OUR PRIZE COMPETITION.

STATE WHAT YOU KNOW OF THE CARE OF PATIENTS SUFFERING FROM A CEREBRAL TUMOUR.

We have pleasure in awarding the prize this week to Miss Thomasina F. Donald, Royal Infirmary, Glasgow.

PRIZE PAPER.

Tumours of the brain may be classified thus :

(1) Infective granulomata-tubercle, gummata, actinomyces;

(2) Neoplasmas, sarcoma, glioma, carcinoma, and benign tumours;

(3) Cysts.

Symptoms:—

(1) *Headache* may be diffuse and of a dull aching character, but is more often acute, stabbing, persistent, and localised, with tenderness over seat of tumour.

(2) *Vertigo* is marked, especially when the tumour affects the cerebellar region.

(3) *Vomiting* is most common when the cerebellum is affected. It is of a persistent character, often painless, and sometimes occurs whether food is taken or not.

(4) *Double optic neuritis,* followed by optic atrophy.

(5) *Mental disturbance* is sometimes absent, but the patient is often in first stages highly emotional, and later dull and apathetic.

(6) *Irritation or destruction* of the affected part of brain, the former leading to convulsions, paræthesiæ, and subjective sense impressions; the latter to paralysis, anæsthesia, and defect of special sensation.

Treatment may be medical or surgical.

Trephining is often done for the relief of pressure, and the tumour if possible is removed, though extirpation can be carried out only in a small percentage of cases.

Lumbar puncture is sometimes performed, so that some of the normal cerebro-spinal fluid is taken away, thus relieving pressure.

Patient may be conscious, sub-conscious, semi-conscious, or unconscious.

Position in bed.—Patient should lie flat on water bed without pillow in a darkened, quiet, and well-ventilated side room. The head should be shaved completely, and icebag applied.

Eyes should be bathed with solution of boracic, and pads of lint (sewn to a piece of tape) similar to and bigger than shape of eyes, should be applied to keep out dust, flies, &c.

Mouth should be washed out frequently with glycothymoline, hydrogen-peroxide, or borax and glycerine.

Nourishment should consist of fluids only. If unconscious, patient may be fed by means of nutrient enemata, or by means of nasal feeding. Fluid should be peptonised, and given very slowly. Nourishment may consist of milk only, or milk and white of egg, meat extracts, or concentrated soups, each having a teaspoonful of glucose added.

Temperature should be recorded four-hourly; there is usually hyper-pyrexia.

Pulse in cerebral tumour usually slow, full, and strong, or weak, slow, and intermittent.

Respiration generally varies with degree of unconsciousness. Cheyne-Stokes is a particular variety of breathing associated with head cases.

Special attention should be paid to (1) pupils, what condition they are in; if unequal, contracted, or dilated, &c.; (2) epilepsy should be watched for; note should be taken how and where fit started, which muscle or group of muscles the twitching affected; (3) paralysis should be reported; (4) cerebral vomiting should be noted. By this means the surgeon will be able to settle site of tumour, for it is during his absence those things nearly always affect patient.

Bladder.—Strict attention must be paid to bladder, either for incontinence or retention of urine. When patients are not conscious, and have no sense of feeling, or have paralysis, they are unable to ask or to know when the bladder needs emptying. The bladder may rupture when too full, and often a constant dribbling may mean an overflow. Therefore patient should have catheter passed every eight hours if in this condition, and the greatest possible care should be taken that everything is thoroughly sterile, thereby avoiding cystitis.

Bowels should be kept regular in all head cases. Croton oil may be given on butter, if patient is unable to swallow, or calomel, gr. v, and jalap 60, followed by mag. sulph. eight hours afterwards (under medical direction), or patient may have saline wash-out (3 pints) night and morning. Head cases have the habit of retaining enemata, and the saline retained will do patient good.

Patient's back should be kept clean by treatment with soap and water. Some emollient ointment should be well rubbed and massaged in. The position of patient should be changed, and sheet drawn every two hours if possible, so that pressure is not always on one part of back. A pillow may be put in at back to keep patient a little to one side. By this means bedsores and the feeling of hot irritating skin is prevented, and the stagnation of blood at bottom of lungs is avoided, and the consequent risk of pneumonia.

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