

is taken off, and the lady placed on *her back*, and as near to the edge of the bed as she can be with comfort, and the bed-clothes drawn over her. In order to facilitate the escape of any fluid that may remain *in utero*, we raise her shoulders slightly on the pillows, as we cannot exert the slightest pressure over the uterus, which is tender and painful to the last degree (or we should not have been injecting it), as we have possibly a case of uterine phlebitis to deal with, and a temperature of 103 degs. marks the prostration of strength induced by it. The patient will require fluid nourishment, according to Medical direction, as soon as she is put into bed, given through a feeder or feeding-tube.

It has very frequently been urged against intra-uterine injections that they are hazardous on account of the risk there is that some of the fluid may find its way through the Fallopian tubes into the peritoneum, and so excite inflammation. Of course there is a possibility of this disaster; but as we only resort to intra-uterine injections, whether antiseptic or hæmodynamic, in grave conjunctures, I think we may very fairly balance the *good* we know they do against the evil that *may* possibly or remotely accrue from their use. At all events, I have done my best to bring this important portion of Midwifery Nursing plainly before my Nursing readers, and to explain to them as briefly as possible *why* we do it and *how*.

When the patient is placed in bed, the basin and protecting carpet or drugget must be removed, and the waterproof sheeting (washed all over with the antiseptic solution) put out into the air if possible. The enema must also be attended to; it should be rinsed in a solution the same strength as the first one prepared, running it through the syringe and vaginal tube, and then washed in plain water (running that through also), drained and wiped dry. In order to protect it from the air, and not to bend the tubing, I keep my enema in a waterproof bag—a large sponge-bag, in fact—which I prefer to a box, and I consider the plan advisable for the syringe you have for every-day use.

At this period and under the conditions we have just touched upon, in addition to those ventilating measures I have so earnestly brought before your notice for *changing* the air of the room, you can resort to "spraying." The best antiseptic perhaps is pinol for this purpose; and here I must reiterate that there is *no substitute* for *fresh air*, and antiseptics, no matter what, only supplement it. There was a time when this point was strangely overlooked, and antiseptics were supposed to do away with the necessity for *ventilating* a room! Was it this fact that gave

rise to the well-known story of the Medical Student who, when asked "What is the use of antiseptics?" replied, "They make such an unbearable smell you are *obliged* to open the window to let it out."

(To be continued.)

## PRACTICAL LESSONS IN ELECTROTHERAPEUTICS.

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(Continued from page 293.)

### (b) THE INTERRUPTED PRIMARY.

THE physiological action of the interrupted primary current will not demand any lengthened discussion. It is sufficient to state that it holds a place—as regards function—between the continuous and the alternating (or secondary) currents. With currents of great strength, it may be that electrolysis is possible\* both with the interrupted primary and the secondary current, but with the Cs ordinarily employed in medical work, we may safely leave this power out of consideration. The catalytic action of the continuous current is to some extent probably present, for we soon observe congestion in the part to which application is made. This is due, partly, no doubt, to local paralysis of the vaso-motor nerves, but chiefly to stimulation of the blood stream in the interpolar regions.

Generally, we may look upon the interrupted primary as a local stimulant, though when the breaks are rapid, it is often of service in relieving pain.

### (c) THE SECONDARY, OR ALTERNATING, OR COIL CURRENT.

Usually the coil-current is looked upon as having its chief use in the regulation of function, whether of muscle or of nerve.

On bringing electrodes connected with the poles of a coil into contact with the skin, the first fact noticeable is that muscles in the neighbourhood contract; the next fact, and this should be clearly impressed on the memory, is that the muscles continue to contract.

This is noticeable also when the interrupted primary current is used, and serves to emphasise the observation which we have already made, in making or breaking contact with the continuous current, that variation—moderate or extreme

\* See paper by Professors Ayrton and Perry, on alternate-current electrolysis, page 200, Vol. XXI., *The Electrician*.

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