## Chamberlen family

<table>
<thead>
<tr>
<th>Name</th>
<th>Years</th>
<th>Role/Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter I</td>
<td>(1560 - 1651)</td>
<td>Barber Surgeon</td>
</tr>
<tr>
<td>Peter II</td>
<td>(1572 - 1620)</td>
<td>Introduction of Midwifery</td>
</tr>
<tr>
<td>Peter III</td>
<td>(1610 - ? )</td>
<td>Associated with Forceps invention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Only cephalic curve</td>
</tr>
<tr>
<td>Hugh (I)</td>
<td>(1670 - 1728)</td>
<td>Let out family secret of 140 yrs</td>
</tr>
<tr>
<td>Hugh II</td>
<td></td>
<td>Continued to be noble, Duke erected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>his statue in honour</td>
</tr>
</tbody>
</table>

18-12-2009
Destructive operations

JOSHI SUYAJNA D.

SUMAN GADDI

SHANKAR J

VIJAYA HARSOOR

VEERENDRAKUMAR C.M

VIMS- LLPT style.

18-12-2009 WISDOM 2009
said to be,

and to have

no place in

modern obstetrics
Operative Vaginal Delivery

District 1 ACOG Medical Student Teaching Module 2009
DESTRUCTIVE FOR THE dead FOETUS

CONSTRUCTIVE FOR THE LIVING MOTHER

JOSHI SUYAJNA D.
OPERATIONS

- REDUCE THE OBSTRUCTION
- AVOID SCAR FOR A DEAD BABY
- PREVENT INFECTION
- EARLY RECOVERY

NO CS for IUD
What is Modern obstetrics?

Shankar….Is there any role of destructive operations in current obstetric practice?
MODERN OBSTETRICS

- It is evidence based practice of obstetrics.
- Accountable and unbiased.
- Less talented, less artistic because it is fact based.
- Offers best possible outcome to mother & baby.
- It has least morbidity to mother & new born.
- Nearly litigation free.

*Modern obstetrician must be expert in destructive operations & second stage L.S.C.S.*

-SHANKAR
DESTRUCTIVE OPERATIONS

- Need few instruments & simple anesthesia.
- Uterus remains intact, (no scar of L.S.C.S.).
- Subsequent pregnancy will be safer.
- Operative morbidity is lesser.
- Hospital stay is shorter.
- Useful specially in teenage pregnancy.

They need to be taught to youngsters & hence to be retained in vogue.
DESTRUCTIVE OPERATION INSTRUMENTS

a tribute
• Frightful instruments were used to open the head of the fetus in craniotomy

• Used to open the thorax and abdomen of fetus in evisceration

- vijaya

HARSOOR
Perforators
Smellie's Perforator
Naegele's Perforator
Simpson's Spring Loaded Perforator
Hooks/Crochets
Cranioclast
DESTRUCTIVE OPERATION

WILL LAST

as long as

obstructed labor exists

JOSHI SUYAJNA D.
DESTRUCTIVE OPERATION

NOT AN ART

• COURAGE

And

PRESENCE OF MIND

18-12-2009 WISDOM 2009
Safe CRANIOTOMY
METHOD TO REDUCE THE FETAL HEAD SIZE SO AS TO EFFECT EASY VAGINAL DELIVERY.

C.M. VEERENDRAKUMAR
INDICATIONS

- OBSTRUCTED LABOR WITH DEAD FETUS

- HYDROCEPHALUS LIVE OR DEAD
CRANIOTOMY IS EASY, NOT DANGEROUS & safer than LSCS

PROVIDED

INDICATIONS ARE STRICTLY & CAREFULLY FOLLOWED!
PREREQUISITES

- FETUS IS DEAD

- TWO FIFTH OR LESS HEAD PALPABLE ABOVE THE BRIM

- HEAD IS IMPACTED
PREREQUISITES

- CERVIX IS AT LEAST 7 CM DILATED
- UTERUS UNRUPTURED/NO IMPENDING RUPTURE
- TRUE CONJUGATE NOT < 7.5 cm
PRE TREATMENT

- CORRECT DEHYDRATION
- TREAT KETOACIDOSIS
- DRAW BLOOD FOR CROSS-MATCHING
- TREAT INFECTION
- CATHETERIZE THE BLADDER
1) PERFORATION

2) EXTRACTION
SITES FOR PERFORATION

- PARIETAL IN FORE COMING HEAD
- OCCIPUT / POST-LATERAL FONTANELLE IN AFTERCOMING HEAD
- PALATE / ORBIT IN FACE
- FRONTAL BONE IN BROW
METHOD OF PERFORATION
METHODS OF EXTRACTION

1) LEFT TO NATURAL FORCES
2) USE FORCEPS/ VULSELLUM
3) CEPHALOTRIBE
4) CRANIOCLASMA
PERFORATION IN AFTERCOMING HEAD
HYDROCEPHALUS BABY

PUNCTURING & DRAINING IS ALL THAT NECESSARY IN MOST OF THE CASES

PER VAGINAL DRAINAGE

SUPRAPUBIC DRINAGE

SPINAL TAPPING IN AFTERCOMING HEAD
DELIVERY OF HYDROCEPHALIC BABY
CRANIOTOMY DOES’T NEED

SKILL

• FOLLOW THE BASICS

JOSHI SUNITA, D.

