TREATMENT OF POSTERIOR FACE PRESENTATION.

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Face presentations are rare, and as a result their mechanism and treatment are not always set out clearly by the different writers.

Dr. A. Charpentier gives the following statistics of face presentations:

Mme. Lachapelle, in 15,779 labors,	72 times.
P. Daboix	2,022 " 11 "
Braun	7,835 " 44 "
At Wurtsburg	8,514 " 58 "
At Gottengen	7,104 " 29 "
Depaul	16,233 " 33 "
Pinard	81,711 " 330 "
Total	139,198 577
Average, 1 in 241.	

Churchill's statistics for face presentation for British, French and German practice are as follows:

British practice:

Dr. Jos. Clark . . in 10,387 labors,	44 times.
Dr. Merriman . . .	2,947 " 10 "
Dr. Granville . . .	640 " 1 "
Dr. S. Cussack . . .	701 " 3 "
Dr. Mansell	839 " 7 "
Dr. Thos. Beatty . .	1,184 " 4 "
Dr. Collins	16,414 " 3 "
Mr. Gregory	691 " 2 "
Dr. Reid	3,250 " 15 "
Mr. Lever	4,666 " 24 "
Total	41,719 143
Average, 1 in 291 $\frac{2}{3}$.	

French practice:

Mad. Boivin . . . in 20,517 labors,	74 times.
Mad. Lachapelle . .	15,652 " 65 "
M. Ramboux	491 " 3 "
M. Daboix	10,742 " 30 "
Total	47,402 172
Average, 1 in 275 $\frac{1}{2}$.	

German practice:

M. M. Moschner and Kursak . . . in 12,329 labors,	122 times.
Dr. Carus	2,557 " 24 "
Dr. A. E. V. Siebold .	1,003 " 10 "
Dr. E. E. V.	494 " 4 "
Dr. Kilian	9,392 " 122 "
Dr. Merrem	157 " 1 "
Dr. Naegle	115 " 4 "
Dr. Kluge	799 " 6 "
Dr. Brunette	100 " 2 "
Dr. Ademan	57 " 1 "
Dr. Jansen	13,365 " 15 "
Total	40,765 311
Average, 1 in 129 $\frac{2}{3}$.	

It would seem strange that the larger percentage of cases occur in German practice, excelling in number those of the British and French, but why it should be so is unaccountable.

Charpentier's statistics give 577 face presenta-

tions in 139,198 confinements, or 1 in 241 cases.

Churchill's statistics give 626 face presentation in 129,489, or one in 206 $\frac{3}{4}$. The statistics together give us 1,203 face presentations in 268,677 labors, or 1 in 223 and a fraction of cases.

The causes of this form of presentation are as numerous as are the opinions of the different authors and writers, the obliquity of the uterus predominating as one of the essential causes. Deventer makes the following statement: If the uterus be inclined to the right side and the head or vertex be in the left occipito-iliac position, the uterine contractions taking place in the direction of the uterine axis after the membranes are ruptured, will force the fœtus from above downwards and from right to left, so that the vertex will strike against the left border of the superior strait; the head, thus arrested, will be thrown back upon the posterior plane of the child.

Baudelocque, while admitting the right uterine obliquity, believes that at the same time a right occipito-iliac position of the vertex exists.

Dr. Charles D. Meigs, the first American writer that seems to have thoroughly understood and described face presentations, writes, "The cause of face presentation is not perfectly well understood; it is, however, probable that they are more commonly occasioned by an obliquity of the womb than by any other cause."

Leishman says: "The causes which lead to this unusual occurrence are not well understood, but the initiary movement which results in the position, can only be, as is obvious, a movement of extension, which at an early stage of labor, or prior to its occurrence, is substituted for the usual movement of flexion occurring during labor in the ordinary positions of the cephalic extremity; in other words, and to take the most simple view of the matter, cranial are converted into facial positions by a simple movement of the head on its transverse axis.

It will be seen with what doubt the above theory is advanced. Be the cause or causes what they may, either simple or complex, the fact remains that we have to deal with a premature extension of the head.

It is remarkable what diversity of opinion different writers have, in regard to the mechanism and treatment of this class of presentation. Many simply state that face presentations have the same mechanism as the vertex, the diameters are of the same dimensions and therefore must go through the pelvis in the ordinary manner of a vertex, an undoubted error. Other writers look upon a face presentation as unnatural labor demanding prompt interference. One author dismisses the subject in just 4 $\frac{1}{2}$ lines.

In 1876, Prof. R. A. F. Penrose¹, of the Medical

¹ Penrose on the Treatment of face presentations. American Supplement to the Obstetrical Journal of Great Britain and Ireland, April, 1876.

Department of the University of Pennsylvania, was the first to accurately describe the mechanism and treatment of this form of presentation.

