

THE MEDICAL AGE

VOL. XVII.

DETROIT, MAY 25, 1899.

No. 10.

ORIGINAL CONTRIBUTIONS.

EUROPEAN OBSTETRICS.*

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Having during the past year made a tour of a number of the medical centers of the old world, and devoted special attention to their obstetric and gynecological clinics, I have thought that a mention of the methods there in vogue, with comparisons, at points, with those obtaining in private practice with us, might prove of sufficient interest to warrant the effort.

Obstetrics and gynecology go hand in hand abroad, as a rule, the two subjects being covered by the same teacher. The time limit imposed on papers by this Association obliges me to confine my remarks to one division, and I have selected that of obstetrics. I would remark, however, that the union of the two subjects seems to me to be eminently proper, as it is natural. The obstetrician should certainly be a gynecologist, if not *vice versa*. The complications which are liable to arise in the lying-in room not infrequently demand a prompt, energetic, and intelligent attention which is impossible in the absence of the knowledge and technique which are best acquired through special gynecological study and experience. Without such knowledge the accoucheur has really little or nothing to commend him over the ordinary midwife. Meddlesome midwifery, which has so much evil charged up against it, is too often the direct outcome of half knowledge. In the lying-in room "a little learning is a dangerous thing."

Gynecological specialism, as a distinctive vocation, is peculiarly American in its origin, cultivation, and development. It has found little favor abroad, where the tendency is rather to regard the body as a

* Read before the Detroit Medical and Library Association.

whole—a mechanism, as it were, made up of a series of interdependent parts, no one of which may be fenced off from the rest and there subjected to special treatment. Incidentally I may remark that outside of the eye-and-ear and nose-and-throat men, those whom I found giving special attention to the diseases peculiar to different parts of the body were men of mature years who had in general practice developed predilections for the study and treatment of peculiar diseases. The graduate who enters college, continues therein and leaves it with the fixed purpose of immediately becoming a specialist, is a peculiarly American product.

I visited and spent some time at the clinics of Vienna, Prague, Dresden, Berlin, Christiania, London, and Dublin, but my chief stay was at Vienna, where I put in nearly three months. Of obstetrics as practiced at the Allgemeine Krankenhaus clinics, of the latter city, I am, I may presume to say, in a position to speak by the card; and my more superficial observation at the other clinics leads me to regard Vienna obstetrics as fairly representative of the foreign art in this field.

The Treatment on Reception.—The treatment of the woman about to give birth may be said to begin at the "Aufnahm," or her reception into the clinic. It is the intention not to admit patients into the maternity wards earlier than two weeks before parturition, although pregnant women are encouraged to present themselves for examination much earlier. The examination at the "Aufnahm" is for the purpose of determining the period of gestation, the presentation of the fetus, the pelvic diameters, and the woman's general condition. There are three obstetric clinics at the Allgemeine Krankenhaus, and at the "Aufnahms," which begin at 5 P.M. daily, an average number of thirty women are found in waiting. The candidate for admission disrobes in an anteroom and enters the examining room clad only in a short gown with which the nurse provides her. She is laid on a cot, where the nurse divests her *mons veneris* of superfluous hair, scrubs the external genitalia with soap and water, and gives her a vaginal douche of a one-per-cent lysol solution. The accoucheur then takes her in charge. The diagnoses of the period of gestation and of the fetal presentation are solely by palpation, percussion, and auscultation, except in cases of unduly heavy abdominal walls, when the vaginal exploration is superadded. The facility with which these diagnoses by the external method are made is a revelation to the practitioner whose experience has been limited to a private clientele. I believe I voice the experience of the latter when I say that in my own case, after attempts to perfect myself in this art running through many years of private practice, I could not by this means, except in

especially favorable cases, make a diagnosis on which I could rely without calling in the aid of the vaginal touch. The advantages of being able to determine the presentation by external examination must readily suggest themselves, particularly through the fact that abnormal presentations may thus be diagnosed before the rupture of the membranes, and while there is still a possibility of converting them by external manipulation into normal presentations. Facility in this method of diagnosis is also of inestimable value as an aid to the vaginal method. It is not always easy, or even possible, especially when the scalp is tumefied, or when a caput succedaneum presents, to determine beyond a doubt whether the bregma is posterior or anterior, and the evils of brute force applied to the forceps in occiput posterior presentation, without any regard to rotation, are among the opprobria of the lying-in room.

