POSTURE OF THE LYING-IN PATIENT.

BY

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THE striking variations in method of posture of the puerperal patient which I have observed in cases seen in consultation practice indicate to me that this is a subject still unsettled. So essential in its results to the future health of the woman, it has not even received the attention to which it is entitled. Frequently specific instruction is not given by the attendant; but the management of the case is allowed to go by default.

An investigation, undertaken for the purpose of obtaining a consensus of the best scientific opinion as to the posture of the lying-in woman has revealed a wide difference in the teaching and practice in this country, and the methods at present advocated by some German obstetricians.

It has seemed of value to present a synopsis of the various dicta, which have been pronounced on the general conduct of the puerperium throughout the obstetrical world. I do this in the hope that a comparison of authoritative expressions may be helpful in determining the care to be given the lying-in woman at a most critical period, the days immediately following her delivery.

These German authorities differ radically from our teachers in advocating most heroic treatment and assure us that women who are kept but three or four days in the horizontal decubitus fare better than those who are longer in bed, a view not new, however, since Dr. White, one hundred and thirty years ago, advanced the idea of having patients on their feet the day succeed-

ing delivery. The following brief reviews may indicate the attitude of some of our German confreres toward this most important subject.

Von Alvensleben (*Zent, fur. Gyn.*, Sept. 5, 1908) gives the arguments for early rising of puerperal subjects, analysing the reports of the clinic at Kiel, where the patients are allowed to be on their feet from the first to the fourth day in normal cases. In his one hundred observed women, the primiparæ were allowed to be up the first day for an hour; finding in these that the functions of appetite, bowels, and bladder all showed improvement over the average, where the customary nine days in bed were required, the multiparæ were subsequently allowed the same privilege. Severe hemorrhage was not considered a contraindication of the permission. The only cases not included were those in which difficulties in delivery resulted in deep lacerations of the soft structures or in severe infection. The woman who was strong and healthy was required to take gymnastic exercise in bed daily. In addition, the first day she was required to take a few steps to a chair, sitting up an hour. The second day she walked once up and down the room. The third day this was repeated twice, and on the fifth day, she would be allowed to be up six hours, lying down three hours after dinner. When out of bed a firm abdominal binder was worn. Of one hundred cases, three were up on the first day, sixty-one on the second, nineteen on the third, eighteen on the fourth day. Of these forty-three were primiparæ, and fifty-seven multiparæ. In ninety cases no untoward symptoms were observed; six patients returned to bed on account of irregular pulse, dizziness, faintness, weakness or bloody lochia. Ten patients had fever which was attributed to the large percentage of gonorrhea in the clinic. In seven cases, the lochia was fetid, two had cystitis, and there were two cases of slight mastitis. On the fourth day, the lochia was white—on the tenth the lochia had disappeared. The muscles of the abdomen had good tonus, and the introitus had closed on the tenth day. In nine cases, (11 per cent.) marked prolapsus was found, in ten there was marked anteflexion, and in six retroflexion. The catheter was never required. Bowel movements were voluntary.

Wilhelm Rosenfeld (*Gyn. Rundschau H.*, 11, 1908) argues on the same line, that the routine position on the back during the lying-in period of nine days is a cause for retro-deviation. He quotes gynecologists who have their patients up in three hours

to urinate, and obstetricians who have their patients taking special gymnastic exercises beginning the third day, including movements of the abdominal muscles, and sphincters of anus, and vulva, mornings and evenings. In patients with normal temperature, the upright posture is permitted the third day for an hour or two. This it is claimed aids in involution and increases voluntary action of bladder and bowels. He leaves open the question as to whether embolism, prolapsus, or retrodeviations may follow, but claims that prolapsus will never occur unless there is a previous lesion of the pelvic floor, resulting from stretching or lacerations of the fibers. The fact that retraction of the torn ends is immediate, he claims, forbids the reunion of these injured tissues no matter how long the patient is kept in bed. In prolapsus, an etiological factor is atrophy of the pelvic floor, and long rest in bed increases the muscular weakness. Natural use of these muscles restores their tonus. His patients begin to be out of bed the third day, increasing the length of time up to the ninth day, when they are discharged. In the Vienna Lying-in Hospital, one hundred and sixty women were confined in three months, and of these one hundred and two were up the third day. In only one was there any temperature, this being, a beginning mastitis, which was relieved by the Bier treatment. On the seventh day, the height of the fundus was at the level of the symphysis, and at the ninth day, it had disappeared. Those of the patients who were multiparæ asserted they felt better and were stronger than when nine days in bed.

