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THE INDUCTION OF ABORTION.

AN INTRODUCTION TO A DISCUSSION ON THE ARTIFICIAL TERMINATION OF PREGNANCY, BEFORE THE HUNTERIAN SOCIETY OF LONDON, ON DECEMBER 3, 1928.

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FOR the purpose of our discussion this evening on the artificial termination of pregnancy, Mr. Lane-Roberts and myself have divided the subject into two parts:—

- (1) The induction of abortion.
- (2) The induction of premature labour.

I will endeavour to give you my views on the induction of abortion, and I hope these may be sufficiently controversial to promote a good discussion, although I regret that I have nothing new to offer you. In nearly every discussion on the subject of abortion the matter is dealt with from three aspects: the legal; the ethical; and the therapeutic; and sometimes there is even a fourth, namely, the ecclesiastical.

The legal aspect need not detain us, except to state that the law teaches us nothing that is not already dictated to us by professional standards and moral pride.

The ecclesiastical aspect is of little importance from the clinical point of view, for obviously any competent practitioner would perform any necessary operation first, and talk about religion afterwards, if necessary.

The ethical and therapeutic aspects are closely related, if not inseparable, and together form the whole theme for debate, for ethics being the science of morals, and morals being so much regulated by conscience and often influenced by environment, it follows that what we conscientiously believe to be ethically sound will in no small measure influence us in our treatment of the pregnant woman. To illustrate this point, I would mention such diseases as phthisis, cardiac disease, vomiting and diabetes.

From the therapeutic aspect each of these diseases has strong indications for the induction of abortion, but there are equally strong reasons with our present knowledge to leave such cases to go on to term. But where the facilities for proper treatment are poor, or the patient's home conditions are bad, it is often ethically sound to terminate such pregnancies. Thus our list of indications can vary much, according to circumstances, and it is almost impossible to lay down any hard and fast rules. Every case has to be judged on its merits, and what might be deemed a justifiable indication for interference by one would be ignored as such by another.

I firmly believe that the indications for abortion are very few indeed; the operation is rare in hospital practice. On the other hand, the reasons brought forward by the private patient and her relatives, and sometimes also by her doctor, are legion. There is, for instance, the dread of a repetition of the dangers and difficulties of a former pregnancy and labour; the greater cost of living; the fear that the child will be born diseased or deformed; to mention only a few perfectly reasonable but unconvincing arguments. The pregnancy may be a source of great inconvenience and dread to the mother, yet we have no right whatever to interfere with it unless we are convinced that the pregnancy, *per se*, is a danger to her health or life in her given circumstances.

In refusing to operate, however, we are

sometimes taking a grave responsibility, for we know that the woman who is determined not to complete her pregnancy will have it terminated elsewhere by some unqualified person, often a local chemist, or even the woman next door. It is indeed a fact that our refusal to operate may be followed by disastrous results, far worse even than in those cases where, in spite of adequate medical reasons, we frequently hold our hands. I have in mind three such cases. In the first, the pregnancy would interfere with the hunting season; in the second, divorce proceedings would surely follow; and in the third, the separation allowance would be forfeited. To my certain knowledge all these pregnancies were terminated by unqualified people, and two of the patients were lucky in escaping with their lives.

But experience of such cases does not in the least help us to sympathize with the views of those who advocate the legalization of abortion. A reference to the state of affairs obtaining in Soviet Russia to-day only strengthens our belief that abortion is anti-social and anti-racial. Before Russia enjoyed the blessings of Bolshevik rule, abortion was illegal and punishable by exile of both patient and doctor to Siberia. The present law provides that anyone can have the operation done, but it must be done by a reputable physician and in a public hospital. Special hospitals have been built for the purpose and separate wards have been assigned for young unmarried girls. As a consequence of all this abortions have increased sixfold, but the number of septic infections has fallen to 4 per cent., in spite of the fact that there has been no diminution in the number of abortions done clandestinely. These figures hold a veiled truth. The 4 per cent. of septic cases is something to be envied when we think of the number of gynaecological troubles which are directly due to uterine sepsis. But the sixfold increase can only mean that side by side with the spread of lawlessness and atheism there has grown up an utter disregard for foetal life, immorality

is almost a virtue, and abortion its accepted culmination.

