Common Pitfalls in Obstetric Practice

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It is a well known fact that many obstetric procedures are controversial and that an obsetrician can achieve equally good results by adopting either of two seemingly diametrically opposite methods of treatment. The reason for this happy ending is that in some instances the processes of pregnancy and labour, like most biological problems, still belong to the realm of mystery. More often, however, Nature takes matters into her hands and repairs or mitigates the damage done by the obstetrician. Unfortunately Mother Nature has her limitations. It is my intention to point out some of the conditions in which the obstetrician can evoke the services of nature as an ally and not as an enemy.

Some of the errors mentioned are of little consequence but others may make all the difference between the life and death of the patient.

PREGNANCY.

1. Omitting the periodic examination of the Blood Pressure.

The importance of having the blood pressure tested is not known to most pregnant women in Malta. Antenatal care is mostly in the hands of midwives and consists mainly in a periodical examination of urine for albumen and glucose. Of the three cardinal signs of pre-eclamptic toxaemia, albuminuria is the last to appear and that is because the albuminuria is brought about by spasm of the afferent arterioles of the glomeruli which is liable to occur when the blood pressure reaches 160mm. of mercury systolic. Toxaemia occupies one of the first places as a cause of maternal death and is responsible for a high percentage of foetal wastage.

2. Relying on external pelvimetry as a means of assessing disproportion.

Except for the diagnosis of gross disproportion, external measurements are worse than useless because they are often misleading. Quite frequently the external measurements are normal and yet the dimensions of the true pelvis are below the average. I have now stopped teaching my students the technique of external pelvimetry. What is really useful is internal pelvimetry; this gives information as to the type and shape of the true pelvis, as to whether the sacral promontory can be easily reached and above all as to whether there is disproportion between the foetal head and brim (Essen Moller's manoeuvre). The aphorism: "The best pelvimeter is the foetal head" is as true today as when Freeland Barbour first said it. If Essen-Moller's manoeuvre proves difficult or inconclusive, the patient should be referred for X-Ray pelvimetry.

3. Failure to correct a breech presentation before the 36th. week.

External version in breech presentation has not received its due attention. The foetal mortality rate attached to this operation does not exceed 2%, whereas the foetal and neonatal mortality rate attributable to a breech delivery is in the neighbourhood of 15 - 20%.

The first attempt at correction should be made at 30 weeks and repeated, if need be, each subsequent week. External version is naturally more difficult the nearer the pregnancy advances towards term.

4. Performing a vaginal examination in cases of APH destined to be sent to hospital.

A vaginal examination would only excite further bleeding should the placenta be praevia, owing to the increased detach-

ment of the placenta which such an examination entails. Moreover, the first haemorrhage of placenta praevia is usually slight — a 'warning haemorrhage', demanding the immediate removal of the patient to hospital. If this danger signal is not heeded, a second and more severe bleeding will sooner or later occur, making the journey to hospital more perilous.

5. Sending a case of Eclampsia to hospital without giving her morphia.

In this connection, in removing such a patient the doctor himself should accompany her, duly equipped with chloroform, Schimmelbusch mask, a mouth gag and an airway, in case an eclamptic fit occurs in transit.

6. Packing the vagina in cases of Abortion or APH.

In order to be effective packing should be done under anaesthesia. Placing a few tampons in the vagina does not arrest the bleeding, but would only pave the way for sepsis. Those who are in favour of such packing argue that the insertion of a few tampons gives the relations of the patient an assurance that something is being done for her. However ignorant the lay people are, they can be certainly persuaded that the correct method of treatment is not to tamper with the vagina.

7. Failure to inject ergometrine in cases of inevitable abortion or retained placenta before removal to hospital.

Ergometrine 0.5 mg. injected intramuscularly exercises its effect on the uterus after a lapse of 5 to 10 minutes; if a firm Crede is performed immediately after this time, a retained placenta may be expelled. Failing this, no harm will have resulted from the administration of ergometrine; on the contrary, the spasm it will have induced in the uterus would check the bleeding for about an hour; in other words it would give sufficient time for the obstetrician to send his patient to hospital with comparative safety.

8. Omitting to ban coitus in the event of an early pregnancy in cases showing a history of repeated abortions.

LABOUR.

FIRST STAGE OF LABOUR.

