AN OUTLINE OF POSTPARTUM CARE*

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THE influence of custom and tradition is shown in obstetrics more than in any other branch of medicine. This is particularly true of the puerperium. Antiquated methods of treatment are still used in an empiric way by many practitioners and it is a fact that practically no two institutions, hardly two individuals, treat postpartum cases alike. In a large majority of cases delivered outside of hospitals these patients may be said not to be treated at all.

The prenatal period approaches a gradual and natural climax, viz., the birth of the baby. Following this event the patient is many times simply placed in charge of the nurse and in the absence of fever or other alarming manifestations, she is allowed to manage the case.

In these days when so much attention has been drawn to the prenatal period and its treatment, it suggested itself to me that it might be well to discuss a few points in the treatment of the postnatal patient. It seems rational to believe that if we are given a normal patient, a normal delivery, and a normal baby, that here at least is one condition in the realm of practical medicine the treatment of which could be more or less standardized. There must be one best outline of treatment for puerperal patients. With this idea in mind I propose to take up in a brief way a few points in the treatment of the normal puerperal patient and to discuss what I think constitutes rational and competent treatment during this period.

What is meant by the puerperal period? It may be stated that this period constitutes the time from the completion of labor until the organs of reproduction return to their normal state, and that this usually takes from six to ten weeks. This return to normal, or involution is most rapid during the first ten or twelve days and while we regard this as a physiologic process it may easily and rapidly become a seriously pathologic one.

The outline of our treatment of this period may be conveniently grouped as follows, 1. To enforce an adequate period of rest.

2. To preserve asepsis in the birth canal.
3. To correctly manage the function of lactation.

Rest.—It is agreed that if there is one person on earth who has earned a good rest it is the parturient woman. An initial period of rest is of very great importance and something which I always insist shall be instituted immediately after delivery. The room should be darkened, the baby and all persons except the nurse excluded and the patient made as comfortable as possible, flat on her back with the head kept

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low. If after a short time a natural restful period is not obtained, I have no hesitancy in using codeine or even morphine in order to secure it. After a long and exhausting labor the patient may oftentimes be too excited to relax into a restful state and an efficient sedative or hynotic at this time is invaluable.

Diet.—Why should not the puerperal patient have a reasonable diet from the start? What is rational about placing the normal postpartum patient on liquids for one or two days and soft diet two or three more before giving them something real to eat? For the past few years in both ward and private patients it has been my custom to give a general diet from the first and I have never seen any untoward results. There is little danger of overeating or digestive disturbances if well cooked food is served to the patient in an appetizing manner. For instance, the diet during the first twenty-four hours may include eggs, toast, ice-cream, bread and butter, cooked cereal, simple salad, baked potato, stewed fruit, rice, and of course soups, water, milk, tea, coffee, cocoa, etc. On the following day a regular diet may be instituted. With sensible reservations the patient may eat anything that she wishes to. It may be furthermore stated that successful lactation is insured by a liberal diet from the first. Our dairy friends who know so much more about the subject of lactation than we do, and from whom we may learn much, agree that a full diet especially rich in protein has an extremely favorable influence in maintaining a rich milk supply. There is also something to be said about the psychologic effect of giving a patient real food when she is hungry. She is more apt to realize that she is convalescing in a normal manner if she is allowed to eat the food to which she is accustomed when up and around.

Bladder.—Diet and digestion naturally lead to the question of excretion. Let me say a few words here concerning the treatment of the urinary bladder in these cases. There is one lesson which we should learn which may be sloganized thus, "Never catheterize except as a last resort." The great danger of prolonged cystitis resulting from catheterization even under the most aseptic conditions must constantly be borne in mind. The patient should attempt early to urinate. If she is unable to do so there are various expedients which may be tried to influence this function. These include warm stupes over the pubes, the sound of running water, and sterile hot water poured over the vulva. Often times a large hot high enema will bring results when other things have failed. We need have no hesitancy about supporting the patient in the upright position by way of further attempt. An odd trick which some of my nurses sometimes successfully employ is that of placing the patient on a bedpan into which has been poured a small quantity of aqua ammonia. Mention should be made of the

hypodermic use of pituitrin .5 to 1 c.c. repeated once or twice at half hour intervals. In patients with marked abdominal relaxation a binder which fits snugly over the pubes often assists by giving the patient "something to push with."

