

reached. The object of this was to avoid the danger of perforation of the ulcerated intestine, and of relapse of the disease. In some cases the result was, ultimately life perhaps, but a life that, unless the patient could afford to supplement our treatment by a long period of rest, was largely devoid of enjoyment, and often totally unfitted for bread winning.

Now, in some cases, chiefly those in which there is diarrhoea from the first, and much abdominal distension, it is impossible to give anything but fluids in the acute stage, but there are a large number of patients that have not any diarrhoea at all, especially if they are not plied with repeated small doses of alcohol, and are hungry from the first. Experience has shown that, as long as we take care to give them no food that they cannot digest, such cases not only recover much more quickly than similar cases fed on milk only, but the occurrence of perforation, or of relapse is not thereby increased.

The decision as to what the patient is likely to be able to digest is in the hands of the physician, and it is not by any means always an easy matter, *but the digestion of that food can be helped by the way in which it is given by the nurse.* The great point is to ensure variety. Never let a patient see the same food in the same way repeatedly, if you can help it. The same food he needs must have, but he should not know it is the same until he has tasted it, and he need not always know then. For instance, bread is frequently the most digestible food we can give in the acute stage, but the bread can be either exhibited as a nauseous mess, or conjured by skilful cooking into a dish that would tickle the palate of an alderman. Remember that the secretion of the digestive juices is influenced by what the patient thinks of the food before he swallows it. Again, some patients can take pounded fish, or delicately cooked eggs from the first; at the level of the ulcers the contents of the intestine are pretty much the same whatever kind of *digestible* food had been taken into the mouth.

There is another kind of patient who cannot digest milk, and in these there is diarrhoea, and the stools contain undigested curds. Though one may temporise by peptonising the milk, they usually do better for a time on something else—albumen-water, bread, beef-tea, and even eggs. Speaking generally, one's aim in feeding in enteric fever should be to avoid diarrhoea, for diarrhoea means increased risk of perforation and hæmorrhage. Fortunately, most of the patients with enteric fever are slightly constipated; endeavour, then, to keep them so.

But there is another point. The chief thing that strikes anyone who has to nurse a patient with enteric fever is the dryness of the mouth and tongue, and, here again, in some few cases they will remain dry whatever one does for them, but in the large majority of patients the dryness is not due to the condition of the stomach and intestines, so much as to the effects of micro-organisms in the mouth itself. It is a local, and not a general condition. Now this septic stomatitis has one real danger. Patients who have a foul and dry mouth are very apt to develop ulceration, and even sloughing of the larynx—one of the most serious and the most easily preventible of the complications of enteric fever; most serious, because it almost always leads to permanent impairment of voice, and not infrequently is fatal in itself. In a patient dead with this complication, we do not find in the ulcerated larynx the bacilli of enteric fever at all, but, instead, there are numerous micro-organisms, which are also found in the mouth.

These organisms are found most commonly in the hollows of decayed teeth, and when these are removed, the condition, as a rule, quickly subsides, but the point I wish to emphasise in nursing, is the necessity for constant cleansing of the teeth and edges of the gums. Simply rinsing or swabbing the mouth will not do. The lotion that is employed—and it does not much matter what it is, as long as it is alkaline, the secretions in the mouth being usually in this condition, acid—should be applied forcibly with a toothbrush.

If you can by these means keep the patient's mouth and tongue moist, not only will he be more comfortable, but his power of taking and digesting food will be proportionately increased. And there is another reason—though a theoretical one—for attending to the mouth in enteric fever. If an animal in the laboratory is given an attack of enteric fever, and is allowed to recover, and then given a dose of the poison produced by these germs that exist in the mouth, it will have, not an attack of septicæmia, as might be expected, but a true relapse of enteric fever. This leads to the suggestion that relapses in human enteric may be due to the products of the septic organisms in the mouth; it is, at all events, an additional reason for cleanliness in that region.

In conclusion, then, if you want to send your patients out well, and fit for work, remember that their power of digesting whatever food is ordered depends very largely on how you give it; also, that ulceration of the larynx is a complication which you yourselves often have it in your power to prevent. Typhoid fever may be a disease of tragedies, but it is also one of triumphs.

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