

A HUNDRED YEARS AGO

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OBSTETRIC MUTILATIONS

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A considerable number of women admitted into the London Hospital as obstetric cases have, to an almost inconceivable extent, a lacerated and bruised lower genital tract, cervix, vagina, and perineum. One would almost infer that the accoucheur had set out to inflict the maximum injury consistent with survival, and been thoroughly successful in his aim. The number of mutilated cases one sees is most disheartening, and constitutes a grave indictment against much of the midwifery of the present time.

Why should there be seen often tragic illustrations of complete lack of judgement on the part of the accoucheur? What strange optimism leads him to practise high risk interventions and to persist long after it is obvious that they are of no avail?

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It is obvious, too, that amongst the poorest classes the septic environment of the patient, the low rate of remuneration of the medical man, together with the incessant calls on his time, all make it doubtful that it is in the national interest that the present system should prevail.

The ideal is not beyond reach. The Infirmary service should be extended to include much more of this class of midwifery in its province than is at present possible. Every such case would be delivered in the local district lying-in ward, and, if normal, sent back, by ambulance, to her home in 24 hours' time. Subsequent attention and visits would be carried out by a nursing staff under the supervision of an obstetrical officer of experience.

Here are two cases to illustrate the calamitous obstetric record.

Case 1: An instance of grave instrumental injury

The patient, a primigravida, was delivered two days before I saw her. The social circumstances were favourable, the surroundings clean, those, in fact, of a small house.

The patient had a temperature of 104°, a pulse of 140, and was lying in a condition resembling the “typhoid state,” gravely intoxicated by septic absorption. The vaginal discharge was intolerably foul; the remains of the labia and the perineum were covered with septic blackish-green sloughs. In addition, the condition of the bladder had escaped notice; an intermittent escape of urine had deceived both medical attendant and the nurse, since about 50 ozs of urine were retained in the bladder, and were drawn off by catheter after the most careful disinfection of the meatus. There were found, in addition to the external injury, two deep tears in the lateral vaginal walls, extending into the paravaginal cellular tissue, and the finger placed in these tears appeared to be practically in contact with the ascending rami of the ischium. The vagina was hurriedly swabbed out with a solution of hydrogen peroxide, and the lacerations plugged to their depths with sterilized gauze to facilitate drainage.

The prognosis I gave was of the gravest, and little hope of the patient's survival was held out. Recovery is rare in this type of case.

The next morning, I had her transferred to the puerperal ward in the isolation block at the London Hospital. The case appeared clinically to be of the severest type of septicaemia, though no streptococcus was actually recovered from her blood. The gauze drainage was reapplied daily for the first four days under anaesthesia, and local disinfection carried out with hydrogen peroxide. The patient was out of danger in ten days. Her recovery owes itself largely to the admirable nursing that characterizes the work in this septic puerperal ward. The patient left the hospital after seven weeks in bed. The sole evidence of her injuries lay in a slight stenosis of the vaginal orifice, which must be kept under observation lest a greater degree of contraction ensue.

Case 2: An East End labour

The patient was an enormously stout Jewess: vaginal examination was difficult. She was admitted following craniotomy for a very slight degree of pelvic contraction. The vulvo-perineal area was severely bruised and lacerated; the sphincter ani was exposed at the posterior margin of the tear.

No attempt was made at immediate repair, for such attempts can hardly ever be successful when carried out on bruised and sloughing tissues. Three days after delivery, large sloughs were detached from the vaginal wall, and heralded the establishment of a large vesico-vaginal fistula; the whole of the floor of the bladder seemed to have disappeared. Local disinfection remained the only treatment that could be carried out till the maximum healing had taken place. The vagina was irrigated three times daily with a hypertonic saline solution.

I did not examine the patient again till three weeks had elapsed, and the parts were approximately healed; under anaesthesia, the vagina now admitted barely one finger, and had contracted down to a cul-de-sac about 1.5 ins in length, and a narrow channel at the top led direct to the bladder. The scar tissue was extremely dense; approach to the bladder from below was practically out of the question.

I proposed later to approach the bladder from above, and, failing exposure of the fistulous track, to turn the ureters into the large bowel. The patient and her relatives were averse to this operation, and she left the hospital with a permanent fistula and an obliterated vagina. The details of the labour point to the fact that impaction of the head in the pelvis for many hours played as large a part in the causation of the fistula as the subsequent craniotomy; but, in any case, the final result has been the unsexing of the patient.

What is the moral to be learnt from this? Simply this: that a combination of lack of experience and judgement, lack of adequate time to devote to a midwifery case, and a mistaken sense of pride in refusing to take advantage of skilled advice which is nowhere remote in the London area, still renders some of our metropolitan midwifery a blot on the reputation of modern obstetrics.

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