OUR PRIZE COMPETITION.

DESCRIBE THE PREPARATION OF THE PATIENT, AFTER TREATMENT, AND NURSING, OF A CASE OF HÆMORRHOIDS.

We have pleasure in awarding the prize this week to Miss G. E. Weeks, Northern Hospital, Winchmore Hill.

PRIZE PAPER.

Operations on the rectum present an unusual risk of septic infection, and hence great care must be taken in the preparation of these cases.

It is essential that the rectum and colon should be emptied completely before the operation, as the bowels must be confined for three or four days subsequently in order to avoid soiling the wound. Hence, owing to its astringent properties, castor oil is the best aperient in these cases, and a full dose should be administered twelve hours before the operation; soap and water enema is given two hours before the operation, and is in turn followed up by a rectal wash-out of saline or boric lotion.

It is important to see that the rectum is thoroughly emptied after the wash-out, for any residue left may be discharged from the rectum during the operation and infect the operative area. If there is any doubt as to the rectum being empty, a large-bored rectal tube should be passed just before the operation in order to ensure the discharge of any residual fluid. On the evening before the operation the parts about the anus should be shaved, well washed, and, if necessary, an antiseptic compress should be applied.

After Treatment.—Pain is often severe after rectal operation, and to alleviate this the surgeon usually introduces a half-grain morphia suppository into the rectum at the termination of the operation. On the day of the operation another small hypodermic injection of morphia may be required in addition, in order to relieve pain.

On the third or fourth day, as may be ordered by the surgeon, ℥i of castor oil; sixth day, large enema Ol Olivæ and castor oil in morning.

In the early stages, heat in the form of hot-water bottles applied to the lower part of the sacrum is often very efficacious in relieving pain.

Diet.—In order to rest the rectum, the patient is kept on a low diet until the bowels are moved, and, although it is customary to give no solid food before the third day, no harm comes from giving fish, bread, jellies, &c. Milk is inadvisable, as it tends to form hard, scybalous masses in the rectum, and in many cases gives rise to flatulence.

Until the wounds have healed, the bowels are kept acting loosely by the administration of Pil Colocynth CO gr. iv to gr. viii at night, followed by a saline draught in the morning, and constipation is to be carefully avoided.

Dressings.—The parts should be kept as dry as possible by powdering with starch and iodoform powder; and after defecation they should be washed with Lysol lotion (℥ss to the pint), carefully dried, powdered with boracic powder, and then covered with a sterile dressing.

Complications.—The nurse should try to guard against all complications, and be ever on the watch for them, such as retention of urine.

Convalescence.—The patient is usually confined to bed for a week or ten days, and at the end of a fortnight he is able to walk about.

HONOURABLE MENTION.

The following competitors receive honourable mention:—Miss E. E. Fowler, Miss Rachel Dodd, Miss M. James, and Miss P. Thomson.

QUESTION FOR NEXT WEEK.

What are the four principal causes of maternal mortality in order of importance, and how can they be prevented?

ANTI-TOXIN IN DIPHTHERIA.

The Ministry of Health, in a Memorandum issued as a White Paper, points out, in connection with the high incidence of diphtheria, that it cannot be too strongly emphasised that early administration of antitoxin not only reduces the mortality, but causes the disease to run a milder and shorter course. It further points out that the decision as to what constitutes a case of clinical diphtheria naturally rests with the individual practitioner, and bacteriological evidence may be essential for a final diagnosis. But once the decision is made on clinical grounds that the case is one of diphtheria, antitoxin should be given forthwith without waiting for the report of the bacteriological examination. On the other hand, it may be noted that the presence of the diphtheria bacillus in the throat or nose of a person not presenting local signs or symptoms of diphtheria is not necessarily an indication for the administration of antitoxin. There is no evidence that antitoxin has any effect in causing the disappearance of diphtheria bacilli from a chronic carrier. Persistent carriers, however, very frequently suffer from abnormal conditions of the nose or throat, requiring special examination and treatment.

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