Recent Advances Course in Obstetrics & Gynaecology

Contributed by

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The recent refresher course in gynaecology and obstetrics at the University of Cape Town highlighted, apart from the usual spate of technical advances, a number of significant new trends and the rejection of old dogmas and established practices.

The resumé deals with the latter.

The High Risk Pregnancy

Selection of pregnancies with high risk for the infant has become mandatory. The criteria are clear and recognition calls for a new routine to anticipate trouble. It is now accepted that cases falling in the high risk category require special monitoring during labour and facilities for immediate intervention when necessary. While a system to meet the new concepts has been established in major obstetrical units, its application has not penetrated the obstetric routine in private practice and all hospitals — certainly not in the smaller centres.

A case has been made out for referring all high risk cases to centres organised, equipped and manned accordingly. If general practitioners and obstetricians in private obstetric practice are to match the results of such special units and retain their full place in the discipline, they need to look at their facilities and routine and the training of their nursing staff in the new approach.

This emphasis on improved obstetrics supplements the modern trend in neonatal care to prevent cerebral deterioration with its later significance as well as immediate morbidity, and also to overcome the erstwhile "fatalistic" acceptance of stillbirth and even neonatal deaths as mysterious or unavoidable.

The need for close liaison between pediatrician and obstetrician to give effect to this breakthrough is a logical outcome of the new outlook and further reinforces the argument for delivery of all high risk cases in special obstetric units.

In Rhodesia such an ideal, even for the European community, poses many practical difficulties and the situation calls for a national reassessment to see to what extent and how our resources of skilled personnel and facilities can best be utilised to implement these advances as far as possible.

Hypoglycaemia.

Amongst the now clearly defined risks to which the neonate is subject, accent is being placed on the danger of hypoglycaemia and the cerebral damage as well as mortality that may result from its neglect. Prophylaxis and treatment can only come from awareness and recognition, hence the emphasis.

The significance of oedema in pregnancy is under examination and it looks as if old concepts will fall in the process. Not all such oedema is pathological nor calls for treatment. The identification of significant oedema and its relation to preeclamptic toxaemia and hypertension is the new challenge in the subject.

Uterine Curretage is under heavy fire. The pendulum is swinging from the old habit of the almost routine "D & C" as a diagnostic essential and treatment panacea for so many gynaecological ills to almost a ban, or limiting the procedure to a few essential indications. The relationship between the supposedly innocent currette and subsequent menstrual and fertility disabilities are now accepted and stressed. In the debate as to how long it will take to alter established practice significantly, the economic aspects are mooted as a major consideration.

The Mutilated Ovary Syndrome.

Prominence given to this subject by Dr. Van de Watt, of Johannesburg, in a recent article in the *South African Medical Journal* has made a major impact. From the ovary being a convenient object of attack (second only to the uterine endometrium) to alleviate a host of pains, menstrual disturbances and sterility, it is now to be treated as rare china. Even handling is to be eschewed and if unavoidable to be an exercise in delicacy. The evidence of gynaecological crippling, of early and late complications of the old approach, is impressive. There is no doubt that the new conservatism in ovarian surgery will rapidly become the new dogma. The only debate continuing is the advisability of ovarectomy at an arbitrary age as a prophylaxis against ovarian malignancy and here again conservatism is gaining ground as evidence of failure accumulates and the adverse effects of early castration are acknowledged.

Gynaecological Diagnosis.

The use of the peritonoscope as a primary diagnostic tool to replace laparotomy is being advanced in some circles. The value is considerable but depends on skill and experience as in all endoscopic work. If this is to become standard procedure, gynaecology will enter a new phase

of specialisation and much of its practice be taken out of the general practice field.

Repair Procedure.

Routine and standard procedures in dealing with prolapse have given way to the more rational approach of tailoring the operation to meet the individual's disability. In addition the practice of repairing symptomless prolapse is now condemned. The change has again resulted from recognition and acknowledgment not only of failures but the relevance of the operative procedure to late disabilities. We appear to be at the end of the era of the routine Fothergill.

Hysterectomy.

The unquestioned correctness of total hysterectomy as the minimum procedure for removal of the uterine body is being reappraised. The removal of the healthy cervix in every case to forestall carcinoma is being seriously questioned. While subtotal hysterectomy is not yet advised as the routine procedure, careful assessment of the cervic clinically and histologically before deciding on its removal, is gaining ground. The cervix is not a useless structure after all nor its removal without sequence.

Transverse Incision.

Vertical incisions give the best exposure but the poorer healing and the worst scare. The importance of the latter is overcoming the advantage of the former, perhaps following the modern trend in body exposure! And with the enthusiasm of the converted the transverse incision is being advocated by some for Caesarian section too.

The Role of Blood.

Gynaecologists, abandoning their isolation, are in the forefront of applying advances in other fields to their speciality. Routine pre-operative use of blood and the "topping up" during post operation is now roundly condemned for the good reasons that circulation specialists have propagated. Blood still has its place but when indicated and the indications are well defined.

The Class of Drugs.

The danger of multiple drug usage—the incompatabilities, antagonisms and potentiation — has come to gynaecology and obstetrics as it has to other specialities. The problem growing with the lengthening list of new preparations requires continuous awareness and attention by a routine of easy reference and checks which perhaps few have implemented comprehensively. But this problem confronts the whole profession and dealing with it adequately remains to be resolved.

Conclusion.

The list of items presented by no means covers the whole field of reappraisal but is sufficient to indicate that in gynaecology and obstetrics as in medicine generally, the trend is to critical reassessment of every aspect of the subject, of old convictions and tenets previously accepted without question. To have broken through the customary preoccupation with technical and theoretical advances and placed prime time on a "debunking" exercise was the major interest in a stimulating symposium.