

In sponging, do not dab at the wound; lay the swab on firmly, and sponge straight across the neck; if serious bleeding should occur, the operator will want to open the trachea at once, so do not hinder him by sponging at all: bleeding, as a matter of fact, almost invariably stops directly the tube is inserted, however alarming it may appear at the time.

After the operation is over, the child should be got back into its steam tent as soon as possible, the head should be laid flat, without a pillow, and the feet, and, if necessary, the body kept warm with hot bottles. An enema of brandy in hot water is frequently required, as well.

So far, the main treatment of the case has been in the hands of the surgeon, but now, the troubles, and also the triumphs of the nurse begin: with most cases there will arise anxious moments, if not emergencies, but, fortunately, the reason why these occur, and the lines on which they must be treated, are easy to understand; the only difficulty lies in keeping one's head for whatever has to be done, must be done at once, hesitation means, most assuredly, loss—of the patient.

What are, then, the dangers that we are to endeavour to avoid? They are:—Obstruction of the tube, heart failure, and inflammation of the lungs.

Of these, obstruction of the tube is the most important, for it can almost always be relieved, temporarily at all events, by the nurse. Fortunately there is no mistaking the condition when it occurs—the child makes convulsive efforts to breathe, but no air comes through the tube.

It may happen in one or two ways. Firstly, the tube may be blocked by a piece of membrane that has been lying loose in the trachea, and has been suddenly coughed up into the tube; one endeavours to prevent this as far as possible at the time of the operation by exploring the trachea with forceps, and removing any loose pieces of membrane that may be there, but it frequently happens that the trachea is lined with membrane that is tightly adherent at the time of the operation, but subsequently, under the influence of Antitoxin, becomes loose, and may at any time block the tube. Sometimes, also, a piece of membrane becomes loose in the larynx, and falls, or is sucked down past the tube, to be subsequently caught up into it: this is unlikely to occur, though, if a sufficiently large tube has been inserted.

Then the tube may be blocked, not by membrane, but by pieces of tough mucus: this, however, does not occur often, and may usually be prevented by spraying the tube with a weak solution of bicarbonate of soda, or boracic acid.

Whatever the cause of the obstruction, the treatment is the same. First remove the inner

tube: in the majority of cases the obstructing substance will be found lying in the inner tube, and can be removed with it, in which case the condition is relieved: But—and this is most important—if the child does not then at once begin to breathe, cut the tapes, and *remove the outer tube*, and then, if you can, put in the tracheal dilators. Remember this, that a child may, and probably will, be able to breathe through a slit in the trachea, but it cannot possibly for one moment breathe through a blocked tube. In the same way, if for any reason you cannot remove the inner tube when obstruction has occurred, do not hesitate, but remove the outer tube at once.

You will find, as a matter of fact, that the tracheal dilators will go into the trachea easily if you have the neck extended over a pillow, and the head straight, and then let the closed instrument *fall* in by its own weight. If the points of the dilators are in the trachea the whole instrument will slip in almost up to the joint; when this occurs, withdraw it slightly and open the blades about half an inch. Having thus inserted the forceps, sit down on the cot, hold the child's head with your left hand, the dilators with the right, and wait till the surgeon can come and insert the tube.

If the child should not commence breathing when the dilators are in the trachea, hand over the dilators to an assistant to hold in position, and at once get the child's head over the side of the cot, with the body lying crosswise, and firmly compress the chest, and start artificial respiration: If there is a third nurse present, she should apply a sponge wrung out of very hot water to the chest, while the artificial respiration is proceeding.

In this way life may often be saved, even though the case appears hopeless.

So then, obstruction of the tube after Tracheotomy is a danger than can be easily recognized, and can almost always be relieved, in fact—in Hospital, it ought never to be the immediate cause of death. We come now to two other dangers that may occur at any time after Tracheotomy—Cardiac failure, and Broncho-Pneumonia.

With these, the case is very different: they will occur, unfortunately, at times, however carefully the patient has been nursed, and treated, but we can lessen the probability of their occurrence by careful attention, from the beginning, to certain points: here it is not the quick decisive action that will save the patient's life, but the constant watching for the chance of anticipating the danger before it occurs.

Heart failure may occur shortly after the operation from shock, or the effects of chloroform, or at any time later on, when it is usually due to cardiac paralysis: *i.e.*, inflammation of the vagus

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