THE OCCASIONAL MIDWIFERY CASE.

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PART I.

The following remarks are written with the object of refreshing the memory of those who find themselves in charge of occasional midwifery cases in out-of-the-way places where no opportunities exist for keeping in touch with recent ideas on this class of work. This applies to many stations abroad and sometimes at home. It is the isolated case that seems to bristle with difficulties, magnified by the circumstances. Let us suppose that you find yourself landed with all the responsibility of conducting, from beginning to end, a first pregnancy, confinement, puerperium, and then, if you have been successful, two months or more pediatric attentions to the infant.


I must preface my remarks by repeating that I am writing for the benefit of those who are out of practice and not for experts. Do not trust Dame Nature too implicitly as a midwife, she often requires help and her results amongst animals, as witnessed on farms, leave room for improvement; at the same time unlimited time and patience is safer than forceps applied too soon. I believe that quite half the women that have been mutilated with forceps would have been delivered uninjured had much more use been made of drugs, such as bromide in big doses and chloral, etc. In order to make these notes practical, we will take an imaginary case and deal with a few of the points likely to crop up. The lady is a primigravida, aged 30; she is of the rather highly strung type, she says she cannot keep anything down and is sick at the sight of food. She tells you that she has only missed one period, but on careful questioning she admits that for the last two months she only "saw" for two days and very little then, and that she put this down to change of climate, as she usually loses for five days. She wishes you to tell her when to order the nurse and to give her something to stop her sickness. Mistakes are so excusable and frequent in estimating the date of full term in these cases that one must exercise care and try to spare the mother all the extra expense and worry entailed in a wrong calculation. In this case disregard the last two abortive periods and calculate from the first day of the last normal full period, taking care to check your estimate at later visits when quickening has occurred at about the seventeenth week. Do not forget that the uterus reaches the umbilicus about the twenty-fourth week.
As regards her morning sickness, if she looks ill put her to bed for a few days and get her bowels well open with enemata and salts. I have no intention of discussing the treatment of morning sickness or hyperemesis in full, but in any severe case of morning sickness a thorough course of corpora lutea injections and capsules of the desiccated gland should be given a trial. Personally I have had good results. Give a hypodermic injection morning and evening for three days and then one capsule three times a day before food for fourteen days. In really severe cases nothing short of removing the patient from her surroundings to hospital will suffice.

Constipation is more the rule than the exception; plenty of water during the mornings is essential, but most women rarely pay attention to this simple rule. Petrolagar (green label) is very suitable, but must be taken three times a day at first.

The question of exercise is sure to arise. In my experience riding has caused abortion in the early months of pregnancy more than once and I forbid it, as an exercise.

Another common question is whether the extraction of teeth is advisable, or should it be postponed until after the confinement? The answer is that the undesirability of retaining any focus of oral sepsis outweighs the slender risk of abortion that is more problematical than real. Extensive extractions under general anaesthesia are contra-indicated.

Varicose veins can be a worrying complication sometimes and our advice is limited to as much rest as possible and the use of crépe bandages, or the less unsightly expedient of wearing two pairs of tightly fitting silk stockings. The injection treatment with thirty per cent sodium salicylate has been undertaken in spite of pregnancy in the earlier months, but as the veins tend to improve greatly when pregnancy is over this treatment is recommended only for severe cases of varicose veins of the vulva that may rupture during parturition.

Blood-pressure registration is as important a routine as examination of urine in ante-natal work. A high blood-pressure is often the first danger signal in the toxæmia of pregnancy and in chronic renal disease.

Do not forget to give a little timely advice about the care and preparation of the nipples. Let them be well washed every day and dried and rubbed with a clean rough towel. The pernicious fashion of wearing tight bust bodices to hide the nipples that would otherwise be very conspicuous through modern dresses increases the number of depressed nipples seen that require pulling out. Try and not leave this to the unfortunate baby to do; its efforts will start a long and painful train of events, commencing with cracked nipples and possibly ending in any of the following disasters: partial starvation, gastro-intestinal troubles, weaning, sleepless nights, and all sorts of worries perhaps ending in breast abscess. When the mother tells you that she has no intention of feeding her baby, quietly impress upon her that her figure has not as good a chance of returning to its original slender shape and form as when breast feeding is undertaken. It
is not necessary to go into the effect of lactation upon involution of the uterus, or to try and explain the inter-relationship of the normally functioning endocrine glands and their effect upon metabolism and her health, both bodily and mental. The point is that the women who will not feed their babies can be appealed to at once by reference to their personal appearance after confinement.

