

## NOTES OF A CASE OF CÆSAREAN SECTION.

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OF the many absorbing topics of medical literature, of the many changes in the art of surgical treatment made in the two last decades, and of the many glorious achievements attained in this period under aseptic and antiseptic methods, to the obstetrician the surgery of the uterus, when complicated with a living foetus at or near the full term of pregnancy, is the most interesting and important subject he may be called upon for his opinion. In drawing your attention to the subject of Cæsarean section this evening it is not my desire that any very special inference is to be drawn from the case I report, but my desire is simply to put it on record among the Transactions of the Obstetrical Section of the Royal Academy of Medicine in Ireland ; secondly, my desire is that it may bring forth a discussion from the members present ; and last, my desire is to thank Dr. Elizabeth Massey for the notes ; also for her promptitude in bringing the patient into hospital I chiefly attribute the success.

CASE—Mrs. T., aged twenty-three. Second pregnancy. Was admitted into the National Maternity Hospital, at 11 30 a.m., on Sunday, July 21st, 1901. She was born in the North, and was considered a weakly child in her first years. She was reared in a chair, as she had not the use of her legs, until she was five years old. First labour, October, 1898, took place in the Rotunda Hospital. Patient was in labour some ten hours, when, after a prolonged instrumental delivery, a dead foetus was extracted. Her last menstruation was on October 22nd, 1900. At 6 a.m. on Sunday,

July 21st, the membranes ruptured. At 10 a.m. she was visited by Dr. Elizabeth Massey, and she diagnosed a highly contracted pelvis, and had the patient at once removed to hospital. I saw her at noon.

*Examination.*—The patient was small, delicately built. Height, 4 ft. 4 ins. Measurement from crest of ilium to sole of foot, 29 inches.

From symphysis pubis to umbilicus .. ..	6 $\frac{3}{4}$ inches.
From ensiform cartilage to umbilicus .. ..	9 inches.
From left ant. spine to umbilicus .. ..	9 inches.
From right ant. spine to umbilicus .. ..	9 inches.
From ant. sup. spine to other in front .. ..	12 $\frac{1}{4}$ inches.
Around pelvis at head ant. spine .. ..	32 $\frac{1}{2}$ inches.
From symphysis pubis 2 + 1 to middle of spine	13 inches.

*Internal.*—From promontory of sacrum to lower angle of symphysis pubis, 2 $\frac{3}{4}$  inches.

The cervix was dilated to about the size of a florin; the head of the child could be felt above the brim. On external palpation it was movable. Back of foetus to the left. The heart sounds were audible immediately below the level of umbilicus, and to the left, about 140 beats to the minute. I at once telephoned to the Rotunda, and have to thank Dr. Lloyd for having supplied me with the particulars of her previous delivery, and as the measurement of the pelvis corresponded with my own, I decided on performing Cæsarean section, the mother having previously expressed the desire that her child should be born alive.

*Operation.*—At 3 30 p.m. patient was placed under chloroform by Dr. Massey, when ether was substituted, assisted by my colleague, Dr. Barry. An abdominal incision was made, extending from three inches above umbilicus to two inches of symphysis pubis. The uterus was delivered through the abdominal wound, which was temporarily united behind it. An incision was made through the uterine wall, commencing high up at the fundus, but avoiding the lower uterine segment. The placenta was in front and was rapidly cut through; bleeding was at once profuse. The child was seized by the buttocks and extracted; the head followed without any difficulty. The infant, a female, at once cried out. The assistant's hand grasped the uterine edges until I applied an elastic ligature. The placenta was detached without difficulty. The uterus contracted well, hot sterilised towels being

applied; the wounded surfaces were brought together by means of six deep sutures and four superficial silk sutures. The abdomen was closed likewise, using silk for the deep sutures and silkworm-gut for the superficial. The operation lasted forty minutes, the patient leaving the table in good condition. Pulse 105.

The child, a healthy girl, weighed 7 lbs. The progress of the case was most satisfactory. Pain was experienced for only some four hours after operation, which was relieved by  $\frac{1}{8}$  gr. of morphia hypodermically. Thirty hours after delivery she was given 5 grs. of calomel; during that night she vomited on four occasions what was described as dark, bilious-looking matter. The bowels were moved by an enema of soap and water, to which a teaspoonful of common salt was added. The further convalescence was uneventful. The mother was able to suckle her child. She sat up on the twenty-first day, and left the hospital on the thirtieth day after operation.