1. Leaving out the administration of an enema.

2. Allowing distension of the bladder.

A full bladder interferes with the neuromuscular coordination of the uterus besides rendering the patient uncomfortable.

3. Ignoring the general condition of the patient.

The temperature and pulse rate should be taken at regular intervals. Increasing pallor of the face and accelleration of the pulse rate may be the only striking indication that a concealed accidental haemorrhage is in progress. One of the causes of foetal death during this stage is infection; in a long and tedious labour, when the membranes rupture early, the administration of Penicillin to the mother may result in foetal salvage.

4. Not giving the patient sufficient nourishment or overfeeding her.

In the former case acidosis may develop increasing the risk of anaesthesia should this become necessary; moreover a starved patient does not have the requisite energy to stand up to the ordeal of labour. A full stomach may on the other hand conduce to inhalation pneumonia should this patient need an anaesthetic. It is important to remember that the food should be easily digestible and assimilated for during labour the functions of digestion and assimilation are extremely sluggish.

5. Withholding the use of Pethidine and/or of Trilene.

There is no need for me to labour this point as many women are solving the problem themselves by demanding some form of analgesia.

6. Letting the patient bear down.

This would only lead to exhaustion and the subsequent development of prolapse of the uterus.

7. Making futile attempts to deliver with forceps.

There is no telling the extent of damage that may be caused by this. Suffice it to say that the maternal mortality rate is 10% and the foetal mortality rate 40% in cases of failed forceps. Now one of the commonest causes of failed forceps is an undilated cervix. Forcible dilatation of the cervix by forceps results in shock of varying degrees of severity; lacerations may be very extensive; post-partum haemorrhage is the rule and the woman is left with a legacy of a tendency to prolapse; in addition, the foetal head is apt to suffer irreparable damage. The correct method of treatment in cases demanding urgent delivery in the presence of an insufficiently dilated cervix is to carry out Duhrssen's incisions or else to perform Caesarean section, according to the circumstances of each individual case.

8. Failure to institute first aid measures in cases of prolapse of the cord.

The simplest of these is the adoption of the Trendelenburg position. Many babies can be saved by this means. This position should be maintained during the time when preparations are being made for delivery. During the time of induction of anaesthesia this method by itself may not be adequate; so it is necessary that during this interval the doctor or midwife should push up the presenting part in order to prevent it from pressing the cord against the brim.

9. Failure to ascertain the position of the chin i.e. whether anterior or posterior, in face presentation.

When the chin is anterior, delivery is not only possible but sometimes surprisingly easy. On the contrary, a face lying with the chin posterior cannot be born as such. In this case, one of the methods of treatment is internal version. Internal version in face presentation is fraught with much danger to the mother; if it has to be done, it must be done early or not at all; in other words, the head must not be allowed to become impacted in the pelvis, in which case if version is resorted to there is great likelihood of rupture of the uterus.

SECOND STAGE OF LABOUR.

1. Failure to auscultate the foetal heart in order to detect early signs of distress.

Routine listening to the foetal heart during labour is far from sufficiently practised. The reason for this neglect is not clear. Is it because the idea still prevails that the life of the mother is the all-important consideration and that therefore both doctor and midwife focus all their attention on the mother? In modern times extremely few mothers should die at child-birth and very few babies should be lost.

When the foetus dies, it does not die instantly but it shows signs of distress long before. A timely application of forceps would result in many babies being saved.

During the first stage, the foetal heart should be auscultated every 30 minutes and during the second stage every 5 minutes at least.

2. Ironing the perineum and/or kneading the uterus, with the erroneous view that labour may thus be hastened.

Ironing the perineum should be reserved for dilating the ostium vaginae in order to obviate or minimise an extensive tear. If it is employed for the purpose of exciting a uterine contraction, one would only exhaust the patient, as the contractions that are produced thereby are usually ineffective. The same may be said of the widespread custom of kneading the uterus. It

should be remembered that uterine action is under the control of a neuro-muscular mechanism which is so delicate as to be easily deranged by the stimulation of kneading.

