Cases of postural treatment in prolapse of the funis / by Robert Dyce.

With the Author's compliments

CASES OF POSTURAL TREATMENT

IN

PROLAPSE OF THE FUNIS.

BY

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CASES OF POSTURAL TREATMENT IN PROLAPSE OF THE FUNIS.

As the two following cases were so eminently successful in this but too fatal complication of labour to the child by this method of treatment, I send them for publication.

The first case was conducted by Dr. Thomas Milne, then a student attending my class in this University, and which most opportunely took place shortly after treating of this method. He reports as follows :—

" Mrs. W., aged 27, second pregnancy; a healthy, rather stout, but well-made woman. When I first saw her she had been in labour for three hours. The membranes had ruptured some time before. The os uteri was fully dilated. The head presented naturally, and was partially through the brim, and hanging in the vagina, and projecting beyond the external parts, was a loop of the funis; it was pulsating feebly, which ceased during every pain. The pains were short, and recurring about every ten or twelve minutes. I endeavoured to push up the cord in the interval of the pain, with the patient lying in the usual obstetric position, but failed; when remembering what you recently, in the course of lectures, had been describing of the success attending the 'postural method' as proposed by Dr. Thomas, of New York, I at once placed the patient on her elbows and knees, with the head and shoulders lower than the pelvis. I now pressed the head of the child a little up, and then steadily endeavoured to push up the cord; it passed away most readily, but during the next pain it came down as before. I again, in the interval of pain, put it up, but the next pain brought it down. The third time I passed my whole hand into the vagina, and carried the cord beyond the head; when the pain came on, I could

only feel it with the tip of my finger, and when the pain left the funis had slipped beyond my reach, and did not again return. The patient was kept in the same position until the child's head was fairly in the cavity of the pelvis and nearly touching the perinæum. I then allowed her to take the usual position, and in about two hours the child was born alive, though rather feeble. Both mother and child have since done well."

The second case of funis presentation was further complicated with placenta prævia.

Mrs. M., during her fifth pregnancy, in the latter months had three several sudden discharges of blood from the vagina—the first time during the night, the second time when dressing in the morning, and the third time also in the morning the day before her confinement; on all occasions the discharge stopped suddenly, and proceeded from no accident or cause on her part. The symptoms were suspicious of placental presentation, but as she wanted a good many weeks from her full time by her own calculation, and more especially as the loss of blood had produced no particular constitutional disturbance, I risked the uncertainty by not making any examination. When summoned on the night of her confinement (twelve hours after the last flooding), I was fully prepared for the announcement that the flooding had returned, but on inquiry I was rejoiced to learn that the waters and not blood had come off—in fact, there was not a stain upon her linen—and that the liquor amnii had been discharged. On now making an examination, I was met by the funis, not merely a loop, but a mass which the hand could scarcely grasp. She had then no pain, but she had had during the evening some weak and distant indications of uterine action. The funis was very tense, and pulsated strongly; the head could be felt through the os, which was open to the size of half-a-crown, and very dilatable. The external parts were also relaxed. I endeavoured to return the funis while she lay on her left side, but as fast as one portion passed up, another came down. Determining to try the "postural method," she was placed on her knees and elbows, the pillows being removed, when, with

the slightest possible pressure, the whole mass of funis passed at once into the uterus. I observed also on this, as on the subsequent attempts, that there was no tenseness of the funis, as if the present position had removed some cause of pressure or obstruction, but when in the ordinary obstetric position the cord was tense and resilient when touched. Finding that on withdrawing my hand prolapse immediately took place, I determined to induce pain, hoping that the descent of the head would prevent its return. I gave her at intervals of ten minutes three several doses of a full teaspoonful of Battley's liquor secalis. Strong pains followed the last dose. The postural treatment was then resumed, and the funis as readily replaced in the interval of pain as before, with the exception of a small knuckle, which seemed adhering near the cervix. The next pain brought it partially down, but on a third attempt, my hand being entirely within the vagina, the funis was passed beyond the head, which was now descending, and retained there with great ease. In another pain it slipped beyond my reach, and gave no further trouble; but still the little knuckle-like portion remained, and which I now discovered to be the placental extremity of the cord and the mass of placenta itself attached closely to the cervix. The patient was now allowed to take the ordinary position, and the child was born in fifteen minutes, strong and healthy.

