



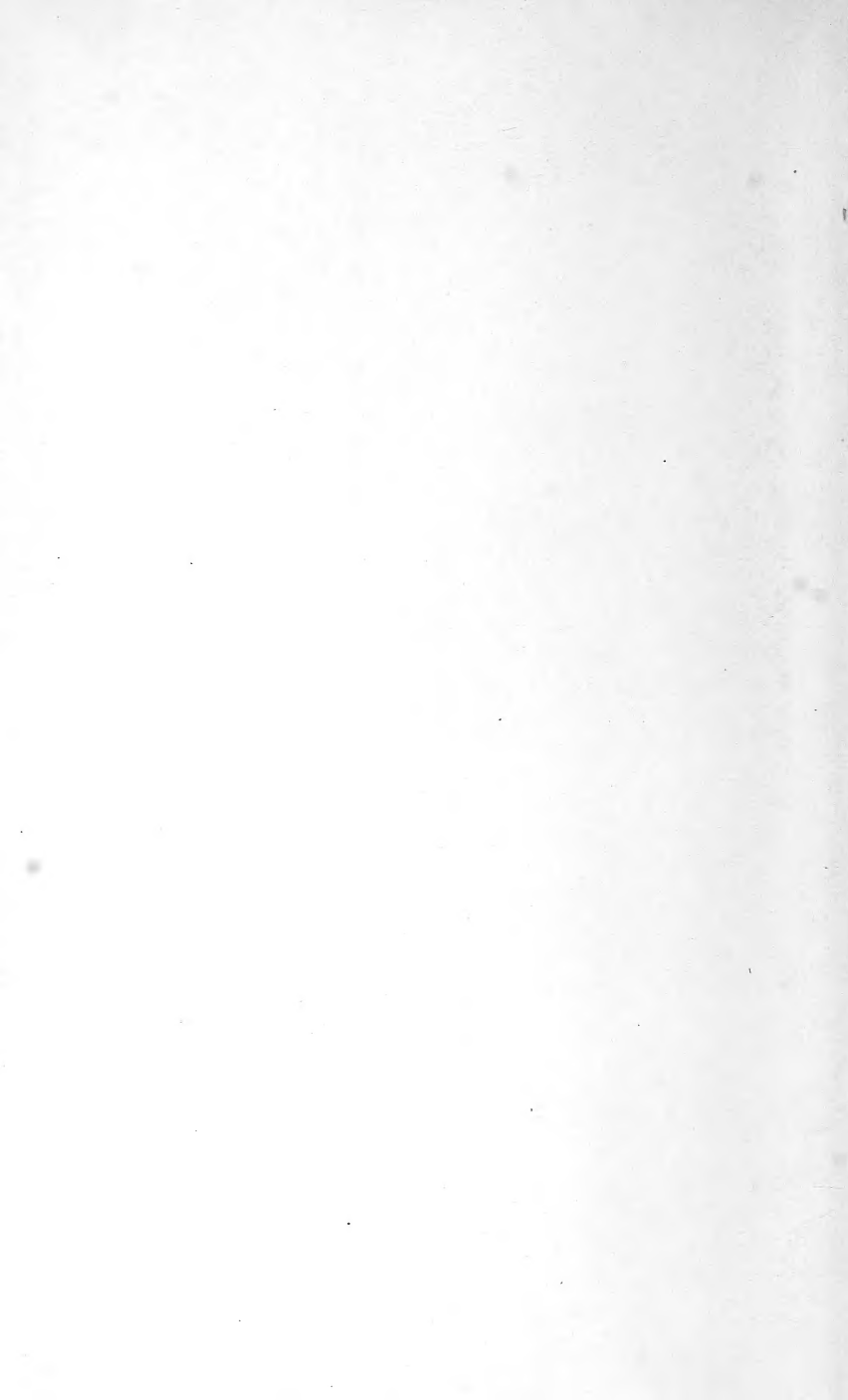
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FOR NURSES

BY  
EMILY M. A. STONEY

Superintendent of the Training School for Nurses, St. Anthony's Hospital, Rock  
Island, Ill.; Author of "Practical Points in Nursing," "Practical  
Materia Medica for Nurses," etc.

Third Edition, Thoroughly Revised and Enlarged

BY  
FREDERIC RICHARDSON GRIFFITH, M.D. (Univ. of Penn.)  
OF NEW YORK  
Surgeon, Fellow of the New York Academy of Medicine

*"Every bit of knowledge that we cannot use for the uplifting of our physical,  
intellectual, or emotional life is so much waste of time and labor. Everything taught  
is worth the knowing, but not worth the putting away in the pigeon-holes of memory,  
to be recalled some day by accident."*

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TO

DR. JOHN R. SLATTERY

THIS VOLUME IS DEDICATED BY THE AUTHOR

IN GRATEFUL REMEMBRANCE OF MUCH ENCOURAGE-  
MENT AND PERSONAL KINDNESS



## PREFACE TO THE THIRD EDITION.

---

THE chief concern in producing the present edition has been to use plain and simple language to teach the surgical nurse to be clean, reliable, successful in her work.

Some well-tried diet recipes have been added, and special operations have been considered a little more fully; and meanings of all the hard words used in the text, it is believed, have been explained in the Glossary.

FREDERIC RICHARDSON GRIFFITH.

NEW YORK, *September*, 1910.



## PREFACE.

---

THE following pages constitute the notes of a series of lectures on "Bacteriology and Surgical Technic" which followed closely upon my lectures on "Materia Medica." The first part of the book is devoted to Bacteriology and Antiseptics; the second part to Surgical Technic, Signs of Death, Autopsies.

No attempt has been made to write a complete treatise on bacteriology, but merely to outline and simplify that branch for nurses.

It was deemed advisable to add the chapter on "Signs of Death and Autopsies," as many nurses are unacquainted with the preparations for an autopsy in private practice.

So many changes have taken place in surgery since the lectures were delivered that it has been necessary to rewrite many of the chapters. In this I was assisted by Dr. A. S. Allen and by Professors J. B. Murphy, Christian Fenger, and Joseph L. Miller, of the Northwestern University Medical College. I am glad of this opportunity to thank them for their assistance.

Free use has been made of the works on bacteriology by McFarland, Crookshank, and Woodhead; of "Aseptic Surgical Technique," by Dr. Hunter Robb; "Operative Gynecology," by Dr. Howard A. Kelly; and "Aseptic Treatment of Wounds," by Dr. C. Schimmelbusch.

I am unable to express my indebtedness to Dr. Joseph P. Comegys for his valuable assistance with the manuscript and its preparation for the press.

I wish also to thank Drs. George L. Eyster and Charles C. Carter for their friendly help and interest in the work.

EMILY M. ARMSTRONG-STONEY.



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# PART I.

## BACTERIOLOGY; ANTISEPTICS.

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### CHAPTER I.

#### HISTORY OF BACTERIOLOGY.

THE eye is one of the most beautiful and delicately contrived organs in the body, and yet its vision unaided is very limited in its scope. We see so much that we rarely stop to think of what an enormous world exists in and all about us which we cannot see at all—a world peopled by organisms so very small that they can be seen and studied only by the aid of the most powerful magnifying lenses, and so numerous that they are quite beyond any calculation.

Bacteria exist nearly everywhere; they are almost universal, except that they are not found deep down in the ground nor high up in the air. They and their spores, or seeds, float in the air we breathe, swim in the water we drink, grow upon the food we eat, and luxuriate in the soil beneath our feet. Wherever man, animals, and plants live, die, and decompose, bacteria are sure to be present. The surface of the body never escapes their establishment, and so deeply are some individuals situated beneath the epithelial cells that the most vigorous scrubbing and washing and the use

of powerful disinfectants are necessary to remove them from the surgeon's hands.

The mouth is said to be always replete with them; and, since many are swallowed, the digestive tract always contains them. The germ of pneumonia, for instance, is said to be habitually present in the mouth of almost every healthy person; consequently, its entrance into the lungs is only a matter of accident.

The existence of these bacteria has been known for many years, but it is only during the past few decades that any great advancement in our knowledge of them has been made.

Over two hundred years ago a man named Athanasius Kircher, a German, mistook blood-corpuscles and pus-corpuscles (leukocytes) for small worms; and built up a new theory of the causes of disease and putrefaction upon this basis. At the same time, Christian Lange, a professor in the medical school at Leipzig, expressed his opinion that the rash that appeared on the skin in the eruptive fevers, etc., was the result of putrefaction conveyed by small living worms in the body. Shortly after these observations came those of Anthony van Leeuwenhoek, a native of Delft, in Holland, who, in his early years, had learned the art of polishing lenses, and who was able, ultimately, to produce the first really good microscope that had yet been constructed. He saw, and described with astonishing clearness, various forms of bacteria found in the material taken from the mouth of an old man who never cleaned his teeth. He gave an accurate description of the rod-shaped bacteria, motile and motionless; now called bacilli; of the spiral threads, or spirilla; and of

rounded micro-organisms, or micrococci. Although he did not attempt to theorize as to the meaning of these organisms at the time, later on, in 1713, after finding similar organisms in the greenish pellicle formed on the surface of the water in an aquarium, he came to the conclusion that the various forms of bacteria found in the material scraped from the teeth found their way into the mouth through the medium of the drinking-water that had been stored in barrels, and that some of these found there a nidus in which they multiplied.

