THE RISKS OF OBSTETRIC PRACTICE.

To the Editor of THE LANCET.

SIR,—The recent trial at Warwick*, and the liabilities attending obstetric practice, render it very important that we should clearly see our position under the various difficulties which may arise. It is as important to know what not to do as to know what to do. Our sins of commission are more likely to be visited by ill-consequences than those of omission, because, doubtless, they are more readily perceived. Yet this does not explain why errors in midwifery are more subject to criminal actions than errors in surgery. Whatever the explanation, it appears to me very important that we should carefully analyse each case as it comes up, in order that we may avoid the recurrence if possible.

The case I allude to is simple, and may be divided into three parts.

1st. There was a rent in the upper vagina behind, large enough to admit the hand into the peritoneal cavity.

2nd. A prolapse of intestines, part of the ileum, the cæcum appendix, and small portion of colon.

3rd. Fifteen feet of intestines were removed, having been cut away in one piece by scissors.

Let us consider these *seriatim*:—

1st. The vaginal rent. This may occur spontaneously. A very common position of this kind is behind at the upper part, transversely placed. Its cause has been pointed out by myself and Dr. Matthews Duncan. Or it may be produced by the blade of the forceps, carelessly introduced. I was once told of a case where this accident occurred to a medical man. A small knuckle of bowel came through, was strangulated, and sloughed away, leaving a fæcal fistula, which ultimately closed, the patient doing well.

In another case, where a rent was found after death, the medical attendant had attempted to use the forceps, but although he was a very good midwifery practitioner before, in this instance he bungled over it, and a neighbour came and delivered by version. This medical man was at the time under the early symptoms of maniacal attack, in which he died. No prolapse of bowel took place, but peritonitis came on and she died. An inquest was held, but the causation of the rupture was not cleared up.

* Queen *v.* Peacock.

In the case now under our consideration there was no proof how the vagina was rent, and therefore we shall be safe in assuming it occurred spontaneously during the uterine action, especially as the patient was forty years old, had had many labours, and had required forceps before.

But whatever the cause of a rent, we know that a prolapsus of the bowel can take place, and this brings me to the second point—namely, How was it so great a length as fifteen feet came down? Could it have occurred spontaneously, or must it have been drawn down? Such a question cannot be answered off-hand. Few can answer it at all, because there are but few who have seen many cases of vaginal rent; and to argue simply without experience in the living body, or without experiment in the dead, does not help us much. I fancy most persons would say, "No, I do not think fifteen feet, half the total length of intestine, could come down spontaneously." Yet reflection for a moment will induce a pause before a final answer is given; for when the vermicular motion of the intestines is considered, and the wonderful intrusions they are apt to make into out-of-the-way corners are borne in mind, one would not like to say positively "No." For if fifteen feet can be drawn down, it is no great stretch to suppose that they might be protruded spontaneously. In Cooper's Surgical Dictionary (art. Wounds of Abdomen), a case is narrated where the whole of the intestines, except the duodenum and the arch of the stomach, had escaped through a wound four inches long on the side of the upper abdomen. These had not been dragged out. But it may be said, the situation is different. Is this really so? Consider the great elongation the vagina undergoes by the end of labour. It has often occurred to me, and doubtless has to most of us, that in removing the placenta, one has had to pass the hand as far as the ribs before the os uteri could be entered. I mean, that the uterus receded so readily, that till it was caught and fixed by the external hand, which is not always easy, the internal hand has reached so high. But in most cases the vagina will reach to the umbilicus very readily. This is just about the centre of the mesentery, and therefore if a rent exist behind, at its upper end, there is an opportunity afforded for a prolapse of magnitude. If, therefore, in searching for the insertion of the funis a coil or two of intestines have protruded through, the entanglement of them in the fingers, and the movements of the latter to avoid them or to find the funis, would be sufficient to bring through a large amount, especially if aided by the straining of the woman and much pressure outside. The opening in this case was said to be large enough to admit the hand; we may conclude that just after its occurrence it was somewhat larger.

Speaking from personal experience, which, as regards rent of the vagina alone, is limited to about six cases, I have seen only a slight hernia of the intestines. I think general experience is similar. Supposing that no such a quantity could be proved to have occurred, this does not expel the possibility of it. Neither in the many cases of simple rupture of the uterus I have seen have I found any great amount pass through the rent, though patent. Generally in all these cases, both of vagina and uterus, or both combined, the shock to the system checks the uterine action and the auxiliary forces, so that the patient remains nearly motionless. Again, in cases of combined rupture of vagina and uterus, of which I have seen about eighteen, I have not found any great quantity. Although in this kind the prolapse has been the greatest, in none would it require much to bring down a quantity. The largest quantity I ever felt was in a combined case, where the uterus gave way as the head was coming through the vulva. The pains suddenly went off, and not returning, after some hours I was sent for. All the symptoms of rupture had come on. The forceps were applied and the child delivered. A rent in the front was found extending from the middle of the vagina to the middle of the uterus. It gaped widely, and a large mass of intestine came through. There was, however, no difficulty in reducing them, and the edges were brought together.