This plan of treatment was originally proposed by Dr. Gaillard Thomas, of New York, in a paper published in the *New York Medical Journal* for March, 1858, and, although several years have elapsed since that time, the method proposed does not seem either sufficiently known, or, if known, is not appreciated, by the Profession. It seems very clear from the numerous methods proposed to remedy this complication, that no one of them can be depended upon for saving the child, as even in the ablest hands the mortality is fearfully great. Churchill states that the mortality is greater than in any other order of practicable labour, more than half of the children in which the funis was prolapsed being lost. Collins lost 73 out of 97 cases, Clark 49 out of 66. I might extend this catalogue, but the fact is so universally admitted, whatever plan is

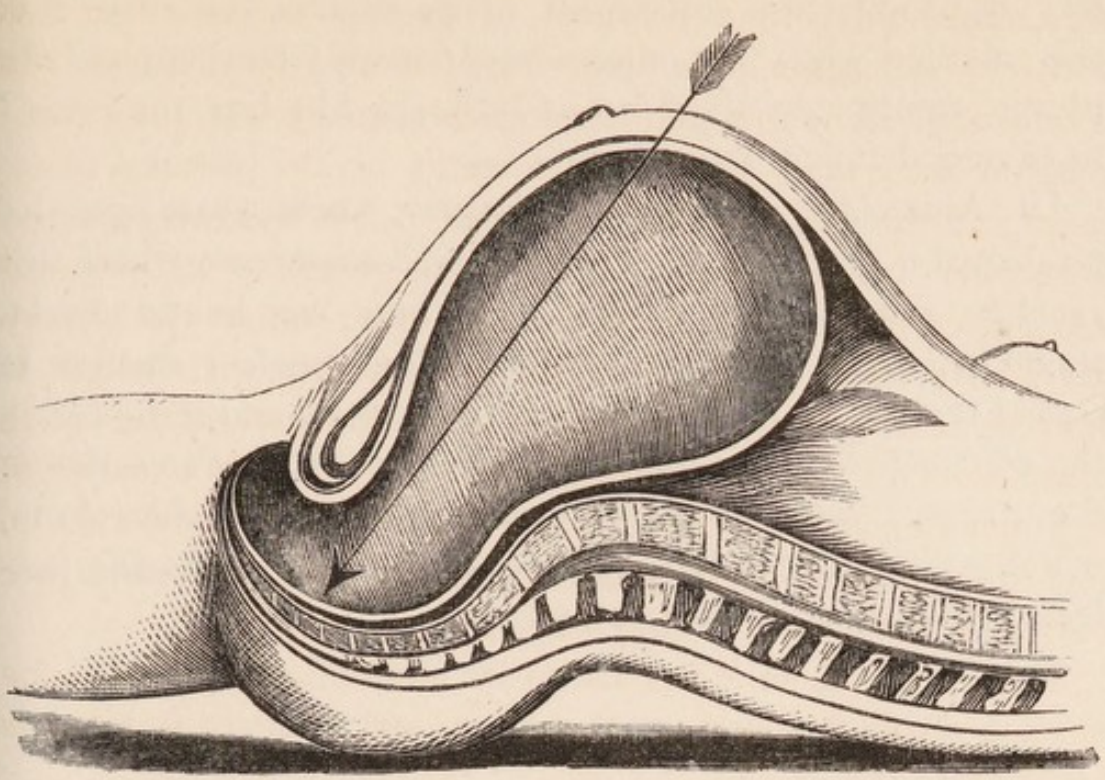
adopted, that it will be unnecessary. Any suggestion, therefore, that holds out a prospect of greater success than has hitherto been attained is deserving of more attention from the Profession. The few published cases scarcely warrant a comparison being made between the result of the postural treatment and the numerous old methods. I feel, however, assured that when it shall come to be more generally known and recognised by the Profession, the rate of mortality will be very materially lessened; besides this, the facility with which it may be accomplished is greatly in its favour, while the entire absence of all danger either to mother or child is a matter of supreme importance. Dr. Thomas's rules are few and simple, and are applicable equally to cases where the membranes are entire as well as where they have been ruptured.

First, if the membranes are entire and the cord detected, he at once places the woman in position, and trusts to this for its return into the uterus, and uses no manual assistance.

Secondly, if the waters have escaped and left the funis below the head, he places the woman in position and pushes it up with the hand, then induces pain either by friction, or better by ergot, and if the presenting part should so occupy the pelvis as to prevent its return by the hand, he uses a gum elastic catheter and tape as a *porte-cordon;* and I would thirdly suggest, from the experience of the two reported cases, that the whole hand should be introduced into the vagina, and if the head interferes push it up and carry the cord beyond the head, having previously induced pain by ergot.

