REMARKS ON THE AFTER-TREATMENT OF NORMAL MIDWIFERY CASES.*

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Old Thomas Denman wrote, at the beginning of this century: "* * There is more than common tenderness mixed with our concern for those who suffer under the circumstances of childbearing, and the mind is not at these times prepared for untoward events. Much industry hath therefore been used for the discovery and establishment of some method by which women might be conducted through the state of childbed with the least hazard of exciting those diseases to which their state was supposed to render them peculiarly liable; or that very great pains should have been taken to discover the safest and most efficacious method of curing those diseases when they actually existed." †

The hundred years which have elapsed since Denman penned these lines have seen great advancement in the obstetric art; but there has been no change in the sentiment he expresses, for we are as solicitous to-day as were the older practitioners in insuring to puerperal women the greatest comfort and the most certain protection from disease during the lying-in period. We have learned many things,—and perhaps one of the most important is that we no longer consider pregnancy and parturition in the light of disease,—but rather as normal physiological processes, in which the accoucheur plays the part of an assistant, aiding nature in the performance of her functions. There is no more reason to consider the puerperal woman as a surgical case, or compare the newly-delivered uterus to an amputation stump, than there is to treat the apple tree after the autumnal crop has been gathered, as dead and worthless firewood. Such ideas

*Read before the Detroit Medical and Library Association, and published exclusively in The Physician and Surgeon.

†Introduction to the "Practice of Midwifery." Volume II, page 443. London, 1805.

belong to past ages, and the sooner we rid our minds of them the better it will be for our patients.

The first duty of the physician following the third stage of labor is to see that the uterus is well contracted. The perfect procedure is to have the nurse's hand follow down the contracting organ until the child is expelled, and the umbilical cord severed, when the physician may grasp the fundus of the womb, and holding it until the first or second pains come on, employ the Credé method of placental expression.

After the casting of the placenta the hand should still grasp the uterus, and by means of gentle friction and massage maintain it as a hard ball-like mass behind the pubes. My experience leads me to believe that this is too often neglected, and there can be no doubt that the majority of cases of post-partem hæmorrhage reported in current medical literature are the result of the failure to control the uterus in the manner described. My own custom is to hold the uterus—either with my own hand or that of the nurse—for one hour after delivery; and I have yet to see a case of hæmorrhage following such treatment. Occasionally, however, even with the uterus well contracted, hæmorrhage takes place, and it becomes necessary to inspect the genital tract for its source. Indeed, as regards examination of the external parts, this should be the routine; for often a severe injury to the introitus and perineum might otherwise escape notice. Such lesions demand surgical treatment, and I believe the Vienna rule to repair lacerations within three or four hours after delivery is a good one. Stitches taken within this period cause comparatively little suffering to the patient, and holding the torn surfaces in apposition during the first few days of involution, usually result in complete union of the lacerated parts.

Although much has been written of late in regard to the primary operation in cases of cervical tear, I cannot accept the dictum of enthusiasts as to the necessity of such a procedure. In rare instances, in which the rupture of the neck extends so high up as to involve the circular artery, severe hemorrhage resulting, it might be necessary to pass a suture around the torn vessel in order to control the bleeding. This, we can imagine, might follow manual dilatation of the os, the unskillful application of the forceps, or some rough manipulation during labor; but it must be of extremely infrequent occurrence, and I confess that, after a very considerable obstetrical experience, I have never seen such a case. As for ordinary lacerations so large a

percentage heal of themselves, that to expose a newly-delivered woman to the annoyance of an operation, to say nothing of the dangers from septic infection, seems to me wholly unnecessary and unwarrantable. It is to the avoidance of septic invasion that the efforts of the profession have been directed since the time of Semmelweis—why then should we incur this unnecessary risk?

