EMERGENCIES IN GENERAL PRACTICE

THREATENED ABORTION

BY

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Threatened abortion is a subject about which little is known. Seldom can an obvious cause be found; and by the law of sheer cussedness those who desperately want a baby threaten to miscarry, whereas the unwanted child appears to have an abnormal tenacity.

Antenatally, it should be impressed upon all pregnant women that any bleeding per vaginam, however slight, is abnormal. No woman can have a period while she is pregnant. The patient should be instructed that if bleeding occurs she should go to bed at once, take two aspirins, and summon her doctor. She should not travel to him, rather he should go to her.

Diagnosis

The patient threatening to miscarry is generally some six to twelve weeks pregnant, and is bleeding slightly per vaginam. The textbooks tell us that she has no labour pain, but this does not mean that she has no pain at all: often premenstrual discomfort is present, but intermittent labour-like pains are generally absent. In checking the history the date of the last period will be asked for, and inquiries made to ensure that it was normal in respect of both date and amount of loss. Then it is necessary to know when the abnormal bleeding began, and the colour of the blood: was it bright red or dark brown? This is an important prognostic point, for those cases in which the loss is dark to start with are often cases of carneous mole, in which, of course, it is impossible to save the pregnancy. Whereas if the loss be pink or bright red the ovum is generally alive and the pregnancy will possibly continue.

Whilst talking to the patient her general condition should be noticed. Is she sallow and ill-looking? Has there been excessive sickness? What are her temperature and pulse, and is there albumin in her urine? If it is difficult to obtain a catheter specimen, a "clean" specimen should be taken, and filtered three times before testing. In considering these points one is thinking of a hydatidiform mole. No patient with this condition looks and feels well. Hyperemesis, pyrexia, and albuminuria are often present. Bleeding may occur before vesicles are passed. Dilution tests on the urine are by no means infallible. Ovarian luteal cysts are difficult to palpate, and the uterus in such cases is by no means always larger than the period of amenorrhoea would suggest. The general condition of the patient is therefore most important, for if she has a hydatidiform mole the uterus must be evacuated or removed as soon as possible.

Pain of some kind, as has already been stated, is generally present. If this is located low in one or other iliac fossa, and has been present mildly for a week or more and then become severe before the bleeding began, beware of ectopic gestation, a condition which is seldom the dramatic picture visualized by the student. It is often difficult to diagnose an ectopic from a threatened abortion, and these points in the history may be helpful. The finding of a particularly tender swelling separate from the uterus is, of course, the outstanding diagnostic point.

Finally, in taking the history, the patient should be asked if she has disposed of any soiled pads, and if so how many, and in particular whether any clots have been passed into the lavatory. Unless this is done the doctor may find himself treating a complete instead of a threatened abortion. It is bad for his reputation, after the bleeding has ceased and

everyone is pleased, to be obliged to explain to the patient that after all the foetus has been lost.

On first being called to visit the patient should an internal examination be made? This is a debatable point; personally I think it should. Without it an unruptured ectopic gestation cannot be diagnosed; in addition the os may be found dilated with some product of gestation protruding through it, showing that the abortion is already inevitable. If conducted gently the examination should not predispose to the turning of a threatened into an inevitable abortion. At the same time a sterilized speculum should be passed, for an extrauterine cause for the bleeding, such as a cervical polypus, may thus be found. Should a polypus be discovered, no attempt should be made to remove it, as bleeding may be severe when this is done during pregnancy. If continued bleeding makes this operation essential, it should be performed under anaesthesia in the operating theatre.

Should the uterus be retroverted, without retention of urine, leave it alone. If retention is present, catheterize the patient, drawing off the urine at a normal rate. There is no need to decompress the bladder slowly in these cases; haematuria will not occur. A self-retaining catheter, draining into a bottle, should be left in the bladder until the uterus becomes anteverted, usually a matter of 24–48 hours. It is advisable to keep the patient's urine alkaline during this period by giving potassium citrate, 30 gr. (2 g.) three-hourly. Whether retention is present or not, if the uterus is retroverted encourage the patient to lie on her abdomen as much as possible.

Treatment

Once a diagnosis of uncomplicated threatened abortion has been made, what should be the treatment? Mental and physical rest are the essentials. Should the patient be admitted to hospital? This must be decided in each individual case. Generally speaking it is better to keep the patient at home and not subject her to the journey. Furthermore, "going to hospital" may be mentally disturbing to her. On the other hand, she may feel safer in hospital and her home conditions may be such that she cannot truly rest at home. This question is an important one for the practitioner to decide. Now that many students work for a few weeks with a general practitioner, house-surgeons are likely to have more insight into, and sympathy with, such requests for admission.

Whether the patient be at home or in hospital, after the preliminary questioning and examination the treatment is essentially the same. Phenobarbitone, 1 gr. (65 mg.), should be given at once, followed by $\frac{1}{2}$ gr. (32 mg.) three times a day. Some advise morphine $\frac{1}{4}$ gr. (16 mg.) initially, but this may have the disadvantage of making the patient severely sick and thus do more harm than good.

No evidence has been produced to show that progesterone does harm in these cases, and my impression is that it is helpful. Progesterone, 25 mg., should be given by injection at once, and ethisterone, 5 mg., by mouth twice daily afterwards until all bleeding has ceased; alternatively a 50-mg. injection of one of the crystalline suspensions of progesterone may be given and this will maintain a satisfactory blood level of progesterone for a week. Either of these methods will save the necessity for many visits.

Instructions and Advice for the Patient

The practitioner must also give certain explicit instructions to the patient and to those in charge of her. It is best to

write the instructions down so that there can be no doubt about what should be done and what must be avoided.

