Sociology of birth

WOLKIND, S & ZAJICEK, E

Pregnancy: a psychological and social study
Academic press 1981 £10.40

ROBERTS, Helen (ed)

Women, health and reproduction.
Routledge 1981 196p. £5.50

LEWIS, Jane

The politics of motherhood: child and maternal welfare in England, 1900-1939
Croom Helm 1980 235p £10.95

Ann Oakley & others

600-620

presentation and position of the fetus; engagement of the presenting part and estimation of the size of the fetus and amount of liquor present. Auscultation of the fetal heart rate is with the Pinard's stethoscope; Doptone or Sonicaid is used if there is difficulty in hearing the fetal heart. Important anomalies may be detected, such as error in dates, multiple pregnancy, hydatidiform mole, uterine fibroids, polyhydramnios, oligohydramnios, small or large fetus, abnormal fetus, abnormal lie and presentation of the fetus, fetal death in utero and cephalopelvic disproportion.

Assessment of cephalopelvic disproportion is repeated at approximately 36-38 weeks gestation. An X-ray pelvimetry is ordered if cephalopelvic disproportion is suspected by clinical estimation, or by a history of difficulty in past labours.

Haemoglobin estimation is repeated at 28 weeks and 36 weeks gestation.

Rhesus negative patients in whom antibodies have not been detected have blood taken for a Kleihauer and repeat antibody titre at 28 and 36 weeks gestation. If antibodies are detected, the patient is immediately referred to the obstetrician responsible for management. As prophylaxis, Anti-D Gamma Globulin is administered to mothers with Rhesus negative blood group and no Anti-D antibodies:

(1) within 72 hours of delivery, when the baby is Rhesus positive, and after abortion (including threatened abortion) or ectopic pregnancy;

(2) after amniocentesis, external cephalic version and placental abruption.

During the antenatal care, special investigations are used to assist in clinical diagnosis and management.

Ultrasonography is used to assess the crown-rump length measurement of the fetus in early pregnancy, for expected date of confinement, fetal viability, diagnosis of hydatidiform mole, fetal growth and maturity, fetal presentation and multiple pregnancy, fetal abnormalities such as hydrocephaly, anencephaly and spina bifida; localisation of the placenta, to exclude placenta praevia

Reading list

International Congress of the Menopause (3rd) 1981:
Oxford: The controversial discussions. The workshop moderators' reports presented at the Third International Congress

ed. D. A. Van Keep,
W. H. UTIAN AND A. VERMEULEN
Lancaster MTP

ISBN 0-85200-410-9

British Natural Biography
1982, Vol. 1.
Unpriced
182 pp.

616.99'4' KG. Women. Breasts. Cancer. Psychological Aspects:
CYLLENSKIÖLD, KARIN. Breast cancer
London. Nelson. Nord 1982. 300p.
ISBN 0-422 768 30-8. £5,50

618 Women, Medical Aspects 1982 ← Patents + Nurse
The Women patient.
(ed) CAROL C. NADELSON +
MALKAH T. NOTMAN
New York 206 pp. Unpriced

362.2. Women, illness, Social aspects 1982
LIVES IN STRESS
(ed) Deborah Bell, London 246 pp
£6.50

Women & the Reproductive cycle

305.4'8. Middle-aged women:
Women = the middle years. Annual knowledge
+ direction for research + policy:
(ed) JANET ZOLLINGER GIELE £23.50
Wiley, New York 1982

sensation requiring prompt relief. The administration of morphine or omnopon may lower the blood pressure and depress respiratory function but these effects must be balanced against the stress of unrelieved pain. However the anaesthetist will be aware of these factors and will prescribe an appropriate drug.

The nurse's responsibilities during the immediate postoperative period have been summarised in Table 5 and the decision the nurse must make is what constitutes a significant deviation from the normal. The following points are guidelines.

1. Any single severe alteration in a recording e.g. a pulse increase of 30 beats per minute.
2. An apparent trend over a series of recordings e.g. a consistent drop of 5 - 10mmHg over 3 blood pressure readings.
3. A recurrent slight symptom e.g. hiccough.
4. Anything that seems odd.

The patient will return to the ward once he has regained consciousness and his condition is satisfactory with vital signs stable and within normal parameters. Many hospitals use postoperative instruction sheets which are completed by medical staff and detail the patient's operation, presence of drains, treatment including drugs, intravenous fluids and give specific instructions for the patient's care on his arrival in the ward. This eliminates the inherent danger of depending solely on verbal communication.