

## Notes on Practical Nursing.

### THE NURSING OF TRACHEOTOMY CASES.

The operation of tracheotomy is usually performed under one of four conditions:—1. For the relief of urgent symptoms caused by the obstruction of the larynx or trachea by a foreign body. 2. In cases of obstruction in the same regions caused by malignant disease. 3. In cases of operation on the larynx where breathing is likely to be impeded. 4. In certain cases of diphtheria. In the first group of cases, with the removal of the foreign body the need for keeping open the wound made in the trachea ceases, and if the operation has been performed under aseptic conditions it usually heals quickly when no longer kept open by mechanical means, and the patient makes an uneventful recovery. 2. When performed in cases of malignant disease the operation is merely palliative, and a tube in the trachea is constantly worn until death ends the sufferings of the patient. 3. When performed in order to admit of comfortable breathing and the administration of an anæsthetic during a laryngeal operation, the wound is usually allowed to heal within the course of a few days. 4. In cases of diphtheria it is performed when it is evident that air is not entering the lungs, and that prompt measures must be taken to save the patient's life. Prominent indications of this condition are cyanosis and recession of the ribs. In cases of this class it must never be forgotten that, while the operation often affords great immediate relief, it in no way affects the disease from which the patient is suffering, but is merely a temporary expedient in order that time may be gained in which to attack the disease itself. The necessity for the operation of tracheotomy in cases of diphtheria is much less frequent now that the disease is treated by antitoxin. Still, the necessity for it does arise from time to time, and, as a nurse who can efficiently care for a case of tracheotomy in diphtheria will usually have little difficulty in nursing any other tracheotomy case, we will here consider it in relation to diphtheria. In the first place, cases of this nature are usually admitted to hospital suffering from urgent symptoms, and the operation is performed very shortly after admission. Arrangements should therefore be made that everything may be in readiness as soon as possible. If, as is the case in some smaller hospitals, a diphtheria ward is not always open, but a special ward opened when a case is admitted, then, if it is to serve any useful purpose, fires must be kept always burning in the cold weather, whether the ward is in use or not. An urgent case cannot be kept waiting in the surgery while the temperature of the ward is being raised to the required point, neither can it be admitted to a cold ward. For the same

reason mattresses, and bed and body linen must always be kept aired. It used formerly to be the custom to place these cases in a tent bedstead. The custom may have originated for the protection of other patients when diphtheria was commonly nursed in general wards, or with the object of protecting the patient from draughts, and of maintaining a moist atmosphere by means of the steam kettle usually ordered. Whatever the reason, wiser counsels now prevail, and it is generally recognised that a diphtheritic patient requires as much pure air as possible, and that the expired air which is likely to collect in a tent must be prejudicial.

If time permits, the patient must either be washed in bed, or, if a very young child, be bathed in front of the fire, and the instructions of the medical officer should be asked on this point. In any case the area of the operation must be carefully cleansed.

Preparation for the operation should be made on the ordinary lines. There will be needed a table covered with a mackintosh and sterilised sheet, a short sandbag covered with jaconet, a light blanket, plenty of sterilised towels. The instruments required include a sharp scalpel, catch or clip forceps, a pair of small retractors, dilators, scissors, needles threaded with sterilised silk, and ligatures. Hypodermic and rectal syringes, brandy, ether, and strychnine should also be at hand, also a drop bottle of chloroform and a piece of lint for the anæsthetist. The operating surgeon will choose the tube he requires, and there should be a variety of different sizes for him to select from. When the selection is made the tube must be threaded with tape. The two principal varieties used, in the first instance, are the "bivalve" and "Parker's." The bivalve being quarter circle in shape is not anatomically correct. Its advantage is that when the inner tube is removed it can be compressed, and so is easily inserted. Its disadvantages are that when it is *in situ* the calibre of the tube is diminished when the inner tube is removed; it may therefore cause difficulty in breathing. Its free edge may also press against the trachea, causing ulceration. Therefore, if this form of tube is selected the nurse must be observant of any blood-stained discharge, and at once report it. Parker's tube is constructed with regard to the anatomy of the trachea. Its disadvantage is that the removal of the inner tube is slightly more difficult than in the case of the bivalve, but it does not decrease in calibre.

The usual bowls, lotions, and swabs, both on sticks and without, must be at hand. Also a cut dressing of moist gauze or lint spread with ointment to go under the shield of the tube, and pads of gauze, which will be wrung out in hot sterilised water or lotion, to cover the orifice of the tube; these, when applied, must be constantly changed.

When the operation is over, the patient must be

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