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OBSTETRIC LIMITATIONS IN GENERAL PRACTICE

BY

DEREK LLEWELLYN-JONES, M.D., M.A.O., M.R.C.O.G.
Obstetrician and Gynaecologist, General Hospital, Kuala Lumpur

It really gives me great pleasure tonight to talk to you, the General Practitioners' Association, on Obstetric Limitations in General Practice, and yet I feel that by so doing I am putting myself into the position that at a subsequent meeting, a speaker, who is a General Practitioner, may well wish to describe the obstetric limitations of hospitals. I would be the first to admit that there are obstetric limitations in hospitals, and that these could well be discussed. But it is important to remember that, although we work in apparently separate compartments we are nevertheless two branches of a unified profession, and our aim in obstetrics is to secure the birth of a healthy live baby and, if possible, to improve the health of the mother during the months of pregnancy when she is under our care. This is our common aim but the conditions under which we work to achieve this end are different.

I remember, as a newly qualified doctor, hearing a Professor of Obstetrics and Gynaecology asking a group of doctors their opinion of a case. The general consensus of opinion was that the patient's unfortunate condition was probably the result of the lack of treatment she had received from a general practitioner. One student was very outspoken about this and was briskly reprimanded by the Professor who said: "Young man, when you have attended the birth of a breech in a small cottage with only the aid of a Hurricane lamp to help you, and with five children yelling through the thin wall, you will not be so ready to criticize the general practitioner." If I make any criticisms tonight I hope you will remember that I am very conscious of the remarks made by that Professor of Obstetrics and Gynaecology to that doctor.

How then do conditions vary, and what are the limitations of obstetric practice outside hospital? Naturally, the conditions will vary from country to country and where the number of doctors is high in relation to the number of patients, and so where the general practitioners are able to devote much more time to each patient the limitations will be less. Medicine is a fascinating and mentally rewarding profession but since we have to live, to clothe and to feed our families we have to think of the financially rewarding aspects too. Obstetric care undertaken in general practice is not only time consuming, but relatively poorly paid. It is far more lucrative to treat a fever or an acute medical disorder than it is to undertake the care of a woman through the ten months of pregnancy and then attend to her, often at much personal inconvenience, during the ten hours, or more, of labour.

A further limitation in Malaya is that many of our towns have too many people crowding into too few houses. In these houses sanitary facilities are often elementary and proper conditions for domiciliary confinement are almost unattainable. In the rural areas it is, of course,

different, and it is here that perhaps the general practitioner can give the most valuable service. But unfortunately all too few of you work in the rural areas.

There is, in Malaya, as in most other countries, a tendency for the patient to seek hospital confinement. This applies particularly to town people, and I am in agreement with it for I am convinced that hospital confinement is safer for the mother and in many ways better. I will agree that home confinement in certain selected cases is valuable, as the mother is then able to deliver her baby in an atmosphere she knows and away from the more rigid institutional atmosphere of a hospital. But when you consider the dangers of prolonged labour, of a difficult delivery and of postpartum haemorrhage and the suddenness with which death can occur, hospital confinement has much to commend it. Perhaps the solution would be to allow general practitioners into hospital so that they may continue the care of their patient in hospital. This has been suggested in Britain but I do not think that it would be practicable today in Malaya. In this connection I must state that I distrust, and disapprove, of small maternity homes and private clinics where few patients are delivered, and where facilities are not always adequate. I do not like them because they have neither the advantages of the hospital in efficiency, care, and safety, nor the advantages of the home for delivery in familiar surroundings. They are often dirty, sometimes dangerous and occasionally death traps.

Having got that off my chest perhaps we may talk of specific instances in which obstetric care is limited in general practice. The first of these is perhaps controversial, and that is the care of the patient who threatens to abort. Most of you, I am sure, feel that when a patient threatens to abort she should be treated with bed rest, and injections of progesterone. It is this latter method of treatment that I would like to criticize. Some years ago a survey was carried out in America to determine the cause of a large number of abortions. The surprising finding of this survey was that the majority of abortions were of damaged ova and that no drug or other treatment would have helped.

