INTERESTING ITEMS FROM OUR EXCHANGES.

The Particular Nursing Problems Presented by Patients with Brain Tumors.

The nurse's special duty towards neurological cases—surgical or medical—may be considered under three headings:

First, it is important to observe accurately symptoms—especially the sequence of events in a convulsion—which may assist in diagnosis.

Second, the nurse must make up for the faculties which the patient has lost through his disease. Obviously, a blind person must be led, and a bedridden one waited upon. It is less obvious that a person with a loss of sensation on one side or in one limb must be closely watched to guard against bruising it or burning it with a hot-water bottle. A patient who has difficulty in swallowing on account of paralysis of half of the larynx should lie on the intact side while being fed. Patients who vomit because of pressure on the medulla may often be fed again at once and retain the second meal. Attention to the bowels is essential in neurological cases.

Thirdly, the most important, is the endless patience and sympathy with irrational or deteriorated subjects. This is best learned in a first-rate psychiatric ward, in which there is a real tolerance and respect for the rights of the mentally unbalanced. It is helpful to think of disturbed patients (perhaps sometimes also of surgeons) as children, who are unreasonable, wilful and stubborn; but it only makes matters worse to be annoyed by them. Force may sometimes be necessary in dealing with the unruly, but it only makes tranquility and equanimity all the more essential Scolding usually defeats its own purpose.

General Plan of an Intracranial Operation.

The head is covered with wet gauze, and closely draped up to the field. The gauze is cut along the proposed incision—usually horseshoe-shaped, and four or five inches in diameter. While assistants press either side of the line of incision to control bleeding from the scalp, a cut is made down to the bone along one side of the horseshoe. Then a whole row of snaps is placed on the fascia under the skin, and turned back over the scalp. So the incision is made in stages. The snaps are held out of the way by loops of gauze.

The skull is next perforated at intervals with a drill, and two narrow pieces of flat steel are passed from one burr hole to another. One of these serves to pull through the wire Gigli saw, the other to protect the underlying tissues from it. The bridges of bone are successively sawed in this way, and the bony flap is broken off at its base and turned up. Bleeding from the bone is controlled by rubbing a special wax into any vessels which are opened.

The dura mater is next incised. There are some rather large vessels in it, and these are secured by tiny clips made of flat silver wire, applied with forceps. These are to be preferred to ligatures because they can be put on so rapidly and without traction on tissues.

Lifting the dura exposes the brain. If a tumor is exposed, an attempt is made to remove it, by the gentlest blunt dissection or with the electric knife. Hemostasis is accomplished by the implantation of bits of muscle on small oozing points.

The wound is kept clean by the use of a suction apparatus, irrigation, and small oblong pieces of wet cotton. Gauze is almost never used, as it is too rough and irritating.

When the tumor is removed, the dura is sewed with interrupted sutures of fine waxed silk, threaded on curved spring-eyed French needles. The bony flap is replaced. Often an opening is made in the lower part of it to relieve pressure. The fascia is sewed with the same suture materials, and the skin is very gently approximated with silk on cambric needles. Drainage is seldom used. A voluminous dressing is applied, and over it a helmet of crinoline.

There are, of course, many other types of operation, which are described in the larger textbooks of surgery. This may serve, however, to give an idea of the peculiar problems of brain surgery, and how they are met.

Summary.

Neurological surgery is full of disappointments. Operations on the brain are extremely difficult and dangerous, and the proportion of favourable results is much lower than in any other field of surgery. The plight of patients with brain tumors is so desperate, however, and their doom so certain if they are left to their fate, that we should be heartless indeed not to do the best we can for them, fruitless though it often be. Success, when it does come, is so dramatic and so gratifying as to make up for many failures.—Dr. TRACY J. PUTNAM, in the *American Journal of Nursing*.

IMMEDIATE POSTOPERATIVE CARE.

Miss Mary Young Regan, R.N., writes in the same Journal:—

The postoperative nursing care of intracranial tumor patients is next in importance only to the operation itself, and the need of careful and intelligent nursing cannot be too greatly stressed.

In constant contact with the patient, the nurse should realise that she has a far better opportunity for watching his condition, and detecting suspicious symptoms than anyone else taking part in his care, and knowing her responsibilities she should make every effort to be an intelligent and assiduous observer. Upon her devolves the responsibility of informing the surgeon of any change or emergency that may arise, and she must have sufficient initiative and judgment to recognise the need when and where it arises.

As soon as the operation is over and the crinoline cast applied, the patient should be made as comfortable as possible on the table; warm blankets and a warm fresh garment applied; and well padded supports placed under the arms. The nurse should immediately acquaint herself with the condition of the patient and the postoperative orders.

In this clinic, the patient remains on the operating table until the cast is dried, nausea has ceased, and his condition warrants a careful transfer to bed. When the cast has been thoroughly dried, it should be cut in the midline (except in cerebellar cases, in which a special dressing is used), in order that there may be no undue pressure over the operative site, and to guard as much as possible against edema, or even slough, sometimes caused by too tight a dressing.

As rest and quiet are most essential, and careful observation necessary, the patient is even then not returned to the ward, but moved to a recovery room where he is cared for by a nurse who devotes her time entirely to him, until the doctor deems it advisable to transfer him to the ward. These first few hours require the greatest resourcefulness and vigilance, since it is during them that most serious changes often occur. A ten-minute pulse and respiration chart is kept, half-hourly rectal temperature is taken, and recorded as is blood pressure if indicated; the comparative grip in the two hands is important and responses should be tested and recorded at least every half-hour—this not being pushed to the point of exhausting the patient.

When no nausea is present, fluids may be given in small amounts, gradually increasing them.

previous page next page