

FEVERS OF THE PUERPERIUM.

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A LARGE number of cases of puerperal sepsis, puerperal scarlet fever, and instances of the two diseases running concurrently have during the last few years come under my notice in the Borough of Sunderland Infectious Diseases Hospital. I have recorded notes¹ on these and scarlet fever in the new-born babe, which did not, however, contain more than brief accounts, much interesting matter with regard to symptoms, diagnosis, and complications being omitted. Several correspondents and one or two critics have asked me to provide further particulars; this, and the fact that little can be found on puerperal scarlet fever in the text-books, prompt this article.

Incidence.

As to the liability of parturient women to infection, I have certainly found that when a case occurs in the home under my supervision, only prompt removal and early diagnosis prevents the spread of infection to other women unprotected by previous attack—so much so that a rise of temperature and sore throat lead to isolation of the patient. It would also appear certain that, in those cases where sepsis complicated the scarlet fever, the sepsis was a separate infection; there was no evidence that scarlet fever itself would cause puerperal sepsis, and in my cases of the double infection the source of the septicaemia was traced in each case, and separate onsets were easily made out. The same strain of streptococci was cultivated from uterine swabs and the blood-stream. As regards new-born babies my records show that only two were discharged who did not have any evidence of the disease while in hospital. In three there was evidence of infection in utero; the remainder developed the disease after birth, the appearance of the rash being observed in from a few hours to five days after birth, the pathognomonic sign of the strawberry tongue was present in each diagnosed case, and thorough desquamation was the rule. The symptoms ushering in the disease in these new-born babies were often severe, convulsions being not uncommon; the throat symptoms were prominent, and a death occurred from oedema of the glottis. The pure puerperal scarlet fever ran a fairly mild course, though signs and symptoms were better marked than in other patients admitted from the town, where the disease was at that time of a particularly mild type. The death-rate was nil in the cases uncomplicated by sepsis. The mothers were in most instances able to feed their babies, and the chief treatment was directed to careful attention to the vulva and to any vaginal lacerations. The cases of scarlet fever complicated by sepsis were much more serious and the mortality was 66 per cent. The scarlet fever having developed, a separate onset, with rigors, headache, and thirst followed, and it was observed that the temperature which had been falling by normal lysis swung up to 105° F. or so, and tended to become hyper-pyretic (in fatal cases rising to 107.4°), attended by all the symptoms of grave septicaemia. The vagina and perineum in most cases were very foul and extensively lacerated; septic blotchy rashes appeared, particularly on the face and lower limbs; the pressure points rapidly became red, and, in fatal cases, within a few hours, black. As the disease progressed the temperature chart changed from one showing remissions of two or so degrees to one which swung three or more. A definite septic look is often present while the patient has a definite sense of well-being. These latter two points are very important both in the diagnosis of puerperal sepsis and its onset during scarlet fever. The pure scarlet fever case feels ill and looks ill. The tongue becomes dry, glazed at the tip, and covered with brownish-yellow fur on the dorsum. Delirium is common.

Diagnosis.

When called in to see a puerperal woman with pyrexia, one should immediately endeavour to exclude sepsis, or to diagnose and notify the disease if present. There appears to be a diffidence in recognising its presence unless there is likely to be a fatal issue; thus, notifications are very few in comparison with the actual number of cases undoubtedly occurring at the present time. All degrees of sepsis require early treatment if the women are to escape after-effects, and if the disease is to be kept from spreading; early recognition also means early treatment, which, when thoroughly carried out, reduces the mortality; I myself favour the hospitalisation of all these cases at the earliest moment, especially any cases of pyrexia in maternity homes where the temperature has remained above 100.4° for more than 24 hours or shows a second rise in the dangerous period of the first five days of the puerperium, and where there is no other obvious cause. All rashes must be regarded as of septic origin until proved otherwise; morbilliform rashes are almost certainly septic in the puerperal woman, scarlatiniform rashes are frequently present, and no diagnosis of scarlet fever should be made without presence of the injected throat and double rash. An inspection of the vagina and cervix should be made, and the presence of tears and their condition of cleanliness considered, in coming to the conclusion of the presence of sepsis or the likelihood of it supervening. The lochia, as a rule, show some change from the normal; in most cases they do not completely stop, but they become offensive. The utmost care, in maternity homes at least, should be taken to diagnose the cause of any rise of temperature other than the "reactionary," remembering, first, that there are many abortive cases of puerperal sepsis which may at any time lead to a serious outbreak, or from which complications may arise after the patient has been discharged; and, secondly, that the occurrence of mild sapraemias indicates that something is wrong in technique which, if undiscovered, will almost certainly prove such group of temperatures to be the forerunner of further and graver outbreaks. Care should be taken in choice of nurses; it should never be forgotten that pyorrhoea in a nurse may set up sepsis in her patient. A nurse suffering from septic teeth or throat, or subcutaneous whitlows, must be prohibited from attendance; ozæna should completely disqualify a nurse for practice. Swabs should be taken from uterus and vagina, and an examination of the blood is helpful for prognosis. Any shiver or rigor in a puerperal scarlet fever case should lead to investigation of the uterus and vagina.

Treatment and Complications.

If the patient is seen early, the question of exploration and washing out of the uterus comes up, and good results may be expected; later this procedure is probably disadvantageous, if not, indeed, dangerous. Tears and lacerations of the vagina must be carefully cleaned; vaginal douches four-hourly are both helpful and comforting. Sleep must be obtained. Alcohol is usually required. Yodil in half-ounce doses four-hourly appears useful. Hyperpyrexia calls for cold sponging or the ice pack. Treatment of diarrhoea depends largely on the individual patient. Plenty of fluids should be given.

Pyæmia and local pelvic collections of pus were observed. One woman was very maniacal, and eventually showed abscesses of finger and elbows. Women who have shown even slight rises of temperature during the puerperium should be kept under observation for two months or so; some at least find their way to the infirmaries with local pelvic troubles, or suffer otherwise from ill-health.

I have several times noticed the following sequence of events: (1) Undue prevalence of discharging or watery eyes in the new-born babies—? ophthalmia neonatorum; (2) slight septic conditions of children's nails; (3) subcutaneous whitlows or small blisters on the nurse's hands; (4) mild pyrexias of unknown origin in the puerperal woman; (5) puerperal sapraemia or septicaemia.

¹ THE LANCET, 1922, i., 1170.