Septic Peritonitis—Chiefly from the Nursing Point of View.

By A. Knyvett Gordon, M.B., Cantab.,

Medical Superintendent, Monsall Hospital, Lecturer on Infectious Diseases in the University of Manchester.

During the last few years only, owing to the work of certain bacteriologists, our views on the subject of the disease known as septic peritonitis have undergone some modifications, and the success, or otherwise, of the treatment of any particular case depends so largely upon the nursing that I propose to describe briefly those aspects of the disease which are important from the point of view of treatment.

It will be first necessary, however, to say something about the nature of the complaint itself.

It is, in the first place, a definite infection which does not "come of itself": in other words, before septic peritonitis can arise it is necessary that organisms—germs of some sort or other—shall be introduced into the peritoneal cavity from without. The peritoneum, as most of you know, is the membrane which lines the abdominal cavity, and covers the digestive tube (stomach and intestines): its numerous surfaces are normally in contact, being separated by only just sufficient fluid to enable the parts to slide smoothly on each other as they move about during the process of digestion. If it is a cavity at all, it is an empty cavity: there is no communication anywhere between it and the inside of the digestive tube. Similarly, the organs of generation, and the bladder, liver, kidneys, and spleen are outside the peritoneal sac.

Now the whole of the digestive tube contains, or may contain, organisms of various kinds, and the vagina in females is seldom sterile, though the uterus is. If once, therefore, a communication be established between the organs inside the peritoneal cavity and the cavity itself, germs are introduced and inflammation occurs, which, in the case of the peritoneal cavity, very soon goes on to suppuration, and the whole sac soon becomes a bag distended with pus. If this pus is not let out, death *always* occurs. There is, so far as I know, no authenticated case in which recovery from general purulent peritonitis has taken place without the intervention of surgery. If, however, the pus be evacuated by incision and drainage, recovery very frequently results. There is no half-way: no amount of medicine or "supporting of the patient's strength" is of any avail unless an opening be made by the knife.

To go a little more into detail: infection of the peritoneal cavity may occur from a perforation in any part of the digestive tube: perhaps the commonest source of infection is the appendix. Attacks of appendicitis are often not easy to detect, and the inflammation may soon go on to perforation of the tip of the appendix, with the result that the contents of the large intestine—containing bacilli of all kinds—escape into the peritoneal cavity. Other common sources are perforation of ulcers in the stomach following gastritis, especially in anæmic girls who live on the "nourishing food" of sweets and stewed tea; or of intestinal ulcers in typhoid fever. Sometimes an ulcerated gall bladder bursts into the peritoneal cavity.

Whenever a perforation of any sort occurs a violent inflammation arises *at the spot*, and the whole may be sealed up by the adhesion of surrounding coils of intestine or by patches of lymph before infection of the general peritoneal cavity has occurred. This sealing-up occurs most commonly in perforations of the appendix, and least frequently in those of the small intestine.

Another source of peritonitis is the uterus in cases of puerperal septicæmia, where pus escapes from its interior into the peritoneal cavity along the fallopian tubes. Sometimes the germs are introduced altogether from without, as when peritonitis follows the opening of the abdomen for the relief of other conditions, such as intestinal obstruction. This, however, is due to imperfections in the performance of the operation, such as improper sterilisation of hands, instruments, and sponges, and should never occur.

So much for the pathology of the condition. We must now see what happens to the patient when the peritoneum becomes infected.

Firstly, there may be—and usually is—abdominal pain. I purposely say nothing about the situation or character of this, because I want you to remember that in a patient who may be likely to have his peritoneal cavity infected, any sort of abdominal pain must be regarded with suspicion: nor is the pain *always* sudden and severe, though it may be both. It may be quite gradual in onset, and, especially if the patient has previously been taking opium, almost unnoticed, but it persists—it does not pass off, as an attack of colic almost always does.

Then there is (I believe invariably) a change of some sort in the aspect of the patient: he *looks* worse, though he may say that he *feels* better. This is a most important point, and one which, as you will see, depends entirely on the powers of observation of the nurse for its detection.

previous page next page