The diet should be normal, but very hot or cold things omitted. "A nice hot cup of tea," hot soup, or ice-cream should not be taken, as by their temperature they may cause reflex uterine contraction from overactive peristalsis. Luke-warm should be the order of the day.

Apart from liquid paraffin, say 2 dr. (7 ml.) twice a day, no aperient of any kind should be given, and above all no enemas; it does not matter if the patient's bowels do not open for a week or even longer, provided she is not uncomfortable. The overenthusiastic nurse, by the giving of an enema, may cause a threatened to become an inevitable abortion. It cannot be too strongly stressed that the patient *must not* go to the ordinary lavatory; a bed-pan or chamber must always be used, and if any blood, clot, or other abnormal product be passed then this must be saved for medical inspection. All soiled pads, bed-linen, clothing, etc., must be similarly saved and not thrown away. Unless these rules are obeyed it is impossible for the doctor in charge of the case to know what is happening to the pregnancy.

Vaginal douching must certainly never be performed in cases of threatened abortion, but the removal of any blood from the vulva with soap and water is advisable. Whilst bleeding continues, the patient should wash in bed. No bath should be taken, and when eventually the patient is allowed up the first few baths should be tepid. For how long should she remain in bed? One week after all bleeding has ceased is the usual advice. This is not always practicable, but one should aim as near to this as is possible.

Many patients who are threatening to abort are often seriously worried that what has happened may have an adverse effect on the baby should the pregnancy continue. They must be reassured that this is not so. The fact that a threatened abortion has occurred does not predispose to a weakly or malformed child in any way; it will have no effect on the child whatever.

When a patient is allowed up again she should be told that if any further bleeding occurs she must go to bed again for further rest. It is advisable that she and her husband should be instructed to refrain from sexual intercourse for the next two months, as in some cases there appears to be a definite relationship between coitus and abortion.

Conclusion

It will be evident from this article that there has been no major advance in our knowledge of the aetiology or treatment of most cases of threatened abortion. It is true that figures have been published indicating that other hormones besides progesterone, such as the oestrogens, or a combination of hormones, may be used with advantage, but the whole problem of hormonal balance remains still unsolved. The slender evidence at present available is not enough, in an article such as this, to justify dogmatic advice. In the management of threatened abortion it is attention to detail which is of the greatest importance.

Next article on Emergencies in General Practice.—
"Acute Delirious States," by Dr. Hunter Gillies.

POLIOMYELITIS VACCINE

A STATEMENT FROM THE MEDICAL RESEARCH COUNCIL

The Ministry of Health has announced that arrangements have been made for the distribution to local authorities of a British poliomyelitis vaccine. This vaccine will be given, on a voluntary basis, to children born between the years 1947 and 1954 inclusive. Since there may be insufficient vaccine for all such children, vaccination will in the first instance be limited to those who were born in certain

months of the year (to be determined centrally later). These vaccinations, the Ministry has announced, must take place before June 30, 1956, when vaccination will be suspended. Detailed information about the composition of the vaccine which will be used and about the nature of the tests of safety and potency to which it will be subjected are given in the article by Dr. W. L. M. Perry below.

The Ministry of Health has invited the Medical Research Council to assess the degree to which the British vaccine confers protection upon the recipients, and the Council has accepted this responsibility. It is expected that the assessment will be made by comparing the attack rate of poliomyelitis in the vaccinated children with the corresponding rate in the children who were registered for vaccination but for whom the supplies of vaccine were insufficient to allow them to be vaccinated. For this purpose each participating local authority has been asked to make a return to the Medical Research Council's Statistical Research Unit of the number of children registered for vaccination, and subsequently to make a return of the number actually vaccinated. These data, differentiated by age and sex, will provide the necessary details of the children involved. Precise details of the cases of poliomyelitis occurring during the summer in vaccinated or non-vaccinated children will also be required. For this purpose the request will be made to medical officers of health to make a brief case report on each notified case of poliomyelitis, paralytic or non-paralytic, in their areas in children born in the years 1947 to 1954. This report will indicate whether the child (1) had been vaccinated; (2) had registered for vaccination but not been vaccinated; or (3) had not registered at all. The name of the hospital to which the patient is admitted will be asked for on this report (or the name of the general practitioner for the cases treated at home). The Council will then make request to the hospital (or general practitioner) for clinical details of the illness. The Council hopes to obtain more detailed information to assist in diagnosis and to this end will be communicating directly with those concerned with the care of patients.

In view of the stringent safety tests applied to the vaccine and of the experience of millions of children who have been inoculated with similar vaccines in the U.S.A. and elsewhere, it is not anticipated that more than trivial vaccination reactions will occur and then only in a very small proportion of those vaccinated. Medical officers of health are, however, asked to record and report to the Medical Research Council's Statistical Research Unit any event coming to their notice which they think might conceivably be related to the vaccination, however tenuous the evidence. It is hoped that general practitioners will make similar reports to the medical officer of health on vaccinated children in their charge.

BRITISH POLIOMYELITIS VACCINE

BY

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For some time the Medical Research Council has been undertaking research upon different aspects of the problem of poliomyelitis. In particular, the Council has had the responsibility of advising the Ministry of Health on the composition and potency of any British vaccine to be manufactured and on the safety tests to be applied to it before it is issued. It is now possible to give detailed technical information on the nature of the vaccines to be used in the coming months. The Department of Biological Standards at the National Institute for Medical Research has been engaged on much of this work and is to be responsible for carrying out tests on the safety and potency of the vaccine. The following