A Short Series of Lectures to Ward Sisters.

LECTURE 4.—PUERPERAL FEVER.

By A. Knyvett Gordon, M.B., Cantab.
Lecturer on Infectious Diseases in the University of Manchester.

I intend to go rather fully into the subject of Puerperal Fever in this course of lectures for two reasons, firstly, because it is above all others, perhaps, a preventable disease, the prevention being usually a matter of nursing pure and simple, and also because a considerable amount of attention has been recently directed to it by the passing of the Midwives' Act. As before, I am not going to describe the details of nursing so much as the principles which make those details necessary.

In the first place, I want you to realise that Puerperal Fever is nothing more or less than a wound infection, and if we are to prevent it we must first see that the wound that occurs in every labour is as slight as possible; secondly, that we do not make another wound ourselves; thirdly, that neither wound becomes subsequently infected.

An attack of Puerperal Fever is really a most terrible calamity. It attacks young healthy women after they have gone through what should be a normal occurrence, and it either kills them outright or leaves in its trail a long story of chronic invalidism and domestic misery. The immediate mortality of puerperal fever is anything from 35 to 80 per cent.: at present the available statistics are not sufficiently accurate on this point, as it is a disease which is often concealed either from ignorance or sometimes intentionally. In this hospital, it is true that we are hardly concerned with its prevention, but as any of you may have to deal with cases of labour subsequently, it will be as well if I say a few words about the causes of the infection.

What happens in the first place in the process of childbirth? Immediately after the child is delivered, the interior of the uterus is just like a sponge. The portion of it to which the afterbirth or placenta is attached is made up chiefly of the open mouths of large veins communicating directly with the mother's own circulation. After the placenta has been expelled, the muscular wall of the uterus contracts, and thus all clots, shreds of membranes, etc. are expelled through the vagina, and the wound is sealed up. The external genitals and the surrounding bedclothes are never aseptic, and often contain large numbers of virulent organisms. In normal labour, however, there is no reason why these should get up into the uterus of their own accord, and even if they did, the contraction of the uterus should close the mouths of the vessels against them.

The wound then may consist simply of the raw placental site, but there may also be some laceration at the outlet of the uterus, caused by the passage of the head of an unduly large child or by the application of forceps by the attending physician. There may also be some tearing at the peritoneal outlet, which again may be natural or instrumental in origin; occasionally this extends right into the rectum. If we want to make as little wound as possible we do not, unless the labour is unduly delayed, use forceps.

The nurse or attendant does not as rule make a wound at all; her function is to infect it when it has been made. How does this infection occur? Obviously, by deliberately carrying germs from the genitals and bedclothes into the vagina and uterus. This could be prevented, theoretically, in two ways; either by completely sterilising the skin of the patient and the bedclothes, so that there would be no germs to be carried up, or by ceasing from procedures which carry them up.

The first method is impossible in practice, even if the patient would submit to it. We can only make the parts as clean as possible, and take care that the bedclothes are not obviously dirty. Frequently, as you know, we have to work in surroundings where it is possible to do neither.

The second plan is the better and the safer, and here the main point is to avoid vaginal examinations. I cannot impress upon you too strongly that the purpose of a vaginal examination is only to afford information to yourself. It is sometimes essential for the patient's safety that you should have this information, but the examination should never be undertaken unless you cannot find out how labour is progressing by abdominal examination alone, combined with the history of the case, and it should scarcely ever be repeated. I am afraid the modern midwife is rather a sinner in this respect; she may take all "precautions" in making examinations (the precautions usually including the use of as many different antiseptics as possible), but she forgets that it is better for the patient not to make them at all. Whenever a vaginal examination is made it is essential that the external genitals be first wiped over with some antiseptic solution, and that the hands of the nurse should be sterile; the only way in which this can be *ensured* is for her to wear rubber gloves. These can be

previous page next page