

Obstetrics

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The Question of the Narrow Pelvis. BY SIR J. HALLIDAY CROOM, M.D. (EDIN.), *Birmingham Medical Review*.

The paper is a review of the modern treatment of labor in a narrow pelvis.

The most usually recognized treatment of narrow pelvis at the present time is, except in some hospitals, the application of *high* forceps or version, or induction of premature labor.

Owing to antisepsis the danger of high forceps delivery is not now so great, but still it is questionable if a patient ever fully recovers from such treatment, however skilfully done.

The first essential in the treatment of narrow pelvis is a correct diagnosis, made early. This is obtained by pelvimetry and abdominal palpation.

Whenever the true conjugate is two to three inches delivery per *vias naturalis* of a living child is impossible and Cæsarean section is the only treatment. In less contracted pelvis, where spontaneous delivery may occur, *i.e.*, in conjugate area $3\frac{1}{2}$ to $3\frac{3}{4}$ in. Here forceps, or turning or premature labor has been advocated, but Sir Halliday Croom states quite truly that over 80% of such labors will terminate without any interference whatever. Therefore they should be left to nature. The fetal mortality is also low, .2%. Hence the number of such cases requiring artificial aid is small.

What are the limits of pelvic contraction that admit of spontaneous delivery in narrow pelvis? In degrees of contraction slightly under $3\frac{1}{2}$ in. for *flat*, and $3\frac{3}{4}$ in. for generally contracted pelvis, spontaneous delivery may be readily looked for. Hence our duty in such cases is to trust to nature, and aid her by the Walcher position. This is maintained by placing the patient across the bed, with the side of the bed raised on blocks, and letting the legs hang over the edge.

As regards the intermediate position, *i.e.*, between Cæsarean section and spontaneous delivery: Here we have induction of premature labor, forceps operations for enlarging the pelvis.