The Midwife.

PUERPERAL ECLAMPSIA.

Dr. C. E. Purslow, Lecturer on Midwifery, University of Birmingham, in opening a discussion on the above subject at the Midland Medical Society on January 27th, as reported in *The Lancet*, said in part :—

For the purposes of this discussion I will divide the subject into the following sections: I., Prophylactic Treatment; II., Treatment of the Fits and of the Toxæmia; III., Obstetrical Treatment.

I.—Prophylactic Treatment.

As regards prophylactic treatment there can be no doubt that in many cases in which the disease is threatened it can be warded off by appropriate means, and success depends on an early recognition of symptoms of the pre-eclamptic state; these are numerous, but I should say that the most constant and important are: albuminuria, persistent headache, and œdema. Other symptoms may be disturbances of vision and hearing and vomiting. One prodromal symptom which is not common, but which when it occurs is, in my opinion, of most unfavourable prognostic import, is severe epigastric pain. The albuminuria associated with eclampsia in which there is usually a large amount of albumin present, is practically confined to the latter half of pregnancy, cases of eclampsia before then being rare. Pronounced albuminuria in the later months is a dangerous complication for both mother and child, and the danger of the condition is greatly increased by the fact that it is so often unrecognised and untreated until the sudden onset of a convulsion calls attention to the case.

It should be made a rule to examine the urine of every pregnant woman in the latter half of pregnancy, and the examination should be repeated at intervals, shorter as full term approaches; if this rule were adhered to the death-rate from eclampsia would be greatly reduced. It should always be borne in mind that a haze of albumin may be due to mixture with vaginal discharge, so that if albumin is present in the specimen passed by a patient we should never base a diagnosis or treatment on that, but should examine a catheter specimen. If, on the other hand, there is no albumin in the specimen voided by the patient it will not be necessary to pass a catheter. If albumin is present a microscopical examination and an estimation of urea are advisable. Statistics show that this disease is more likely to occur in primiparæ, and in my experience it has seemed that its occurrence was more to be feared in well-developed women who had been in the habit of taking a large amount of exercise and eating much solid food.

II.—Treatment of the Fits and of the Toxæmia.

The practitioner is generally sent for as soon as a fit has occurred, and in some cases it will happen that there will have been no prophylactic treatment because the patient had not been under medical care, and neither she nor her friends will have suspected that anything was wrong until they are alarmed by the occurrence of a fit. The patient should be at once put to bed in a darkened room and preserved from all external causes of irritation as far as possible. An efficient nurse should be obtained, and she should be instructed that if another fit comes on the patient should be watched carefully to see that no harm befall her, as by suffocating in the bedclothes or falling out of bed. During the fit a piece of wood should be placed between the teeth to prevent the tongue being badly bitten. It is a good plan to place one side of the bed against the wall, as the nurse can then more easily control the patient. During the coma which follows a fit the head should be brought to the edge of the bed and turned well over on one side so as to allow saliva to escape and prevent it entering the trachea.

If the patient is able to swallow she may be given water, but no food, not even milk, should be given. A quickly acting aperient may be given, and one of the best is croton oil 2 minims, made up with powdered sugar and placed on the tongue; in addition a copious enema of soap and water may be given, and when this has acted a further rectal injection may be slowly given of 4 ounces of water containing 2 ounces of sulphate of magnesia. If the apparatus is at hand it is also well to wash out the stomach. Poultices to the loin probably encourage action of the kidneys, and at all events can do no harm. I am not in favour of hot-air baths. One of the few methods, in addition to purgation, upon which almost all writers are agreed is the administration of subcutaneous or intravenous injections of saline; chloride of sodium 1 dram to the pint, or, better still, 1 dram each of chloride and acetate of sodium; the salt may be obtained ready for use in glass containers, and Horrocks's small saline infusion apparatus is in my opinion the best and simplest, and should be carried in every midwifery bag.

III.—Obstetrical Treatment.

Personally, if labour has started and can be terminated quickly under an anæsthetic by forceps I should not hesitate to interfere, but the difficult cases are those in which severe eclampsia is in progress, fit succeeding fit, with no lucid interval, and in which there is no sign of labour, the os remaining closed and the cervix not taken up.

I have treated cases of this kind on both the expectant plan and on the lines of active interference. In an article on the treatment of eclampsia which I wrote three years ago for Latham and English's "System of Treatment" I stated that, on the whole, I thought that the results from interference were slightly better than

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