

THE CARE OF THE PUERPERAL WOMAN¹

BY IRVING H. EDDY, M. D., CHICAGO, ILLINOIS

Instructor in Gynecology, College of Physicians and Surgeons (University of Illinois)

IT is not my purpose in presenting this paper to add anything new on the management of the puerperium, but rather to make an earnest plea for a more careful application of the measures at our disposal and to bring about better results of the so-called "physiological process of childbirth."

All will agree with me that it requires from six to eight weeks under the most favorable circumstances, before the uterus has regained its normal size, that a longer time is required for the various ligaments to be restored, and that the pelvic outlet never quite regains its normal tonicity. In considering the etiological factors of prolapse and displacement, we find that any condition which increases the weight of the pelvic organs or decreases the carrying power of their supports favors this much dreaded pathology. Nor is there any factor so important as childbirth.

Hence one of the essential points in the management is to keep these patients in a position most available in preventing these conditions, until nature has had time or nearly time at least to restore the tissues to a normal state. It is generally agreed that following laparotomy, the patient should be in bed nearly three weeks for the organs to recover their shock, regain their functions, and for the incision to heal sufficiently to prevent hernia; yet we have been willing to let our obstetrical cases out of bed in ten days, when conditions could not be more favorable for pelvic hernia, prolapse of the pelvic organs, chronic congestion and infection with their ultimate results, endometritis, salpingitis, cystic degeneration, adhesions, rectocele, cystocele, and a multitude of other pathological conditions, because some one has said that "rest in bed for so long a period makes our patients semi-invalids." In my judgment there never yet has been an invalid made of a mother by keeping her in bed too long, unless her attending physician has unwisely kept her in the dorsal position, while thousands and thousands of mothers have been made invalids through negligence on the part of their physicians, by letting them about doing household duties, when they must needs be in bed.

In a very able paper (N. Y. M. J., 1890, vol. 52, page 126), Dr. Wm. B. Wood called attention to the much needed rest, and says that "at least four weeks are required in other positions than the upright for the proper involution to occur, and the sagging that occurs when in the upright position

separates the tears in the cervix; this being one of the important factors in subinvolved conditions."

The human race is not perfectly adapted to the upright position, as demonstrated by the study of comparative anatomy, and only in the genupectoral position does the uterus have perfect support, hence the double necessity of guarding against these conditions.

Dr. Bacon (J. A. M. A., 1902, vol. 39, page 355) speaks of the much needed rest in bed during the relaxed condition of the abdominal walls, during the diminished intra-abdominal pressure, and disturbed circulation, and of their influence upon a general splanchnoptosis if the patient be allowed to be up; and the disadvantage of autointoxication, and its prevention through massage and exercise, the application of which he fully describes.

Dr. Holmes, in discussing the above paper, says it is not necessary to keep patients in bed two or three weeks, that no arbitrary rule should be followed, and calls attention to three important tests to determine the time of getting up, viz.: 1st. Tenseness of the abdominal walls. 2d. Lacerations of the perineum. 3d. Involuting process, character of the discharge, pain, tenderness, etc. Probably in the average primipara, we will find a degree of tenseness of the abdominal walls, but we never find it in so short a time in the multipara. Lacerations of the perineum cannot heal firmly in less than two weeks, and we must remember that we are not dealing with a simple perineorrhaphy, but an overstretched and paralyzed muscle that requires a much longer time to regain its normal tonicity. While the involution may be going on properly, yet clinical experience, borne out by the observations of Lusk, Williams, Peterson, and others, shows that the uterus at the end of the second week weighs three hundred and seventy-five gms., or in other words six times its normal size. With this brief review of the above tests I feel that Dr. Holmes will agree with me that his first statement is not consistent with the latter. During the first twenty-four hours, the patient should be kept in the dorsal position, to prevent air embolism. If such a condition really occurs, however, it is generally agreed that the cases of death during the puerperium ascribed by older writers to the entrance of air in the uterine sinuses was in reality due to infection of the bacillus *aerogenes capsulatis*.

After the first twenty-four hours I am much in

¹For Discussion see Transactions of Chicago Gynecological Society.

favor of the right and left Sims' position, which affords the uterus a better opportunity of remaining forward and aids the return circulation. I use both positions, to give all the ligaments affected an equal chance for involution. After the first week the knee chest position should be insisted upon for use at short intervals, several times daily, and continued over a period of several weeks.

My first point then is that obstetrical patients should be kept in a suitable resting position until the organs are more nearly restored to a normal condition.