This was the real beginning of bacteriology; and from this origin the study advanced with considerable rapidity in spite of ridicule and much opposition. Various opinions regarding the connection of these germs with disease and putrefaction, were put forward; but it was not until 1831 that any important advance was made in our knowledge of this connection. Previous to that time a large mass of facts in regard to these little living organisms was being gradually accumulated, and fresh discoveries were constantly made by various workers; but since no systematic attempts to classify the newly observed facts were made, the scientific results were very small.

The first real advance made in our knowledge of the presence of a living contagious element in the production of disease and fermentations was made by Frederick Müller, of Copenhagen, and was the result of a systematic attempt to arrange the knowledge which had been accumulated during all those years. From that time to the present, the science has made great strides; so that we have now an accurate knowledge of the bacteria which cause a

number of different diseases. The knowledge of methods and details of work is now so general that the science of bacteriology is rapidly growing, and has revolutionized already very many branches of medicine.

In 1840, Henle was led to believe that the cause of miasmatic, infective, and contagious diseases must be looked for in living fungi, or other minute living organisms. Unfortunately, at that time the methods of study employed prevented him from demonstrating the accuracy of his belief. It was left for Pasteur and Koch to complete the work. Davaine, in 1848, was the first to see and to recognize disease-producing bacteria—he saw anthrax-bacilli in the blood of sheep dead of splenic fever.

Pasteur then took up the work; and in 1857 his faultless demonstration of the germ-theory of disease was brought out as a result of his experiments on fermentation and putrefaction, and on the bacteria of wine and those of the silkworm. He showed that the acetic fermentation, viscosity, bitterness, and turning flat of wines are due to the action of certain organized ferments, and demonstrated a causal relation between certain lowly-organized parasitic organisms and special diseases in animals and insects. Upon Pasteur's observations Lord Lister based his successful system of the treatment of wounds, known as "antiseptic surgery."

We all know of the wonderful success which now marks the operations of major surgery, and of the daring boldness of operators who attempt what was utterly impossible as long as antiseptic surgery was unknown. Lister, accepting the truth of Pasteur's



statement—that germs are the producers of fermentations—concluded that germs entering wounds from the outside might be the cause of suppuration; and since germs are always and everywhere floating in the air, suspended in water, and attached to the surgical instruments, dressings, and sponges used in operations, he judged correctly that it was highly advantageous to employ an antiseptic agent in order to kill any of the suspended or adherent organisms before any materials could be allowed to come in contact with wounded tissues; consequently, the hands of the operator and his assistants, the surgical instruments, sponges, dressings, sutures and ligatures, were kept constantly saturated with a solution of carbolic acid (1 : 40), and the operation was performed under a spray of carbolic acid (1 : 20). Carbolized dressings were used; and if the discharge was profuse, the dressings were changed once in twenty-four hours under a constant use of the spray. The researches of a later date have shown, however, not only that the atmosphere cannot be disinfected, but also that the air of ordinarily quiet rooms, while containing the spores of numerous saprophytic organisms, rarely contains many pathogenic bacteria. We also know that a direct stream of air, such as is generated by an atomizer, causes more bacteria to be conveyed into a wound than ordinarily would fall upon it, thereby increasing instead of lessening the danger of infection. Lister, we must remember, was not the discoverer of carbolic acid nor of the fact that it would kill bacteria; but, convinced that inflammation and suppuration were caused by the entrance of germs from the air, instruments, sponges, and dressings, into wounds, he suggested the antiseptics which

would result from the use of sterile instruments, clean hands, dressings, towels, and the like; and made applications intended to keep the surface of the wound moistened with a germicidal solution in order to kill such germs as might accidentally enter. He also introduced the practice of concluding operations by the application of a protective dressing, such as would tend to preclude the entrance of germs at a subsequent period. This procedure defeats its purpose for usefulness by reason of the moisture retained acting as a direct growth medium for those bacteria already upon or in the skin. Listerism has spread slowly but surely to all the departments of surgery and obstetrics.

Since Lister's treatment was first inaugurated, many details of its application have been variously modified and great additions to our knowledge have been made. In bacteriology much important work has been done, and great advances are being constantly made. There are a number of diseases, each one of which has been definitely proved to be caused by a germ of its own, a germ which causes no other disease. There is also a list of diseases in which the proof is not yet conclusive, but for which the probability is that a specific germ will be found. The following data have been gathered chiefly from the works of McFarland and Woodhead.

In 1845, Langenbeck discovered that the specific disease of cattle known as actinomycosis could be communicated to man. His observations, however, were not given to the world until 1878, one year after Bollinger had discovered the cause of the disease in animals.

In 1847, Semmelweis, on the basis of his own

observations, formulated the precept that puerperal fever is the result of the introduction of organic ferments into the puerperal genital tract. This discovery, established by himself and confirmed by the observations of many others, marked an era in obstetrics. The organic ferments have since been identified as specific bacteria. Semmelweis, in this way, anticipated in practical antiseptics the discoveries of Lister and Pasteur; while the late Oliver Wendell Holmes, in a paper entitled "Puerperal Fever a Private Pestilence," published in 1843, and republished in 1855, in treating of its prophylaxis, anticipated the teaching of Semmelweis. Semmelweis was first led to recognize the source of puerperal infection by the case of Prof. Koletschka, of the University of Vienna, who, having received a dissection-wound, became thereby fatally infected. In consequence of this, Semmelweis concluded that there was an identity between this infection and that of which so many hundreds of puerperal women died. In the school for instruction in practical obstetrics, with which he was connected, there were two departments, one for medical students, the other for midwives; the students going as a rule directly to the obstetric ward from the autopsy-room. He first noted the much greater mortality in the students' ward, and in May, 1847, began to require the students to wash their hands in chlorin-water before making vaginal examinations, thereby reducing the puerperal mortality to a point lower than had been ever before reached.

In 1863, Davaine established by experiments the bacterial nature of splenic fever, or anthrax.

In 1869, the first complete study of a contagious affection was made by Pasteur, in two diseases affecting silkworms—*pébrine* and *flachérie*—which he showed to be due to micro-organisms.

In 1875, Koch described more fully the anthrax-bacillus, gave a description of its spores and the properties of the same, and was enabled to cultivate the germ on artificial media; and, to complete the chain of evidence, Pasteur and his pupils supplied the last link by reproducing the same disease in animals by artificial inoculation from pure cultures. The study of the bacterial nature of anthrax has been the basis of our knowledge of all contagious maladies; and most advances in technic have been made first through the study of the bacillus of that disease.

In 1879, Hansen announced the discovery of bacilli in the cells of leprous nodules. They were subsequently clearly described by Neisser. From the nature of the symptoms and from the course of the disease, leprosy up to this time was long considered to be a disease similar to tuberculosis, and the discovery of the bacillus paved the way for the reception of Koch's discovery of the tubercle-bacillus.

In the same year Neisser discovered the gonococcus to be the specific cause of gonorrhoea.

In 1880, the bacillus of typhoid fever was first observed by Eberth, and independently by Koch.

In 1880, Pasteur published his work upon "chicken-cholera," an epidemic disease which affects turkeys, pigeons, chickens, ducks, and geese, and which causes almost as much destruction among them as the occasional epidemics of cholera and small-pox produce among man.

In the same year Sternberg described the pneumococcus, calling it "Micrococcus Pasteuri," which he secured from his own saliva; and in the same year Pasteur also found the same organism in saliva; though it is to Fraenkel, Talamon, and particularly Weichselbaum, that we are indebted for the discovery of the relation which the organism bears to pneumonia.

In 1882, Robert Koch made himself immortal by the discovery of and work upon the bacillus of tuberculosis, one of the most dreadful, and unfortunately most common, diseases of mankind. While great men of the earlier days of pathology clearly saw that the time must come when the parasitic nature of this disease would be proved, and some, as Klebs, Villemin, and Cohnheim, were "within an ace" of the discovery, it remained for Koch to succeed in demonstrating and isolating the specific bacillus, and to write so accurate a description of the organism and the lesions it produces as to render the discovery one of the most complete ever made in the history of medical science.

In the same year Loeffler and Schütz reported the discovery of the bacillus of glanders, an infectious disease almost confined to certain of the lower animals; although occasionally persons whose habitual association with and experimentation upon animals bring them into frequent contact with such as are diseased, have become accidentally infected.

In 1884, Koch discovered the "comma-bacillus," the cause of cholera.

In the same year Loeffler discovered the diphtheria-bacillus, and Nicolaier that of tetanus.

On October 26, 1885, Pasteur made the first application of his method for the treatment of hydrophobia, nearly ten years before the time we began to understand the production and use of antitoxins in human medicine.

In 1890, Koch issued to medical men what is known as tuberculin, a brownish, syrup-like fluid used experimentally in the diagnosis of tuberculosis.

In 1892, Canon and Pfeiffer discovered the bacillus of influenza.

In the same year Canon and Pielicke first found a bacillus now thought to be the specific cause of measles.

