

7. Take the measurements of the patient's pelvis.
8. Take the history of the patient.
9. Have ready the blood pressure apparatus, so that the Dr. can take her blood pressure. The Dr. will, also examine the patient's chest and abdomen before ordering any treatment.

Medicines.

1. Mist Ferri et Nux Vomica 1 ounce (x-xxx gr. in 1 oz. of water). T.D.S. or 2 or 3 iron pills T.D.S.
2. Hepamoxyl or Hepanovina 1 ampoule by mouth B.D., on an empty stomach.
3. Raw liver juice made on the ward 1 oz. O.D.
4. Marmite 1 teaspoonful daily, in either soup or as sandwiches (contains Vitamin B).
5. Liver injection either 1 c.c. or 2 c.c. daily.
6. Calcium may be given in addition, to replace the calcium absorbed by the foetus.

Diet.

1. Extra milk 1 seer daily. Contains all vitamins.
2. Fruits—oranges, grapes, pineapples, raisins. Contain Vitamins B,C, and the raisins contain iron.
3. Red meats, unless too ill.
4. Extra vegetables—tomatoes, spinach, cabbage, sprouting gram, contain Vitamins B,C.
5. Restrict fats.

The patient must have as much fresh air as possible, her bed should be put on the verandah. She should also be given complete rest and if a severe anæmia, the patient may have a blood transfusion given by the Dr.

Urine.

Reaction, albumin tested for daily.

Stool.

Sent to the laboratory for hookworm examination.

Blood pressure.

Taken daily.

Blood count.

Taken on admission and usually weekly afterwards.

Fluids.

Intake and output should be measured and a chart kept for the Dr.

Weight.

Every week if the patient is not too ill.

RECENT CHANGES IN OBSTETRIC PRACTICE

By Mr. Leonard Philips, of Queen Charlotte's Hospital, London.

In choosing the above title for my lecture I have purposely used the word 'changes' rather than 'advances.' The science of obstetrics is always changing, but time alone will show whether these changes are an advance on previous methods, or the reverse. Some things come to stay, but others are less permanent.

Treatment of White Asphyxia

First of all, I want to discuss the treatment for white asphyxia in the newly born. The Schultz method was stigmatised sometime ago as a 'dirty

and dangerous method of artificial respiration,' and it is not in vogue nowadays. The condition of the baby is not one of true asphyxia, but may more accurately be described as one of foetal shock. The baby is, in fact, almost dead; consequently, any rough treatment may extinguish its feeble spark of life altogether. The method employed nowadays in treating such cases is to separate the child as quickly as possible, leaving six inches of cord attached to it. The child is held with the head lower than the feet, and is placed in a warm cot in an inclined plane position, and surrounded by warm blankets and hot-water bottles. The mucus is then sucked out of the air passages, using a mucus catheter with a short length of rubber tubing attached to the end, so as not to damage the infant's delicate mucosa. It is no use just cleaning out the mouth and back of the throat; the whole of the air passages must be freed from mucus and liquor amnii.

Even Sylvester's or Byrd's methods of artificial respiration may be too drastic for the infant; the best thing to do is simply to place the thumb on the child's chest and the fingers behind, and press very gently, avoiding all vigorous movements. The child's tongue can be pulled out as the pressure is released, and allowed to slip back when the chest is pressed on, as in Laborde's method. In addition, we usually give an injection of alpha lobeline into the umbilical vein. The fluid is pressed along the cord, and a new ligature applied above the needle prick. Alternatively, an injection of coramine can be given.

Another very useful stimulant is a mixture of carbon dioxide 6 per cent. in oxygen. This stimulates both the mucous membrane and the respiratory centre. It can be procured in small cylinders which you can easily carry in your bag, the initial outlay being about 12s. 6d., and the cost of refills 2s. 6d. As the use of this mixture has been proved to increase the child's chance of reviving, it is well worth your while to purchase this equipment. You must always remember that, while efficient treatment may save the baby's life, ignorance or injudicious methods of treatment may hasten its end, and no midwife likes to have to tell the waiting relatives downstairs that the child would not breathe.

