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LECTURE.

THE PREPARATION FOR AND AFTER-TREATMENT OF ABDOMINAL OPERATIONS.

BY HERBERT J. PATERSON, C.B.E., M.C., F.R.C.S.

At the beginning of what proved to be a most instructive and interesting lecture on the preparation for and after-treatment of abdominal operations, Mr. Paterson reminded his audience of the practice, in comparatively recent times, of using strong antiseptics to disinfect wounds. The modern practice is to ensure asepsis, as opposed to antisepsis. With this aim in view everything which can come in contact with the wound is rendered sterile by means suitable for the material of which it is composed. All dressings, towels, instruments and the gloves, gowns, caps and masks of the surgeon and his assistants are sterilised. Success in operative surgery depends on attention to detail. The staff of an operating theatre can be likened to a team, and success in an operation is due to the combined efforts of all concerned. Each individual assisting in any way at an operation is a link in the aseptic chain. Just as a chain is only as strong as its weakest link, so the team work of the operation theatre breaks down if there is a fault on the part of any one concerned. It has been said that the patient's fate is sealed as soon as the wound is closed, but the lecturer strongly dissented from this opinion, because not seldom, in seemingly hopeless cases, good nursing and careful after-treatment bring their reward in the recovery of the patient. Much can be done by careful pre-operative treatment and good after-care to promote the patient's comfort and to hasten his recovery.

Preparatory Treatment.

A week spent in preparation for an abdominal operation is time well spent and the minimum time should never be less than four days. To operate in one or two days is taking a grave risk and is both unnecessary and unjustifiable. If a patient is allowed to go about and to partake of ordinary food until only a day or so before operation, the stomach and intestines will be full of germs. There are very great advantages in keeping the patient quiet in bed for a week prior to operation. The risk of the operation is lessened, comfort after operation enhanced, the patient becomes used to his surroundings and to his nurses and, in addition, the preparatory ritual occupies his mind and gives confidence by encouraging the belief that everything possible is being done to ensure a successful result. This is a psychological factor not always sufficiently recognised. Every detail of pre-operative treatment must be regarded as important. In order to avoid as far as possible risk of hypostatic pneumonia the patient should be encouraged to do deep breathing exercises every hour, so that the lungs may be expanded to the fullest extent. To accustom him to the Fowler's position, which will be necessary afterwards, it is a good plan to prop the patient up in a sitting position for at least one night. With regard to purgation the lecturer said that in surgery, as in daily life, shibboleths die hard and the custom of giving strong aperients is still widely advocated. Purgation is wrong for three reasons: it causes loss of fluid from the tissues, it seriously disturbs the patient, and it gives rise to unnecessary flatulence and discomfort after operation. As rest is needed the action of the bowels can be ensured safely by giving an ounce of liquid paraffin night and morning during the whole preparatory period. It is imperative, however, that only the best liquid paraffin should be used, the poorer kinds being of too low a specific gravity to be of use, and they are no more economical, as larger quantities are required. A good nurse should soon be able to judge whether the paraffin supplied is of inferior make. Not only should strong purgatives be avoided, but even the classical enema on the morning of operation is abandoned except for operations on the rectum and large intestine.

The diet for the last four days prior to operation should consist only of sterilised milk and weak tea. In addition, two oranges may be sucked during the course of the day. Twenty grains of bicarbonate of soda should be given every four hours until the urine is alkaline, and a pint of normal saline containing half an ounce of glucose should be given per rectum night and morning. It is possible by these means to render sterile the stomach and jejunum, thereby greatly diminishing the risk of infection from within. Special attention must, of course, be given to the mouth and teeth, and frequent mouth washes are essential. It has been proved that these pre-operative measures go far to ensure the comfort and well-being of the patient after the operation.

The preparatory dressing is important, the sterilisation of the skin being always a difficult matter. Twenty-four hours before going to the theatre, the patient has a hot bath. The abdomen is shaved, then thoroughly washed with spirit or ether soap, swabbed liberally with acetone and painted with a solution of picric acid (1 per cent. in water), and covered with a sterile dressing which is held in place by a many-tailed bandage. The clothing of the patient when he goes to the theatre is very important. The chest should be covered with a layer of cotton wool beneath the gown, and the limbs should be swathed in cotton wool likewise. Warm blankets are necessary and a gamgee mask to place over the patient's face when he is on the trolley.

In the Theatre.

Usually there are too many nurses in the theatre. There should be no more than four—the theatre sister, the nurse in the sterilising room who prepares the instruments, the nurse whose duty it is to fetch and carry whatever is required and the ward sister or staff nurse who has come with the patient. Many surgeons like a nurse to thread their needles, and if so another nurse is required. The lecturer here handed round some of the special needles which he uses for his operations. These are threaded prior

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