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A CASE OF CONSERVATIVE CÆSEREAN SECTION.

BY

WILLIAM GARDNER, M.D.,

Professor of Gynæcology in McGill University; Gynæcologist to the Royal Victoria Hospital, Montreal,

With Report of Previous History,

BY

DAVID J. EVANS, M.D.,

Lecturer in Obstetrics, McGill University, Montreal.

Reprinted from the Montreal Medical Journal, December, 1900.

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On September 24th, 1900, I was called by Dr. Morphy of Lachine to see Mrs. R. S., aged 29 years, IIpara, who was shortly expecting her confinement. Dr. Morphy informed me that two years previously he had delivered her of twins at the seventh month of pregnancy, after performing version. The extraction in each case was only accomplished with the greatest difficulty, and both children were born dead.

On examination, I found the patient to be an undersized, well-nourished woman. She presented no evidence of rachitis in the long bones of the limbs or in thorax or head. The heart and lungs were normal. The abdomen was greatly distended, the fundus uteri reaching to the ensiform cartilage. The umbilicus was prominent, the flanks full, and the skin over the abdomen presented the usual pigmentation and lineæ albicantiæ. Fœtal movements were observed.

On palpation, the excavation of the pelvis was found to be unoccupied. The fœtus was in an oblique position, the head resting in the left iliac fossa, while the breech could be felt at the fundus to the right of the middle line. The fœtal back was directed posteriorly, which would account for the fact that at no time could the fœtal heart sounds be heard in spite of repeated auscultation.

Pelvimetry.—The pelvic measurements were as follows:—A. II., 11 inches; If. II., 10¼ inches ; Ext. conjugate, 6½ inches : Diagonal con-

* Read before the Montreal Medico-Chirurgical Society, Oct. 19, 1900.

jugate, 3¾ inches; Conjugate vera, 3 inches (estimated). By vaginal palpation the promintory could be easily reached. The sacral alæ projected forward into the brim, thus causing a sharp bend in the posterior part of the iliac bones. The lower part of the sacrum and coccyx were sharply bent and projected forward into the pelvic cavity. The pubic bone was thickened in its upper part, further tending to obstruction of the pelvic inlet.

Diagnosis.—A diagnosis of flat rachitic pelvis with marked obstruction of the inlet, was made. An attempt was made to bring the fœtal head into position over the pelvic inlet but without success, as the head seemed to be particularly large.

In view of the peculiar projection into the brim of the alæ of the sacrum and the posterior parts of the iliac bones, and the sharp forward bend of the lower part of the sacrum and coccyx, it was deemed imposible to deliver the child through the natural passages, and therefore it was thought best to recommend Cæsarean section in preference to symphysiotomy. Accordingly, that afternoon the patient was removed to the Royal Victoria Hospital and placed under the charge of Dr. William Gardner.

Report of the operation.

The case was ideally favourable for the saving of both mother and child and conservation of the uterus. The woman was pregnant to full term and had been examined only by Drs. Morphy and Evans besides myself, in each case presumably with aseptic precautions. She was admitted to the gynæcological ward of the Royal Victoria Hospital on the evening of one day. At four o'clock the next morning labour had commenced. Fœtal heart sounds could not be heard, but movements were unmistakable. At eleven o'clock of the morning of the same day when operation was commenced, the os was of the size of a silver dollar. No attempt of any kind to deliver had been made and the temperature was normal. The operation was thus, in the full sense of the word, elective. I was most ably assisted by my colleague, Dr. Garrow of the Surgical Department, and Dr. Casselman, my House-Surgeon.

The incision in the abdominal wall, six or seven inches long, was two-thirds of its length below and the other third above the navel. In doing this my experience amply bore out that of others—how easy it is to wound the uterus. One comes unexpectedly soon through the abdominal wall. Palpation before operation led to more than a suspicion of anterior implantation of the placenta. Palpation of the exposed uterus showed that this was beyond a doubt. Statistics show this position of the placenta in 50 per cent. of the cases.

Dr. Garrow making pressure on the abdominal walls around the uterus,

a six-inch incision was made in the anterior abdominal wall. Dr. Casselman was directed to control by finger pressure any large bleeding points and, if necessary, to compress the uterine arteries by grasping the cervix. The incision exposed the placenta. It was rapidly peeled off to the right, the membranes ruptured, the child's feet grasped, and extraction effected. The cord was pulsating strongly. It was clamped by two artery forceps and divided between them. The child was skillfully resuscitated by Dr. Evans.

The uterus was now delivered through the incision. It did not contract satisfactorily and, as bleeding was going on, the placenta was detached and extracted, and kneading and friction of the uterus were kept up while the uterine sutures were being put in. But the womb did not contract until hot water had been dashed over it and normal salt solution had been injected under the breasts. The loss of blood was somewhat alarming, and I thought it might be necessary to amputate the uterus to prevent the woman from bleeding to death.

Interrupted silk sutures, a centimetre apart, were used to close the uterine wound. On the serous surface the needle was entered about a quarter of an inch from the edge of the incision and brought out just short of perforating the mucosa. Each suture was tied as soon as passed. After cleansing the abdominal cavity, the abdominal wall was closed by silk-worm gut sutures through all the layers.

Recovery though complete was tedious. About the ninth day the temperature rose a little and the right thigh and leg became painful in the course of the saphenous vein, but there was no swelling. A little later a small indurated, tender mass appeared inside the brim of the pelvis on the right side. At the examination of the woman before her discharge all morbid signs and symptoms had disappeared. The uterus had undergone complete involution and was movable.

The child was suckled throughout and throve perfectly.

In reflecting on the events of the operation some thoughts are uppermost. The fact that the application of hot water was promptly followed by contraction of the uterus, seems to favour the idea that it might have contracted sooner if it had been kept inside the abdominal cavity while the incision was being sutured. The anterior implantation of the placenta doubtless conduced in a measure to the free bleeding. The incision of the uterus here must have interfered with as complete contraction as elsewhere. The advocates of Fritsch's fundal incision would doubtless find in this case a favourable argument. I have no experience of it, but in the next case of similar position of the placenta I shall be disposed to adopt it.

In my experience of Cæsarean section this is the first case indicating;

or rather I should say demanding, conservative methods. I am inclined to think it is the first successful conservative Cæsarean section in this city, if not in the Dominion. If I am correct, the fact speaks volumes for the rarity of those conditions of impaired nutrition which bring about contracted pelvis. This woman had lost all her previous children and was naturally anxious for offspring. The fact that she is left in a condition for subsequent pregnancies is naturally a matter for satisfaction to the operator if not to the patient. In watching the case one could not help seeing that the sum total of suffering was much less than in normal labour in a normal condition of the birth-canal.