

incision had to be made to the ensiform cartilage to lift out the abdominal portion; and, secondly, because the pelvic part of the growth had burrowed into both broad ligaments, and had also to be dissected out from firm adhesions on the floor of the pelvis. However, she recovered perfectly from the operation, and the stitches were removed on the eighth day. Two days afterwards she suddenly died, and at the *post-mortem* it was found that, whilst the abdomen and pelvis were perfectly healthy, the heart was the subject of most extensive fatty degeneration, the thickness of the wall of the ventricle being only about that of a sheet of blotting-paper. It is a good many years ago since I pointed out the important pathological fact that fatty degeneration of the heart is caused by long-continued upward pressure on the part of abdominal tumours, and this case is an excellent illustration of the fact and of the grave mistake which, if for that reason alone, is made in postponing operations on such cases.

The second case to which I have referred was very similar in so far as the size of the fibroid tumour was concerned; but in this case the mass had grown within the last year, the patient was only forty-four years of age, and the heart's action and sounds were fairly normal. The operation was more difficult than in the former case, because the fibroid was degenerated, and there were extensive adhesions to the intestines and to the pelvic floor. This patient, however, recovered rapidly and without a single bad symptom. The modern operation of hysterectomy for the removal of fibroid tumours is so successful—the above case is the only death, for example, I have had in my last twelve months' hospital and private operative work—that the risk cannot be weighed against the detriment to the patient's health and strength involved in a steadily-growing abdominal tumour, whilst the secondary consequences on the heart produced by such tumours must be remembered, not only because of the constant possibility of syncope and sudden death occurring, but also because such degeneration so greatly lessens the patient's chances of recovery from the operation when this is finally performed.

A Progressive Step.

At the last meeting of the Chelsea Board of Guardians it was unanimously determined that in future the examinations of the nurses should be conducted by an examiner unconnected with the Infirmary. The arrangement has the support both of the Medical Superintendent (Dr. Moore) and of the Matron (Miss Barton), and is undoubtedly a step in the right direction. Ultimately, no doubt, we shall have a Central Examining Board composed of Medical Practitioners and Superintendents of Nursing, charged with both the theoretical and practical examination of nurses.

Notes on Practical Nursing.

THE DIETING OF PATIENTS.

LECTURES TO PROBATIONERS.

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XIV.—(b) DIET IN ENTERIC FEVER.

In order that you may thoroughly appreciate how important is the question of diet in cases of enteric fever, we must first briefly consider the nature of the disease, and notice its long duration.

Enteric fever is caused by certain bacteria which are supposed to find their way into the human body by means of some article of food, such as milk or water, which provides them with a vehicle for entrance into the alimentary canal.

These bacteria bring about certain morbid changes in some of the intestinal glands, causing them first to swell and then form sloughs; these, coming away, leave ulcers in the walls of the intestine, which take some time to heal. The disease is further marked by profound constitutional disturbance, the temperature rising considerably and remaining high for some time. Diarrhoea is generally present, and there is always much wasting of the body tissues.

The sloughs usually separate in the third week of the illness; sometimes when this occurs a blood-vessel may be torn open, causing hæmorrhage from the bowel. There is another complication to be feared in the third and fourth weeks when the ulcers are formed after the sloughing—one may be deep enough to perforate the intestinal wall, and this is always so much weakened, even in the most favourable cases, that any solid particle of food swallowed by the patient before the healing process has developed far enough may easily cause perforation at the ulcerated spot. This will in all probability prove fatal.

In a straightforward case of typhoid fever the temperature does not fall to normal until the third week (after the twenty-first day of the disease), and if there be any complications it may remain up for some weeks longer. During the whole of this time the patient's strength must be supported by fluid foods only, and, on account of the condition of his intestines, all liquids should be strained before administration to ensure the absence of any solid matter, however soft or minute.

As in the other acute febrile diseases, the patient should have at least three to four pints of milk in each twenty-four hours, diluted with water, soda water, barley or lime water, in the proportion of $\frac{3}{4}$ v. milk to $\frac{3}{4}$ iij. diluent, and given either warm, cold, or iced, every two hours, in $\frac{3}{4}$ viij. quantities. Soda water should not be used if there be much abdominal distension or trouble from flatus.

Drinks of plain water or barley-water should be

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