

The fact that she possessed considerable experience in other branches of her work was of little consideration when she could not prepare the prescribed dressings, pass a rectal tube, or bougie, or even regulate the patient's diet.

Now this demand on the part of our leading surgeons and physicians, that Nurses must possess an extensive and thorough practical knowledge of their work is a very hopeful sign, and will go far to counteract the depressing influence of the less liberal minded, who would still endeavour to impress upon us that we have not the mental capacity to acquire knowledge on a scientific basis, or to exercise any reasoning faculties; and that Man, not God, must control the development of our intelligence. This can never be; there never has been, and there never can be, any limit to the infinite possibilities of the human mind. I would have you all, therefore, parched with a thirst for true knowledge, so that your desire for an efficient Nursing education shall, in the future, swell into a strong and deep demand to which there can be no denial upon the part of those persons who now control the education of Nurses and who therefore accept the great responsibility of providing, or denying to, the sick, really skilled attendants.

The alimentary canal, as we learn from our textbooks, begins at the mouth; the intestinal canal, proper, from the pyloric opening of the stomach with which the small intestine is continuous. This intestine is from twenty to thirty feet in length, and terminates by opening into the large bowel in the right iliac region. The small bowel is divided into three parts, the duodenum, jejunum and ileum, although of course all form a continuous canal. And its structure is composed of four coats—the serous, muscular, submucous and mucous.

The large intestine is about five or six feet in length, it is sacculated and is thicker than the small intestine. It commences in a large pouch-like dilatation, the cæcum, placed in the right iliac fossa, passes up in front of the right kidney, as the 'ascending colon,' to the under surface of the liver, then crosses beneath the stomach to the spleen, as the 'transverse colon,' bending downwards and passing in front of the left kidney, as the 'descending colon.' On reaching the left iliac fossa it becomes twisted like the letter 'S' forming the sigmoid flexure, then enters the pelvis, becoming the rectum, and so terminating at the anus. The large intestine has the same coats as the small, but certain differences between them require to be noted. The serous coat completely surrounds the cæcum, the vermiform appendix, the transverse colon and the sigmoid flexure, but the lower part of the rectum has no peritoneal covering. The muscular coat deviates considerably from the arrangement found in the small intestine; the longitudinal fibres being gathered into three bands, and the circular fibres being thickest in the hollows between the sacculi so formed. The sacculations of the large bowel is supposed to be designed in order to delay the flow of the intestinal contents, thus allowing time for the absorption of their fluid constituents to take place. In the lower part of the rectum, the longitudinal fibres are spread out over the whole tube, so that it ceases to be sacculated, and the circular fibres are much increased in number and aggregated to form the internal sphincter of the anus. Around the anus, is a strong circular band of striped muscle, the external sphincter. So much for the anatomy of the intestines which are subject to various

diseases, upon which numerous operations may be performed, and upon which, therefore, a Nurse may be required to attend.

To begin with Intestinal Obstruction, Mr. Arthur Durham has defined under this term 'all those cases in which the contents of the intestinal canal are obstructed in their onward passage by causes or conditions occurring within the abdomen or pelvis.' Cases in which obstruction is due to causes or conditions affecting protruding or protruded bowel are included under the head of

HERNIA.

To be brief, a rupture is formed by a protrusion of some portion of the bowels through the front wall of the abdomen. The protrusion usually occurs in one of three situations—at the navel, in the groin, or at the upper part of the thigh; and the hernia is termed, accordingly, either an umbilical hernia, an inguinal hernia, or a femoral hernia. If a hernia is not reducible by taxis—that is to say, by mere gentle pressure and manipulation; if the swelling becomes painful, if the bowels do not act, if flatus is not passed, and symptoms such as vomiting set in, these facts are usually due to the obstruction of the passage of the bowel contents through the hernia, owing to the constriction of the bowel by the ring through which it has passed. Then the hernia is said to be 'strangulated.' It is under these circumstances that it often becomes necessary for the surgeon to operate, with the object of releasing the bowel and returning it into the abdominal cavity.

In these cases, the Nursing is simple. Beforehand, as little liquid nourishment as possible should be given, and only according to the surgeon's directions. Everything vomited must be saved. The progress of danger is often gauged by the matter thrown up—usually at first it is the food last swallowed, more or less digested, and mingled with bile. In the second stage it becomes yellowish and greenish, and at last it is what is called fecal—offensive to smell, of a brownish colour and frothy, and often in great quantities. Palliatives may be employed, opium is often administered by the mouth, enemata are administered, and local applications of ice are used. After operation, a pad should be kept firmly pressed over the wound, being kept in position by a spica bandage; the patient should not be allowed to move, and if coughing, retching or sickness occur, the strain must be prevented by gentle pressure over the wound. The diet will probably consist of very small quantities of liquid—hot water, milk and water, or fluid of some kind; and any complaint of pain must be at once reported to the surgeon. Recovery is usual unless the bowel has suffered irreparable damage by remaining over-distended or constricted for too long. A suitable truss is usually worn during and after convalescence, in order to prevent any recurrence of the rupture.

INTESTINAL OBSTRUCTION.

The causes of Intestinal Obstruction are given in the text books as follows:—(1) strangulation by bands, or in apertures; (2) volvulus; (3) intussusception or invagination of the bowel; (4) impaction of gall stones; (5) contractions; (6) stricture; (7) compression; (8) impaction of foreign bodies or intestinal concretions; (9) impaction of feces; (10) congenital malformation.

It is unnecessary for us to consider these causes

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