OUR PRIZE COMPETITION.

HOW WOULD YOU ACT IN THE FOLLOWING EMERGENCIES IF THE DOCTOR WERE NOT IMMEDIATELY AVAILABLE? (a) WHEN A TYPHOID PATIENT DEVELOPS SEVERE ABDOMINAL PAIN? (b) WHEN A PATIENT WITH PULMONARY TUBERCULOSIS HAS A SEVERE HÆMOPYTSIS? (c) WHEN A PATIENT WITH DIABETES BECOMES COMATOSE?

We have pleasure in awarding the prize this month to Miss Ethel Stachey Laing, Mayday Road Hospital, Thornton Heath.

PRIZE PAPER.

(*a*) The development of severe abdominal pain in a patient suffering from Typhoid Fever might indicate either of the following conditions:—

(1) Perforation of the Bowel.
(2) Meteorism.
(3) Retention of Urine.
(4) A relapse in a patient who has reached the convalescent stage.

(1) *Perforation of the Bowel.*—Is the most dreaded of all complications, and as immediate operation holds out the only hope, there is, unfortunately, very little a nurse can do. Dry hot wool can be placed over the abdomen, and the weight of the bedclothes taken off the abdomen where this has not previously been done. The intense pain will cause shock in a greater or lesser degree, so the foot of the bed should be raised and the patient kept warm with a heated blanket and hot water bottles in good flannel bags. Morphia gr. 1/6 may relieve the pain and lessen the shock. The patient will have to be operated upon if life is to be saved.

(2) *Meteorism* (distension of the abdomen by gas).—Relief can be obtained by the passage into the rectum of a warmed, lubricated, rectal tube, the distal end of which rests in a bowl of water. Should this fail, a small turpentine enema can be given very gently with a soft rubber catheter, glass connection, rubber tubing, and funnel. Neglected meteorism may result in perforation of the bowel.

(3) *Retention of Urine.*—May occur at any period of the disease, and the distended bladder rise from the pelvis into the abdomen. A catheter must be passed with strict aseptic precautions.

(4) *A Relapse.*—During convalescence this possibility must always be borne in mind. The patient should be put to bed on absolute rest, and the diet restricted to small quantities of milk and water *ad. lib.* The nurse should explain to the patient that he has probably tried to do a little too much, or something which has been eaten has caused the return of the abdominal pain.

(*b*) *A Patient having a Severe Hæmoptysis.*—Must be supported while the blood is being coughed up, otherwise there is great danger of the blood being drawn back into the trachea, and asphyxia being the result.

When the attack is over, the exhausted, often very frightened, patient requires every skill and kindness which can possibly be shown.

The two great principles in the immediate treatment are:—

(*a*) Absolute rest of body.
(*b*) Peace of mind.

If morphia is available, without hesitation give Gr. 1/4. This not only quietens the patient mentally, and physically, but tends to lower blood pressure, and will thus lessen the chance of a recurrence. The patient should be encouraged to lie quiet and still, and told that this will prevent another attack. Small pieces of ice can be given to suck, and an icebag suspended over the affected lung if known.

Shock is always more or less evident, and although general stimulation is inadvisable, the patient must be kept warm by blankets, and well protected hot water bottles to the extremities, always remembering that it is general warmth that is required and not local heat.

The head of the patient should be kept low, and turned to the side. The foot of the bed can be raised to help overcome any existing shock.

For the next few hours small iced or cold drinks should be given and the bowels opened as soon as possible, if necessary by a gentle enema.

(*c*) *Diabetic Coma.*—Insulin is the only remedy of any real value. If the patient is already having insulin treatment give 50 units, otherwise 30 would be sufficient with which to commence. Sugar in some easily assimilated form, preferably glucose solution, should be given at the same time, by mouth, if possible (*i.e.*, if patient not yet totally unconscious) or by rectum.

Watch the general condition carefully, and if an improvement is followed by a relapse, it is wise to consider that it is probably insulin poisoning and give more sugar. Should the previous improvement not now reassert itself, it will be safe to assume that it is still coma, and give another 20 units of insulin. Recovery generally follows, although if consciousness has not been completely regained in two hours, 10 to 20 more units can be injected.

Stimulants may be necessary, and alcohol and strychnine are useful, never adrenalin as it inhibits the action of insulin.

When conscious, give and encourage the drinking of large quantities of water and barley water to combat the acidosis.

A full stomach, or loaded rectum, should receive their appropriate treatment.

Strict observation and utmost care is necessary to make sure that the patient is not transferred from a condition of diabetic coma, into one of hypoglycæmia (*i.e.*, too little sugar in the blood, because the dose of insulin has been too large).

N.B.—Insulin is made up in unit strength, there being 20 units in 1 c.c. Therefore for every five units required, four minims should be given.

HONOURABLE MENTION.

Miss Janet Mears and Miss Susan Crisp receive honourable mention.

Miss Mears quoting Dr. Frederick W. W. Hipwell, of Toronto, reminds us that the metabolic disturbance known as Diabetes Mellitis has not yet become the easily explained malady that the discovery of insulin promised.

Miss Susan Crisp writes: "In acting promptly in the absence of the doctor, do not overstep the mark."

QUESTION FOR NEXT MONTH.

Give the History of the Thermometer and its Use.