

Midwives Association

Pulmonary Infarction After Delivery

By

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Sarla, a young hale and healthy woman, aged 20 years, admitted to the hospital with the history of full term pregnancy was a regular antenatal case. Admitted to labour ward, membranes having ruptured at home; she was having mild labour pains. Chloral grs. x, pot. bromide grs. x and Kapalin tablets; 2 given. Two hours after admission the patient started having good pains. From 9 p. m. to 4 a. m. she was having very strong contractions and at 4 a. m. there was pressure on the perineum. At 6 a. m. the head could be seen, so the patient was prepared for delivery. She was encouraged to bear down during pains, which she attempted to do to the best of her ability, but no progress was evident. The doctor was informed and she came and applied forceps for a delayed second stage of labour. A male child was delivered who cried after some stimulation; placenta was expelled complete. A first degree tear was repaired with one cotton stitch. At 7-30 a.m. patient was left in good condition, no vomiting during anæsthesia, pulse was good throughout, respiration normal; the anæsthetist left the patient in good condition at 8 a.m. At 8-30 a.m. the patient vomitted twice and had severe coughing paroxysms associated with the expectoration of fresh frothy blood. The patient became cyanosed, markedly restless and apprehensive. The pulse 120 per minute, and irregular. B.P. 140/70. Our medical specialist was called and in view of the above symptomatology made a diagnosis of Pulmonary Infarction

consequent to an embolus from the pelvic sinuses. A little later the patient

Members of the Midwives Association will be interested to know the name of their newly elected Hon. Secretary.

Miss Marykutty Isaac,

Matron,

**Norowji Wadia Maternity Hospital,
Parel, Bombay.**

Miss Isaac will welcome letters from members.

developed a pleural rub at the right lung base. The patient was moved very gently from the delivery table to comfortable bed and her head was raised slightly; pulse remained unchanged. She continued to be bothered by a severe cough and hæmoptysis. Oxygen was started as patient was cyanosed. Inj. Pethadine 100 mgm. was administered to control restlessness. Cyanosis deepened, the pulse rapidly increasing in infrequency.

At 11 a.m. the patient's condition became very much worse. She was cold and clammy, and her skin was pale and blanched; the radial pulse was imperceptible, respiration shallow and rapid, B.P. 70/40, she presented the typical picture of vasomotor collapse in all its dramatic suddenness. To see our patient in this state was most distressing. The doctor then started I.V. drip of Plasmosan, pint one; injection Methadrine (a recent powerful vasoconstrictor) was given I.V. to increase blood pressure and one Amp. was given I.M. concurrently. Blood grouping and matching was

done. Injection Percoten, one ampoule given to combat shock. Inj. Heparin 5000 units given, but not repeated for fear of increasing uterine bleeding. Inj. Digilanid one ampoule given very slowly; in the mean time patient started a postpartum hæmorrhage. Inj. Neoghnorgen one ampoule given to control it. Inj. Methadrine one ampoule repeated I.V. with saline. 12-30 p.m. condition remained the same. The patient was literally battling with death. She was severely dyspnoeic, deeply cyanosed and her skin was still cold. B.P. was low at each recording, radial pulse was almost imperceptible. Even though the patient started talking, there seemed to be no improvement in her general condition. At 3 p.m. 500 cc blood transfused slowly; Inj. Penicillin 5 lakh; Inj. Streptomycin 1/2 gram given 6 hourly. Patient began perspiring profusely, so linen was changed frequently. Inj. Digilanid 1/2 ampoule and Inj. Methadrine 1/2 ampoule repeated again. Fluids by mouth given. At 7 p.m. no change in general condition, all concerned looked worried and less hope for the patient's life was entertained. Sarla remained cyanosed and hæmoptysis persisted. At 9 p.m. B.P. was 70/40, temperature 101, pulse imperceptible, general condition unchanged. Inj. Morphine grs. 1/6 given. Urine voided naturally: uterus was well contracted. Even though patient said she was feeling better, no change in general condition was visible. At 10 p.m. our patient was left in the hands of night nurses with very little hope of seeing her again in the morning.