Keeping strictly to the therapeutic aspect, we customarily divide the indications for abortion into two groups :—

(1) Where the pregnancy itself is the sole cause of disease in the mother or the ovum is itself pathological.

(2) Where some chronic disease in the mother is complicated by pregnancy.

In the first group I place such conditions as :—

- (1) The toxæmias of pregnancy.
- (2) Hydatidiform mole.
- (3) Incomplete and missed abortion.
- (4) Excessive hydramnios.

In the second group I place such conditions as :—

- (1) Diseases of the urinary tract.
- (2) Heart disease.
- (3) Phthisis.
- (4) Nervous and mental states.

It is in this second group that we meet with our greatest difficulty in arriving at a decision, for every case has to be judged on its merits, and the results of abortion are by no means uniformly good. It cannot be too strongly emphasized that no social or eugenic criteria must be allowed to influence us.

I will give a brief summary of my own opinions in each of these two groups.

THE TOXÆMIAS OF PREGNANCY.

Albuminuria in the early months is in my opinion rare, unless it be associated with some other condition, and I shall refer to it again in the second group.

In pernicious vomiting we have a condition over which there is endless controversy, and we are rather apt to order our treatment according to our views as to causation rather than according to the condition of the patient. There are some who claim that pernicious vomiting is never of primary toxic origin, and that all such so-called cases are at first of the hysterical type and have become toxic through lack of proper treat-

ment. There is no doubt that some of the cases arise in this way, but there is equally no doubt that there are cases which are toxæmic from the first, else how are we to explain those occasional cases which show profound toxæmia after only a few days of what was apparently merely morning sickness? I cannot help feeling that those who claim that there is no such thing as a primary toxic vomiting are indeed fortunate in never having seen a case of it. Nevertheless, almost every case of vomiting yields to proper treatment, and only very rarely is it necessary to interfere. Unfortunately, the severe cases are sent to hospital too late often to make abortion of any value. In these the danger signals have been overlooked, and some 60 per cent. die, no matter what is done; and therefore I feel that we should realize this fact early, and not wait until the patient's death reminds us that a toxin was the primary source of the trouble.

I regard as important danger signals the following :—

- (1) Marked albuminuria.
- (2) Blood in the vomit.
- (3) Jaundice.
- (4) Wasting.
- (5) Rapid pulse.

Any of these is an urgent indication for abortion, and of them I regard jaundice and blood in the vomit as the most important, as they are evidence of extensive degeneration of the liver. To operate even at this stage may bring a happy result, but to wait until the patient becomes delirious or even comatose is to court disaster. Natural miscarriage at this time brings no benefit, and to operate is merely to bring the operation into greater disrepute.

HYDATIDIFORM MOLE, &c.

In hydatidiform mole the uterus should be emptied as soon as the diagnosis is made. In incomplete or missed abortion there is nothing to be gained by withholding the operation; whereas in excessive hydramnios which sometimes occurs in the early months,

interruption is certainly justified if the liquor amnii is in such an amount as to cause respiratory or cardiac distress, for natural abortion will almost certainly occur, and it may be as well to anticipate this.

DISEASES OF THE URINARY TRACT.

I come now to the important second group, and will deal first with chronic nephritis, which is a very common indication for abortion.

When albuminuria occurs in the early months apart from such conditions as pernicious vomiting, I tend to regard it as evidence of chronic nephritis, although we may not be able to obtain any history of an exciting cause of the nephritis. Although many such women complete their pregnancy without apparent harm, nevertheless pregnancy entails serious risks in chronic nephritis. There may be a complete though temporary breakdown in the renal function; further permanent damage may be done to the kidneys; accidental hæmorrhage is common; and maceration of the foetus occurs in about half the cases. It is not, however, justifiable to induce abortion merely to avoid the risk of antepartum hæmorrhage or of maceration, or indeed any natural risk of pregnancy, but with these facts in our minds we are less ready to hold our hands in the face of a threatened breakdown in renal function. We have to detect the danger signals and evacuate the uterus when they arise. Œdema of the face, a high blood-pressure, a diminished renal function, and the onset of eye-changes leading up to blindness, all these are urgent indications for abortion, and if any of them has occurred in a previous pregnancy in a woman known to have chronic nephritis, nothing but harm can result from allowing a pregnancy to go on.

