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President, R. P. RANKEN LYLE, M.D.

THE INDICATIONS FOR CÆSAREAN SECTION.

The opening papers by Professor Munro Kerr and Mr. Eardley Holland will be found on pages 338 and 349.

DISCUSSION.

Dr. W. ROBINSON (Sunderland) was glad that the operation had not been recommended for nearly every variety of difficult labour, as the tendency now was because it was so easy of performance and so dramatic in character. It was easy for the woman as well as the surgeon. One patient had said to him some days after an operation, "They all ought to come that way, doctor." He thought, too, that all first labours at least, and all in which complications were expected, should take place in homes or hospitals, so that the woman and child might have the benefit of asepsis and of surgery if required. For placenta prævia (central and marginal) the operation should be done in preference to turning—so fatal to many children. His experience made him opposed to the operation for eclampsia, or at least doubtful of its utility. The collection of the statistics up to date was a most valuable piece of work. That the operative mortality, in clean cases, by various surgeons should be as low as 1.6 per cent. was another triumph of modern aseptic surgery, but it must be taught emphatically that the safety of the procedure for patients actually in labour lay in operation before the membranes had ruptured, as certainly as did operation for acute appendicitis immediately after its onset. Delay spelt danger. He hoped that the low transverse extra-peritoneal incision recommended to be used in all cases to prevent the occurrence of a subsequent weak scar, and the possibility of rupture in a future pregnancy, might occasionally prevent the fatal peritonitis which took place in some of those operated upon after the membranes had ruptured and frequent examinations or attempts at delivery had been made.

Lady BARRETT (London): What Professor Munro Kerr and Mr. Eardley Holland, in their extremely useful papers, had been

able to give in the short time at their disposal only hinted at the vast amount of work they had done in preparing the statistics of all cases of Cæsarean section since 1910. On the usefulness and safety of Cæsarean section for cases of contracted pelvis all were agreed, and she would refer briefly to one or two of the other indications that had been discussed. Cæsarean section in cases complicated by fibroids showed a surprisingly high mortality. She suggested that in cases complicated by fibroids, in which quite clearly the fibroid would cause obstruction to labour, the safer treatment would have been to remove the fibroid by myomectomy during the pregnancy, thus allowing a natural labour to take place at term. In Cæsarean section for eclampsia, in which the results also showed a very high mortality, it was not so easy, as was sometimes suggested, to distinguish the cases which were especially dangerous. Some cases in which Cæsarean section was performed very shortly after the advent of albuminuria, and possibly with no other symptoms, might develop postpartum eclampsia and die, while advanced cases with almost total suppression of urine might have uneventful recoveries. She believed the mortality of Cæsarean section for placenta prævia in primigravidæ would be very much lowered by a united opinion that it was the right treatment; the mortality, she thought, was high just because doubt existed and so many of the cases were subjected to other attempts at delivery or to frequent examinations before the operation was performed. She heartily agreed with Professor Munro Kerr that accidental hæmorrhage occupied a different position. If the abdomen was opened in accidental hæmorrhage it was to perform hysterectomy instead of or after Cæsarean section. The mortality of the latter was so high that she thought it should be rejected and that hysterectomy should only be undertaken in extreme cases, because not only did the mother lose the present child but was deprived of the possibility of having others. Lastly, she would like to emphasize the usefulness of Cæsarean section in cases of extreme heart failure, because delivery by that method subjected the patient to less effort and less shock than any other. She believed that a general anæsthetic for this purpose, such as open ether with oxygen, was more desirable than spinal anæsthesia. With regard to method, she confessed to having used the classical operation only, probably because she saw such bad results following the low incision in Vienna. Certainly morbidity had been high there in association with all methods, but it seemed to her particularly high in cases of the low incision. She rather doubted whether the drag on the wound in the more muscular part of the uterus was as great as Mr. Eardley Holland had suggested; if it were, it was difficult to imagine how, in the days preceding suture, any cases at all healed.