Sarla was restless but slept on and off. At 6 a.m. she woke up after 2 hours good sleep feeling much better, her pulse was now palpable at the radial artery. Our doctor stayed with the patient constantly while she was in a serious condition and instituted an effective regime. At 7-30 a.m. the patient was definitely better. We all felt happy but were warned by the doctor that you have to watch

your patient for 7 days for the development of any lower nephron nephrosis or brain damage. Even though we were slightly discouraged, we optimistically hoped for the best.

9-8-55. Sarla's pulse was fast but could be felt: 138-148 per minute; B.P. 110/70-120/80; bleeding time 4½ minutes, clotting time 2½ minutes; R.B.C. 3,720,00; Hb. 63%. Temperature 101, Pulse 136. At 8 a.m. the chest surgeon was consulted for the further management of her pulmonary infarct. As the patient was still passing blood stained sputum, Pencillin and Streptomycin were continued. Catheter specimen of urine sent to the Laboratory (for any R.B.C., casts or albumen); oxygen continued. I.V. Glucose Saline started. Fluid intake and output was recorded. Fluids—6 oz. given every hour. Hot sponging carried out. She voided urine spontaneously and also passed five loose stools. The pulse was improving; B.P. remained steady. Sulphaguanadine tabs. 2 given 4 hourly. The prognosis now was hopeful.

11-8-55—Penicillin and Streptomycin continued. B.P. was checked carefully, pulse was recorded 2 hourly, temperature normal, pulse 130 per minute, B.P. 120/170. W.B.C. 16,400, bleeding and clotting time 2 and 4 minutes; stools less, general condition was improving. Oxygen was discontinued. Urine passed freely.

12-8-55—Injection Penicillin 2 lakhs, Inj. Streptomycin 1/2 gram B.D. given, temperature normal. B.P. charted 4 hourly. Inj. B. complex 1 cc. Inj. Exhepar 2 cc. Mouth treated with boroglycerine and Condys mouth wash after all feeds. Festal Tabs T.I.D. given because it contains Pancreatic Enzymes which aid digestion; patient had been troubled by flatulence. B.P. remained normal, pulse steady, temperature normal.

13-8-55—The same medicines given, urine voided freely, no blood stained

sputum, X-ray of chest revealed an area of pneumonitis at the right base.

15-8-55—Patient's progress was satisfactory, but in the afternoon she complained of pain in abdomen; Spasmocibalgen Tab. 1 given for intestinal muscle spasm.

16-8-55—Sarla looked as we saw her eight days ago and felt much better. There was no respiratory distress, pulse normal, she was febrile and her

lochia was healthy.

17-8-55—19-8-55. Nothing of note to report.

20-8-55—O happy day! The patient walked. Screening was done and revealed healing of infarction. The patient was now pronounced to be out of danger.

Powerful new drugs, medical science and skilled nursing had saved her life.

Scholarships Available

Applications are invited for the following scholarships of Rs. 900/- to Rs. 1000/- for:

(a) Post-certificate combined course in Teaching/Administration at the College of Nursing, Delhi, or School of Nursing, Vellore. Men or Women Nurses eligible.

(b) Public Health course at All India Institute of Hygiene, Calcutta. Women only.

1. Margaret Jahan's Memorial Scholarship.
2. Tata Scholarship.
3. Lady Linlithgow Scholarship.

Qualifications.

- (i) Matriculation or equivalent examination.
- (ii) Candidates must be State Registered Nurses and Midwives; in case of men nurses evidence of having taken training in a special subject in lieu of nursing of women.
- (iii) Not less than 3 to 5 years experience of nursing in a school of Nursing.
- (iv) Candidate must have been a member of the TNAI for 3 years.
- (v) Attested copies of confirma-

tion of the following must be attached to the application form when returned.

- (a) Confirmation from the Principal, College of Nursing, New Delhi; or the Dean, School of Nursing, Vellore; or the Director, All India Institute of Hygiene and Public Health, Calcutta, that she/he is eligible for admission to the post-certificate course.
- (b) A letter from the employing body that he/she will be relieved in time to commence the course, July 1956.

Note: Men Nurses are not eligible for the Public Health Course.

Agreement.

An undertaking to continue in service for two years within three months of completion of the course or to refund the amount paid to her in case of default, will have to be executed by the candidate on the prescribed form.

Application forms may be obtained from Miss B. G. Dawson, Hon. Secretary, National Florence Nightingale Committee, Lady Hardinge Hospital, New Delhi.

Closing date for receipt of completed applications—May 1st 1956.