

ABNORMAL MIDWIFERY*By Dr. CAPTAIN*

LADIES, It is with great trepidation that I approach you this evening. When you saw announced on your programmes that this address was to have been given by Dr. Albuquerque, the Principal of the Medical School at Bangalore, your expectations naturally were placed very high. But owing to her unavoidable absence this evening, I have been asked to take her place, a very poor substitute indeed. I hope you will pardon me if this talk appears very dull and uninteresting and I pray you to forgive all short-comings with your usual magnanimity.

The subject of this address is Abnormal Midwifery. As you are all probably aware, the maternal mortality in our country is very high indeed as compared with other highly civilised countries of the West. The Maternal mortality figure for England and Wales is 1.5 per 1,000 births. In India it is at least 10 times as great, i.e. 1.5 per cent or even 2 per cent. Similarly, the Infant mortality rate is also very high. There are a great many reasons for this high Maternal and Infant mortality, reasons which are both economical and social; among the economical conditions may be mentioned the poor nourishment and low vitality of the mothers due to the prevailing economic conditions. You are all familiar with the extreme poverty of the masses in India, where the majority can rarely afford more than one square meal per day; of the extremely bad housing conditions, where a family of 10 or 15 dwell in one room tenements. Among the social causes are the early age at which girls are married before they have had a chance to develop physically or sexually, and the chronic ill-health of the mothers due to the prevailing endemic diseases such as malaria, tuberculosis, hookworm disease, etc. With these economical and social causes, we are not directly concerned this evening. A very large proportion of Maternal and Infant deaths are caused by the huge amount of abnormal midwifery met with in our country. Fortunately for us, many of the conditions comprising Abnormal Midwifery, are avoidable; and amenable to treatment if tackled early enough; and, it is up to us, as members of the medical profession, to help to prevent this wastage of human life, by lessening the cases of Abnormal Midwifery in this country. You may well ask, 'How are we going to accomplish this?' It can be done by the establishment of Ante-natal clinics far and wide all over the country, at which the pregnant women could be thoroughly examined periodically as a routine. In this way, cases of chronic ill-health would be brought to light, and treated suitably before the woman goes into labour; and with her increased vitality and improved stamina, she would be better able to withstand the strain of labour. In addition, diseases peculiar to pregnancy such as the Toxæmias of pregnancy would be detected early and suitably treated. Also cases of contracted pelvis would be recognised early and suitable advice given as to the nature of delivery, instead of what happens at present, viz. the poor woman goes into labour; after 3 to 4 days of suffering, she is brought into hospital in an exhausted condition, where, all you can do is to attempt and save the mother by some destructive operation on the child, such as craniotomy or decapitation and you would be thankful if you succeeded in saving her life.

The causes of abnormal midwifery are many and it would take up a lot of your valuable time if I were to enumerate them all. I shall just select a few of the more important and common causes, which, if detected early enough and suitably treated, would appreciably lower both the Maternal and Infant death rates.

1. Let us first of all, take *Albuminuria* of pregnancy. It can be easily detected at Ante-Natal Clinics by the routine examination of the urine of

pregnant women during the latter half of pregnancy. If neglected, you all know it may lead to the dread disease called Eclampsia in which the life of both mother and child are in grave danger. It may also be the cause of accidental Ante-partum Hæmorrhage in which the child invariably dies and the mother is exposed to the grave risk of further Post-partum Hæmorrhage and Sepsis.

On the other hand, if promptly treated by suitable dietetic and medical measures, it can be readily controlled in the majority of cases; and thus we can definitely lower both the Maternal and Infant death rates due to this cause.

2. *Eclampsia*. I have already mentioned that one of the premonitory signs of this disease is albuminuria. In a few cases, Eclampsia may occur without albuminuria but there are other premonitory signs that put us on our guard. They are œdema of the feet and lower eyelids, persistent headache, ocular disturbances such as flashes of light before the eyes, diplopia or even sudden blindness. There is epigastric pain and nausea or even vomiting. There is a persistent and steadily rising blood pressure. These should lead us to suspect the onset of the Eclampsia, unless energetic treatment is at once adopted. As you know, a large number of babies in these cases are still born and the mother herself is exposed to the grave risk of death from Coma, Cerebral Hæmorrhage aspiration Pneumonia and Sepsis.