In 1894, Yersin and Kitasato independently isolated the bacillus causing the bubonic plague then prevalent at Hong-Kong, and now threatening Europe.

Sanarelli, in 1896, reported the discovery of the micro-organism of yellow fever. His conclusions were based on the presence of a certain germ (*Bacillus icteroides*) in 58 per cent. of cases examined, and the production of symptoms and pathologic changes in the lower animals resemble those present in man. Sanarelli's observations have been confirmed by a commission of the U. S. Marine-Hospital Service. Some doubt has lately been thrown upon this germ being the specific cause of yellow fever. However, the mode of transfer of the disease from sick to well persons has been proved. Mosquitoes, it is now known, act as the disseminators of yellow fever. The females of the species called *Stegomyia fasciata*, twelve days after biting an individual sick of yellow fever, act

the rôle of carrier for several months' time thereafter. This mosquito is prone to inhabit thickly populated districts rather than the open country, its presence and multiplication depending upon the continuance of stagnant water. It is most active between the hours of 4 P. M. and midnight, and ceases to bite when the temperature falls below  $62^{\circ}$  F. This last fact bearing out the long-known observation that the first frost killed the fever, no new cases developing afterward in a given district liable to extremes of temperature. Preventive measures call for the destruction of all the mosquitoes in the house of a patient taken with the disease, best accomplished by closing up and screening all the doors and windows of the premises and burning sulphur (1 pound of roll sulphur to every 1000 cubic feet of room space). Screening of the patient, sick or dead, must be carried out for the common protection. Spirits of camphor, oil of pennyroyal, or 5 per cent. menthol ointment applied frequently to exposed parts of the body—neck, face, wrists, and ankles—may be employed to keep off the mosquitoes in the non-immune.

Epidemic cerebrospinal meningitis, or spotted fever, is now known to be caused by a specific germ present in the cerebrospinal fluid of patients suffering from this disease. The route of infection is not fully determined, but it is probably through the nose.

Malta-fever, a disease of the Mediterranean islands, and occasionally of the Antilles and Central and South America, is due to a micrococcus discovered by Bruce, and called *Bacillus melitensis*.

Malarial fever is an infectious disease; but, unlike those mentioned, it is not caused by a vegetable germ,

a bacterium, but by a microscopic animal, the *Plasmodium malarie*, which is found in the blood of the afflicted individual, its entrance being brought about by the stings of mosquitoes (females of certain varieties).

There is some grounds for a belief that malignant tumors—cancers and sarcomas—are due to microorganisms. The nature of the parasite is as yet unknown; but the latest researches point to a tiny organism, a yeast-plant or blastomycete.



## CHAPTER II.

### BACTERIA AS THE CAUSES OF DISEASE.

DISEASES may be divided into two great classes—the constitutional, which are due to such causes as errors in diet, alcoholic excesses, overwork, or age; and the infectious or contagious, which are due to the introduction into the body of a living poison. We no longer look upon infectious and contagious diseases as due to an unexplainable something, whose source we cannot know, whose course we cannot predict, and whose end cannot be hastened by any efforts on our part. Investigation has shown that we are no longer fighting an unknown enemy in the dark, but that we have before us a definite, living thing, whose part in the plan of creation is as surely fixed as our own, whose life-history can be told, and whose growth is as dependent on the right amount of light, food, heat, and air as that of the rose in our garden.

The word *bacteria* is a general name for all the plant micro-organisms. Of these there are many different classes with different names. They vary much in shape and size, some being round, some thread-like, some rod-shaped, and some of a spiral form. Each single organism consists of a small speck of protoplasm or vegetable albumin, to which may be given the name of a cell; and these cells are so minute that they can be seen only with the aid of the best

microscopes at our command. The rounded organisms, or micrococci, as they are called, are seldom more than  $\frac{1}{25000}$  of an inch in diameter; the elongated cells average a little more perhaps, and are from  $\frac{1}{12000}$



FIG. 1.—Various forms of bacteria: 1 and 2, round and oval micrococci; 3, diplococci; 4, tetrads; 5, streptococci; 6, bacilli; 7, bacilli in chains, the lower showing spore-formation; 8, bacilli showing spores, forming drumsticks and clostridia; 9 and 10, spirilla; 11, spirochetæ (McFarland).

to  $\frac{1}{8000}$  of an inch in length. Different forms naturally vary from this standard of size; but these figures will give a good idea as to the actual size of the forms under consideration.

The fungi connected with disease in man are divided into three classes :

1. Moulds, or hyphomycetes.
2. Yeasts, or blastomycetes.
3. Bacteria, or schizomycetes.

Some bacteria, or schizomycetes, induce the various fermentations; while others are productive of putrefaction, and are called saprophytes. Others, again, known as the pathogenic bacteria, are the cause of various diseases; while those which do not ordinarily cause disease are known as the non-pathogenic bacteria. The chief forms of bacteria are :

1. The coccus—berry-shaped or spherical bacterium.
2. The bacillus—rod-shaped bacterium.
3. The spirillum—corkscrew bacterium.

And these, which are species relatively monomorphous—*i. e.*, preserve their shape—are practically the only ones with which we have to do.

The cocci are named according to their arrangement with one another; if, for instance, they are in pairs, they are called diplococci; if in a chain, they are

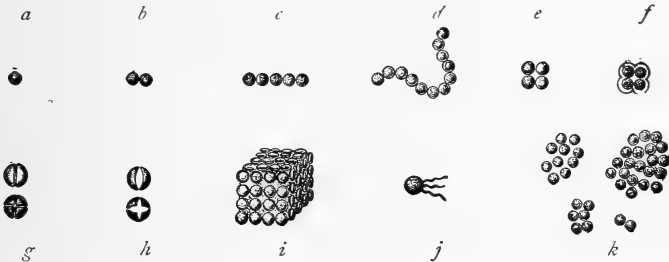


FIG. 2.—Diagram illustrating the morphology of cocci: *a*, coccus or micrococcus; *b*, diplococcus; *c*, *d*, streptococci; *e*, *f*, tetragenococci or merismopedia; *g*, *h*, modes of division of cocci; *i*, sarcinæ; *j*, coccus with flagella; *k*, staphylococci (McFarland).

called streptococci; if in a cluster, like a bunch of grapes, they are called staphylococci; and if in an irregular mass, stuck together by a thick substance, they constitute a zoöglea. Those developing in fours are called tetrads; in eights, sarcinæ.

The cocci are also named according to their functions, as, for instance, “pyogenic,” or pus-forming; the specific name also describing the form, arrangement, color, and function; for example, *Staphylococcus pyogenes aureus* signifies a spherical colorless micro-organism forming a yellow pigment, arranging itself with its fellows into the form of a bunch of grapes, and producing pus.

As the surgical nurse carries on a daily warfare for the destruction of pus micro-organisms and prevention of their growth, she cannot be too familiar with every

aspect of these germs. The two most constant pus formers are : (1) the Staphylococcus (Fig. 2, *k*), which, when present in a wound, may cause a free flow of pus ; still it generally manifests a milder disease condition than the virulent (2) Streptococcus germ (Fig. 1, No. 5).

Staphylococci may be observed under the microscope by placing a drop of the pus upon a cover-glass, afterward spreading the specimen by applying another cover-glass ; dry over an alcohol lamp and stain with a solution of methylene-blue. Wash away the excess and place the specimen face down upon a glass slide. Streptococci are best stained by the so-called Gram's method. To a dried and spread drop of pus upon a cover-glass apply an excess quantity of the following :

Anilin,	4 parts.
Saturated alcoholic solution of basic anilin dye,	11 "
Water,	100 "

Stain in this for fifteen minutes ; transfer to Gram's solution :

Iodin,	4 parts.
Potassium iodid,	2 "
Water,	300 "

Stain for four minutes ; remove and wash the specimen in 95 per cent. alcohol ; finally stain in the following for half a minute :

Bismarck brown,	3 parts.
Water,	70 "

Wash in 95 per cent. alcohol ; clear the specimen by

adding a few drops of carbolxylol ; place upon a glass slide for observation. Anyone capable of developing an ordinary kodak film will find but little difficulty in learning this apparently deeply mysterious technic of the bacteriologic laboratory.

Bacteria reproduce in two ways : By direct division (fission) and by the development of spores or seeds (sporulation). The most common mode is by binary division, one body dividing itself so as to form two other bodies; these two re-dividing; and so on. It can readily be imagined how quickly an appalling increase in their numbers can be thus brought about; but fortunately this multiplication only takes place to advantage under certain favorable conditions; if these are not present, the bacterium begins to degenerate, but usually does not die until it has left behind a spore. When the formation of a spore is about to commence, a small bright point appears in the protoplasm, and increases in size until its diameter is nearly or quite as great as that of the bacterium. As it nears perfection a dark, highly refracting capsule is formed about it. As soon as the spore arrives at perfection the bac-



FIG. 3.—Diagram illustrating sporulation: *a*, bacillus inclosing a small, oval spore; *b*, drumstick-bacillus, with terminal spore; *c*, clostridium, with central spore; *d*, free spores; *e* and *f*, bacilli escaping from spores (McFarland).

terium seems to die, as if its vitality were exhausted in the development of the permanent form. As soon as the young bacillus escapes it begins to increase in size, develops around its soft protoplasm a character-

istic membrane, and having once established itself presently begins the propagation of its species by fission. In those forms of organism in which spores are not found the germs die very rapidly unless the conditions for their nutrition and multiplication remain very favorable. If all bacteria were of this kind, it would be possible to exterminate them with considerable rapidity. Spores will survive a great heat, a heat which will kill the organism from which the spore came; they will also live under a treatment with germicidal solutions which renders the bacteria inactive. In other words, the spores are much more resistant to the effect of germicides than the bacteria themselves. Cold does not kill them; they live through it and develop whenever favorable surroundings for their growth present themselves. They may lie dormant in the system for years, waking into activity only when they come into contact with some damaged, weakened, or diseased part which affords them a nest in which to develop and multiply, the cellular activity of the weakened part being unable to cope with the organisms.

