

words. In the old days, a rag with a hole burnt in it was supposed to answer every requirement, but nowadays cutlery is cheap, and scissors do the work more neatly. The cord should be packed in plenty of good powder—not containing too much boracic—and wrapped neatly in clean rag or lint. Thus kept antiseptic, dry, and clean, it will drop off naturally in a few days. This is one of those small points which no good midwife or nurse can afford to attend to in a perfunctory manner. Septic infection of the cord is a complication involving so much trouble, with the risk of the death of the child from subsequent tetanus, that ordinary care to avoid it is care well bestowed.

Thoughtful attention to details is the essence of midwifery, as it is of all good nursing, and the results of care bestowed on even such a small detail as the umbilical cord will amply repay the conscientious worker.

Method for Reviving Children Born Apparently Dead.

Dr. Ogata, *Beiträge zur Geb. und Gynäkologie*, gives an illustrated description of his method of resuscitating children born asphyxiated. It has been used in his clinic and elsewhere in Japan during the last twelve years, with constantly increasing satisfaction. The infant is held in the left hand, its head and extremities hanging down, the abdomen and trunk curving upward. The right hand is held flat, the fingers close together, and the infant's heart region is struck light, regular blows with the tips of the fingers, from ten to fifteen times a minute. This striking is a stimulus to the skin, but it also compresses the chest wall and lungs, and thus induces expiration. As the fingers are raised, the elastic chest wall springs back to place, and this induces inspiration. The heart action is also stimulated and the circulation becomes more active. In case more energetic measures are required he takes the ankles in the right hand and with the left hand under the back of the chest—the thumb and forefinger clasp the neck—without any pressure on the chest, the trunk of the child is slowly bent over until its face touches the top of the feet, or even a little farther. This movement presses the thorax and the abdominal cavity close together, pushing up the diaphragm. The lungs are squeezed together until there is strong expiration, while the rise of pressure inside the thorax stimulates the heart action and starts the column of blood in the aorta to moving. Any fluids in the air passages can readily run out of the mouth as the head hangs down. The infant is held a few seconds in this attitude, then the trunk is raised and forced back to the horizontal plane or beyond. The air rushes in as the air passages thus open and the diaphragm descends. After a few seconds the expiration movement is repeated, and so on, until natural respiration is established. In extreme cases, he takes away the left hand,

holding the child only by the ankles with his right. As the trunk falls to the perpendicular the arms droop forward and the chest stretches and visibly protrudes, the traction from the pendant arms helping thus to induce deep inspiration. More blood flows to the medulla oblongata in this position, and this stimulates the respiratory centre. From this position the child is brought back to the expiration position. These movements are repeated at rhythmic intervals, from eight to ten times a minute. To prevent chilling, the child is dipped into a warm bath about every minute. The duration and intensity of the procedures are regulated by the colour of the skin, control of the limbs, spontaneous movements of the extremities, spontaneous efforts at breathing and the heart beat. A crackling sound during the inspiration movement sometimes accompanies the inflow of air into the lungs.

An Artificial Pelvic Floor for Demonstration Purposes.

Dr. C. J. Nepean Longridge describes in the *Lancet* an appliance which is likely to prove very useful to teachers of midwives for demonstration purposes. He writes of this artificial pelvic floor:—“Everyone who teaches midwifery to nurses must be aware of the difficulty of making them really understand what the pelvic floor is and does. The article illustrated was designed with a view to lessening this difficulty. It consists of a ring of whalebone which fits into the pelvis at the level which is usually described as the plane of the cavity of the pelvis. A hammock-like arrangement of batiste is suspended from the ring and opens forward. At the two extremities of the opening pieces of elastic are inserted, thus allowing of considerable distension



of the artificial vulval opening. This improvement was suggested by Dr. R. J. Collie. When placed in the pelvis and folded up the model gives the nurse a rough idea of the pelvic floor in its ordinary condition. When a foetal head is passed through a pupil cannot but appreciate the action of the pelvic floor in rotating the head, and the distension of the vulva by the various diameters of the head is realistically demonstrated. These pelvic floors are used in the London County Council lectures to midwives.”

The model is constructed by Mr. J. H. Montague, 69, New Bond Street, London, W., of the best material, and can be obtained for 4s. 6d. We are indebted to Mr. Montague for the accompanying illustration.

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