# THE DYSENTERIES.

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"Dysentery" is a term usually employed to describe a group of symptoms of which diarrhœa, with mucus and blood in the motion, griping abdominal pains and rectal pains are the most prominent.

Do not forget, however, that pain and diarrhœa with blood and mucus can be caused by many other conditions, such as foreign bodies in the rectum, malignant growths in the bowel, tuberculosis of the intestine, syphilis, hæmorrhoids, and other parasitic infections, such as schistosomiasis, Balantidium coli, etc.

The principal kinds of dysentery are as follows :—

1. *Bacterial. Bacillary* Dysentery, due to infection with Shiga's bacillus, the Flexner-Y group (V.W.X.Y. and Z. strains) and Sonnes bacillus.

2. *Protozoal. Amœbic* Dysentery, due to infection with Entamœba histolytica. *Balantidial* Dysentery, caused by Balantidium coli.

Probably because they are so widespread, in tropical medicine the term has come to be applied mainly to two diseases, bacillary dysentery and amœbic dysentery.

## Bacillary Dysentery.

This disease occurs all over the world in the tropics and sub-tropics.

*Cause.* As stated above, the bacilli of the Shiga or Flexner-Y or Sonne types. In camps, prisons and asylums, or where sanitation is defective it may occur in epidemics. When famines or wars occur and when dust and flies abound outbreaks may take place.

*Infection.* This is acquired exactly as in typhoid fever, that is, the bacilli enter the body by the mouth. The patient's stool being very infective, hands may convey the germs, water supplies may become contaminated, and food may be infected in various ways by flies or dust from latrines. Carriers exist.

*Pathology.* The bacilli develop rapidly in the large intestine causing acute inflammation, ulceration and bleeding of the mucous membrane. Ulcers form on the ridges and parts of the mucous membrane may peel off as sloughs. The poisons from the germs are absorbed into the blood and cause great weakness and toxæmia, fever and wasting. Parts of the intestine may even become necrotic and gangrenous.

*Incubation period.* One to seven days.

*Symptoms.* The attack may be mild, acute or fulminating, later the disease may become chronic.

In a mild attack there may be diarrhœa with mucus and perhaps a little blood, headache, lassitude, anorexia and a coated tongue; but even this attack is important, because stools are infective, and the disease may become chronic.

An acute attack is usually sudden in onset, with feelings of chill, abdominal pain (griping) and urgent desire to pass frequent small stools. The stools are liquid and show more and more mucus and become tinged with more and more bright blood till they are almost pure blood and mucus. The temperature is usually raised. Headache, intense thirst and a dirty tongue are present, and vomiting is common. The patient is very toxic, very ill, soon exhausted and wastes quickly. The pulse is rapid and feeble. Cramp may occur in the muscles and the abdomen may be retracted or distended and is tender.

In a fulminating attack the onset is sudden, the patient being overcome with toxæmia from the beginning. Vomiting and rigors occur with a high temperature, which later becomes sub-normal. The motions of almost pure blood and mucus are nearly continuous. Later pus and sloughs appear. With the increasing toxæmia the patient may die in a few days. From such an attack recovery is rare. Some attacks simulate cholera.

## Complications.

1. Prolapse of rectum occurs in children, the part must be cleansed and replaced after each motion.

2. Arthritis. One or more joints may become swollen and inflamed. The knees are often affected. Treatment is by rest and local applications to relieve the pain which may be very severe. Later, massage may help.

3. Inflammation of the iris of the eye (iritis) and parotitis may occur. Little or no reading should be allowed in convalescence.

4. Dysuria may occur in the acute stage. See that retention does not occur in severely ill patients.

5. Bedsores. All the usual methods must be used to prevent these.

6. Gangrene of the bowel and perforation and peritonitis may occur in very severe cases.

7. The condition may become chronic.

## Treatment.

This is directed to cleanse the bowel by washing out the bacilli and their toxins.

Magnesium or sodium sulphate in 60-grain doses is given every hour or two hourly until copious stools are established. Then the interval between the doses is increased. The sodium sulphate draws forth protective mucus from the bowel and empties the small intestine of the often contained fermenting contents which have been prevented by spasm from passing on to the inflamed colon. Where patients are already exhausted the medicine is given less frequently. The appearance of fæces again in the motions is a sign to reduce the doses. Castor oil is sometimes used instead of the sodium sulphate.

Serum treatment is good if given early. A large syringe should be in readiness. Intravenous salines may be required.

Chlorodyne or Tr. opii m.x is sometimes given to relieve pain at the onset.

Stimulants, such as camphor in oil, may be needed. Alcohol should not be given without definite orders. In convalescence alcohol may cause a relapse. Where there is doubt of malaria being present, quinine is given.

## Nursing.

Keep the patient warm in bed. Keep the abdomen warm with hot bottles or turpentine stupes. Exclude glare, but not fresh air. In the early stages of the attack, if the stools are numerous, washing out the bowel by means of an enema of 2 to 3 pints of normal saline may give the patient a rest and some sleep. Where the continuous use of the bed-pan is too exhausting, wrap round the buttocks with old linen or pad the anus with an absorbent wool pad or pack, only disturbing the patient every few hours or so for the toilet, cleaning the patient with wool and antiseptic lotion (cresol, etc.). Disturb the patient as little as possible. Watch the pulse and give hypodermic stimulants as ordered by the doctor. Perforation may occur, but is commoner in amœbic dysentery.

Injections per rectum of normal saline or hypertonic saline salt ʒii to oi of water may be used in the early stages, to wash out the bowel. An injection of sodium bicarbonate solution (half a drachm to a pint of normal saline) may lessen the tenesmus. But rectal treatment cannot be long borne owing to the pain of the tube in the inflamed rectum. Cocaine ointment to the anus may lessen tenesmus and enable the tube to be more easily passed.

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