SOME OBSTETRICAL PROBLEMS ENCOUNTERED IN GENERAL PRACTICE*

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False Labour Pains

Not infrequently cases are referred to hospital, or the obstetrician is called into consultation, because in spite of severe uterine pains there is no progress in labour. Many of these cases are women with false labour pains. These women are often told some fantastic tale about why the baby cannot descend and that the only hope for mother and baby is a Ceasarean section.

Painful uterine contractions do not necessarily mean that labour has commenced. When these patients are examined it is noticed that the force of contractions is out of all proportion to the pain. False labour pains may vary in intensity from niggling discomfort to severe pain.

The important fact which is forgotten is that dilatation of the cervix is the only true indication that labour is in progress. If a rectal examination or, under suitable circumstances, a vaginal examination is done, the doctor will save himself unnecessary journeys because of a so-called obstructed labour. I can recall very vividly being called into the country to see just such a case. The nervous, worried mother and relatives had already been told that a Caesarean section was imperative. Examination showed that the woman was obviously having false labour pains. Unfortunately, the practitioner would not yield and insisted on a

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Caesarean section. Ours is a profession where honesty and integrity are of first importance. The doctor must not be afraid to 'lose face'.

Pelvic Assessment

Two cases of vesico-vaginal fistula recently seen were both associated with 'failed forceps'. If some attempt at a pelvic assessment had been made, in neither case would the hopelessly contracted funnel character of the pelvis have been missed. There are senior practitioners who are unaware of the value of pelvic assessment, and some junior men are so ready to apply forceps under inadequate supervision that the simple routine examinations for application of forceps are forgotten, with disastrous results both for mother and child.

Where the foetal head has entered the pelvis and obstruction has occurred, it is as well to remember the possibility of funnelling of the pelvis with a small sub-pubic angle and a narrow bi-ischial diameter.

Is the patient at term?

Cases are frequently seen going 1, 2 or even 3 weeks past term, and the question arises, is the case truly post-mature? It is extraordinary how very unobservant some women are about their monthly physiological processes, but careful questioning about the last menstrual period will very often help in coming to a more satisfactory conclusion about the due date.

Another very important point is the state of the cervix. Cases are frequently referred because the woman is supposed to be due and on vaginal examination a long, uneffaced, undilated cervix is found. Such women cannot be at term and may be sent home.

Premature Rupture of Membranes

Spontaneous rupture of the membranes 2 or 3 weeks from term without the patient's going into labour is a problem which occasionally confronts the practitioner. In these cases the following procedure should be adopted:

1. Examine the vulva for any obvious sign of cord prolapse. Listen for the foetal heart.
2. Avoid doing vaginal examinations. A woman will seldom go septic with spontaneous rupture of membranes, but once fingers are introduced into the vagina the risk of sepsis is considerable.
3. Use medical induction, giving castor oil, hot shower and enema, and repeat, if necessary, 36 hours later.
4. Order the bed linen to be changed completely every 24 hours.

These patients, even if they do not go into labour, seem to come to no harm.

Premature Labour

The chief danger of premature labour to the baby is cerebral haemorrhage. The premature infant has a low prothrombin blood-level. Its cerebral tissues cannot take the strain of the birth process. I give 10 mg. of vitamin K by intravenous injection to the mother.

In these cases the premature infant will easily traverse the pelvis, but catastrophe occurs at the perineum. Rather than watch the foetal head straining at the rigid perineum of the primipara, it is far better to do an early episiotomy. The doctor will not usually hesitate to do an episiotomy for a full-term baby, but for some unknown reason he always feels that the head of the premature infant is too small to be held back by the perineum. I do not hesitate to do an episiotomy for a premature infant in a primipara. It is much better to have a 2-inch incision in the perineum than a tear in the falx cerebri.

Keeping the perineum intact has become an obsession with many midwives and doctors. The teaching of the evils of perineal tear has been overdone. Every midwife feels that the biggest disgrace in a delivery is a perineal tear, with the result that sometimes the foetal head is subjected to so much pressure in an attempt to maintain flexion and a slow delivery that a 'cerebral' baby is born. But the midwife or doctor has the boast of an intact perineum. What does a small tear in the perineum really matter? What does matter is a healthy baby. A small tear can be stitched within minutes.

Credé's Expression

Credé's method is still used on conscious patients, in spite of the fact that this way of expressing the placenta is universally condemned. It is indeed a distressing experience watching an outsize doctor or midwife grasping the uterus and trying to squeeze the placenta out in spite of the woman's groans of protest. One has only to see the resulting profound shock, or a woman bleeding from an inverted uterus as a result of this manoeuvre, to appreciate its danger. Credé's expression should only be attempted under general anaesthesia, and then only once.

Toxaemia of Pregnancy

There are 2 points worth mentioning. It is most important to check the blood pressure when a patient is first seen. Very often this essential feature is left until the patient is 7 months pregnant or more. Many fail to appreciate that a hypertensive toxaemia, i.e., a toxaemia superimposed on an essential hypertension, carries a far worse prognosis for the infant than a pure toxaemia (pre-eclamptic toxaemia).

