Practical Obstetric Problems

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PREFACE TO THIRD EDITION

THE task of preparing this edition, as compared with the last, has grown. In roughly the same period of time between editions more has happened and attitudes are changing. To anyone who has the responsibility of keeping a textbook up to date and in line with his own practice and teaching and that of his colleagues it must be apparent that the rate of progress in obstetrics is taking another surge forward just as it did in the years following the last war. An attempt has been made in these pages not only to add new facts but to explore critically new outlooks and ideas.

As authors and teachers we may have mixed feelings about the place of textbooks in postgraduate education, but at least they fly the flag of our philosophy. In my own case it has taken the better part of a clinical lifetime to rid my intellectual system of its conservative upbringing. Too long tradition has overshadowed, for example, the management of the third stage and the puerperium and has put a heavy-handed brake upon the wider use of operative methods of delivery, more often in the name of inflexible routine than humanity.

The last vestiges of that line of alleged thought which regarded the baby as expendable, particularly when apparently in conflict with the mother's interests, have practically disappeared and the genuine medical need to terminate a pregnancy must now be rare indeed for it is the very negation of the obstetrician's art and skill.

In place of maternal mortality, perinatal mortality has now become the yardstick by which we review our work. This is at least a sound beginning which acknowledges our custodianship of the baby's future, but only lately have we become increasingly mindful of the tragedy of the handicapped child and the obstetrician's part in preventing it. The indiscriminate abandon with which drugs were often prescribed in pregnancy received a jolt with the thalidomide disaster and we are now awake to the vulnerability of the unborn child. We have modified our fatalistic attitude towards fœtal abnormality and intra-uterine health and development will undoubtedly come to occupy a more important place in the obstetrics of the future.

The accidents of early pregnancy now seem more important than ever and the whole varied subject of abortion, once so callously brushed aside by the old teaching hospitals, has developed a new interest and significance. In the last edition I forebore to give any account of ultrasonography (sonar) on the grounds that it was an

experimental technique, but we have travelled too far along this road now to ignore it any longer and we believe that it will presently find its place amongst standard hospital diagnostic procedures. As a means of diagnosing hydatidiform mole or confirming the presence of fœtal parts long before radiology is of any help it has involved me and Dr. John MacVicar in at least a weekly diagnostic session for cases referred from surrounding hospitals. We have established it as a method of measuring the growing fœtal head *in utero* and Dr. James Willocks in my Department has undertaken a special study of this application.

Last time I funked an account of gross obesity as a complication of pregnancy, mainly because of the rather scanty literature on the subject and not for want of a well-founded personal dislike of its significance, a point of view shared by most clinicians. I have now sought to fill the gap.

The detection and correction of anæmia is amongst the greatest of all antenatal services and much has been added to the account of megaloblastic anæmia although it will be a long time before the last word has been said on this fascinating condition. From overseas comes the drama of partial exchange transfusion for the horrifying degrees of anæmia encountered in underdeveloped countries. In fact, any hope of improving maternal health throughout the world must surely start with "blood health".

The account of jaundice has been considerably enlarged and the action of viruses in pregnancy has been more fully evaluated. I am grateful to my colleague, Dr. Wallace Barr, for continuing his contribution on vomiting, much of which he has rewritten. He has further emphasised the possibly ominous significance of vomiting in late pregnancy.

The chapter on toxæmia has been almost entirely rewritten by Professor Harvey Carey in the midst of moving to his new Chair at the University of New South Wales. To have accomplished a feat of such erudition under these distracting circumstances has reminded me of the intellectual stamina which I learned to appreciate in him when we were together at Hammersmith Hospital.

Urinary infections have ceased to be a matter of potassium citrate and a few days of sulphonamide treatment. Their importance in relation to chronic pyelonephritis as sources of subsequent ill-health, of anæmia and unsuccessful pregnancy has so grown in our view that one of my staff, Dr. Iain McFadyen, is devoting the greater part of his research activities to the subject.

My colleague of former St. Thomas's Hospital days, Mr. Gordon Garland, has kindly revised his chapters and I am proud and happy to maintain this link with my old hospital in the pages of this book. The tendency of the case of unstable lie to go postmature is now

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recognised together with the bad fœtal prognosis which is by no means necessarily related to placenta prævia as a cause.

My radiological colleague, Dr. Ellis Barnett, who joined our staff here some years ago from Hammersmith, has increased his contribution in the form of an account of placental localisation by radiography. I am also grateful to him for his revised section on pelvimetry and the illustrations which he has contributed on both subjects.

The chapter on antepartum hæmorrhage probably cost me more effort than any other because of our rapidly expanding knowledge and changing viewpoints. The importance of the supine hypotensive syndrome in abruptio placentæ is now recognised and in the pathological bleeding states which may complicate this condition the role of abnormal fibrinolysis is reviewed in the light of our present incomplete knowledge.

