View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by ZENODO

DANGERS TO THE CHILD IN OPERATIVE DELIVERIES.*

BY S. A. HOUGHTON, A.M., M.D., BROOKLINE, MASS.

THERE is one fundamental conception, it seems to me, that should govern all obstetric practice which the preceding readers have barely touched upon; certainly they have not given it the weight to which it is entitled. I refer to the life and health of the baby, and I shall confine my part in the discussion to this one subject.

From nature's standpoint, pregnancy has just one definite object in view, that is the birth of a healthy, living child. It is a truism to say that when such a result in any pregnancy and labor does not occur, that pregnancy and labor have been absolute failures. And in so far as our conduct of any case of labor leads to the death or injury of the baby, either by sins of omission or commission, to such an extent has our conduct of that case been a failure.

Every obstetric operation entails some risk to the child. This is especially true of the delivery by high forceps. I care not how expert the operator may be, he does not know just where the ends of the forceps blades are. There are many, many people walking the streets to-day with scarred faces and injured eyes caused by forceps wounds. The cases of obstetrical paralysis with which we are all altogether too familiar are usually found in cases where there has been an operative delivery. It is a terrible thing to send a child through life with a practically useless arm.

We read and hear of the dangers to the child from a long first stage of labor. I think that this is a traditional mistake. I know of no reason, either theoretical or practical, why a long first stage of labor *per se* should injure the child, if that labor can be terminated naturally. It is only in the prolonged first stages which have to be terminated by operative measures that the child is injured. I believe by all means in operating and operating early, when you are convinced that the natural forces will not push the child's head into the pelvis. But I do not believe that the long first stage in itself, due only to inertia of the uterus and not to obstruction, injures the child in the slightest. By the kindness of Dr. C. M. Green, I was permitted to examine some of the records of the Boston Lying-In Hospital with this point in view. I took fifty successive cases of what might be termed prolonged first stage labors, occurring during a period of about six months in the year 1891. I examined the records of all cases for that period, in which the first stage was twenty-four hours or more. The shortest case was twenty-four hours; the longest, one hundred and seven hours; the average of the fifty cases, thirty-eight hours and twenty minutes. In every case labor was terminated naturally or by low forceps, the child was born alive and was discharged well from the hospital two weeks later. Personally I approach operations at, or above, the brim, with much more concern than I did a few years ago. I exhaust every method known to me to get that head into the pelvis before I use compression and traction on it. Of course what I have said does not apply in the slightest to a low forceps delivery. A prolonged second stage is very dangerous, and does kill many babies, and the element of risk in a low forceps operation is as slight as it can be in any operative procedure.

It is a fact known to all pediatricians, and to most obstetricians, that premature babies do not stand mauling and handling. In my own personal experience, — limited, of course, — I have never lost a premature baby born at seven months or later, and weighing three and one-half pounds or more, when the delivery was a natural one. In my own practice, and that of my friends, I have seen many dead or dying premature babies brought into the world by high forceps or version. It is a self-evident fact that a baby whom you do not dare to even bathe or have take the breast for days and weeks after its birth cannot be pulled and hauled through the birth canal without great risk to its life.

I think it is the feeling of many expert operating obstetricians that, if the baby only breathes and cries after birth, the case has been successful. Nothing could be farther from the truth; that baby must continue to breathe and live and thrive. I used to feel, — I think that many of the younger men do feel, — "What if we do lose the baby? It is not so very important; they can have another." They cannot always have another, the many cases of one-child sterility prove that, and if you have taken away from those parents their one opportunity to have a child, you have done them irreparable harm. Then again, pregnancy is not a trifling matter. In these days of complicated living, it is a serious question. Rail at it as we may, a woman must do what other women in the community do, and if on top of social duties, children's education, household duties, and above all the domestic problem, we add the handicap of pregnancy, it is a great deal for any woman to endure and then have nothing to show for it. All this may seem a far cry from the question, "When to interfere in labor," but I think it is of decided importance in the consideration of that question.

With this question of the dangers to the baby in mind, I have looked through the records at the Boston Lying-In Hospital with the following results. In the years 1892–93, there were 1,008 babies born in the hospital. To compare with this I have taken the same number of cases fifteen years later, — that is, in 1907 and a part of 1908.

	1892–93.	1907–08.
Number of cases,	1,008	1,008
Stillborn babies, excluding macerated fetuses,	25	48
Babies died in hospital,	32	62
Low forceps,	78	58
High forceps,	7	44
Version,	13	37

That is, with the decrease in low forceps operations, and the great increase in high forceps and

* In discussion of the papers by Drs. Reynolds and Newell, before the Suffolk District Medical Society, Feb. 17, 1909.

