Lectures on Gynæcological Nursing.

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Lecture III.

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The catheter having been rinsed through with carbolic lotion (1 in 20), and then warm water, and thoroughly warmed so as to make it perfectly soft and flexible, is well oiled and taken between the finger and thumb of the right hand, while with the left hand the urethal orifice is carefully exposed.

After this particular operation, the manœuvre requires greater care and gentleness than under ordinary circumstances, because the effect of the operation will probably have been to cause a certain amount of swelling of the surrounding tissues. Sometimes the plastic procedure is carried so far forwards as, for the time, to completely close the vaginal orifice; the swelling then round the urethra may be so great, and at the same time the difficulty of exposing it to view be so considerable, that the discovery of the orifice, and therefore the passage of the catheter, is by no means an easy matter. Consequently, the Nurse will always require an excellent light, and very great patience and gentleness, in some cases, before she can expose the orifice. This being done, the tip of the catheter is gently introduced, and is then permitted to find its own way, very slight pressure only being exercised, until it has reached the bladder.

In withdrawing the catheter, especial care must be taken to hold the finger over the opening of the tube until it is completely removed and placed in the receptacle; because this will prevent the exit of the few remaining drops of fluid in the catheter, which otherwise would run into the wound, and might cause the failure of the whole operation by setting up irritation in the healing surfaces. In the great majority of cases in which this operation fails, that fact is due to this accident having occurred; so that the necessity for the precaution being observed—not only as a matter of neatness and cleanliness—will be obvious.

The next important point for the Nurse to notice is the maintenance of the dressing, externally, in a perfectly clean and dry condition; and when the catheter ceases to be used, it is a useful precaution that before the bladder is emptied, the outer layer of the dressing should be formed of two or three layers of lint or non-absorbent wool, and this may be even further protected by gutta-percha tissue or a little green protective. The object, of course, being, once more, to prevent any contact of the urine with the wound itself.

Then comes the equally important question of the regulation of the rectum. As was said at first, in some cases, the laceration of the perineum extends right through the sphincter ani, and even for one, two, or three inches up the anterior rectal wall. Many operators prefer in such cases to close the rectal laceration first, and when they have successfully accomplished this, then to carry out the further operation of narrowing the outlet of the vagina. As a matter both of convenience and safety to the patient, however, it is perhaps more usual to complete the operation at once, because even if part of the wound breaks down, it is more easy to remedy that if the rest of the laceration has been successfully closed; and it will readily be understood that the deeper the wound which is formed, and the larger the extent of surface which is brought together, the greater will be the chance of part, at least, being successfully united. But, in any case, especially when the rectal wall has been involved, there will be the greatest care necessary to avoid any tearing through the wound, either from muscular action or from undue distension of the rectal wall. It is therefore, as was previously said, essential to the success of the treatment, that the whole intestinal tract should have been cleared out before the operation, and that for three days at least after the operation, the patient should be restricted to as small a quantity of nourishment as possible, and that in the most concentrated form which can be found.

Then will come the crucial question as to the best method of clearing the rectum; and here opinions differ very considerably. Some operators will order a purgative on the third or fourth day, and others, especially in bad cases, will postpone such treatment until the end of the week. It is essential, therefore, that the gynaecological Nurse should always inquire as to this, and she would be wise also to take down in writing, the instructions given to her upon this essential matter. It will be understood that, in those cases in which the rectal wall has been repaired, considerable danger of breaking down the newly-uniting surfaces would be caused by the administration of an ordinary enema. The new tissue in such a case would be like an artificial dam across a lake or river, the slightest aperture in which would let through fluid when nothing else would pass, and the moment one drop of fluid passes through there would be an inevitable tendency for the aperture to enlarge and extend, until the water flowed through with all its force. So it often happens that, in these cases, the newly-united surfaces in the rectal wall break down when an enema is given, and for the last state of that patient to be even worse than the first. The Nurse should therefore never give an enema or

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