Clinical Notes on Some Common Ailments.

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

(*Concluded from page* 204.)

When inflammation attacks the respiratory organs, the signs vary according to its extent and its intensity, an intense affection being not necessarily extensive, nor an extensive lesion intense. Thus, when the nose only is affected, we have at first the feeling of heat and pain, with swelling of the lining membrane, and when the secretion commences, there is a running from the nose—in fact, a common cold. When the inflammation spreads lower down (which, of course, does not always happen), and the bronchi are involved, we get bronchitis, and if there is a further extension to the alveoli, we have pneumonia or inflammation of the lungs. We need not now consider the common cold, but we will dwell a little, firstly on bronchitis, and in the next paper pneumonia will be dealt with.

Bronchitis practically always begins with a cold in the head, and the first sign that this has extended downwards is to be found in the presence of a cough, which is nothing more or less than a forcible expiration with the larynx, or voice box, closed, and its object is to expel secretion from the bronchial tubes, where it would otherwise lodge.

At first this cough is frequent and shallow, or tickling, as we say, but later on, as the secretion becomes more profuse, it is easier and deeper, and accompanied by the ejection of the secretion, which in children is swallowed and in adults spat out. If the attack is very acute, and especially in children, there may be a slight rise of temperature at first.

So long as the inflammation is confined to the larger tubes we have nothing more serious than the discomfort engendered by the coughing, and the act of breathing is not interfered with, because there is plenty of room in the large tubes both for air and secretion, but if the inflammation extends to the smaller tubes, we have a different state of things altogether, because there is no longer room for both air and secretion, so that if the latter is not expelled, air cannot pass through the small tubes into the alveoli, and the patient dies of suffocation, being in fact drowned in his own secretions. However uncomfortable, therefore, the cough may be, we must look upon its presence as an advantage, and the more vigorous it is, within limits, the happier the nurse should feel about the safety of her patient.

The first sign of danger, then, is to be found in the diminution in the force of the cough, and this is soon followed by the next sign—namely, cyanosis, or blueness of the lips and ears, which is obviously due to the fact that the blood is not getting its proper supply of oxygen. Along with this, we have extreme distress as the patient tries to force air into his lungs by using all the muscles of his chest and neck. He is restless, and cannot lie down, but has to be propped up in bed with pillows. At this stage the patient may either die from an insufficient supply of air, or his strength may hold out until the inflammation begins to abate, and he then coughs up large quantities of secretion and recovers. If he dies, he succumbs painlessly and apparently sleeps, and the relatives will think that he is getting better, but so long as the lips are blue, the sleep must be regarded as a sign of danger, not of hope.

On listening to the chest, preferably behind over the lowest part of the lungs, we can hear (usually without a stethescope) two kinds of abnormal sounds with each respiration; these are rhonchi, or snoring sounds, which are due to the air passing through tubes that are narrowed by inflammation, and râles, or bubbling sounds, which are caused by the air making its way through the fluid secretion in the smaller tubes.

The outlook is determined mainly by two factors—the presence or absence of cyanosis and the extent to which the patient's strength is being maintained, this latter being estimated roughly by the force of the cough and the rapidity of the pulse—quickening of the pulse being a sign of danger—and more accurately by the careful examination of the heart, which is always made by the physician. Babies and old people bear bronchitis badly.

The treatment of an attack of bronchitis resolves itself into attending to the following points:—Firstly, in the beginning, when the tubes are hot and painful, we have to soothe the lining membrane and encourage it to secrete. The best way to do this is to let the patient breathe air saturated with steam, which is perhaps the most comforting thing we can give. In adults this can be effected by means of an inhaler (which can easily be extemporised from a jug of boiling water and a folded towel), because by this way the steam is confined to the patient's lungs, and does not also saturate his clothing and the walls of the room. As a general rule, therefore, unless a patient can be taught to use an inhaler—and even small children usually can if they are encouraged to think of it as a game and not as an invention of the man with the black bag—it is best not to use steam at all, except in the case of babies with bad attacks, when we have

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