Clinical Note

A Technique for the Relief of Some Kinds of Obstetric Pain

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Pain across the lower part of the back is common during labour. It may be relieved or abolished by lifting the patient by one knee when the uterus contracts, so that the opposite hip swings clear of the bed. In detail, the patient is allowed to lie on her back between the uterine contractions, and as soon as a contraction begins, the attendant passes his forearm beneath the nearest knee and begins to lift. For example, the attendant's right forearm is passed from within outwards beneath the patient's right knee. Lifting the knee will first flex the knee and hip joints to right angles, and a continuation of the process will abduct the hip and roll the patient on to her opposite side. A little further lifting will swing the patient's opposite hip clear of the bed.

It will be observed that this manoeuvre exerts considerable traction across the pelvis and probably allows free movement at the sacro-iliac joints. Body wall pains such as those arising in the posterior ligaments of the sacro-iliac joints and also those in the iliac fossae usually disappear. So also does the pain of uterine contraction which now takes place painlessly. Pains such as those which arise from direct pressure of the foetal head on an anterior lip or on the inner aspect of the pelvis through slight degrees of disproportion are usually unrelieved, as is pain from a tight vaginal orifice.

Lifting the patient in the manner described is a somewhat arduous procedure, but it is valuable in the type of patient whose pains are not relieved by analgesics. I usually reserve it for such cases and have on occasion conducted a painless labour in this way. I believe that labour is accelerated since the patient can bear down uninhibited by pain. It is also a useful aid in the analysis of the various types of obstetric pain.

Some examples may now be adduced to demonstrate the phenomena observed in lifting the patient by the knee in the manner described.

Case 1. A primipara in labour was experiencing severe pain across the lower part of the back. The pain was abolished when she was lifted by the right knee, and she seemed almost to go to sleep during the uterine contractions. When she was allowed to experience a contraction while lying flat on her back the pains recurred as before. This was an early case, and I did not therefore pursue the observation further.

Case 2. A multipara had severe pain behind the symphysis pubis, unrelieved by pethidine, but which disappeared when the patient was suspended by the right knee. The next contraction was accompanied by a pain in the right

sacro-iliac region, which in turn was abolished when she was lifted by the right knee, but which returned when she was allowed to have a contraction while lying on her back. In two subsequent confinements, the patient asked for this method of relieving pain and refused pethidine, and gas and air. In her last confinement she had pain in the back when the cervix was 3/4 dilated. When she was lifted by the right knee the delivery took place with little discomfort after two further uterine contractions.

Case 3. The confinement of a multipara was making little progress although the cervix was fully dilated. After the patient had been lifted by the knee the baby was born with the next uterine contraction.

I have records of 15 cases collected over the past ten years in which lifting the patient by the knee has been usefully applied to the relief of pain, or overcoming delay in labour. The method was unsuccessfully applied to patients suffering from pains due to (1) anterior lip, (2) disproportion at the brim, (3) pressure on the rectum, or (4) pressure on the coccyx.

In two patients suffering from unrotated occipito-posterior presentations, ' knee-lift ' relieved the pain, but had no effect on the position of the head.

Domiciliary Midwifery. A. E. DE LA T. MALLETT, *D.S.C.*, M.D., *Practitioner*, 1958, **180**, 277.

Dr Mallett outlines the problems of domiciliary obstetrics in a paper which is part of the month's symposium on Domiciliary Care published in *The Practitioner* of March 1958. After estimating the number of abnormalities the general practitioner may expect to see in a lifetime, Dr Mallett stresses the need for sense of proportion. He advocates the formation of domiciliary obstetric teams, with increased liaison with the midwife, and the consultant available in emergency with his flying squad.

Adequate antenatal care is discussed, and the author describes his own technique. He concludes with some details of the complications of labour as they affect the general practitioner.

Care of the Bedridden Patient. D. CRADDOCK, M.B., D.OBST.R.C.O.G., *The Practitioner*, 180, 288 (March) 1958.

Dr Craddock briefly surveys the problems of domiciliary geriatrics, and lists a team of trained workers who should operate under the direction of the gneral practitioner. These include the district nurse, home help, night attendant of the Women's Voluntary Service, occupational therapist, dental surgeon, optician, and health visitor. He goes on to discuss diet in chronic illness, the need to maintain movements of old joints, skin care, bowel troubles, urinary infection and incontinence, insomnia and other problems seen commonly in practice.

He sums up by stressing the improvement in outlook that the general practitioner can effect by his attentions.