Clinical Notes on Some Common Ailments.

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ENTERIC FEVER.

(Continued.)

We now come to the complications of enteric fever. These are rather numerous and embrace affections of almost every part of the body, but the majority are in the nature of clinical curiosities, and only three need be considered as of practical importance. The interesting feature of all of them is that the diagnosis has to be made by the nurse, as they all occur rather suddenly. Moreover, for any treatment to be of avail, prompt measures must be taken, so I will consider each in detail. They are three in number—namely, heart failure, hæmorrhage from the bowel and perforation of the intestine.

Heart failure may, of course, be gradual, in which case it will be detected by the physician and dealt with accordingly, but in enteric fever we also get a variety of cardiac distress which is almost dramatic in its onset and in its results. It is due to sudden and extreme dilatation or stretching of the right side of the heart. Its onset cannot be foretold, and it may occur in those whose illness has not been very severe, though it is certainly uncommon in children.

The exact pathology of the occurrence is not very clear; it may be due to poisoning of the heart muscle, or to a sudden block in the transmission of nervous impulses to the heart, but whatever the cause the symptoms are the same.

Sometimes the patient feels the attack coming on, and cries out that he is dying, or feels as if he were falling through the floor, or he is dizzy and cannot see. More often, however, he does not give us any warning, and the first sign then is a sudden pallor of the face, and the patient falls down in bed if he was previously sitting up. When we feel for the radial pulse we generally find it imperceptible, though there may be a faint flicker in the carotids. If now we examine the chest we cannot feel the cardiac impulse at all, and on percussion we find that the left edge of the left ventricle, instead of being situated in, or just outside, the nipple line, is three fingers breadths outside it.

In very many instances the attack is immediately fatal, but the patient's life can often be saved by promptness on the part of those present at the time. The treatment consists first of all in completely inverting the patient. He must be seized by the legs by the nurse (who should jump on the bed for the purpose), and turned as completely as possible upside down. If another person, such as a ward maid or a convalescent patient, is available, he or she should continue to hold the patient suspended by the legs while the nurse places a hot wet sponge or towel on the bare chest over the cardiac area, and keep up these applications until the patient recovers consciousness. Later on, a hypodermic injection of strychnine is often useful, though neither this nor any other form of drug treatment is of any avail as a measure of first aid. Valuable time is often lost either by attempts to pour brandy into the mouth (whence, incidentally, it often trickles down the larynx), or by giving hypodermic injections when the patient has practically no circulation at all. It may be as well to mention that the same variety of heart failure is apt to occur in diphtheria and in influenza, and should then be treated in the same way.

The next complication that we have to consider is hæmorrhage from the bowel, and of this there are two varieties. In the first the blood oozes from the surface of one or more ulcers and is not necessarily of grave significance, while in the other the hæmorrhage is due to an ulcer having eaten its way into a deep blood vessel, and this is always a serious matter. In the former case we simply find blood in the stools without any symptoms or signs in the patient, but in the latter we get danger signals, which are followed by the appearance of a considerable quantity of blood per rectum.

The first of these signals is sudden collapse, with acute pain and pallor of the face. The patient breaks out into a cold perspiration and practically faints; the abdomen is temporarily rigid, and the knees are usually drawn up. From a few minutes to half-an-hour afterwards the bed is found to be full of blood.

Now it will be noticed that all these signs, with the exception of the passage of the blood per anum, are identical with those which are given in the text books as being due to perforation, and in practice, until we find the blood, we cannot always be sure which of the two has occurred. But the point that I wish to make very emphatically—for its realisation by the nurse has saved many lives—is that perforation is not always sudden in onset, or accompanied by collapse. It will be convenient to take now the symptoms of perforation, and to consider the treatment of both later on.

What happens in perforation is that an ulcer goes still deeper than the layer where the blood vessels are, and a hole is formed right through the bowel itself, so that the contents of the intestine find their way into the general

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