Opening Remarks from Congress Chairman

E. Saling

It is a great pleasure to welcome you to the 2nd Berlin International Meeting of Perinatal Medicine.

The numerous contacts between German obstetricians as well as perinatologists and foreign colleagues have in the meantime developed a traditional character. One of the reasons for this may be that some of the very first activities in this field started in German-speaking countries. The first National Society for Perinatal Medicine - namely the German Society was founded here in Berlin more than 14 1/2 years ago and the European Association only one year later.

How important this new development in medicine is, can be seen from the fact that in the meantime societies or units for perinatal medicine have been formed in many countries throughout the world, and more and more meetings are being held.

May I inform all of you who are taking part in a Berlin perinatal congress for the first time, that our meetings are known as being real "working" congresses. During the day there are panels, special lectures and numerous free lectures; during the evening from 8 p.m. onwards every participant has the opportunity of taking part in open discussions with the experts who contributed to the special topics talked about during the day - if so desired we can go on talking until midnight.

As Congress Chairman I always comment on some up-to-date matters concerning the field of perinatal medicine in my opening remarks. Such a topic which has been discussed on an international level for some time is the high rate of cesarean sections. It is true that operations are done too often and too willingly in many places, and there can be no doubt whatever that a cesarean increases the risk, particularly to the mother. How can we achieve some improvements? Last year we developed a so-called "Cesarean saving programme". It includes the following points (Fig. 1). The first part covers the medical and clinical factors.

Point 1: Cardiotocography should be combined with fetal blood analysis so that a cesarean is only then performed when there really is a manifest danger of hypoxia. Without doubt, even with this combination sometimes unnecessary cesareans will be performed, but certainly much

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less frequently than would be the case without fetal blood analysis.

Cesarean Saving Programme
Medical clinical factors
1. Combine cardiotocography with FBA.
2. Try a vaginal delivery in cases with previous cesarean, if this is not strictly contraindicated.
3. Make an external version under uterus inhibiting agents in cases with breech presentation.
4. Apply PG—Gel into the cervix in cases with premature rupture of membranes,unripe cervix and indicated induction of labor.
5. Perform elective induction if at all only if a) cervix is undoubtedly ripe b) gestational age is exactly confirmed c) patient is at least 10 better 7 days before or even closer to term.
Psychological factors
1. Reconcile yourself with the fact that the conduction of vaginal labor is mostly longer lasting and often not as convenient as a cesarean.
2. Concerning legal aspects perform a cesarean only if there is an apparent danger of legal conflicts if you were not to operate.
3. Do forget the higher honorarium for a cesarean.

Figs. 1 & 2

Point 2: one should always try to avoid a repeat cesarean if there are no evident contraindications and no considerable objections against a vaginal delivery, such as for example, if the previous cesarean was performed on account of relative disproportion. In more than 60% of the cases with previous cesarean we have been successful in delivering an infant vaginally, and in cases with two previous cesareans the figure is around 25%. It is true that we have to reckon with an occasional incomplete uterus rupture in 2% of the cases and a complete rupture in 1%; nevertheless in the past ten years there has been no serious incident in this connection in 238 of repeated cesareans. The most important presupposition is to pay attention to the possible danger of uterus rupture during the management of such a labor.

Point 3: external cephalic version from breech presentation to vertex presentation near to term is not performed often enough. This procedure alone can reduce the absolute cesarean section rate by about 1.5%. It looks as though prejudice takes priority over better knowledge. I do not think on account of single infant deaths that occurred in small collectives - almost all of them were due to clinical failures as can be proved from the available data - that it is correct to develop more or less fantastic theories about the danger of external version and spread these about. It would be better to perform a version under strict medical preconditions, as described, to collect personal experience in a sufficiently large group and report on these findings.

Reports are equally useless that describe fetal deaths after versions in previous periods when there was no facility for fetal monitoring.

In the meantime my coworkers, Pluta and others, have been able to show in an evaluation of more than 500 cases with attempted versions, how minimal the potential danger of this procedure is, if one respects the necessary preconditions; there was no fetal or neonatal death that could be related to the version.

Point 4: in cases of premature rupture of membranes the cervix is often unripe and in the conventional attempt to induce contractions immediately by oxytocin infusion, this can often lead to prolonged labor and to an increase in the cesarean section rate.

An evaluation done by my coworker Goeschen in our department has shown that immediate application of prostaglandin E_2-gel has led to an improvement in cervix ripeness in numerous cases, and thus several cesarean sections have been avoided.

