normal. In a comparatively small number of cases, although the pulse-rate remains below 90, the evening rise of temperature may persist for one or two weeks, although the wounds when dressed appear clean and free from retained pus.

The pulse-rate and general condition of the patient is a much better index of the well-being of the wound than the temperature.

After a few days the outer dressings may acquire a very offensive odour. This is due to decomposition in the dressings themselves, and if they are removed the wound is found to be perfectly sweet. The outer dressings are more offensive than the inner. At one time we changed the outer dressings when they began to smell, leaving the packing in the wound untouched. The objection to this is that it is difficult to change the outer dressings without disturbing the deep pack. We then used various substances, such as Sanitas powder, potassium permanganate, and cupad powder, thickly dusted on the dressing immediately beneath the outermost layer of gauze. All these diminish the odour. With Dakin's chloramine-T powder, which we are now using, all odour is practically abolished. Mixing chloramine-T tablets with the salt tablets in the deeper dressing was found to be unsatisfactory, as it did not prevent the smell.

Indications for Changing the Pack.

Indications that the wound is not doing well, and that the pack must be changed are :—

(1) A continuously rising pulse-rate.

(2) Increasing œdema in the limb.

(3) Sudden onset of severe pain. This generally means spreading gas infection.

(4) A persistent *rise* of temperature for which no other cause can be found.

(5) A change for the worse in the patient's general condition in cases in which a raised temperature has persisted from the beginning.

(6) Oozing of pus from under the edge of the dressing. This is generally due either to the dressing having been left unchanged too long, or having been too loosely applied.

(7) The dressing must be re-applied when the pack has become loose from diminution in the circumference of the limb as œdema disappears.

Some Other Details.

Where the innermost layer of gauze is found to be firmly adherent to the wound surface, it is not removed, but a new pack is applied within it. If it is removed, bleeding is caused, the protective barrier is broken down, and a rise of temperature takes place.

When once the wound is granulating healthily it is not advisable to continue the salt pack, as the granulations become exuberant, pale, and œdematous. If the wound cannot be closed, any of the simple dressings should be applied.

Occasionally a wound becomes sluggish, even during the separation of sloughs. A change from the salt pack to a dressing of gauze soaked in pure glycerine usually causes a rapid change for the better. Where a wound is not doing well with a salt pack, and a pure streptococcal infection is present, the use of a 1 per cent. salt solution as a wet dressing, continuous irrigation, or bath, will sometimes be found to effect an improvement.

Conclusions.

The salt pack has given very good results with flush amputations and in excised joints. It appears to be of great value in field ambulances and clearing stations, as in time of stress it may be impossible to renew dressings for two or three days. Those cases we have received from clearing stations in which the treatment has been thoroughly carried out have arrived in excellent condition, and contrast very favourably with those treated by other methods. Cases treated by eusol irrigation, however clean they may be when leaving the clearing station, often have their wounds in an unsatisfactory state on arrival at the base twenty-four hours later.

Our advocacy of this method of treating wounds is based entirely on our clinical experience, and we do not in this place advance any theories to explain its action. It is based originally on the well-known work of Sir Almroth Wright.

The *Indian Medical Gazette* says that after a cataract extraction, in order to produce an even pressure over the front of the eyeball swabs of wet, sterilized wool are used. The wool is pulled, not cut, into pads about an inch thick and three inches in diameter. These are sterilized by boiling in 1 in 5,000 biniodid solution. Two of these, sopping wet, are laid on the eyes; with the straightened fingers they are gently pressed down over the eyes, so that the swab becomes moulded to the eye and fills in the hollows around it. Over this is placed a wet pad of lint, or six layers of gauze; then a figure of eight bandage is applied fairly firmly. Next day the wool and gauze will be found to form a complete mould of the eyeball and orbital opening. It is very comfortable, produces no feeling of uneven pressure, while it allows the eye to move easily, and renders it almost impossible to open the eyes.

previous page next page