

bowls, dressings, sponges, medicines and lotions, spirit lamp, sterile towels etc. These are kept in a special room in the Maternity Block and at the city dispensary, where they are returned and made ready again after the case is over. There are also two doctor's boxes with instruments, sterile sheets, gowns, anaesthetic and everything needed in addition to the equipment in the ordinary basket for dealing with an abnormal case. Here it must be said to the credit of the district staff that more often than not the abnormal case is recognised and the patient persuaded to come to the hospital, but there is still the occasional low forceps or breech case, or the more desperate village case that have to be dealt with on the spot. In the case of the village work the influence of the trained dai is being felt and it is gratifying to see the abnormal cases that have been discovered antenatally and brought to hospital for delivery. Last September one such dai brought a woman with contracted pelvis, and, realising that she needed a Caesarian Section, brought the husband to give permission. Another woman from another district persuaded a breech primipara to come into hospital because she said she thought it safer for her to be admitted.

Nurses, midwives and nurse dais visit the homes with the staff for ten mother nursings. The baby is bathed, the mother sponged down, condition of the breasts and the flow of milk noted, height of the uterus measured and the lochia inspected. Any fever or other abnormality is reported to the assistant doctor, who visits and advises.

Antenatal clinics are carried on by the Maternity doctors in five different centres each week. It is found that pregnant women cannot come far for antenatal visits, so centres have been opened in connection with the three health centres in various parts of the city, in the city dispensary and in the hospital health centre. Some 15,000 antenatal visits are made annually and as a result there is a satisfactory decrease in the number of abnormal cases.

The Maternity Block itself consists of only 40 beds, 20 cots and two labour rooms but it is the centre of the midwifery teaching and a considerably larger midwifery practice than could be done in the block itself. It is interesting to compare results between the in-patient and district midwifery. If anything the incidence of maternal morbidity and foetal mortality is less on district than in hospital. This is partly because the more ill patients or abnormal cases are referred to hospital but it speaks well for the constant vigilance of the district staff.

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A Case Study of Spina Bifida Baby.

A baby was admitted into Clara Swain Hospital, Bareilly, on December 23rd 1945, at 4 P. M. with Meningocele in the lumbar region.

The mother of the baby had attended the out patient department of this hospital for antenatal treatment but had her delivery at home. The baby was seen for the first time the morning after it was born and admitted in hospital in same evening. On admission temperature was normal: she was passing urine and stools normally and there were no signs of paralysis as the baby could move her limbs freely.

Meningocele was the size of small guava, vessels crossing over it: there was slight ulceration on the right surface with oozing. The tumour was translucent.

With the exception of this meningocele the baby was otherwise normal. The tumor was dressed with sulfanilamide ointment and the dressing changed frequently. She took the breast feeds nicely. Her temperature was normal all the time and the drainage from the ulcer was a small amount.

On December 26th the meningocele ulcerated more and the foul-smelling drainage was free. The baby was given a daily bath and cord dressing done. Her weight was 5 pounds 8 ounces. The baby took breast feed nicely. As she could lie only on her side her sides were changed frequently. A sterile dressing with sulfanilamide ointment was applied and to prevent friction a pad of cotton wool was placed over it.

On December 27th meningocele had ulcerated more widely and there was a profuse, foul-smelling discharge; there was a line of gangrene at the base and the general condition of the baby was not good. She could not nurse at all and when the breast expressed milk was given to her she could not take it and spat it all out. She could neither cry nor move about and was very quiet and still all day. The meningocele was draining a lot. She was in the same condition till 2 A. M. and then she suddenly became cold and cyanotic. Spirit of ammonia inhalations and artificial respiration were given. She had three convulsions and at 3:30 a.m. she died.

The points of interest of the case described are:

- (a) The apparent well being of the child for the first three days.
- (b) The onset of septic gangrene even under hospital care.
- (c) The rapid transmission of this septic condition into the meninges causing a toxic meningitis as evidenced by the child being unable to swallow, having stiffness of the body and inability to move the limbs, and finally dying of respiratory failure.

As regards Spina Bifida there are several varieties of it:-

1. **Meningocele** in which only the meninges protrude through the defect in development of the spinous process of the vertebra to form an external cystic mass. The skin is of translucent membrane filled with cerebro spinal fluid. It is fluctuating and compressible and if we light a torch against its wall the inside is seen clearly. It is found in the lumbosacral region and 3-4 vertebrae are involved.

2. **Meningo-myelocele** in which the spinal cord protrudes through the defect and the underlying nerves are stretched. This condition is associated with increased pressure of cerebro-spinal fluid and thus the tumor tends to become enlarged and as the tumor enlarges the walls get thinner and thinner and at last the tumor ruptures spontaneously or may be ulcerated and these conditions lead to meningitis or paralysis which usually terminate fatally. This is found in the lumbo-sacral region and if we light a torch against its wall the shadow of the cord and nerves will be seen.

3. **Syringomyelocele** in the cord becomes hollow, the anterior portion of the cord and the underlying nerves are normal but only the posterior portion of spinal cord is involved. This is found in cervical or dorsal region.

4. **Myelocele** in which even skin is not developed and the spinal cord is seen on the skin surface; the area is raw. This type is usually not seen often as the child may be still-born or may die within a few days. This is found in the lumbo-sacral region.

5. **Spina Bifida Occulta** is a type when there is no change in cord or meninges and the condition is hidden and symptomless and only discovered by X-Ray.

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