

Public Health and Midwifery Section

Soya Beans for Babies

BY SISTER MARY LAETITIA, HOLY FAMILIES HOSPITAL, PATNA.

Roasted.—The beans are roasted in an iron pot with a little sand for about ten minutes. The fire must not be too hot and must not scorch the beans. They are roasted sufficiently when the outer husk is a light yellow and the bean itself a light brown.

Ground.—They should then be ground very finely. An ordinary coffee grinder will not do this, but they can be ground in the bazaar.

Sifted.—The powder must then be sifted three times through a fine flour sieve.

To make a substitute for cow's milk :

Roasted, ground, sifted soya beans	...	...	oz. 1,	drs. 4.
Flour	...	...	...	drs. 2½.
Sugar	...	...	...	drs. 5.
Sodium Chloride	...	...	...	grs. 8.
Calcium	...	...	...	grs. 20.
Water, enough to make	...	...	pint 1.	

(Or in grams, which is a little more exact)

Roasted, ground, sifted soya beans	...	...	gms. 50.
Flour	...	...	gms. 10.
Sugar	...	...	gms. 20.
Sodium Chloride	...	...	gms. ½.
Calcium	...	...	gms. 1½.
Water, enough to make	...	...	500 cc.

Mix well and add the water slowly.

Boil—Boil for one hour, stirring all the time. Add water to replace the amount lost in the boiling.

Finished mixture :—The finished mixture contains :

Protein 4.15% Fat 1.40% Carbohydrate 10.17% Calcium 0.076% Phosphorus 0.060%.

Vitamin B complex, iron, phosphorus and potassium are present in sufficient quantities, but vitamins A, C, and D, must be added.

In making a formula for a newborn or an older baby, dilute as ordinary cow's milk.

Each ounce contains 20 calories.

To purchase soya beans.—Write to your department of agriculture. They can be obtained in practically every province for Rs. 10 per md. In Bihar for Rs. 6 per md.

The babies do well on the formula, perhaps better than on cow's milk, as they have not the fat with which to contend.

The labour involved is considerable, but a servant can be trained to do the roasting and the boiling.

After the roasted beans are ground the colour should be a nice golden brown, not dark brown. If over-roasted the taste will be bitter.

As the mixture will keep awhile a pint or two could be given out once a day in a milk kitchen or a dispensary.

The Patient's Toilet after Labour

Rules The Midwife Should Observe

BY MISS K. V. CONI, S.R.N., S.C.M.

There is no better indication of first-class work than the observance of the fulfilment of routine duties. The midwife who is flustered by the visit of her inspector is probably either consciously or unconsciously doubtful of the perfection of her technique. The importance of good training is to lay the foundations and to form habits which ensure methodical work in accordance with vital principles.

Careful Examination after Labour:—A good example of this is the method employed for the patient's toilet after labour. As soon as the placenta has been delivered and carefully examined, the patient herself is examined in a good light to see if any perineal tears have occurred. If they have, they should be repaired as soon as possible by a doctor. This applies to internal lacerations extending into the muscles, even though the perineum itself is intact. It has been proved beyond doubt that such lacerations neglected form a fruitful source of infection with all its attendant evils.

The uterus should be well massaged to ensure that it is empty and well contracted. The bed is then cleaned up, *i.e.* the long mackintosh and soiled sheet removed, the patient's thighs and buttocks well washed with soap and water and dried, her night-gown rolled down, and stockings removed if they are soiled. The patient is then tucked up with warm bottles and blankets and encouraged to rest, and a drink is given to her.

It is customary in my training school for the midwife to keep guard over the uterus for an hour. She stands by the bed with the left hand gently holding the body of the uterus, the line of the thumb level with the symphysis pubes, the fingers well down over the posterior wall of the uterus behind. This hand should be there simply as a watch-dog if the uterus remains well contracted, but should it unduly relax and bleeding occur, firm, even massage is at once applied.

I had occasion in my training days to observe the value of this method and have never altered my opinion. The main part of my training was taken in hospital, but we spent two or three weeks on the district where the sister was a very experienced midwife, but rather "set" in her ways. She said, "We don't bother with holding the uterus on district," and I found it was no uncommon thing for the patient to bleed so freely in the first 24 hours after delivery that the mattress was soaked through; also, the rate of involution was slower and after-pains much more troublesome than with hospital patients. When the midwife is satisfied that the uterus is well contracted, if she is working single-handed, she will then probably bath the baby before finally fixing up the mother. In a hospital or district training centre, with a midwife and a pupil in attendance, the pupil usually baths the baby while the midwife guards the uterus.