The Boston Medical and Surgical Journal as published by
The New England Journal of Medicine. Downloaded from nejm.org at VANDERBILT UNIVERSITY on September 17, 2016.
For personal use only. No other uses without permission. From the NEJM Archive. Copyright © 2010 Massachusetts Medical Society.

versions, there has been an increase of nearly 100% in the stillborn babies and in the deaths in the hospital. It is perfectly true that there are more pathological cases received in the hospital to-day than fifteen years ago, but there were more than twenty Cesarean sections in the later series and none at all fifteen years ago. And this operation would surely take care of a large proportion of the increased number of pathological cases; and of course the danger to the baby in a section is practically *nil*. So it seems to me that even with the increased admission of pathological cases to-day over fifteen years ago, it is more than a coincidence that the death rate should be double at the same time with the great increase in high forceps and version deliveries.

As to the effect on the mothers of prolonged labor, surely it may be serious. But I feel that if much more attention were given to the after care of our cases we should have much better results. Don't consider every case a surgical case to be operated on and then dropped or left to the care of a nurse. The patient needs the attention and help of the doctor. Have her on your mind for two months after the labor, attend to details, help her in every way you can, and do all that is possible to prevent all unnecessary worries. I am sure that such care is far more important as regards the health of that woman than it is to shorten the first stage of labor by an hour or two.

I agree perfectly with the readers that there is a class of women constitutionally ill equipped who will not stand labor well, and who should be delivered as early in labor as possible. But my plea is that these cases should be selected with the greatest care and discrimination, and that due weight must be given to the health and life of the child.

SYMPTOM-COMPLEX OF A SERIES OF EXANTHEMATOUS DISEASES. OR IS THERE A NEW CONTAGIOUS EXANTHEM?

BY J. WM. WATSON, A.M., M.D., SOUTH BRAINTREE, MASS.

(Concluded from No. 24, p. 783.)

THE DISEASE.

Occurrence. — This epidemic occured in the late autumn, winter and early spring at about the same time as the Chicago epidemic of so-called mild scarlet fever. Rubella and fourth disease occur in spring and summer.

First symptoms. — Sore throat and malaise, soon followed by rash.

Incubation period. — Almost invariably seventeen days.

Eruption. — Sometimes appeared as almost the first symptom. It is an old-rose red rash. It is punctiform and sometimes encloses the hairs. Appears upon the forehead, the arms, and especially on the chest, abdomen and legs. It does not entirely disappear on pressure. There is a little areola of a light shade around each point. (Fig. 4.) There is considerable itching. After the second or third day it begins to fade. The top of each point grows lighter. Under the hand-glass it will be seen that each point contains a minute particle of liquid. About the fourth day this dries up and is followed by

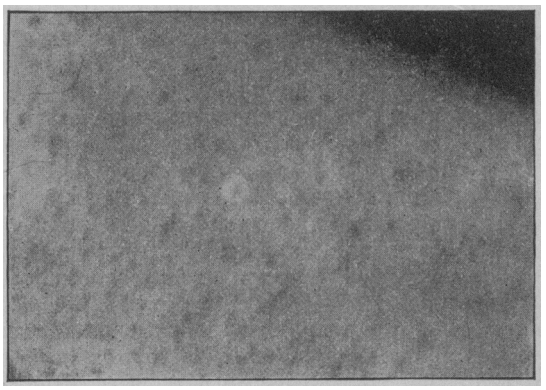

FIG. 4. From Beverly cases. Rash is four days old and is about four times natural size. The eruption: Punctiform, with a whitish top. Old-rose red rash. There is an areola of a slightly lighter shade around each eruption. On second or third day each point contains a minute particle of liquid.

Desquamation. — This follows the fever. I believe that every case peels, but it may be so fine as to be hardly noticeable. This continues for a period of from two to six weeks. Fig. 3 shows desquamation after two weeks. Fig. 6 shows it in one week. The desquamation period averaged about three weeks. The desquamate was anything from a slight fur, branny (characteristic in Duke's disease), to large scales and strips of epidermis. Fig. 5 shows an attempt to photograph a scale in its natural size, but a better view of same is seen in Fig. 6. Fig. 2 shows parts of molds of fingers and toes one inch in length. These represent the smaller scales, as the larger ones were burned up before I asked to have them saved for me.

The *throat* varies in soreness. It may be insignificant from one to five years, increasing in puberty and the young adult. It has often happened that when the angina was severest the rash was small in quantity or altogether absent.

The *eyes* were usually normal, but on exposure to bright light would be sensitive and slightly reddened.

Glands. The superficial cervical and posterior auricular are enlarged but not tender.

The *kidneys* must be watched, as acute nephritis is a possibility, but not so frequent as in scarlet fever.

Sensation of illness. — In almost every case this is decided. It appears to depend somewhat on the amount of the rash. There were very few cases that were really comfortably sick.

The tongue is coated slightly, but this disappears about the fourth day, leaving the tongue raw and beefy. When protruded, it resembles a strawberry in shape, but not in appearance.

The pulse is rapid in proportion to the fever. The same may be said of the respiration.

The temperature may rise gradually or suddenly, irrespectively of the rash. It may vary from almost down to normal up to 105 F.

The Boston Medical and Surgical Journal as published by
The New England Journal of Medicine. Downloaded from nejm.org at VANDERBILT UNIVERSITY on September 17, 2016.
For personal use only. No other uses without permission. From the NEJM Archive. Copyright © 2010 Massachusetts Medical Society.