THE GRANDE MULTIPARA

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The problem of the grande multipara has naturally always been with us. It wasn't, however, until 1934 that our attention was first focussed on it when Bethel Solomons termed the patient who had borne five or more children as "the dangerous multipara". Solomons had found that the maternal mortality rate increased progressively from the fifth to the tenth parity. A para 10, for example, had five times the likelihood of a para 5 of her pregnancy ending fatally. Eastman (1940) and Greenhill (1951) agreed with this view and brought up evidence of their own to show that there was an increased maternal mortality attached to great multiparity. From a study of his cases, Eastman deduced that para 9 had three times the chances of a fatal outcome than the woman who was para 5 or less. The result was that the multipara was considered such a bad risk that often sterilisation was resorted to prophylactically on the basis of multiparity alone.

Since those days, the picture has changed considerably. Firstly, the average family of to-day is unlikely to reach the size that was commonplace previously. The reason for this is mainly economical rather than medical, though, paradoxically, it seems to be that women in the lower income groups are the ones who still beget the larger families. Secondly, great multiparity no longer offers the same grave possibilities from the obstetrical standpoint that obtained in the past. Eastman (1955) was one of the first to recognise this. More recent reports reflect the same opinion. Scharman and Silverstein (1962) write that "the oldfashioned designation, the dangerous multipara, should unalterably be stopped"; while Israel and Blazar (1965), after an exhaustive study conclude that "the present evidence is clear-cut that she (the grande multipara) is nowadays cared for with no greater

risk of life than that of any other pregnant woman."

Material and Findings

In this survey, a study was made of all the para 7 or over delivered at St. Luke's Hospital, Malta, during the two-year period 1963-1964. A comparison was also made between the results obtained in all para 5 patients and those who were para 10 or over during the same period. The figure for the para 7 or over was 638 out of a total of 4052 admissions, constituting 15.7 per cent. This high figure indicates the class of paitents admitted, mostly from the lower social strata. A large proportion of these patients converge to the one hospital from the villages. Though they all had their delivery in hospital, antenatal attendances had often been erratic.

TABLE I

Distribution according to parity of 638 grande multipara

Parity	%
7	22.6
8	20.5
9	15.4
10 or over	41.5

The highest parity recorded in this group was 22. The patient was aged 43 and had a normal pregnancy and delivery.

TABLE II

Distribution according to age

Age	%
— - 29	4.3
30 - 34	20.7
39 - 39	47.8
40 - 44	26.0
45 or over	1.2

The youngest patient was 24 years old and was para 7. There were three patients aged 46, the oldest in the series.

Toxaemia. Under this heading are included all patients whose blood pressure was found to be above 140/90 on more than one occasion during the pregnancy. There were 142 cases, forming 22.9 per cent. This is a high rate and is possibly related to the frequent occurence of gross obesity in the series, which together with glycosuria forms almost a picture of endemic disease in this class of patient in Malta. Another factor for the high figure has been the difficulty in following up and adequately treating hypertensive patients who refuse in-patient treatment.

There were 13 cases of abruptio placentae i.e. 2.03 per cent. and 10 cases of placenta praevia i.e. 1.56 per cent. There were 6 cases of retained placenta or 0.95 per cent.

Operative intervention. Caesarean section was carried out in 43 cases or 6.7 per cent. of the series. Hysterectomy was performed in 5 cases, three times for the three cases of rupture of the uterus in the series and twice for intractable bleeding during Caesarean section on friable uteri. The three cases of uterine rupture occurred in women who were para 7, 8 and 9 respectively.

There was one maternal death or 0.15 per cent. This was para 11, aged 38, who had a Caesarean section for fulminating toxaemia and died five days later from pulmonary eodema and heart failure. (Table III).

Prematurity — here taken as being 5 lbs. 8 ozs. or less at birth — accounted for 5.8 per cent. or 37 cases. There were 11 sets of twins or 1.8 per cent. The rate for still-births was 5.0 per cent. or 32 cases — an understandably high figure when considering the incidence of toxaemia.