The other point is this: A patient manifesting features of a mild toxaemia is often sent home and told not to eat salt. The patient, and often the doctor does not appreciate the significance of the words. In these cases, what is intended is that the intake of sodium should be restricted. It is most important then that the patient should not take any antacid preparation containing sodium. She is told not to eat salt, and thinks in terms of the salt cellar—but the doctor should point out that foods like ham, bacon, corned beef, smoked fish, are salt foods rich in sodium and therefore to be avoided.

Caesarean Section

Those of us who are practising in the smaller towns must accept the fact that classical Caesarean section has given way to the lower-segment operation. It must be most disconcerting to the young houseman who at his medical school was taught all the advantages of the lower-segment Caesarean section to start work at a hospital and see only the classical approach. But he is impressed by the apparent ease and drama of the classical section, and when he starts out on his own, the classical section may be perpetrated. Therefore I cannot but feel that it is well worth while repeating the advantages of lower-segment Caesarean section and the reasons why it has established itself as the operation of choice:

1. The incision is well away from the placental site and the uterine sinuses, so that less bleeding occurs.
2. It is the part of the uterus which involutes slowly; hence a stronger scar will form and be less likely to rupture.
3. The scar is low down and covered by peritoneum and, therefore, there is less chance that adhesions will form.
4. It is far easier to suture because of the thinness of the uterus in this area.
5. The incision is directly over the foetal head, so that the head is far more easily delivered by a scoop of the hand, and it is easier to apply Wrigley's forceps should it be necessary to deliver the head in this way.

I do not completely condemn the classical operation, and I still feel it is justified in conditions such as the following:

(*a*) Neglected shoulder presentation where the liquor has drained away and the uterus is in tonic contraction on the foetus.

(*b*) Where there is likely to be difficulty in gaining access to the lower segment because of adhesions of fibroids.

(*c*) The presence of placenta praevia.

While on the subject of Caesarean section I should like to mention where considerable time can be saved in the operation. It should be the primary concern of the surgeon and anaesthetist to produce a crying infant. The purpose is to avoid apnoea in the infant, and, as a general practitioner who is also called upon to give many anaesthetics, I find nothing more exasperating than to watch a surgeon waste 10-15 minutes in tying off superficial skin bleeders.

Manual Removal of Placenta

This a far too often done as a routine procedure after the application of forceps. Having seen the dangers of this method—sepsis or rupture of the uterus—I feel that it should only be done as a last resort.

An alternative and, in my opinion, a more satisfactory procedure is an intravenous injection of 0·5 mg. of ergometrine given when the head is born. When delivery is completed the cord is grasped in the right hand and a firm steady pull is applied while the left

hand carries out a rubbing-up movement of the uterus. Again I have seen a complete placenta delivered in this way.

Blood Transfusion

In no branch of medicine does blood loss occur so dramatically and in such large volume as in obstetrics, and after the haemorrhage the woman will be more subject to infection and her recovery back to normal will be slow. However, by transfusion with whole blood the general health of these women is quickly restored.

In the smaller towns we are less fortunate than our colleagues in the cities. We have not got skilled technicians at our service 24 hours a day, and we therefore have to be doubly careful when administering blood. It is necessary to remember the following points:

1. The correct technique must be used and great care taken in cross-matching donors' cells against recipients' serum; otherwise fatalities may occur.

2. Infected blood, owing to haemolysis, looks like red ink, and the supernatant fluid is reddish instead of pale yellow. Such blood should of course not be administered. Dangerous infection however, may be present in the blood without these gross signs.

3. Blood which has been cooled down excessively may be haemolysed, and is dangerous to use.

4. Blood which has been heated above 40°C may also be haemolysed, and dangerous to use.

5. The giving of too much blood, and too quickly, is dangerous especially in cases of anaemia of long standing, and in old people. The heart muscle cannot deal with the excessive amount of blood and acute pulmonary oedema may result.

6. No Rh negative woman should ever get Rh positive blood. The South African Blood Transfusion Service will group and test the Rh factor free.

A baby developing jaundice after the first 24 hours is unlikely to be a case of haemolytic disease of the newborn.

Puerperal Pyrexia

I should like to give a scheme of approach in the examination of patients with temperatures during the puerperium:

1. *Uterine and Vaginal Sepsis.* All lacerations should be sutured and blood clots cleaned away after delivery or any obstetrical manoeuvre. The anaerobic streptococcus will multiply rapidly in the presence of blood clots. A sudden rigor with temperature and headache early in the puerperium is very suggestive of haemolytic streptococcal infection. Both these organisms respond well to penicillin. The character of the lochia and the rate of uterine involution, will give a good indication of the source of infection.

2. *Respiratory-Tract Infections.* Examine (*a*) the throat and (*b*) the chest, for pneumonia or small areas of collapse, particularly if an aneasthetic has been administered.

3. *Thrombosis.* Examine the legs for thrombophlebitis or phlebothrombosis. A woman developing signs of white leg will respond dramatically to paravertebral block.

4. *Renal Tract.* If a temperature develops from the 6th day onwards, it is well worth while to examine the urine for pus.

5. *Engorgement of Breasts.* This rarely produces a temperature of more than 100°F.

6. *Megaloblastic Anaemia.* This should be remembered as a cause of pyrexia, especially when dealing with the poorer sections of the community.