In bacillary infections of the urinary tract, little if any good can come from interrupting the pregnancy; attention must be paid to the disease. I would make one exception to this rule, and that is when one kidney has been

removed for some reason or other. I have recently been faced with a case of renal tuberculosis which has caused me very considerable doubt as to procedure, and I will relate the details and ask for your criticism and advice. A lady, aged 35, had had her right kidney removed for tuberculosis. There were at the time of the operation multiple tuberculous ulcers in the bladder, but these rapidly healed after the operation. When I saw her two years afterwards, she was in the third month of pregnancy. She has two living children. The function of the left kidney is good and no tubercle bacilli can be found in the urine proceeding from that kidney. I advised that the pregnancy should be terminated on the grounds that should a coliform pyelitis supervene the results in this case would be very grave. I insisted that the operation should be performed by the abdominal route and that sterilization should be performed at the same time, for the pregnancy in question had resulted from a breakdown in the technique of contraception. The patient had been led to suppose that a simple curettage was all that was necessary, and it was a bit of a shock for her to learn that a severe operation was the most desirable course. She required time to discuss the necessity with her friends, and during these preliminaries she fell ill with influenza and had a natural miscarriage. I was then asked as to the advisability of removing the Fallopian tubes at that date. I find great difficulty in advising such a course, bearing in mind the fact that the patient has already had two abdominal operations. I would like, therefore, to make this my first point in the discussion this evening, and will put it forward in the form of a question, "Is it justifiable to perform sterilization in order to avoid the necessity of aborting a future pregnancy?"

CARDIAC DISEASE.

In cardiac disease complicated by pregnancy we are faced with a very difficult problem, and one where the prognosis

is often of a purely speculative nature. When confronted with such a case the question we have to ask ourselves is this, "Will this particular heart bear the strain of this particular pregnancy and later of the labour?" I have never met anyone who can answer this question. For myself, I take four points into consideration :—

- (1) The valve lesion.
- (2) The condition of the myocardium.
- (3) Whether the woman has had children before.
- (4) The behaviour of the heart in the last pregnancy and labour.

The valvular lesion is not of great importance, but it must be recognized that mitral stenosis is of graver importance than any other lesion, although, provided that the stenosis is not associated with aortic regurgitation or with heart block, these cases can as a rule be left for natural delivery at term. Prolonged rest in bed and digitalis are all that is necessary in the majority of cases.

The condition of the myocardium is the all-important thing, and it is a pity that we have no certain way of estimating the reserve power of the cardiac muscle. The best we can do is to watch the behaviour of the heart under graduated exertion, and if this brings on signs of failure of compensation the case must be watched with a view to termination.

The primigravida usually bears the strain well, but the multigravida is a perpetual problem to us, for every labour leaves the cardiac condition a little worse. We are so apt to overlook the future of these patients, and having tided them over their pregnancy and labour we write them up as our successes, forgetting that there is a post-hospital stage to think of, and often they go home to face a serious cardiac breakdown and sometimes death. I look upon cardiac failure as the most serious complication of labour, and, although I have never seen a patient die during labour, yet I have known many die during the puerperium or shortly afterwards. Therefore our treatment in the early

months should be to the end of anticipating post-natal calamities. I cannot convince myself that abortion does any good, in fact it may do considerable harm, and consequently I firmly believe that the correct treatment, so far as the multigravida is concerned, is long rest in bed followed by Cæsarean section with removal of the tubes at term. Thus the second point I wish to make is that abortion in the early months is not called for if rest in bed can be enforced, for any good claimed for the operation is, in my opinion, due to the lying in and not to the operation.

PHTHISIS.