One can hardly pick up a newspaper without reading something about "maternal mortality," and the oft-repeated statement that sepsis accounts for the majority of deaths. We know that the worst cases of sepsis are due to the hemolytic streptococcus. We can and do determine the relative susceptibility of individuals to certain infections such as scarlet fever and diphtheria by means of the Schick and Dick tests, and it is possible that a similar test to determine susceptibility to puerperal streptococci will soon be part of the routine prophylaxis of midwifery. The concentrated scarlet fever antitoxin has been used in puerperal fever with much more encouraging results than was the case with the older sera. Since the tonsil is such a favourite place for the hemolytic streptococcus to thrive, it is well to remember this when looking at the patient; it is even more important that the nurse and doctor should have clean throats and wear gauze masks when delivering a patient or stitching up the perineum, in a poor light and breathing right up against the wound. The presence of hemolytic streptococci in the cervical canal of women is not rare. If the presence of a vaginal discharge is discovered during pregnancy cultures should be made. A useful douche that follows Nature's provision is pure lactic acid, one drachm to one pint of warm water.

Pelvimetry forms such an important part of ante-natal prognosis, and is so much a matter of personal judgment, that very little can be attempted in these notes. What we are here concerned with is the detection of cases that will require skilled assistance, and at such an early stage that the patient has time to make arrangements to go to an institution for her confinement. Later on when the best test of all can be applied, viz., the fit of the head into the pelvic brim, will be much too late to alter arrangements if abroad. Whatever measurements you take at this stage, be sure to take the diagonal conjugate in the case under review. Do not mistake the "false promontory" (the ridge felt between the first and second sacral vertebrae) for the true promontory just above. If you can touch the true promontory and the measurement to the lower edge of the pubic arch is under 4½ inches, you are probably in for trouble, and your patient should be placed under expert supervision.

PART II.

A word or two about the last few weeks of pregnancy. In the case we are considering, the head should be well fixed in the brim during the last two weeks. In gauging its fit, hold the front of the fingers tightly against the abdominal wall just above the pubic crest, and then raise the patient
up into a sitting posture when you should be able to feel the head enter the cavity and not over-ride the crest of the pubes. Another point, if the two poles of the foetal head are both felt about the same level just above the pelvic brim, it indicates extension of the head and probably some degree of flat pelvis. One would feel uneasy if the case was overdue at all, and knowing how much easier moulding is in a head that is not too hard or ossified from possible post-maturity, it is good practice to try the simple expedient of giving the "castor oil induction method" a trial a day or two before the expected date. This is done as follows: At 7 a.m. give 1½ ounces of disguised castor-oil, followed two hours later by a mixture containing 10 grains of quinine sulphate which is given again every two hours up to three doses. Do not use pituitary extract at this stage, ruptured uterus has followed it. Labour may not start in the successful cases for twenty-four hours. It is no use trying this method earlier than two weeks before term. It gives rise to a certain amount of discomfort. When the head is in the pelvic cavity it usually succeeds. In fact, a good dose of castor oil followed by 10 grains of quinine has often done what was necessary.

Sleeplessness is common at this stage, with discomfort in the pelvis. An occasional dose of fifteen grains of bromide in warm milk at bed time will secure the necessary sleep. Vaginal examinations should be avoided. In fact, if the head is in the pelvic cavity, which is easily felt per abdomen, it is seldom necessary to make any vaginal examination from beginning to finish of the labour.

**PART III.**

There is no intention of going into the conduct of labour. A few suggestions that have proved useful are all that is intended. Quiet and cheerful, but definite, reassurance that everything is normal and that the pains are essential, in fact that there will be about a hundred of them before Nature has done her work, often helps to get the right mental outlook on the very trying time that is at hand. When the pains are well established in the first stage a mixture containing chloral hydrate 20 grains, and potassium bromide 20 grains is useful, and can be repeated in a couple of hours if necessary. Veramon (Messrs. Schering) 6 grains every hour with plenty of water is well tolerated, up to 18 or 24 grains. Whatever you give avoid morphia in the last four or five hours of labour. Combined with \(\frac{1}{180}\) grain of hyoscine, a ¼ grain of morphia is almost a routine with many, but the morphia should not be repeated however often the hyoscine is given. In any case, during the last hour, when the first signs of perineal pressure begin, chloroform should be given with a Junker's apparatus. The nurse can manipulate it or the patient herself at first, and it is the best method for general use that I know. Specially arranged gas and oxygen given with each pain is now much in use, but the apparatus is expensive. It is often remarkable what a change can be effected in the general behaviour of a nervous and anxious patient flinging herself about
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the bed groaning and crying *between* the pains by sitting down beside her bed and quietly and firmly insisting on her shutting her eyes and completely relaxing all her muscles the moment the pain is over. It takes a few minutes to teach her, but once she has done it she soon realizes the rest it gives. This is well worth remembering if you have not tried it.

