

## The Midwife.

### Oligohydramnios.

Cases of oligohydramnios or deficiency of the liquor amnii are comparatively rare. They occur in about 1 in 3,000 pregnancies. The condition, however, especially if at all marked during the early months, is one of very grave import to the foetus, and even the mother will sometimes suffer serious inconvenience and pain from it towards the end of pregnancy.

Normally the functions of the liquor amnii are almost entirely protective. It relieves the foetus from pressure and muscular effort, allows it freedom for growth and development, and protects it from change of temperature.

Any secretion less than the normal amount (1—2 pints) tends to injure the foetus by depriving it of its natural freedom, whilst an extreme deficiency nearly always results in the premature expulsion of a more or less defective ovum; absence of the protecting fluid causing irritation of the uterus, and arresting or misdirecting the growth of the foetus, which dies, and acts as a foreign body in the uterus, so bringing on an abortion.

During the early months of pregnancy the amniotic cavity should become distended by the accumulating fluid, which lifts the amnion from the dorsal surface of the embryo, and pushes it out until it joins the chorion. An insufficient secretion will prevent this distension taking place, and failing to separate the amnion from the newly forming skin of the foetus, may give rise to amniotic adhesions. As pregnancy advances, and the uterus grows, these adhesions become stretched into bands, and may so seriously interfere with the development of the foetus that very grave deformities result. Intra-uterine amputations are sometimes caused by these bands twisting round the limbs and constricting them so that, either they are entirely separated, or their growth is arrested and they atrophy. Cases of dry gangrene from constriction have also been recorded. If the cord should become entangled and compressed the foetus may die of asphyxia, or during labour there may be such traction on the placenta that it will separate prematurely, and the child die of hemorrhage. Other malformations, such as anencephalus and protrusion of the abdominal viscera occasionally result from the amniotic adhesions, which prevent the proper closing and union of the walls of the body cavities during the early weeks.

If the pregnancy should go on to term the

foetal movements are likely to become quite painful to the mother, and labour will almost certainly be longer and more difficult, owing to the absence of the lubricating and protecting fluid; there will also be greater liability to cervical tears at the end of the first stage of labour, as the os may be rapidly distended by the hard foetal head instead of being gently dilated by the soft bag of membranes.

The causes of this abnormality are somewhat obscure. It is thought by many authorities to be partly due to absent or defective foetal kidneys, and there is no doubt that during the later months a certain proportion of the fluid is derived from the urinary secretions and skin excretion of the foetus. It is, however, generally allowed that the amnion is mainly responsible for the production of the liquor, and it is therefore much more likely that the deficiency is due to some defect in the secreting cells of that membrane.

Another condition very similar to that of oligohydramnios is brought about when the membranes rupture early in pregnancy at some point remote from the os. The liquor drains slowly away, possibly for many weeks, and the pregnancy ends in either a premature or a difficult labour. This condition is known as amniotic hydrorrhoea.

An interesting case of oligohydramnios is described by Dr. Leonard C. Blackstone in the *Lancet*. The patient, aged 30 years, was a 5-para, and had a uterus unicornis. She had already had several abnormal labours. The first, a face; the second, a ruptured cornual gestation, when the right cornu and appendages were removed; the third, difficult third stage; the fourth, breech presentation with prolonged third stage and adherent membranes. With the fifth pregnancy she had oligohydramnios. The labour was a quick one, not more than two and a half hours altogether. The patient lost no water either before or after the birth of the child. The child's left leg was swollen and cedematous, and a tough fibrous band was twisted round it three quarters of an inch above the ankle. The skin under the band was found to be divided round the whole circumference of the leg. The child was able to flex and extend the foot and toes, proving the tendons, etc., to be undivided. There were no congenital deformities; the skin was normal, and no renal or cardiac affections could be detected. The child died of marasmus three weeks after birth. The third stage lasted half-an-hour. The placenta

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