The chief disorder which gave the older observers the most concern, and which has been left to us as a legacy, was the so-called puerperal fever, a term which we now know was a *multum in parvo* definition including a great variety of conditions associated with elevation of body temperature. The after management of midwifery cases was, therefore, in former years directed largely to a supposed inflammatory state which was promptly met by a more or less active antiphlogistic treatment. But the investigations and discoveries of the past few years have shown us that this theory was wholly untenable, and that the normal puerperal woman *is* as normal during the lying-in period as during menstruation, or at any other time. Painful experience and careful observation have taught us that the three stages in the reproduction act are not separated by a sharp line of demarkation but are intimately connected and dependent, the second on the first and the third on the preceding two, so that if we would insure a normal puerperium we must anticipate it in pregnacy and parturition. If puerpery is to be wholly free from the taint of infection, we must look to it that the patient is not infected previous to that state.

Szabo* has found that infection increases in proportion to the number of local examinations made before and during labor, —and Leopold and Pantzer's† experience coincides so closely with this that they urge that such examinations be omitted almost entirely, and information as to the position of the child and progress of labor be obtained by external manipulations. Hegar's‡ statistics from Baden show that, other things being unequal, too much reliance is not to be placed even on the employment of antiseptics,—for since the introduction of the latter into obstetric practice in that Duchy, the occurrence of puerperal morbidity has not been materially affected. The cause for this he finds in a lack of cleanliness which the antiseptics were supposed to overcome,—a false notion of security being thus engendered.

* *Archiv für Gynakologie*, Band XXXVI, page 77.

† *Archiv für Gynakologie*, Band XXXVIII, Heft 2.

‡ *Volkmann's Sammlung Klinische Vortrage*, Number CCCLI.

But because this state of affairs has obtained in Baden, we are not to lose our faith in antiseptics and cleanliness,—for to these alone are due the great strides in progress made by the obstetric art during the past decade.

But, on the other hand, shall we adopt the method of Steffeck,* which consists in a prolonged rubbing of the vagina with the finger, before labor, while irrigating with an antiseptic lotion, in order that each fold and crease may be reached, and any, possibly, lurking germ washed away; or shall we follow Perairet in advising women to use a mild bichloride douche twice a day from the beginning of pregnancy, washing the vulva with soap and water, and keeping the parts covered by an antiseptic pad? In short, are we to turn the physiological conditions of pregnancy and parturition into pathological states, in order that the lying-in period may run a normal course? Emphatically, no!

Again, shall we douche the recently delivered uterus and sensitive vagina with chemical lotions in order to remove infection-producing organisms which, probably, are altogether absent? From my experience all these methods seem not only futile, but absurd in cases which present no evidence of infection or disease. If such are necessary to insure a normal puerperium, how is it that Mermann can report four hundred labors without a death, and with only six per cent. of the puerperæ having a temperature of 38° centigrade (100.4° Fahrenheit),—without the use of these antiseptic precautions,—and Glöckner and Keller a smaller morbidity where the douche was omitted, then where employed? All modern discussion of these important questions indicates that the pendulum has now swung back to the middle point, and that the theories for meddlesome interference until recently advocated, must be abandoned as far as normal cases are concerned. What we want is cleanliness,—of patient, of linen, of atmosphere, of nurse and accoucheur,—and to aid in this we must use, but not abuse, the antiseptics best suited to the case.

In the matter of food for lying-in-women, a great variety of opinions have also been advanced. Discussion on this point, however, seems hardly necessary. The puerperal woman is not necessarily in a diseased condition, and certainly should not be kept on a slop diet at a time, when she needs the best of nourishment both for herself and her child.

* *Zeitschrift fur Geburtshulfe und Gynakologie*, Band XV, page 395.

† *Annales de Gynecologie*, July, 1890.

No dietary list can be arranged that will be found suitable for every case; but, before the bowels are moved, cocoa, milk, animal broths, eggs, toast, or any other easily digested food may be given—beginning immediately after delivery, if the patient expresses a desire for something to eat. After the second or third day the woman may take any digestible food for which she expresses a liking; and green vegetables, salads, etc., omitting only the legumens—should not be denied her. Such a course will prove more satisfactory to the patient, and is followed by better results than was the former custom of having the diet restricted to gruels and teas.

