Position in Childbirth

At least forty different postures adopted during labour by women of various races and cultures have been described. Whether the position of the mother during the first and second stages matters or not has been debated interminably, though the debates have usually generated more heat than light and have usually relied on untested assumptions. The assessment of the best position for the woman in labour is influenced by a number of conflicting requirements. Among these are the comfort of the mother, the choice of a position which does not impair the speed of dilatation of the cervix or expulsion of the baby, the reduction to a minimum of any risk of damage to the foetus and mother, and the convenience of the attendants, who must be able to examine the patient and carry out obstetric procedures. Factors such as the presence of cardiac or respiratory disease must also be taken into account.

There is no factual knowledge on the effects of posture during the early part of the first stage of labour, the latent phase, when the cervix has not dilated beyond 2 cm. Until more is known, the emotional and physical comfort of the woman should determine her activities and position in this period. During the later first stage, at 3 cm. dilatation, R. Caldeyro-Bacca and his colleagues1 have shown that the pressure of the amniotic fluid is diminished when the woman is on her back, and the strength of myometrial contractions is greatest when she is on her side. The lateral position might also be supported on the grounds that the inferior vena cava is not compressed and renal function is not impaired.

Perhaps there is most dispute about the optimum position during the second stage and delivery. H. Speert,2 discussing Walcher's position, notes that G. J. Engelmann3 mentioned 16 different postures in various races, and H. Ploss and M. Bartels4 expanded this number to 40. F. H. Howard5 has written much about position in childbirth, and this stimulated F. Naroll, N. Naroll, and F. H. Howard6 to analyse data from 76 non-European societies. Of these the women in 62 normally give birth in a more or less upright position, and in 14, mainly from Asia, in a "neutral" position. Sitting or leaning on some support, squatting with the weight chiefly on the feet, kneeling with the weight mainly on the knees, and standing were all described as upright positions. The neutral position was defined as prone, quadrupedal, or supine, the last being in the European tradition. In primitive societies cultural attitudes are the main determinants of position in labour: it would be a mistake to assume that these are relevant in Western civilized communities.

Adele Blankfield7 makes a plea, on anatomical and physiological grounds, that the woman in the second stage of labour should have her shoulders and occiput raised from the bed by assistants during her bearing-down efforts. This makes the spine flex along its length and allows optimum conditions for closure of the glottis and for muscular efforts to expel the foetus. The value of this posture, which seems to be a compromise between the upright and the supine positions, is inferred rather than shown by the evidence.

Old woodcuts of childbirth, especially those showing the use of the birth stool, throw further light on this subject. In Rösslin's Rosengarten, published in 1513 in Germany, the woman is depicted sitting upright. In Rueff's De Conceptu et Generatione Hominis, of 1587, the woman being delivered is semi-recumbent. With the introduction of forceps delivery in the eighteenth century women on whom this operation is being performed are shown fully recumbent. Perhaps in this progression one may see the increasing importance attached to the needs of the attendants. The left lateral position for delivery was called the "London method" by Smellie and was dictated partly by modesty and the ease of vaginal examination, and partly because this was the easiest position in which to perform internal version in the unanaesthetized patient. Now it offers fewer advantages, and it may slow the progress of the second stage. Smellie's8 words in 1752 were:

"She is commonly laid on her left side, but in this particular she is to consult her own ease. . . . But if the labour should prove tedious, the Parisian method seems most eligible; because, when the patient half sits, half lies, the brim of the pelvis is horizontal. . . . In this position, therefore, the weight of the waters, and, after the membranes are broke, that of the child's head, will gravitate downwards, and assist in opening the parts, while the contracting force of the abdominal muscles and uterus is more free, strong, and equal, in this than in any other attitude. Wherefore, in all natural cases, when the labour is lingering or tedious, this or any other position, such as standing

5 Engelmann, G. J., Labor among Primitive Peoples, 2nd ed., 1883, St. Louis.
or kneeling, ought to be tried, which, by an additional force, may help to push along the head and alter its direction when it does not advance in the right way. Nevertheless, the patient must by no means be too much fatigued.”

Could it be better said? To-day if the patient is “too much fatigued” forces application, preferably under local anaesthesia, is so safe in skilled hands as to make much of the discussion about position in the second stage of labour unprofitable.

Acne: Tetracycline or Not?