In only 3.5 percent of cases was it concluded that there might have been some advantage in giving female sex hormones in an effort to improve the chances of survival of the foetus in the uterus. This may be put in another way. Swyer and Daly in England treated two groups of patients who had had two or more abortions previously. One group of 60 patients received bed rest and progesterone; and the second group of 53 patients were treated with bed rest and reassurance, and no other drug. There was no statistical difference in the number of live babies delivered by the two groups.

The evidence of the value of injections of progesterone seems to me to be very flimsy, and indeed recent work indicates that if progesterone is to be given the daily dose should be at least 100 mg. a day, or, should one of the norethisterones be used, the equivalent dose. Disturbing reports have appeared following the use of these latter drugs and some

children have undergone partial sex reversal in utero. Moreover, these drugs are very expensive, and until there is a national health service in Malaya, (which is never free as some would believe, but would cost the citizens of the country a considerable sum) the purchase of these drugs in the doses required must put the cost well beyond the finances of most of your patients. I would, therefore, suggest to you that if you wish to treat the case of threatened abortion you should put the patient to bed, tell her to stay in bed and to avoid intercourse. Since the patient will require something more than just your reassurance, I would suggest that you use a sedative rather than a hormone. Your results will be just as good; for you must remember that 20 percent of all pregnancies end as an abortion whether you give treatment or not.

Should the patient pass the danger of abortion and should the pregnancy continue, further hazards await her in the second and third trimester. These hazards can be circumvented by diligent attention to antenatal care, and this diligent attention can be given by the enthusiastic general practitioner, probably better than it can be given by a busy hospital. I must admit our faults in respect to antenatal care. The hospital clinics are far too busy and the process of antenatal care is far too much a mechanized procedure, one which resembles an industrial assembly belt rather than a sympathetic consideration of the patient's needs. In general practice, if you have an interest in obstetrics and wish to conduct obstetric care, the encouragement which these patients so much require can be given and the problems which affect them in pregnancy can be dealt with sympathetically and individually. This sympathetic approach is the basis of all Grantly Dick Read's suggestions. Of course he was an enthusiast and he carried his suggestions too far. But the basis of his theory is a good one — a relaxed patient in labour leads to a relaxed cervix and a shortened period of painful contractions.

In the months preceding labour the rapport developed between the doctor and the patient does much to ensure this relaxation, but it does mean that the doctor must have time to discuss her problems with his patient. She should be seen at frequent intervals, for not only is it the doctor's duty to increase his patient's confidence in her ability to deliver her baby, but also he must detect the dangers I noted earlier and treat them. The three main dangers are those of the presence of anaemia, the onset of pre-eclamptic toxaemia, and antepartum bleeding, which may be due to one of several causes.

The presence of anaemia in a pregnant woman can be a matter of serious consequence, particularly in Malaya where anaemia is widespread. The average haemoglobin level of patients attending the hospital clinics in Kuala Lumpur has been found to be 60 percent. Severe anaemia in pregnancy may lead to premature labour, to an aggravation of the severity of postpartum haemorrhage and is a contributory factor in many cases of maternal death. Pregnant women who attend for antenatal care must be tested for the presence of anaemia. It will be found that almost all patients are suffering from nutritional iron deficiency anaemia and a proportion (which is probably no more than 1 percent) will also

be suffering from megaloblastic anaemia. The treatment of anaemia is simple: it is to give iron by mouth in the first instance, and if necessary later to give iron by intramuscular injection. If it is considered that the anaemia is megaloblastic, folic acid should be given for 10 days in a dose of 10 mg. twice daily. The oral iron should continue throughout pregnancy and it doesn't matter which particular kind of iron salt is given provided that the equivalent of 25 mg. of utilisable iron is given daily. The amount of utilisable iron in the common commercial preparations varies between 15 and 20 percent, so that to obtain 25 mg. of utilisable iron a varying amount of iron salt is required. Of the commonly used iron preparations the following dose is needed:

Ferrous fumarate - -	365 mg.
Ferrous sulphate - -	600 mg.
Ferrous gluconate - -	1,000 mg.
Ferric ammonium citrate -	7,000 mg.

