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The Immediate Application of Forceps  
to the After-Coming Head in Cases  
of Version with Partial Dilata-  
tion of the Cervix

BY

H. C. COE, M.D., M.R.C.S.  
NEW YORK

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## THE IMMEDIATE APPLICATION OF FORCEPS TO THE AFTER-COMING HEAD IN CASES OF VERSION WITH PARTIAL DILATATION OF THE CERVIX.<sup>1</sup>

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It is not my purpose to enter into a discussion of either the advisability of extracting the child immediately after version, or the best method of manual extraction to be practised in ordinary cases. I limit myself entirely to cases in which the os is just sufficiently dilated to admit the introduction of the hand and the performance of version, the soft parts being more or less rigid, and in which the life of the child is imperilled by even a slight delay in the extraction of the head. There is considerable difference of opinion among writers on obstetrics regarding the application of the forceps to the after-coming head under these circumstances, so that it is with much satisfaction that I find my opinion on the subject supported by such an authority as Lusk, who affirms that "where the arrest of the head is due to stricture of the os externum or internum, the forceps will sometimes bring the head rapidly through the cervix when traction upon the feet only serves to drag the uterus to the vulva" ("Science and Art of Midwifery," p. 366). Barnes ("Obstetric Operations," p. 67) teaches essentially the same. Busch and later English writers attribute their low infant mortality after version to the prompt use of the forceps. Whether this is true or not, I regard it as a matter of regret that the application of the forceps to the after-coming head has become a comparatively rare ob-

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<sup>1</sup> A paper read before the New York Academy of Medicine (Section in Obstetrics and Gynecology), December 27, 1888.

stetric operation. I never saw it practised in the Vienna clinics, probably because the conditions happened to be such as to render it unnecessary. The following unsuccessful cases will serve to illustrate the point which I wish to make :

CASE I.—(Seen with Dr. J. B. Hunter.) Primipara, aged thirty-five. Moderate contraction of pelvis antero-posteriorly, with rigidity of soft parts; albuminuria and œdema of face and ankles; severe headache, eclampsia imminent; so that labor was induced within two weeks of term. Cervix dilated with Barnes's bags, version, and immediate extraction, as the foetal heart was rapid and irregular, and a living child was most earnestly desired. The head (which was large) was encircled by the non-dilated cervix and could not be extracted; the cord had stopped pulsating, when the forceps were applied. The head was delivered in a few seconds, the perineum being torn through the sphincter. I worked over the child for an hour, but could not resuscitate it. The mother made a good recovery, the perineal wound healing with a primary continuous suture.

CASE II.—(Seen with Dr. J. L. Morrill.) Multipara, aged thirty-five. She had borne two or three dead children, all of whom were delivered by high forceps, there being a moderate contraction of the conjugate. The pains were ineffectual, and after several hours the head remained movable above the brim, the cervix being partially dilated. Version was performed, but the head was grasped by the cervix; after prolonged efforts had been made at manual extraction the forceps were applied and the head was easily delivered, but the child was dead.

CASE III. (Infant Asylum.)—Primipara, aged sixteen years and eight months. Suppression of menses at fifteen, and they did not appear again before pregnancy.

March 21st.—Urine examined on account of œdema of lower extremities, and found to contain fifty per cent. of albumin. Under treatment the œdema disappeared, and the amount of albumin diminished two-thirds.

March 27th, 3 A.M. The patient was suddenly attacked with convulsions, which recurred at frequent intervals and were unusually severe. The resident physician, Dr. Davis (who conducted the case throughout with excellent judgment), at once administered an anæsthetic and introduced water-bags, so that I was able to turn at 6 A.M. The after-coming head was tightly grasped by the cervix, and time was thus lost in attempts at manual extraction. It was easily delivered with forceps, but the child could not be revived. The perineum was torn partially through the sphincter, in fact, it was lacerated at the outset by the introduction of my hand. It was sutured with silver, and the patient had good retentive power at the end of six months. She had two convulsions after delivery, became comatose, had complete suppression of urine, and developed general œdema of the lungs. Under the use of pilocarpine, dry cupping, and diuretics she recovered; the albumin disappeared in a day or two, and on the twelfth day after delivery she sat up.