Most people in Great Britain, whether medical or lay, will have tried their hand at treating acne vulgaris at one time or another. It lends itself to private enterprise. Sufferers abound, the lesions are conveniently situated so that their progress can be followed without the need for undressing or for the use of special instruments, and the natural variability of the condition ensures continuing interest week by week as the latest remedy is assessed.

The decision on which to apply of most of the treatments available can hardly be considered vital. The choice between one sulphur lotion and another, for instance, will make little if any difference to the outcome. But in the last few years systemic antibiotics have been advocated for the treatment of acne, and in the consideration of these flappiness must depart. Tetracycline and its relations have been the chief drugs suggested, dosage usually starting at 250 mg. four times a day and falling gradually, against the usual canons of antibiotic therapy, even down to 100 mg. daily in some reports. The recommended course usually lasts some months.

Apart from the expense entailed, these drugs have undesirable side-effects of varying incidence and severity which must be weighed against their therapeutic effect. The most important are nausea and vomiting, presumably due to a direct action on the gastric mucosa, and superinfection by antibiotic-resistant organisms. Among these are Candida albicans, Proteus and Pseudomonas species, and Staphylococcus aureus.¹ Liver toxicity has also been reported, notably in association with pregnancy and with high dosage.² Photosensitization may occur, especially in patients exposed to strong sunlight, while inhibition of protein synthesis has been postulated as the cause of the hypoplasia of tooth enamel and retardation of bone growth occasionally seen.³ Tetracyclines are also deposited in bones and teeth which are calcifying, causing a permanent discolouration. Consequently clear-cut evidence that these antibiotics in fact help to clear the lesions of acne or prevent new ones from developing would be welcome. This is where the difficulty lies.

The natural variability of acne is so great that any assessment of therapy is difficult. What is more, anyone with much experience of treating acne will have been impressed by the frequency with which patients report an initial improvement on almost any remedy. In other words, the expectancy of the patient often brightens his own assessment of the severity of his acne and, perhaps less often, even produces actual improvement of the lesions. There are many reports of the favourable effects of systemic antibiotics in trials both with⁷ and without⁸ a placebo, but in two double-blind cross-over trials with a placebo⁹,¹⁰ there was no significant difference between these drugs and the placebos. What therefore is one to do until the situation is further clarified?

In the first place tetracycline and related drugs should probably seldom, if ever, be given for acne to pregnant women or to children when the teeth are still calcifying. People with hepatic or renal impairment should be especially carefully watched. The milder cases of acne would not seem to call for this treatment. There is no good evidence yet that antibiotics are particularly effective in clearing up certain types of acne, such as the predominantly cystic or pustular varieties, although it is a widespread clinical impression that they are. The difficult cases, in which the usual homely remedies have been tried and found wanting, are the ones where the temptation to prescribe antibiotics becomes acute. Should it be resisted? Opinion at present seems to be divided.

New Year Honours

Baroness Summerskill has been created a Companion of Honour in this year's New Year Honours, for her political and public services. After serving on the Middlesex County Council from 1934 to 1938 she was returned to Parliament in that year and sat in the Commons continuously until 1961, when she was translated to the House of Lords. Ever a champion of social justice and welfare, she was Minister of National Insurance from 1950 to 1951 and chairman of the Labour Party from 1954 to 1955.

Surgeon Vice-Admiral Sir Derek Steele-Perkins receives the K.C.B. for his outstanding services as Medical Director-General of the Royal Navy since 1963. Graduating from Edinburgh in 1930, he entered the Navy two years later, and accompanied the Queen on her visits to the Commonwealth in 1953-4 and 1959. The knighthood conferred on Dr. Ludwig Guttmann is a further recognition of his services at the National Spinal Injuries Centre at Stoke Mandeville to patients disabled by paraplegia. A former director of the department of neurology and neurosurgery at the Jewish Hospital in Breslau (now Wroclaw), Dr. Guttmann came to Britain as a refugee in 1939, and after working in the department of surgery at Oxford became director of the Centre in 1944. Professor I. W. J. McAdam's far-sighted direction of the department of surgery at Makerere University College Medical School at Kampala, Uganda, has been recognized by the conferment of a knighthood. It comes at a time when medical men from Britain are playing an important part in helping emergent nations in Africa and elsewhere to develop their medical schools. Professor A. A. Miles, who also receives a knighthood, has made many distinguished contributions to bacteriology. He is director of the Lister Institute of Preventive Medicine and has been Biological Secretary of the Royal Society since 1963. Before going to the Lister Institute he was director of the M.R.C. Wound Infection