I still remain critical of the indiscriminate use of the oxytocin drip and even more aware than ever of its contra-indications and hazards. We are still a long way from "elective delivery".

I have accepted with regret the offer of Dr. Hilda Roberts to withdraw from revising her contribution on Pain Relief in Labour since her clinical practice in Canada has moved further away from obstetrical anæsthesia and analgesia. I have therefore incorporated the subject of pain relief into an enlarged chapter on prolonged labour and the subject of anæsthesia into the chapter on forceps delivery.

We now recognise, even more acutely than before, the hazards of delayed labour in breech presentation and in multiparæ. In such cases Cæsarean section is no admission of defeat; it is, in many instances, only a sensible alternative to fœtal death.

In operative obstetrics the introduction of the Ventouse into British obstetrics and its increasing acceptance is a major development. The prejudice which, in some quarters, still greets this continental idea persists mainly amongst those who have the least personal experience of this delightful instrument. Needless to say it receives enthusiastic treatment in this book since we have used it extensively, although we cannot claim to convert a difficult forceps delivery into an easy vacuum extraction. We likewise have a growing preference for the transvaginal route for introducing pudendal nerve block anæsthesia.

The subject of resuscitation of the newborn has been thoroughly shaken up with the debunking of intragastric oxygen as a treatment for the asphyxiated baby. Hypothermia and cardiac massage are described but have hardly found their way into routine practice as yet, but hyperbaric oxygen treatment in a pressure caisson has, in recent months, shown itself so successful in Glasgow in resuscitating

the newborn that we are likely to hear very much more in the future of this simple and atraumatic approach to a very old and desperate problem.

Delivery of the placenta by cord traction is becoming steadily more fashionable as is also a more active attitude towards the third stage of labour where it is clear that Nature often lets us down and masterly inactivity is only acceptable if coupled with really high-grade intelligence, an unusual combination. Our greater readiness to intervene in the third stage has considerably reduced the amount of blood we have had to transfuse in meeting its complications. Nevertheless, I have included some notes and practical hints on blood transfusion. Dr. James McGarry of my Department has pointed out, to my surprise, that blood transfusion after postpartum hæmorrhage following vaginal delivery is now indicated only slightly more often than after Cæsarean section, a striking change. While on the subject of Cæsarean section I might mention that we, in this unit, are all converted to the use of the Pfannenstiel incision.

Cæsarean section is now accepted as a treatment for incipient sepsis in dilatory labour, such is the modern confidence in our ability to combat the risk of peritonitis not only by antibiotics but, even more important, by electrolyte control with intravenous infusion and continuous naso-duodenal suction. I now preach to my residents that all deaths from peritonitis are the result of inadequate care, an overstatement perhaps but a challenge nonetheless.

I was very sorry to receive the request of Dr. William Hayes to drop out. His chapter on the misuse of the antibiotics was a really brilliant part of the last edition, but he has withdrawn from clinical bacteriology into the intellectual fastnesses of microbial genetics. In the place of his previous chapter I am delighted to welcome two young contributors from the Department of Bacteriology here, namely, Dr. J. M. Stark and Dr. T. A. McAllister who have produced a truly worthy successor to Dr. Hayes' chapter on the subject of Rational Chemotherapy. Their coverage must surely provide the practical clinician with everything he wants to know on the subject and more besides.

The fog which has, for so long, surrounded postmaturity has not yet cleared although we continue vaguely uneasy about the possibility of placental insufficiency. Vaginal cytology, enzyme studies, œstriol excretion rates and ultrasonic biparietal cephalometry are all being invoked to give some indication that the baby may be outgrowing its placenta but I can give the reader no clear-cut answer as yet.

Our understanding of kernicterus is now very much wider and its role as a complication of prematurity, quite apart from Rh iso-immunisation, is more fully discussed. At last exchange transfusion has become an accepted method of treatment.

To one who has spent much of his research life trying to grapple with the problem of hyaline membrane disease and the respiratory distress syndrome of the newborn the new therapeutic attack, in the form of the biochemical control of the associated respiratory and metabolic acidosis, has brought a real ray of hope in this remorseless condition which still contributes so much to our neonatal death rate.

These are a few of the matters which have been woven into the text which follows. Although I have tried to prune it as far as possible the book has inevitably grown in size, for which I must apologise. My main apology, however, is owed for being more than a year late in completing the preparation of this edition. It is more months than I like to think of since the last copy of the previous edition, after several reprintings, disappeared from the bookshops. I have to confess that I yielded to the temptation of availing myself of the excuse of having had to undergo mitral valvotomy. The experience shook me, of course, but not enough to prevent me from delivering a paper to the Royal Society of Medicine five weeks after the operation and while still an in-patient in the Western Infirmary, Glasgow. My failure to get down to the job as a convalescent task was due, not to physical disability but to downright disinclination and preoccupation with other exciting matters, like commissioning the new Queen Mother's Hospital, which is now on the point of going into action. I owe Mr. Douglas Luke, my publisher, a particular debt of gratitude for his great forebearance with my dilatoriness and for the continuing and scrupulous care with which he has ferreted out all my textual mistakes.

