Puerperal Sepsis following Childbirth.

The only, but significant, reduction in the causes of maternal deaths is due to a fall in the number of deaths from puerperal sepsis following childbirth, the rate of which, as shown in the graph, has dropped almost continuously by successive steps from 2·01 (total deaths 56) in 1927, to 0·33 (total deaths 8) in 1935. The death-rate from this cause has been so low since 1931 that the almost dramatic reduction last year comes as a surprise.

It has followed and is possibly due to the replacement of disinfectants chosen in a very haphazard manner without reference to their suitability for the purposes of midwifery with antiseptics specially selected for their bactericidal action upon streptococci. The choice of antiseptics was based upon the researches of Colebrook and others into the bacteriology of puerperal sepsis and Garrod's investigations into the selective properties of antiseptics with regard to their special suitability for midwifery.

Analysis of Notified Cases of Puerperal Sepsis following Childbirth.

Ninety-three cases of puerperal sepsis were notified as compared with 141 in 1934. Of these 89 were investigated by the Medical Officers of Health and Nurse Inspectors. Eighty of these occurred among Europeans and nine among Maoris. The European notifications probably include the actual number of cases occurring; those among the Maoris, who in the majority of instances do not seek professional advice until the patient appears to be very seriously ill, are obviously inaccurate. The fact that four out of the nine Maori cases notified died confirms this view.

The number of deaths among the eighty Europeans was eight, giving a case fatality of 10 per cent., while that of the Maori cases was 44·4 per cent. The inquiry into each case gives information on the following points: The place where the patient was confined—that is, private house, public or private hospital—the qualifications of the attendants—namely, doctor, registered midwife, or maternity nurse, or unregistered woman; normality or abnormality of pregnancy and labour; methods of delivery of infant and placenta; number of vaginal examinations; probable source of infection—*i.e.*, whether ascribed to attendant, faulty aseptic technique, pre-existing infection, or whether undetermined; total duration of illness up to twenty-eight days and the final result. The published details of all these points would be beyond the scope of a report of this nature, and many of them appear to have little value as a guide to methods of prevention. The following figures are, however, significant: The percentage of instrumental deliveries in these cases was 19·1, or approximately two and a half times as high as that of the 19,034 cases recorded in Table II, which was 8·88; the percentage of manual removals of the placenta either with or without instrumental delivery of the infant was also 19·1, which is twenty-two times that of the percentage of 0·87 shown in the same table for this method of delivery of the placenta. Though the total number of cases is small and percentages taken from small numbers must be accepted with a certain degree of reservation the difference is so great that it must be regarded as confirming the opinion that manual removal of the placenta imports a very high risk of septic infection especially in cases where the facilities for maintaining efficient asepsis are not available.

Hæmorrhages and Accidents of Labour.

The death-rate from hæmorrhage due to placenta prævia, post-partum hæmorrhage, and other accidents of labour has risen from 0·78, total deaths 19, to 1·00, total deaths 24. In connection with this rise it might be regarded as significant that the number of Cæsarean sections for placenta prævia, accidental hæmorrhage, contracted pelvis and obstructed and delayed labour and other pathological conditions other than eclampsia have increased from 78 in 1934 to 120 in 1935. There is, however, a measure of satisfaction in the fact that, whether the increase in this method of delivery is justified according to the principles of sound obstetrical practice or not, the deaths following these operations did not influence the rise in 1935. I have no doubt that the problem of reducing deaths from these causes will receive the attention of the Obstetrical Society. Generally speaking it is apparent that increased safety must come from more accurate ante-natal estimation of difficulties likely to arise, thus reducing the number of emergencies and permitting better provision for dealing with these serious conditions.

Eclampsia and Other Toxæmias of Pregnancy.

The death-rate from eclampsia and other manifestations of puerperal toxæmia has risen from 1·24, total deaths 30, to 1·42, total deaths 34. In an appendix to last year's report attention was drawn to certain deficiencies in the method of ante-natal investigation, notably the failure to use the sphygmomanometer as the most ready means in most cases of detecting by a rise in blood pressure puerperal toxæmia in its early stages. It was obvious in many cases that were supposed to be dieted or otherwise treated in their own homes the directions were not carried out. Treatment in hospital would be more thorough and,