When we compare the mechanism of vertex and face presentation, apparently it will seem that there is no difference, but in reality a great difference exists. In vertex we have the body of the child completely flexed, the chin well thrown on the chest and the head, consequently, in the most desirable position to enter the superior strait; the full force of the contractions is received through the spinal column of the child in practically a direct line to the flexed vertex, the head reaching the floor of the pelvis, the necessary resisting force is encountered, and rotation takes place, the head passing under the arch of the pubis. Face presentations are much more difficult and much more dangerous presentations. In face presentation we have a state of extension, the chin leaving the chest and the head thrown back on the posterior plane of the child; the parturient or propelling forces, instead of passing through the spinal column of the child in a direct line, pass at a right angle; what is the result? The face instead of advancing steadily like in a vertex presentation, advances slowly and uncertainly, descends only as far as the length of the child's neck, one and a half inches, and to advance any farther, it must do so by dragging down the trunk aided by the misapplied parturient forces, increase extension to its utmost limit, we have a jamming of the presenting part, should the chin rotate anteriorly labor may eventually take place. If the chin remain presenting posteriorly, the completion of labor becomes impossible.

O B—Occipito bregmatic diam., $3\frac{1}{2}$ in. T B—Trachelo bregmatic diam., $3\frac{1}{2}$ in. D S—Dorso-sternal diam., 3 in. O D—Occipito bregmatic diam., $3\frac{1}{2}$ in., $6\frac{1}{2}$ in.

All things equal, that is, where there exists a normal relation of diameters of the pelvis and head, my experience has been that if the chin presents posteriorly (either to the right or left) at the commencement of labor and engages

in the superior strait as such, unless changed by manual interference, there remains a posterior position throughout labor.

It will be remembered that the parturient forces are sent through the spinal column in a broken line, at right angle. If, as the picture below will show, the driving force is met by the unequal resistance of the two arms of the face lever. A. F., being the long lever or arm, offers more resistance than A. M., the short lever or arm, the result is, the chin descends and the forehead ascends.

Attitude of the head in face presentation. (Ribémont.)

When the chin is in this position, the neck is put on its extreme tension, the extension increased to its utmost limit, it is compelled to sweep down the sacrum and coccyx, a distance of fully five inches, over the length of the perineum, which is about three inches, making in all a distance to be traversed by the chin, of eight, if not more inches, the child's neck is only one and a half inches in length, therefore before the chin can slide down the sacrum and off the anterior edge of the distended perineum, the child's thorax must be pulled and jammed down into the cavity along with the presenting face. If we study Picture No. 1, it will be seen that we have here presented, the occipito-bregmatic diameter, which is $3\frac{1}{2}$ inches, with the dorso-sternal diameter of 3 inches, making together $6\frac{1}{2}$ inches, to go through a diameter of 4 to the utmost $4\frac{1}{2}$ inches, a radical impossibility.

In anterior face presentation, the chin, by passing under the arch of the pubis, the entire

head can be born before any part of the thorax of the child begins to enter the cavity, but no such act occurs in a posterior face; here the forehead appears first under the arch of the pubis, not acting as a pivot but firmly jammed against it. The first to escape is the chin, then the mouth, nose and eyes, top of the forehead, crown, and at last the vertex, as it will be seen, a mechanism diametrically opposed to an anterior-mento-position.

Anterior face presentation.

Posterior face presentation.

The treatment of mento-posterior positions practically resolves itself into two methods, version and craniotomy.

Several other methods have been suggested, prominent among which is Schatz's method. It is supposed to do away with the introduction of the hands or instruments in the maternal parts. It consists in restoring the normal attitude of the child's body by flexing the trunk and leaving the head to resume spontaneously its proper position as it sinks into the pelvis. The shoulder and breast are seized by the hand and pressed backward, at the same time the breech is raised with the disengaged hand applied near the fundus, making the long axis of the child conform to that of the uterus; then, finally, press the breech directly downward. As the child is raised, the occiput is allowed to descend, then as the body is bent forward, flexion of the head occurs by the

resistance of the side walls of the pelvis. This method is fraught with the danger of the head flexion only partially occurring, leaving a brow presentation in its stead.

In regard to the use of the vectis, I have invariably failed to obtain any good results. Prof. R. A. F. Penrose,² who strongly advocates its use in mento-anterior positions, says: "In mento-anterior position the treatment I have described (vectis or blade of forceps to be applied to the posterior cheek of the child, rotation allowed to occur of itself, not forced) should be resorted too. If, however, the chin be turned to the posterior part of the pelvis (mento-posterior position), we have one of the gravest cases in obstetric surgery to deal with. Anterior rotation of the chin under these circumstances is possible, but so exceedingly improbable, that we have no right to expect it and we should, as soon as the difficulty is recognized, treat the case as one of impossible labor."