It is well to recognize the fundamental difference in the degree of surgical cleanliness obtainable in, say, an abdominal section and an obstetric operation. You can render the skin through which the incision is made, more or less germ free, but the vulvar and anal region is always infected, and the places where wounds occur, viz., the cervix and perineum, must be reached through this infected area. A good light, warm soap and water gently applied, followed by the careful use of scissors, is probably better than the shaving operation as it is usually done. After shaving, one often sees little abrasions and scratches that, together with an inflamed skin in a very sensitive part, may quite well result in pustules and gland infection. Iodine and spirit is commonly applied all over this area, but acriflavine, 1 in 2,000 with spirit, is not so irritating. For general use I advise bichloride of mercury 1 in 2,000. Lysol in sufficient strength to be of much use is severe on the hands.

One word of warning, because the accident is so very frequent and the results so serious; if you have to use forceps, do make absolutely sure before you apply them that the head is not lying in the occipito-posterior position. If it is you will experience "slipped forceps" with all it entails. To avoid this, insist on an anesthetist and introduce your whole band, gloved, of course, into the vagina, and do not rely on sutures and fontanelles, but make certain of the lobe of the ear to indicate the position of the occiput, unless of course the head is so low that you can make certain of the occiput without. In repairing the perineum, wait until you have a really good light, and have your patient in a position that enables you to do your job comfortably without any fumbling. Use 30-day No. 2 catgut for the posterior vaginal wall and silkworm gut for the external stitches.

**PART IV.**

The third stage of labour may give you trouble in many ways, but here we are trusting that post-mortem haemorrhage need not be mentioned. Before leaving the case to the nurse have a good look at the placenta and membranes, they are quite often forgotten by the doctor who only sees a case now and then. You have turned the mother over on to her back and waited patiently for a pain to assist you to express the placenta. Gentle kneading has produced the pain, but the placenta refuses to pass into the vagina. You have waited nearly an hour, ought you to "go up" for it? Emphatically no; the risk of puerperal sepsis is enormous if you do, no matter how carefully you introduce your gloved hand. It is safer to go and lie down and sleep in the house near at hand, in
case you are forced into manual removal by haemorrhage, rather than manually remove it to save time. You may try injecting sterile water into the vein of the umbilical cord with a boiled Higginson syringe. It will help to pass the time and may detach the placenta without doing any harm; it “comes off” sometimes. The membranes may be nipped in the contracting cervix, and although you have “roped” them they are reluctant to slip out. Clip on a pair of artery forceps and wait till the contraction has passed off before gently pulling again. If some membrane is unfortunately left behind, do not hunt for it in the vagina. Keep the patient well propped up in bed to help drainage, and tell the nurse to keep a sharp look-out for the missing piece.

In the past the use of pituitrin has sometimes been contra-indicated in cases with high blood-pressure, in certain toxæmic states and so forth. Pitocin (P.D. and Co.) is now on the market, and will give the necessary uterine contraction without any vaso-pressor effect.

**PART V.**

During the puerperium one or two points worth mentioning are the necessity for obtaining thorough drainage by position; the avoidance of that pernicious old custom of keeping women lying on their backs after a confinement, and the importance of sitting up to pass urine.

The first point is most important, unless the patient is propped up or given a suitable foot rest she will remain recumbent with the result that puddling of the lochia will occur and some degree of sepsis is likely.

If the perineum has been torn, she should be taught to pass urine on her hands and knees to avoid soiling the stitched perineum. The nurse must be very careful to dry the parts after urination or defaecation.

The dorsal position after parturition is responsible for many cases of retroversion of the uterus and must be guarded against, especially at the end of the first week when the involuting uterus is becoming just the right size to drop back into the hollow of the sacrum.

Let a normal patient move about in bed as much as she likes, and teach her to spend most of her lying-down time on her side in the position of rest. Early exercises for legs, arms, abdominal muscles, and the pelvic floor, should not be forgotten. The pelvic diaphragm can be exercised by doing the reverse to “bearing down,” viz., tightening up the muscles in between the legs as if in the effort to prevent the rectum emptying itself at the same time the breath is drawn in through the nose. This is best done in the “knee elbow” position.

Binders are not necessary after confinement as a rule, but I have seen cases of acute intestinal distension that were alarming due to sudden release of the abdominal contents combined with abnormally lax muscles. For these cases a roller towel binder very firmly adjusted is the only way to combat the collapse that results.
In conclusion, if you decide to adopt four-hourly feeding, see that it is genuine, and that for the first two weeks the baby is fed at 2 a.m. The mother will be relieved and will sleep all the better, and the baby will get its required amount.

If you are unlucky enough to meet with pyrexia during the puerperium, let me remind you not to forget B. coli pyelitis as quite a common cause. I mention it because in my capacity as consultant under the notification of puerperal pyrexia I have seen it overlooked and its recognition and treatment by large and frequent doses of potassium citrate with plenty of water is so very gratifying to all concerned. Contrexeville water is a very good addition to the treatment, but never give hexamine in the acute stage. Reserve your vaccines and hexyl-resorcinol (Boots and Co.) for the chronic stage only.

In conclusion, I must apologize for the disjointed and sketchy composition of these notes, but if they solve a doubt or two in the mind of some worried "occasional obstetrician," they will have served their purpose.