OUR PRIZE COMPETITION.

DESCRIBE THE CAUSES AND SYMPTOMS OF INTESTINAL OBSTRUCTION. HOW WOULD YOU PREPARE A PATIENT FOR OPERATION SUFFERING FROM ACUTE INTESTINAL OBSTRUCTION?

We have pleasure in awarding the prize this month to Miss E. Stachey Laing, F.B.C.N., Mayday Hospital, Thornton Heath.

Intestinal Obstruction—may arise from a variety of causes, as will be seen in the following classification :—

(1) Those operating from outside the bowel wall :

(*a*) Direct pressure from growths of neighbouring organs.

(*b*) Strangulated Hernia.

(*c*) Volvulus, or twisting of the intestine upon itself.

(*d*) Constriction of the intestine by "bands" formed from peritoneum, also adhesions.

(2) Causes due to Disease of the Bowel wall :

(*a*) Malignant Tumour of the Bowel.

(*b*) Result of previous ulceration of the Bowel, which has healed and the scar tissue has contracted.

(*c*) Intussusception, where one portion of the bowel has slipped inside the adjacent portion.

(*d*) Paralyticus Ileus, a "functional" obstruction, occurring sometimes after an operation on the intestines. The affected part of the bowel is paralysed, therefore peristalsis ceases at the site. Distension and stoppage of the bowel is the result.

(3) Foreign Body impacted within the bowel wall :

(*a*) Accumulation of masses of hardened fæces.

(*b*) Foreign Bodies which have been swallowed.

(*c*) Gall-stones. These when large enough to cause obstruction, have been known to avoid the bile ducts, and ulcerate through the neck of the Gall Bladder into the duodenum, causing acute obstruction at once.

Intestinal Obstruction—may be Acute or Chronic.

The symptoms of Acute Intestinal Obstruction are very severe and characteristic. There is sudden onset of acute abdominal pain, diffuse or localised. The abdomen rapidly becomes distended, rigid, and very tender to the touch. In some cases peristalsis may be visible, and in children with intussusception a sausage shaped tumour may be observed on examination of the abdomen. Constipation is absolute, *i.e.*, no passage of fæces or flatus, the one exception being intussusception, in which case blood and mucus are passed per rectum.

With the onset of the abdominal pain, vomiting of the "progressive" type sets in, undigested food from the stomach, bile stained fluid from the duodenum, and finally if not relieved the vomitus becomes of a fæcal nature.

The general condition of the patient is extremely serious. The face assumes an expression of anxiety, and is pale with sunken eyes. The mouth and tongue are very dry, sores quickly form if the toilet of the mouth is neglected, and the breath becomes offensive. The breathing is hurried and shallow, on account of the rigidity of the abdominal muscles. The patient lies in bed as still as possible with the knees well drawn up in an endeavour to relieve the acute pain and tension. Absorption of toxins is rapid, and an acute toxæmia supervenes. The pulse is rapid and small, temperature is often sub-normal.

In Chronic Intestinal Obstruction—the symptoms are less severe, and extend over varying periods of time. Chronic Constipation and carcinoma of the rectum and colon present the greatest number of chronic cases. There is often a history of alternating constipation and diarrhœa, combined with "tenesmus," *i.e.*, a constant desire to defæcate, attempts at which are largely ineffectual, and a little blood and mucus only are passed. Sooner or later this chronic stage merges into the acute and all the symptoms as above described commence.

The Preparation of a patient for the relief of acute intestinal obstruction requires the utmost care and gentleness.

The enema is often omitted, but a very small one administered with a soft rubber catheter, tubing and funnel *may* be ordered. Of far greater importance is the washing out of the stomach, especially where vomiting is in progress, not only to avoid the stomach contents being ejected during anæsthesia, and the accompanying risk of asphyxia, but also to delay absorption of toxins, particularly where the vomiting is already of a fæcal character.

Any false teeth should be removed from the mouth at once on account of the pending operation, as well as to prevent any tendency to swallowing them during the persistent vomiting. Urine must be tested and any abnormalities reported, the presence of which will influence the anæsthetist as to which anæsthetic he is willing to risk.

The abdomen being so tender, the local preparation should be performed very gently. Often the Surgeon prefers to do what is necessary himself in the theatre, when the patient's condition is very grave, and relief is urgently needed.

The usual injection of Atropine Gr : 1/100 either alone or combined with morphia Gr : 1/6 to 1/4 is given prior to the operation. These patients are very liable to sudden collapse, and should be kept very warm from the moment the nurse takes charge. It is essential to have normal saline in readiness, and the intravenous apparatus in working order.

Although the preparation must of a necessity be carried out quickly, the nurse should bear in mind constantly, that however ill the patient is he remains acutely conscious of his surroundings, even till the end, should death occur. Every kindness and sympathy must be extended, together with the assurance that the pending operation will give the desired relief and comfort.

HONOURABLE MENTION.

The following competitors receive Honourable Mention : Miss Amy Phipps and Miss M. Diggle. Miss Diggle notes that "the bladder of the patient to be operated on should be empty, and if this cannot be done naturally, a catheter is passed. The urine is examined for albumen, acetone and sugar."

QUESTION FOR NEXT MONTH.

Give the incubation period and describe the nursing care and treatment of a case of Whooping Cough. What complications might arise?

previous page next page