The Midwife.

ASPHYXIA NEONATORUM.

Asphyxia neonatorum (asphyxia, or suffocation, of the newly-born) is caused by—

(*a*) Interference with the *foetal circulation*; due firstly to premature separation of the placenta with consequent cessation of the blood supply; and, secondly, to pressure on the head or cord. Also (*b*) by interference with *respiration* due to premature efforts at breathing, especially in a breech presentation, or to obstructed respiration.

Asphyxia neonatorum is of two kinds, Asphyxia Cyanotica (blue) and Asphyxia pallida (white). The difference between the two forms can be tabulated thus :—

ASPHYXIA CYANOTICA.

Infant cyanosed, firm.

Tries to breathe.

Umbilical cord pulsating strongly and regularly.

Facial contortions.

TREATMENT.

Turn infant on its abdomen, clear air passages with a piece of clean gauze or catheter. Encourage respiration by smacking the buttocks, rubbing the spine briskly with cold water. If this fails, sparate the infant. Place it in a warm bath (99° F.). Sprinkle with cold water, and again immerse in warm bath. Try artificial respiration for at least twenty minutes; if this fails, some authorities advocate placing a clean handkerchief over the baby's mouth and blowing down its throat.

If the baby does not at once show signs of responding to treatment, a doctor must be sent for.

ASPHYXIA PALLIDA.

Infant very pale, limp.

Makes no attempt to breathe.

Cord pulsating weakly, slowly, and irregularly.

Face still and motionless.

TREATMENT.

Handle as gently as possible; avoid all slapping, friction, or immersion in water, and at once start artificial respiration. A few drops of brandy may be poured down the infants' throat; it must be kept as warm as possible. Of course all mucous must be cleared from the air passages.

The midwife must send for a doctor at once in case of white asphyxia.

GLADYS TATHAM.

REPAIRING THE PERINEUM.

The question of the repair of the perineum when torn during labour is one which does not come within the province of the midwife to decide, but it is her duty to make a very careful examination to ascertain whether such a tear has occurred, and, if so, to notify a medical practitioner.

Dr. Frederick Blume, in an American contemporary, suggests a reason amongst others why the torn perineum is sometimes left unsutured, and it is one which midwives also should note, and should not allow themselves to be influenced by it. It is, as reported in the *British Medical Journal*, "that patients regard the torn perineum as a sign of incompetence on the part of the doctor. They are shocked, and they show that they are shocked, when their physician tells them that he has had to put a stitch or two into the skin. He feels sure they will criticise him severely in discussing his management of the case with other women, and especially with other women who have been attended by doctors who did not confess to perineal tears by announcing the insertion of sutures. More than this, when he meets with a really deep laceration—one which certainly ought to have six or seven sutures in it—he contents himself with putting in one or two stitches, and so risks failure of union altogether rather than confess to what his patient may, and almost certainly will, regard as the result of mismanagement. There are patients, it seems, who 'estimate the efficiency of the obstetrician according to the number of sutures which he uses in the repair of the perineum'; the fewer he puts in the higher he is in their regard!"

Our contemporary points out that "there are other things, of course, which must be attended to: the best method of managing the passage of the head over the perineum must be taken, the lateral posture in labour should be adopted, and the like; but the chief matter at present is to counteract the prevalent belief that laceration is always avoidable, and so make it possible for the conscientious man, without loss of prestige, to do what is needful and right."

Another reason why the torn perineum is sometimes left unsutured, and which Dr. Blume does not mention is, our contemporary states, "simply because the medical attendant does not look to see whether it is torn! He does not put a thumb on each side of the perineum and hold the parts aside; he forgets that after soft parts have been widely distended they fall together again naturally; he sees no gaping wound, and concludes that there is no wound at all." This is a point in routine practice about which midwives cannot be too careful.

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