A case bearing somewhat on the Warwickshire one occurred to me some years since. I was called to see a woman in whom there was considerable prolapse of the omentum from the vulva. I was told a curious modification of the placenta existed, but the medical man, fearing all was not right, asked me to assist. The pains had subsided while the head was above the brim, a prominent sacrum impeded

somewhat, but a fibroid tumour in the lower part of the uterus also impeded. Turning was accomplished, when this something came down to the vulva. During examination and manipulation it came outside three or four inches, where some two or three hours after I saw it, with the usual appearance of the somewhat fatty kind. Knowing a lesion must exist, I passed my hand within, and found a slit in front from the middle of the vagina to the middle of the uterus. The omentum passed through this, and also a bunch of intestine as large as one's fist. The funis could be traced up to the placenta, which was in that part of the uterus above the rent. Had this omentum not been looked at, but treated as a portion of the membranes (a not difficult mistake to make), dragged down, and very possibly endeavoured to be peeled off, as the membranes sometimes require, the case would not have been without many points of resemblance to the melancholy one we are considering.

But, putting aside the question whether all this mass of intestine could spontaneously come through the opening, it appears to me that the case developed itself in somewhat the following manner:—The child having been separated, and the time having arrived to remove the placenta, the medical man, passing his hand along the side of the funis, which probably was not held firm in the other hand as a guide, not knowing that a rent existed, came to some intestines. Off his guard, he would think both them and the mesentery a portion of the membranes (the most likely error to make), and then, knowing that the membranes lead to the edge of the placenta, he would proceed to detach them, expecting to come to its edge in time. By this means the mesentery—a tender membrane—would be broken through; and then the finger, entangled in the coils of intestine, would readily separate a considerable length before the error was noticed. It is very important that we should recognise the feeble resistance of the mesentery. If a butcher be noticed removing the entrails of a sheep, &c., the ease with which he throws off long lengths will evidence this well: a small rent once made through the mesentery, they are torn off with surprising readiness. Dr. Goodhart, of Guy's Hospital, has kindly tried this point for me in the human subject. He reports the following:—"I tied up the mesentery of a coil of small intestine, and fastened to the tape weights, one by one. The mesentery began to tear away at 11 lb., and gave way suddenly at 13 lb. I next tried hand traction in another part in two places. In both instances the amount of steady traction requisite to tear away the bowel from its attachment was by no means great—more, perhaps, than the traction ordinarily made on the funis, but not more than would be made where the placenta is not readily extracted, and where the funis is torn across in the delivery of it. When once there is a tear, and the bowel separated in the least, and even where only the peritoneal layers are cracked through, leaving still the vessels and the true substance of the mesentery, the coils may be torn away as easily, and almost in much the same manner, as dough may be torn, with no seeming resistance whatever." This it is important to bear in mind, because if we should even scratch with our nail the mesentary unwittingly we might before we are aware have unravelled a foot or two of the intestine.

But there is another source of confusion—namely, in the resemblance of the funis to the intestine. To say we ought not to make a mistake in our diagnosis is, perhaps, quite correct; but to say there are no points of resemblance tends to throw inexperienced men off their guard, and lead careless men into error. The faulty habit of pulling at the cord may lead to the pulling at something like it, with the intention of removing the placenta. The large varicose funis, perhaps not when fully injected by blood, but when half flaccid, is not so very unlike an intestine; nor is the smaller tortuous one unlike a contracted firm small intestine, say near the cæcum. At any rate, I have been shown a portion of both cæcum and ileum as a piece of funis.

Is it not possible that under some circumstances, such as mental fatigue, just roused from bed, cold hands, or a little want of careful examination, the error might occur to many of us? And knowing, from my own experience of hard work in this department, how difficult it is to be always wide-awake, I can scarcely find heart to say to those engaged in its responsibilities more than "Sleep not, for a life depends."

3rd. Regarding the third point of this case, what can be said? When I first heard of a like case I felt at an utter loss to conceive the state of mind which would lead any medical man to remove a quantity of intestine; the descent or pulling down of a length was comprehensible, but to cut away seems so irrational a procedure that I explained it to myself by some temporary loss of control of mind liable to overtake some in appalling circumstances, such as you have alluded to, and such as Dickens, in "Pickwick Papers," portrays when Mr. Pickwick falls in through the ice and Mr. Tupman rushes off exclaiming, Fire! But when I heard of other instances, I was led to reflect whether there were any explanation for it. For this case does not by any means stand alone. I have heard of four other cases brought to trial; and two I have heard of privately. I was once shown about a foot of small intestine and cæcum with appendix, which had been removed in like manner. What can the reason be? Is it, after being torn through as I have suggested, thought to be the funis of another child? Yet one would say this was scarcely possible, because it would be only cut between the two ties. I can scarcely think that it can have been done with the surgical views which were brought to support the Warwickshire case. A gentleman who had an inability to know the funis from intestine would hardly have such transcendental knowledge of surgery as to lead him to cut off half one's bowels as a lesser evil to allowing them to remain. I think we cannot attribute to him so advanced a surgical mind. Is it from dread of consequences and attempt at concealment; from a fear of blame ever so ready to fall upon the smallest misadventure, avoidable and unavoidable, occurring in midwifery; knowing the extreme danger of the rupture and prolapsus, and thinking that it will make no real difference as to the final result; is it that they have determined to conceal it by extirpation?

But *does* it make any difference in the result? Is a patient sure to die with a large intestinal prolapse through a large rupture? Are there no parallel cases in which recovery has followed? Let us look at it in another light. Is there any chance of persons living deprived of half their bowels? May we not at once say No? A patient may lose a foot or two, but fifteen feet, both small and great, how can it be expected? But rupture of the uterus has been recovered from not infrequently, and so has prolapse of the bowels of large extent; and why may not a patient survive both under great care? In my own experience, I remember a woman ripping up her abdomen, and nearly all her bowels came through the opening, and were carried by her in her apron for some two or three hours. They were returned and the wound closed, and she recovered without a bad symptom, as also did the case quoted above from Cooper's Dictionary. But it may be answered, Yes, but you cannot keep the wound in the uterus or vagina closed, even if you return the prolapsed parts. No doubt it is difficult. I think the reduction of the hernia would be readily done, if the mesentery be not torn, by gently drawing down the vagina, whilst pressing the bowels through the rent. This would bring the hole below the reach of the mesentery, and virtually draw up the bowels. Pressure on the uterus from above would help, but of course great care would be required lest much displacement should occur. Some have advised stitching the edges of the rent together *in situ*; but in the case of the vagina only, if the coils of bowels were once reduced the pressing of the uterus well downward into Douglas's pouch would fill it up, and keep up the intestines. The patient should be then kept on her back rigidly for two weeks, when adhesions would be strong if she survived. But it is almost impossible to stitch *in situ*. You may, if you could, wound the intestine. If the patient were in hospital she might be placed on the table, and, the uterus being drawn down, as in some cases of operating on vesico-vaginal fistula, the edges might be sewn together; but in home practice, and in out-of-the-way places, it is nearly impracticable. If the uterus were also ruptured, it would be next to useless. Practically it generally comes to careful restoration and replacement of the edges, with absolute rest. However small the chance, it certainly is better than taking every chance away by removing half the intestines. But would restoration be impossible? I can hardly conceive it would be so. It may be tedious, but assisted by another, and also plugs, &c., it might be done. The funis is troublesome to restore, but then this is because we are afraid of using pressure sufficient to stop the circulation; in ovariotomy, even with vomiting,

it is no very difficult matter to keep the intestines in place.

I have already occupied too much of your space; but the lessons derived from such a case are so important to all practising midwifery that this must be my excuse. But I may end with one question—Of what possible use can the sojourn for six months in a prison be? Will it teach better knowledge of midwifery, or will it steady the judgment of one who already was perhaps so appalled by the fearful character of an accident for which he was possibly not blamable as to commit the rash act? If the latter, the punishment will add to the evil. If the former, it is scarcely there that knowledge will be obtained. If the error was through ignorance, then who is so much to blame, those who habitually cast a slur on the value of obstetric knowledge, and endeavour to reduce the requirements at examinations to the lowest possible point—who recommend, as I have had recommended to me, to give lectures alternate years, as if the urgencies of midwifery were worth less study than botany and the accidentally allied subjects of our profession; I ask, who is so much to blame, these or the student, who, looking at the estimate set on obstetrics by their guides as fair indicators of its value, thinks that it is a matter of only secondary importance, to be grievously undeceived by the loss of practice, *perhaps in a prison?*

I am, Sir, your obedient servant,

J. BRAXTON HICKS.

George-street, Hanover-square, March, 1875.

P.S.—I have, since writing the above, received the following from Dr. Goodhart, Guy's post-mortem room:—"A woman was examined this afternoon. She was spare of habit, and with a very retracted abdomen, so that the spine formed a prominence on the surface of the abdominal wall; and not much pressure could be exerted on the contents of the cavity. However, I made a rent in the upper part of the vagina, behind the os uteri, about three inches in length; but, with the utmost squeezing in the power of myself and one of the clerks, we were unable to do more than to make a single knuckle of small intestine appear at the osteum vaginæ. I seized this and tore it away from its mesentery without much force, and then it was easy, as in yesterday's experiment, to run the tear along the attached border of the bowel, and so to pull away a continuous string of intestine some eight feet in length. The bowel, in tearing away, elongated and contracted in its calibre; and the same thing I have repeatedly observed before when the intestines have been removed carelessly, so that it came to show as a rounded cord about the size of an ordinary fœtal funis; and it was remarked by all that it would not have been at all difficult, in a careless moment, to have mistaken it for the funis. I could not extract as much as fifteen feet in this instance, but I think that if a longer mesentery existed it would be quite possible to do so."