FIG. 880.—BRINGING DOWN POSTERIOR ARM IN HEAD PRESENTATION.

Dystocia Due to the Shoulders.—If, after delivery of the head, the shoulders do not immediately follow gentle traction, applied as indicated under the conduct of normal labor, the accoucheur should make an examination with four fingers to determine the cause of delay. One or the other of the following conditions will be found: (1) The shoulders are broad and firm or the pelvis contracted; (2) they have

followed an unfavorable mechanism, the anterior shoulder being caught on the ramus pubis, or having over-rotated, and, the accoucheur not observing this, he tries to bring the shoulder-girdle down in the wrong diameter; (3) the cord is too short; (4) the chest of the child is too large (anasarca); (5) locked twins or a monster exists.

The head springs backward against the perineum, pressing this well up into the pelvis, and traction serves only to stretch the neck. Not a few children have been lost at this stage of delivery.

Treatment.—If the woman is conscious, she should be exhorted to bear down strongly, failing which the assistant makes a strong Kristeller expression. Now, by means of the fingers inside and the hand outside, the shoulder-girdle is rotated into the most favorable pelvic diameter—one of the obliques. Next, the accoucheur inserts four fingers of the left hand into the vagina in search of the posterior axilla, into which he puts his index, and, pulling gently, he tries to bring the posterior shoulder down into the hollow of the sacrum. This may be aided by crowding the anterior shoulder into the pelvis from above the pubis (Fig. 880). After the posterior shoulder has been brought to the perineum the hand is withdrawn and the child's head allowed to drop—even a little gentle traction may be made downward to bring the anterior shoulder under the pubic arch combined with pressure from above the pubis. If this fails, one finger is hooked into the axilla from over the back, and the anterior shoulder rotated into the opposite side of the pelvis. Combining the rotation with slight downward traction, the torso is given a spiral motion which will usually effect delivery. Excessive caution is here required because only too easily is the clavicle fractured or the cervical plexus torn or pulled out of the spinal cord.

Failing these plans, next to do is to deliver the posterior arm, it being necessary to insert the whole hand in order to reach it, and it is wiped down over the face—not over the back. Now extraction is always possible unless there is some monstrosity. This will at once be discovered by the hand which has been introduced, and, of course, the treatment will be guided by what is found. Exenteration, cleidotomy, or other cutting operation will usually be advisable under such circumstances.

Since these manipulations take much time, during which the child may die, a few moments should be spared to insert a catheter into the child's trachea and to blow sufficient air into its lungs to prevent asphyxia. Time to effect the disengagement of the shoulders is thus obtained, the operator may work deliberately, and more certainly avoid damage to the child and the mother.