The conditions which influence the growth of bacteria are, first, a temperature ranging from  $85^{\circ}$  to  $104^{\circ}$  F., some forms requiring a higher and some a lower temperature. Some forms of bacteria are not influenced in their growth by the presence or absence of light. To some, sunlight is destructive. A few hours' exposure to the sun is fatal to the anthrax-bacillus and to cultures of the *Bacillus tuberculosis*. The rays of the sun, however, must come into contact with the germs and are usually active only on the surface of cultures.

The majority of bacteria grow best when exposed to the air. Some develop better if the air is withheld; some will not grow at all if the least amount of oxygen is present. Those that grow in oxygen are called the aërobic bacteria, and those that will not grow in the presence of oxygen are the anaërobic bacteria.

A certain amount of water is always necessary for the growth of bacteria, though the amount required may be very small. If dried, no form will multiply and very many forms will die.

A soil consisting of highly organized compounds is also necessary for their growth and multiplication, and slight modifications in it may prove fatal to some forms of bacterial life, but be highly advantageous to others.

With age bacteria lose their strength and die. So we see that a suitable soil, and a proper amount of light, heat, and air are absolutely necessary for the growth and development of bacteria, for they carry on all the functions of a higher organized life; they breathe, eat, digest, excrete, and multiply.

The disease-producing bacteria effect entrance into the interior of the body through the skin and superficial mucous membranes, wounds, alimentary canal, respiratory tract, and placenta.

The entrance of bacteria into the tissues through the sound skin is very rare indeed, although some authorities claim that infection has taken place through the rubbing of bacteria or their spores upon the skin. The dangers of infection through the broken skin are well recognized; hence every wound, no matter how slight, should be protected as soon as possible.

Bacteria enter the alimentary canal through the food and drink. Typhoid infection has taken place through the rectum, its occurrence being due to the wearing of underclothing previously worn by typhoid fever patients, and to the use of enema syringe tips which had not been sterilized after their previous use.

Bacteria enter the respiratory tract through the mouth and nose, as in a deep inspiration, or an act of coughing, sneezing, or the like. Pneumonia and tuberculosis are said to be the result of inspiration of the specific organisms. The direct transmission of bacteria from a parent to the fetus has long been a disputed question, but is now generally conceded. The micro-organisms pass through the placenta and infect the fetus. Tuberculosis of the ovaries, Fallopian tubes, and uterus may originate through the blood, and infection from without through the vagina. Infection through the blood is evidenced by the general tuberculosis of all the viscera. Infection from without may result in tuberculosis of the uterus, ovaries, and Fallopian tubes.

The channels by which bacteria can enter the body are, then very numerous; and there is scarcely a moment in which some part of the body is not in contact with them. All the disease-producing germs have their favorable seat in some part of the body where they grow more or less luxuriantly, and in the secretions and excretions of which the chief source of their infection lies. The pneumonia-germ prefers the lungs; the typhoid fever germ selects the lower portion of the small intestine; the diphtheria-germ the throat; the cholera-germ the intestinal tract; the germ of tuberculosis prefers the lungs, but it is



called a "medical tramp," because it will lodge in any part of the body and make its home there. Hence we hear of tuberculous glands of the neck, tuberculous knee, intestinal tuberculosis, tuberculosis of the kidney, bladder, uterus, ovaries, Fallopian tubes, tuberculous peritonitis, etc. A tuberculous area is always a danger to the system, and may infect distant organs or give rise to a general tuberculosis.

To prove that a microbe is the cause of a disease it must fulfil Koch's circuit. It must always be found associated with the disease, and it must be capable of forming pure cultures outside the body. These cultures must be capable of reproducing the disease, and the microbe must again be found associated with the morbid process thus reproduced. In other words, we must prove the bacteria to be always present; we must then isolate them, then prove that they can produce the disease in a healthy animal, and, finally, having succeeded in doing all this, we must prove that no other form of bacteria can produce the disease, and that where these bacteria cannot be obtained the existence of the disease is impossible. All these requirements have been met in many instances, and now there are a large number of diseases each one of which has been definitely proved to be caused by a germ of its own, a germ which produces that disease and no other. Most of the germs need a special train of circumstances in order that they may be active, so that, fortunately for us all, the mere presence of the germ itself is not sufficient to produce the disease. For instance, we know that diphtheria is caused by a germ of its own which causes that disease and no other; still, exposure to

that germ does not invariably produce diphtheria—if it did, we should all be infected with it. This is because other conditions than the mere presence of the germs are needed to produce the disease. The germs must be active, and they can act only under certain conditions. It will usually be found that the attack of the disease has been preceded by a local inflammation of the throat, thus making a suitable place for the specific action of the diphtheria-germs. In typhoid fever the germs require a suitable condition of the bowels before they can produce the disease. This is also true of cholera, and explains why taking care of the health makes such a difference in the taking of this disease. The germs find their way into the body through the food and drink. Cases are reported that show how the germs enter drinking-water, which is sprinkled over vegetables sold in the streets of cholera-infected districts, how they are carried about in clothing, and taken to articles of food upon the table by flies which have preyed upon cholera excrement. Healthy lungs are not a suitable location for the development and activity of the germs of tuberculosis. If we are not fully in good health, or if we inherit a tendency to this special disease, we may acquire it very readily, since we often inhale the germs of it. Should the disease take root in our lungs, it may be controlled to a certain extent by a change of climate and surroundings; by going, for example, from a low and damp locality to the mild and dry atmosphere of Colorado, the Carolina mountains, Southern California, or of the other South-western States, where there are few cloudy days and where violent atmospheric changes are rare. The

germs there cannot be so active, for the air is stimulating, pure, and invigorating to the nervous system. The rarefaction of the air causes deep and strong involuntary respiratory movements, and there is consequently enforced a better ventilation of the lungs and a better oxygenation of the blood, in consequence of which there follow more active tissue-changes throughout the body and a strengthening of the respiratory muscles.

On finding favorable conditions it takes germs some days to develop and produce the disease; this time is known as the period of incubation.

The question is often asked, Why, when we are so constantly in contact with disease-germs, do we not contract the diseases? All bacteria leave the body through the skin, lungs, kidneys, or bowels; and by a faithful use of disinfectants and antiseptics the germs may be kept confined to their original position. After their escape from the body they are difficult to control. The scales of skin or dandruff from a case of scarlet fever, measles, or small-pox, or the dust that arises from the dried sputum of a pneumonia or tuberculosis patient, or the poisonous material which may enter our drinking-water from too close proximity of the well and the sewer into which typhoid discharges have been emptied, may readily be the means of propagating disease. These sources of infection should be scrupulously avoided. Another protective factor is the natural or acquired power of resistance to disease-producing germs.

Immunity is either natural or acquired. Of acquired immunity we have two varieties, that which comes from acclimatization, and artificial immunity.

By **natural immunity** is meant the natural and constant resistance to disease-producing germs. The individual is immune by Nature, and sometimes by racial characteristics. **Acquired immunity** is a power of resistance attained through various circumstances. Thus, a single attack of some of the infectious and contagious diseases usually confers immunity against subsequent attacks. Such immunity generally follows an attack of typhoid fever, small-pox, scarlet fever, mumps, whooping-cough, measles, or yellow fever. Second attacks may occur; but, as a rule, a patient who has had an attack of one of these diseases has immunity for life. Influenza, pneumonia, cholera, diphtheria, and erysipelas are among the diseases in which one attack is not protective. Vaccination usually insures immunity against small-pox; but this is ordinarily not so complete or permanent as that resulting from an attack of the actual disease.

**Acclimatization immunity** is exemplified by various diseases which do not trouble natives or those long resident, but which may affect strangers not immured to the climate.

**Racial immunity** is that in which certain races are safe from certain diseases; for instance, negroes seldom suffer from yellow fever, but are more susceptible than whites to small-pox. In the former case doubtless due to the sweat odor of this race proving repellant to mosquitoes, the recognized medium of transfer of this disease germ. It is asserted that the Arabs seldom or never have typhoid fever. An analogous example is afforded by the fact that white mice are not affected by the same diseases as the gray mice

are, even though subjected to the same influences in respect to climate, food, and surroundings.

