OUR PRIZE COMPETITION.

(a) WHAT IS MEANT BY PROLAPSE OF THE CORD? (b) WHAT ARE THE CHANGES OF SUCH A POSITION? (c) HOW WOULD YOU TREAT SUCH A CASE UNTIL THE DOCTOR ARRIVES?

We have pleasure in awarding the prize this week to Miss E. Douglas, Maternity Hospital, Union Infirmary, Belfast, Ireland.

PRIZE PAPER.

(*a*) Prolapse of the cord is said to have occurred when the cord comes down in front of the presenting part, the membranes being ruptured.

(*b*) Presentation of the cord occurs when, before the rupture of the membranes, it can be felt in front of or in conjunction with any other presenting part. Under these circumstances, as soon as the membranes rupture a loop of cord descends through the os uteri, and can be felt on either side of the presenting part; the cord is then said to be prolapsed.

Prolapse of the cord may occur for the first time at the moment when the membranes rupture, a loop coming down with the liquor amnii, particularly if there is an excess of liquor amnii or a premature child.

There is also a third mechanism by which prolapsed funis (cord) may be brought about, one which might more properly be called expulsion of the cord. In this case the cord does not drop down passively, but is forced or expelled by intra-uterine pressure through some space between the child and the lower uterine segment, as in the case of a transverse or other malpresentation, where the presenting part does not closely adapt itself to the lower uterine segment, or, in a normal vertex presentation, there may be deformity of the brim of the pelvis, especially flattened pelvis.

As soon as a midwife diagnoses presentation or prolapse of the cord she should send for medical assistance. If the child is alive, immediate action will have to be taken to prevent pressure on the cord and asphyxiation of the infant.

(*c*) *Before Rupture of the Membranes.*—In the first stage of labour the great object is to defer rupture of the membranes until the os is fully dilated.

The only method of restoration at this time is by postural treatment. Place the woman in such a position that the fundus of the uterus is directed vertically downwards. This can be attained either by Trendelenberg's or the knee-chest position.

Trendelenberg's position can be obtained by placing an ordinary square kitchen chair on its face on the bed, cover it with a pillow; the patient lies with her head and shoulders on the bed, her body on the pillow covering the back of the chair, and her legs flexed at the knee over the highest part of the chair. This is just as efficient and a more comfortable position than the genu-pectoral one, *i.e.*, kneeling on her knees on the couch, and stooped forward until her shoulders and face touch the couch, which is an uncomfortable position and one difficult to maintain for long.

When the cord has receded well above the presenting part, the woman may be placed in the semi-prone position, lying on the side at which the cord is felt. The fundus of the uterus will tend to fall over towards the side the woman is lying on, and the cord also will gravitate to the lowest point.

Tell the woman not to strain or bear down; by so doing she might rupture the membranes prematurely and cause prolapse.

If the membranes have ruptured and no pulsation in the cord can be felt, the child is dead, and no treatment will avail.

If, however, there is pulsation and the os fairly dilated, there are three lines of treatment which the doctor may carry out:—

1. Reposition of the cord.
2. Substitution of a position which permits descent of the fœtus without pressure on the cord.
3. Immediate delivery of the fœtus.

The midwife or nurse must consequently have everything ready for the carrying out of any obstetric operation.

HONOURABLE MENTION.

The following competitors receive honourable mention:—Mrs. Farthing, Miss Dora Vine, Miss P. Thomson, Miss M. Robinson.

QUESTION FOR NEXT WEEK.

Describe the phases of an epileptic seizure. State what you would do for a patient during one, and afterwards.

Extension after amputation of the thigh, with the object of coping with the retraction of flaps, can be obtained by the use of a Thomas' knee splint cut short, and an aluminium end-piece bent at a right angle and attached to sides of splint.

Four strips of rolled gauze are cut, attached to stump at each side above and below with Sinclair glue. When thoroughly dry, the extension is obtained as required by pulling on free ends of gauze, and tying to end-piece of splint.

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