In phthisis we are on much more certain ground, for there is no denying the fact that a tuberculous woman is left worse by her pregnancy as a general rule. It is claimed by some, and with good reason, that the child born of a tuberculous woman has a more than usual chance of itself becoming tuberculous, and that therefore we need not hesitate to terminate these cases. This argument would be just as reasonable for every communicable or hereditary disease, and therefore we direct our attention entirely to the mother as to whether her disease be quiescent or active.

Some two years ago, during a discussion on this subject, fairly strong arguments were brought forward to show that the puerperium after an abortion was every bit as bad as after a full time labour, and that therefore the proper treatment is to put the patient into a sanatorium and to leave the pregnancy alone. No doubt this is the ideal, but up to the present I have been unable to find a sanatorium that will take a pregnant woman, and I consider the only alternative is to terminate the pregnancy at once and afterwards place the woman under proper supervision. During pregnancy the disease often seems to be in abeyance, and sometimes there is an apparent improvement, but once labour is over the patient goes downhill very rapidly and often dies where she might have been saved but for our reluctance to

interfere. In quiescent cases it is quite illogical to interfere, but they should be watched for any return of activity, and if such should occur the pregnancy ought to be terminated at once. These cases have proved themselves possible of control, and we ought not to lose the chance of saving them. A few years ago I saw a lady who had been discharged as cured from a sanatorium, and had married six months afterwards and had become pregnant almost immediately. At the end of the third month her doctor, who had been watching her throughout, detected signs of activity in the apex of the left lung. He took her to a physician, who urged that the pregnancy should be terminated. When I saw her I gave it as my opinion that sterilization should be performed. The husband would not give his consent for this, his argument being that if a simple abortion were done his wife could go back to the sanatorium and might in the course of a few years pass safely through a pregnancy. As events turned out the husband was correct in his opinion. During the fourth month, I did a miniature Cæsarean section. She had a very stormy lying in, during which time the activity in the lung extended down to the bases, but she ultimately recovered and went back to the sanatorium. Three years later she had a baby, and both have remained perfectly well.

I believe that in tuberculosis we have our strongest indication for abortion as a means of forestalling the rapid decline which we are bound to expect in the puerperium of a full-time labour.

NERVOUS AND MENTAL STATES.

Of the nervous and mental states I am not well qualified to speak. I have had no experience of pregnancy complicating insanity, or of pregnancy occurring in a family afflicted by insanity, and in this class of case we must be guided entirely by what the alienists say. I think, however, that with regard to puerperal insanity, most obstetricians are agreed that no pregnancy

need be terminated for fear of this; for since puerperal insanity' when it occurs most frequently supervenes upon eclampsia or puerperal sepsis, and as we have no just reason for expecting either of these states to complicate the next puerperium, so there is no indication for inducing abortion in order to anticipate dementia.

Some of the most difficult cases we have to deal with in this class are those who have been told that they must not become pregnant again. More often than not they have been told this for some quite insufficient reason, such as a bad tear of the perineum, post-partum hæmorrhage, or puerperal sepsis. Such women have been done a great wrong, for with the exception of phthisis and perhaps chronic nephritis I know of no condition where it is justifiable to warn a woman against pregnancy. Having been so warned, and having again become pregnant, she soon becomes obsessed with the delusion that it will be her undoing. She is sent to the obstetrician, not so much for his opinion but that he should do the abortion, and nothing he can say will remove the misapprehension from her mind. These are very genuine cases and far from being neurotic. I hardly know how to advise in these cases, but believe that the threat of a hysterectomy often has a salutary effect.

OPERATIONS OF ABORTION.

I do not wish to enter into a detailed account of the operative treatment, but I would state that I think that the vaginal route should be reserved for those cases where the pregnancy is pathological. The abdominal route should be employed in every case where termination of pregnancy is desirable on account of some chronic disease, for it gives the opportunity to remove the Fallopian tubes. I firmly believe that if it is ever necessary to terminate a pregnancy which is complicating a chronic disease, as in our second group, then it is urgently necessary to provide that the patient never becomes pregnant again. Contraception will fail sooner or later.