The various experiences of the hospitals and private practitioners who have reported their cases in which early getting up was advocated is tabulated by Robert Mullerheim (*Berliner Klinsche Wochenschrift*, Nov. 8, 1909).

He at first objected to the gymnastic exercise in bed and also to allowing women to be up a few hours after labor and leaving the hospital at the end of the week. He has been convinced by observation that the gymnastic exercises have considerable value, but has adopted a middle course in reference to the radical change of posture. His idea is that however well the early getting up resulted in the hospital, it is of doubtful benefit if advocated among working women in their homes, as they are no sooner out of bed, than they resume their work. He doubts whether weakness of muscular walls of the abdomen, prolapsus, and ptosis of the viscera, will not follow later on, the examination made on the eighth or ninth day being too early for a final conclusion.

As to the occurrence of embolism, the practice in Java is a very interesting, and valuable object lesson. There the parturient is not allowed to go to bed after delivery. Embolism as well as prolapsus, anemia, and neurasthenia are very frequent. Mechanical thromboses without fever in cases of heart and circulatory disturbances are found to occur more especially in the pelvis, and legs, resulting from the slowing of the circulation. In these cases, Mullerheim asserts muscular movements and aids to increased circulation are of value. In septic thromboses, any exercise invites serious results. Hence he concludes early rising should be carried out only in carefully selected cases.

I was particularly impressed by the contrast to these German Obstetricians, in a consultation case met last year in which a normal primipara was kept for five weeks by the obstetricians in charge, lying on her back, not even being allowed to get up to empty the bladder, for no apparent reason, that I could see, other than a persistent pink lochia.

This led me to take up the question with several of my friends among the leading obstetricians of America, to find their method of teaching and practice. From these the following quotations are of great interest and value.

Dr. Reuben Peterson says, "If the patient is a working woman, and not too much exhausted by severe labor, I think best to have her out of bed on the ninth day. Sometimes for one reason or another this period is cut down. I do not urge early getting up, not that I think it would injure the patient, but because rest in bed is favorable to the lying-in woman. I am very much opposed to the passage of the catheter in the nonpregnant, the pregnant, or the lying-in woman. If after twelve hours, the puerpera has not passed water after effort to have her empty the bladder, I have the nurse swing her out of bed. and place her on the commode. I have done this even when stitches have been taken. It is usually successful. I urge the patient to lie on the side as much as possible to insure drainage. I allow her to sit up in bed after a few days. I have made no observation as to the involution of patients up early or those remaining long in bed. Personally, I think subinvolution, in the majority of cases, is a matter of infection, not of position of the patient. If no infection, involution proceeds normally. If there be sepsis, involution will be delayed.

Dr. Barton Cooke Hirst says, "I have so far modified my former practice as to allow a patient to sit up in bed after child-

birth to use the bed-pan, if it is impracticable for her to do otherwise. I do not allow the patient to get out of bed, because of the possibility of embolism. I had one case in which the patient got out of bed on her own responsibility about forty-eight hours after childbirth and dropped dead on the floor alongside of the bed, from embolism. While this is not common, still it is possible and I do not think we ought to chance it."

Dr. J. Whitridge Williams writes, "I have not yet been able to convince myself of the correctness of the advocates for early rising, and I believe it will soon prove a useless and possibly dangerous fad. I note that Dr. Charles White advocated it in 1780. Goodell also recommended it in the early seventies, but as the practice did not find many imitators, I imagine it was not found advantageous. It is my practice to keep the woman in bed for ten days, or two weeks following labor, and then to allow her to be about on the floor on which delivery took place, until well into the fourth week. While patients are in bed no restraint is placed on their movements. They are allowed to eat their meals in a sitting posture. This is done whether the perineum has been injured or not.

