

draughts of cold air, leading to chills; to traumatic or spontaneous injuries; to improper food; to neglect or mismanagement at the time of labour. It is important that an Obstetric Nurse should understand and hence be able to observe intelligently the symptoms that mark the difference between inflammation of the uterus and "after pains." These last set in almost immediately after delivery; they are intermittent, recurring at uncertain intervals, and lasting for uncertain periods. If you place your hand on the uterus during one of these post-partum contractions, you will feel it hardening whilst they last, and softening when the muscle relaxes, and the "pains" are followed by discharges from the uterus of blood or coagula. They are often accompanied by profuse perspiration, but no other general symptoms, no rise in temperature or pulse, no coated tongue. The "after pains" diminish when lactation begins, and disappear when it is established. I have referred to these points in a previous paper, and just now reiterate them to impress them upon your mind.

There is another and rarer form of post-partum uterine pain that gives rise to great suffering after delivery, and differs from "after pains" or inflammation, and requires different treatment, hence I will briefly call your attention to it as neuralgic pains of the uterus; they often exist during pregnancy, and are then called rheumatism of the uterus, and delicate, nervous patients are most prone to them. These neuralgic pains may be distinguished from inflammation by the natural feel of the abdomen, which is soft and free from pain, by the size of the uterus, which is very little increased, and feels unusually firm under the hand, and is exceedingly painful when pressed upon. This form of uterine inflammation is chronic, becoming acute under the strain of parturition; its seat is referred to the fibrous tissue of the uterus. The remedies are chiefly medicinal, opium and morphia being used. *Dry* warmth, such as wadding made hot and placed over the uterus, is comforting; but a binder cannot be borne in the least light, but it may be used to keep the wadding in its place. Sometimes a flannel binder, instead of wadding, is good. Sustaining food, care, and quietude are essential. In some instances lactation has to be abandoned, as suckling adds to the uterine pain. This distressing condition is not dangerous, and may be regarded rather as a coincidence than a consequence of child-birth.

We will not enter into any detailed account of post-partum inflammation of the uterus, but just bring before your notice those premonitory symptoms that as an Obstetric Nurse you will have to observe and report to your Medical chief.

And here let me remind you that the uterus being at this time an abdominal organ, there is a grave risk of the inflammation extending to the peritoneum; hence we get puerperal peritonitis, which is a very serious form of child-bed fever.

Attacks of puerperal inflammation come on most unexpectedly and with extraordinary severity. Hence the supreme necessity for vigilant observation and prompt action on the part of the Nurse in the *first instance*. Like all other inflammations, they are preceded by a rigor, and in Obstetric Nursing we may feel almost sure that either the breasts or the womb will be the seat of the invasion. I have told you in a recent paper that "shivering" often precedes a determination of blood to the breasts, which is physiological, followed and relieved by the lacteal secretion. Determination of blood to the uterus (congestion) is a pathological condition, tending to disease. The "rigor" that precedes inflammation of the uterus generally comes on at night or early morning, when the vital powers are at a low ebb, and after the third and before the seventh day from delivery, and the more severe the rigor and the more intense the nervous depression, often amounting to a sense of *fear*, that accompanies it, the more severe will be the feverish re-action and *pain* that follows it. The pallid cheeks, the livid lip, the chattering teeth, the convulsive movements of the extremities, particularly the arms and hands, the deathly cold, are some of the outward signs of the severity of the nervous shock the system sustains by the attack.

I have pointed out to you in an early paper that a Nurse should always have a fire in her bedroom at night, and before retiring to rest see that there is a plentiful supply of fuel and water brought up to the room. You will now see the advantage of this plan. We will assume that the rigor comes on unexpectedly at three a.m.; your first care will be to excite the action of the skin, and set up surface warmth. Fill up the kettle and put it on the fire to boil; you will want hot water for several purposes *as soon as possible*. Make some flannels *hot* and place them over the abdomen and next the skin. Get a woollen shawl or small blanket; make it hot and wrap the patient up in it from head to foot. Make a cup of drink, preferably *milk* made *hot* with boiling water, and a tablespoonful of brandy added; but I do not recommend stimulants to be given recklessly in these cases—better none at all than too much, as they are apt to increase the feverish reaction that will follow the attack. I have found the different stimulants useful here; a drachm of Sp. Ammon. Co., four ounces of camphor *water*, half for a dose made up to four ounces with *warm* water. The alkali should *never* be given in cold

[previous page](#)

[next page](#)