judge from Press cuttings we receive, the only two journals in the kingdom which have not warmly supported the scheme are two which are known to be supplied with news by a member of the staff of the *Hospital*—a fact which needs no comment.

OBSTETRIC NURSING.

— By Obstetrica, M.B.N.A. —

PART I.—MATERNAL.

Chapter VII.—The Lochial Period (Duties During).

(Continued from page 292.)

BEFORE entering upon this eventful period of convalescence, I must call the attention of my nursing readers to the instructive lectures on the use of antiseptics in surgery that have so recently appeared in the pages of our journal, and also commend to their perusal Dr. Cullingworth's paper on Obstetric Nursing he read to us last May, for they are full of interest to women engaged in Midwifery and Midwifery Nursing.

In one of my early papers I touched upon this subject of antiseptics, and pointed out the apparent inconsistency of our Obstetric Nurse being enjoined to use them in a non-infectious case, and in itself fraught with no danger to the patient nor to others; hence I drew the inference that the evil was to be found in malign influences from without.

As regards our patients, there are three media of infection to be feared for them, impure air, impure water, and the zymona. There are three paths of attack: the respiratory, the gastro-intestinal, and the utero-genital tracts; parturient women may die from broncho or pleuro-pneumonia, from exhaustion consequent on uncontrollable vomiting or diarrhœa, from the results of injuries, spontaneous or traumatic, to the genital tract, from the effects of zymotic infection, notably scarlatina or erysipelas; and any one of these disasters may befall them during the period of convalescence we are about to consider.

I have brought before your notice in my earlier papers (to which I must refer my nursing readers) the methods we pursue to secure our patients from aerial contamination and water pollution; our task now is to diminish as far as possible the risk of contagion to the utero-genital tract, a special and important duty of an Obstetric Nurse.

I must first direct your attention to the discharges that immediately follow the detachment and expulsion of the placenta, commonly called the lochia. At first they are purely sanguineous, mostly mixed or capillary blood, but at times almost arterial, and the flow so copious and rapid as to amount to uterine post-partum hæmorrhage, of which I shall tell you more in a future paper. This eruption of blood escapes from the bared uterine vessels at the placental site, and this fact may have led to its being compared to a stump after amputation, which, if not wholly correct, is to my mind not otherwise than a felicitous illustration.

All Surgical Nurses know that the Surgeon arrests hæmorrhage from the severed blood-vessels by ligatures or the actual cautery, and sometimes styptics as well, and also that after every such operation there is a *risk* of secondary hæmorrhage more or less serious.

Now how does Nature deal with the exposed vessels at the placental site? I have alluded in a previous paper to this most interesting subject, and briefly pointed out how venous regurgitation is prevented, and the out-pouring of arterial blood arrested, by physiological means alone, due to the structural peculiarities of the arteries and veins of the gravid uterus. Nature neither "ties" nor "burns," and in addition to the means for arresting hæmorrhage just mentioned employs a tampore of marvellous force—the muscular contraction of the uterus. It is during the relaxations of this muscle that blood escapes from the uterine vessels, accumulates and coagulates in the cavity of the uterus, and gives rise to those painful and irregular contractions, known as "after-pains," all about which I have told you in a previous paper. The sanguineous character of the lochia may continue for two or three days after delivery, but in young and healthy mothers not more than twenty-four hours.

What are the next changes we notice in the lochia? A change in colour, a paling down, no longer arterial, a lessening in quantity, a difference in consistency, a thickening, oleaginous in character and dark in hue, and lastly, thin and serous, and a quantity of greenish fœtid fluid flows from the vagina. These discharges mark successive and significant changes in the uterine cavity, and continue for about ten or twelve days, when the wound is healed, and the mucous membrane is being gradually restored to its original character.

And let us say a word or two about this invisible and singular uterine wound. We cannot watch its healing as we could that of a stump or an ulcer; is it any the less interesting on that account? Normally aseptic, as Mr. Stanmore Bishop told us all surgical wounds are, how shall we keep it so? And if septic mischief is feared, how are we to render that uterine wound

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