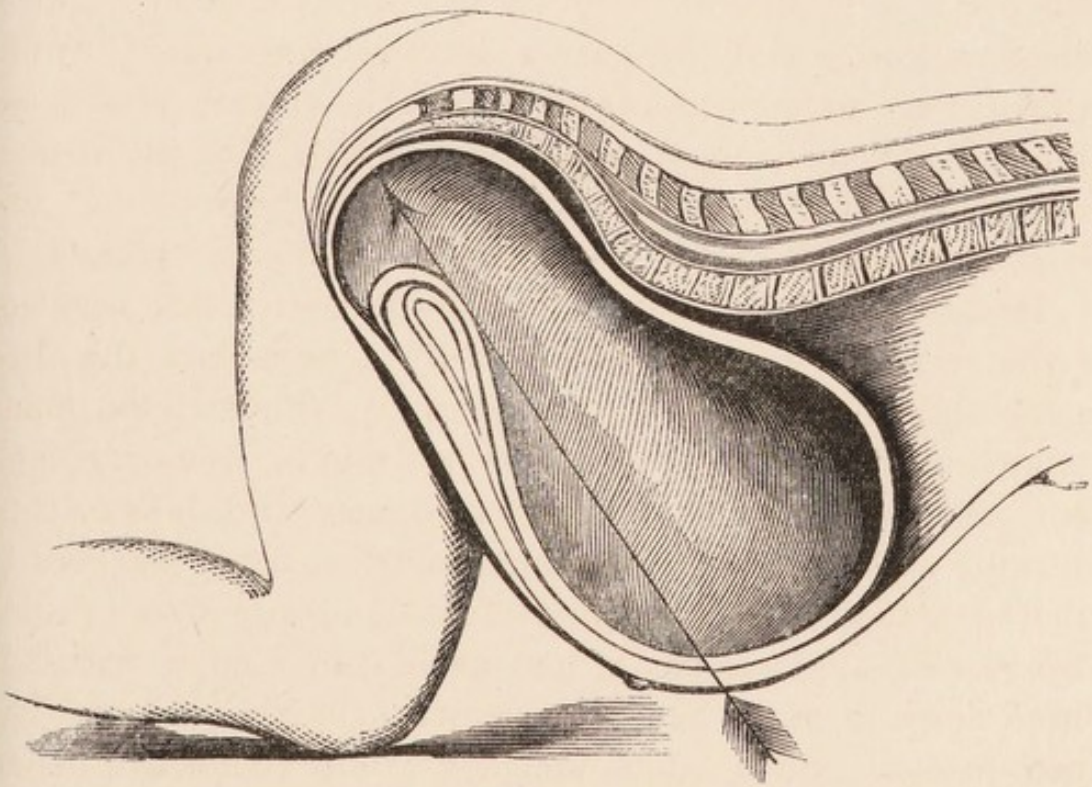
He believes the causes of the persistence of this accident (whatever may have first produced it) to be mainly the slippery nature of the cord, and, secondly, the inclined plane offered by the uterus by which to roll out of its cavity; and his principle of treatment is to invert this plane, thus turning not only this plane, but the lubricity of the cord to our advantage. This he found could be readily accomplished by placing the woman on her knees and elbows with the head down upon the bed, thus inverting the uterine axis. The accompanying plate, which is copied from Dr. Thomas's paper, shows the principle of the practice better than by words.

FIG. 1.



In Fig. 1 the arrow represents the direction of the uterine axis, which is forwards and downwards, the woman being on her back.

FIG. 2.



In Fig. 2 this axis is represented inverted by the change of position.

Another American author, Dr. Brandies, of Louisville, who has published three successful cases, doubts the success of this method when the waters have entirely escaped, and the uterus firmly contracted around the child ; but the cases I have now detailed disprove this.

Dr. Alexander Simpson, of Glasgow, three years ago, also published a very interesting and complicated case where this practice was equally successful. There can be no doubt, therefore, of its practicability as well as perfect success in saving the child's life. Should any difficulty occur in replacing the cord, whether arising from passive or active contraction of the uterus, I would strongly recommend the use of chloroform, which would greatly facilitate the operation by inducing perfect relaxation of the whole uterus.