

back into the abdomen and causes obstruction to the onflow of its contents. The mesentery is gripped, and the blood supply is so interfered with that it cannot nourish the bowel, which becomes congested, and its vitality is endangered. Under these circumstances the object of the operation is to save the patient's life by relieving the obstruction of the bowels; the cure of the hernia, as such, is quite a secondary consideration. After the strangulation has been relieved, and the damaged bowel dealt with, the treatment, from the nursing point of view, is quite different from that of a case of radical cure. We have to deal with a piece of bowel which may be paralysed. If so, there will be an accumulation of flatus and faeces above the constricted loop, with pain and rigidity of the abdominal wall. There will be stagnation of the bowel contents, the organisms may get through into the peritoneal cavity and set up peritonitis. On the other hand, the bowel may gradually regain its power of propelling its contents, and, although it has had its vitality depressed, no organisms pass through its walls, and so peritonitis is avoided. Should we hasten motion of the bowel? Formerly it was the practice to keep the bowels closed for eight or ten days, but now the usual treatment is to make the bowels move as soon as possible, as, if the replaced bowel is going to get better at all, it will do so very soon. If possible, we endeavour to get the bowels to move within twenty-four hours. An enema, with turpentine, may be given twelve or fourteen hours after the operation, and a dose of castor oil within twenty-four hours. For this purpose we have found castor oil better than either calomel or salts. After getting the bowels to move, and getting rid of the flatus, then the treatment is much the same as for radical cure. For some days the patient should only have fluids, to prevent the formation of solid faeces, and so to favour the complete recovery of the damaged loop of bowel.

Appendicitis.—This common condition is an inflammation of the vermiform appendix—a short, narrow, *cul-de-sac* of bowel attached to the caecum or blind end of the large intestine. There are two conditions under which we operate for appendicitis:—(1) In recurrent cases, the operation being done in an interval between two attacks; and (2) during an acute attack, accompanied either by abscess formation or by diffuse peritonitis.

(1) In *recurrent appendicitis*, we choose an interval between two attacks for operation, as then the appendix and the adjacent bowel and the peritoneum are normal. The abdomen is

opened, the appendix found and removed, and the stump is sealed by stitching the peritoneum over it. When this has been done, the bowel is left as sound for all practical purposes as it was before. If properly stitched, there should be no leakage, and no risk of peritonitis. The abdomen is then closed, without drainage, as the peritoneum can absorb and dispose of any effusion that may take place as a result of the manipulations. The progress should be as uneventful as after a radical cure for hernia, and the after-treatment should be on the same lines. With ordinary care to avoid sepsis, the possibility of infection is extremely slight. In performing the operation, it is an advantage to have the foot of the table slightly raised, to bring the caecum and the appendix out of the pelvis and within reach of the abdominal wound. In private practice the nurse should have some means of raising the foot of the table ready, for example, some thick books, such as bound volumes of magazines, etc. The bowels should be opened in two days. The patient should lie up for about three weeks to avoid stretching of the scar. The patient may be put upon convalescent diet within a few days of the operation. He should wear a supporting bandage for a week or two longer, but, except in the case of stout females, no permanent belt is necessary.

(2) *Acute appendicitis, with localised abscess*, is a very different state of affairs, as peritonitis is present. The abscess may be looked upon as a partially successful attempt on the part of the peritoneum to overcome the infection. Nature has been trying to check this inflammation and limit its spread. The *staphylococcus albus* has come out and set up phagocytosis and plastic inflammation. The intestine and omentum round about get matted by adhesions and prevent the inflammation from spreading further. There is, however, a certain mortality among the phagocytes and the organisms, and these dead cells are represented by the pus, which constitutes an abscess, in the midst of which lies the appendix, inflamed, perforated, or perhaps even gangrenous. As there is danger of the abscess spreading in the peritoneum and causing further septic absorption, the abdomen is opened to let out the pus and to admit of drainage being established. As a rule, the appendix is removed at the same time. There are many methods for draining such an abscess cavity; of these, perhaps, Keith's tubes are the best. It is an advantage to pass a wick of iodoform worsted into the glass tube. Sterilised, or iodoform worsted, wrapped up in green protective, to form a "cigarette" drain, is often employed.

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