SOME DANGER SIGNALS IN MIDWIFERY

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In midwifery practice most patients have a normal straight-forward delivery but in the small proportion where complications occur it is of the utmost importance to recognise the early indications of trouble ahead. The prolonged first stage, foetal distress and the high head are three conditions where failure to recognise early the departure from the normal may result in unnecessary damage to the mother and danger to the child.

I. The Difficult Cervix

Delay in the dilatation of the cervix can be divided into three groups:

(a) Lack of a good dilator; this includes mal-presentations, tumours in the pelvis, cases of disproportion, etc.
(b) Lack of good contractions.
(c) A cervix that will not easily dilate in spite of good pains and a satisfactory presenting part. Apart from cases of organic rigidity of the cervix resulting from operations on the cervix, extensive scarring of the cervix, previous treatment by radium, presence of growths such as cervical fibroids, carcinoma of the cervix, there are several types of cervix which give considerable trouble:—(1) The tough cartilaginous cervix; (2) The thin cervix with the knife-like edge; (3) The tubular cervix which is very tightly stretched over the low presenting part, so that the junction of the vaginal wall and the cervix is difficult to reach though the presenting part is almost shewing at the vulva. Such a condition with slight dilatation of the cervix after a considerable time in labour with good pains is an indication of true rigidity of the cervix and an indication for lower segment Caesarean section. The treatment of this condition by accouchement forcé is too dangerous. Caesarean section may also be necessary in the case of the tough cartilaginous cervix and the knife edge type. Often these cases dilate to two fingers and make no further progress. A cervix that is dilated to four fingers will usually go on to complete dilatation if other factors are favourable.

It is important to examine the cervix before doing a surgical rupture of the membranes for conditions such as toxaemia, for the tough and tightly contracted cervix may not easily dilate and there may be considerable delay in the onset of labour. In such cases the pains may start and stop so that several days may pass before the patient is really in labour and then the tough cervix may need several more days to reach full dilatation. When termination is urgently required for conditions such as toxaemia, and the cervix is tough and tightly contracted, Caesarean section may be the best method of treatment. Another indication of trouble during labour is the flapping cervix, i.e., the cervix hanging down in the vagina with the presenting part high above it. This is an indication of serious trouble for it means that for some reason such as disproportion or malpresentation the presenting part is not applied to the cervix. Such a cervix may not continue to dilate as the membranes have usually ruptured and there is no satisfactory presenting part to complete the dilatation. It may even become smaller later because of the occurrence of oedema. A sudden and extensive oedema of the cervix can occur during labour when a globular swelling forms usually on the anterior lip of the cervix. There is also the case of the unfortunate patient who has been allowed to bear down for hours in the first stage of labour with consequent oedema of the cervix. A powerful sedative such as heroin gr. $\frac{1}{2}$ should be given and elevation of the foot of the bed may help. It is important to remember that when the greatest diameter of the head has passed through the cervix, no further dilatation will occur, also that prolonged manipulations may result in the reformation of a rim of cervix in a case where full dilatation has previously been present.

II. The Problem of the High Head

In a primigravida the head is mobile above the brim in 20 per cent to 40 per cent of cases at the end of pregnancy. Many of these cases are due to deficient flexion of the head, posterior positions, obliquity of the uterus, a full bladder, or a loaded rectum. Provided that the head can be pushed into the pelvis there is usually no cause for anxiety but when the head cannot be pushed down there may be disproportion between the head and the pelvis, malpresentations of the head such as face and brow, pelvic tumours, or placenta previa. Still more serious is the case with the head above the brim when the patient is in labour and the membranes ruptured; it is very important in such a case to do a bi-manual examination for the moulded head with its caput may appear to be low in the pelvis, and may even appear at the vulva, and yet if the left hand is placed on the abdomen most of the head may be above the brim. Note should also be taken in such a case of the amount of overriding of the sutures. Caesarean section may be required in these cases. The occasional occurrence of marked contraction of the outlet with normal brim and cavity must be remembered. A routine vaginal examination during pregnancy in every primigravida should prevent an unpleasant surprise in the second stage of labour.
III. Foetal Distress

It is in the first stage of labour that foetal distress may present a difficult problem. It may be due to prolonged, powerful and frequent uterine contractions and whiffs of chloroform may be the best emergency treatment in such a case to control the pains. Search must be made for other causes of foetal distress such as prolapse of the cord, excessive stress and strain due to disproportion, prolonged labour, etc., and in cases where the membranes are unruptured and no cause for the distress can be found there is always a possibility that some weakness or abnormality of the child may be present. Temporary improvement in the rate and quality of the foetal heart beat may be obtained by the injection into the mother of stimulants such as Coramine, Camphor, and Lobeline, and it is always wise to give an injection of Vitamin K. Should definite foetal distress occur in the first stage of labour and there is no response to treatment, Caesarean section should, in my opinion, be considered if conditions make this a practical proposition. In the second stage of labour foetal distress is best treated in the majority of cases by forceps delivery. The injection of Vitamin K and a stimulant such as Coramine to the mother does, in my opinion, improve the child’s chance of survival but expert use of the mucus extractor with the child’s head held low is by far the most important method of treatment of the child.

MEDICAL NEWS

International Surgical Society

Arrangements have been made to hold the next Congress of the International Surgical Society in London from September 14th to September 20th, 1947. The president will be Dr. Leopold Mayer of Brussels, and the general secretary of the society is Dr. L. Dejardin, of Brussels. A very interesting programme is being prepared.

Local arrangements will be in the hands of a British committee, of which Professor G. Grey Turner is chairman, and Mr. H. W. S. Wright, 9 Weymouth Street, Portland Place, W.1, is the honorary secretary.

There will be a clinical meeting of the Medical Society of the L.C.C. Service on Thursday, August 8th, at 3 p.m., at Hammersmith Hospital and Post-Graduate Medical School, Du Cane Road, Shepherd’s Bush, W.12. Cases will be demonstrated by the staff of Hammersmith Hospital.