The use of liver injections in the treatment of anaemia is not only costly, but of no benefit whatsoever.

Much has been written about the care of the patient in order to avoid pre-eclamptic toxaemia. But the main thing to note is that albuminuria is a late sign and it is always preceded by a rise in blood pressure and usually by oedema. Thus it is that the sphygmomanometer is a more valuable instrument than is the test tube or the pelvimeter. If you have any pelvimeters in your surgeries I feel you can well dispense with them or give them to your children for drawing circles in the dust. They have little of other value.

The sudden gain of weight in a pregnant woman is a dangerous sign and should be watched carefully. Nowadays when chlorothiazide drugs are available, patients who were previously sent to hospital can be treated at home by you, but they must be seen weekly in case a sudden increase in blood pressure occurs, and if there is any deterioration they should be sent to hospital. And the patient whose blood pressure exceeds 140/90 should always be referred to hospital. Until we know the cause of pre-eclampsia we can only treat the symptoms, and there is no doubt that symptomatic treatment is more successful in a hospital than it is in the home.

The problem of antepartum haemorrhage is much more serious. Even today, all too often, we receive patients in this hospital who have been examined vaginally by general practitioners because of bleeding in the last three months of pregnancy. I would like to ask you to consider the dangers of the vaginal examination of a patient bleeding in the last three months of pregnancy. By examining such a patient in your surgery you may start a sudden severe haemorrhage which may prove fatal. Vaginal examination of the pregnant patient who is bleeding in the last trimester should never be done except in a hospital which is equipped with full facilities for all obstetrical operations. If this talk has no effect other than to prevent such examinations it will have served its purpose.

It is only in recent years that adequate attention has been paid to the ten months of pregnancy rather than to the ten hours of labour, and the spread of antenatal care has been slow. Most women in the countries of the world are conservative in outlook and unwilling to change their views. So it is that many of those who most require antenatal care do not seek its benefits. You all know the type of woman. She is large in figure, and loud in voice, the former because of her frequent pregnancies, the latter because of the need to control her many children. She has no time for antenatal clinics or for doctor's attentions, as pregnancy, like the income tax demand, is an annually recurrent affair, and her last ten pregnancies were all easy. The dangers of this are all too evident from the deaths we have had in Kuala Lumpur in the last five years. Between 1953 and 1958, 27,500 patients were delivered in the maternity wards of the General Hospital, and of these 132 died. But of the 22,000 patients who had received antenatal care only 39 died, whereas of the 5,348 patients who did not attend antenatal clinics 93 died, ten times as many. In 50 of the deaths the major factor leading to the death was lack of co-operation by the patient in that she did not attend the clinic, or if she did, did not follow the advice given. But a change is occurring and more and more emphasis is being placed on the value of antenatal care.

Should the dangers of the antenatal period be passed the dangers of labour may even be greater and perhaps the limitations of obstetrics in general practice are best shown by difficulties in labour. Good antenatal care will diminish but not eliminate these difficulties and the question is at what stage should you seek specialist help. To discuss this fully would take far more time than I have at my disposal tonight, but I would suggest the following rules which you might wish to consider:

(1) No labour should last more than 24 hours without a further opinion being obtained. In general it is wise to transfer a patient whose labour has lasted 24 hours or more to hospital.

(2) The old rule you were taught as students that the foetal head should have engaged in the pelvis of a primigravida by the 37th week of pregnancy still stands. Should you encounter a primigravida at the 37th week whose baby's head has not yet engaged in the maternal pelvis, please refer her to hospital. The reason for the non-engagement may be a simple one, such as a posterior position of the vertex, but it may be something much more sinister, such as contraction of the pelvis. Pelvic assessment cannot be made satisfactorily in the surgery. I know for I have tried it myself!

(3) As women have more children their babies tend to get larger and the fact that a woman has delivered a baby weighing 7½ lbs. previously does not mean that she can deliver a baby of 9 lbs. She is a possible candidate for disproportion. Such a patient must be watched very carefully if labour is to be conducted outside hospital.

