Session No. 1—19th January 1956
From Unit "A," Kandang Kerbau Hospital for Women.
Moderator: PROFESSOR B. H. SHEARES.

Case of Attempted Criminal Abortion

Case Report:

Presented by Dr. S. H. Tow.
Case No. 113-B—H.L.T.—Chinese—Age 44 years—Married. Para V. Abortion 0. Youngest child 3 years.

Admitted as an emergency on 13th January 1956 at 3.10 p.m. History of amenorrhoea 2 1/2 months. Commenced intense abdominal pain at 8.00 a.m. on day of admission, accompanied by moderate amount of vaginal bleeding.

Findings:

Nutritional status—fair. Generally distressed by the pain. B.P. 110/70—Pulse 120/min. Temperature 101°F.

Abdomen: Tender in both lower quadrants of the abdomen. No palpable swelling or shifting dullness of flanks.

Pelvic Examination:

A green twig wrapped with surgical cotton wool about $\frac{1}{4}$" in diameter seen protruding at the introitus. It measured $8\frac{1}{4}$" long and about $\frac{1}{4}$" in diameter.

The ovum enclosed in its sac and some placental tissue was lying in the vagina and it was removed digitally.

The uterus was anteverted and retrocessed and enlarged; mobile but with tenderness. Palpation of fornices elicited peri-uterine tenderness.

Management:

On general lines as for incomplete septic abortion. Prophylactic injection ATS was given and also therapeutic doses of Penicillin and Sterptomycin. Tenderness in the lower abdomen and the temperature subsided on the 3rd day.

The case was presented on the 6th day. Curettage of the uterus had not been carried out to date.

Discussion.

DR. L. S. da SILVA discussed the medico-legal aspects.

Excerpts:

1. Primarily the doctor should concern himself with treamtent of the grave emergency as it presents itself on admission. If she dies the coroner must be informed. He stressed the point that the first duty of the medical attendant was to treat the patient. and not act as poilce agent.

He then touched on the various indigenous methods used to procure abortions in Malaya. Drugs were rarely used. Instrumentation with stems of various plants was the commonest. Cheraka Merah twig was the most popular. It contained a glucoside which has an irritant action. He quoted a case of 1953 where a woman died after an abortion criminally induced with the Cheraka Merah twig. Before she died she told the police the name of the person who performed the abortion. A trap was set, and the woman was caught red-handed with all the paraphernalia of her trade, consisting chiefly of various sized twigs of the plant, and a green papaya. Her method was to insert the twig into the green papaya, and then introduce it into the uterus. The patient was then told to leave the twig in situ for 2 days when the desired effect would be obtained. The commonest causes of death from such abortions were haemorrhage and sepsis. Acute streptococcal infection and tetanus were usual; B. Welchii and other gas gangerene infections rare.

He quoted another case where the caudal end of inserted twig had impinged on the vaginal wall. This case died from tetanus and at post-mortem her genitalia were removed with the twig in situ. This interesting specimen is currently housed in the Department of Pathology.

DR. WILSON RODDIE spoke of an interesting case of his experience where a woman tried to procure an abortion with a piece of slippery elm bark. She did not succeed, but during the course of pregnancy suffered from attacks of cystitis. At term, a routine X-Ray picture was taken and a vague shadow was seen in the region of the bladder. Cystoscopy was carried out and the piece of slippery elm bark removed from the bladder. The woman ultimately delivered normally.

DR. SINHA asked whether surgery, that is, hysterectomy, was ever advisable in these cases, especially in those infected with gas gangerene organism.

PROF. SHEARES replied that in his opinion, such radical surgery had no place in the treatment of such cases, as the infection had assumed the proportions of a septicaemia and, in any case, the patient was too ill.

DR. da SILVA suggested that in addition to anti-tetanus serum, anti-gas gangerene serum might be given prophylactically for such cases.

PROF. SHEARES however, said that he had greater faith in broad-spectrum anti-biotic coverage, as it is well-known that the gas-producing organisms assume virulence only in the presence of streptococci and other pyogenic organisms.

Prolapse of the Umbilical Cord

Case Report:

Case No. 129—W.K.M.—Age 50 yrs —Gravida 19

Para 14—L.M.P. & E.D.D. Unknown

Previous Obstetric History:
All previous full-term pregnancies and deliveries uneventful.

Complaint:
Cord-like structure presenting at vulva since 11.00 p.m. This occurred when she got out of bed to micturate. Simultaneously there was no abdominal pains, and foetal movements were felt.

Past Medical History:
For the last 3 years she had been attending The Tan Tock Seng Hospital for treatment of Hansen's Disease.

General Examination:
Good nutritional status.
Pulse 86/min. B.P. 130/80.
Heart: Clinically clear
Lungs: Clinically clear.
Contractures of all fingers of both hands, the sequalae of Hansen's Disease.

Obstetric Examination:
Fundus: Height of 28-30 weeks.
Vx. presentation. F.H.H. Estimated weight of baby 3 lbs.
Long loop of cord seen protruding from vulva to a length of 8".
Liquor amnii draining.

Vaginal examination:
Os 2 fingers dilated.
Cervix firm—not effaced.
Vertex Presentation.
Membranes ruptured.
Cord pulsating.