Concerning the commode, I do any thing to avoid the catheter. Patients are allowed to sit upon the pan, and even to use the commode, if necessary, within twenty-four hours after delivery. I do not know what effect rest in bed has upon involution of the uterus, but I am now engaged with one of my assistants in studying the matter. For a number of years, I have been impressed with the fact that my private patients, in well to do circumstances, upon final examination four weeks after delivery, show a much greater proportion of displaced uteri than the women of the ward who are discharged at the end of two weeks. I now have the latter class of patients return at the end of two weeks for a subsequent examination, and am not yet prepared to state whether or no the same condition will be found to exist."

Dr. Joseph B. DeLee says, "Regarding puerperæ, and their posture, usually I ask them to remain in bed for nine to eleven days, quietly on the back or side for two days, then give them the full freedom of the bed.

In bowel movement, and urination, they may sit on the bed-pan if the result cannot be obtained on the back. Backrest is given from the eighth day. Out of bed the ninth to fourteenth day, depending on labor (whether forceps, etc.) condition of lochia and fever."

The letter of Dr. Franklin S. Newell suggests that the method varies with individual cases. He does not keep the patient long in the dorsal decubitus after labor, but allows her to assume any position which she can while lying down, whether on the side, or on her face, shifting the position as often as she desires, believing that a frequent change in position assists in drainage from the uterus, and also adds to the patient's material comfort. If able to use the bed-pan, it is approved during the first two weeks after delivery, but he prefers to have the patient raised in bed rather than to be catheterized.

Rarely he has allowed the patient up to the commode from the time of delivery. Patient is kept practically flat for two weeks, the back rest is given the first, and at the end of the third week the patient is up in a chair. He believes involution goes on better in this way, than if earlier allowed on her feet. He also believes that the patient gets up better both nervously and physically, than if she is earlier out of bed.

During the third week, the patient is encouraged to take such exercise for strengthening the abdominal muscles as she can take in bed, but the routine is varied to meet individual needs.

He finds his work dealing in an increasing degree with the unfit, and that three weeks is not too long for this type of woman to rest and recuperate.

The only possible disadvantage is the question of milk supply which, is more apt to prove deficient, but this he holds to be of minor importance compared with the gain in the patients' general condition, obtained by prolonging the convalescence.

Dr. Charles S. Bacon follows more closely the German method above outlined. He says, "My instructions for 'setting up exercises' in bed when ordered is generally that on the fourth day they begin and continue throughout her stay in the hospital. When allowed to get up, she is to walk across the room, and sit down, but will remain out of bed only ten minutes the first day, and twenty minutes the second day.

"These 'setting up' exercises are breathing exercises; arm flexion and extension; arm extension, foot flexion, and extension, and eventually thigh flexion and body flexion. About the seventh day, the private patient adds a walk of a minute to each exercise. After two days of walking, she is allowed to sit one to five minutes each time. The time of sitting up is extended five minutes each time, until at the end of the third week, she is around as usual with the understanding that she always lies

down to nurse the baby. Then she has the horizontal position twenty minutes to thirty minutes every two to three hours a day. This method, which I have evolved during the last ten years, has been very satisfactory, favoring involution and frequently, as I believe, preventing enteroptosis.

"Dr. Bacon has his patient try to urinate when the bladder becomes distended, as determined by her own feelings, and by the external examination of the nurse. Within ten hours, if no desire is manifested, she would be urged to evacuate the urine even if the bladder does not seem distended. If she cannot urinate, lying down on the douche pan, she may sit up or when necessary be out to the commode or a rectal enema may be given, making the urination easier. The use of the catheter should be avoided, if possible; when, however, she cannot urinate even if sitting up or in case she be very weak after labor and sitting up is not to be allowed, she should be catheterized."

Dr. J. Clarence Webster, writes, "I am certain that patients recover strength less quickly when they are kept too long in the recumbent posture, I do not use the catheter until twelve or fourteen hours have elapsed after labor, and all other means have in the meantime been exhausted. The back rest is used the day after labor twice daily at first for a short period, then for a longer period and more frequently. I advise sitting up out of bed for a short period the twelfth day, a few steps being taken on each occasion, the commode is to be used after the fifteenth day."

My own method has grown from the observation of 2700 cases of labor seen in private practice, and in the clinic, in an experience of twenty years. I was taught as a student to have the woman on her feet the tenth day. This rule was *ex cathedra*, and admitted of no discussion. It is no doubt of good average limit, for those mothers whose circumstances compel them for economic reasons to early resume their responsibilities regardless of future conditions of the pelvic organs.

