OUR PRIZE COMPETITION.

WHAT IS MEANT BY "DESCENT OF CORD," AND WHAT COMPLICATIONS AND DIFFICULTIES DOES THIS CREATE?

We have pleasure in awarding the prize this week to Miss E. O. Walford, 235, Maldon Road, Colchester.

PRIZE PAPER.

Descent of cord is the term used when the cord comes down with, or in front of, the presenting part. Cases of descent of cord are divided into three classes—presentation of cord, prolapse of cord, and expression of cord —according to the stage in which it occurs.

(*a*) *Presentation of cord* is the name given when the cord is felt in front of the presenting part *before* the rupture of the membranes.

(*b*) *Prolapse of cord* is when the cord is in front of the presenting part *after* the rupture of the membranes, the cord being carried down by the liquor amnii.

(*c*) *Expression of cord* occurs in the second stage, and is when the cord, having prolapsed, becomes squeezed between the presenting part and the brim of the pelvis. Descent of cord may be caused by any condition which prevents the presenting part from fitting in the brim of the pelvis. Foremost among these conditions are :—

(*a*) Malpresentations—face, brow, breech or transverse.
(*b*) Contracted pelvis.
(*c*) Small fœtus, as in premature labour.
(*d*) An abnormally large child.
(*e*) Hydramnios.
(*f*) Twins.

It may also be due to :—

(*a*) Low attachment of the placenta, in placenta prævia.
(*b*) Insertion of the cord into the margin of the placenta, *i.e.*, battledore placenta.
(*c*) An abnormally long cord.
(*d*) Velamentous insertion of cord.
(*e*) Lax condition of the uterus.

Descent of cord is not dangerous to the mother, but is to the child, especially if the membranes have ruptured. The condition is more common in multiparæ, on account of the greater laxity of the abdominal muscles, but it is more dangerous when it occurs in primiparæ.

In either class of descent the doctor should be sent for at once, a note being written to say whether the membranes have ruptured or not, and, in the former case, whether the cord is expressed, also whether the cord is pulsating. While waiting his arrival *try to keep the membranes from rupturing,* if they have not already done so. Do not make vaginal examinations, and tell the patient not to strain or bear down. Place the patient in the knee-chest position—that is, kneeling on the bed, with the chest and face resting on the bed. This makes the fundus of the uterus become lower than the os, and enables the cord to slip back into it. If the cord does slip back, and the presentation is either a head or breech, pressure should be made on the fundus to make the presenting part fit down into the brim, and it should be kept there by a firm binder. Then when the membranes rupture, encourage the patient to bear down.

If the membranes have ruptured, and the doctor cannot arrive soon, try to replace the cord above the presenting part. Sometimes it can be pushed up with the hand in the interval of a pain; but if not, a gum-elastic catheter, and a piece of tape should be boiled, a hole made in the catheter near the eye, and the tape passed through both holes. The tape should then be made into a loose noose, and placed round the cord, and the catheter pushed as high as possible into the uterus and either held or fixed there by a bandage attached to either side of the binder. The patient should be made to lie on the opposite side to which the cord came down in a breech, on the same side in a vertex. If the cord cannot be replaced, it should be placed where it will get least pressure, that is, in either sacro-iliac synchondrosis.

If the cord is expressed, try to replace it by means of a catheter, failing this, to protect it as far as possible from pressure as above.

Preparation should be made for delivery by forceps, and everything necessary to revive a child born in white asphyxia.

HONOURABLE MENTION.

The following competitors receive honourable mention :—Miss Gladys Burke, Miss E. Batty, Miss E. K. Dickson, Miss E. Douglas, Miss R. E. S. Cox, Miss Henrietta Inglis, Mrs. Farthing.

Miss Gladys Burke writes :—If simpler methods do not prevail the doctor may have to perform version, either external or internal. There should be ready, besides the usual antiseptic precautions, a douche (Lysol ℥ ss to water, one pint, temperature 105° Fahr.), also binder and towel, to be used as a pad to keep the child in position.

If the cervix is sufficiently dilated to ensure rapid delivery the doctor may decide to apply forceps.

QUESTION FOR NEXT WEEK.

How would you prepare and apply an extension for a case of compound fracture of the femur? What precautions would you take?

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