OBSTETRIC NURSING.

— By Obstetrica, M.B.N.A. —

PART I.—MATERNAL.

Chapter VI.—Lactation (Duties During).

(Continued from page 232.)

LACTATION does not always run a smooth course in the cases we have just considered, and we not infrequently get a deficiency in the secretion of milk from constitutional causes, combined with two opposite breast conditions, either of which impedes, if it does not entirely prevent, continuous suckling.

First, we have the large, loose, flabby breast, with insufficiency of milk. The infant cannot get enough to sustain him, and gets wearied out with unavailing efforts to "fetch" the milk, although the nipple may be perfectly normal; and we have to substitute artificial feeding for his natural aliment. There may be no pain to the mother from this form of breast-trouble.

Secondly, with scanty milk secretion we get a totally opposite breast condition—a small, tense and extremely tender breast, suckling giving much pain.

In the first case there is nothing to be done; in the second, hot fomentations with arterial sedatives, and the very *gentlest* friction afford relief. And here I generally use belladonna ointment instead of liniment, and apply it in this wise: take a piece of clean soft rag and fit it to the size of the breast, rounding it plaster fashion; cut a hole in the middle for the nipple, and large enough to clear the areola; smear the ointment over the rag, and *after* you have fomented apply it to the breast; then place white wadding over all. You will scarcely require slings here, as there is no weight to sustain, and the wadding can be fastened here and there to night-dress with small safety pins. Assuming that you dress the breasts at night, leave them till the next morning, when they must be washed with warm soap and water, softened with borax, as I told you in a former paper, and if necessary the belladonna ointment repeated. If the mother goes on with suckling, the infant must take the breast from a long nipple shield, so as not to disturb the dressings in any way. Do not forget to cut a hole in the centre of the wadding as well as the rag. There is no real remedy for these two opposite and adverse breast conditions, combined with scanty secretion of milk, but *weaning*, and no difficulty, except from the insuperable objection so many of our patients raise to it. It is so hard to persuade them to avert disaster by anticipating defeat (which *must* come), and only too often, alas! they have to accept both!

Nipple defects, again, will impede, if they do not altogether debar a patient from suckling. There is the flat nipple, where there is nothing for the infant to grasp; the depressed, where the nipple is so driven in, if we may so say, that the infant has not strength to draw it out. These defects may be remedied in a manner by shields, which give the infant a sort of *point d'appui* in sucking; but, although they are useful for temporary, they are undesirable for permanent use, and not much more comfort to the child than feeding-bottles. Last, and worst, is what we may almost call absence of nipple, for there will only be a sort of chink or narrow fissure in the centre of a small areola. Sometimes a little colostric milk will ooze from the aperture; no infant can possibly fasten on to it, nor are shields any good; nor am I aware of anything that is.

The defects I have enumerated are more often found in primapara. We shall touch upon the nipple difficulties of multipara when we come to that part of our subject.

Before entering upon the fourth division of it, I will say a few words upon a most important point of breast management, especially in first cases, although it holds good in *all* cases. When is the infant to be put to the breast? Common sense would suggest, When the flow of milk sets in. And when is that? There is no definite answer to this question. Sometimes milk is secreted during pregnancy in quantities sufficient to fill the breasts about as soon as delivery is over; and again it may be three or four days before the milk-flow sets in. Now you would naturally conclude that this simple fact—the presence or absence of milk—would decide the treatment. But such has not been, and, I regret to say, is still not the fact, for there is the widest divergence of opinion on this subject amongst practitioners in Midwifery (men or women), and consequently opposite Medical directions, enough to confuse the mind of any Nurse, and to obscure rather than to define the course to pursue.

It used to be a prevalent, though, I trust, now a fast waning, practice to order the infant to be put to the breast *at once*, in some instances even *before* he was washed and dressed. This custom was most observed in the rural districts, the fountain source of almost everything that is wrong or fallacious in child-bed Nursing. Accoucheurs of high authority have ordered, and may for all I know still order, the infant to be placed as soon *as possible* to the breast, be the circumstances of the labour what they may, and the practice used to be defended upon the grounds:—

(1) That irritation of the nipple from the act