesia is one of the characteristics of the disease. It is therefore of importance that they should be briefly considered, because many of them do not immediately suggest to the physician the presence of cardio-vascular disorder. I have arranged these roughly in order of descending frequency as noted in one hundred consecutive cases.

Shortness of breath on exertion and headache vie for pride of place. I have previously shown² that the headache is of two types: one is the true dull ache, not uncommonly present even with the decline of high pressure; the other is an acute lancinating pain, the head feeling as if it were about to burst. This pain is always associated with, and presumably due to, a definite exacerbation of the hyperpiesis. In contradistinction to the true ache, it responds promptly to measures which lower the blood pressure. On the other hand, one is struck by the patients presenting

* An address delivered before the Dover Division of the British Medical Association, May 11th, 1929.