Point 5: a lot of nonsense has been spread about elective induction of labor. There is no doubt that elective induction is dangerous when it is not handled properly, that is when the preconditions are not considered. This can lead to an iatrogenic increase in the cesarean section rate. So it is logical to say: certainly there are dangerous obstetricians who undertake a badly considered elective induction, but there is scarcely a dangerous elective induction. In the future we ought rather to call this procedure "correct elective induction". "Correct" means

a) being highly certain about the real gestational age, by means of ultrasonic examinations, without any doubt that the pregnancy is near to term; in this way unexpected prematurity can be avoided;
b) there should be no doubt about the cervical ripeness, at least 8 or more on the Bishop Score; in this way iatrogenically prolonged labor and an unnecessary increase in the cesarean section rate are excluded;
c) the patient must have specifically expressed the desire to have an elective induction, after having been told the pros and cons; in this way negative psychological reactions of the patient are excluded.

In conclusion on elective induction one can say without prejudice that, as also in all other walks of life, an exaggerated or extreme opinion is mostly wrong. I mean that it is short-sighted to reject elective induction dogmatically. But it is equally as short-sighted to make recommendations for its wider application. Unfortunately in this day and age we have too many extremists, not only in politics but also in perinatology.

Psychological factors also belong to the "cesarean saving programme;" I think that the three points do not require any comment.

Another up-to-date topic being discussed on an international level is the positioning during labor, but unfortunately some confusion has also arisen. In any case it is recommendable to compare the results of the various positions during labor under modern scientific examination conditions. This is happening in various centres at the present time, and Dr. Mendez-Bauer will report on this. Misunderstandings can arise if unrealistic comparisons are made which are clinically irrelevant and in so far useless. I mean comparing labors in a lying supine position with other positions such as walking about or sitting. Today, at least in this country, nobody allows a patient in labor to remain lying on her back for longer periods. I know of no hospital practising this - apart from the short period when bearing-down efforts occur. According to our information up to now, the differences between a lateral position and walking about or sitting do not appear to be as great as to justify the fuss and bother made in the mass media about positions during labor.

Now a few words on the psychological and emotional aspects of pregnancy and labor - one of today's popular topics for discussion. Prophets and pseudo-experts in psychosomatics have shot up out of the ground like mushrooms during the past few years. It is namely so easy to attract attention and even cause a sensation in psychological and philosophical fields by spreading theories that cannot be proved. How much more difficult it is to perform acknowledged examinations on solid medical and scientific basis or such that are respected by outstanding psychologists.

It is regrettable that even highly respected perinatologists occasionally pour oil onto this fire. At the world congress on psychosomatics held here in Berlin last year, it was impressively reported by my friend Dr. Roberto Caldeyro-Barcia, that when a woman in labor is kissed by her partner, this leads to a naturally caused oxytocin production. A fantastic symbolism which has underlined even more in the press and among laymen the onesidedness of emotional considerations of all the events during pregnancy and labor. The curious fact about this event is, that particularly the Montevideo Institute was, as is known from many excellent publications, one of the most active users of oxytocin infusions. So one of the next research projects should clarify why German, respectively non-Uruguayan women, are preferred for application of kisses during labor

to produce oxytocin and why Uruguayan women had to do without this pleasant way of oxytocin production.

A number of things concerning over-psychologising settles down by itself. I am thinking of a series of television programmes about so-called natural birth in our country. Numerous patients have told me that such pictures produced rather an aversion against natural childbirth and such behaviour is only suitable and representative for minorities.

Essential medical progress through high-flown concentration on psychosomatic aspects of obstetrics, measured according to strictly scientific standards, have not yet been achieved up to now. Really one can only say that a faulty development that started some decades ago has become normalised. What this wave a few years ago has really set in motion, was hospital delivery that was inhuman and without enough consideration of psychological aspects, which really has been practised in many places during the last decade since obstetrics moved from the private home to the hospital. Over-hasty critics have seen the reasons for this undesired trend in the technicalisation of obstetrics. How ill-founded these assumptions are, can be seen from the fact that as far back as in the '50s and the beginning of the '60s, the non-family and non-psychologically orientated hospital delivery already existed, and at that time obstetrics was not at all highly technicalised. In the meantime, through the widespread and fully justified criticism, the shortcomings in this field have been replaced to a considerable extent. In many places obstetrics is practised on a balanced, psychologically and family-orientated level. This is clear from the results published from various questionnaires filled out by patients. The activities of individual people or groups going on far and wide should be regarded as individual speculation, wishful thinking and demands of minorities important only as such.

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