(4) Most drugs as well as being beneficial may be dangerous. An example is oxytocin. Pitocin (oxytocin) should not be used in obstetrics except in a physiological intravenous drip. The use of

injections of Pitocin intramuscularly to stimulate or to induce labour is dangerous. Only two years ago we received from an estate hospital a patient who had been in labour for three days. The labour had been slow and the contractions poor. The hospital assistant, taking on the responsibilities of the doctor, decided to stimulate the labour and promptly gave 10 units of pitocin intramuscularly. One hour later the patient was brought to hospital moribund. The sudden injection had been followed by tumultuous contractions which had succeeded in rupturing the uterus. There was little we could do when she reached us except to see her comfortably to Heaven.

(5) The safe delivery of a breech baby is a matter of personal skill and of practice. The safest way to reduce the mortality of breech deliveries is to have experienced doctors working with a team of experienced nurses. Since it must be difficult for those conditions to be found in general practice I would recommend that all patients whose baby presents by the breech should be delivered in hospital.

(6) The only kind of forceps delivery which should be attempted outside hospital is a low forceps delivery. In such a case the foetal head is presenting at the vulva and the occiput has rotated to the anterior-posterior diameter of the outlet. Mid-forceps should be avoided as it may be very difficult and certainly requires as much skill as a Caesarean Section. Moreover, mid-forceps requires the use of general anaesthesia, and general anaesthesia in the home or in the small nursing home can be dangerous. During labour the stomach emptying time is delayed and many patients feel it necessary to fill their stomachs with rice to find the energy for the strain of parturition. When a general anaesthetic is given this rice may be vomited and some of the vomit may be inhaled into the lungs. Such inhaled vomit may well cause death. A general anaesthetic is not needed for low forceps delivery which can easily be effected under a pudendal nerve block. This method of anaesthesia should be taught to all students and practitioners. It is the only anaesthesia which should be used in domiciliary practice, unless an emergency occurs when a general anaesthetic is needed, or if the practice is too far away from a hospital for specialist aid to be obtained.

Finally, there is the problem of postpartum haemorrhage. All too often I am sure you are called out to see patients who have been delivered by a midwife, or more frequently by a friend or relation, and who have postpartum haemorrhage. The placenta may or may not be in the uterus. Until it is possible for us to have an obstetric flying squad I would recommend that these patients are given an intramuscular, or intravenous, injection of Ergometrine and are transferred to hospital. Postpartum haemorrhage kills more patients in Malaya than any other single cause. Most of the deaths are due to mis-management of the 3rd stage of labour. Where the patient is being delivered by a doctor there is a great deal to commend the practice of using ergometrine intramuscularly, or intravenously, with the birth of the baby's head. Following the birth of the baby (which must be undertaken slowly) and having

made sure that the child is breathing properly, a hand on the fundus will show that the uterus has contracted strongly and that in most cases the placenta has separated and is lying in the lower segment. By the combined use of fundal pressure and of gentle cord traction the placenta can be brought into the vaginal. At this point the hand which is placed on the fundus should be placed suprapubically and upward pressure exerted upon the uterus, whilst cord traction is maintained. The uterus will move upwards and the placenta will move outwards appearing at the vulva. This method will prevent much postpartum haemorrhage. Used by general practitioners it should be a very great safeguard against the dangers of postpartum haemorrhage and the new method is a valuable indication that obstetric limitations in general practice are not static, but change as advances occur in obstetrics.

Can one sum up? I think so. The hospital obstetrician starts his care of the pregnant woman with many advantages. Behind and beside him he has all the ancillary facilities available. He can call easily upon the advice and experience of others; he can discuss his problem readily. He works in a team. In general practice you are alone, you have none of these advantages, and in consequence your anxiety must be increased if everything is not quite normal.

The parturient woman can give rise to great anxiety. And to those of you who care for them in general practice, I offer my admiration — but I wouldn't change places with you, for I don't think I could cope!