The presentation having been diagnosed, abnormal and particularly transverse positions are rectified by external manipulation under narcosis. The agent employed at Schauta's Klinik is the Schleich mixture—sulphuric ether two parts, petroleum ether one part, and chloroform one part. Schauta is especially partial to this anesthetic. Since employing it he has not had a single untoward result from anesthesia in either his obstetric or gynecological clinic. He claims for it also less nausea and less depression as sequelæ of the anesthesia than follow the use of either chloroform or ether uncombined.

Pelvimetry.—Every woman appearing at the "Aufnahm" is measured with the pelvimeter and the measurements recorded, the internal measurements being, however, reserved for such cases only as show a contraction in the external measurements. The measurements taken externally are between the trochanters, between the crests, between the spinous processes and the external conjugate, or the diameter of Baudelocque. In connection with the pelvimetry, the woman's head, sternum, and tibiæ are also examined for evidences of rachitis, which, for some unexplained reason, is known in Vienna as "die Englische Krankheit" (the English sickness). If its relative prevalence in different countries had aught to do with fixing to the disease a pseudonym, one would certainly call rickets the Austrian rather than the English disease. It must be very prevalent in Austro-Hungary, from the traces one sees of it at the Allgemeine Krankenhaus clinics. The poverty of the masses, with the accompanying underfeeding, overwork, and bad sanitation, have their natural effect in this disease. The consequence is that there is probably nowhere else in the world so much dystocia as one finds at the maternities in Vienna, due principally, of course, to pelvic contractions, the foundations of which were laid before maturity. In an experience extending over thirty

years, and embracing over two thousand cases of labor, it has been my fortune never to have encountered in my own practice a case which I have not been able to deliver by means of the forceps, without puncturing the child's head. During my visit to the maternity of Christiania, Norway, inquiry revealed the information that neither craniotomy nor Cæsarian section had been practiced there within the experience of any of the physicians in charge of the institution. During my stay in Vienna I witnessed no less than five craniotomies. Cæsarian section is very rarely practiced there, and only in carefully selected cases. The preference is for craniotomy and subsequent vaginal hysterectomy. The increased safety to the mother by this procedure is held to more than counterbalance the better chance for the child through Cæsarian section. Another potent reason for the disfavor into which the latter operation has fallen lies in the fact that most of the cases sent to the clinic for operative delivery are infected, through the efforts of outside physicians to accomplish delivery by either version or the forceps at the women's homes, where proper aseptic conditions are not to be relied upon. The mortality attending the Cæsarian section in such cases caused the operation to fall into disrepute. It is now made only on cases in which no operative procedure has been attempted prior to their admission.

The question occurs whether the rigid system of inspection and physical examination pursued at the "Aufnahm" is applicable to private practice in this country. Certainly the necessity for it is not so urgent with us, where rachitis is a rare disease and serious pelvic contraction is so seldom encountered. On general principles, however, no primipara should be allowed to progress to parturition without having been carefully examined with a view to determining her ability to discharge the supreme function of child-bearing. This ability cannot be predicated in any case without a careful examination, and certainly pelvimetry is much less objectionable than digital measurements *per vaginam*. While from a professional standpoint we could not condemn the fellow member of this Association on whom, a few years ago, an irate young husband visited physical castigation because of his making digital pelvimetry *per vaginam* on his wife, she being in the seventh month of her gestation, nevertheless we could not withhold from the combative spouse of a buxom young wife a certain meed of sympathy. In our treatment of these cases we may not disregard the obligations imposed by modesty. In further support of the wisdom of the careful preliminary examination of the woman pregnant with her first child, I would urge its salutary moral effect. Very few young women thus situated but have serious apprehensions, and the positive assurance that "everything is all right," which the

physician may give after a proper examination, removes a weight of anxiety which, if allowed to be borne until labor actually sets in, is not in the interest of eutocia. Should everything on the contrary be "not all right," the sooner the fact is discovered the better it must certainly be for all concerned.

