OUR PRIZE COMPETITION.

DESCRIBE THE NURSING OF A CASE AFTER THE EXCISION OF THE TONGUE.

We have pleasure in awarding the prize this week to Miss W. M. Appleton, University College Hospital, Gower Street, W.C.1.

PRIZE PAPER.

Excision of the tongue is an operation usually done where there is malignant disease. The after treatment requires constant alert attention on the part of the nurse.

The chief points to be considered are:—Position, hæmorrhage, asphyxia, feeding, sepsis, and respiratory complications.

Position.—Patient must be well propped up in bed; turning the head to one side allows blood and mucus to escape from the mouth more freely. Some surgeons prefer this position immediately upon return from the operating theatre, even while returning on the trolley; others prefer a recumbent position until the post-anæsthetic effects have passed off. If part of the tongue has been removed, or where there is a stump liable to fall back and obstruct respiration, the surgeon leaves a strong silk suture attached to the base of the tongue so that it may be drawn forward and held if necessary.

If tracheotomy is done before the main operation, the surgeon usually removes the tube just before the patient regains consciousness, and a small dressing is applied. Should the tube be left in, the nurse must keep it clean and clear, and have at hand the usual sterilised requisites for nursing tracheotomy, and watch for expulsion of the tube and signs of dyspnœa. A nurse must be cool and resourceful, and reassure the patient, bearing in mind that delay in performing a necessary attention may be fatal and by forfeiting the confidence of her patient she makes it harder to do difficult duties.

After this operation there is liability for severe hæmorrhage, either recurrent within a few hours of operation, or secondary even when patient appears to be making favourable progress. An important artery may not have been tied, a ligature may have slipped, or septic ulceration may have eroded a blood-vessel.

To control the hæmorrhage until a surgeon arrives, draw the stump of the tongue firmly forward, hold the head well forward to prevent blood trickling back into trachea or gullet. Both lingual arteries may be involved, and prompt and temporary arrest may be obtained by passing forefinger down to the epiglottis and hyoid bone and drawing the base of the tongue upwards towards the chin.

Most of the causes of asphyxia are met by keeping the patient in a correct position and drawing the thread attached to the stump of the tongue. The possibility of tracheotomy having to be performed at short notice must be borne in mind, and necessary preparations made in case of such an emergency. Rectal feeding is usually ordered for first few days. A saline is usually given upon return from the theatre and many surgeons prefer glucose saline ʒ viii. to x. every four to six hours to nutrient enemata.

After forty-eight hours, œsophageal or nasal feeding, or by means of a spouted feeder with rubber tubing attached. The mouth can be frequently and effectively cleaned by means of syringing with diluted peroxide of hydrogen or weak boric solution. Food must not come in contact with area of wound because healing is delayed, also food is contaminated with discharges. Blood is liable to trickle into the larynx, and owing to damage to the upper part of the pharynx patient has great difficulty in swallowing. All feeding apparatus must be well washed and boiled, the mouth should be syringed before and after feeding and redressed. Wounds inside the mouth heal by granulation with discharge of pus and are not aseptic, but careful hygiene and antiseptic methods limit the septic process and forward recovery, therefore the mouth must be frequently and carefully washed out by the antiseptic lotion ordered by surgeon. In doing this keep the head forward and the lotion readily runs out of the mouth and not back to the throat.

Septic bronchitis or pneumonia due to septic inhalation are liable to occur, and should be treated on general principles.

As the mouth heals, soft food is given; the liquid diet should be nourishing—every two hours if by feeder, and four if œsophageal feeding. An aperient is usually given at end of 28—48 hours, or an anema, and bowels kept well regulated.

During first forty-eight hours mouth must also be swabbed gently and constantly.

HONOURABLE MENTION.

The following competitors receive honourable mention:—Miss Henrietta T. Inglis, Miss Alice M. Burns, Miss Y. Simmonds, Miss P. Thomson, Miss M. Matthews.

QUESTION FOR NEXT WEEK.

How would you treat: (*a*) an extensive superficial burn; (*b*) a ruptured varicose vein?

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