A Series of Lectures to Ward Sisters.

THE ASEPTIC TREATMENT OF WOUNDS.

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In previous lectures I have purposely omitted the details of the aseptic treatment of wounds, etc., in wards, as these details are familiar to the Sisters at Monsall Hospital, to whom the lectures were in the first place addressed. It may be as well, however, to describe the technique of the Monsall routine for the information of others who may happen to have read the previous lectures.

In the first place, it is essential to remember that the term "surgical" is not confined to cases where an actual wound exists. For practical purposes all mucous membranes may be regarded as wounds, because bacteria may grow as well on these mucous surfaces as on broken skin; and their products be absorbed and give rise to the various kinds of poisoning that I have previously described: in other words, the cleansing of a throat of a patient suffering from a "medical" disease should be conducted at least as carefully as the dressing of an open wound. In private practice we have only the one particular patient to consider, unless there is more than one ill in the house at the time; but even then we have to take every possible precaution to prevent dirt from the patient's surroundings getting into the wound or on one of his mucous surfaces. Still, the surrounding dirt in any hospital is likely to be much more virulent than that in a private house. In theory, then, the cleansing of a throat should be a surgical operation, and the preparations for it should be as complete as it is possible for us to make them. It is obvious, however, that if some ten or twelve throats have to be cleansed at the same time in a hospital ward, it would require a far larger staff than any hospital authorities would be likely to provide us with to treat each process as a separate operation. There must be, then, a compromise, but it must be one well within the margin of safety.

The first point is to make sure that we are not introducing germs or other products into the patient in the course of treatment. That is to say, not only must every instrument we may use be clean, but we must use as few as possible. For this purpose we must discard anything that cannot be sterilised and kept sterile; any Higginson's or rubber-ball syringe must be tabooed entirely. In fact, I should like to see all these banished altogether from the wards of every hospital; at the most, they should be used only for rectal injections.

The only instrument that can be sterilised and kept sterile is a douche-can and tubing, the inside of which cannot possibly become infected. To the end of the tubing is fitted a separate recently-boiled nozzle for each patient.

Then it must be recognised that the hands of the nurses become freely contaminated at every operation. Here, again, it is manifestly impossible for these hands to be completely sterilised for each patient. In the first place, antiseptics applied to the skin do not completely sterilise it, and, in the second place, they would soon render even the toughest skin rough, and, therefore, the reverse of clean. I do not personally like any antiseptic to be used for the cleansing of hands as a matter of routine. I admit that there are certain occasions on which the use of a strong disinfectant, such as izal, would appear to be necessary, but for all practical purposes a thorough and prolonged scrubbing with soap and hot water, followed by the rubbing of the hands, especially the finger tips, with a cotton swab dipped in turpentine, and then similar friction with methylated spirit, not only renders the hands as sterile as it is possible in practice to make them, but does not in itself ruin the skin. On the sterilised hands is placed a pair of fairly thick black rubber gloves which have been recently boiled and taken out of the sterilised water or, what is more convenient in practice, boracic lotion. These gloves cost about 4s. 6d. a pair (retail price), and it is an economy to secure the best that are made. The cheaper white so-called "protection" gloves should be avoided for surgical purposes, though they are very useful for covering the hands of the nurses in handling bed-clothes, bed-pans, etc. in enteric wards.

What we aim at in cleansing a throat is to flood the mucous membranes with a large quantity of water or some mild antiseptic—in practice, after prolonged trials, I prefer ordinary tap water for this purpose. The douche-can should be at a height of not more than two feet above the head of the patient, and should contain at least three pints, all of which should be used for one patient.

The next point is the position of the patient, and here it is important to remember that he will require to breathe freely during the operation. Consequently, he must be placed on his face, with the head hanging over the edge of the bed and the fluid injected upwards. In this position the larynx is higher than the nozzle of the douche. The nose should be irrigated first with the mouth wide open, the