

## INFLUENZAL PNEUMONIA IN PREGNANCY

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The frightful mortality among pregnant women with pneumonia accompanying influenza is well illustrated by the report of these five recent cases:

Case 1.—Mrs. G., age 24, white, was expected to be confined on October 9. She had one child living and well, four years old. Her condition during pregnancy was normal. There was no albumin in the urine. She became ill on September 26, complaining of pains all over the body. I visited her on that day and thought she had a slight cold. I told her I believed she was going into labor, as the cervix was obliterated and would admit one finger. A purgative and formin tablets, seven and one-half grains each, were ordered and she was instructed to stay in bed. Her temperature was 100°. She got up and went to the supper table on September 29. That night she had a chill and next day, September 30, there was a slight dullness to be made out over the left back and there was bronchial breathing. Temperature 104°. She looked ill. She was sent to the hospital. Leucocytes 9,000. That evening at 6:30 she was complaining of a few abdominal pains. She was delivered at 8 P. M., after she had had a few severe labor pains. No anesthetic was used. Her temperature at that time was slightly above 104°. The baby was well and strong and is still living. The patient gradually grew worse and died with double pneumonia complicating influenza on October 5. Oxygen was administered therapeutically at intervals for some hours before death.

Case 2.—Mrs. G., age 21, a primipara, was thought to be due for delivery on December 15. She had influenza on September 25, developed double pneumonia on September 29, went to the hospital on the 30th with a temperature of about 104°, with leucocytes 9,000, lips blue, and was bringing up blood-stained, frothy sputum. She was given oxygen to inhale, which somewhat relieved the cyanosis, which was very marked, but did not clear up the condition. She went into labor and was delivered of a dead baby on the night of October 2. She inhaled oxygen for cyanosis during labor, which was short. No anesthetic at all was given. She died October 3, some twelve hours after having been delivered.

Case 3.—Mrs. B., age 27, white, was taken sick September 27 with influenza. She developed pneumonia and went to the hospital October 8. The leucocytes on admission were 7,500. She expected to be confined about November 15, but did not go into labor and died of double pneumonia on October 11, after having inhaled oxygen therapeutically most of the time for the previous forty-eight hours. I saw this patient in consultation.

Case 4.—Mrs. C., age 21, white, had engaged me to confine her about January 23. She had never borne any children. Her condition had been normal during this pregnancy. Her husband developed influenza followed by pneumonia and she had nursed him till he went to the hospital, at which time she was feeling badly and had been instructed to stay in bed. I saw her on October 11, when she was found to have pneumonia. She died on October 14 without going into labor.

Case 5.—Mrs. B., aged 23, white, a primipara, was expected to reach term on November 19. She became ill on October 4 and I saw her in consultation with Dr. B. L. Wyman on October 12, when she was found to have lobar pneumonia in the lower lobe of both lungs. Temperature 101°; lips blue; she looked very sick; and on account of my recent sad experiences as well as on account of the low temperature, I felt that the prognosis was bad. I was told by the attending physician that the pneumonia had developed the day before (October 11). She had a crisis on October 17, went into labor and on October 19 was delivered of a live, healthy baby that is still living and weighed approximately 6½ pounds. Labor was easy and chloroform was used during the latter part of the second stage. The mother and baby are both doing well today, October 28.

### SUMMARY

Of the five cases of pneumonia following influenza that I have seen during the last few weeks in private practice, four of the mothers have died, while one is living and well and out of all apparent danger. Two of the children are living and well. Three of the mothers went into labor and were delivered before death. One child was born dead. Two of the mothers were not delivered. An anesthetic (chloroform) was used in one (the only case which recovered), as it was felt that the shock would prove more serious than a light anesthesia.

All of the pregnant women with pneumonia following influenza whom I have heard of in the last few weeks, except the one I have just reported (Case 5), have died.

The first two patients having influenzal pneumonia who went into labor, died. Only the patient who had a pneumonia crisis two days before delivery recovered.

In all of the above cases which were seen in consultation, the family doctors wished to settle the question of whether or not to induce labor on account of the extremely critical condition of the patient

from the pneumonia. In view of the experience with this small series of cases, the writer is strongly of the opinion that labor should not be induced during an attack of pneumonia, as the shock incident to it would be sufficient to turn the tide adversely for the patient.