18-12-2009 WISDOM 2009
SECOND STAGE CS is not SAFE
Complications
DURING PERFORATION

INJURIES TO

- Bladder And Urethra
- Vagina, cervix And Uterus
- Rectum And Intestines
DURING EXTRACTION

INJURIES TO SOFT TISSUES

- Wrong Tissue Holding
- Wrong Directions Of Pulling
- Spicules Of Bones
- By instruments per se
IDENTIFICATION OF COMPLICATIONS

- Fresh Bleeding
- Urine Dribbles
- Faecal Matter Flows
PREVENTION

- Adhere To Criteria
- Catheterisation
- Willingness To Abandon
- Good Assistance
- Adequate Light Source
CONT....

- Use Large Sims Speculum
- Incise (Nick) The Scalp And Perforate
- Guide And Protection Of Soft Tissues By Left Hand
Bladder & Urethral Injuries:

Don’t Abandon Procedure

Repair & Catheterize for 14 Days

Check in the next follow-up
CONT....

- Vaginal, Cervical tears Repair
- Rupture Uterus-laparotomy
- Rectal, Intestinal injuries Repair
CRANIOTOMY IS A BOON

rather than a disgrace

FOR THE OBSTETRICIAN IN INDIA
Is there any place?

J. Shankar
Decapitation: indications

- Neglected shoulder with hand prolapse
- Interlocked twins.

**Prerequisites:**
- Neck of the fetus should be accessible per vagina.
- No evidence of impending rupture.
- Cervix should be at least 7 cm dilated
Prolapsed hand brought down & traction given to stabilize the neck.

Decapitation knife passed under guidance.

Tip turned down over the neck.

Decapitated head extracted by hooking the mouth by finger or crotchet.
Decapitation

- No role in modern obstetrics
- Unpleasant
- Unacceptable level of maternal traumatic and psychological morbidity
- Complicated intrauterine procedure
- Chances of injury to obstetrician
  - In HIV era
- Caesarean section is safer alternative

suman
gaddi
Decapitation step 1
Decapitation step 3
Decapitation step 4
DO YOU HAVE ANY OTHER PROCEDURES IN MODERN OBSTETRICS?
CRANIOTOMY YES...

- BARRING CRANIOTOMY
- OTHER PROCEDURES HAVE NO PLACE IN
- MODERN OBSTETRICS

- Veerendrakumar C.M.

18-12-2009 WISDOM 2009
MOST OF THESE PROCEDURES ARE INTRAUTERINE

- LEARNING PHASE LONGER

- ACCOUCHEUR EXPERT IN BOTH C.S & DESTRUCTIVE OPERATIONS

- HIGHER COMPLICATIONS

- CS IS MORE SAFE
has it

vanished

STATISTICS
<table>
<thead>
<tr>
<th>Procedure</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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<tr>
<td>Craniotomy</td>
<td>09</td>
<td>07</td>
<td>06</td>
<td>21</td>
<td>11</td>
<td>10</td>
<td>09</td>
<td>08</td>
<td>07</td>
</tr>
<tr>
<td>Evisceration</td>
<td>-</td>
<td>04</td>
<td>-</td>
<td>01</td>
<td>01</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>01</td>
</tr>
<tr>
<td>Spondylotomy</td>
<td>-</td>
<td>02</td>
<td>01</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>02</td>
<td>01</td>
</tr>
<tr>
<td>Decapitation</td>
<td>-</td>
<td>-</td>
<td>01</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>01</td>
</tr>
<tr>
<td>Total</td>
<td>09</td>
<td>13</td>
<td>08</td>
<td>22</td>
<td>12</td>
<td>09</td>
<td>09</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

18-12-2009      WISDOM 2009
<table>
<thead>
<tr>
<th>Operation</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL DESTRUCTIVE OPERATIONS</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>INCIDENCE OF DESTRUCTIVE OPERATIONS</td>
<td>-</td>
<td>0.19%</td>
</tr>
<tr>
<td>CRANIOTOMY</td>
<td>68</td>
<td>66.02%</td>
</tr>
<tr>
<td>EVISCERATION</td>
<td>12</td>
<td>11.06%</td>
</tr>
<tr>
<td>DECAPITATION</td>
<td>08</td>
<td>07.70%</td>
</tr>
<tr>
<td>OTHERS</td>
<td>15</td>
<td>14.50%</td>
</tr>
</tbody>
</table>

18-12-2009 WISDOM 2009
Do you think destructive operations can be performed on a live baby?
- Moribund baby.
  
  *FHR below 40 per minute, Sinusoidal pattern, non re-assuring FHR pattern.*

- Where LSCS is hazardous to mother.
  
  *Severe anemia, shock, poor anesthetic risks.*

- LSCS scar is not acceptable in view of future child bearing performance.
DESTRUCTIVE OPERATION IN A LIVE FETUS?