Posterior face presentation. (Hodge.)

As to the forceps, they should never be applied when the chin is to the sacrum, it is invariably followed by serious injuries to the mother without due compensation.

While I consider version as the main treatment in this class of presentation, a treatment which rebounds to the benefit of the mother and child, I would urge the greatest discrimination. It should only be performed before the presenting face has passed out of the mouth of the uterus; after the face has entered the pelvis all attempts at version I consider unjustifiable, for version performed under the circumstances has been known to cause laceration of the uterus and other injuries to the maternal passages. Should all attempts fail to produce a favorable change in the presenting face, craniotomy should be performed, not after hours of ineffectual labor, when the mother's

tissues are sodden and their vitality destroyed by the continuous pressure of an impacted face, she herself thoroughly exhausted, but should be done at once. The child's viability is destroyed, though alive, is practically dead, and it devolves upon us to deliver the unfortunate woman as safely and quickly as possible.

The two following cases are taken from my note book: January, 1872, I was requested by a brother physician, (who had broken his forceps in attempting to deliver a patient) to bring my craniotomy instruments. On my arrival I found the patient had been in labor since the previous Wednesday; the day of my call was Saturday. She had been at first in the care of a mid-wife, who had allowed the patient to remain in labor from Wednesday to Saturday; the family, seeing no termination, in spite of the repeated assurance of the mid wife that everything was all right, insisted upon a physician being called. The physician, having diagnosed a posterior position of the chin, attempted to deliver with the forceps, which resulted in a broken pair of instruments. On examination, I found the chin just engaging in the superior strait, free from the mouth of the uterus, presenting in the left oblique diameter, posteriorly. I attempted to force an anterior rotation, the woman's pains being good, I held the face in the anterior-mento for fully half an hour; believing the position permanent, I withdrew my hand, examination a few moments later, revealed the chin in its original posterior position. I then used one blade of the forceps as a vectis, applying it against the posterior cheek of the child, but with no results. Craniotomy was performed and the patient delivered within twenty minutes.

In August, 1885, I was called to assist a brother physician in a case. The patient had been in labor since the previous evening. Examination revealed a posterior chin presentation, not yet out of the mouth of the uterus and just about engaging. The medical attendant, prior to my arrival, had attempted to produce an anterior rotation of the chin without avail. By the time I arrived at the bedside, the patient was exhausted and incessantly crying to be relieved. I determined to perform version at once; ether was administered and within ten minutes a living child was born. Mother and child did well.

It will be seen that in neither case had the chin or presenting part entered the cavity—that has been my experience. Mento-posterior presentations of the chin do not enter deeply into the pelvic cavity, on account of presenting at the superior strait larger diameters than could pass through any of the diameters of the strait.

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* Fenrose on Face Presentations.

MINOR UTERINE SURGERY.

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In these days of major uterine and pelvic surgery, the minor operations on the uterus, of which we used to hear so much, have been in great measure lost sight of by students of the diseases of women. In consequence of this very fact of being overshadowed by newer and more alluring procedures, fortunately many of the abuses of the old days have disappeared from the practice of those working in gynecology in our large medical centers. Unfortunately this is not equally true of the vast majority of practitioners either in the cities or in the rural districts; the old teachings and the old books still manifest too much influence. The time has come when we should carefully look back over our work of the past few years and see what lessons it has taught us.

The one great fact which stands staring us in the face in this connection, is that most of the troubles which we have been in the habit of considering as situated in the uterus, are not in that organ at all. Thus with one sweep we are able to dispose of a large proportion of the so-called uterine diseases. It is then manifestly improper and dangerous to direct treatment to the uterus, when that organ is perfectly healthy and the trouble is situated in the neighboring tissues—most probably of an inflammatory nature. In a large proportion of the remaining so-called uterine diseases the womb itself is undoubtedly affected, but the lesion in the uterus is only secondary to a lesion in the uterine appendages, or if it was the seat of the primary disease, its continuance is surely due to the inflammatory condition of the contiguous organs. Here again, a treatment directed against the uterus itself is both irrational and dangerous. This leaves us but a comparatively small number of cases of pure uterine disease; such is the true situation. Uterine disease, such as metritis, endometritis, pathological displacements, etc., uncomplicated by other and more serious troubles, is the exception rather than the rule, and in a large dispensary practice during the past few years the small number of such cases which have come under observation, has been a matter of surprise to me.

It would seem, then, that the old methods proposed for the treatment of uterine diseases were not in themselves necessarily faulty, although most of them have undoubtedly been carried to excess, but that the trouble lay in faulty diagnosis and consequent application of methods of treatment unsuitable for the true disease. If the true lesion be overlooked and many of the