

backed up by proper knowledge, is what the doctor looks for and what he has a right to expect.

First, then, remember that the tonsils are two glands, like lymphatics, situated at the sides of the throat and buried between two folds of mucous membrane known as the anterior and posterior pillars. The free surface, which is toward the mouth, shows little openings called follicles; the buried surface is covered with a compact membrane called the capsule. The whole tonsil, after it has been freed from the pillars, can be shelled out from its bed, like a pea from a pod. There are numerous small arteries and veins supplying the tonsil which pierce through the capsule and ramify in the substance of the tonsil. As a usual thing, when the operation is nearly done and the capsule is not torn, there is some hæmorrhage at the time of the operation, but the small blood vessels rapidly contract into the muscular tissue at the back of the tonsil, so that when the patient leaves the table the bleeding has completely ceased, although no vessels have either been tied or ligated. During the operation the patient loses at the most about a teaspoonful of blood, and this is generally swallowed. This amount varies within wide limits, depending on the skill of the operator and the method of doing the operation. If this amount of swallowed blood were all, there would be no difficulty in recognizing a hæmorrhage. In the vast majority of cases, however, immediately at the conclusion of the tonsil part of the operation, the adenoids are removed with a sharp curette or forceps. Following this procedure there is a sudden hæmorrhage which exceeds by tenfold the amount lost by the tonsil operation. The blood is sponged out of the mouth, but, in spite of the utmost care, a considerable amount is swallowed.

If now the patient vomits blood after leaving the table, as he is recovering from the anæsthetic, there are two points to decide: First, does the blood come from the tonsils or from the adenoids? Second, is the child vomiting blood swallowed at the time of the operation or from a fresh hæmorrhage? This is a most important question for the nurse to decide, and experience has taught me that we can be governed by an empirical rule in most cases which will solve the question and still be on the safe side. When the patient vomits the first time after an anæsthetic and the vomitus contains a large quantity of dark blood, the blood has almost invariably been swallowed during the operation, oxidized in the stomach, and so

become dark. At any rate, it is not yet the nurse's duty, under these conditions, either to examine the throat herself or to send for the doctor. It often happens that the first vomiting will be followed by a second one almost equal in quantity and colour. If, however, this occurs a *third time* and the blood becomes a little lighter in colour, it is time to investigate thoroughly, for a hæmorrhage is taking place.

Of course, accompanying this bleeding other signs of hæmorrhage are to be looked for. If the patient is thoroughly awake he will be alarmed, complain of a faint feeling, and a look of anxiety will spread over his face; the lobes of the ears will begin to lose colour, and the whole face and inside of the eyelids will begin to pale. The most characteristic sign is a yellowish colour. The pulse will begin to run up above 100 and weaken in volume, and the patient may complain of feeling chilly. If the patient is a child and has been deeply narcotized, the blood from the bleeding point may all be swallowed while the patient sleeps. The nurse will suddenly find that the little one is pale, has a yellowish colour, and suddenly vomits large quantities of blood.

The first thing to do in all cases is to get the attending physician. Under no consideration whatever delay for his arrival. Call the house physician at once. Never let the attending physician leave without finding out where he can be reached by 'phone at all hours of the day and night. Attention to this matter will save many anxious moments.

Having determined that a hæmorrhage is present, immediately prepare the following instruments: A (1) Extension light; (2) head mirror; (3) small gauze sponges; (4) sponge holding forceps; (5) tongue depressor; (6) long Kelly hemostatic forceps. Unless special solutions have already been ordered, have ready: B (1) Adrenalin solution; (2) peroxide of hydrogen; (3) 10 per cent. nitrate of silver; (4) ice chips. C. Have everything in readiness for an anæsthetic, as the usual custom now is to take the patient back to the operating room, administer an anæsthetic and sew the pillars.

These directions have all been preliminary to the stopping of *severe* hæmorrhage, as yet the nurse has done nothing herself in the way of stopping the bleeding. Before going, however, into these details let us give directions as to what the nurse can do in the lighter cases where she suspects some slight bleeding, but does not feel called upon to make an examination of the inside of the mouth.

The routine which I follow in all cases, whether bleeding is suspected or not, is as fol-

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