CASE IV. (Infant Asylum.)—Sextipara, aged thirty-eight. Pelvis normal. Confinement expected the latter part of April.

June 1st.—There was a sudden great increase in the amount of liquor amnii; cause unknown. Her health deteriorated rapidly; the heart-action was at times alarming, and on June 13th labor was induced.

June 14th.—The cervix was partially dilated with water-bags, after she had had slight pains for upward of twelve hours. Membranes ruptured; head large and would not engage. Uterus atonic by reason of over-stretching from hydramnios; the water escaped slowly.

June 15th.—Constant pain in abdomen, but uterine contractions feeble, and patient exhausted, with tumultuous heart action. Head freely movable above the brim; foetal heart rapid and irregular. Version was easily performed at 7 P.M. The head was arrested at the brim, being firmly grasped by the cervix. Several minutes were wasted in futile attempts to extract it. The forceps were

then applied, after the pulsation in the cord had stopped, and the head was delivered with some difficulty. The perineum was only slightly torn, but the patient had enormous hemorrhoids, which ruptured and gave rise to sharp hemorrhage, requiring the application of artery-forceps. Weight of child, eight pounds and three ounces. Head large and incompressible, the posterior fontanelle being closed. The child was resuscitated after a long struggle, but died in convulsions seven hours later. Autopsy showed extreme cerebral congestion. The mother recovered slowly, after presenting alarming heart-symptoms, and a general subnormal temperature, except on the fifth day when it rose to  $102^{\circ}$  F. without appreciable cause, but fell at once. She had in all probability a fatty and dilated heart. [I am indebted to Dr. Davis for notes of the last two cases, which occurred in my service at the Infant Asylum.]

In citing these examples of unsuccessful extraction I need only add, in order that the difficulties may be assumed as real; and not apparent, that the operator possessed a fair amount of experience in this class of cases, and that he was in each instance assisted by skilled physicians and nurses, so that all the elements of success were present. The obstacle to delivery was the same in every case, *i.e.*, the head was grasped by the rigid, partially dilated cervix in such a manner that traction upon the trunk simply dragged the uterus down to the vulva without liberating the head at all; moreover, it was impossible to introduce a finger into the child's mouth. Pressure upon the fundus uteri simply forced the organ downward, but did not advance the imprisoned head. Of course the large size and premature closure of the foetal head in one of the cases reported, and the narrowing of the anterior conjugate in another would partly account for the arrest at the brim, but these factors do not concern me now. I wish to invite discussion on the single topic which I proposed. I believe that in each of the four cases cited the child would have been saved if the forceps had been applied just as soon as I had dis-

covered why the head did not escape. The application of the forceps to the after-coming head is quite easy if the child's trunk is strongly extended, and the entire operation usually occupies only two or three minutes. Of course there is considerable risk of lacerating the cervix and perineum by delivering so rapidly; but what is that when a living child is obtained which would otherwise have been sacrificed when on the threshold of safety? Those of us who are attached to lying-in hospitals, and are constantly striving to keep our maternal mortality at the lowest possible figure, are apt to attach comparatively slight importance to the survival of the child. In private practice, however, we must view the matter in an entirely different light. It often happens that we are consulted by an old primipara, who has been led to believe that she cannot have a living child, or by a multipara who has borne several dead ones. Such women are extremely anxious that the infant should be saved at all hazards, and will make light of severe lesions if we are successful in obtaining their wish. I feel that some apology is necessary for introducing such an old theme, but since writing the above my attention has been directed to a short, but suggestive, paper by Dr. P. M. Schiedt, of Philadelphia, on "The Treatment of the After-coming Head" (*American Journal of Obstetrics*, March, 1888). The writer holds even stronger views than those which I have outlined, and his arguments and statistics are quite convincing. Among other indications for the use of forceps in this connection he mentions that which I have discussed. I quote from his concluding sentences: "The most vigorous supporters of the manual method declare that it requires from five to six minutes to extract the child's head, while Freudenberg and others say that the forceps should be applied and the head extracted in from two to three minutes. It is manifest that the difference in time, at a moment so critical, will result in the saving of many children. Time is the great factor, and by the forceps time is saved."