Artificial immunity may be produced in various ways. It is said that an injection of the antitoxin of diphtheria will give protection against the disease for from four to eight weeks. Tetanus has been prevented in a similar manner. It is impossible here to enter, except in a slight degree, into the consideration of the many theories of immunity, since they are very intricate, and not one has been advanced so far that can clearly explain it. The theory of phagocytosis and the theory of antitoxins are the two most important.

Phagocytosis is the destruction of bacteria by the white cells of the blood and the cells of fixed tissues. The cells which eat up and destroy the germs are called "phagocytes." When the two meet a battle occurs, the bacteria fighting the cells with their active fer-

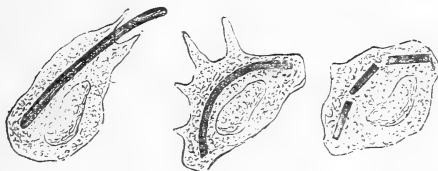


FIG. 4.—Phagocyte destroying a bacillus (Landerer).

ments, while the cells on their side put forth every effort to protect the body against the assaults of the disease. In a majority of the cases the bacteria win to the extent that the phagocytes die; but others take their place until the infection is overcome or the patient dies. The white blood-cells and tissue-cells having thus been educated to withstand the poison,

their descendants inherit this capacity and are born insusceptible. This theory was suggested by Carl Roser in 1881. Sternberg and Koch afterward put forth the same view, but it is usually credited to Metschnikoff, who published his observations in 1884.

The other theory—the so-called antitoxic theory—is founded on numerous more or less convincing experiments. If an animal be injected with certain pathogenic bacteria or their toxins in gradually ascending doses, it can be immunized to doses that under other circumstances would prove fatal. The blood-serum of an animal thus immunized has the power, when injected into another animal, of rendering it also immune to the bacteria that have originally been used; and in some cases the serum is even capable of curing the disease after it has developed in another animal. These properties with which the blood-serum has become endowed depend upon the presence of what are called antitoxins and antibacterial bodies. In man also, after recovery from certain infectious diseases, it is possible to demonstrate in the blood-serum the presence of antitoxic substances; and it is now the general belief that immunity, at least of the acquired form, is due to such antitoxins. The uses and practical preparation of antitoxins will be described in the next chapter.

The most important of the special surgical microorganisms—*i. e.*, those most frequently met with in surgical work—are the following, the majority being pus-producers:

1. *Staphylococcus Pyogenes Aureus*.—This is the

most common form; it is quickly killed by carbolic acid (1 : 20), bichlorid of mercury (1 : 1000), or by a few moments' boiling. It is found in the mouth, alimentary canal, and under the nails; it lives in the eyes, nose, ears, mouth, in the superficial layers of the skin, and is distributed in the water, soil, and air, especially in the dust of houses and surgical wards where the proper precautions are not taken.

2. *Streptococcus pyogenes* is a most important pathogenic micro-organism, and is thought by many authorities to be identical with the streptococcus of erysipelas. The *Streptococcus pyogenes* is frequently associated with internal diseases, and has been found in the uterus in cases of infective puerperal endometritis, ulcerative endocarditis, acute septicemia, and other diseases. It is one of the most common causes of post-operative peritonitis.

3. The *Bacillus coli communis* is always present in the intestine, and, while ordinarily active in the processes of digestion, it is thought to be a frequent cause of acute suppurative peritonitis.

4. The *Staphylococcus pyogenes albus* resembles the aureus in form, but is less virulent. It is a common cause of suppuration, and although it has been found alone in acute abscesses, it is usually associated with other pyogenic cocci, chiefly the *Staphylococcus pyogenes aureus*.

5. The *Staphylococcus epidermitidis albus* is a micrococcus which is almost always present upon the skin, not only upon the surface, but also in the outer layers.

6. The *Staphylococcus pyogenes citreus* is not quite so common nor so pathogenic as the other forms, and is less important.

7. The *Bacillus pyocyaneus* exists in pus (especially in open wounds), and gives to it a peculiar bluish or greenish color.

8. The *Bacillus aërogenes capsulatus* is a gas-producing bacillus that sometimes causes death after operations on the uterus; it may also enter through accidental wounds.

9. The *Bacillus tuberculosis* is the cause of all tuberculous processes. The chief cause of the spread of infection is found in the dried sputum, which becomes pulverized and is then inhaled as dust; and since one patient may expectorate as many as four billion bacilli in twenty-four hours, his capacity for harm is very considerable. The bacilli retain virulence for five months in dried sputum, and in putrid sputum for forty-three days.

10. The *Micrococcus lanceolatus*, known also as *Streptococcus lanceolatus*, pneumococcus, and *Diplococcus pneumoniae*, is the cause of croupous pneumonia and of many of the acute inflammations of the serous membranes of the body. It is also a pus-producer, and has been found in empyema and acute abscesses.

11. The *bacillus of tetanus* is found particularly in garden-soil, in the dust of halls, walks, cellars, street-dirt, and in the refuse of stables. It is not a pus-producer. Tetanus is a disease due to the absorption of its toxins, which poison the nervous system precisely as would dosing with strychnin.

12. The *diphtheria-bacillus* causes the dreaded diseases diphtheria and membranous croup, as well as inflammations of the eyes and nose; at times it also attacks open wounds.



## CHAPTER III.

### THE THEORY OF ANTITOXINS.

GREAT progress has been made of late in the field of serum-therapy, though much remains open to question and many recorded facts cannot yet be explained. The field for the investigator is perhaps larger than ever before. For a better understanding of the subject of antitoxins and their therapeutic application, a few essential facts should be borne in mind. An antitoxin is not the direct result of bacterial action, but is properly described as an unknown body resulting from the resistance of the healthy organism to the toxins of pathogenic bacteria. According to the prevailing theory, antitoxins are the products of the body-cells, formed under the influence of the bacterial toxin. In therapeutic practice the antitoxic body comes to us in the blood-serum of an animal, usually the horse. When properly prepared and properly kept in aseptic containers the antitoxins are not at all dangerous; they are as innocuous as an equal amount of blood-serum or normal salt solution administered in the same way. Antitoxins are used both to counteract the effects of the toxins which are elaborated by pathogenic bacteria in the body, and to render the system immune, so that it may resist the action of the bacteria should they gain access to the body. The antitoxins do not destroy the bacteria; in other words,

they are not germicides. In fact, the antitoxic serums are themselves good culture-media. One theory of their action is that they neutralize the toxin, thus giving the natural bactericidal powers of the body an opportunity to exercise their function.

The following is a brief description of the process employed in the laboratory of Parke, Davis & Co., for the preparation of diphtheria-antitoxin :

Young horses in perfect condition are selected and kept under careful observation by an expert veterinarian for three or four weeks. During this time they are carefully tested with tuberculin for the possible existence of unsuspected and undeveloped tuberculosis, and with mallein for glanders. When a horse is found to be perfectly healthy it receives its first dose of diphtheria-poison, or more properly a solution of the toxin of the diphtheria-bacillus. This is prepared in the following manner : A culture is obtained from the throat of a patient suffering from a virulent attack of diphtheria. The diphtheria-bacillus is isolated from this culture and planted in a flask of bouillon or beef-tea, which is then kept in an incubator from three to four weeks. At the end of this time it has attained its maximum toxicity and the bacteria begin to die of their own poison. The toxin which they have elaborated in the course of their existence is held in solution in the beef-tea. This bouillon solution of toxin is then filtered through porcelain to remove the bacterial cells and any other extraneous matter. It is then ready for injection into the horse. About one-tenth of one cubic centimeter is injected intravenously. The horse responds with all the constitutional symptoms of diphtheria, such as a chill, fever,

loss of appetite, more or less pharyngeal paralysis, with regurgitation of food. Sometimes death occurs from heart-paralysis. Upon recovery, which comes within a few days, a slightly larger dose is given. This treatment is continued for about one year, at the end of which time the horse will take from 2000 to 3000 times the initial dose without reaction. It is then ready for bleeding. About 6000 cubic centimeters of blood are drawn from the external jugular vein. This is allowed to clot, and the serum obtained is known commercially as antitoxin. It is customary to add an antiseptic, such as trikresol, to preserve the serum.

In preparing the streptococcus antitoxin a culture is made of bacteria obtained from two sources—erysipelas and puerperal septicemia. This is done because some eminent bacteriologists believe that the streptococcus of erysipelas is not identical with the streptococcus of puerperal fever. It is but fair to say, however, that others equally eminent assert the identity of the two streptococci. To meet the possibility of the non-identity of the organisms, a culture obtained from the two sources is used. Its virulence is increased by passing it through rabbits. After passing through about fifty rabbits a culture is planted in beef-tea, and the same course pursued as for diphtheria-antitoxin. Antitubercle serum is obtained by immunizing horses with the original Koch's tuberculin.