Malpresentations. There were 16 cases involving a transverse presentation or prolapsed cord or both, an incidence of 2.5 per cent. 12 of these required a Caesarean section, 1 had a hysterectomy for rupture of the uterus and three had a normal delivery. The rate of breech delivery was 6.2 per cent. i.e. 40 cases. There were 2 cases of face presentation, one of which, a persistent mento-posterior, necessitated a Caesarean section.

A comparison is made below between the obstetrical behaviour of the para 5 group and that of the patients who were para 10 or over. There was no appreciable difference in the incidence of placenta praevia and premature births. Toxaemia

TABLE III

Showing incidence of obstetrical complications in women who were para 7 or over according to various authors.

	Toxæmia	*Abruptio placentæ*	*Placenta prævia*	*Retained placenta*	*Prematurity*	*Still-births*	*Maternal mortality*
Miller (1954)							
563 cases	4.1	3.1	1.0	1.6	8.8	1.9	0.17
Schram (1954)							
502 cases	11.1	2.39	1.6	2.9	5.9	3.1	0.4
Scharfman et al. (1962)							
403 cases	9.6	0.74	1.5	0.99	9.6	1.0	0.2
Present series							
638 cases	22.2	2.03	1.56	0.95	5.8	5.0	0.15

was more frequent in the higher parity group. Abruptio placentae and Caesarean section were approximately four times as common, while malpresentation and still-birth rates were twice as high.

Discussion

The grande multipara is or should be at no greater risk to her life than the one who has borne less children. The improved results are directly related to improved ante-natal care with early recognition and treatment of abnormalities, better nutrition and hygiene, the introduction of blood replacement therapy and antibiotics and the increased safety and more frequent use of Caesarean section. The result is that the atmosphere is now rightly one of optimism.

The findings of the present series are in consonance with the above statement. This is not to claim that the grande multipara is the equal physically of the woman of lower parity. The title "grande" is often synonymous with "elderly" and thus any medical disease that might be present, such as hypertension and diabetes, is bound to be more advanced. Repeated pregnancies take their toll in the form of obesity, lordosis, varicose veins and the fatigue associated with caring for a large family. Moreover, she is often in economic straits and her nutrition is correspondingly poor.

The delivery of the grande multipara should on no account be undertaken in the home. The most favourable domiciliary conditions can never provide sufficient safeguard against the complications that are more likely to arise in this particular type of patient. The increased incidence of malpresentations and abruptio placentae and the possibility of uterine rupture

TABLE IV

Showing incidence of complications according to parity.

	Toxæmia	*Abruptio placentæ*	*Placenta prævia*	*Retained placenta*	*Prematurity*	*Still-births*	*Breech*	*Uter. rupture*	*Cæsarean sect.*	*Maternal mortality*
Para 5										
259 cases	16.9	0.39	0.39	0.39	5.79	2.7	3.47	0	1.54	0
Para 10 or over										
265 cases	23.4	1.5	0.37	1.1	6.04	5.66	6.8	0	6.41	1 case.

make it imperative for all facilities for operative intervention and blood transfusion to be near at hand. Only in this way can the maternal risk be held in check.

Summary

A series of 638 grande multiparae is studied. The findings, and those of other authors, show a higher rate than average for certain obstetrical abnormalities such as toxaemia, abruptio placentae, still-birth and malpresentations. The maternal mortality is not appreciably affected.

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PUBLICATIONS LIST

The following is an incomplete list of scientific publications since 1961 by graduates of our medical and dental schools; we would be glad to add to it in our next issue.

AGIUS, E. 1962. A comparative study of the action of demethylchlortetracycline and of tetracycline hydrochloride on *Bruc. melitensis*. Arch. Inst. Pasteur de Tunis. 39, 373.

AGIUS, E. 1962. Further comparative studies on the action of demethylchlortetracycline and of tetracycline hydrochloride on *Bruc. melitensis* and on *Salm. typhi*. Arch. Inst. Pasteur de Tunis, 39, 381.

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