To my loyal and never-failing secretary, Miss Adèle Ure, I owe special thanks. Within a few hours of composition my sentences appear in immaculate typescript, are corrected and typed again, often in the same day. To be blessed with such a secretary is to double one's productivity.

I am grateful for the many letters I have received from all over the world with suggestions and helpful criticisms, most of which I have used in this revision, but, above all, I stand humbly in the debt of my junior colleagues, one of whose functions is continually to instruct me and to save me from the abyss of seniority.

Glasgow,
November 1963

IAN DONALD

PREFACE TO FIRST EDITION

THE art of teaching is the art of sharing enthusiasm. The teacher must, therefore, love what he teaches if he is not to become "as a tinkling cymbal". If, then, exuberance occasionally bubbles through the pages of this book, I know that my past students will understand, and I ask no forgiveness.

I have often wondered what drives men to write a textbook. In my case it was the persuasiveness of my publisher. He felt, and of course he is right, that there was a place for a book of a practical sort which would appeal to the clinician who lives in the rough and tumble of it all, as well as to aspirants for additional diplomas in the subject.

We agreed upon a strategic size, and therefore, we hope, upon a palatable price, but apart from that I was given a completely free hand. I gladly accepted the excuse to omit the inevitable dreary irrelevance of such matters as ovulation, menstruation, conception, infertility, diagnosis of pregnancy and the early development of the ovum, which can be found in most textbooks of midwifery, making them heavy upon the knee as well as upon the mental digestion of the reader. Having got rid of this burden, I found myself free to get down to the real business of midwifery. In doing so I may or may not have pleased my public (if any) but I certainly pleased myself. The would-be pianist does not struggle through his Beethoven because of the imagined needs of a hypothetical audience. His efforts are owed to the Master. It is in this spirit that I have written, and I can only hope that some will find it infectious.

The task of nearly two years has been made pleasurable by all the willing and at times argumentative help I have had from colleagues and friends, above all, Gordon Garland, who has scrutinised every sentence I have written and at times supplied sobering criticism. I owe much to his encouragement, though it would not be fair to hold him in any way responsible for my statements. In addition to writing two chapters on the malpresentations he has read the proofs and has provided many of the illustrations. The toxæmias of pregnancy are not easy to deal with in a modern way without becoming "woolly", and I am therefore very glad of Harvey Carey's chapter thereon with his uncompromising clarity. Hilda Roberts, besides giving most of my anæsthetics in the last two years, has devoted years of practical research to the relief of pain in labour and has very fittingly written this chapter.

My views upon the misuse of the antibiotics are so strong that I

thought it a good plan to seek the help of one whose views are even stronger and certainly more expert. I therefore asked William Hayes for a chapter on these lines before his recent visit to the U.S.A. The book is worth while if only for this authoritative piece of work, the like of which is not to be found in most other volumes.

Illustrations are often more of a problem to the author than the text itself, unless he happens to be a collector from lifelong habit. A great many are the work of the photographic and X-ray departments of the Postgraduate Medical School and Hammersmith Hospital, whose help is gratefully acknowledged. In other instances acknowledgements are made in the appropriate places. The line drawings are by Miss Pat Burrows who, besides her rapid skill, has the convenient property of being able to rise to the occasion demanded, regardless of the Sabbath.

One could not write a book, even of this modest size, in the midst of ordinary professional activity without the help of a good secretary, and I have been fortunate in Miss Joan Bush. She worked fast and well, and her cheerful composure helped to prevent things from getting out of hand when time appeared to be running short.

The Postgraduate Medical School library is a remarkable place, the more so because of the efficiency of the Librarian, Miss Atkins, for whose help I am much indebted.

I started this preface by alluding to the persuasiveness of my publisher, but Mr. Douglas Luke is more than that. He is a delightful slave driver, but he is also patient and meticulous, for all his enthusiasm. Our association has been a very happy one, although I will try to discourage him, for the present, from making me write another book.

It would not be fair, in all these acknowledgements, to omit mention of my long-suffering wife and family, who have put up with me and my book for so many months. Most of the time that I gave to the task was really their time and their contribution has been the calm with which they have managed to surround my domestic life and without which I would surely have failed.

In retrospect it has been worth while and if, in the pages that follow, I have at times provoked, instructed and amused, then I am content.

September 1954 IAN DONALD

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