Thorough Vulval Cleansing Essential:—The patient should now be prepared for bed and a long sleep. A bed-pan should be given and the patient encouraged to pass urine (the practice of measuring all urine passed in the first 24 hours is an excellent one and avoids all risk of over-distension of the bladder passing unnoticed). A careful vulval toilet is then performed. Wash the groins and surrounding area with soap and water. A clean bed-pan is then placed under the patient and on a trolley the necessary antiseptics, swabs, and a sterile pad should be ready. The nurse makes her hands surgically clean and with all aseptic precautions separates the labia and swabs the inner side and then the outer side, using each swab once only and swabbing from above downwards. The labia are then irrigated with lotion and carefully dried. Remove the bed-pan with the left hand, turn the patient on to her side, and swab the perineum and dry with a dry swab. Put on a sterile pad. The use of an abdominal binder has, to a certain extent, been discontinued, but where there has been any over-distension and there is much relaxation of the abdominal walls, the use of a roller towel as a binder, for the first 24 hours, is often a real comfort.

The height of the fundus should be measured and any undue tenderness of the abdomen noted.

Rubber gloves are not in general use, I believe, for puerperal nursing in wartime for reasons of economy, but a mask must always be worn.

At this stage in hospital the patient is removed from the labour ward. As soon as she is comfortably tucked up in bed, a nourishing drink is given and the baby is brought to her. It should go to the breast for five minutes and complete the psychological process by the satisfaction both mother and baby obtain.

After this a normal patient should sleep soundly for several hours. The midwife must, however, observe her carefully at intervals all the time. The pulse rate should drop immediately after labour and it is usually between 70 and 80 beats a minute; the

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colour of the patient should be good and the skin normal, the respiration even. The uterus should remain well contracted.

The C.M.B. rules forbid the midwife to leave the house until an hour has elapsed. She should never leave until the uterus is firmly contracted and the pulse normal. She will re-visit in approximately six to eight hours to assure herself that all is well and to give the necessary nursing care.

—By courtesy of "The Nursing Mirror."

The Treatment of Wounds and Burns by the Envelope Method.

(Report on a lecture given at the London Hospital by John Bunyan, Surgeon Lieut.-Commander (D), R. N. V. R.) (Continued.)

Treatment of Burns.

The general treatment of shock etc., need not be detailed here. It may be mentioned that when a general anaesthetic is necessary for the debridement and dressing of burns, it need only be a slight one.

There is much confusion regarding the best method of first-aid treatment for burns, and guidance has hitherto taken the rather negative form of instruction to do nothing. Since some time may elapse before admission to hospital, it is felt that the application of packs of E. S. H. to the burn is a considerable advantage; the relief of pain and the practical disinfection, together with prevention of fluid loss, are of great importance. Packs may be applied anywhere quite easily and cannot possibly do any harm.

First degree burns may be bathed in 50 per cent. E. S. H. for 10 minutes, after which the concentration is lowered to 10 per cent. for 10 minutes. The area is dried and then covered with adhesive plaster. Relief of pain is found to be immediate, and after 24 hours there will be little sign left of the burn. Second and third degree burns may be classed as either primary or secondary. Primary burns are those that arrive for treatment without having received any attention other than first-aid.

It must here be noted that it has been found most difficult to decide at first whether a burn is a bad second or of actual third degree. There can be no doubt that many second degree burns progress to third degree because of sepsis and trauma, and it is felt that the use of this method will enable treatment to be carried out without the possibility of any harm until the degree of the burn is established. By then any form of treatment may be undertaken without having run the risk of the catastrophies associated with the treatment of deeper burns.

A patient with a second or third degree burn is premedicated and anaesthetised as may be necessary, and local treatment is begun. When the blisters are unbroken the area is washed over on the surface with 20 per cent. E. S. H. at 100° F. Blisters should then be aspirated with a fine needle and some 10 per cent. E. S. H. injected into them.

This should be left in for five minutes, and then withdrawn with a syringe and needle, and the skin pressed down flat with a dry dressing. When the skin is broken the dead skin should be cut away under a stream of E. S. H., bathed for 10 minutes in a 10 per cent. solution, and covered with a sheet of the special coated silk sealed at the edges with adhesive tape.

To deal with large burnt areas a suitable silk envelope, previously sterilised—except the seal—in 10 per cent. E. S. H. is fitted. E. S. H. in the strength described is run through the envelope, washing all the affected areas. The envelope is drained well and then inflated with oxygen, the inlets being sealed with adhesive tape or rubber-covered clips. Next day the irrigation routine begins: 5 per cent. E. S. H. is employed at 100° F. and is run through the envelope over the affected area for 20 minutes. This procedure is carried out three times a day, draining thoroughly for half an hour after the irrigation and then inflating with oxygen. A sheet of coated cotton is placed under the affected part to prevent wetting of the bedclothes, and the tube from the outlet is run into a basin, all this being explained in the directions for applying the envelopes.

In the case of hands, the envelope may be filled with E. S. H. for the last 10 minutes of irrigation to encourage the patient to move the fingers and wrist. A jet of E. S. H. from a Higginson syringe through the inlet opening may be used to remove sloughs and exudates.