NO

• In modern neonatology the word moribund has no meaning.
• With grave risk consent even peri-mortem caesarean section is acceptable.
• Scarred uterus can be managed electively and better in next pregnancy.

suman gaddi
CAESAEAN SECTION IN SECOND STAGE IS MORE DANGEROUS THAN DESTRUCTIVE OPERATION.

suyajna joshi
AVOID CAESAREAN SECTION FOR OBSTRUCTED LABOUR WITH DEAD BABY
NECESSITY FOR THE DESTRUCTIVE OPERATION REMAINS THE SAME

ONLY THE OUTLOOK CHANGES
Veerendrakumar. Should we continue to perform, teach and develop destructive operations?

or

allow them to go into history?
DESTRUCTIVE OPERATIONS ARE STILL RELEVANT TO OBSTETRIC PRACTICE IN DEVELOPING COUNTRIES
WHAT IS NOT SEEN, IS NOT LEARNT

WHAT IS NOT LEARNT, IS NOT PRACTISED!
2947 patients with obstructed labor
67 met the criteria for dest. operation
Only 11 underwent dest. operation
56 underwent LSCS
• 3 MATERNAL DEATHS IN LSCS GROUP
• NO DEATH IN CRANIOTOMY

• INFECTION, BLOOD TRANSFUSION, VVF, ASHERMAN HIGHER IN LSCS GROUP

• CONSULTANTS MORE LIKELY TO DO DESTRUCTIVE OPERATIONS
Why Destructive Operations? In Modern Obstetrics!

- Psychological Effect
- Beginners Not to Experiment on Patients
- Litigation Problems.
- Complications May Be Life Threatening.

SUMAN GADDI
18-12-2009
Safe Motherhood-widespread C/S.
( Amj Obst Gynaecol 1990 July:163 )

Destructive Operation is an option to C/S-rarely performed in developed countries.
( Moodley, J Obst Gynaecol 2002 Feb:16 (1)117-31)

Pts. Request For C/S.
( Birth 2000 Dec:27 / 256-63 )
Era Of Peri-Mortem C/S

Public Demands The Highest Skill
Attainable in Obstetrics.

Vaginal Birth Causes Pelvicfloor Disorders
Which can be Prevented By C/S.
What is Not Seen is Not Learnt,
What is Not Learnt is Not Practised
NOT SEEN

NOT LEARNT

is your Laziness to learn
NEED OF THE DAY

IS CHANGE OF

MIND-SET

JOSHI SUYAJNA D.
DESTRUCTIVE OPERATIONS

Obstetrics of DEVELOPED COUNTRIES

Obstetrics of Developing Countries

Obstetrics of Underdeveloped Countries
modern obstetrician
MUST BE AN EXPERT IN

BOTH

second stage c. section &

DESTRUCTIVE OPERATION

suyajna joshi d.

18-12-2009 WISDOM 2009
**Dead Baby** - the major decision is between craniotomy and Caesarean section.

### FOR A LIVE BABY

<table>
<thead>
<tr>
<th></th>
<th>Amount of baby's head above the brim.</th>
<th>Contractions of the uterus</th>
<th>Is the baby distressed?</th>
<th>Lower abdomen</th>
<th>Moulding score</th>
<th>Does the head move down to the ischial spine?</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–2/5</td>
<td>Weak</td>
<td>No</td>
<td>No bulge</td>
<td>2</td>
<td>Yes</td>
<td>Oxytocin drip</td>
</tr>
<tr>
<td>2</td>
<td>1/5</td>
<td>Good</td>
<td>No</td>
<td>No bulge</td>
<td>2–3</td>
<td>Yes</td>
<td>Vacuum extractor or Forceps</td>
</tr>
<tr>
<td>3</td>
<td>1–2/5</td>
<td>Good</td>
<td>Yes</td>
<td>No bulge</td>
<td>4–6</td>
<td>No movement</td>
<td>Symphysiotomy</td>
</tr>
<tr>
<td>4</td>
<td>3/5</td>
<td>Good</td>
<td>No</td>
<td>No bulge</td>
<td>1–2</td>
<td>Yes</td>
<td>Trial of Vacuum or Symphysiotomy</td>
</tr>
<tr>
<td>5</td>
<td>3/5</td>
<td>Good</td>
<td>Yes</td>
<td>No bulge</td>
<td>4–6</td>
<td>No</td>
<td>Transfer for Caesarean section</td>
</tr>
<tr>
<td>6</td>
<td>3–4/5</td>
<td>Weak</td>
<td>Yes or No</td>
<td>Bulging</td>
<td>4–6</td>
<td>No</td>
<td>Transfer for Caesarean section</td>
</tr>
<tr>
<td>7</td>
<td>4/5</td>
<td>Good</td>
<td>No</td>
<td>No bulge</td>
<td>4–6</td>
<td>No</td>
<td>Transfer for Caesarean section</td>
</tr>
</tbody>
</table>
OBSTRCTED LABOUR with IUD is UNIVERSAL

BE CAREFUL - NOT FOR JUST IUD “TRIPLE TRAGEDY OF OBSTETRICS”
mother must not see

After any destructive operation, wrap up the baby immediately
THANK YOU

18-12-2009 WISDOM 2009