Treatment of Post-maturity

From the foregoing evidence the following views on treatment seem justifiable:

Overmuch weight should not be given to the occurrence of post-maturity *per se*. For uncomplicated post-maturity no treatment is required: this also is the opinion of Clayton (1941) and of Wrigley (1946). The patient should be reassured, but she should not be admitted to hospital, for rest serves no useful purpose. A medical induction is not reliable as a test for post-maturity, nor is it likely to succeed in the case in which the head is high or the cervix is long and uneffaced.

If post-maturity is complicated by a minor degree of cephalo-pelvic disproportion, surgical induction may sometimes be desirable. Munro Kerr and Chassar Moir state: "Management of post-maturity largely resolves itself into the determination of the size of the foetus relative to the pelvis." In deciding for or against induction of labour, each case should be individually considered and routine induction avoided. Better subsequent uterine contractions and minor improvements in the attitude and position of the child may more than compensate for a week's delay.

With a history of a stillborn small baby associated with a small placenta, induction is advisable a few weeks before the time when the previous baby died. As already stated, these cases are rare.

Nothing in the foregoing remarks is intended to imply that the high head, possibly in the occipito-posterior position, is free from danger to mother and baby. These cases require careful watching and management.

Conclusions

Post-maturity with placental insufficiency is extremely rare. In the present series of 171 post-mature pregnancies it accounted for only one death.

A foetus may die *in utero* for no apparent cause at any time during pregnancy. Deaths during the post-mature period in the 171 post-mature cases amounted to no more than 9 (5.2%). In all save one of these an adequate cause for death was found.

Malpresentations and cephalo-pelvic disproportion are a frequent cause of a high presenting part and a poorly formed lower uterine segment, and are hence the cause rather than the result of post-maturity.

In hospital statistics the foetal mortality tends to be high in post-mature cases. This is because the selection of patients is different from that of patients going into spontaneous labour at term, and failure to diagnose disproportion is common.

The problem of post-maturity resolves itself, to a great extent, into the proper management of malpresentations and minor degrees of cephalo-pelvic disproportion.

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Medical Memoranda

Fatal Case of Acute Ulcerative Colitis with Multiple Perforations

The outstanding features in the following case are the acute onset with no previous history of ulcerative colitis and the complete lack of signs which would lead to a diagnosis of intestinal perforation.

Case Report

A housewife aged 27 was admitted to hospital with a history of some years' constipation and pain and bleeding from an anal fissure. The anal canal was dilated and the fissure excised. The surgeon made a note that there was considerable oozing from the upper rectum, which would require further investigation when the fissure had healed.

Five weeks after the operation the patient was readmitted with a history of diarrhoea for the past two weeks, with blood and mucus in the stools. The abdomen was not distended but was slightly tender. Her temperature was 101.4° F. (38.55° C.). On admission she was given 100,000 units of penicillin four-hourly. Her temperature stayed at 101–103° F. (38.3–39.4° C.) for three days, when 3 g. of phthalylsulphathiazole was given four-hourly in addition to the penicillin. This reduced her temperature to normal by lysis in two days, where it stayed; but her condition deteriorated, the abdomen showing tympanitic distension and, although fairly solid, having a doughy feel. The motions were four or five a day and were liquid, greyish in colour, and very offensive. Repeated laboratory examinations of the blood and faeces yielded no useful information. The patient became gradually worse, and in spite of blood and saline transfusions she died 10 days after admission.

At necropsy the abdominal incision opened into a cavity containing liquid faeces. This cavity was bounded anteriorly by the abdominal wall and posteriorly by the omentum, which was firmly bound down to the colon all the way round and to the posterior brim of the pelvis. So complete was this attachment that the coils of the small intestine under this floor showed no sign of peritonitis. There were numerous perforations in the large intestine; two in the ascending colon, each nearly 2 in. (5 cm.) long and over 1 in. (2.5 cm.) wide; three in the transverse colon of about the same size; and six in the descending colon. These varied in area from the size of a halfpenny to one which was 3 in. (7.5 cm.) long and involving most of the wall. All the ulcers had ragged edges. Where the colon turned over the brim of the pelvis the gut was reduced to one longitudinal muscle band, and the almost free end of the pelvic colon was expanded to resemble a funnel and filled the space between the sacrum and the uterus.

It would appear that liquid faecal matter found its way through the numerous perforations into this false cavity and eventually was collected by the pelvic funnel and passed as a diarrhoeic stool. Histological examination of the wall of the intestine as far away as possible from a perforation showed the mucosal epithelium to be almost completely denuded. The mucosa and sub-mucosa, and in parts the whole wall, were diffusely infiltrated with plasma cells and lymphocytes and some polymorphs. At the edge of the ulcers there was an acute pyogenic exudate into the mucosa.

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