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THE MEDICO-MORAL PROBLEM REGARDING HYDRAMNIOS*

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Hydramnios is a condition in which an excessive quantity of liquor amnii collects within the membranes. The average amount of fluid occurring in patients at term has been determined to vary from 1000 cc. to 1200 cc. A quantity greater than 2000 cc. is usually considered excessive, and amounts of 15 liters or more have been reported at the sixth month. While the chief factor responsible for this excessive production or retention of fluid is unknown, amnionitis, deformity of the foetus and maternal toxæmia are contributing agents.

Acute hydramnios complicating pregnancy at the fifth or sixth month is indeed rare, but when it does occur, we are faced with a moral problem as to treatment. Since the foetus is viable from the seventh month we will limit our discussion as to the propriety of rupturing the membranes at the fifth or sixth month, or before the time of viability of the child.

Polyhydramnios arises early in pregnancy, and at the fifth or sixth month may give rise to severe pressure symptoms due to the rapid accumulation of fluid. Dyspnoea so severe as to absolutely preclude the patient's lying flat;

cyanosis, oedema of the lower extremities, with pain in back and abdomen are also present. The skin is under excessive tension, and the entire abdomen is hard and tense. Foetal parts are not palpable, nor are heart sounds heard. Extreme exhaustion, cardiac embarrassment and death of mother may follow.

Thus we have a picture of a condition which requires intervention, for if treated conservatively, a fatal outcome may ensue. What is the Catholic physician to do?

In all text books on obstetrics we read that the treatment for acute hydramnios is active and consists of rupturing the membranes and allowing the fluid to escape. The patient is then left to a spontaneous miscarriage which almost always occurs.

This operation, in my opinion, is a direct attack on the foetus, and it is fatal to it. Theologians condemn this procedure, stating that the liquor amnii is necessary for the life of the foetus, and that the rupture of the membranes with the escape of all the fluid procures a direct miscarriage. They explain their teaching in regard to the rights of the unborn child to life, even when it threatens the life of the mother. There is no other alternative but to accept this decision and not rupture the membranes. How then

* The two remarkable articles by Dr. Schmitt and Fr. Davis, S.J., respectively, should be read in conjunction with each other.

can a Catholic physician successfully manage such a case?

Doctors Dieckmann and Davis, of the Chicago Lying-in Hospital, have carried on extensive studies on the nature and mechanism of formation of the liquor amnii in the human. In the course of these experiments it was necessary to puncture the amniotic cavity in late gestation in the normal women as well as in women with hydramnios. From these studies Dr. Davis states that in acute hydramnios it would be entirely possible to drain off a certain amount of amniotic fluid and have the patient continue with her pregnancy.

I, therefore, suggest puncturing the amniotic sac through the abdomen with a long needle or fine trocar and canula and drain off slowly by mild suction amounts of fluid varying between 850 to 3750 cc. The technic is simple and unless the patient has extensive adhesions due to a previous operation there is no danger of injuring the intestines, as the over-distended uterus presses firmly against the anterior abdominal wall. The uterine cavity can best be entered five to six cm. above the symphysis when the patient is on her back and the bladder completely emptied. The right or left of the mid line is chosen, depending on which side fluid is more easily palpable, and a local anaesthetic is all that is necessary. The foetus in utero is not injured.

If the puncture yields pure blood the needle is withdrawn and

reintroduced higher up, as there is probably present a low-lying placenta which was pricked. The immediate results are always good because the pressure symptoms are relieved at once. To prevent labor pains morphine is given in small repeated doses after the operation.

Dr. A. Mayer of Vienna reports twelve cases of hydramnios in which he punctured the amniotic sac through the abdomen at the fifth and sixth month. In five cases, labor followed in one, three, six, eight and ten days respectively, while the remaining seven continued on to near term.

Drs. Dubrovsky and di Fonzo observed hydramnios in 209 pregnant women out of a group of 38,500 who were cared for at the Maternity Hospital of Buenos Aires from 1928 to 1936. The condition was of slow evolution in 162 cases and acute or subacute in forty-seven. In this latter group there were eight twin pregnancies. Twenty-six of the acute cases were carried to or near term. Whenever warranted, puncture of the uterus for elimination of hydramnios was practiced. On all occasions it improved the condition of the mother. However, in about 50% it was followed by a spontaneous miscarriage or premature delivery.

I recently had one case at six months where percutaneous puncture for hydramnios was performed. The patient continued with her pregnancy until the sev-

enth and one-half month when she delivered twins, but both died of prematurity within thirty-six hours.

Rupture of the membranes through the cervix with an orange stick or other device is different from puncturing the membranes through the abdominal and uterine wall with a fine needle or trocar. In the former there is no control over the amount of fluid which escapes, in fact, all eventually is lost. In the latter procedure we can measure just how much fluid we wish to remove, leaving a sufficient amount necessary for the life of the foetus. This excessive amount of liquor amnii in hydramnios is pathological, and it is only that amount which is removed in the uterine puncture.

Dr. Davis has observed that there was absolutely no leakage of fluid through the needle puncture in the uterus. Furthermore, since it was a simple procedure with apparently little risk to the patient, he concluded that abdominal puncture of the uterine cavity was entirely feasible. To quote "In acute hydramnios it would be entirely possible to draw off a certain amount of amniotic fluid and have the patient continue with her pregnancy. After some of the fluid was withdrawn it would be well to have an x-ray picture of the foetus made in order to rule out a possible monstrosity which is so often associated with this condition."

In my opinion, therefore, this operation is not a direct attack on the foetus, as enough fluid always remains within the sac necessary for its life and growth. It does not procure a direct miscarriage.

In a recent book on "Moral and Pastoral Theology" by the Rev. Henry Davis, S. J., of Oxford, England, I found the following statement under the title of the Medico-Moral Problem Regarding Eclampsia—"But if a mother can be saved by a method which is the only one available, and which is not a direct attack on the child, viable or not, although which may prove fatal to the child, the surgeon is justified in operating."

I believe that the procedure which I have here outlined belongs in this category.

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