3. Unnecessary traction on the foetal head.

As soon as the foetal head is born, it is a much too common practice to pull on the head, with the mistaken view that the foetus might choke to death unless the remaining part of the delivery is not speeded up. Once the mouth is free the foetus will be able to breathe even though the trunk is still in the birth canal. After the head is born the correct attitude of the attendant should be to wait for the next pain, when the shoulders would come out; namely by downward pressure of the uterine muscle itself. Traction from below may result in Erb's palsy. That is why cases of Erb's palsy are so common in Malta. If speed is essential, traction on the head should be exerted only after making sure that the anterior shoulder is not impinging on the symphysis pubis. An attempt should first be made to bring the shoulders in the transverse diameter of the brim; if this does not succeed, pressure should be applied suprapubically in the hope that the anterior shoulder is dislodged.

4. Not holding the baby by the feet immediately after extraction.

In some cases the inhalation of liquor or blood may set up an inflammation in the lungs which might prove fatal.

5. Not taking into account the general condition of the patient prior to undertaking Obstetric Operations.

Quite often a patient has to be rescuscitated before she is able to withstand the strain of an obstetric operation. Thus it comes about that after the performance of an 'easy' version or forceps operation, the patient drifts into deep shock from which she may not recover.

6. Withholding the use of anaesthesia in operative procedures.

This custom is still widely followed. No wonder most women in labour are terrified at the very sight of the doctor. Others are delighted with his presence only in so far as he would employ anaesthesia. Besides the amount of pain that operative procedures entail, there is greater danger of causing damage to the mother and/or child when anaesthesia is not employed. To those who entertain the idea of performing version on the non-anaesthetised patient, I would only say that they should re-read the oath of Hippocrates.

7. Standard application of forceps irrespective of the position of the occiput.

Certain doctors adopt the procedure that if the forceps lock, all is well and good. Surely, this attitude is most unscientific, to say the least. The rational method is to ensure a cephalic application of the forceps. This, of course, presupposes a correct diagnosis which in cases of doubt can always be reached if the operator introduces his half-hand in the vagina — a thing which is not difficult to do provided the patient is anaesthetised. The principle underlying the advisability of a cephalic application of the forceps is that the base of the skull is the least compressible part of the foetal head, and that therefore tentorial tears are less likely to be induced. It is only by this means that one can minimise the incidence of intracranial haemorrhage with the disastrous consequences that follow in its trail.

8. In breech deliveries failure to have a pair of forceps ready or failure to administer anaesthesia in nervous patients.

These omissions are responsible for a great many foetal deaths. On occasion the Mauriceau-Smellie-Veit manoeuvre fails

and forceps will have to be applied if the baby is to be saved. In this connection, it is better that the patient is not anaesthetised at all rather than that she should be only half anaesthetised.

THIRD STAGE OF LABOUR.

1. Failure to empty the bladder.

As was said before a full bladder interferes with the function of the neuromuscular mechanism of the uterus. In addition, pressure on it causes pain. This is one of the reasons why Crede's method of expressing the placenta may not succeed.

2. Withholding the use of ergometrine and pitocin.

3. Not having an intra-uterine douche handy.

A hot douche is one of the most efficient ways of arresting post-partum haemorrhage. The Temperature should be 118-120 degrees. A lower temperature would excite more bleeding whereas a higher one would bring about scalding of the vulva and thighs.

4. Inadequate suturing.

There is a widespread belief among the laity that two, three or at most four stitches would be needed for the repair of the perineum. This belief is perpetuated by doctors who make it a habit not to exceed this number of stitches whenever they have to repair any perineum. These doctors 'get away with it' because the effect of inadequate suturing is not at once apparent. The perineum should be repaired in layers, i.e. vaginal wall, levatores and skin. Incidentally I have found mattress suturing of the skin most effective as the edges are brought into accurate opposition.

POST-NATAL EXAMINATION.

This is very often omitted altogether here in Malta. Not infrequently, parturition incapacitates the woman in all her activities except in that of child-bearing. There are circumstances when a subsequent pregnancy might be risky or might result in the death of the patient. It is the midwife or doctor who should guide her in this respect.

Another obvious advantage of a post-natal examination is that the defects which are the result of pregnancy and parturition can be stemmed at their origin, before they have time to assume greater proportions.

CONCLUSION:

Some of the statements mentioned in the above discussion may sound harsh or unwarranted. I may assure my readers that they were made in a vein of constructive criticism.