Posture in Obstetrics.

The intelligent appreciation of the value of posture in obstetrics is valuable to both midwives and monthly nurses. A good position greatly adds to the facility with which manipulations are carried out, hastens or retards the course of labour as desired, is sometimes preventative of complications, and contributes to the comfort and safety of the patient. The effects are of two characters, firstly, by the elevation of the pelvis its relation to the trunk may be altered; secondly, owing to the mobility of the pelvic joints, the shape of the pelvis may be modified and the inclination of the pelvic brim considerably varied. During pregnancy there is serous infiltration of the joints, which allows of a certain amount of swinging movement in the pelvis, thus changing the diameters of the pelvis. We will now consider briefly the best positions for a woman to assume, during normal labour, complications, obstetrical operations, and the puerperium.

To make an abdominal examination the patient should be in the dorsal position, well to the side of the bed; the shoulders should be slightly raised, the arms extended on either side, and the thighs moderately flexed to assist the relaxation of the abdominal muscles.

To make a vaginal examination, Sim's position is by far the most convenient. The patient lies on her left hip, the chest nearly flat on the bed, the head being turned away from the operator; the left arm hangs over the side of the bed, the buttocks are level with the edge, and the right leg is flexed and drawn up above the left knee. The diagonal conjugate should be taken in this position. Where contracted pelvis is suspected the dorsal position is advisable; it is easier then to press the presenting part per abdomen into the pelvis with the right hand, and form an opinion as to whether it engages or no. Ballottement is more easily obtained if the patient is in a half-sitting posture. The left lateral position, known as the English obstetrical position, is, however, most commonly used for making a vaginal examination of a woman in labour in Great Britain. She lies on her left side across the bed, with buttocks well to the edge, the knees being flexed on to the abdomen. This position is far less disagreeable to the patient than the dorsal position, almost invariably used on the Continent. It allows, too, of a careful inspection of the external genitals and scrupulous disinfection.

In the management of normal labour with a vertex presentation, it is usual for the patient to walk about during the first stage; the standing position facilitates the engagement of the head in the pelvis, owing to the effect of gravity; the reflex effect of the head pressing on the cervix stimulates uterine contractions, and assists in the dilatation of the os. The pelvic inclination is about 60 degs. Where it is desirable to keep the membranes intact, e.g., in presentations other than vertex, in contracted pelvis, or where there is an infectious vaginal discharge, etc., the dorsal position is indicated. If the pains are strong it is better to raise the pelvis, either by lowering the head and placing pillows under the buttocks, or by raising the foot of the bed. The presenting part then sinks away from the cervix and uterine contractions diminish in force and frequency. In cases of exaggerated anteversion of the uterus, the patient should lie on her back to correct the mal-position; where there is marked obliquity it is better for her to lie on the side opposite to that to which the fundus is directed, otherwise a brow or face presentation may be produced.

During the second stage of labour the left lateral position is usually the one adopted; for delivery it is certainly the most modest, the expulsive pains are not so violent, and the strain on the perineum is less than in the dorsal or lithotomy positions. The right leg is raised during the passage of child. It is, however, better for the patient to remain in the dorsal position, with knees bent outwards, till the head is on the perineum. The pelvic inclination is then 40 degs., and the antero-posterior diameter of the outlet is increased by the movements of the joints and the pressure of the coccyx backwards. On the Continent it is usual for the patient to be delivered on her back. In cases of uterine inertia a change of position is sometimes efficacious.

If there be slight disproportion between the pelvis and the presenting part, and it remains at the brim, the patient should be put into what is known as Walcher's position. It is claimed that the true conjugate is increased by as much as half an inch. The woman lies on her back across the bed or table, so that the sacrum rests upon the edge; the thighs and legs hang down by their own weight, the pubes swing forwards and downwards. Owing to the movement in the sacro-iliac joints the pelvic inclination is greatly diminished, being only about 12 degs. The disadvantage is that it is uncomfortable for the patient. The discomfort may be somewhat modified by supporting the legs on chairs during the intervals in the pains, and by passing a roller towel over the chest and beneath the arms of the patient, attaching it to the side of the bed, thus relieving the strain of the weight of the lower extremities. This position is occasionally used in forceps operations, where the head will not come through the brim; the bed, or table, should be high, otherwise it is awkward. After the head is through the brim the left lateral, or lithotomy position will answer as satisfactorily. The latter position is the best for breech deliveries. The patient lies across the bed, the buttocks well to the edge; the knees are widely separated, the legs are flexed, and either held by two assistants, or more conveniently kept in position by Clover's crutch. There is also a cheap and useful lithotomy strap formed of bands of webbing on the market.

In ordinary forceps, or craniotomy operations, it is a great aid to the doctor if the trunk of the patient is kept at right angles to the edge of the bed, with the buttocks well over the side. This will be secured by the nurse grasping the iliac crests and pulling in the opposite direction to which traction is being made. The knees should be bent

previous page next page