t is very rarely indeed that such a tube becomes blocked by anything being coughed into it from below. That danger does not occur when the modern large tubes are used, though it is present when the tube is of insufficient size.

The signs of a blocked tube are quite unmistakable: the child is making convulsive efforts to breathe, but there is no air coming through the tube. Under these circumstances, obviously the first thing to do is to take out the inner tube—this will, in nine cases out of ten, bring the obstructing matter out with it. Dangerous obstruction can practically only occur when the inner tube has been left out (which it never should be) and the outer tube thus becomes blocked by a piece of membrane being coughed into it.

Under these circumstances there is one thing, and one thing only to be done: the nurse, whoever she is, must cut the tape and take the tube out. The child cannot breathe for one minute through the blocked tube, though he can do so to a certain extent through a slit in the trachea, even if that slit be not dilated. Get in tracheal dilators, therefore, if you can while you are waiting for the surgeon, but do not be very flurried if you cannot. If you have any difficulty, push the bowed end of a hairpin held sideways, deep into the wound, and then turn it round.

There is another occurrence that sometimes gives rise to alarm: when the child is being fed you are sometimes horrified to see some of the milk coming out of the tracheal tube. After tracheotomy, the epiglottis is very seldom capable of acting properly, and a little of the milk is apt to trickle down the larynx, and may then be coughed up through the tube. The remedy for this is to hold the child upside down by its heels: any milk that is in the trachea can then run out. Incidentally, this is also the best immediate treatment for ordinary heart failure whenever it occurs in a child with diphtheria.

After an operation of intubation there is often considerable difficulty in feeding the patient, and as the tube is much smaller in calibre than a tracheotomy tube, obstruction is more likely to occur. When it does it is best for the nurse to pull the string and remove the tube altogether, of course sending for the surgeon immediately. It is usually, in my experience, necessary to resort to nasal feeding after intubation.

Nowadays it is not usually considered advisable to keep the patient in an atmosphere of steam after either operation, but if a steam tent be ordered it is as well to see that the steam is supplied in the right amount and in the right place. I have known a steam kettle occupied mainly in dropping scalding water on to a patient's toes! Usually, the mistake is made of giving too much steam, and it is better to err on the side of giving too little.

One of the disadvantages of this method is that the child's clothes are almost certain to become wetted, and there is considerable risk of subsequent broncho-pneumonia. Still, when they are properly arranged, steam tents are occasionally of service.

A word in conclusion: no nurse, under any circumstances, should ever push a feather or any other implement down the tracheal tube on her own responsibility. Nowadays, feathers are usually tabooed altogether: when they are employed they should be only in the hands of the surgeon. Their chief disadvantage is that they cannot be sterilised, and their use frequently results in septic broncho-pneumonia. I do not, personally, like them to be used even for cleaning inner-tubes that have been removed from the patient.

A small brush is preferable for this purpose, and it has the advantage that it could not, even in a moment of excitement, be pushed down the trachea.

The tendency, at first, is to over-nurse cases of laryngeal diphtheria: they become surrounded, for some reason or other, with a sort of halo of interest, and this usually means fussiness on the part of the nurse. By all means watch them as closely as you can, but do not be in a hurry to act, especially when you do not know what you are going to do or why you are going to do it.

FINIS.

The Passing Bell.

We regret to record the death at Margate last week, after a long illness, of Miss Frances Hole, the late Matron of the National Orthopædic Hospital, Great Portland Street, W., and the daughter of the late Mr. H. Frederick Hole, of Newforge, Magheralin, Co. Down, Ireland. Miss Hole, who was possessed of much personal charm, was trained at Addenbrooke's Hospital, Cambridge from 1878-1879, and after a year's experience at the Montgomery Infirmary as Matron, and at the Royal Hants County Hospital, Winchester, as Sister, returned to Addenbrooke's as Assistant-Matron, a post which she held until her appointment as Matron at the National Orthopædic Hospital in 1888. It is now nearly two years ago since she was granted leave of absence on account of the unsatisfactory condition of her health, hoping to resume her work later, a hope unfortunately never destined to be fulfilled.

previous page next page