Management:
No active measure was decided upon. Antibiotic cover instituted.

PROGRESS:

January 17, 1956—

7.00 a.m. Maternal pulse = 102/min.
Foetal heart = 124/min.

11.00 p.m. Cord pulsation ceased.

3.30 p.m. Catherised and 28 of urine obtained.
Vaginal examination.
Cervix 2 fingers dilated.
Vertex presenting. The possibility of posterior placenta praevia was conjectured.
Abdominal Binder applied.
Inj. Pitocin m 3 intramuscularly commenced and given hourly for 3 doses.

5.30 p.m. Weak labour pains commenced. Pitojin inj. reduced to m 1 hourly.
General condition satisfactory.

January 18, 1956—

12.10 p.m. Patient asleep.
Maternal pulse 84/min.

7.00 a.m. Pains dissipated.
Maternal pulse 112/min.

January 18, 1956—

7.00 a.m. (i) Cord cut flush with vulva. Raw ends covered with gauze soaked with antiseptics.

(ii) Inj. Streptomycin 1 gm. Stat. & b. d. for 3 days.

1.10 p.m. No pains—Afebrile.

Discussion.

Professor SHEARES was of the opinion that in this case the chief etiological factor was prematurity, and the low implantation of the placenta. In general the cause for prolapse of cord may be said to be due to ill-fitting of the presenting part in the pelvic brim. Under this heading would come:—

(i) Contracted pelvis, especially flat pelvis and Naegle s pelvis.

(ii) A large pelvis and a small head, and

(iii) Mal-presentations of the foetus.

DR. SINHA suggested that the patients with a pendulous abdomen have a greater tendency to prolapse of cord and that the length of the cord was not a contributory factor.

In discussing the treatment of this case it was generally agreed that the conservative treatment adopted was quite correct in view of the multiparity and the prematurity of the foetus.

DR. RODDIE suggested that the exhibition of antibiotics in this case may be an indirect contributory cause to the uterine inertia. In his opinion, with the onset of infection and a rise of maternal temperature, uterine contractions usually become very brisk and the products of conception would then be rapidly expelled.

DR. SINHA asked what treatment was advisable if the case had been a primigravida, and full facilities for looking after the premature baby were available.

PROF. SHEARES, answered that in such a case he would discuss the matter with the prospective parents stressing the poor prognosis for a baby with that degree of prematurity and let them decide whether they would like a Caesarean Section to be done, provided that the cord was pulsating well.

DR. SINHA stressed the importance of occult presentation of the cord as he had 2 cases of still-births following forceps deliver in which the cord was nipped by the forceps blades.

Treatment for prolapse of the cord with a viable baby was next discussed.

DR. SINHA stressed the importance of early diagnosis.

In this connection Professor Sheares emphasised the importance of doing a vaginal examination as soon as the membranes ruptured in cases where the head was floating high up and in mal-presentations of the foetus. He added that a valuable diagnostic sign of occult prolapse of the cord was the foetal heart tones, especially the time taken for the foetal heart rate to become normal after a contraction. This should normally not be more than 10 seconds. The first measure he said should be to relieve compression on the cord, and the steep Trendelemberg position he thought was the best. 100% oxygen atmosphere should also be ensured, and with this treatment if the pulsation of the cord becomes normal within 10 minutes and the os if 2 fingers dilated or less a Caesarean Section is indicated. If on the other hand the pulsations did not return to normal within 10 minutes then no active treatment would be indicated, for the chances of salvage of a living baby in this situation was practically nil.

If it were a case of breech presentation, all that might be necessary would be to shift the cord to the ventral aspect of the foetus if it is compressed between the foetal back and the maternal pelvis and the os 3 fingers or more dilated. Breech extraction, however, would be indicated at full dilatation.

DR. SALMON quoted a case in which this was done and a live baby was delivered spontaneously.

Continuing, *Professor Sheares* said that if the os is 3 to 4 fingers dilated the choice of treatment would be one of replacement of the cord. In this respect the technique recommended was to wrap the cord with a piece of gauze and put it as high up as possible. An alternative method was internal version, and of the two methods. *Professor Sheares* preferred the former. Caesarean Section had a place also in the treatment of this type of case, especially if the baby is an over-valuable one.

DR. RODDIE emphasised the importance of not following hard and fast rules and treating each case individually. If the os is fully dilated, the treatment should be extraction of the foetus per vaginam. In treating these cases, he said the possibility of the presence of contracted pelvis should be uppermost in the obstetrician's mind.

Premature rupture of membranes was next discussed, and *Professor. Sheares* stated that the causes of this condition was one of the few fields in obstetrics that had not been properly explored. The question was then raised as to when one should exhibit anti-biotics after the rupture of membranes. It was generally agreed that anti-biotics should be exhibited 12 to 24 hours after rupture of membranes if the case had not been interferred with outside the hospital.

The use of Pitocin intramuscularly or by intravenous drip was next discussed. Dr. Roddie said that in Belfast it was customary to give Pitocin in doses of 3 minims hourly for 3 doses, after the membranes had been ruptured surgically to induce labour.

PROF. SHEARES, however, stated that in his experience Pitocin by intravenous drip was easier to control as regards total dosage and rate of administration.

The meeting ended at 4.30 p.m.