The three important questions I had to decide on my first visit to this patient were:—First, should I allow the labour to proceed, with the object of giving nature a chance of so moulding the head that I might eventually deliver by means of forceps or symphyseotomy; secondly, should I perform a Porro's operation; or finally, a Cæsarean operation. I chose the latter for two reasons—namely, the mother was most anxious a living child should be born, and knowing the result of her previous labour, besides the most important condition that there had been no examination previous to her admission to hospital. The important points to my mind of this case, and upon which I would like to have the opinion of this Section of the Academy, are in connection with the uterine incision, whether one should adopt what is known as the classical anterior incision, or longitudinal, or the transverse incision, as recommended by Fritsch. Recent authorities, notably Schroeder, are much in favour of the latter. The advantages he claims: When made on a woman in the Trendelenburg position this incision allows the waters to escape over the thorax of the patient; the peritoneum is

thus exposed to far less risk of infection. Moreover, it is the best way to avoid the placenta, and finally, as the incision is parallel to the vessels of the fundus, it is not followed by more hæmorrhage than the longitudinal one; in fact, among ninety-four cases of the transverse incision, Schroeder has only found fourteen in which any considerable hæmorrhage at the time of the incision is recorded, and in most cases it is stated that the bleeding ceased when the uterus contracted. Again, by the incision of Fritsch a more rapid extraction of the foetus is accomplished. By it one almost invariably comes upon one end of the child, either the head or the breech, by the longitudinal incision upon the trunk. When the foetus has been removed it is perfectly easy to inspect the whole of the uterine cavity down to the lower segment. Objection has been made that the transverse incision is likely to be followed by adhesion to the intestine, but in a paper published in the *Centralblatt f. Gyn.*, 1899, by H. Ludwig, of Vienna, in two Cæsarean operations on the same woman the uterus was opened by a transverse incision through the fundus, and the child extracted alive. The result of the first operation was blameless in so far that the adhesion to the uterine cicatrix was only evident through the old silk suture.

I shall not discuss the Cæsarean operation in its relations to other operations, such as symphyseotomy, craniotomy, and the Porro's operation, as the time at my disposal is too limited, even if I had the desire. We cannot, however, shut our eyes to the fact that the Cæsarean operation is gradually being restored to a position not unlike that of ovariectomy, so that we can speak with confidence, as a rule, to a favourable result. No longer shall we be confronted with the words or saying—"Spare the mother, no matter about the child." The dangers attending the Cæsarean operation ought not to be as great—certainly not greater—than an ovariectomy, but students must be more fully instructed in the recognition of degrees of

pelvic obstruction, so that it will not be necessary for the obstetrician to learn through delay, or through failure with forceps, version or craniotomy, that a Cæsarean section is demanded. I shall not touch on eclampsia, placenta prævia, prolapsed cord, &c., on the light of these forming the most recent indications for Cæsarean section. In the performance of Cæsarean section our motto should be: Operate early, delay is fatal.

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DR. ALFRED SMITH said he had listened with great pleasure to Dr. Horne's case. It left nothing for criticism, but much for praise. He could say nothing more than that he congratulated Dr. Horne on the successful issue of his operation.

DR. GLENN agreed with Dr. Horne on the risk of sepsis with which vaginal examination is attended. He thinks the bold, good cut going right through the placenta, if it lies in the line of incision, is good surgery. The risk of soiling the peritoneum by the liquor amnii may be avoided by binding round the uterus; bringing out the womb through the abdominal incision adds to the shock. For a living child he recommends the Cæsarean section, but if the child is dead he prefers Porro's operation. Removal of the placenta is sometimes difficult, and it is advisable to swab out the cavity with hot water. Packing the uterus with gauze, and bringing a portion of the tissue through the dilated os uteri into the vagina is recommended.

DR. W. J. SMYLY desired to add his quota of praise to Dr. Horne on the very successful result of the case. Nothing could be better than an afebrile case and an aseptic recovery. Pelvic deformities were not often met with in Ireland compared with other countries. During his seven years term as Master of the Rotunda he had had only four Cæsarean sections and four symphyseotomies, yet from a letter he received from Glasgow he learns that one of the surgeons of the Maternity in that city had nine Cæsarean sections in nine months. In all these cases the question arises—Should the woman be made sterile at the time of the operation? He thinks not. Can you choose your time for operation? If so, by all means select daylight.

DR. HORNE, in reply, stated that he used silk sutures; he passed

six of them deep through the uterine wall, but not through the lining membrane, and the superficial sutures were through the peritoneum covering the uterine incision. He neither packed nor swabbed the uterus, there having been no risk of infection. He looks on the making sterile of the patient as unjustifiable. After operation he thinks the less interference with the uterus the better. Foreign bodies introduced into it are very likely to set up after-pains.