### AUTHORS' ABSTRACTS

#### *Surgery*

*The Induction of Labor at Term.* Charles B. Reed, Chicago, Ill. *Surgery, Gynecology and Obstetrics*, Vol. 28, No. 2, August, 1918, p. 163.

In this second series of 100 cases, the Voorhees bag was used in primiparas 51 times and multiparas 49. The average duration of the labors was eight hours and eight minutes, which is slightly more than in the first series—possibly because of more primiparas. The longest labor was 28 hours (rigid cervix) and the shortest, one hour. The bag broke during or shortly after introduction three times, but it was reinserted only once. The membranes were ruptured during the introduction of the bag five times—once purposely in a case of hydramnios. There were no maternal deaths. Forceps were used sixteen times for various obstetrical indications. There were no premature babes. The average time for the expulsion of the bag was three hours and nine minutes. The longest detention of the bag; in the cervix was nine hours. The shortest, ten minutes. In all but two cases a weight was attached to the bag after introduction, just enough to keep up a mild irritation of the cervix. In no case was dilatation necessary previous to bag introduction and in only five cases an anesthetic. These were neurotic women. Involution was normal in all cases. There were no infections. The author claims that labor is shortened six or seven hours and much vitality conserved. The technique is easy to acquire. There are apparently no serious objections to the method when carefully worked out and both patient and doctor are accommodated by the knowledge that labor may and does occur on a certain day and date with all the care, cleanliness and scientific precautions of a surgical procedure.

*Some Observations on the Blood Supply of the Uterus, with Special Reference to the Operation of Vaginal Hysterectomy.* Howard Crutcher, Tularosa, New Mexico. *New York Medical Record*, Vol. 94, No. 3, July 20, 1918, p. 103.

The main purpose of the author of this paper is to press home the fact that the great evolutionary forces of Nature operate within as well

as without the limits of the human body. The uterine artery in the virgin subject and in the uterus after parturition pursue different courses so far as curvature is concerned. In no case does the uterine artery pass into the muscular wall of the womb, except possibly through violent pathologic changes. The facts set forth concerning the uselessness, not to say the folly and danger, of ligating the main trunk of this vessel in uncomplicated vaginal hysterectomy may startle all those who lack actual operative experience in this line of work, but the teaching is already perfectly familiar to those who have pursued the clear revelations of the tissues themselves. It will be noted that the fundus of the womb is brought forward through the anterior or superior fornix, which is a far easier procedure than attempting to draw it into view from below. The writer believes that much mischief and many deaths have resulted from the utterly useless attacks upon the main trunk of the artery, when artery, ureters, base of bladder, rectum, and all, may be easily and safely pressed out of the way of all harm in all uncomplicated cases of the operation.

*The Cause and Prevention of Post-Operative Gas Pains.* Walter C. Alvarez, San Francisco. *California State Journal of Medicine*, Vol. 16, No. 7, July, 1918, page 338.

Considerable amounts of gas formed normally in the intestine are rapidly excreted by the lungs if the mesenteric circulation is normal. Under certain conditions gases may even pass back into the bowel from the blood. Physicians have desired a clean bowel—they should strive for a normal circulation and a normal gas exchange. Purging upsets this mechanism and causes severe flatulence in many people. Experiments show that purgatives weaken and poison the intestinal muscle. They do it unevenly, leaving paralyzed regions in which gas accumulates and whence it can not be driven. Why do we starve and purge our patients? Not to empty the bowel, because we do not restrict the practice to gastrointestinal operations. The small bowel will empty overnight by itself and the colon can easily be cleansed by enemas. This practice can be traced back to Greek medicine with its humoral pathology. The ancients purged as we do, but to get rid of "black bile."

Pre-operative purgation is becoming milder, but it should be stopped altogether. Some cases may need enemas. Food should be given as late as possible before and as early as possible after operations, for its tonic effect on the gut and its tendency to restore peristalsis. Handle tissues gently and avoid peritoneal drying. Give water ad libitum by the mouth after most operations. Avoid the Murphy drip, as it often keeps up distress. Avoid post-operative purgation and all heroic treatment. The results obtained by many surgeons without "preparation" have been excellent.