Preparatory Treatment.—The woman, having been accepted at the "Aufnahm," is assigned to a bed in the lying-in ward during her preliminary stay, in which her general condition receives careful attention, her bowels being kept soluble and the action of her kidneys closely watched. This is very important. The careful surgeon places his patient on preparatory treatment to a contemplated operation. He sees that the excretory apparatus is active, so that all excrementitious matter which is liable to deteriorate the blood-serum, Nature's great antitoxin, is carried off and the serum put in condition to destroy morbid microorganisms. In this respect also it is well to consider the parturient woman as if she were undergoing a surgical operation. Certainly the separation of the placenta, as well as the progress of the child through the soft parts, leaves solutions of continuity which may be avenues for the entrance of noxious micrococci. After a course of depurative and tonic treatment, the woman, enervated by the various demands peculiar to the unnatural environments of modern life, is much better prepared to resist the dangers to which childbirth subjects her. We have in several of our indigenous drugs very valuable remedies in such a course of treatment. Among these I might particularly mention golden-seal, black haw, black cohosh, and wahoo. They make a tonic, sedative, and cholagogue laxative combination peculiarly adapted to the last two months of gestation.

With the onset of labor the woman is removed to the "Kreis Zimmer," or parturition room, where she is at once given a full soap-and-water bath, her external genitalia receiving special attention. At the end of her cot is posted the report of her examination at the "Aufnahm." When this report shows no aberration the woman is left very severely alone, no examination being made in such cases unless undue tardiness should be manifest in either of the stages of labor. A vaginal examination being considered necessary at any time, the examiner's hands are as carefully prepared as if they were to enter the peritoneal cavity. They are first scrubbed with a brush and soap under a strong stream from the faucet, then washed for several minutes in a huge basin of alcohol, and afterwards soaked in a 1:1000 bichloride solution. No lubricant is permitted, the finger or fingers (index and middle finger) being introduced while still dripping with the bichloride. In normal labors the attending accoucheur is little more than a spectator of the procedure, the "dirty work"

being done entirely by the nurse. The latter is not permitted to touch the patient's genitalia until after the head has begun to distend the vulva, when she supports and pulls forward the perineum with a handful of absorbent cotton saturated with a one-per-cent lysol solution. Under no circumstances is she permitted to introduce her finger.

Episiotomy.—The attending accoucheur watches closely, and should there seem to be danger of rupture, he forestalls it by episiotomy. The incision is made with a blunt-pointed scissors of special construction, but may also be made with a blunt-pointed bistoury. I did not see a single case of rupture of the perineum in the several hundred deliveries which I witnessed. This was in pleasing contrast with the records of our private practice, especially in the confinement of primiparæ. The wisdom of substituting the definite, clean, lateral artificial wound, which is so easily repaired, for the indefinite, ragged, spontaneous tear in which coaptation of the divided ends of the transversus perinei is so difficult, is too apparent for argument. One can hardly have witnessed the systematic resort to episiotomy without coming away with the conviction that it is, to say the least, a sin of omission for the accoucheur to permit a laceration of the perineum. The woman is not delivered under cover, as is too frequently done in private practice, in deference to an exaggerated modesty (which is not always confined to the patient), and the sense of sight is much more reliable than that of touch in detecting threatened dangers during the passage of the child's head.

Digital Interference.—While the rule against vaginal examination and assistance of labor by the accoucheur's manipulations in the vagina is, in the main, commendable, its enforcement in private practice would, in my opinion, not be satisfactory to the patient. The private patient cannot, in the very nature of the case, be subjected to the discipline possible in a hospital, and especially in the Allgemeine Krankenhaus, over whose entrance might appropriately be written, "Who enters here leaves all independence behind." To leave a private parturient in this country absolutely alone until the child's head begins to distend the vulva, although she has been in the severe throes for five or six hours, would be to call down the anathemas, if indeed it did not call down something more tangible, from the free and independent American husband. Our women expect to be "helped," and few of them would be satisfied to have their attendant merely stand by and watch them, even though he might throw whole volumes of sympathy into his facile face. Then, too, the accoucheur may really help the woman by means of his finger in the vagina. To say nothing of the promotion of rotation, the titillation of the os tincæ to stimulate

contractions has, for instance, been practiced with benefit from time immemorial, to the best of our knowledge and belief. The shoving back of the fold of cervix which is prone to form between the pubis and the child's head is also so much in the interest of both mother and fetus as not to be neglected. And then, again, the stretching of the perineum, as recommended by Lusk, is a valuable prophylactic against laceration. These valuable interferences, which also assure the woman that something is being done for her, may moreover be resorted to with impunity if proper aseptic precautions be observed.