Lacerations. To me an extreme exhaustion most frequently due to hæmorrhage is the only contra-indication to immediate repair. Silk-worm gut should always be used, as it is supportive as well as lasting, two features necessary to insure good results. I have seen a number of cases where catgut had been used, even a continuous suture, which absorbed in a short time and gave way before union had occurred. It also materially favors infection. In placing the sutures one should go deep enough to get well out into the levator ani muscle, and remember that swelling and œdema of the parts occur; consequently, the stitches should be tied loosely to secure the best result. Some writers state that the best time for repair is after the swelling and œdema disappear, but this affords too great an opportunity for infection of the parts to occur. The importance of care given these patients, as especially applied to lacerations, is summed up by Hirst (*American Medicine*, Phil., 1902, vol. 4, page 849) as follows: "If any one physician in general practice calculates the number of cases he sees in a limited time, of rectocele, of cystocele, of uterine retroflexion, originating in the puerperium, of injured cervix, and all its consequences, including cancer, of prolapsus uteri following childbirth, of subinvolution and endometritis following abortion or labor, of the pelvic inflammations of puerperal infection, of splachnoptosis following diastasis of the recti muscles and coccygodynia; if he multiplies his experience by that of thousands of his colleagues in America, if he reflects that every one of these conditions represents the fault of a physician, that every one of them could have been prevented, or could have been cured without delay, he must be appalled by the thought that the medical profession itself, is responsible for five-sixth of the diseases of women as we see them to-day."

Repair of the cervix is not generally done at the time of delivery although strongly recommended by Hirst. I believe that much better healing of the cervix will be accomplished if the general principles of this paper are adhered to, and, that

all the ill effects cannot be laid at the door of lacerations.

Toilet of the perineum. Before delivery one should make it a routine practice to shave his patient. This affords a much better opportunity for cleanliness and the prevention of sepsis.

External irrigation or sponging from above downward with lysol or bichloride followed with the sterile dressing are alone indicated, and under no circumstances should the douche be used during the first ten days of the normal puerperium. There is very little excuse for sepsis at the present time, as definite means of preventing it are at our disposal, and this condition should be unknown among our patients except for pre-existing infection which is extremely rare at the time of delivery compared to the frequency of infection found in the pelvic organs, and is probably explained, in part at least, by the enormous increase in the blood supply during the period of gestation, and to the development of opsonins.

Relative to the uterus, our first attention should be directed to the presence or absence of hæmorrhage, and if present should be controlled by removing membranes, placental tissue, massage by grasping the uterus as a cricket ball, ergot in some form, and if need be, the uterus packed with gauze, best accomplished with the least danger of sepsis through the use of the Holmes' packer.

Ulrich (*Surg., Gyn. and Obst.*, 1906, vol. 3, p. 650) says, "The tamponing of the puerperal uterus immediately after labor and during the puerperium is a procedure of great importance and not appreciated by the average practitioner of midwifery and seldom by the specialist." I cannot approve of this procedure as a routine measure. In my experience hæmorrhage of an alarming nature is not a frequent condition, and we should realize that needless procedures are dangerous, to say the least.

The contraction, position, and involution should be carefully guarded from day to day, and the character and amount of the lochia determined, as a relaxed uterus associated with the disturbance of the lochia, pulse, and temperature, indicate strongly retention of placental tissue, membranes, blood clots, or infection. For the past two or three years, I have made it a routine practice to prescribe equal parts of ergot and hydrastis in from 40 min. to dram doses, three or four times daily, and am fully convinced of its virtue in keeping the uterus firmly contracted, preventing blood clots, decreasing the amount of blood to the organ, relieving "after pains," aiding drainage, and lessening the amount of lochia, all of which are valuable adjuncts to a proper involution.

If at the end of the second or third week, involution is not progressing satisfactorily, or the normal position maintained, measures should be instituted promptly to remedy this condition, for if there is ever a place in gynecology for palliative treatment, it is found at this time. The displacement, if there be one, should be corrected, and a gauze or wool tampon of ichthyol and glycerine or boroglyceride inserted, to aid in maintaining the normal position. Hot douches are of great benefit at this time if given properly, as the dorsal position is the only one suitable, and that as usually taken in the bathtub objectionable. I wish to call your attention to a simple douche board that can be made without expense and will be found of great service in every home.

The board should be about fifteen inches wide four and one-half feet long, with an eight inch opening in a position suitable to the hips, which may be guarded by a small piece of rubber tubing encircling it to prevent the possibility of water escaping upward. The notched cross bars should be sufficient in length, to catch on the sides of the tub, and the upper one about three inches thicker than the lower, to afford sufficient fall. After the patient has passed the period of the possibility of infection, the plain hot water douche may be greatly facilitated by coupling the tube directly to the faucet, and the temperature and pressure regulated by means of the hot and cold water. In this manner the benefit of large quantities are afforded, and should one desire this may be followed by an antiseptic douche. After involution has been completed, if there is still a tendency to displacement, a properly fitted pessary should be inserted and the patient kept under careful surveillance.

The Sims' and knee chest positions should be especially urged in these cases. If the above measures fail and the uterus remain large and the cervical canal patulent, endometritis is present and a curettage is indicated.

Breast. The nipple should be hardened during the later months of pregnancy through frequent bathing with alcohol, and properly cleansed before and after each nursing, to prevent any possible infection that may necessitate the child's removal, for there is no one condition more essential in the proper involution of the uterus than the nursing of the child.

