nerve (which goes to the heart) caused by the poison formed by the Diphtheria bacillus. In the latter case it may come on gradually, the child simply getting weaker, and weaker, or suddenly, when the patient starts up, and falls back dead, without any warning whatever.

Now, in Diphtheria, there are three signs which usually precede heart failure: vomiting, quickening of the respiration, and pallor of the face with blueness of the lips—all of them due to the fact that the brain and head are not being properly supplied with blood. If the patient is seen directly any of these signs appear, the subsequent heart failure can sometimes be prevented by the use of stimulants, and so on, so it is of extreme importance that the nurse should recognize them as signals of danger.

Broncho-pneumonia, similarly, may occur in the acute stage, from actual spreading downwards of membrane from the trachea into the smaller air tubes until the lungs are blocked up with membrane. This is one of the most distressing forms of Diphtheria: the child is breathing with all its might and is taking large draughts of air into its trachea, but cannot use the air when it has got into the lungs, so it dies of a gradual suffocation for which there is no remedy: fortunately insensibility comes on, in proportion to the amount of apparent distress.

Inflammation of the lungs may also occur later on: the actual cause is, probably, the inhalation of various germs, but the resisting power of the lungs has often been lowered by a previous chill, or draught of cold air.

Now, in Diphtheria, you have to try and prevent heart failure and inflammation of the lungs, by your nursing: prevention is many times better than cure, because cure is so frequently impossible. Prevention is difficult—I think that the successful nursing of a restless child after Tracheotomy is one of the most difficult things you can have to do—but the reward is in the fact that the mortality has gone down largely, as the direct consequence of sheer good nursing. Is it not possible that it may be brought lower still? The difficulty comes in the fact that it is impossible to lay down any hard and fast rules, one can only go on certain general principles. Of these the first is: let the child alone as much as possible—touch its tube as seldom as possible, and, above all things, do not worry its stomach.

Now there are two reasons, and two only, for changing the inner tube: it may be necessary when the secretion is profuse, and the tube gets full of mucus, so that the child cannot cough it all out on to the dressing, or it may be required when the mucus is scanty, in order to prevent the two tubes being glued together by dried-up secretion. It is not necessary to change the tube whenever the child coughs.

Change the tube, therefore, as seldom as possible, and only when there is a definite reason for doing so: when you take out the inner tube, always fix the shield of the outer tube with your other hand, otherwise you may tilt the lower end of the outer tube against the back of the trachea, and start a fit of coughing: always keep an aseptic pad over the orifice of the tube.

Then, it is important to feed the child in such a way that he does not dread the operation: the milk may be flavoured, now with a little weak tea, and again with cocoa, or a little extra sugar: variety is the secret of success: frequently, nasal feeding disturbs the child least: err, rather on the side of under, than of over feeding: do not be too anxious to "get in the quantity" especially during the first forty-eight hours: sleep is more important.

Another important point is position: If possible keep the child flat without a pillow, but it is not always advisable to insist on this. Some small children, in particular, will sit up, and worry themselves into a temper if any attempt is made to restrain them: If sudden heart failure occurs, or vomiting, the child should at once be held up by the legs, or the feet of the cot raised.

As long as a child after Tracheotomy is noisily coughing up much mucus, and can sleep, the outlook is good: when the secretion becomes scanty and sticky, especially if the child is restless, the progress is bad: diminution of secretion frequently means the outset of Broncho-pneumonia.

Do not, on any account, ever push a feather into the inner tube, and down the trachea: you can do no good, and you may do harm by inserting either germs, or, what is almost as bad, strong antiseptics, into the trachea: the usual result of the use of this deadly implement is Broncho-pneumonia.

Finally, use your eyes—to watch the colour of the face, your ears—to listen to the respiration, but restrain your hands, for the most successful policy is, after all, that of masterly inactivity.

Sketches.

At the Zanzibar Hospital.—Perplexed Nurse (in a very doubtful tone): "I can't help thinking that the patients must *steal* the castor oil, it seems to diminish so very rapidly."

Experienced Matron (in a brisk voice): "Of course they do if they have the chance, but not because they like it to drink, but for outside application. Like the rest of the world, a darkie loves to shine!

previous page

next page