If, however, your efforts are crowned with success, and you finally persuade the child to breathe, do remember not to leave it yet awhile. You must stay by the side of the cot until the child has not only breathed, but had a good cry as well, and is a nice, healthy pink colour. Unless you wait till all danger of atelectasis is past, a fatal relapse may occur.

Prevention of Puerperal Sepsis

The next point I want to touch on concerns the prevention of puerperal sepsis. During the last five or six years an enormous amount of bacterial research has been done on this subject. Nearly 40 per cent. of all maternal deaths are due to puerperal sepsis, and, of these, 90 per cent. die from infection with an organism called *streptococcus hæmolyticus*. This organism inhabits the throat and nose. It is seldom found round the teeth, but is present in large numbers in such conditions as antrum trouble, discharging ears, severe colds and sore throats. It is not, as a rule, found in the anal and vulval regions, and it is never found in regions which cannot be touched, such as the interscapular region.

It therefore follows that when hæmolytic streptococci get into the genital canal of a lying-in woman the infection has either come from the throat or nose of the doctor or nurse, or from the patient herself. The result of this research means that every attendant *must* wear an efficient mask during the whole of the labour. In addition, any condition which may be connected with streptococcal infection in the woman before labour must be treated, and

MARMITE

in
VITAMIN B DEFICIENCY

and as
ANTI-ANÆMIC AGENT

Marmite is a rich source of vitamin B₁ and the B₂ complex, and it possesses a potent anti-anæmic factor.

Doctors are continually prescribing Marmite for the prevention and treatment of beri-beri, pellagra and other disorders connected with malnutrition and deficiency of the vitamins of the B group, and also for its remarkable curative power in the treatment of tropical macrocytic anæmia.

Nurses in India recommend Marmite particularly for expectant mothers as they appreciate its value in preventing the severe macrocytic anæmia so often associated with pregnancy in tropical countries.

The regular use of Marmite for inclusion in the diets of infants and children is also well recognised.



**Marmite is a yeast
extract and is entirely
vegetable in origin**

For sample and literature write to:—

THE MARMITE FOOD EXTRACT CO., LTD.

N. J. Ind. 137

P.O. BOX 258 BOMBAY

if possible cured, before she goes into labour. The same thing applies to other members of the family. If the patient has a cold or sore throat when labour commences she, too, must wear a mask.

The Necessity for Masks

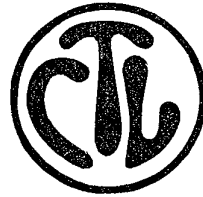
It is a criminal act for any who has this knowledge to attend a delivery when suffering from a sore throat or cold, or after being in contact with infectious disease or sepsis. In addition, we have always to be on the look-out for carriers. Some people habitually harbour this organism in their upper respiratory tract, but exhibit no external symptoms whatever, and the condition may only be discovered after a swab has been taken. This makes the wearing of a mask of even greater importance. Masks can be made very cheaply from gauze, but as research has proved that organisms can pass through several layers of gauze, an impermeable layer must be inserted in the mask. The best way to do this is to make the mask in the form of a bag or pocket, leaving one side open, and slip in a sheet of paper or a piece of batiste. The masks are then sterilised with this in position. All this is of the utmost importance; in my opinion, the use of masks should be made compulsory. Of course, it is easy to maintain an efficient technique in hospital; but outside, where one is only subject to the dictates of one's own conscience, it is easy to get slack and careless. The droplet method of infection may then become a terrible menace.

Value of Prontosil

Now a word about prontosil. Up to 1935 we knew of no drug which would exercise a specific action on the *streptococcus haemolyticus*. Every method of treating puerperal sepsis was tried, but the results were deplorable, the mortality rate being from 18-28 per cent. During 1935 an aniline dye product was tried out in Germany, the subjects for experiment being mainly erysipelas cases. Experiments all went to prove that this drug had a specific effect on haemolytic streptococci. Curiously enough, the dye has no effect on the organism in a test tube; it is only efficacious when actually inside the human body.

The use of this drug has brought down the mortality rate to under 4 per cent. Fatal results from its use are rare, though one or two have been reported. Minor toxic actions may be associated with it, and, as up to the present it has only been found to have a specific action on haemolytic streptococci, every case of puerperal fever should be bacteriologically controlled. It is useless to give it in infections due to anaerobic bacteria. The dose by mouth is from 4-6 grammes in twenty-four hours. In severe cases it can be given by injection. The temperature and pulse usually come down to normal in about three days. The dose can then be reduced, and, as soon as possible, it should be discontinued.