Professor WALTER SWAYNE (Bristol) drew attention to the fact that the class of cases with the highest mortality-rate consisted of those in which attempts had been made to deliver in spite of an unrecognized obstruction. A large number of such cases could be avoided by more careful supervision and examination during pregnancy; although this would not prevent some cases coming into the category, there was no doubt that the number could be and ought to be diminished. He thought that for complications other than disproportion there was a tendency to make use of Cæsarean section as a means of treatment without a clear idea as to the objects to be attained. Its indiscriminate application in such cases was to be deprecated and definite limitations should be laid down. He suggested that such an investigation as that carried out by Professor Munro Kerr and Mr. Eardley Holland should be carried out at much more frequent intervals, say every two years, in order that all the workers in this field might have an opportunity of comparing their work and revising their methods. One great advantage of such an investigation as the present lay in the comparison of the conditions obtaining in different localities for which it gave opportunity. In the West of England, for example, contracted pelvis was relatively uncommon, while the other complications of labour were, in some instances, above the average. These local differences were important, since they had a direct bearing on the relation between the number of emergency and elective operations and produced differences in immediate indications and technique.

Mr. R. J. JOHNSTONE (Belfast) joined in the hope that the collection of statistics would be continued, say, for the next five years. He was himself a convinced supporter of the operation, and thought that the indications for it might be reasonably extended to many cases in which the life of the child was exposed to more than ordinary risk by the ordinary methods of delivery, as, for instance, in prolonged gestation, or in breech presentation in a primigravida with an abnormally large child. Such an attitude would be, of course, indefensible were it not clearly shown, as it had been, that in uninfected cases the risk to the mother was very small. He differed from Mr. Holland's view of the physiological activity of the uterus after parturition, and regarded it as being in a condition of mild tonus, rather than in active contraction. He thought the fears expressed as to the probability of obtaining a sound scar in the upper part of the uterus were exaggerated. He always used catgut for the suture, and put in three tiers of continuous suture. In over eighty operations he had had one case of rupture of the uterus.

Mr. GORDON LEY (London) was glad that Professor Munro Kerr had emphasized the possibility of extending Cæsarean section to

those cases of prolonged labour with early rupture of membranes, one of the most troublesome complications in midwifery, particularly met with in elderly primigravidaë. With regard to the action of the uterine muscle in inhibiting healing of the uterine incision, he could not agree with Mr. Johnstone. Surely, he said, the uterine contractions during the puerperium were similar in nature to those during labour—that is, they tended to make the site of union gape, as was seen at operation, and thus to inhibit healing. In two cases of laparotomy for spontaneous rupture of the uterus he had found the uterus partially inverted through the tear in the anterior wall. This emphasized the drawing apart action which was noted at operation.

MR. BECKWITH WHITEHOUSE (Birmingham) said that the change of opinion during the past ten years with regard to resort to Cæsarean section in the treatment of placenta prævia was extremely interesting. About ten years ago, at a discussion at the Royal Society of Medicine upon this subject, Jellett had, he believed, made the statement that, “although he did not think the Cæsarean operation wrong for placenta prævia, he could not see the necessity for it.” This was the view expressed by the majority of speakers at that discussion. To-day the position was reversed, and Cæsarean section was being advocated as the ideal treatment for central and lateral cases. Personally, he was in complete agreement with this view. The tendency had been, and by many practitioners still was, to regard placenta prævia as an obstetric complication which could be dealt with quite satisfactorily by version. If the mother was saved all was well, and the loss of the child was not considered. As a matter of fact, version in placenta prævia was not an operation free from danger to the mother, quite apart from the terrible foetal mortality. In statistics covering ten years at the Maternity Hospital, Birmingham, the maternal mortality in cases of version for placenta prævia amounted to over 4 per cent., whilst the foetal mortality reached the appalling figure of over 70 per cent. Institutional figures, in estimating the value of any method of treatment, were always the most reliable, since the personal factor was eliminated. There was little doubt that in placenta prævia a real difficulty was to define when Cæsarean section should be done and when it should not be done. Were all cases to be treated by operation, and, if not, what was to be the guiding line? Mr. Whitehouse’s own practice in all cases of central and lateral placenta prævia at or after the eighth month of pregnancy was to perform Cæsarean section. The initial hæmorrhage was the important symptom which should lead to examination and diagnosis and to immediate treatment. Personally, he would like it to go forth from the Section that placenta prævia was an obstetric

