Bulletin Lying-In Hosp(NY) 1911-12

THE CARE OF THE NORMAL OBSTETRICAL PATIENT DURING THE THIRD STAGE OF LABOR AND THE PUERPERIUM.

By ROSS McPHERSON, M.D., Attending Surgeon.

With the successful termination of the second stage of labor, a large number of physicians seem to feel that their work is practically concluded and apparently they do not give to the remaining portion of the case that careful attention which it most assuredly deserves. When we consider that the third stage of labor, beginning as it does with the birth of the child and ending with the complete delivery of the placenta and membranes, is the stage during which we have adherent placentæ and membranes, when while waiting for its conclusion we discover lacerations of the perineum and cervix, with or without the attendant hemorrhage, when after an apparently normal delivery, the patient develops sudden shock and examination reveals a uterus which, since it has not been carefully watched and controlled, suddenly becomes enlarged and is found to be full of blood with the patient exsanguinated, when again fortunately rarely, still the accident does occur, we may discover that the uterus is

Digitized by Google

history-of-obgyn.com
obgynhistory.net

ruptured and the hemorrhage, while not appearing at the vulva, has taken place to an enormous extent into the abdominal cavity, then we must realize the importance of proper care at this time. Also, during the third stage it occasionally becomes needful to manually extract the placenta and membranes, an operation of considerable gravity to the mother, especially when done in the careless way which we so frequently see.

Careful examination during the stage under consideration may reveal lacerations of the rectum, urethra, and bladder, which, if recognized and properly treated will heal and save the patient from months of suffering, whereas if unrecognized, may lead to permanent incurable injury. To no one particular cause can post-partum hemorrhage be more often assigned than to the improper handling by the physician of the uterus at this time, and while it is not true that with proper precautions *all* post-partum hemorrhages can be avoided, they can be markedly diminished in number by consistent and thoughtful treatment of the third stage of labor.

From the foregoing statements, of which actual illustrative cases are continually coming under the notice of the writer, as indeed they are to any surgeon who has a maternity service in a large metropolitan hospital, it will be seen that if a realizing sense of the importance of the third stage of labor can only be impressed on the accoucheur, even the most thoughtless will give his cases the care which during this period they deserve.

After the birth of the child, with the subsequent ligating and cutting of the cord, the cord dressing and the treatment of the eyes, during which process the uterus is held by the nurse or some attendant who can be trusted, in either case always under the constant watch of the physician, the latter himself should then take the uterus, and keep it under his own hand until the conclusion of the labor. Just at this time the most common mistake begins, and that is the kneading and squeezing of the uterus commonly known as "massage" of the fundus. The normal uterus immediately contracts as soon as the fœtus escapes, and the reason for "holding" it is merely that we may keep ourselves informed as to the condition of the organ. Occasionally if there is a tendency for the uterus to soften, a little gentle stimulation with the finger tips of the person holding it through the abdominal wall is permissible, but violent squeezing and continuous rubbing produces no valuable results at all and is extremely uncomfortable for the patient. Indeed, cases have come to our notice where the abdominal wall has been seriously bruised by violent and athletic attempts to make the uterus contract in this manner. We should remember that at this time there are distinct periods of contraction and softening which are physiological and a uterus which is alternately soft and hard is behaving in a perfectly normal manner. As these contractions continue, it will be noted by the careful observer that the periods of contractions grow longer and that those of softening grow shorter, until finally there will usually be felt a sharp decrease in the size of the body of the uterus showing that the placenta has separated from the uterine wall,

Digitized by Google

history-of-obgyn.com
obgynhistory.net

the organ thereafter, at any rate to all intents and purposes, remaining hard and firm. The placenta and membranes being no longer of any use, should be removed, and instead of waiting for them to be spontaneously expelled from the lower uterine segment and the vagina, they are assisted by means of the method of Credè. Probably no obstetrical manoeuvre has been more often and more unjustly criticized than has been the above mentioned method of removing the placenta and membranes; the reason for this, being not the fault of the method, but the fault of the men who do not understand its application. The Credè method was never intended to separate the placenta from the uterine wall but merely to expel it after such separation had taken place, and if uniform success is to be assured, certain rules laid down by Credè and emphasized by J. W. Markoe must be followed. These being, first—to wait until separation has taken place; next—before attempting the expulsion, to be sure the uterus is hard and firm; third—grasping the contracted uterus with the operator's thumb on the anterior wall, and the four fingers of the same hand on the posterior wall while the organ is slightly retroverted by the thumb pressing downwards thus bringing the uterine canal into a straight line with regard to the axis of the vagina, and the uterus is then gently squeezed by the fingers posteriorly and the thumb anteriorly. The operator's other hand is held in front of the vulva and as the placenta appears it slides into the palm of the hand which is ready to receive it. Contrary to the usually advised custom, the placenta is not turned over so as to twist the membranes into a rope or cord which we believe makes them more easily torn and retained, but it is simply held still and the hand which has been used in the uterine manipulation through the abdominal wall is removed. After a short period without the stimulus caused by the hand, the uterus relaxes a little, as does also the cervix, and the membranes generally slide out of the os of their own accord.

