OUR PRIZE COMPETITION.

DESCRIBE IN DETAIL THE NURSING OF A CASE OF ACUTE APPENDICITIS DURING THE FIRST WEEK AFTER OPERATION. WHAT COMPLICATIONS MAY OCCUR ?

We have pleasure in publishing the paper awarded the prize last month, by Miss J. M. Dunbar, Alexandra Hospital, Coatbridge, Lanarkshire.

PRIZE PAPER.

A hospital patient with acute appendicitis is taken to the theatre and operated upon as soon as possible. The appendix may be very inflamed, but the bowel not infected, in which case the wound is closed, as healing is expected to take place by first intention.

In some cases the appendix is gangrenous or an abscess may have formed, when there is usually much inflammation in the bowel near the appendix. In such cases a drainage tube, or gauze soaked in some antiseptic, is inserted into the wound. Some have a "stab" wound with tube, or gauze drain, made in the right iliac region for counter drainage. Surgeons vary greatly in their methods of drainage and the dressings they employ.

On return from the theatre, a saline infusion is usually given per rectum. The patient is gradually raised on pillows and the head of the bed put on blocks if necessary. If the patient has no sickness, and takes fluids well, salines can be discontinued. Flatulence can be relieved by a solution of bicarbonate of soda or by peppermint water.

A wound which heals by first intention requires no dressing until the stitches are taken out unless there is a rise of temperature and pulse rate or the patient complains of pain. After an operation for appendicitis an aperient is usually given on the third morning, after which the diet is gradually increased.

Morphia, or some other sedative, is usually ordered a few hours after operation, and may have to be repeated next evening to ensure a restful sleep.

When there has been an abscess, or the appendix has been gangrenous, the patient is very ill for some days. There is usually a good deal of peritonitis. The abdomen is hard and distended. The drainage tube is removed after thirty-six hours, and a gauze drain inserted. The wound will require dressing twice daily, or oftener, according to the amount of discharge. The patient is nursed in an upright position with the head of bed raised on blocks. The patient must have plenty to drink (not soda water, unless the gas is out of it). The mouth and teeth require attention; they are always very dirty. Salines are usually given six- or eight-hourly on the first day, but if the patient drinks well, and has no sickness, there is no need to continue them.

An enema or bowel wash out is usually given on the second day, which helps the patient very much. An aperient is given on the fourth day. When the sickness has stopped and the patient has recovered from the effects of the operation a light diet is given, and very gradually increased.

Complications.—If the operation has been a long one, or the patient has a weak chest, sometimes an "ether chest" follows. The patient has a cough, which causes much pain in the wound, and he has difficulty in breathing. Heat in some form is applied to the chest. An expectorant mixture such as Ammon. Carb. Mist. is given four-hourly, or a sedative mixture, such as Glyco-Heroin, is given six-hourly, and usually the condition clears up in a few days. The patient is kept in a sitting up position. Patients who are old, or extremely weak, are apt to develop hypostatic pneumonia. This is usually a very grave condition. They are nursed in an upright position if possible. Sometimes they find a position which is more comfortable, and slip into that. Antiphlogistine or a linseed poultice is applied to the part affected, and a gamgee jacket applied. They are given expectorant mixtures and cardiac stimulants. They must have plenty to drink. Their mouths require very special attention.

When the appendix has been gangrenous, or there has been an abscess, and where the bowel has been affected the bowel wall is very fragile and the slightest pressure wears it through. This causes a fæcal fistula. The fistula usually appears from the third to the seventh day. There is no mistaking a fistula, the odour is characteristic. The wound takes a long time to heal, but it does usually eventually heal. The diet has to be as dry as possible, but must be very nourishing. A good tonic is necessary. White of egg may sometimes help to heal the opening.

Paralysis of the large bowel sometimes occurs, but fortunately not often. The patient is sick after every meal. The abdomen is hard and distended. An enema or bowel washout does not relieve. Pituitrin, or physostigmine gr. $\frac{1}{100}$ is very helpful. The patient gets very thin and emaciated. The recovery is very slow. The patient's mouth and back must be carefully watched. The diet must be very light and gradually increased.

HONOURABLE MENTION.

The following competitors receive honourable mention Miss E. L. Rand and Miss Gladys K. Bush.

Miss Rand writes:—"Hourly record of pulse rate is essential for twelve hours and four hourly records of temperature and respiration must be made.

"Pain may be relieved by cradle lifting bedclothes from abdomen, by alteration of bandage, and by passage of urine, or if flatus is present the passage of flatus tube, Sedatives such as aspirin, bromide, or even omnopon or heroin may be ordered by the surgeon.

"Thirst is often very distressing and may be due to much loss of fluid from the skin during operation, or to the administration of atropin before operation. Rectal salines with 5 per cent. solution of glucose given in eight ounce quantities every six hours will do much to relieve this and fluids ad lib; when these are allowed."

QUESTION FOR NEXT MONTH.

State what you learnt at the International Congress of Nurses.

N.B.—The paper should deal with deductions which would result from intelligent observations, and new ideas.

previous page next page