complication which could be dealt with satisfactorily only in a hospital or nursing home, and one in which Cæsarean section was very likely to be required. Version was not to be regarded as being an operation free from risk to the mother, and statistics did not place it on as favourable a basis as modern Cæsarean section. He had performed the lower segment operation upon two occasions, according to the method advocated by Professor Munro Kerr in 1920 at the Royal Society of Medicine. Each time, however, he had experienced some difficulty. At the first operation there was much troublesome venous hæmorrhage from vessels in the lower uterine segment. On the second occasion considerable difficulty occurred in extracting the child. Apart from this criticism, the operation appeared to be based upon sound principles, and possibly these initial difficulties would disappear with further experience of the method.

M. J. WEBSTER BRIDE (Manchester). The remarks made by Mr. Bride are embodied in his paper on page 463.

The President, Dr. RANKEN LYLE, said: I desire on behalf of the Section to offer to Professor Munro Kerr and Mr. Eardley Holland a most cordial vote of thanks for their extremely interesting and very learned papers. The writing and compilation of these papers must have entailed much hard work and thought, and we all most cordially congratulate both writers. When the committee selected this subject for discussion it had in mind two most important considerations: First, that there were no definite rules or indications laid down for the performance of Cæsarean section, and consequently in many cases it was not performed when it might have been of great advantage, and in some cases it was performed when the indication for it was not very definite; and, secondly, that owing to the rapidly improving results obtained, the operation was justifying its extension to many cases in which hitherto the indications for it were not considered sufficient. The committee thought that by choosing this subject for discussion the Section would be able to lay down more or less definite indications which would act as an authoritative guide to all operators in the selection of cases for operation.

Professor Munro Kerr, in his most able paper, has, I think, completely fulfilled the wishes of your committee. He has given a large number of indications, and has indicated in what cases he considers the operation is of doubtful propriety. I entirely agree with him in everything he has laid down, with one exception, and that is in cases of contracted pelvis. I consider that a true conjugate of $3\frac{1}{2}$ in. should be a definite indication for Cæsarean section at term rather than $3\frac{1}{4}$ in. He has shown that Cæsarean section in eclampsia, although frequently performed, is not desirable on

account of the very heavy mortality, and has also stated that more attention should be given to prophylaxis and medical treatment. With this I most cordially agree. There is only one other point I should like to criticize in his paper. He says that in those cases in which one might anticipate a rupture of the uterus on a subsequent occasion the patient should be sterilized. I am not of this opinion. I am a strong supporter of conservative Cæsarean section, and I do not think that any form of prospective trouble should be an indication for sterilization. In 1910 very few teachers in this country believed in absolute conservative Cæsarean section. At the present time I think that nearly half the teachers in this country advocate it, and I believe that before many years it will be the unanimous opinion of the profession that conservative Cæsarean section should be adopted in all cases.

Mr. Eardley Holland has taken an infinity of trouble in collecting and tabulating nearly 4,000 cases of Cæsarean section performed in this country during the last ten years. The results which he has shown in definite percentages are a most valuable guide to everyone as to the nature of the cases in which the operation is highly desirable, and of those in which the operation is of doubtful propriety.

The high mortality in the third and fourth classes—namely, patients very long in labour, patients after forceps, etc.—is, I have no doubt, going to be reduced very considerably in two ways: First, by the ever-increasing number of patients who are seeking institutional treatment, when the necessity for the operation will be either anticipated or discovered at a much earlier period; and, secondly, by the extension of pre-maternity work all over the country.

I am deeply impressed by the importance and value not only of these papers but of the subsequent discussion thereon, and have no hesitation in stating that they mark a great advance in our knowledge of the indications for the performance of this operation.