In teaching students, it is the writer's custom to ask " When in the third stage would you deliver the placenta and membranes? " and the almost universal answer is that the student would deliver the placenta and membranes in from twenty minutes to half an hour after the birth of the child. On this point we desire to protest that there is nothing more universal in the practice of medicine than the custom of having a time limit in obstetrics, such as the application of forceps after two hours in the second stage or the fact that the head has been on the perineum for one hour, and at the same time we believe that there is no more pernicious teaching extant, such an action being on a par with that of men who induce labor for commercial reasons or who hasten it to suit their own convenience, and the man who puts on forceps simply because two hours have passed, shows only the grossest ignorance of his subject. Some cases may require a forcible delivery five minutes after the second stage has begun, while others may go perfectly well three or four hours or longer, the whole matter depending upon the general condition of the mother

Digitized by Google

history-of-obgyn.com
obgynhistory.net

and child, and the rate of progress of the labor. So with the delivery of the placenta and membranes; when the uterus remains firmly contracted, when the placenta and membranes are separated and are no longer of any use in keeping closed the uterine sinuses, then and only then is it proper to remove them, irrespective of the hands of the clock.

The writer desires to make an earnest plea for the greater recognition of the absolute folly of a "time limit" in the practice of obstetrics, for only by such recognition can intelligent and satisfactory work be done. With the placenta and membranes delivered and the uterus well contracted, we should, under the strictest aseptic precautions, examine the perineum, vagina and cervix for possible tears, not forgetting to carefully inspect the vestibule and sides of the vulva as well as the perineum itself. Surgeons are divided as to the advisability of examining the cervix after a normal labor, many fearing infection. The writer, however, believes that the danger of infection has been much exaggerated, and that careful asepsis with the constant use of rubber gloves will render such infection most unlikely, while he considers that the absolute knowledge of the condition of the maternal soft parts gained by the procedure is of sufficient value to warrant its employment. If no lacerations are discovered, the vagina is wiped free of any clots with a sterile sponge on a sponge forceps and the patient's legs are extended, the feet put together, a clean vulva pad put on and the fundus carefully held for a sufficient length of time to be sure that the uterus remains well contracted. This may be done by the nurse or attendant but should be inspected from time to time by the physician in order that he may assure himself that no internal bleeding has taken place. When he is satisfied that the uterus will remain firm and hard, it is the writer's custom to take the uterus between the thumb and four fingers and sqeeze it once with the idea of causing the expulsion of any clots which have formed in the uterine cavity. The binder is now applied and the patient put to bed. No douches are ever employed and ergot is not given except in cases where bleeding occurs, due to relaxation, when twenty minims of Ergotol is given by needle deep into the thigh muscle. Ergot by mouth is rarely used, as its action is at best slow and somewhat doubtful.

Regarding the repair of lacerations, cervical tears are not sutured unless very extensive or unless for the purpose of controlling hemorrhage from the cervical vessels. On the other hand however, all perineal, vaginal and vulvar tears, no matter how slight, are carefully brought together, the operator assuring himself that in every instance the ends of the torn muscles are secured. No powder nor other dressing is applied with the exception of a dry, sterile pad which is changed from time to time as necessary.

With the conclusion of the labor which, as its name denotes, has been attended by the hardest kind of physical work, the patient is tired and should have absolute rest. All persons should be excluded from the

Digitized by Google

history-of-obgyn.com
obgynhistory.net

room, including the baby, the shades drawn, fresh air admitted and the woman given the opportunity to sleep as long as she desires. This may vary from one-half hour to several hours, at the end of which time she awakens refreshed and the daily routine begins.

In treating the normal puerperal woman, the prime factor which we must remember is that we are dealing with a physiological and not a pathological condition, and that our functions as physicians are largely those of watchfulness rather than of activity, taking care to see that the excretory organs perform their duties, that the patient has a sufficient amount of nourishment, that the breasts are properly cared for and their secretion established, that the external genitals are aseptically and sufficiently often cleansed and that most important of all, nothing is done by either doctor or nurse which will make the patient depart from the normal line along which she should travel. Meddlesome, even if well meant interference, at this time is responsible for many cases of sapremia, septicemia, cystitis, mastitis, etc., which, in a large majority of instances can be traced directly to unnecessary manipulations by those in attendance upon the case.

As soon as the patient wakes from her first period of rest, she will be likely to demand something to eat or drink, and it is our custom to keep her on a liquid diet for the first twenty-four hours, not because she is sick, but because she has been doing hard physical work and her muscular system therefore has undergone a considerable strain. For the sake of the digestive functions, accordingly, liquids are given until the first night's sleep has been obtained, and after this the patient is placed upon regular diet and allowed to eat anything which she desires. This method of feeding has been employed by us in a very large number of cases without, as far as we have any knowledge, a single mishap, and has the advantage of convenience, making less trouble in the kitchen arrangements of the family, satisfying the patient's desire for food, cheering her up, and also of giving her nourishment to meet the strain of nursing which will shortly be placed upon her. She is not sick, she is merely confined to bed, allowing involution of the abdominal wall and pelvic organs, and there is no reason why she should not receive the nourishment to which she is entitled.

