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# SOME LIFE-SAVING MEASURES IN OBSTETRIC WORK.*

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It is not the intention of the writer to present anything novel or new, but to call attention to some procedures and remedies that have proved beneficial in obstetric work, often saving life.

It is self-evident in this day that aseptic deliveries with complete emptying of uterus are essentially life-saving measures. The physician who fails in either adds mortality statistics in proportion to his failures. Leaving out of this discussion instrumental deliveries, Cæsarian section, symphysiotomies, etc., we have, as I consider, the most important life-saving measures:

First—Saline Infusions;
Second—Medicinal remedies;
Third—Serum treatment;
Fourth—Hydrotherapy;
Fifth—Drainage.

In cases of placenta prævia and postpartum hæmorrhage, saline infusions or intravenous injections are of prime importance, not only to sustain life immediately, but to lessen susceptibility to infection and hasten recovery. In infection after labor with marked prostration, saline infusions act well in many cases, diluting toxines adding volume to circulation, favoring elimination by skin kidneys, and in some instances tends to check the virulence of the infection.

Strychnia and digitaline are well-tried remedies, and worthy of confidence. In many instances they have sustained life and stimulated the vital energies, braced up a weak heart and carried patient over dangerous lines until Nature comes to the rescue.

Quinine in 10-grain doses renders valuable aid in sustaining the patient, modifying course of the infection and counteracting the effect of absorbed toxines.

The serum treatment has not yet fully established its claims but gives promise of utility where streptococci have been demonstrated to be present.

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The cold bath or pack in cases with high temperature is often of value, but the hot pack is more so, especially in weak, anæmic patients. It favors elimination, cutaneous and renal; tones up nervous system, and tides over the critical period in many instances.

Elimination by skin, kidneys, and bowels are potent factors in puerperal infection, but drainage—uterine and vaginal—are life-saving measures.

I do not mean to indorse but to urge against the common practice of curetting and tamponing the uterus in cases of *septic infection following labor at or near full term.*

By uterine drainage I mean the use of as large a soft-rubber tube as cervix will admit, with a strip of gauze about the same length carried into the uterus, along with and by the side of the drainage-tube. This double, tubular and capillary drainage, to be kept up first few days in severe cases, then ordinary tubular drainage, with soft or hard-rubber drainage tube will answer.

Irrigation of uterus and cleansing tube once or twice in twenty-four hours is sufficient. Strong antiseptic solutions are contra-indicated; they irritate parts, interfere with Nature's process or repair, while mild solutions of boric acid, sterilized water, or normal salt solution cleanse parts, do not irritate, and aid in repair of endometrium.

In draining uterus, apply same principles as are used in abscesses and septic infections in other parts of the body.

What are the indications in abscess of the appendix, the brain, or any part of the body? Free drainage. What would the surgeon advise in septic infection of the hand or foot, involving lymphatics of arm or leg?

When once free drainage is established, with proper cleansing and disinfection of the part, the local condition improves, the adjacent lymphatics are relieved, and constitutional symptoms subside.

The greater the lymphatic and vascular supply, the more active the infection and the greater need for elimination with adequate drainage.

Let us remember the physiological hyperplasia of tissue that takes place in the pelvic organs of the female during pregnancy. Also remember the retrograde changes that occur after labor with the process of absorption and elimination, adding to these the traumatisms that occur during labor, and what would be a rational conclusion in cases of infection? If Nature in normal cases establishes a process of elimination by the way of the womb, let us profit by Nature's example in cases of infection.

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If free drainage is the guiding principle elsewhere in the body, why should the uterus be an exception?

If free drainage will relieve abscesses and infections extending to lymphatics in other parts of the body, why not in the pelvic organs.

Uterine drainage in puerperal infection is doubly imperative, Nature having established the precedent in normal cases to eliminate effete material, which process is often checked by the infection. At this time the parts are in such condition as to form a hotbed for germ development and their rapid absorption.

To my mind a more ideal condition demanding efficient drainage could not be found. I am fully convinced that a fair and impartial trial of combined tubular and capillary drainage in these cases will convince the most skeptical and prove its utility.

Vaginal drainage is a life-saving proceedure under two conditions: First, where we have pus accumulation in the pelvis, threatening life of patient, that cannot be safely removed by abdominal section. Second, in cases of infection where the inflammatory process continues to spread in spite of uterine drainage and other remedies referred to in this paper.

With hysterectomy in septic infection after labor, I have had no experience, as I have not had occasion to resort to such a measure since learning how to use uterine drainage efficiently.

To illustrate some points in this paper, I report briefly a few cases that have occurred in the last six months.

*Case I.*—Mrs. L., primipara; husband had gonorrhœa before marriage. Patient had a vaginitis and cervicitis, which was relieved by local treatment. At fourth month of pregnancy removed by continuous strip a lot of warty growths, surrounding posterior three-fourths of vaginal outlet. Labor normal, no lacerations. Twelve days after labor had slight elevation pulse. Headache, temperature 99° F. Next day slightly increased; third day, had two chills; temperature nearly 105° F.

Found uterus large, containing a half pint or more of pus; irrigated, inserted double uterine drainage, and gave the usual remedies. Drainage-tube collapsed and bent at cervix, obstructing drainage; hence, but little improvement first twenty-four hours. After that, a rapid improvement, reaching a normal temperature in a few days. Patient recovered, with pelvic organs normal.

*Case II.*—Mrs. H., aged 22, primipara. Called to see her September 2d, then seven and one-half months pregnant, suffering with acute articular rheumatism, involving all four of extremities; pulse, 115 to 120; temperature, 102° to 103° F. Labor occurred second day afterward,

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normal in character, no lacerations. Temperature day of labor ranged from 99° to 100° F.; after that, gradually increased each day, reaching above 106° F., about six days after labor developing a severe rash over body, very red and angry looking, cuticle soon pealing off in large flakes. Patient had scarlet fever when a child. Large doses of anti-rheumatics, quinine, etc., had no influence on temperature. Womb was investigated, found large, flabby, seven or eight inches deep, bleeding easily; on irrigating, flakes of endometrium slipped off, leaving raw surfaces, which were soon covered with diphtheritic deposits. Double drainage used, anti-rheumatics and quinine continued. Temperature reduced by cold wet pack. Second day heart failure followed cold applications, which was controlled by hypodermics of strychnia, nitro-glycerine, and digitalline. After this the hot pack was used, acted well, increasing elimination. Patient was also put on rubber cushion filled with tepid water, cushion reaching whole length of spine. Uterine drainage kept up until temperature was normal. Had considerable inflammatory deposits in pelvis, but patient recovered, with pelvic organs normal, a slight difficulty with joints yet remaining.

*Case III.*—Mrs. L., aged 21 years, primipara. Miscarriage at about four or five months, two physicians in charge tried to empty uterus with instruments, causing great pain. Some four or five days afterwards a third physician took charge and called the writer in consultation. Found patient in a marked septic condition, temperature 103° to 104° F., pulse 120 to 140, abdomen distended, tender, tympanitic, with abundant pelvic exudate, uterine wall and cervix sloughing. Removed some débris from uterine cavity with forceps, not curette, irrigated and instituted double drainage, giving usual remedies. Patient's general condition improved. Uterus rapidly assumed a healthier condition, practically normal in a week. At this time vaginal incision was made and abscess cavity drained. Patient made good reeovcry, is stout and hearty, only complains of some pain at menstrual periods.

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