Anesthesia.—An anesthetic is never given to the parturient woman, except when operative interference is deemed necessary. I have seen women in hard labor for thirty-six hours, and on asking why something was not done to ease the agony of the throes have been met with that peculiar elevation of the eyebrows and diagonal shrug of shoulders and the word "Wissenschaft," all of which being interpreted went to say that the exhibition of an anesthetic for such purpose is not in the interest of science. The physician in private practice in this country who should regard his patient as simply a scientific study, and oblige her to suffer as the women do in the European lying-in wards, would soon find himself minus his clientele. The news would soon be bruited abroad among the ladies that he is an inhuman monster. In deference to the demand for chloroform which seems to have sprung up among our women, more particularly, I think, during the past ten or fifteen years, we probably employ the anesthetic in many cases in which it might be dispensed with. I believe, however, that obstetrical anesthesia, as distinguished from surgical narcosis, is not only free from danger, but is a positive benefit to the parturient woman. But the arguments in support of this opinion would be too lengthy for insertion here.

The Postpartum Douche.—This is not employed at Vienna as a routine measure. This, I may say, is contrary to my own practice, although I am willing to concede that with the rigid aseptic methods in vogue there the necessity for it is not imperative. Could we enforce these methods as thoroughly in private practice, the necessity would not be so great here. We should, I think, give weight to the fact that the conditions in private houses are different from those which obtain in a well-regulated maternity, in which the aseptic precautions are quite as stringent as those of a surgical hospital. No one would to-day perform a major surgical operation in the bed-chamber of a private house, with its dusty carpets and curtains, and time-stained, papered walls, in which the woman is confined. I believe the postpartum daily antiseptic douche to be necessary against

the microorganisms which infest even the most cleanly of the lying-in chambers of private houses. The accumulation of blood-clots and detritus in the vagina favored by the prolonged dorsal decubitus forms a most favorable culture medium for microbes. When we remember, furthermore, that this culture medium lies in immediate contact with a part of the body particularly rich in lymphatic supply, and that with the woman lying on her back drainage therefrom is necessarily imperfect, we must recognize a combination peculiarly favorable to septic infection, a combination which the surgeon would scarcely permit after an operation on the vagina. It is my practice to flush out the vagina at least once a day, for three or four days after delivery, with a 1:4000 bichloride solution, and I have been quite satisfied with the result. I have been impressed with the fact that in the three cases of puerperal septicemia which I have seen in consulta-

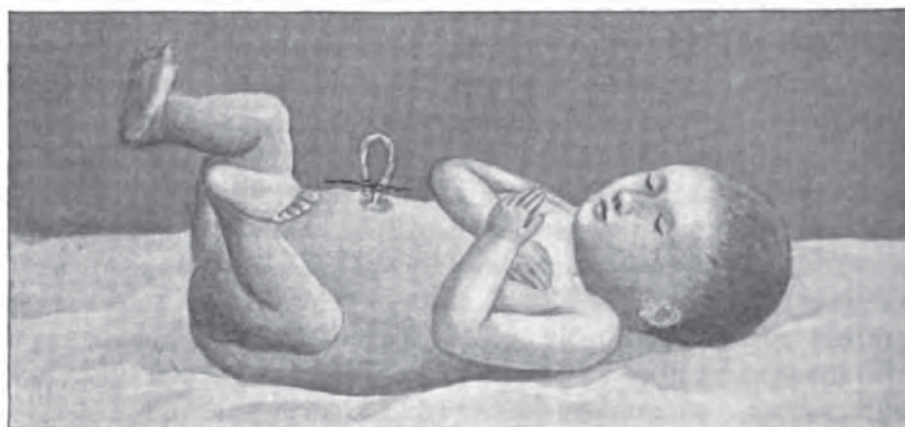


FIG. 1.

tion during the past six months, the vaginal douche had not been employed until after the chill and rise of temperature had occurred. When those who oppose the routine employment of the postpartum antiseptic douche can demonstrate to me the difference between puerperal septicemia and the septicemia which is the *bête noir* against which the surgeon takes such stringent precautions, I may change my practice.