3. Next, let us take *Abnormal Presentations*. Let me just take one or two examples. 'Transverse Presentation'. You all know that a transverse or oblique lie of the child can be readily recognised at routine abdominal examinations of pregnant women during the last few weeks of pregnancy. This can readily be changed into a longitudinal lie by external manipulations thus producing either a Vertex or Breech presentation. The abnormal lie is very liable to recur, therefore the woman should be very carefully watched until she goes into labour, and the vertex or breech fixed in the pelvic brim.

If such a Transverse presentation is undetected and the woman goes into labour, the membranes rupture early, the hand prolapses, and labour becomes obstructed. If this happens in the patient's home, attempts are made at delivery by traction on the prolapsed hand by kindly relatives or friends, or even the village dai comes to help without success. The next thing that happens is that the uterus goes into tonic contraction and finally ruptures as it is unable to overcome the obstruction. Then when the woman is in a collapsed condition, i. e. with cold and clammy extremities with beads of perspiration on her forehead, temperature subnormal, hurried respiration, and an almost imperceptible pulse at the wrist, she is rushed into hospital. Well, at this stage, you all know we can do little or nothing to save either mother or child. Ladies, here again is a preventable cause of both Maternal and Infant mortality. Both could have been saved if the presentation was corrected during pregnancy or early in labour.

Similar, other abnormal presentations may be mentioned, such as a persistent occipito-posterior, mento-posterior and brow presentations. If these are allowed to persist, again labour will become obstructed and there is grave danger of rupture of the uterus.

4. Next, let us consider *Contracted Pelvis*. It is a fairly common condition due to the increased prevalence of Rickets and Ostomalacia in this country. It can be readily recognised by the small stature of the woman and her abnormal gait, i. e. waddling gait of Ostomalacia, which you all are familiar with. Then we can actually measure the pelvis by means of a Pelvi-metre or by means of Radiography, but what we can't measure is the foetal head. Remember it is not the actual size of the pelvis that matters, as the

child may be very small ; but, it is the relative size of the child's head to that particular pelvis through which it will have to pass during labour, that matters ; in other words we have to determine the cephalo-pelvic proportion.

If the amount of disproportion is slight, we may permit the woman to go into labour and then perhaps help her out by the application of forceps, later, if necessary. If the amount of disproportion is greater, we may advise induction of labour or a Caesarian section at term.

If such a woman with a severe or a moderate degree of contracted pelvis, goes into labour, again labour will be obstructed, and it will result in the death of the child and expose the mother to the grave risk of a severe operation, i.e. craneotomy or to the risk of tonic contraction of the uterus, rupture of the uterus and sepsis.

5. *Puerperal Infection.* Again infection is quite common in this country due to the lack of proper hygienic surroundings during labour, and also due to the lack of skilled professional assistance during labour. The village dai or the kindly old neighbour that come to help at the labour, have no knowledge of aseptic methods and consequently, have no scruples about using any dirty rag which happens to be handy to wipe the vulva or even to clean her hands. Consequently, sepsis is very rife in this country and is responsible for a large proportion of maternal deaths. Again even in hospitals, infection is very liable to occur unless (1) precautions are taken, i.e. the external genitalia are well cleaned before labour ; (2) unless vaginal exam. are strictly avoided except under exceptional circumstances and then performed with strict aseptic precautions ; (3) unless the hands of the attendant and swabs used, etc. are rendered aseptic.

Ladies, Here again is a preventable cause of Maternal mortality by the conduction of labour in suitable hygienic surroundings and with the help of skilled assistance by a trained midwife. Puerperal Infection can be prevented and the Maternal mortality lowered.

6. Ladies, I think I have said enough this evening to point out how, we, of the Medical Profession can help to lower the Maternal and Infant death-rate by lessening the number of Abnormal Midwifery cases in this country.

PROVINCIAL ANNUAL REPORTS

Bangalore and Mysore

The T.N.A.I. activities this year commenced with a picnic organised by the Sister Tutor—to the Waterworks some miles out of Bangalore. It was a great success both financially and otherwise.

In June we had a Tea Party in the Nurses' Quarters to meet Miss Hartley when she visited Bangalore. Nurses from all other Hospitals in Bangalore and Private Nurses were invited, and a splendid number turned up.

In July another Tea Party was held to meet the members of the Executive Committee when they were in Bangalore for the half-yearly meeting. Since July we have been very busy in our spare time organizing entertainments in aid of the Hospital, owing to the fact that the Government is making drastic cuts in our budget, and we have not therefore had the time to arrange any further T.N.A.I. activities. However, as we have given a small percentage of all the money made at these Hospital Fund functions to the T.N.A.I. I will just give a brief list of the entertainments :

- A Tea Dance,
- A Picnic,
- A Mah Jong Party,