

SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class.)

A Note on Malaria as a Complication of the Puerperium.*

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THERE may be some surprise that this subject has been brought before you this evening. Its rarity is sufficient explanation. The whole nature of the complicated case which I shall report caused me so much anxiety that I thought a recital of my troubles might save future worry to some of the Fellows so unfortunate as to encounter such a fever in their practice. The principal case was the first of a sequence of three, the last two of which, however, proved to be simple.

Case of Mrs. M., the wife of an officer in the Indian army. She was an apparently healthy primigravida; the pelvis was normal by external pelvimetry; breech presentation by palpation. The membranes ruptured at 7-30 a.m. on June 4th: labour pains started at 6 p.m. At 4 p.m. on June 5th the foetal heart rate, which had been between 130 and 140 to the minute dropped to 120: an hour later the rate was 114, and the mother's temperature was 99 degrees F. Labour pains had been strong from the commencement. The frank breech was still high in the pelvis: and the case was evidently one of impacted breech.

The vagina was so narrow, that there was difficulty in inserting two fingers. Under chloroform anæsthesia, I dilated the vagina manually and very gradually. The first finger was then hooked into the anterior groin: an assistant pulled on my wrist and the breech was delivered. There was great difficulty with extended arms. The baby, whose weight was 8 lbs. 3 oz., was born in white asphyxia: it recovered as the result of the usual measures and is strong and healthy now. The perineum was torn into the rectum and far up in the vagina. This was not surprising owing to the narrow vagina and the large baby. The vagina and rectum were repaired by means of catgut suture and the skin edges were

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approximated by means of silkworm gut. There was no post partum hæmorrhage. As haste was necessary in effecting delivery, I could not in this case employ such methods of dilating the vagina as Champetier de Ribes' bag or pledgets of cotton wool.

The temperature and pulse chart read as follows :—

First evening temperature	100.4°.	Pulse 92, bladder catheterised.
Second „ „	99.4°.	Pulse 104, bladder catheterised.
Third „ „	100.2°.	Pulse 112, bladder catheterised.
Fourth „ „	102.2°.	Pulse 120, vaginal and uterine douche. Some non-odorous lochia came away.
Fifth „ „	100.0°.	Pulse 112.
The temperature ranged between 99° and 100° for four days.		
Tenth evening temperature	101.2°.	Pulse 120.
Eleventh „ „	100.2°.	Pulse 104, culture taken : uterine douche. No result from the douche.

Dr. Rowlette reported that the smear was negative, and later that the cultures were also negative.

From the commencement of the fever quinine hydrobromide 5 grains thrice daily, liquid extract of ergot one drachm twice daily, and whiskey six ounces daily, were being administered. All these were discontinued on the advice of Dr. Rowlette.

The question of malaria had been present in my mind, but as Fry¹ says in an excellent paper on puerperal malarial fever, it is far safer to treat malaria for sepsis than vice versa.

On the 15th day the urine contained a slight amount of albumin but no pus. The chest was normal. There was nothing to suggest septicæmia beyond the high temperature and the rapid pulse rate. Blood was removed from a vein in the arm. The cultures were negative. At the same time the blood was examined for the malaria parasite, and Dr. Rowlette found it present. Quinine bisulphate, 10 grains three times daily, was then given, which brought the temperature to normal after six days. It remained thus for nine days, and the patient had been allowed to leave her bed for two days when without any apparent reason, on the 30th morning, the temperature rose to 101.4°; on the 31st evening it was 102.2°, the 32nd evening it was 103.2°, 33rd evening 101°. Quinine was again administered, and the temperature fell to normal and remained so (with the exception of the 39th and 40th days when it reached 100°) until she left the home in good health on the 48th day.

It may be asked why the diagnosis of malaria was not made sooner. It had never been my lot to meet a case of puerperal malaria. The patient had not mentioned that she had suffered

from the disease, and only informed me later after close investigation that she had had an attack two years previously. The difficult and complicated nature of the confinement made one think firstly of septic infection, although needless to say all aseptic precautions were taken. The fact that the upper part of the vaginal laceration did not unite at first made infection all the more possible, as fæces were issuing from the vagina. The difficulty in diagnosis was increased by the temperature curve which was hectic in type: there was no liver or spleen enlargement: no sickness or nausea. Rogers,² in his work "Fevers in the Tropics," states that a rise of temperature in the morning is against other fevers. The type of malaria which was present in this case seems from the chart to be the double tertian variety.

Daniels and Wilkinson³ in "Tropical Medicine and Hygiene," Part 1, note that malaria can be diagnosed from (1) discovery of the parasite, (2) pigmented leucocytes, (3) increase in the relative proportion of large mononuclears without increase in the total number of leucocytes. It is to be regretted that there was no differential blood count made, though the discovery of the parasite may be regarded as a positive indication of the disease.

It is easy to imagine my feelings when I was called to attend the two patients which followed the last.

Case of Mrs. D., a white woman married to an Indian, an apparently healthy 2-para with a history of malaria. This woman had a normal confinement and gave no trouble until the fourth day, when she had a shivering fit with a rise of temperature to 99° F. This "fit" seemed to be hysterical and the remainder of the puerperium was apyretic.

Case of Mrs. B. A primigravida who gave a history that she had nearly died of malaria in Rhodesia. She had the marks of abscesses in her arms where quinine had been hypodermically administered. She had an idiosyncrasy against quinine and arsenic. The delivery was a very difficult breech but happily the puerperium was without incident.

Malaria complicating the puerperium is a very rare condition. The four text-books⁴ which I have consulted ignore it. I have enquired from many Indian Medical Service men, who all report that they have never seen a case. A search of the *Indian Medical Gazette*⁵ from 1880 until the present day revealed no reported case. I found in the literature four papers,⁶ and reference to nine others which were not obtainable in Dublin. Fry,¹ whom I have already quoted, warns the physician against the unproved diagnosis of malaria. He reports fully one case: its similarity to mine is noteworthy. Coe⁶ communicates two interesting hyperpyretic cases in the puerperium. He considers malaria to be a cause of one of them, although no blood examination was made. The few

American writers who have reported cases seem to consider that the question of a miasmatic origin of a rise of temperature should always be raised. If this is to be believed, the Dublin maternity hospitals should have many such cases.

REFERENCES.

1. Fry. *American Journal of Obstetrics*, xxxv, 1897, p. 1.
2. Rogers. "Fevers in the Tropics," 1908.
3. Daniels and Wilkinson. "Tropical Medicine and Hygiene," part ii, 1909.
4. "Tropical Diseases," 1904, and Castellani and Chambers, "Manual of Tropical Medicine," 1910.
5. *Indian Medical Gazette*, 1880 until present day.
6. Hamill, *American Journal of Obstetrics*, xxi, 1888, p. 317, and Norton, *American Journal of Obstetrics*, xxxiv, 1891, p. 62, and Coe, ditto, p. 647.