The next subject which concerns us and one which is of the utmost importance, is the care of the bladder after delivery. Fortunately for themselves, the large majority of patients will void at the time when it is desirable for them to do so, and only occasionally do we meet a case who cannot empty the bladder of her own volition, due either to the pressure which has occurred during the birth or from inability to use the bed pan, and there is no condition in the puerperium which requires more delicate care than here, or where the ill-effects of improper manipulation are more pronounced than in the handling of this particular function. In the first place, we must remember that the patient recently confined

Digitized by Google

history-of-obgyn.com
obgynhistory.net

has more room in her abdominal and pelvic cavities than she has had before delivery and that for this reason the bladder will usually stretch so as to contain, without inconvenience to the woman, more urine than has been the case for some months. Again, during the labor, all the excretory channels of the body have been actively employed, the patient has been perspiring, she has been breathing rapidly, the bowels have been well emptied, and it is furthermore a matter of fact that a certain proportion of women do not secrete urine as rapidly directly after labor as they do in normal life. We should not give orders to catheterize because a patient does not void at a certain given time, here again bringing out the question of time limit. Nothing is more annoying than to see upon a report book—a patient is " due to void," at a certain time. No patient is ever due to void until the bladder is full and it is not a difficult matter to ascertain whether or not the bladder is full in a woman recently confined. Probably there is no manipulation in surgery less to be desired than that of artificially emptying the bladder at this time and all means should be urged and tried to avoid the use of the catheter. Suggestion by means of running water, low enemata, hot stupes over the bladder, gently raising the patient to a semi-sitting posture on the bed pan; all of these should be tried before resorting to the abomination known as the catheter. In a recent ward service of the writer covering four months, in which over one-hundred cases a month were delivered, in no instance was it necessary to pass a catheter for the emptying of the bladder after labor.

When we consider the care of the bowels, it is a fact that women are prone to constipation. Nearly all pregnant women are constipated and it is axiomatic that all women are constipated in the puerperium, so that while they remain in bed, it will be necessary in most instances to give them cathartics, and those should be employed which will produce results most satisfactory to the needs of the individual. It is our custom to give divided doses of calomel during the first twenty-four hours after labor, the last dose to be followed in eight hours by some saline, such as citrate of magnesia or Epsom salts. Laxatives and enemata are employed throughout the puerperium according to the perference and judgment of the physician.

During the past few years, breast treatment has somewhat changed, and from an extremely complicated system of binders, stupes and applications of various sorts, we have simplified the treatment until it consists of doing nothing except to keep the nipples covered with sterile gauze, occasionally resorting to saline carthartic and restricted liquids when the breasts become engorged, and the application of astringents to the nipple if cracked or painful. If the secretion does not appear sufficiently profuse by the third day, resort is had to free liquids, cocoa, corn meal gruel and malt extract in some of the various forms.

Regarding the dressing of the external genitals, these should be cleansed after each and every defecation and urination or when a collection

Digitized by Google

history-of-obgyn.com
obgynhistory.net

of lochia occurs which is sufficient to render a new pad necessary. The vagina should never be entered during the process of cleansing and sterile salt solution or one of the weaker antiseptics is all that is required. The dressing should, of course, be done in an aseptic manner, the hands of the nurse being covered with sterile rubber gloves, and in case of a perineorrhaphy, the perineum should be handled with care. Long binders are used for four days in summer and five days in winter and replaced at the end of this period with a T binder. The objection to the binder which has been advanced, that it is the cause of retroversion, is purely theoretical, and it is a source of immense comfort to the patient. We believe that our patients should be kept in the recumbent posture, and it seems to the writer that the modern system of early rising is greatly to be deplored. Many of the patients have weak, badly-stretched abdominal walls and if they are gotten out of bed before these walls have recovered their normal tone, the viscera are thrown forward upon them and there occurs a condition of visceroptosis which remains for the rest of the patient's life. Furthermore, we do not believe that involution is as rapid with the patient in the erect position as it is with the patient in the recumbent posture, emphasizing the statement, by recalling to mind that in the treatment of sub-involution the first step in proper treatment is to put the woman to bed. There is nothing to be said in favor of early rising, excepting that it favors drainage, and this is not at all difficult to secure with the patient recumbent either by means of raising the head of the bed or allowing the woman to turn over on her abdomen once or twice daily. Patients do not grow weak by a few days in bed; on the contrary, the majority feel vastly better for the enforced period of idleness, and the writer, whose experience may be considered to be reasonably extensive, having had the care of a considerable number of thousands of puerperal women, desires to put himself on record as emphatically opposed to what he considers the pernicious custom of getting patients up on the second or third day after their babies are born, even if only for the purpose of using the bed-pan.

In conclusion, lest his readers should feel that he has given unnecessary importance to a subject seemingly so elementary, the writer in justification desires to add that he has been inspired to write this article mainly on account of the non-observance of these simple facts that he is constantly seeing in the daily routine of hospital and private practice.

Digitized by Google

history-of-obgyn.com
obgynhistory.net