The Tying of the Cord.—I was struck with the method in which the cord was tied in Vienna. I regard it as the ideal method. A ligature is tied at a point about five inches from the umbilicus, then the cord is severed and allowed to bleed from the maternal side. The ends of the ligature are then seized and carried back to a point half an inch from the umbilicus, where the second tie is made. The result is a loop of cord between the two ligatures (Fig. 1). A more

effective precaution against hemorrhage and septic infection of the cord cannot be conceived. No antiseptic dressing is necessary to the cord thus treated. To find exit, it will readily be seen, the blood must pass the two ligatures, and in addition through the included loop, where it is likely to form a restraining clot.

Immediately on delivery the child's eyes are washed off with pure water and afterwards with a solution of boracic acid. The instillation of the nitrate of silver solution after the manner of Cr d  is practiced only in cases of actual or suspected gonorrhoea of the mother.



FIG. 2.



FIG. 3.

Artificial Respiration—The Schultze Method.—As might naturally be expected, from the great frequency of pelvic contraction with consequent dystocia, the occurrence of asphyxia in the fetus is very frequent in Vienna. Artificial methods for resuscitating the child have consequently been developed there as they probably have at no other clinic. The excitation of the reflexes is first attempted by vigorous spanking of the nates. This failing, plunging the child into alternately hot and

cold baths is tried, and this procedure not succeeding, the Schultze method of stimulating respiration is resorted to. Two forms of asphyxia are recognized, viz., the anemic and the apoplectic. In the former, when recognized prior to the ligation of the cord, as it readily may be from the child's pale and limp appearance, the treatment consists in first allowing the child to remain attached, even for a considerable time after the placenta has been delivered. It thus receives the greatest possible amount of placental blood, and through the exposure of the uterine surface of the placenta to the atmospheric air oxygenation of the blood is promoted. While thus connected the reflexes are sought to be stimulated by vigorous spanking. The Schultze

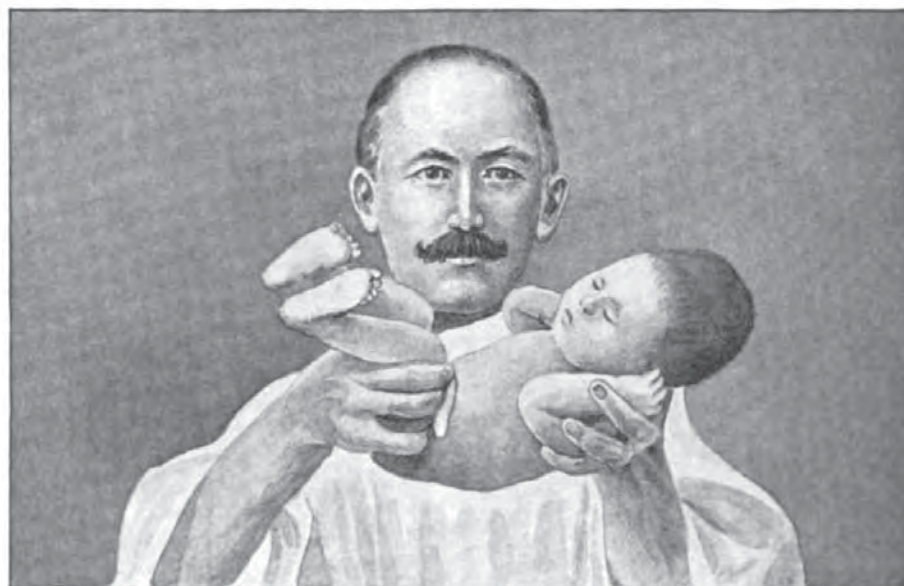


FIG. 4.

method consists in seizing the child just below the neck, the fingers resting on the dorsum, and the thumbs on the thorax, the child facing in the same direction as the operator. The first step is the holding of the child downward, its feet touching the floor, and the second movement consists in the operator's swinging it at arm's length upward and backwards over his shoulder (Figs. 2 and 3). This motion is repeated about eight times a minute. Certainly a more effective method of alternately expanding and compressing the thorax has not yet been introduced. The compression of the abdomen through the flexion caused by the upward and backward movement drives the diaphragm upward, and the downward sweep favors its descent, during which the air rushes in to fill the vacuum, again to be expelled by the upward and backward swing and flexion. The impact of the air during the

swing also doubtless excites the reflexes. The movement must be kept up as long as the slightest cardiac pulsation remains, and I have seen children brought to after a full half-hour of apparently useless effort. The Schultze method is manifestly best adapted to cases of apoplectic asphyxia. Personally I should give preference to the

Byrd-Dew Method in cases of anemic asphyxia, principally because of the fact that it can be practiced while the child is immersed in a hot bath, heat being so important in the resuscitation of this class of cases, in which respect they differ from those of the apoplectic variety. In this method the child is held with its neck between the finger and thumb of one hand, while the nates are held by the other



FIG. 5.

hand. Thus held, the body is alternately flexed and extended on itself and the respiratory movements thus imitated (Figs. 4, 5, and 6). The extension must be to a degree which might be regarded as flexion of the dorsal surface. This is important, for the greater this extension the further is the diaphragm pulled down, and the greater the consequent vacuum in the thorax. The flexion must be to the extent of bringing the child's knees in contact with its sternum.

If the American graduate who has spent some time at the Vienna maternity were to interrogate his recollections for a special lesson which has been impressed on him, he would find it, I think, in the close attention to minutiae which is there taught. This attention cannot at all times be regarded as having been prompted by an undivided

concern for the patient's welfare. The scientific rather than the humanitarian spirit seems to pervade the institution, and while the former is supposed to cover and embrace the latter, an observation of its practical operation in the lying-in room does not always bear out the supposition. As between the two spirits, if one alone must be the guiding force of the accoucheur's conduct, there can, of course, be no difficulty of choice. But there is no reason why one should rule exclusively. Pure science may at times prove harsh, but it is much to be preferred to the mawkish sentimentalism which caters entirely to the woman's whims. There is too much of the latter in American practice. The woman must be handled with the iron hand, but there is no

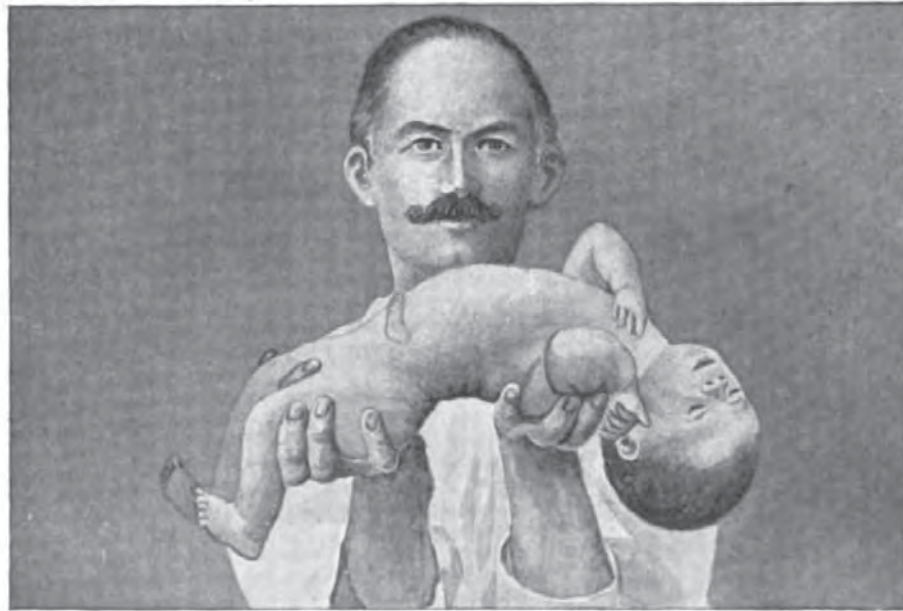


FIG. 6.

objection to its being gloved with velvet. The thorough familiarity with the mechanism of labor, combined with the absolute knowledge of the anatomical configuration of the pelvis of each woman brought to bed, which are so much in evidence in the foreign maternities, might with profit be emulated by us. Is it too much to say that the graduates of our schools go forth but indifferently equipped in these regards? This much may nevertheless be affirmed, that regardless of the equipment with which he goes forth from his alma mater, it will stand the practitioner in good stead to frequently revert to first principles. The beauty of the mechanism of labor becomes more and more beautiful as one becomes more and more familiar with its intricacies. Herein is a field in which familiarity, so far from breeding contempt, heightens admiration and deepens reverence.

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