rolled. But we have estimated within the margin, and have laid especial prominence on this point because we have reason to believe that the promoters of the scheme cannot have altogether realised the many difficulties and the greater expenses of the undertaking, to which, in the abstract, we may say at once that we most cordially wish the most complete success.

OBSTETRIC NURSING.

By Obstetrica, M.B.N.A.

PART I.—MATERNAL.

Chapter IX.—Lesions.

Deviations from Normal Convalescence.

(Continued from page 76.)

At their completion, this Course of Lectures will be published as one of the Series of "Nursing Record Text Books and Manuals."

THE Nursing duties required in cases of injury to the perinæum vary according as to whether or not operative interference has been resorted to. Now what are the points that would naturally occur to us in either case. First, to bring the surfaces of the torn tissue into apposition; second, to keep those surfaces surgically clean; third, to keep the patient quiescent. With respect to the first point, we know that in ordinary wounds—such as cuts on our fingers or thumbs—we bind them up in the blood with a piece of clean rag, and they heal by what Surgeons call "first" intention—*i.e.*, an adhesive inflammation without the formation of matter. In lacerations of the perinæum the torn surfaces cannot be brought together in the same way; they do not heal by first intention, and we have to promote healthy granulation—a natural reparative effort to affect the healing process.

Let us see how Nature deals with the lesion in respect to the first point we have mentioned—the apposition of the torn surfaces. This is brought about by the marvellous contractility of the tissue itself. After the enormous distention of parturition, the perinæum contracts from side to side, and from top to bottom, and the open surfaces are brought together; and were it possible to keep the patient perfectly quiescent, in all ordinary cases nothing more than cleanliness would be needed, and this view is entertained by many Obstetricians of great eminence, who decline to operate unless the sphincter is involved in the disaster. But difficulties beset us in this matter of repose. The pains that follow after delivery render the patient more or less restless. Again, the recumbent position so necessary to be observed immediately afterwards, as I have pointed out to you in a previous paper, is not favourable to the lesion, which requires the patient to lie on her side—right or left is a matter of little consequence—and, in fact, the lateral position must be assumed as soon as possible after delivery. The knees drawn up, and the feet resting against some *firm* support—such as a footstool with a pillow over it, or the bolster placed across the bed. The binder must be placed well below the trochanters and kept firmly pinned. Some accoucheurs advise pads to be placed on each side of the perinæum to keep the surfaces together. I have found Southall's *smallest* sized absorbent pads about the best for the purpose, each pad to be *firmly* pinned to the binder back and front with small safety pins. There is another point we have to consider—catheterism—which in cases where operative measures are *not* taken mnst be resorted to from first to last, that is until the wound is healed. The catheter *must* be passed whilst the patient lies on her side, but with the exception of *position*, all the other methods and precautions are to be strictly observed that I pointed out to you in a previous paper.

And here I must digress a few moments to point out to my young sister workers in Midwifery Nursing the practical usefulness of being *ambidexter*—equally able to perform their duties on emergencies with either hand—and I can speak from personal and no small professional experience on this matter, for I do *all* my most important Midwifery work with my *left* hand. In the case before us we will assume that the patient is lying on her *right* side, and on the *left* side of the bed (the reverse of what we like to have), and as we know that the slightest *unnecessary* movement must be avoided, you will find it more gainly to pass the catheter with your *left* hand. Were the conditions reversed, with your *right*. The same rule holds good in applying the Obstetric binder; you must accustom yourself to do so, whether the patient lies on the right or left side of the bed; we cannot always have things as we wish. In the latter, which we will call *left*-handed binding, we begin at the *top* of the binder instead of the bottom, and pin *downwards* instead of upwards. Before you begin to pin, place the binder in position over the hips. I often put a pin in to keep it there temporarily, removing it when I am half way down in my binding, and in this wise we can bind very securely, though not so perfectly as in the orthodox Obstetric position. As I said before, I advise all young Nurses to learn to bind right and left handed as occasion requires, and do many other things besides, as I

previous page next page