Should the breast show irritation or beginning infection it should immediately be put in a resting position, the ice-bag applied, the shield used, and a saline administered. Compound tincture of benzoin and silver nitrate will be of service in case of fissure. Should it become necessary from any

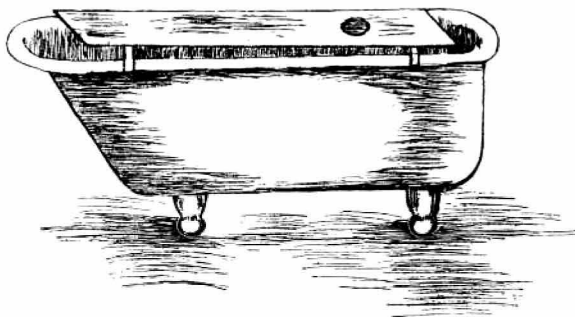


Illustration of douche board.

cause to dry up the breast, it has been the custom to apply a firm binder, belladonna ointment, restrict the fluids, massage, and administer salines. In a recent article in *Surg., Gyn. and Obst.*, October, 1909, Henry J. Storrs quotes reports from the obstetrical department of Johns Hopkins Hospital and the private practices of Drs. Williams, Slemons, and Goldsborough, in which gratifying results have been obtained by the conservative method of leaving this condition entirely to nature. This broad experience dates over a period of four years and is worthy of our consideration.

Bowels and bladder. In no condition with which we have to deal is constipation more injurious than during the two months of the puerperium. The straining occasioned by this condition can do more toward bringing about displacement and prolapse through increased intra-abdominal pressure and drawing downward on the posterior vaginal wall, than any other factor engaged in their production. Sufficient laxative should be given to move the bowels regularly without straining and one that will not have a detrimental effect. After the initial dose of castor oil, I know of no drug that has a better effect than the effervescent sodium phosphate. Unless the patient is able to relieve herself without straining, an enema should be given. In this condition one can see the real benefit of massage and exercise as outlined by Dr. Bacon. I have found massage of the abdomen with a small iron ball rolled in the direction of the large bowel of special value. Electricity is an unquestionable aid in stimulating the circulation, toning the abdominal walls and viscera. Urination should be carefully guarded and the bladder examined for distension, but every means should be exhausted before resorting to the catheter, for once used it is difficult to overcome; however, in cases where its use is imperative, it should be done frequently enough to avoid the ill effects of an overdistended bladder.

The binder may be used for the first twenty-four

hours to assist in preventing hæmorrhage, after which time it should be interdicted, as it undoubtedly favors backward displacement. Williams says, "It cannot do harm after the tenth day, or after the uterus reaches the true pelvis."

Though it may not crowd the fundus backward, by direct pressure it must, of necessity increase intra-abdominal pressure, and by so doing must crowd the pelvic organs downwards; instead, where the abdominal muscles are relaxed they can be strengthened by having our patients lie on their backs and rise to a sitting posture several times daily without aid from the arms or hands, as recommended by Von Wild.

Diet. Generally speaking the diet should be liquid for the first two days, or until the bowels have been moved, after which there can be no objection to a liberal amount of good wholesome food. The pulse and temperature should be carefully observed for the first few days, and should more than a slight disturbance occur the cause determined.

"After pains." Since the adoption of ergot and hydrastis I have not had sufficient trouble with this symptom to demand any other medication, and I would caution the use of morphine as recommended by Williams, not only for its influence upon the patient, but by relaxing the uterus it favors hæmorrhage and clot formation. It goes without saying that plenty of fresh air and a light room have their important place, and that a good nurse agreeable to the patient is indispensable, for a state of mental quietude has a favorable influence upon the general functions. With infection eliminated, as it should be to-day, and the advancement of surgery that affords immediate repair with favorable results, it behooves us to institute a régime of treatment that cannot be reflected upon

as being the cause of eighty per cent of diseases found in mothers at the present time.

With no better showing than this can we wonder at the fear with which women approach motherhood and at the problem of "race suicide" confronting us? In closing let me with all sincerity in the interests of the mother, who is dearest to the heart, make one more earnest plea in her behalf and close with the following conclusions.

1. That too early rising after labor is baneful to the patient, as is demonstrated by our class of clinical patients, who remain in bed but a short time.

2. That it is inconsistent to maintain that a longer period of rest will render our patients semi-invalids, and is proven by the fact that eighty per cent of the diseases found in women to-day are due to childbirth.

3. The genupectoral position being the only one in which the uterus has perfect support, calls for this line of treatment.

4. The immediate repair of lacerations is inductive to proper involution.

5. Sepsis should be unknown except for the cause given.

6. That packing the uterus as a routine measure especially in private practice, is not justified.

7. The use of ergot and hydrastis should be adopted as a routine measure, and opiates interdicted in the treatment of "after pains."

8. The opportune time for palliative treatment exists during the latter part of the puerperium.

9. Constipation should have especial attention, and measures instituted to prevent straining at stool.

10. The ill effects of the binder explained fully to the patient, and other indications given for restoration of the normal figure.