naturally. Apoplectic patients have been choked by fluids poured into the mouth by meddlesome friends or Nurses. Indeed they have been suffocated by their own vomit; the fluid has gone the wrong way and caused choking. No nourishment should be allowed at first; but afterwards, in the treatment, the Nurse must give the nourishment ordered (always of course fluid) very slowly and cautiously, in small quantities at a time. To go back to the fit—the Nurse should take notice of any desire in any way expressed by the patient to pass water. If she finds no water has been passed, she must report to the Medical attendant. Later on, if dribbling occurs, she must not mistake that state for the proper passage of plenty of water. The Nurse must be prepared to have to give croton oil in drops, or calomel. The former is usually dropped on to sugar, and placed on the back of the tongue, far back. The calomel powder must also be put far back on the tongue. This may be done with a spatula, thus: take up the calomel on the extreme end of the spatula, convey it into the well-opened mouth, and, when it has reached far back on the tongue, turn it upside down, and wipe off the calomel on the tongue. We will suppose the croton oil or the calomel in the back of the mouth. How is the person to be made to swallow it? Thus: pinch the nose and close the lips, and involuntary swallowing will take place. If this does not occur, the drug must be left to dissolve, and be absorbed from the mouth or gullet. Besides the purge, the Nurse may expect to have to apply mustard plaisters to the calves of the legs and soles of the feet; also to have to administer enemata, and to apply ice to the head. Every severe case of apoplexy is attended by *shock*. The Nurse must be cautious not to attempt to bring on reaction quickly, not to put hot bottles to the feet, to use hot blankets, stimulants, or anything of that nature. She must leave the Physician to do what he thinks proper in that respect.

As to the course of the disease, I have only to say that the Nurse must make use of her powers of observation, and report any changes to the Medical man as they occur.

When a case of apoplexy is accompanied by *shock*, the face is pale and ghastly, the eyes are open and dull, one pupil is—or both are—dilated, face and body are covered with cold, clammy sweat, and the pulse is very small and weak. The respiration is occasionally *sighing*.

You may note that if a case which at first presented flushed face, staring eyes, full, strong pulse, snoring breathing, becomes no better but seems weaker, and breaks out into profuse perspiration over the body, death may soon be expected; that cold sweat is the forerunner of death.

Epilepsy is a purely functional disorder, and depends in no way upon any definite structural disease of the brain. The loss of consciousness is complete. If standing at the time of seizure, the patient will probably fall. There is a rigid spasm of the muscles, the face and limbs become convulsed, and he probably froths at the mouth. After a few minutes this passes away, the patient regains consciousness, and he is probably ignorant of what has occurred. A Nurse's duty, when called upon to render aid in such a case, is to see that her patient has plenty of air. She should open the windows, unfasten the clothing about the neck, protect the tongue (which is liable to get bitten by the convulsive movements of the jaw) by placing a cork between the teeth.

Place the patient on his back with his head *low*. Remember that in apoplexy the *head and shoulders must be raised*. Until Medical assistance arrives, the Nurse should apply cold water cloths to the head and mustard poultices to the calves of the legs.

Fainting or *syncope* arises from weakness of the system, sudden shock or loss of blood sufficient to affect the heart's action. It is easy to distinguish fainting from apoplexy or epilepsy by the pallor of the face and the flaccidity of the muscles and the absence of convulsions. Place your patient on the back, with the head on a level with the body; undo the dress, especially about the neck; allow plenty of fresh air, and bathe the face in cold water.

This seems a convenient time to speak of *coma*.

The term, which is Greek, means profound sleep—a state of sleep, with loss of consciousness, from which a person cannot be roused, or only transiently, and partly, with difficulty. In strongly marked coma there is no power to perceive or to will anything; the limbs are like logs, they drop as if dead; the pupils are dilated, the eyeballs may be touched without causing winking or flinching; the breathing is stertorous; the secretions are passed without the patient's knowledge.

Coma may be brought on by disease directly, or may arise in the course of a disease which did not begin in the nervous system; it may occur from injury which was not at first inflicted upon the nervous system. On seeing a case of *apoplexy* in a state of *coma* you will be puzzled, not once or twice only, to distinguish it from *intoxication*, or poisoning by opium. Whenever you meet with a case which, in the absence of positive trustworthy information, may be one or the other, you must push inquiries as far as you can. You may elicit a history of taking poison or hard drinking from the friends or bearers of the patient. Try to elicit any facts or reliable intelligence about the case. Conjectures are not reliable. Smell the breath,

previous page next page