much has been done to ease the shortage of this type of house. The real problem is, therefore, to provide houses for the weekly wage-earners."

We strongly recommend Nurses possessing the Social Service spirit to read this most interesting and enlightening pamphlet.

OUR PRIZE COMPETITION.

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

We have pleasure in awarding the prize this week to Miss Phœbe Goddard, S.R.N., North-Western Hospital, Lawn Road, Hampstead.

PRIZE PAPER.

On the patient's return to the ward from the operating theatre he is placed in a warm bed on his side, and covered with a warm blanket, on the outside of which are some well-protected hot-water bottles in flannel bags; the remainder of the bedclothes are placed over the patient in the ordinary way. A towel is placed under his neck and a receptacle, in case he should vomit. The patient's temperature, pulse, and respiration are taken and charted, and if normal one feels happy for the time being. If a rectal saline has not been given in the operating theatre, this is now done. On no account must the patient be left while he is unconscious. If a tracheotomy was performed before the main operation, then the tube is removed just before consciousness returns, and a small dressing applied to wound in neck.

The nurse in charge of this case has to consider the following points:—

1. *Position.*—As soon as shock has passed off the patient is carefully lifted into the Fowler position; this will help him to breathe more freely, and the stump of the tongue is not so likely to fall back over the larynx, and also he is better able to empty his mouth of any excess of saliva or blood or mucus.

2. *Bleeding.*—This is indicated by the general appearance of the patient: skin cold and clammy, with profuse perspiration; pulse is small, weak, and rapid; breathing, sighing or gasping. Hold patient's head well forward directly bleeding begins, to prevent blood trickling into larynx, and pull the thread attached to stump of tongue firmly forwards until the arrival of surgeon, who will decide the best method of procedure according to nature of bleeding.

Asphyxia.—Due to blocking of upper part of larynx over which lingual stump falls; also blood and mucus and food may get into air passages. Keep patient upright, and make traction on thread attached to stump.

Feeding.—After the first twelve hours the patient may take fluids through a rubber tube attached to a feeder; by so doing the food is prevented coming in contact with the raw area of wound.

Sepsis.—This cavity can never be aseptic, but the inevitable septic processes can be kept within limits by appropriate care, and this is best done by carefully syringing the mouth before and after any food with some antiseptic. Good results can be obtained with hydrogen peroxide, temp. F. 99°, placed in a douche can, and with the aid of a good light gently syringe the buccal cavity, head well forward to prevent fluid entering larynx (strength 1 in 10). This is followed with boracic lotion, and great care and attention to teeth and gums.

Bowels.—Careful attention is most necessary in obtaining normal excretion of fæces. The morning following the operation an enema saponis may be given if patient's general condition allows. After this, aperients may be given, p.r.n., taking care not to let the latter come into contact with raw area of wound.

Most surgeons agree to allow patient out of bed in two or three days from operation. The routine treatment then consists in syringing the mouth before and after food, but he must be constantly watched for the first fortnight.

Miss Ballard writes:—*Feeding* is a difficult problem at first, but patient quickly learns to feed himself. An œsophageal tube may be necessary at first, but a long tube on a feeder spout, about twelve inches long to pass well into pharynx may be used with success. Concentrated nourishing fluids must be always given to build up patient's strength; almost all beverages can be made with milk and thin arrowroot, and Benger's Food can be given this way. By having a long tube on feeder the difficulty of swallowing is lessened, and food is not contaminated with blood and discharge from the wound. *Blockage* of a tracheotomy tube if left in may occur at any moment, and a dilator and cleansing material and a solution of soda bicarbonate must be in readiness by bedside always.

HONOURABLE MENTION.

The following competitors receive honourable mention:—Miss Henrietta Ballard, S.R.N., Miss M. Ramsey, S.R.N., Miss Violet G. Smith, R.M.N.

QUESTION FOR NEXT WEEK.

What signs and symptoms would you expect in a case of gastric ulcer? Describe the nursing in such a case.

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