OUR PRIZE COMPETITION.

DESCRIBE THE POST-OPERATIVE CARE OF TONSIL AND ADENOID CASES.

We have pleasure in awarding the prize this week to Miss Dorothy Humphreys, St. Bartholomew's Hospital, London, E.C.

PRIZE PAPER.

In taking charge of a post-operative case of adenoids and tonsils, the nurse must first of all watch for signs of suffocation and hæmorrhage as the possible result, and guard against collapse. Suffocation may supervene as the result of clots or mucus blocking the trachea. The function of respiration is naturally impaired in these cases, difficulty in breathing being a typical symptom, owing to the growth obstructing the passage of air through the posterior nares, so that recovery from the anæsthetic takes place under rather unfavourable conditions. The nurse should therefore always have a tracheotomy set in readiness, since it is sometimes necessary to perform this operation; and by swabbing out the mouth and keeping the head sideways, and not thrown back, assist the patient's respiration.

Hæmorrhage, that is to say, secondary hæmorrhage, is a possible sequel. Primary hæmorrhage naturally always occurs immediately after the operation, owing to the laceration of the tissues. If the patient is a child, it should be carried from the operating table face downwards, access of air being insured. This position assists it to vomit, and prevents regurgitation. Immediately after the operation, the patient should be laid flat, well covered up, and with the head sideways. The face should be well sponged with cold water, and the patient given a little ice to suck. Primary hæmorrhage should be arrested after ten or fifteen minutes. Swallowed blood, of a deep blackish colour, is frequently vomited in considerable quantities after a time. If the hæmorrhage does not shortly cease, it becomes secondary hæmorrhage. It may also be brought on by a coughing or vomiting attack, even after the lapse of a day; the nurse must watch to see if any scarlet blood is vomited. Ice should be given to suck, and applications of ice to the nose and neck; gargles of tannic acid, injections of adrenalin and other astringents may be ordered.

Sudden collapse is not infrequent, and all the necessary precautions should be taken; the patient being kept warm and quiet, and the hypodermic apparatus put in readiness. A careful watch should be kept on the pulse for several hours after the operation.

In hospitals it is usual to send the out-patients home after the operation, in a few hours, with orders to keep them in bed. The usual treatment is rest and quiet for two or three days. The patient should not be allowed to talk too much; all food at first should be soft and lukewarm; and a mouth wash given frequently. In most cases recovery easily takes place without complications. Watch, however, should be kept for signs of ear trouble, septic throat, or enlarged glands, which sometimes supervene, especially if the patient is exposed to chills or draught. The Eustachian tubes frequently convey sepsis from the throat to the ear and set up ear trouble. It is therefore important to keep the mouth, throat, and nose thoroughly clean by syringing (if ordered), mouth washes, and frequent swabbing.

As soon as possible, instructions should be given in the art of breathing properly. If this is neglected, and the child allowed to breathe through the mouth instead of the nose, the air passages may be again obstructed, and a second operation prove necessary.

HONOURABLE MENTION.

The following competitors receive honourable mention :—Miss C. G. Cheatley, Miss A. K. Banham, Miss M. James, Miss B. Robson, Miss M. Macfarlane, Miss O'Brien, Miss K. Köhler, Miss Blackburn, Miss M. Tobin, Miss A. Harding.

Miss Cheatley writes :—" Directly the operation is finished, the patient should be put back into bed and covered with a warm blanket, over which the bedclothes are placed. The head should be placed on a low pillow or quite flat, and turned to the side. The patient must not be left until consciousness is quite recovered, as he may choke from getting vomited matter in his larynx. With an unconscious patient the danger of vomiting is that he will suddenly inspire and inhale vomited matter into his trachea, and rapidly become asphyxiated. After the operation is over hæmorrhage must be watched for, though it is not very common, although large quantities of blood may be vomited, having been previously swallowed."

QUESTION FOR NEXT WEEK.

What are the special points to be observed on receiving a patient for admission to a hospital or infirmary ward?

We regret that a number of papers arrived too late this week to compete for the prize. For this they must arrive by the first post on Monday morning.