The use and abuse of the bandage has more than once occupied the attention of obstetricians in lengthy dissertations, and a vast number of theories have been advanced as to its influence on uterine involution and the preservation of the form. From careful observation of many lying-in women where the binder has and has not been employed, I am certain that it has no effect one way or the other on involution of the pelvic organs, and any one who has had experience with the binder in this country, and has then studied the cases in the great maternities in Germany, where it is never used, will be difficult to convince that, as a form producer, the bandage is not a failure. The scientific aspect of this question has been studied by Herman,* who, from measurements of patients who had worn the binder as usually applied, found that it had no effect on the waist measure whatever.

But the binder exerts great influence in a direction which is usually overlooked, namely, in promoting involution of the abdominal walls. My experience with cases of abdominal tumors, in which the parietes are often greatly distended, and where the slack, after removal of the growth, causes no little inconvenience and annoyance, has taught me the value of the bandage in this direction, and I believe that this is the only effect it can possibly exercise as applied after child-birth.†

The question of getting up is one that interests every lying-in woman, as well as her physician. I believe that for the better part of the month following delivery, the woman should be kept in the horizontal position. My reasons for this are that

**British Medical Journal*, March, 1890.

†The possible action of the binder in partially immobilizing the abdominal walls—and thus preventing the formation of a vacuum, which would favor septic absorption, must not be lost sight of. See BRAXTON HICKS: *American Journal of the Medical Sciences*, 1888, page 37.

uterine involution† not being completed until near the end of the second month and involution of the broad ligaments, vagina, etc., requiring a still longer period—the less the strain placed upon these structures during the early period of childbed, the quicker and surer will involution progress; and the recumbent position offers the most certain aid in promoting this desired result. That the simple metamorphosis which restores the broad ligaments to their normal condition following delivery is a slow process, I have recently seen demonstrated in a patient upon whom I performed laparotomy three months after labor. While the uterus had regained its normal size, shape and appearance, the broad ligaments were redundant and flabby, the tissues falling together so as to form a kind of cup or *cul de sac.*

In the few remarks on the subject of the post-partum management of normal midwifery cases which I have offered, I have but touched on a few of the most important points, leaving these to be elaborated, and others, which I have omitted for fear of unduly lengthening my paper, to be mentioned in the discussion which will follow. In briefly summing up my experience in the treatment of normal lying-in cases, I subscribe to the following creed:

(1) I believe that the normal pregnant and parturient woman should be examined as infrequently as possible, and left entirely alone as regards douching.

(2) I believe that the external genitals should be cleansed with a mild antiseptic lotion and pledgets of absorbent cotton immediately following delivery and at least twice a day afterwards, the vulva in the interval being covered by an aseptic pad.

(3) I believe that the vaginal douche should not be employed in normal childbed until after the lochia alba have become established, when all abrasions of the vaginal mucous membrane will probably be healed, and the dangers from infections by means of the douche nozzle, the fingers, etc., will be practically *nil.* The lochia alba are usually established about the eighth day post-partum.

(4) I believe that at this time, while the hot vaginal douche is not absolutely necessary, it is comforting and grateful to the patient, and, as has been pointed out by Pinard,* undoubtedly exerts an influence in promoting both uterine and vaginal involution.

(5) I believe that slop diet following delivery is both

* *Journal de Medicine*, February 9, 1890.

†LOHLEIN: *Deutsche Medicinische Wochenschrift*, February 9.

unreasonable and pernicious in its effects upon the mother, while easily digested food, and, after the bowels are moved, "full diet," assists her in rapidly regaining her strength, and produces better breast milk for her offspring.

(6) I believe that the obstetric binder is of the greatest service in affording comfort, and furnishing support to the relaxed abdominal walls, while it hastens their involution and prevents pendulous abdomen.

(7) I believe that, as careful investigation has shown that uterine involution is not wholly completed until the end of the second month, the lying-in woman should be kept in the recumbent position for the first four weeks post-partum.

(8) I believe that the practical application of this creed would result in fewer cases of subinvolution and the host of minor local ills from which so many of our American women suffer.

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