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## LECTURE:

### SOME POINTS IN THE TREATMENT OF ACUTE ABDOMINAL CONDITIONS.

By HERBERT CARSON, Esq., F.R.C.S.

On Friday, February 13th, we had a most interesting lecture on the above subject from Mr. Herbert Carson, indeed it was one of the most helpful we have had at Queen's Gate, and it is to be regretted that the audience was not very large, owing partly to the epidemic of influenza and partly to very stormy weather. Miss Cattell took the Chair, and at the close of the lecture thanked Mr. Carson very warmly for his kindness in coming over to give the lecture at a time when, like other members of the medical profession, he was unusually busy.

In commencing his lecture Mr. Carson said that there were certain definite principles to be applied in connection with the early recognition of acute abdominal conditions. It was important that one should know something of these and the emergencies arising on the appearance of certain symptoms. Twenty or thirty years ago any abdominal case, brought for surgical interference, was, as a rule, strangulated hernia; now such cases were hardly ever seen because hernia was tackled so efficiently and quickly, specially in children. Nowadays the cases, requiring operation, were mostly appendicitis, intestinal obstruction, in some form or other, or cases of ulcer.

Among the first signs of acute abdominal trouble were pain, shock and vomiting, the latter usually of short duration. A question, which those dealing with the case might well ask themselves was, "What does this pain mean?" "Why does the patient get this pain?" Pain is always the first sign of the conditions under discussion. One can easily understand how it may arise in cases where an abscess has formed, perhaps at the appendix, and, perforating, pours its contents into the abdominal cavity. It is less easy to understand why there should be acute pain when the appendix has merely got to the stage of being swollen and inflamed. What happens then is that the appendix tries to empty itself and induces thereby a spasm of contraction, and, as you know, there is nothing more painful than such muscular spasm. One has experienced it in cases of cramp in the limbs, and equally painful is it in the case of the unstripped muscle of the intestine, when muscular spasm arises from the effort of the appendix to empty itself. The pain thus induced arises long before perforation takes place, and it must never be disregarded. It is a very bad symptom when the patient suddenly loses his pain, as this sudden change usually points to perforation; there is no longer muscular spasm, but the situation has nevertheless become very grave.

A second cause of pain in these cases arises from the fact that parts of the bowel in the region of the inflamed part tend to become paralysed and the small intestine tries still to push food along into these parts.

Associated with the pain there may be shock and vomiting. These are not so common when the inflammation is in the lower part of the abdomen, but, when the upper part is

affected, the huge nervous ganglia, upon which the abdominal mechanism is dependent, become involved and so the whole of the digestive tract suffers acutely.

Now, when some inflammatory abdominal condition does arise, such as appendicitis, the peritoneal cavity at once starts its preparations to combat the trouble. Long before we could discern the fact that there is anything the matter with the appendix, inflammation will have commenced inside it, and as soon as this happens fluid begins to be poured out from the peritoneal wall, and this fluid is highly antagonistic to micro-organisms. It collects in the pelvis long before it is seen anywhere else; the inflammation usually starts from below also and passes upwards. The result of the outpouring of the fluid is that the amount in the arteries and veins is very considerably diminished and the patient suffers from a definite fluid depletion; the results of this are most obvious when the patient is a child, and they are most readily observed in the state of the eyes, which seem to sink back into the head—a condition best seen in such cases as acute enteritis, which is often so prevalent among young children in summer time. We have the same thing in many abdominal conditions although the symptoms may not be so striking. The fluid which collects in the abdominal cavity is, as we have said, at first protective, but it is fighting an unequal battle and, as a result of the invading bacteria, it gradually becomes thick and purulent. The inflamed intestine cannot push along its contents so that, at last, the patient is actually poisoned both by the now purulent fluid, given off as a protection earlier in the illness, and by the contents which lie in the immobile intestine.

Now if one understands what is taking place one can think intelligently of how best to give relief. To begin with opium ought not to be given as, although the patient loses his pain, the drug brings about an increased degree of paralysis and also renders it impossible to make a correct diagnosis. Only to make transport of the patient to the hospital more easy for him may its administration be excused, but even then it is not usually expedient to give morphia, for, in most cases, examination into the patient's condition will be necessary when he gets to the hospital. One of the first measures, usually adopted for relief, is a turpentine enema and after this water ought to be injected into the intestine for, already, there will exist the fluid depletion already referred to. Give a pint or so of water from the tap; this is very much better than the saline enema frequently used because the latter makes the patient thirsty and so aggravates his condition. It is most important that, in these acute stages, nothing should be given by the mouth; generally, at the commencement of abdominal pain, the first thing one rushes to is an aperient, a sort of atavistic memory gives rise to the instinct to swallow something!

Posture has an important effect in the management of these cases. The patient should be set up; there are now all sorts of folding beds, "donkeys" and bolsters for helping to keep the patient in a sitting position. Thereby the fluid tends to remain in the pelvis and there is also less danger of

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