Some Points in the Nursing of Scarlet Fever.

By Knyvett Gordon, M.B.(Cantab.),
Medical Superintendent of the Manchester City Fever Hospital, Lecturer on Infectious Diseases in the University of Manchester.

There are, I think, few occasions on which both the power of observation and the manual dexterity of a nurse are so severely tested as in the treatment of the more serious infectious diseases. In them it is often only possible for the surgeon to prescribe the outlines of the treatment to be adopted, and it is on the way in which those details are, so to speak, filled in by the nurse that the progress of a case so often depends; furthermore, he is sometimes dependent on the observations of the nurse when he is not there, for the power to make an early diagnosis of an impending complication. I propose, therefore, in this paper to describe a few of the conditions met with in the course of an attack of scarlet fever, and to indicate the principles on which their treatment should be conducted.

Now, my first point is that, in a large number of cases, an ordinary attack of scarlet fever does no harm, but even sometimes good to the patient. In hospital patients, the occurrence of this disease means that the child has six weeks of rest and good food, and, sometimes, the absence of contact with the paternal boot or the maternal tongue is also beneficial. Moreover, the child has a lesson in personal hygiene that is often of lasting benefit to itself, and sometimes even to its home also. In the average case, the patient feels quite well in a week or ten days, and the remainder of the time in hospital is spent in comparative happiness. An additional advantage is that an attack of scarlet fever in childhood usually protects from that disease later on in life, when the illness is more commonly a serious one.

It is the complications that matter, and it is to the intelligence of the nurse that we look for their prevention, and to her dexterity for their treatment when they do occur.

What are these complications that matter? Roughly, they are four in number—nephritis, otitis, endocarditis, and pyæmia. All these are to a great extent preventable, and all may be fatal; the first two test the dexterity of a nurse, the last two her powers of observation.

Let us take nephritis, or inflammation of the kidneys. I want, to begin with, to point out that this disease is not the same as an ordinary inflammation of the kidney from cold, or Bright's disease. In fact, it bears no relation to it, inasmuch as a different part of the kidney is affected, and the symptoms are different. The peculiarity of scarlatinal nephritis is that in the large majority of cases, unless death occurs, the patient recovers completely without any weakness of the kidney, such as so often follows Bright's disease. The reason of this is that it has a different cause, being, in fact, an infection of the kidney with germs, which are themselves derived, in all probability, from the throat in the acute stage; moreover, a different part of the kidney is affected by the inflammation that results from this infection. We aim, then, at preventing its occurrence by a careful cleansing of the throat when a patient is first taken ill.

Now, in this cleansing there are two essentials: firstly, that it shall be thorough—that all germs that are lying loose in the throat shall be taken away (not killed, by the bye, for it is not possible to use a lotion that is strong enough to do that with safety to the patient); and, secondly, that no fresh infection shall be introduced in the process of treatment.

To ensure thoroughness, it is essential that all parts of the throat, nose, and of the space between the nose and throat shall be flushed with a large quantity of whatever mild antiseptic may be preferred. In practice, I usually use a weak solution of "Sanitas" made alkaline with bicarbonate of soda, but the kind of antiseptic is not so important as the way in which it is used. It is also necessary that very little force or pressure of fluid shall be used, and that the patient should be able to breathe freely during the operation. The method is somewhat as follows:—

The patient, rolled up in a sheet if necessary, is placed across the bed on his stomach, and the nurse sits beside him, steadying the back and head with elbow and left hand. The head hangs freely over the edge of the bed, and a basin supported on a small stool is ready underneath. The lotion is then introduced from a douche-can, placed at a height of not more than 2 ft. above the patient's mouth, through a bone nozzle, the flow being regulated by a small clip on the tube from the douche-can. The nose is douched first, care being taken that the patient's mouth is wide open, and the flow is continued for about half a minute after the solution has returned quite clear. If there is no obstruction, the stream should flow out of the other nostril, but, often, the naso-pharynx is blocked by adenoids which may require to be removed by the surgeon. As in this position the head is lower than the neck, the fluid does not go down the windpipe, provided that the stream is only allowed to run while the patient is breathing comfortably, and is stopped whenever he holds his breath or coughs.

In order to prevent the introduction of other germs during the process, it is essential that a douche, and not a syringe of any kind, shall be employed, and that a separate sterilised nozzle shall be used for each patient. With all syringes, it is possible for infective matter that has lodged on the nozzle to be sucked back into the instrument when it is refilled; moreover, all syringes are either difficult to sterilise or awkward to use for the cleansing of throats, and the flow varies in force. Then the

previous page next page