

to being sterilised, and the needles and sutures are then threaded through a piece of butter muslin and boiled. It is impossible for the type of needle which was shown to become unthreaded, as it has an eye which grips the suture so that it cannot slip. The pads which Mr. Paterson uses for his abdominal operations were also exhibited. They were of cellular cotton material bound round the edges with tape. Reference was made to the fact that it is quite easy for a swab to be overlooked when the abdomen is closed after the operation. Mr. Paterson said that he always checks the number of swabs himself, so that he is responsible if any are missing. These swabs are put up into bags of ten for sterilising, and the numbers in each bag are counted by the theatre nurse and checked by a second nurse. Both then initial the label which is affixed to the bag. The "clicker" was also handed round for the audience to examine. This is a small instrument which records the swabs as they are put into the abdomen and as they are removed. At the end of an operation the figures "in" and "out" must correspond. Speaking of many-tailed bandages, Mr. Paterson said that these should be at least 7 ft. long. They should *not* be stitched up the back, and should be put on starting from the top and working downwards. The advantage of this method of application is that the greatest pull on the bandage comes at the bottom over the pelvis, and not at the top over the lower ribs, where it might restrict the patient's breathing. During the conveyance of the patient to the ward the mask already mentioned is placed over his nose and mouth as a protection against the cold air in corridors and passages. This is most necessary as the air of the corridors is often 20° colder than that of the theatre.

AFTER-TREATMENT.

The patient's clothes, if they are at all damp, should be replaced by warm ones on his return from the theatre. As soon as he is put to bed, he is propped up in Fowler's position unless there is shock. The difficulty of keeping the patient in this position is well known, but a good method is to pass a broomstick through a bolster and attach the ends of this to the bed with straps. Continuous rectal saline is begun as soon as the patient is back in the ward. The fluid is allowed to run in at the rate of from one to one and a half pints in two hours, and the treatment is continued for several days if necessary. The value of the saline is that it dilutes the toxins, raises the blood pressure and helps to prevent thirst. The apparatus with which this continuous saline is given was handed round for the audience to examine. The regulation of the temperature of the fluid is particularly easy with this apparatus, because an electric attachment maintains it at a constant heat, 125° F. in the container, so that it reaches the rectum at a temperature of from 99°-100° F. The saline should not be given under pressure, therefore the bottom of the container must not be raised more than from four to six inches above the level of the bed. The tubing and rectal tube employed have a diameter of three-quarters of an inch, the reason for this being that with the low pressure and large tubing it is possible for the saline to run back if the patient has flatulence. By this means the familiar trouble of "returned saline" is avoided. The use of a clip on the tubing to regulate the flow is strictly forbidden. After operation the patient is usually given one-sixth of a grain of morphia. The importance of starting breathing exercises as soon as possible should be recognised. If the patient feels that he wants to cough but is afraid of the pain, a good method is to place the hands over the lower ribs on either side and to press firmly. The patient can then cough without difficulty and should be encouraged to do so. If he cannot hold the ribs tightly enough himself, the nurse should place her hands on either side of the patient's hands to give extra support. One teaspoonful of

hot water at a time may be begun very shortly after the patient is conscious, and soon this can be replaced with milk and water. Next day Benger's food is allowed, then calves' foot jelly and beaten egg. Purgatives should never be given after an operation and the liquid paraffin treatment is recommenced the morning after operation. If, after four days, the patient has not had a motion an enema may be given. The length of time that the patient should be kept in bed after operation is a moot point. Four weeks is advocated as a safe time, and the lecturer said that he had never had a patient who expressed any desire to get up before the elapse of three weeks.

COMPLICATIONS OF ABDOMINAL OPERATIONS.

The chief complications mentioned were pain, shock, vomiting, hypostatic pneumonia and acute dilatation of the stomach. Since adopting the procedure described in this lecture, Mr. Paterson said that he found that post-operative pain, as apart from discomfort, has been almost abolished. Pain may be due to a too tight bandage or suture, but much more often it is due to flatulence and intestinal colic. The best method of combating shock is the use of continuous saline already described. Vomiting is not nearly so common as it was when chloroform was the regular anaesthetic used, and the careful dieting before the operation has made it still less troublesome. The breathing exercises and careful protection of the patient's mouth and nose on the return from the theatre are very useful for preventing chest complications. Acute dilatation of the stomach is a complication not always recognised. In its later stages the patient shows signs of severe shock. The remedy is simple, namely, the washing out of the stomach.

At the conclusion of the lecture, Mr. Paterson showed a wonderful motion picture of the whole technique of an abdominal operation, appendicectomy. This demonstrated the practices advocated in the lecture and added enormously to the value of it.

Very great appreciation has been expressed of Mr. Paterson's kindness in giving such a very valuable and instructive contribution to our round of monthly fixtures. We feel most grateful, indeed, for all that we have gained from it, for the great amount of trouble involved in having brought over and set up the cinematographic apparatus, and for the privilege of putting questions and receiving Mr. Paterson's answers to them.

OLD COSTUMES.

A double lecture on old costumes was specially arranged for Members of the Association at the Victoria and Albert Museum, and proved very fascinating, partly because of the sidelights which it let in upon many characters in history. We admired exceedingly the beautifully embroidered linen and silk garments of the fifteenth and sixteenth centuries and some of the "black work," as it was called, was specially attractive in the perfection and delicacy of its design. Especially beautiful was a long robe and jacket said to have been worked by Queen Elizabeth and worn by her. The iron corsets with their wire lacings were anything but hygienic, and it is easy to realise that, encased in these and weighted with the voluminous clothing of her time, the virgin Queen could be forgiven her lapses of temper if not her lack of charity. Added to the tortures of the tightly constricting heavy corsets the hairdressing, and its preservation once complete, must have been the proverbial "last straw," and no pleasant dreams could crowd about the hard pillows required to preserve such elaborate head-dress. The evolution of the boot was another interesting branch of study.

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[previous page](#)

[next page](#)