How long may we allow these patients to wait before resorting to catheterization? It is perfectly safe to wait until the bladder forms a definite tumor over the symphysis and in any case 18 or 20 hours may elapse before catheterization is thought of. There is one psychologic point which I have observed in these patients that have to be catheterized, and that is occasionally they become profoundly depressed and unhappy because of their inability to urinate. I mention this so that when it occurs every form of encouragement and assurance may be given them by the physician and nurse.

Care of the Bowels.—The routine use of castor oil and other drastic purgatives following childbirth is as unnecessary as it is unpleasant. Since McPherson[1] made his report in 1917 I have avoided the old regimé of purgation and have adopted the following plan. In normal cases 24 or 36 hours after labor if there has been no spontaneous movement a low soapsuds enema is given. This is repeated daily if necessary. If the bowels seem to act in a sluggish manner a mild vegetable cathartic or mineral oil is given at bedtime.

Let me summarize McPherson's interesting results with regard to this method of treating the bowels postpartum. His experiments were carried out in 1917 at the Lying-In Hospital in New York City and were briefly as follows: In 322 cases in which ordinary catharsis was used 28 had fever at some time during the puerperium. In the same number (322) of cases in which no catharsis was used only three had fever at some time during this period and one of these had a mammary abscess. Allow me to quote the author's conclusions, "When we consider the lessened danger of infection caused by the spreading about the mother's soft parts, of loose diarrheic movements, when we consider the enormous amount of labor saved for the nurses as well as the comfort of the patient, and when we consider the figures quoted in this series, it gives us some intimation of the necessity for active thought on the part of the obstetrician for every move that he makes, every drug that he prescribes, and for less habit and more individualization. The writer is far from believing that there is never any necessity for administering a cathartic in the puerperium; quite the contrary; but what he wishes to emphasize is the danger and uselessness of routine drugging, and the assigning of certain effects to conditions which have not been shown to be the cause of the symptoms exhibited."

It has been shown furthermore by Kettner[2] that milk production is often greatly influenced by catharsis and he states that "a dose of castor oil or any other purge may turn the scale against the normal

development of lactation, especially if the child does not take hold well."

The Birth Canal.—As before noted, our efforts in this regard should be simply to preserve or maintain asepsis. It is essential that the discharges shall be absorbed and not allowed to accumulate. For this reason the vulval pads should be composed of aseptic absorbent material. These should be changed whenever soiled, the number in 24 hours varying according to the amount of discharge. For the first two or three days this should be at least every 3 or 4 hours and each time that there has been urination or bowel movements the genitals should be well washed from above downward. This is best accomplished by vulval irrigation followed by sterile cotton wipes. We may or may not use an antiseptic solution. An antiseptic solution is not necessary as has been shown by E. W. Plass[3] in comparative observations made at the Johns Hopkins Hospital. Here equally good results were obtained, even in cases where there had been perineal laceration, by the use of boiled water. Douches are distinctly not indicated at any time during the normal puerperium. It has been repeatedly shown that infection has followed their use.

Care of the Breasts.—The beneficial influence of lactation on uterine contraction and involution must not be forgotten. After the first rest following delivery the breasts and nipples are thoroughly cleansed with soap and water and a simple ointment applied to the nipples on sterile gauze or oiled silk or paper. Either sterile vaseline or lanolin may be used for this purpose. Eight or ten hours after birth the baby should be put on the breast. This early initiation of nursing is very valuable for a number of reasons. The uterus by reflex stimulation expels clots more easily and any tendency to hemorrhage is checked. The milk production is augmented and the colostrum which acts as a natural cathartic prepares the baby's intestinal canal for milk digestion.

It does not seem out of place at this point to speak concerning some very interesting work which has been recently reported concerning the significance of colostrum in newborn calves. Theobald Smith and R. B. Little[4] have demonstrated conclusively the importance of this fluid at least for newborn calves, and I think we may draw an important analogy from their work. Because of the difficulty in keeping alive calves which have not received colostrum, these investigators experimented with two groups of animals. In one group of ten calves which received colostrum, they report three deaths. In a group of twelve calves which did not receive colostrum they report nine deaths. Their conclusions were that the calf which is deprived of colostrum lacks something which permits intestinal bacteria to invade the body and multiply in the various organs, and they further conclude that the

function of colostrum is essentially protection against the miscellaneous bacteria which are harmless later on when the protective functions of the calf have begun to operate.

It is my custom to place the baby on each breast for five minutes every four hours until the secretion of milk begins to take place. At this time three hour intervals are assumed in the daytime and four hour intervals at night. Nothing further is done for the breasts except cleansing before and after each nursing with boric acid solution.