My next topic is that of disproportion. It is a very important subject; obstructed labour may result in the death of the mother or child, or both. At present the minds of obstetricians are in a very plastic state about this subject. As you probably know, it is very difficult to estimate disproportion *before* the birth of the infant. The pelvic measurements may be unreliable, and even the fact that the head cannot be pushed into the brim before labour may be misleading. Certain factors in child-bearing must always be taken into consideration, the strength of the uterine contractions on the one hand, and the dilatability of the cervix, vagina and maternal soft parts on the other. These factors cannot be estimated prior to labour. A case of apparent disproportion can be changed into a normal labour in a few hours, given strong pains and easily dilatable soft parts, and vice versa.



"CURTAINIA"

the fashionable furnishing fabric
handwoven
available in over
100 patterns.

"COMTRUST"

Ladies', Men's and Children's
Underwear and Sportswear.

Handwoven

Table-Linen, Bed Linen, Towels, Etc.,
Sponge and Pique Dress Materials, Etc.

Please write for our illustrated Brochure
and samples sent post-free from

THE
COMMONWEALTH TRUST, LTD.,
CALICUT — MALABAR.

Local Depôts :—

1/30, Mount Road,
Oriental Buildings,
Kodaikanal Co-operative Stores Ltd.,

MADRAS
OOTACAMUND
KODAIKANAL

When replying to this advertisement please mention Dept. 'B'

The Question of Disproportion

Well, what policy are we going to adopt in these cases of queried disproportion? We used to induce labour prematurely about the thirty-sixth week. It certainly should not be induced earlier than this, or the child will have only a poor chance of surviving. But fewer and fewer inductions are now being done; in fact, we seldom do an induction except for albuminaria or post-maturity. We no longer put in bougies or stomach tubes, owing to the risk of sepsis which these methods involve. Instead we rupture the membranes artificially, with full surgical technique, and labour usually starts in a few hours.

The alternative method is to use drugs, but drug inductions seldom succeed in primigravidae, especially at thirty-six weeks. They usually have to be repeated within twenty-four hours, and are very unpleasant for the patient. In any case, induction of labour has a great many disadvantages. The foetal mortality rate is rarely less than 11 per cent; it is the greatest single cause of delayed labour; and the difference in diameter between the foetal head at thirty-six weeks and at term is often only $\frac{1}{8}$ in. It therefore follows that the majority of these women are best left alone to have a trial labour, with a Cæsarean section if necessary. The cases in which the latter is necessary are relatively few. Unfortunately, these Cæsarean sections show a high foetal mortality rate; but, on the other hand, no one can estimate whether the cervix will dilate up easily before labour.

Classic Operation

The classic operation is very rarely performed nowadays when doing Cæsarean section in such cases. Lower segment Cæsarean section is practically always done when the woman is in labour. Any infection is then low down, there is less risk of adhesions forming, and obstructions and ileus are of rare occurrence. It seems probable that lower segment Cæsarean section will eventually be done in all cases, whether they are in labour or not. Those who are not in favour of this say it is more difficult, and that there is a greater risk of hæmorrhage occurring than in the classic operation, but I am inclined to question this.

—From *The Nursing Mirror and Midwives' Journal*, January 29, 1938.

STUDENT NURSES' ASSOCIATION SECTION

Reports and Articles for this Section will be welcomed by the Hony. Organising Secretary, Miss Sharwood-Smith, Lady Hardinge Hospital, New Delhi.

DEAR STUDENT NURSES,

9th March 1938.

You will be very pleased to hear that a new Unit has been formed at the E.T.C.M. Hospital, Kolar with 23 members. We are very pleased to welcome them and hope that they will have a very successful year with their unit.

Yours sincerely,

K. SHARWOOD.

The Student Nurses' Association

Medical College Hospital, Calcutta

A meeting was held in connection with the Student Nurses' Association on 6th November, 1936. It was decided and carried unanimously to form a 'Unit' at the Medical College Hospitals. We started with a membership of fifty-one. The following were elected officers for the ensuing year: