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TERUGGEHOUE MISKRAAM

Die toestand van die dood van die embrio sonder uitdrywing van die produkte van bevrugting binne 'n redelike tyd, wat bekend staan as teruggehoue miskraam, is nooit baie duidelik omskryf nie. Daar word egter gewoonlik aangeneem dat dit ses weke lank duur. Dit kan ook maande lank duur. Die feit van die saak is dat dit klinies dikwels moeilik is om seker te wees van die diagnose voordat ses weke verloop het. Die toestand gaan oor in 'n voorgeboortelike fetale dood gedurende die laaste helfte van swangerskap.

Wanneer die dood van die embrio of fetus die eerste verskynsel is by 'n proses van miskraam, volg terughouding gewoonlik vir 'n tydperk wat varieer van ongeveer twee weke tot ses weke.

Tot ongeveer die derde of vierde maand van swangerskap kan dit baie moeilik wees om 'n differensiële diagnose tussen 'n normale swangerskap aan die een kant, en dreigende miskraam, onvolledige miskraam, buitebaarmoederlike swangerskap, trosvormige mola, skynswangerskap, of teruggehoue miskraam, aan die ander kant, te maak. Dit is veral waar as 'n mens die pasiënt nog nie vantevore ondersoek het nie, en veral as die pasiënt naby die menopouse is. Die grootte van die uterus moet akkuraat by elke ondersoek vasgestel word en die gebrek aan die normale uitsetting van die uterus moet verdag wees. Definitiewe inkrimping van die grootte van die uterus oor 'n tydperk is 'n baie definitiewe diagnostiese bevinding.

Die dokter behoort besonder versigtig te wees om nie 'n oorhaastige diagnose van teruggehoue miskraam te maak nie aangesien selfs die afwesigheid of ophou van die subjektiewe tekens van swangerskap, soos naarheid, of veranderinge in die borste, of fetale bewegings, veral in die middelste maande, nie noodwendig fetale sterfte aandui nie. Die definitiewe afwesigheid van fetale hartklanke, as hulle sonder twyfel voorheen gehoor is, is sterk bykomstige bewys van fetale dood. Verdere ondersoeke bestaan uit bepaling van chorioniese gonadotrofien en röntgenondersoeke. Bepalings van chorioniese gonadotrofien word gewoonlik negatief binne 'n week nadat die ovum dood is, of dit nou ook al uitgedryf of teruggehou is; somtyds bly 'n swak positiewe reaksie selfs maande lank voortbestaan in die teenwoordigheid van teruggehoue miskraam. Hierdie reaksie dui die bestaan van aktiewe chorioniese weefsel aan en nie noodwendig 'n lewensvatbare ovum of fetus nie. 'n Swak positiewe of 'n negatiewe reaksie mag ook by 'n normale swangerskap voorkom. Die urinetoets is dus nie altyd 'n betroubare diagnostiese hulpmiddel nie. Sommige röntgenologiese waarnemings is egter dikwels waardevol, bv. oorvleueling van die fetale skedelbene (Spalding se teken); hierdie teken is egter gewoonlik betroubaar net in die laaste weke van swangerskap. 'n Beter teken is kollaps van die fetale geraamte met 'n abnormale houding van fleksie en somtyds die teenwoordigheid van gas in die fetale buik. Knettering van die skedelbene lewer afdoende bewys. In die meeste gevalle egter kan 'n diagnose eers gemaak word nadat die grootte van die uterus by meer as een geleentheid na geskikte tydperke bepaal is.

Terughouding van die dooie fetus veroorsaak, as dit ongesteurd gelaat word — anders as wat gewoonlik geglo word — geen skade nie. Die meeste gevalle sal spontaan eindig met baie min moeite, maar spontane lediging mag soms eers na verskeie maande voorkom. Sulke afwagtende behandeling mag knellend wees vir die moeder en familie, wat teen die gevare van aktiewe chirurgiese tussenkoms gewaarsku moet word, bv. bloeding en infeksie.

Die gebrek aan sametrekking van die uterus, wat oorspronklik verantwoordelik is vir die toestand van teruggehoue miskraam, veroorsaak waarskynlik dat die uterus in atoniese toestand bly na gedwonge lediging, met die gevolg dat bloeding en daaropvolgende infeksie ontstaan.

Fetale weefsel sonder lewensvatbaarheid lei ook tot infeksie — die gasvormende bakterieë is belangrik in hierdie verband. Dit is algemeen bekend dat die uterus in hierdie gevalle weerstandig is vir die oksitotiese middels.

Hipofibrinogenemie by die moeder, wat selde voorkom, met die gevolglike neiging tot bloeding, ontstaan ongeveer vier weke na die dood van die fetus teen die einde van die middelste trimester van swangerskap. Die moeder mag ook 'n sterk begeerte hê om so 'n swangerskap te beëindig. Die uterus mag sensitief wees vir hoë dosisse van ,pitosien' wat met binneaarse indruppeling gegee word; of 'n mediese induksie met stilbestrol, of (aangesien die fetus alreeds dood is) met kina, kan probeer word.

Chirurgiese induksie word nie aanbeveel nie aangesien die besondere gevaar van infeksie, wat alreeds genoem is, bestaan. Met die ontwikkeling van abnormale bloedingsneigings, wat ontdek kan word deur toetse vir standaard bloedings- en stollingstye, moet konserwatiewe behandeling gestaak word. Binneaarse toediening van oksitotiese middels mag genoeg wees om spontane kraam en uitdrywing van die fetus te veroorsaak. Pogings om in sulke gevalle in te meng, moet nie aangedurf word sonder dat vars bloed of fibrinogeen beskikbaar is nie, aangesien die toestand, alhoewel dit selde voorkom, ernstig is. As dit om redes van geestespanning of om ander goeie redes nodig mag blyk om die uterus te ledig, moet chirurgiese lediging onder ideale toestande (en as dit tegnies moontlik is) onderneem word. In ander gevalle mag vaginale histerotomie nodig wees; abdominale histerektomie is selde te regverdig vir hierdie toestand.

THE NEWLY QUALIFIED DOCTOR AND THE MEDICAL ASSOCIATION

It has become a tradition for professional men all over the world to organize themselves into learned societies to safeguard their material interests and to provide a medium through which they can give expression to their cultural and scientific aspirations. In most of the countries of the Western world doctors have organized national

medical associations which are, in turn, members of the World Medical Association. In the same way we, in this country, have established the Medical Association of South Africa 'to promote the medical and allied sciences and to maintain the honour and interests of the medical profession'.

Since the early days of its existence it has been the explicit aim of the Medical Association to function as a responsible body of professional men who are fully aware of the great and important obligation which rests on them — to keep abreast of the times in scientific and cultural matters.

Admittedly, the Association has, in recent years, been subjected to severe scrutiny and criticism. It must, however, be borne in mind that it has had to face extremely difficult problems especially in the field of the economics of medical practice. The Association can only continue to deal with these problems on a satisfactory level if it can be assured of the whole-hearted support, not only of all its members, but also of each individual practising doctor.

The advantages of membership of the Medical Association have been well known to a large number of its members all over the country, but there are still many doctors who are unaware of these advantages. Furthermore, by the time this article is published, a large number of newly-qualified doctors will have joined the ranks of the medical practitioners of the country. It is to these two groups of doctors — those who qualified some time ago but who have not yet joined the Association, and those who have qualified recently — that we should like to extend a special invitation to become members of the Association.

In particular, we should like to draw the attention of all newly-qualified doctors to the excellent article on 'The Medical Association: its rôle in the past and its ideals for the future' which was published in the issue of the *Journal* for 21 May 1960 (**34**, 423). This article was written by Dr. J. H. Struthers, Past-Chairman of the Federal Council, and deals with the services rendered by the Association to the profession in the fields of the economics of medical practice, the publication of the *Journal*, the rôle of the Association in promoting medical education in the widest sense of the word, international affiliation, and the Association's hopes for the future.

Following is a brief summary of all the services which are at present being provided by the Association:

1. Opportunities for meeting colleagues, holding scientific meetings and providing a forum for the exchange of opinions.
2. A *Journal* for the spreading of medical knowledge.
3. Means for the settlement of ethical disputes between members.
4. Means for negotiating with medical aid societies and provision of some measure of control for medical benefit societies.
5. Means for negotiating with the Workmen's Compensation Commissioner.
6. Acting as the voice of the profession in all matters concerning medical practitioners, and being recognized as the official body in various Acts and Ordinances.
7. Legal protection for individual practitioners.
8. Procuring of income tax concessions of various kinds.
9. Obtaining preferential insurance of various forms for members.
10. Assistance to members by the Agency departments.
11. Amenities for members travelling overseas by reciprocity with the British Medical Association and the Canadian Medical Association, and through membership of the World Medical Association.
12. Improvement of salary scales of full-time personnel.
13. Influence on medical schools and medical education generally, e.g. encouraging and working towards the establishment of the College of Physicians, Surgeons and Gynaecologists of South Africa.
14. Postgraduate courses, provided directly or through medical schools.
15. Library facilities through grants to medical school libraries.
16. Assistance to needy dependants of members, through the Benevolent Fund.
17. Acting as a unifying factor, through Branches and Divisions, among practitioners.
18. Liaison with other professional bodies and the public.

The Association can succeed in playing a satisfactory and worth-while rôle in medical professional life only if it has the wholehearted support of *all the doctors* in the country.