If the breasts are very pendulous a light binder may be applied, never so tight as to interfere with the free access of air. At the beginning of lactation the breasts very often become engorged and painful. As a rule this is largely due to venous congestion and not to milk retention. When this occurs fifteen or twenty minutes' steaming with a large hot compress of boiled water will relieve the pain and congestion almost immediately. Occasionally a single dose of codeine may be given in conjunction. I never use the breast pump for this purpose for this appliance unquestionably stimulates the breast to further activity a short time after it is used. If fissures are treated immediately on their appearance, breast infection will seldom occur. Various astringents such as glycerite of tannin, tincture of benzoin, or witch hazel may be used. If relief is not secured in a very short time the use of the nipple shield should be begun immediately. A glass shield is used similar to that at the Sloane Hospital, in combination with a three hole anticolic nipple. Of course this is boiled before each nursing. If the fissures persist and become deep it may be necessary for a light cauterization with the silver stick and the restriction of nursing on that side for one or more periods. Mention should also be made of the use of the lead nipple shield which I have sometimes used with success.

The Abdominal Binder.—"To bind or not to bind that is the question." The proper treatment of the relaxed abdominal wall following childbirth demands our attention not only to prevent a pendulous abdomen but also to secure comfort for the patient. While I do not advocate the routine use of the abdominal binder I do not think it can be entirely dispensed with. This is particularly true in multiparæ where there is sagging and relaxation of the abdominal wall. In these cases no amount of massage or abdominal exercise is going to have appreciable effect at least during that part of the puerperium which is spent in bed. These patients need abdominal wall support not only for comfort but to help them during defecation and micturition, to give them something to push with. The binder should be well fitted and not too tight. I do not believe all the dire results that have been attributed by numerous writers to the use of the abdominal binder, such as compression of the uterine and ovarian veins, retardation of

involution, constipation, subsequent prolapse. After the patient is up and about it seems to me time enough to begin the kind of abdominal exercises which will prove really beneficial in restoring muscular tone to the abdominal wall. At this time also I think that a properly fitting corset is essential, particularly in cases where a corset has been worn previous to delivery.

When Should the Patient Get out of Bed?—There have been more various opinions and more discussion about the length of time the patient should remain in bed following childbirth than any other question concerning the puerperium. Writers have advocated everything from keeping patients in bed three weeks to getting them out of bed 48 hours after delivery. I think very little analogy may be drawn from animals or primitive races in this regard. With regard to the former an entirely different mechanical problem presents itself. In human beings the floor of the pelvis in the erect posture is subjected to a downward pressure which does not obtain in animals in the quadrupedal position. In the latter, a careful study of the differences in musculature, carriage, habits, and athletic ability between these and their more civilized sisters will soon demonstrate why the latter should not go about immediately after delivery.

I think we should first consider posture in bed. Here one of our first problems is free drainage and if the patient is kept lying on her back the entire time free drainage is impossible. In order to insure this in normal cases on the fourth and occasionally on the third day I begin propping them up in bed. The general rule that I follow is as follows: The first few hours after labor the patient is kept flat on her back without pillows. After 24 hours she may turn on her side for a short time. After the third day she is encouraged to lie on one side and then the other and for a while each day on her abdomen. On the third or fourth day she is propped up for a short time one notch on the Gatch Bed. This is increased daily so that by the seventh day the patient is sitting up in bed practically ad libitum. If on the tenth day the fundus has reached the level of the symphysis she is allowed out of bed in a chair a few minutes. This is increased daily as the patient's strength permits and the thirteenth or fourteenth day a few steps are taken.

Three weeks at the hospital is not only not excessive but quite ideal and when patients insist on going home before this time careful instructions are given so that the hospital regime shall be continued at home. Patients are not allowed to climb stairs under three and one-half weeks and are allowed to ride in the open air after the fourth week.

As soon after this time as the patient is able to come to the office I make the final examination. At this time a thorough pelvic and gen-

eral examination is made and the case referred to the family physician if no further treatment is necessary.

In this somewhat discursive paper I have tried to emphasize the main points in the care of the normal puerperal patient. It is only the careful study of a definite postpartum regime that the physician will do his whole duty to his patient. If he will take the time to explain the reasons for exacting care at this time he will find that every intelligent patient will willingly cooperate.

REFERENCES

(1) Bull. Lying-In Hosp., New York, May, 1917. (2) Med. Klinik, Oct. 29, 1916. (3) William's Obstetrics, pp. 365, New York, 1917. (4) Jour. Exp. Med., 1922, xxxvi, 181.

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