As to the therapeutic action of antitoxin, little or nothing is known positively. It seems reasonable to conclude from experimental evidence that the antitoxin neutralizes the toxin in the body and thereby gives the natural germicidal powers an opportunity

to dispose of the bacteria. It may be that it has the additional property of stimulating the phagocytic and possibly other bactericidal functions. The following experiments made by Martin and Cherry, of Melbourne, Australia, and described in the *Jour. of the Amer. Med. Assoc.* of August 27, 1898, are of interest in this connection. Behring, Ehrlich, and Kanthack have advocated the theory that the antagonism between toxins and antitoxins is a chemic one, somewhat analogous to the neutralization of an acid by an alkali; while Buchner, Metschnikoff, and others have maintained that it is indirect and operates through the cells of the organism. Martin and Cherry used a snake-venom antitoxin. A large number of guinea-pigs were used. At 60°C. the antitoxin was destroyed, while the venom retained its virulence. In the control-experiment with the venom only, all the animals died within a few hours. A number of mixtures were made of 1 c.c. of antitoxin with twice the fatal dose of venom; others with three or four times the fatal dose. These mixtures were allowed to stand at the usual laboratory temperature (20° to 23° C.) for two, five, ten, fifteen, and thirty minutes respectively, then heated to 68° C., and afterward injected.

As remarked above, this heat destroyed the antitoxin, so that none was injected. The animals subjected to the mixture of the stronger doses of ten minutes or less died or were seriously affected; all of those receiving the fifteen-minute mixture survived; while the thirty-minute mixtures produced no symptoms whatever. Similar results were obtained with diphtheria-antitoxin and toxin. These experiments seem to show, as far as anything can, that the neutraliza-

tion of toxins may occur in the test-tube, and that the vital processes in the organism and the body-cells are not essential. These gentlemen made further experiments by passing a mixture of toxins and antitoxins through a Pasteur-Chamberland filter. This was porous for toxin, but not for antitoxin, owing to the difference in the size of their molecules. The toxin which passed through the filter, after having been mixed with antitoxin, was neutral. The unavoidable conclusion from this experiment is that the toxin was neutralized before filtration.

Experiments have been tried in order to prove the theory that toxins are albumoses and antitoxins globulins; but these experiments do not appear to be conclusive as to this point.

The supposition that the administration of antitoxin is followed by a stimulation of the germicidal powers of the body seems to be reasonable, at least in the case of the antistreptococcic serum, since the streptococci disappear with the passing away of the signs and symptoms. On the other hand, the Klebs-Loeffler bacillus is found in the throat for weeks and even months after the disappearance of all symptoms of diphtheria in cases treated with the antitoxin.

The present status of diphtheria-antitoxin may be presented in a few words. It has established itself as a specific in the treatment of this disease. During the past year the use of larger doses has become more general, and it seems certain that better results were obtained. The administrators of the Chicago Department of Health give 2000 units in all cases of suspected diphtheria, and employ 1000 units as an immunizing dose. During the months of November

and December, 1898, this department treated 219 cases of bacteriologically proved diphtheria—all charity cases—with a death-rate of 4.1 per cent. Some two and a half years ago, when antitoxin was not used, the death-rate from diphtheria treated by this department was about 35 per cent.

Antistreptococcic serum gives promise of being second only to the diphtheria-antitoxin in point of therapeutic value. It has been most successful in erysipelas and puerperal septicemia. Cases of scarlet fever are reported in which it has been useful in shortening the duration of the disease and in preventing unfortunate complications and sequelæ, such as otitis media and other suppurative processes due to streptococci.

A mixture of the toxin of the streptococcus of erysipelas and the products of a harmless germ, the *Bacillus prodigiosus*, is used by Coley and others as an injection in malignant tumors that are past the stage of operation or are so situated that an operation is impossible.

It is to be regretted that tetanus-antitoxin does not in clinical use do all that it will do in the laboratory. It has been used in a considerable number of cases, but in nearly every instance without any result that would justify us regarding it as a great curative agent. Nevertheless, it should be used early in every case of tetanus, the patient thereby having a somewhat better chance of recovery.

One or two cases have been successfully treated with intracerebral injections of antitoxin, the theory being that the antitoxin should be placed where it could neutralize the toxin which is producing the

convulsions by means of its action on the nerve-centers. The value of this method of administration has not been proved.

As a preventive measure the use of tetanus-antitoxin is strongly commended.

An antityphoid fever serum has lately been developed which, if proved successful, must become of the greatest value in the prevention and cure of this insidious disease.

The antitubercle serum has not shown itself to have more value than a great number of other remedies vaunted as specifics in tuberculosis.

**Method of Injecting Antitoxin.**—The serums and toxins are given hypodermically, the injection being made into the back, thigh, side of the breast, or over the chest. Perfect antisepsis for the operation is absolutely necessary. The puncture-wound is closed with a collodion dressing. It is not necessary to use massage for the purpose of causing more rapid absorption of the injected serum—the swelling generally disappears in a short time of itself. Sometimes the site of the injection becomes very painful. In certain cases, pains in the joints and various skin-eruptions (erythema, hives) develop after the injection. They are not of great moment, but the physician's attention should be called to them.

The reaction following an injection of Coley's mixture is sometimes severe, and may correspond to the symptoms beginning an attack of erysipelas—chill, local redness, and high temperature.

## CHAPTER IV.

### ANTISEPTICS, DISINFECTANTS, AND DEODORANTS.

SUBSTANCES which retard or check the growth of bacteria amid otherwise suitable surroundings are called antiseptics.

Articles and wounds which are entirely free from bacteria and their spores are termed aseptic or sterile.

Disinfectants or germicides entirely destroy the vitality of bacteria. Excessive heat, dry or moist, is a true disinfectant, because it entirely destroys bacteria, while cold is an antiseptic; it does not kill bacteria, but retards their development.

A chemic agent which will cause the death of bacteria is called a *germicide*.

A deodorant is an agent that destroys bad odors. A disinfectant is an antiseptic, and may be a deodorant; but because a substance has the power to destroy bad odors it does not follow that it has the power to destroy the bacteria which are the cause of the odor. Carbolic acid, for instance, is a disinfectant and deodorant; while Platt's chlorides is a prompt deodorant, but has almost no disinfectant power.

The power of a chemic agent to destroy bacteria depends on several conditions :

First. The kind of bacteria, some being easily killed



by an agent which is entirely harmless to others. Spores are much more resistant than the bacteria from which they are derived.

Second. The number of bacteria present.

Third. The temperature at which the exposure to the disinfecting agent is made; the higher the temperature the greater the effect.

Fourth. The strength of the solution; a small quantity of a strong solution of corrosive sublimate is much more efficient than a large amount of a weak solution.

Fifth. The nature and quality of the associated material. If the bacteria are associated with a large amount of organic matter, the chemical agent used may combine with the latter and may thus be converted into an ineffective material before it has an opportunity to act upon the bacteria. This result must be especially guarded against in the disinfection of sputum and fecal matter.

The agents capable of destroying bacteria are numberless; but there are many which cannot be employed in practice because they are too weak or act too slowly, or are too poisonous, or too expensive for general use in the required quantity, or are too destructive to the objects with which they come in contact. Water at a high temperature cannot be used for the disinfection of the hands of the surgeon or of the field of operation, or of organic substances in general. Corrosive sublimate cannot be employed in the sterilization of instruments, since it corrodes and blackens them; it also discolors clothing and furniture when used in strong solutions. Potassium permanganate stains everything with which it comes in contact.

By long-continued action in concentrated solution some of the agents which arrest the growth will finally lead to the death of those bacteria which have been subjected to them. Many agents, however, which arrest the growth of bacteria, are not capable of destroying them, and particularly their spores. Cold, for example, will arrest the development of bacteria but has no power to destroy anthrax-spores even when applied with the most extreme intensity. The resistance of spores is one of the strangest phenomena in nature; some can be boiled and some can be subjected to the intensely cold action of liquid air without perishing. The chief disease-producing bacteria which form spores and those which do not are :

Non-spore-forming :

1. Streptococcus pyogenes.
2. Staphylococcus pyogenes aureus, albus, and citreus.
3. Streptococcus of erysipelas (believed to be identical with the Streptococcus pyogenes).
4. Diphtheria-bacillus.
5. It is doubtful whether the tubercle-bacillus is spore-forming. The weight of opinion favors the absence of spores in this organism.

Among the spore-forming pathogenic organisms are :

1. Bacillus of malignant edema.
2. The tetanus-bacillus.
3. The anthrax-bacillus.

The germicidal or disinfecting agents at our command are of two kinds chiefly, heat and chemic agents. The term "disinfection" is employed for

the action of chemic agents, and "sterilization" for the action of heat.

Among all germicidal or disinfecting agents heat is entitled to the first place, and fire, for its thoroughness, is superior to all others. All infected articles of little value, books, playthings, etc., that can be burned should be thus destroyed, as should also sputum and bowel-movements. The very best way to treat the latter is to mix them with sawdust and then to burn them.

In surgical work, for the perfect sterilization of articles capable of withstanding it, fire is preferable because of its certain action. Edged instruments and forceps may be exposed for a very short time to the direct flame; but if continued too long the temper of the steel is affected.

We must remember that after sterilization there is always the danger of contamination, and the articles must, therefore, be carefully protected immediately after sterilization. If they are left uncovered for dust to collect upon them, the object of sterilization is defeated.

Light, especially sunlight, acts as a germ destroyer.

Heat may be applied in the form of hot air, moist air (steam), or boiling water.

*Boiling water* kills germs on contact, and destroys anthrax-spores, as a rule, in from two to four minutes.

