

The drug should not be given, as a rule, when kidney disease is present. It should not be given with sulphur-containing drugs, as Epsom-salt, or with foods rich in sulphur, such as eggs, or else it may produce extreme cyanosis of the patient due to the conversion of the oxygen-carrying pigment of the blood into a compound useless to the patient, called sulphæmoglobin. No fatality has so far been recorded from this condition, but, if the cause were unrecognised and the drug continued, the patient would die, as his blood could no longer carry oxygen to the tissues. On stopping the drug this cyanosis speedily disappears. It is probable, if this drug were used in puerperal cases where sepsis was more likely owing to instrumental interference, etc., or in any severe accident cases, as a preventive, that the grave complication of streptococcal invasion might be prevented. This has not yet been proved, but all experience so far suggests that in this new drug we have a very valuable agent for combating a formerly intractable form of infection.

ANTE-NATAL AND POST-NATAL HAEMORRHAGE

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This is a subject about which there ought to be no two minds as regards the treatment. To the midwife it is a matter of first-aid and the simpler the treatment the better. A case may occur in a West End house where there is every luxury or in a country cottage where there is no luxury at all. Any mother is liable to it. Ante-natal hæmorrhage is the alleged cause of 8 per cent. of the present maternal mortality, and post-partum of 6 per cent. The latter is the more common and the more essential for the midwife to understand clearly that it may not prove fatal. Post-partum hæmorrhage is any bleeding in excess of the normal from the time the baby is completely born up to six weeks after delivery; primary post-partum hæmorrhage occurs within twenty-four hours after birth, secondary from any time after that until the end of six weeks. The loss of from half a pint to a pint of blood with the placenta is normal, and there is also the loss of red lochia from six to ten days. Occasionally when a woman has not fed her child she may have a menstrual period at the end of six weeks which may be a very heavy one.

Three Categories

Post-partum hæmorrhage falls into three categories—when the placenta is not born, when placenta and membranes are born, and when placenta and membranes are incompletely born. It is of the utmost importance that no piece of placenta should be left behind, and it is impossible to over-stress the need of putting the placenta in a bowl or bath and making absolutely certain that it is all there. A statement should be put on every patient's chart to the effect that the placenta has been examined and found perfect. Now in the case of bleeding after the baby is born what is the midwife to do? There may be a trickle of blood from the placenta or there may be profuse hæmorrhage. The placenta must be expressed in the safest, quickest and easiest way. The uterus must be massaged until it is hard and squeezed from above downwards.

The external method of expressing the placenta entails no risk of infection, and is completely satisfactory in a large number of cases. It may hurt the patient somewhat, but it must be done. If you find it impossible to squeeze the placenta in this way it will be necessary to put the hand into the uterus and remove the placenta manually. This is not often called for, and it is dangerous, for it is very possible to infect the mother by this means. Of course, medical aid should ideally be summoned at once in such a condition, but if a patient is pouring with blood there is no time to send

for a doctor, and risk must be taken and the placenta removed by hand, making that hand as clean as possible. If the woman continues to bleed, control the fundus and ask someone else to bring the placenta to see that it is complete. It is more difficult to express a portion of a placenta than the whole of it.

Post-partum hæmorrhage occurs in cases when you are not anticipating any trouble, and may be due to your own negligence. Sometimes it occurs from trying to get rid of the placenta too soon. Also, in the first two stages of labour the mother is the focus of attention, but when the baby is born it absorbs much notice. What is its sex? Is it like its grandmother? It is put into the cot, and the mother only too often left to herself at a most dangerous time. She should be at once placed upon her back and watched most carefully.

Nature delivers a baby, the midwife stands by to see that the mother comes to no harm. She must not become impatient, and, in her haste for the placenta to come away, pound the uterus into a jelly. If bleeding continues after the placenta has arrived the uterus must be squeezed from above downwards; this will expel all clots from its cavity. In this way you may prevent severe trouble. Never tie a patient's binder till an hour after delivery; in some hospitals the patient is made tidy and popped into a neat bed and the sheet tucked up at a correct angle long before she ought to be. A patient when she comes into labour should have as much blood as possible, and if during pregnancy shows signs of anæmia should be treated regularly with iron. The third stage of labour must be allowed to take its own time and not hurried on because the doctor or midwife wishes to get away. Post-partum hæmorrhage occurs in less than one case per thousand, so midwives are not likely often to have to deal with it, but they must be prepared. The system cannot stand the sudden loss of a quantity of fluid. Ordinarily there are 11 pints of circulating fluid in a body; take away five and a half pints and a person will die, for the fluid is no longer sufficient to keep the pumping action of the heart going. Therefore in acute hæmorrhage fluid is needed. Give the patient fluid by mouth, not, as is so often done, spend about ten minutes preparing a rectal saline when the patient is crying for a drink. An intravenous saline is, of course, the quickest way of increasing the fluid.

Every Case is Serious

Ante-natal hæmorrhage is any bleeding from the genital tract that may occur from the 28th week of pregnancy to the second stage of labour. It must be remembered that every case is serious. Unless proved to the contrary it may be taken that such hæmorrhage is due to placenta prævia. If sent for to such a case the relatives are often alarmed, eager to show stained sheets, etc. Even if the place is a shambles, do not stop to examine it, thus losing time. Go straight to the patient. If bleeding has stopped it must be decided if the patient's home is a suitable place for treatment, and if not she must be moved. In every case a doctor must be called in and the midwife can be very useful in helping him to judge whether the woman can be treated at home. In the average middle-class or working-class home this is not advisable. Of course, if a woman is moribund, to remove her may take away her slender chance of survival. If the woman is to be treated at a hospital it is better for there to be no vaginal examination by the general practitioner or midwife. Hospitals do not want cases coming in diagnosed as placenta prævia; they prefer to make the diagnosis there.

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