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EDWARD W. JENKS, M.D.,
DETROIT.

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REPORT OF A CASE OF CESAREAN OPERATION, WITH SOME COMMENTS.

BY EDWARD W. JENKS, M. D.,
Detroit.

On the evening of February 27th last I received a message to "come to Comber, Ontario,[1] and bring your obstetrical instruments with you." I arrived at the patient's house between 9 and 10 P. M. The reasons which led to my being summoned, what had been done for the patient previous to my arrival, and also the various steps in the Cesarean operation, I will give in the language of my friend Dr. J. L. Bray, of Chatham, late President of the College of Physicians and Surgeons of Ontario, who reported the case at a meeting of the Ontario Medical Association, at which I was also present by special invitation and participated in the discussion of the various obstetrical and gynecological papers that were read during my brief attendance.

On the 27th of February last I received a telephone message from Dr. Abbott to go at once to Comber and bring my obstetric case. On my arrival at Stony Point I found a man waiting to bring me to his house, about six miles south, where Drs. O'Keefe, of Libbany, and Abbott, of Comber, were awaiting my arrival. The former had been called at three o'clock to attend Mrs. G. in labor. She was about twenty-seven years of age, 5 feet 6 inches high, well proportioned, and the mother of one child five years of age. She had a tedious but not serious delivery of her first child, which terminated, without artificial aid, in about twenty-four hours. Some three years ago she was the

[1] Comber is a town in the Province of Ontario, on the line of the Canada Southern Railway, and distant about thirty miles from Detroit.—E. W. J.

victim of an accident, which proved to be the cause of her present trouble. At that time a corn-crib fell upon her, fracturing the right ilium and producing the deformity in the pelvis which eventually caused her death. There was nothing externally to show that any deformity existed, and it was only on attempting to apply the forceps that this was discovered.

As I said before, Dr. O'Keefe was summoned at 3 A. M., and found the os high and but slightly dilated. He waited some time, during which she was having strong labor-pains, and the os becoming more dilated, with no advancement of the head. He thought it best to apply the forceps. He attempted to do so, but found it impossible, as the fetal head was thrown forward over the pubic arch ; and although he could apply one blade, it was impossible to introduce the other, as there seemed to be a wall of bone on the right side of the pelvis, forming, as it were, a shelf upon which the fetus rested.

After several unsuccessful attempts he sent for Dr. Abbott, who also failed. They then sent for me, and, when I arrived, about 3 P. M., I found the os dilated, fetal head very high, labor-pains strong and continuous ; patient in good condition. We succeeded in getting the blunt hook into the foramen magnum, and used all the force possible, but could not budge the head ; so we had another consultation, which resulted in sending for Dr. E. W. Jenks, of Detroit, who arrived about 9 P. M. the same day. He tried the forceps, cephalotribe, etc., as we had done, but with no better success, as he found it was impossible to apply more than one blade.

Now, what was to be done? After having exhausted every known means of delivery by the vagina, and the patient being yet strong with forcible pains, we concluded the only thing remaining was abdominal section, and this we decided upon. At about 2 A. M., or about twenty-four hours from the commencement of labor, the patient having been removed from the bed to a table and placed under chloroform by Dr. O'Keefe, Cesarean section was begun, Dr. Jenks commencing about two inches above the umbilicus. He continued his incision a little to the left till below that point, when he kept down the median line to about three inches above the pubes, when it was found impossible to go any lower, as, on cutting through the ab-

dominal walls and peritoneum, he came upon the bladder, which was full, notwithstanding a catheter had been previously introduced. The neck was tightly wedged between the uterus and bones of the pubes, so that the catheter could not have entered the bladder. On cutting through the uterus, the placenta, which was immediately beneath, was unavoidably incised, and you can imagine how appalling the hemorrhage became—in fact, we thought it would prove fatal ; but Dr. Jenks quickly finished the incision and removed the fetus and placenta in less time than it takes to describe it. Of course, the moment this was accomplished, owing to the strong uterine contractions, the hemorrhage ceased ; but, in removing the fetus, the uterus was torn near the neck, which gave us some trouble, owing to a good deal of blood oozing from this rent. One of the most troublesome things connected with the operation was the difficulty of keeping back the intestines, and, when they did come out, to keep them warm. This we endeavored to do by means of napkins dipped in hot water applied to them. We tried to keep the room at a temperature of 80° ; but that was very difficult with the thermometer about zero, and with no assistants other than the medical gentlemen named. The cut edges of the uterus were brought together, and ten deep and four or five superficial sutures of carbolized silk were put in, which, when done completely, closed the opening. The abdominal cavity was sponged out, and, singular to say, the sponges were hardly colored, so little blood having found its way in, owing to the pressure made on the abdominal walls by the assistants. The abdominal wound was then closed by means of ten deep and ten superficial silk sutures, the deep ones, of course, embracing the peritoneum. By this time the patient had completely rallied, and had come from under the influence of chloroform. She was removed to bed, and hot-water bottles placed all around her ; a quarter of a grain of morphine was injected into her arm with the hypodermic syringe, and she appeared very comfortable. The extremities and body soon became warm, and she fell into a nice sleep. The temperature was normal and the pulse 120 when we left.

I did not see her again ; but Drs. O'Keefe and Abbott were in constant attendance, and from them I learned that she

progressed nicely till Monday morning about one o'clock, when she began to get very weak, and died about 6 A. M.

. . . . . .

I will conclude this imperfect report of this most interesting case by saying that, taking it all together, it was a remarkable one, as this is the first case that has ever come under my notice when a woman had borne a child naturally and then had to be delivered subsequently by Cesarean section; and when you consider the many disadvantages we labored under—performing the operation in the country at midnight by the light of two small coal-oil lamps, with only the assistance of the medical men, and the thermometer at zero—the wonder is that we succeeded as well.

Had I the same case to attend to again, I should never perform craniotomy, as I believe it destroys the only chance of the mother, and of necessity destroys the child, which in this instance might perhaps have been saved.

The foregoing description by Dr. Bray of the various steps of the operation is in the main correct, and sufficiently full. It shows very plainly how much was done, and the many fruitless attempts resorted to, for the delivery of the woman prior to having recourse to the *only* means by which delivery could be effected.

Dr. Bray in his paper speculates as to the cause of this patient's death, as no post-mortem examination was made. It was not until a few days ago that I learned some facts (of which Dr. Bray had no knowledge when his paper was read) which leave but little chance for doubt as to the immediate cause of her death. While at the meeting of the Canada Medical Association, after parting with Dr. Bray, I met the physician who had charge of this patient in the beginning of her labor and following her delivery, and was informed by him that the woman was doing admirably up to the beginning of the third day. The nurse, who had orders not to leave the room unless her place was supplied by some one in her stead, disobeyed the order and left the patient alone. Soon after she heard a scream, and, on entering the sick-room, dis-

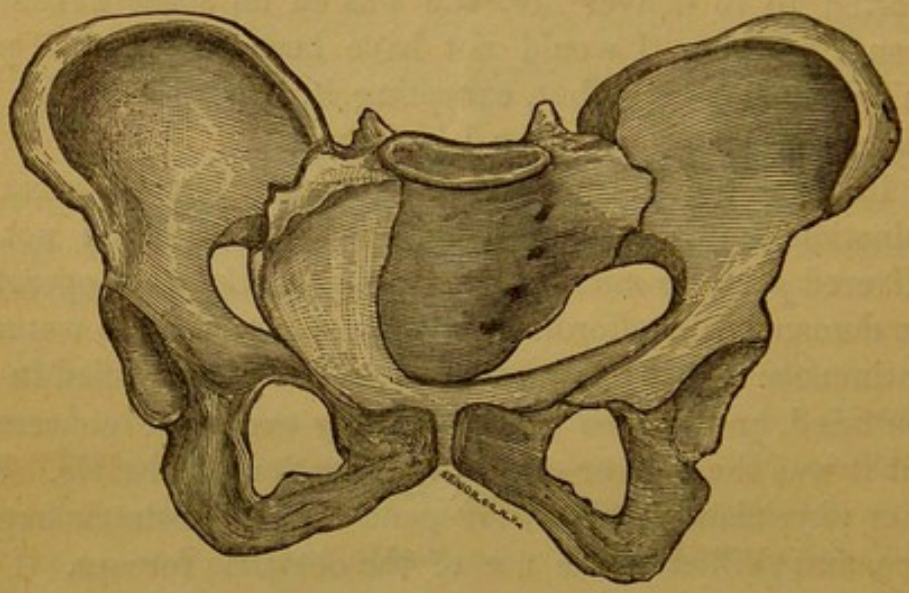
covered the patient standing on the floor, who said she had had a bad dream, and when she awoke found herself in the position described. She further said that she felt something "give away inside," and that she was now "feeling badly inside." Soon after being placed in bed she began to show signs of failing, and died in a very few hours.

Until I learned of this I could not understand why the patient had died so soon, for, although considerable time had elapsed, and there had been many and various kinds of efforts resorted to to deliver her, she was in no sense exhausted when I left her. I would not have been surprised if peritonitis had developed, but, excepting it, the chances for her recovery seemed good when I last saw her.

In the outset, as soon as I had completed my physical examination, I was convinced that the woman could not be delivered *per vias naturales*, and that the Cesarean operation was demanded, as affording the only chance for the woman's continuance of life; but I wished to be fully justified in my own mind, and also be able to satisfy every one concerned, that it was the proper and only operation admissible. The other physicians present were gentlemen of obstetric experience, and skilled in the use of the obstetric forceps. I did not expect to succeed with the forceps after their failure. I found, as they had, that only one blade could be introduced. I tried alternately the left-hand and right-hand blade first, but the proper introduction of the second blade was a mechanical impossibility. I also attempted the use of the cephalotribe, with the same result. The child being dead, I felt as did my colleagues—that it was desirable it should be delivered if possible without having recourse to abdominal section. Laparo-elytrotomy was mentioned, but it was not deemed practicable; in fact, owing to the nature of the deformity of the pelvis, and its locality, it was believed to be an impossibility to extract the body of the fetus by means of this operation. The accompanying cut will enable the Fellows to form an opinion of the nature of the deformity.

The dilated os uteri rested on the projection of bone on

the right side of the pelvis, and the uterus and contents were held up to such a height by this projection as to stretch the vagina to its utmost, and thereby cause its walls to be very tense. The projection or shelf of bone was above the brim of the pelvis, and extended into the canal sufficiently to obstruct about one half of the passage. It was my belief then that laparo-elytrotomy was impracticable, and could not be made with a fair prospect of success; and I am still of the same opinion.



1, Represents the portion of fractured ilium or "shelf of bone" which extended almost to the median line of the parturient canal. This shelf was above the brim of the true pelvis. The cut does not represent the deformity very correctly.

As there seemed to be no other method than the Cesarean operation by which the delivery of this poor woman could be effected, it was decided upon. About 2 P. M., or twenty-four hours after the commencement of labor, she was removed from her bed to a table prepared for the operation. I will not repeat the different steps of the operation, as they were stated by Dr.Bray in his paper, which has already been quoted. Yet there are a few points I will allude to, and then add some remarks relating to the Cesarean operation.

The woman seemed to be in good condition, neither showing signs of exhaustion or even fatigue.

The peculiar shape of the abdomen previous to making an incision was noticed by all present. The uterus and contents occupied an oblique position, the lower segment resting, as before stated, on the shelf of bone, caused by the fractured ilium of the right side. It was brought around so as to occupy a position corresponding to the median line, and thus maintained with the firm pressure of an assistant's hands through the main portion of the operation. Owing to the high position of the uterus and contents, I was compelled to begin my incision about two inches above the umbilicus. I then carried it downward as far as the bladder would permit, and then upward as far as was necessary. There was but little loss of blood prior to reaching the uterus. The uterus presented an appearance as if it had been bruised or severely manipulated, and yet I did not learn that it had.

I consider it a very unfortunate occurrence that craniotomy was performed in this case. It must be apparent to any one that if there exists a deformity of the pelvis to an extent that will not admit the hand above the pelvic brim, or will not allow the introduction of the second blade of an ordinary obstetric forceps, or a crushing instrument, craniotomy offers no chance for the delivery of the fetus *per vias naturales.* A medical acquaintance, on learning the particulars of this operation, remarked to me that he believed Braun's cranioclast would have been an effective instrument, and its proper use would have saved the patient from abdominal section. I am positive in my belief that this opinion is an erroneous one, as the effective use of the cranioclast, or any other instrument that the ingenuity of man has ever devised for the reduction of an undelivered fetus, was a mechanical impossibility by reason of the pelvic deformity.

In 1877 I published an account of a successful case of Cesarean operation,[1] which was a remarkable one, especially as to the length of time the woman was in labor previous to the section being made. In connection with the

[1] "Report of a Successful Case of Cesarean Section after Seven Days' Labor," etc. *American Journal of Obstetrics*, vol. x, No. 4, October, 1877.

report of this case the comparative merits of the Cesarean operation and craniotomy were briefly discussed. In this paper there occurs the following quotation from another writer: "If craniotomy is practicable, it should undoubtedly be done in preference to the Cesarean operation." At the present time I am not willing to speak as favorably of craniotomy. I believe the Cesarean operation, and certainly laparo-elytrotomy, made on a healthy woman at an early stage of labor, will be more successful than craniotomy, particularly as it is generally done on women exhausted by protracted labor and various attempts at instrumental delivery. In transverse fetal presentation, the long and often fruitless attempts to perform version, when mutilation of the child becomes requisite before it is delivered, jeopardizes the life of the mother as much as the Cesarean operation.

In fact, the latter seems to be far preferable, as it is no more hazardous for the mother, and affords an opportunity for saving the life of the fetus. Laparo-elytrotomy, if practicable, will diminish the risk to maternal life still more.

The question of craniotomy, embryotomy, laparo-elytrotomy, or Cesarean section, in extreme cases of pelvic deformity, can not be determined by any given rule, as each case must be determined by itself. Craniotomy and embryotomy have unquestionably been performed in recent times too often. In these days of such successful abdominal surgery as we know prevails, it is the bounden duty of every one who practices obstetrics to familiarize himself in the *technique* of other obstetrical operations than those which aid in the consummation of labor only by the destruction of fetal life.

When an obstetrician has intrusted to his care a pregnant woman that he knows has a deformed pelvis or any morbid condition that will prevent delivery of an unmutilated child *per vias naturales*, the performance of craniotomy or embryotomy by him can not be justified. Under such circumstances deliberate arrangements can be made for her delivery by laparo-elytrotomy or abdominal section, with good pros-

pects for saving her life, and almost a certainty of delivering the child alive. Under the term of abdominal section referred to I include not the Cesarean operation alone, but its modifications, such as the Porro operation, and the Müller modification of Porro. But the scope of this paper will not permit their full discussion. One of the most interesting and instructive papers bearing upon this class of operations which has been published of late years is one by Dr. E. Richardson, of Philadelphia, in the *American Journal of the Medical Sciences* for January, 1881.[1] This paper illustrates in a marked manner the great advantages for all concerned in deliberately preparing for the operation, and then making it with trained assistants and with the most favorable surroundings. This is the first successful operation of its kind that has been made in the United States.

The great mortality of the Cesarean section has been chiefly due to delay and other causes not strictly inherent in the operation itself.

I believe the last statement expresses the opinion of the majority of those who have given the matter careful thought and investigation. In my paper, previously referred to, similar views were expressed, and some statistics from a paper by Dr. R. P. Harris[2] were quoted to prove the value of timely surgical interference in the Cesarean operation.

Among these statistics is a list of cases operated on during or before the close of the first day of labor, showing "that $73\frac{8}{13}$ per cent. of women and $86\frac{2}{13}$ per cent. of children were saved by operating early." The statistics of Dufeilhay, cited by Lusk, show 81 per cent. of women saved. On Monday, September 21st, while in Philadelphia, Dr. Harris kindly furnished me with the following statistics bearing upon the importance of early operations. It is also a comple list of all the early Cesarean sections made at full term in this country:

[1] This paper is entitled "Cesarean Section with the Removal of Uterus and Ovaries after the Porro-Müller Method," by Elliott Richardson, M. D.

[2] "The Cesarean Operation in the United States," by Robert P. Harris, M. D. *Amer. Jour. of Obstetrics*, November, 1871, and February, 1872.

"Out of 28 Cesarean operations in the United States up to date performed in good season on the first day of labor, there were women saved, 21; women lost, 7; children living, 23; children dead, 5."

The successful case reported by myself, where the woman had been in labor seven days, could not have been a successful one but for one fact, as the length of time she was in labor would of itself seem to be an insuperable obstacle to her recovery. If this case had the common history of protracted labors it could not have been otherwise than unsuccessful, but, fortunately, there were no attempts at her delivery until about two hours before the abdominal section was made. Prior to the operation she was attended solely by women, who simply sat near by, encouraging her with their presence and conversation, while waiting for Nature to complete her work. She had not been subjected to prolonged manipulation by many hands, nor bruised or otherwise injured by any form of obstetrical instrument.

Regarding the case which serves as the text of this brief paper, I firmly believe the woman would have recovered but for the unfortunate accident heretofore related. Dr. Harris informed me that a similar case, followed by the same results, occurred in the practice of Dr. Fisher at Sing Sing, New York.

One of the frequent causes of death after Cesarean section has been in consequence of gaping of the uterine incision and escape of lochia into the peritoneal cavity. Various modes of treating the uterine incision have been suggested, among which are the methods of Sänger, Kehrer, Cohnstein, and others, which were discussed by one of our Fellows[1] in 1883, and to which you are referred.

In conclusion, I desire to present the following propositions:

I. The capabilities of the Cesarean operation are unjustly shown by the general record.

II. The statistics of this operation plainly exhibit the

[1] Dr. Garrigues, in *Amer. Jour. of Obstetrics*, April, 1883, *et seq.*

great mortality following fruitless attempts at delivery, and a recourse to Cesarean section as a *dernier ressort.*

III. The statistics further show that the Cesarean section, when made on the first day of labor, is no more dangerous to the life of the mother than embryotomy, and it does afford an opportunity for delivering the child alive.

IV. The statistics still further show the great advantage of making the Cesarean operation early—i. e., before the woman becomes exhausted.

V. The best results obtained thus far, with few exceptions, having been obtained without any of the improved methods of the present time, we are warranted in reiterating the first proposition, and further adding that the recent improvements in the *technique* of the operation furnish for the future a promise of much better results.

VI. The success of ovariotomy at the present time, owing to the wise precautions of operators and their improved modes of operating, sustain the conclusion that, if the same precautions are instituted and similar modes of operating are carried out in timely Cesarean cases, success will be more common, and the record will show that recoveries following Cesarean operations will be quite as frequent as those which follow other abdominal sections.