In recent years, however, I have found that all women are not given the same recuperative powers after labor any more than that all men are created free and equal, two arguments which are based on wrong premises.

The number of women who have prolapsus, and retrodeviations taught me that there was a cause for such conditions. I attribute these conditions to relaxation and subinvolution which I believe is benefited if not cured, by rest in bed during the time lochia rubra persists. Consequently I made a rule years age that

the woman should be on her feet when she can have a record of two days in which no red color is shown. This puts my average patient up about the fifteenth day. She walks to a chair, is up an hour, increases the limit daily, as she shows her recuperation, judging by the lochia, and height of fundus. I examine her the fourth week, and caution her to lie down part of each day through the sixth week. I have had the fundus at the brim by the ninth day, and the lochia serosa at the same time, and I have had the patient in bed eighteen and twenty days. Usually she may be up half the day the third week, and out the fourth week, but I find a routine practice during the first ten days of raising the head of the bed 8 or 10 inches an advantage in assisting drainage without subjecting the patient to any effort or exertion as is done when on the back rest. Our American women of the better class are not to be compared in their physical strength with the German peasantry, so that conclusions drawn from hospital statistics of the latter class cannot serve as a criterion for us in putting the patient on her feet. On the other hand, the modern young mother of the present generation who has had an education and an opportunity to live the normal life under direction of her advisor will be found to come through her ordeal in better shape by the adoption of the conservative rule then if she followed the heroic teachings of our brothers across the sea.

As to the change of posture in bed, my own experience has led me to allow the patient to be turned on her side after the first few hours, this gives her a sense of comfort after the long enforced cramped position on her back with her knees flexed, as she was during labor. I have never been unfortunate enough to see a case of embolism following labor, but appreciate that one is never too old to learn.

A vexed question as to the lying-in has always been that of the emptying of the bladder. My early teaching was in case of laceration requiring repair to put a binder around the knees, and always catheterize. In the light of present day methods, this plan is inexcusable from any point of view.

My students are instructed to make the catheter a last resort. The patient is to be urged to use the pan while lying on her back with various devices of pitcher, douche, water poured from height into a vessel or from a faucet to aid by suggestion the emptying of the bladder. If these expedients fail, she may be turned gently over on her face, lying across the pan to aid by gravity the expulsive effort. Then as a last resort, rather than

to catheterize, she is, if the pulse is ninety or under, allowed to be helped out to the jar, which, giving her the upright posture usually accomplishes the desired result. Contrasted with my early teaching when the patient was kept on her back for voiding the urine, and the catheter passed under the sheet to avoid exposure of the person of the patient, the German practices as given by my quotations in beginning this paper are revolutionary.

The question then is one in which there has been room for great divergence of opinion throughout the history of midwifery practice. My friend, the late Dr. Theophilus Parvin, whose writings I consider to rank with those of Charles D. Meigs, and Sir Thomas Watson, as examples of medical classics, quotes Sydenham whose wise observation taught him that in case of those who died after child-birth the result was in many cases from getting up too soon, that is before the tenth day. The axiomatic statement of Dr. Churchill, the famous obstetrician, was that for one evil result from error in diet, he had seen ten from assuming an upright attitude or too early leaving the bed. Dr. Parvin closes his argument with the advice that it is better to keep a woman a week too long in bed rather than to have her up a day too soon. The condition of the woman is a better criterion than the number of days after labor. While sitting up in bed may be permitted for most patients during their meals after the third day, it is better that the puerpera remain in her room at least three weeks.

So while a number of men who have favored a policy of extreme rapidity in the putting of their patients on their feet have been able to produce arguments which, if always based on facts must be very convincing as to the individual instance, still, on the other hand, the majority of the profession during all the ages adhered to the more conservative method. I would therefore make a plea for more uniformity in teaching the subject of posture in the puerperium, basing the conclusions on my own experience as well as on the observation of obstetricians in our great maternity hospitals, as to the effect on these cases as regards involution and recuperation where the two extremes are practised.

In the meantime, the rule to be laid down from the present state of knowledge, is that the involution of the uterus, the color of the lochia, and general condition of the individual patient must govern the conduct of the case, rather than an arbitrary time limit, based on the number of days following delivery.