Moist heat (steam) is the next most powerful agent. It is more thorough and more penetrating than hot air. Steam exerts its full influence only when the air is saturated with it. Saturated steam may be simple steam (quiescent), live steam (circulating steam),

high-tension steam (confined under a certain pressure), or superheated steam (that which has been heated secondarily to a temperature above  $100^{\circ}$  C.).

*Live steam* destroys anthrax spores in from five to fifteen minutes, according to their degree of resistance.

*Disinfection by steam* is applicable to clothing, linen, blankets, towels, surgical dressings, instruments, curtains, carpets, brushes, mattresses, pillows (the two latter should be ripped open), and a number of delicate fabrics. It is not applicable to linen soiled by feces, blood, or pus, since the stains would become fixed by the process (soak first in plain cold water), nor to rubber articles. Under certain conditions many articles are exposed to the action of steam for one hour on three successive days, being kept during the intervals at a temperature of  $70^{\circ}$  to  $80^{\circ}$  C. to favor the development of bacteria. This is called "intermittent" or "fractional" sterilization, the object of which is to kill all bacteria that may have developed from spores that escaped the first steaming. The last sterilization is for the purpose of making sure.

*Hot air* is inferior to both steam and hot water. Steam at a temperature of  $100^{\circ}$  C. is more effectual than hot air at a much higher temperature. According to investigations, exposure to a temperature of  $150^{\circ}$  C. ( $302^{\circ}$  F.) for one and a half hours in a hot-air sterilizer will kill all known bacteria and their spores.

*Ozone*, formed by electric discharges in water, may be used to improve its quality for drinking purposes.

The list of chemic substances used as germicides is constantly changing, and those which are now

considered the most valuable may in a little while be considered not so effectual as newer ones. Among the recognized antiseptics and disinfectants now in use are :

*Chlorin*, in the free gaseous form or in watery solution, is used for general disinfecting.

*Sulphur dioxide*, best used in the presence of moisture, is produced by burning roll sulphur (flowers of sulphur) in a closed receptacle.

*Corrosive sublimate*, or bichlorid of mercury, has, like carbolic acid, the advantage of being both efficacious and cheap. It has the disadvantages that it is decomposed by alkalies, that it is precipitated by albumin, and that it corrodes metals. It is used in strengths of from 1:10,000 to 1:500. The solution should be made as it is needed, because in old solutions most of the soluble corrosive sublimate has been converted into insoluble calomel, and the solution is not germicidal. By using the compressed tablets now on the market fresh solutions are readily made. A tablet usually contains the requisite amount of corrosive sublimate to make when added to one pint of water a 1:1000 solution, and by increasing or diminishing the amount of water the strength of the solution may be altered at pleasure. The tablets are very convenient, and almost compel accuracy in the preparation. Corrosive sublimate is of less value for the disinfection of the excreta than carbolic acid, as it hardens the albuminous material which covers the outside of all fecal masses, and thus protects the inside from the desired action. Tartaric acid, chlorid of sodium, or chlorid of ammonium is often added to prevent this. Compressed

tablets, each containing tartaric acid or ammonium chlorid and  $7\frac{1}{4}$  grains of corrosive sublimate, or equal parts of chlorid of sodium and corrosive sublimate, are in common use. The convenient form in which this drug is put up and the readiness with which it can be used in surgical and medical work have made its adoption universal. Its poisonous character must be kept constantly in mind. The first symptoms of poisoning in consequence of the absorption of the bichlorid are profuse salivation, fetid breath, a metallic taste in the mouth, sore teeth, spongy gums, and swollen tongue. Should any of these symptoms appear they should at once be reported to the surgeon. As the solution has no odor, it is occasionally swallowed in mistake. Should this occur, symptoms of a violent gastro-enteritis appear—vomiting, burning pain, bloody stools; the kidneys are also affected, and an acute Bright's disease develops. The immediate treatment of this acute poisoning consists in the giving of white of egg, flour, or milk and lime-water, and washing out of the stomach.

*Carbolic acid*, derived from coal-tar by distillation. When pure, it is a solid, white, or faintly rose-colored, crystalline body, readily soluble in water, alcohol, or glycerin. On exposure to air it absorbs 5 per cent. of moisture. A solution frequently employed is one of 5 per cent. strength. To make a 5 per cent. solution, 1 part of carbolic acid is added to 20 parts of very hot water and the whole shaken thoroughly. Any excess of carbolic acid above that strength falls to the bottom of the vessel as pinkish globules. Before using the solution care must be taken that the

globules have been dissolved, or they will burn any living tissue with which they come in contact. Carbolic acid is considered now to be the most reliable and useful of all the germicides and antiseptics. It has the advantage over corrosive sublimate in that it does not discolor instruments nor clothing; but, on the other hand, it irritates and benumbs the skin. Pure carbolic acid is a reliable disinfectant for instruments. If an instrument that is indispensable happens to fall to the floor during an operation, it may be laid for a moment in pure carbolic acid, then rinsed with sterile water, and it is ready for use. Long-continued submersion in the acid will, however, deprive knives and scissors of their temper and edge. Symptoms of poisoning have been produced by the absorption of the drug from surgical dressings and from the use of carbolic solutions for irrigation. The first evidences of poisoning are a very dark greenish or a blackish coloration of the urine, headache, giddiness, ringing or singing in the ears, and lassitude. The odor of carbolic acid is, to a certain extent, a protective against accident; yet fatalities occasionally occur. The antidotes of carbolic acid are alcohol, milk, and lime-water, or flour and water. The strength of the solutions used varies from 1:80 to 1:20. The acid is bought usually in the liquid form, having a strength of 95 per cent. To make a solution 1:20 (5 per cent.), 1:40 ( $2\frac{1}{2}$  per cent.), 1:50 (2 per cent.), 1:80 ( $1\frac{1}{4}$  per cent.), 1 ounce of the 95 per cent. solution is added to 20, 40, 50, or 80 ounces of water. When obtained in the solid form, it may readily be liquefied by placing the bottle in a vessel of hot water.

*Crude carbolic acid* mixed with strong sulphuric

acid makes a powerful disinfectant where possible to employ it.

There are other products of coal-tar distillation akin to, but not so poisonous as, carbolic acid. Among them are the following :

*Creolin*.—This is a non-irritant and practically non-toxic germicide. Though toxic symptoms have been reported, it certainly is the least poisonous of the powerful germicides now in use. Its chief disadvantage is that when mixed with water it forms an opaque emulsion ; consequently it is inapplicable for the sterilization of instruments, since they could not readily be found in it. For cleansing the hands and for irrigation, creolin is used in strengths of from 2 to 5 per cent. The antiseptic value of creolin would seem to be discounted, as this reviser recalls several deaths from tetanus in puerperal women where tap-water—later proved to contain tetanus germs—was employed in making up creolin solutions for irrigations. To make a 2 per cent. solution,  $2\frac{1}{2}$  teaspoonfuls of creolin are added to 1 pint of water.

*Lysol* is a brown, oily-looking, clear liquid, with a creosote-like odor, obtained from tar-oils. When added to ordinary hard water it forms a clear, soapy liquid, as it precipitates the lime-salts in the water, but is clear if distilled water, alcohol, or glycerin be mixed with it. Its antiseptic properties under no circumstances are impaired. On account of its saponaceous character it cannot be used for instruments, because it renders them slippery. It is much employed in surgery and gynecology, in solutions of from 1 to 5 per cent. To make a 1 per cent. solution, 5 drams are added to  $\frac{1}{2}$  gallon of water. Its chief



advantage over other antiseptics lies in its non-irritant and much less poisonous properties. It can be used for the disinfection of everything in the sick-room.

*Sozal* is an antiseptic obtained in small crystals which have an odor of coal-tar. It is said to possess the same advantages as corrosive sublimate without its toxic properties. The crystals are readily soluble in water, glycerin, or spirit.

*Saprol* is a dark-brown oily fluid with an odor of carbolic acid. When mixed with water it divides into oil drops, some of which fall to the bottom of the vessel, while others float on the top of the water, consequently it cannot be used for surgical purposes. It is a powerful disinfectant, especially valuable in disinfecting excreta, and possesses the property of diffusing evenly through the material to which it is added.

Other disinfectants outside of the coal-tar products are :

*Iodoform* has been largely used as a surgical dressing. It has no decided antiseptic properties. It does good by absorbing the liquids of the wound, thereby removing one of the factors for germ growth. When applied to large moist surfaces it gives off free iodine. It prevents decomposition and inhibits, but does not destroy, the germs of putrefaction and pus formation if they are present before its use. When applied to raw surfaces it is occasionally absorbed into the system, and causes symptoms of poisoning. On account of this danger salol is often substituted for it, as is also a mixture of iodoform, 1 part to 7 parts of boric acid, it being both antiseptic and unirritating.

