The Nursing of Laryngeal Diphtheria.

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An apology is perhaps needed for writing on such a trite subject as this, because, probably, to many nurses the substance of this article will be a matter of every day occurrence, but I believe there are some to whom a short printed statement of some of the chief points in the nursing of Laryngeal Diphtheria may be of value, especially as the subject is not treated accurately in any general text book of nursing.

Only as far back as 1892, nearly every child on whom Tracheotomy was performed for Diphtheria, died, the actual death-rate being from 80 to 95 per cent: in fact the operation was regarded by the general public as equivalent to the signing of the death certificate; now, as we know, two-thirds of the cases recover.

For the greater part of this reduction of mortality, we have to thank the direct effect of Antitoxin on the poison of the disease, but that is not all—it is largely due to the fact that the introduction of Antitoxin has brought about a great change in the nursing of the cases. It has made it possible to nurse them with a light heart, and—as a result—to give them ease, to allow them to recover of themselves.

There is, I think, no disease more fascinating to nurse, than Laryngeal Diphtheria, for every little thing that the nurse does has its effect on the patient, the cases can be pulled through by sheer good nursing, and they can assuredly be killed by thoughtless fussiness.

To turn to details: A child is brought in suffering from severe Diphtheria of the Larynx: where there should be a free air passage, there is now only a narrow chink, through which he can breathe. On the surface of the vocal cords there is a deposit of membrane, and the inside of the Larynx itself is swollen, and ulcerated; every breath is causing the child pain, partly from the increased effort necessary to draw the air through the narrowed passage, and also from the cold air irritating the diseased surface of the Larynx itself.

Now, the first sign of this deficiency of air is restlessness—the child is continually changing its position, and tossing itself from side to side; also, there is an in-drawing of the lower ribs, and epigastrium, with each inspiration, and we hear the noise of the air passing through the narrowed Larynx with each breath.

But—and this is most important—neither of these signs is an indication for opening the windpipe, they used to be before the days of Antitoxin, but now we know that we can safely leave a patient in this condition, as, after a large dose of Antitoxin, the membrane may separate, the swelling subside, and a patient who has had all these symptoms, recover without an operation.

Now, this stage is a state of active, vigorous, discomfort, but it soon gives way, if the patient is getting worse, to a state of apparent ease; the child becomes quieter, the retraction of the ribs *less*, and there is less noise with the breathing. This is the stage of danger, for its onset indicates that the vital powers are failing, and the first point in the nursing of the patient is, *to detect when the stage of active breathing is beginning to pass into the stage of failing breathing, for it is then that the trachea must be opened.* Fortunately there is one infallible sign to be found in the colour of the patient: as soon as the lips begin to get blue, send for the surgeon.

In the first stage, we can relieve the discomfort, while the Antitoxin is doing its work, by placing the patient in a tent with a steam kettle; the air is then moistened, and warmed, so that it is less irritating to the diseased Larynx than the colder air of the ward. It is best to place the nozzle of the kettle some way from the patient, and to have a good supply of steam; there is thus less risk of accidently scalding the child. Owing to the restlessness, there is often some difficulty in feeding, so that the nasal tube is usually required.

For the second stage, there is only one remedy —Tracheotomy: this is, if possible, best performed without an anæsthetic, for the pain caused by a rapid incision is, I believe, not as uncomfortable as the sense of suffocation with chloroform, and there is great danger of the vomiting caused by the latter turning the scale against the patient in a critical case.

For the operation itself, it is as well to have ready a large flat sponge, or pad of lint, which can be wrung out of hot water, and a hypodermic syringe filled with brandy, in case respiration should fail; the selected tubes should be threaded with tape, and boiled. Under no circumstances should any instrument be placed in strong carbolic lotion, even a few drops of which are most irritating to the trachea.

If the operation has to be performed in a hurry, first put the patient on the table, with a sandbag, then get ready, first the tracheal dilators, forceps, and tubes, and then the swabs, wrung out of water, if there is no perchloride lotion at hand; anything else that may be wanted can be got when the trachea is opened. If you should have to hold the head, sit down behind the patient, and keep the neck extended with the chin in a line with the notch at the top of the sternum: above all things, do not let the neck move sideways.

previous page next page