The symptoms of absorption are headache, loss of appetite, rise of temperature, a rapid, feeble pulse, restlessness, and insomnia. These symptoms may pass away if the dressing is removed and discontinued. In grave cases there is marked anxiety, a bright-red eruption appears on the face and limbs, and there is retention of urine, with stupor, delirium, collapse, and death. Some patients are very susceptible to the toxic effects of the drug. It has a penetrating odor, which many persons find disagreeable. Spirit of turpentine will at once remove the objectionable odor from the hands, instruments, and vessels that have been in contact with the drug. Iodoform darkens upon exposure to a bright light and is likely to cake when it becomes moist. It is used for impregnating gauze-dressings, for dusting on ulcers and wounds, and for injections, dissolved in ether or olive oil, into sinuses or tuberculous abscesses. It is also used in the form of ointment.

*Iodol* is a pale yellow crystalline powder, almost insoluble in water, but readily soluble in ether and alcohol, less so in glycerin or oils. It is often used as a substitute for iodoform, having the same properties. Like iodoform, it darkens if exposed to a bright light. It is used in the form of powder, solution, and ointment, and has the advantage of not being so poisonous as iodoform.

*Formaldehyd* is a gas formed by the partial oxidation of wood alcohol; it may be produced by burning wood spirit in an ordinary alcohol lamp. Its use is greatly facilitated by having it combined with water in a definite proportion, so that the quantity used may be certain and positively known. Its solution in

water is called formol, formal, and formalin, and contains about 40 per cent. of formaldehyd gas. Formaldehyd is non-poisonous, colorless, with a pungent, irritating odor, and possessing great antiseptic, disinfectant, and deodorant powers. Its activity as a germicide is considered to be equal, if not superior, to that of bichlorid of mercury, and it is available in many cases in which the latter cannot be used. It does not corrode or tarnish metals, nor injure the finest fabrics either in texture or color. As a deodorant it removes immediately the odor of feces, urine, septic, or gangrenous material. It may be used externally in the form of solution, spray or vapor, and is sometimes added to powders. In solution as a wash or irrigation in wounds, it is employed in strengths varying from 0.5 to 20 per cent. As a dusting-powder it is used in combination with gelatin. Sheets of moist gelatin, after exposure to formalin fumes, are ground to a coarse powder, used in the dressing of wounds. A slight disadvantage is that for four or five hours after its use on a raw surface it produces more or less pain of a burning nature. In the form of vapor it is used for sterilizing instruments and surgical dressings, and for the fumigation of the sick-room and its contents. The simplified method of fumigating consists of diluting one pound of formalin with three times its volume of hot water, and boiling over a flame for half an hour. The generated gas is very penetrating, and having the same specific gravity as the air, soon permeates the room in which it is confined, and kills all germs, not protected by moisture, in about three hours. Special portable forms of apparatus have been devised for purposes of room-disinfection. Spray dis-

infection of rooms with a 2 per cent. formalin solution is also very satisfactory.

For the sterilization of instruments a 1 : 2000 solution is used.

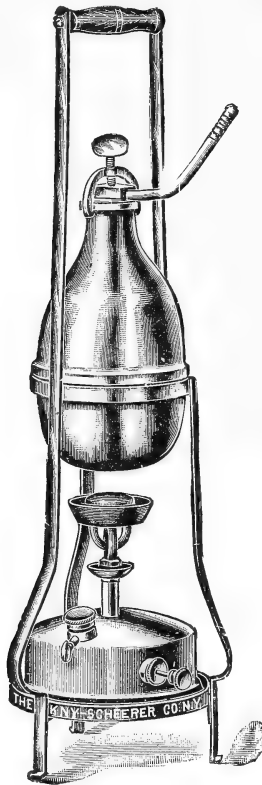


FIG. 5.—Formaldehyd generator.

*Formaldehyd* vapor when inhaled irritates the lungs. It also irritates the eyes and nostrils, causing them to smart.

A fatal case of formalin-poisoning is reported, the

amount taken being about 3 ounces of a 4 per cent. solution. Immediately after taking there was pain in the stomach and vomiting. The vomited matter was blood-stained and had the pungent odor of formalin. The patient died of heart-failure thirty-two hours afterward. The treatment consisted in albumin-water, free emesis, heart-stimulants, and normal saline solutions given both hypodermically and intravenously.

*Aristol* (thymol iodid) is a reddish-brown powder containing about 45 per cent. of iodine. It is used as a substitute for iodoform. It has not the disagreeable odor of iodoform, and its use is attended with less danger of poisoning. It is used in the form of fine powder or ointment, the strength of the latter varying from  $\frac{1}{2}$  to 1 dram to the ounce of pure lard.

## CHAPTER V.

### ANTISEPTICS (Continued).

*Hydrogen dioxid* or *peroxid of hydrogen* is a popular antiseptic. It is an excellent agent for the destruction of pus-cocci. When poured or injected into a wound, effervescence takes place, the result of chemic reaction between the wound-secretions and the hydrogen peroxid, causing coagulation of albumin and the setting free of gas. This active frothing serves to carry off any shreds of tissue in the wound that cannot easily be reached. It may likewise do harm by burrowing the cellular tissues. The peroxid is also applied to the throat in diphtheria to destroy and remove the false membrane. It readily decomposes by coming in contact with metals; consequently, if used as a spray, a glass atomizer must be employed. The hydrogen peroxid in common use is a clear, odorless fluid, having a bitter taste. The official solution contains 3 per cent. of the pure dioxid, which corresponds to about ten volumes of available oxygen, and it is upon its readiness to yield oxygen that its activity depends. The solution should be kept in a cool, dark place, and the cork forced tightly into the bottle; when removing the stopper always point the bottle away from the face.

*Boracic acid* (boric acid) is a mild antiseptic. It is non-irritating and practically non-poisonous. It is therefore frequently used to wash out cavities, for in-

jections, and in ophthalmic and aural practice. It is used in the form of powder, solution, ointment, and gauze. In solution, a saturated solution is used (a saturated solution is one in which the water dissolves as much as it will of the drug; the remainder lying at the bottom of the vessel as an indication that the solution is sufficiently strong). It is easily made by placing one-half pound of boric acid in a half-gallon bottle filled with boiled water and shaking thoroughly until saturated. It is impossible to use a solution which is too strong, because the water cannot take up any more than 1 in 30 (about 4 per cent.), which is the usual strength used. In rare cases it acts as an irritant to the skin and produces an eczematous condition.

*Boroglycerid* is a non-poisonous antiseptic solution made from boric acid and glycerin, and is used as a wash, an irrigation, and for saturating tampons.

*Thiersch's solution* is an antiseptic of moderate power, unirritating and non-poisonous; it contains salicylic acid, 2 parts; boric acid, 12 parts; hot water, 1000 parts.

*Alcohol*.—Absolute alcohol is an antiseptic and disinfectant used for cleansing the skin, for the preparation of sutures and ligatures, and for the disinfection of cutting-instruments. To sterilize the hands, they are scrubbed for five minutes with soap and hot water, then scrubbed for the same length of time in absolute alcohol, and finally rinsed in an antiseptic solution. The results obtained by the disinfection and cleansing of the skin with alcohol have been ascribed to the solvent action of the alcohol upon the fatty matters on the skin, thus allowing corrosive

sublimate and other antiseptics to come into immediate contact with the bacteria. Scrubbing the hands in absolute alcohol for five minutes takes up both the fatty matters of the skin and also the bacteria, which are thus washed away.

*Potassium permanganate*, or permanganate of potassium, is an antiseptic, disinfectant, and deodorant, depending for its action on its oxidizing properties. It parts with its oxygen very readily to organic substances and becomes inert. Its chief disadvantage is that it stains everything a brownish-black color. It is used in solutions varying from 1:100 to 1:10. When employed for sterilizing the hands, it is followed by oxalic acid solution, which has the property of removing the stain. It is also used on wounds, especially those which have an offensive discharge, as, for example, gangrenous ulcers, on which it acts as a deodorant as well as a disinfectant. It may also be employed to disinfect bowel-movements, to flush water-closets, etc. Its advantages are that it is non-poisonous in ordinary strengths, rapid and complete in its action, and shows by its change of color from reddish-purple to a brown whether it is acting or whether it is exhausted. The strength of the solution generally used is from 20 to 16 grains of the crystal to 1 pint of water.

*Oxalic acid* is a powerful germicide, though it is not used alone, but to remove the stains of potassium permanganate from the skin. It is very poisonous and quite irritating, but the irritation can in a measure be avoided by immersing the hands and forearms afterward in either plain water or lime-water. A



series of experiments by Dr. Howard A. Kelly, to determine the relative part played by these two chemicals in the process of disinfection, led to the conclusion that both the permanganate of potassium and oxalic acid were germicides, but that the oxalic acid at a temperature of about 40° C. (104° F.) is a much more powerful germicide than the permanganate of potassium. Oxalic acid also removes permanganate stains from white goods, and ammonia will remove the stains from black goods.

Potassium permanganate is frequently used in a solution called *Condy's fluid*, which consists of a strong solution of the impure drug, and may be employed to disinfect and deodorize urinals and closets, but cannot be employed to disinfect rooms. It must be mixed with the discharges it is intended to neutralize.

*Pyoktanin* (methyl-violet, methyl-blue, blue pyoktanin), an aniline derivative, is a disinfectant and antiseptic. It occurs in two colors, blue and yellow, the yellow variety being used in ophthalmic practice only. Its great disadvantage is that it stains everything with which it comes in contact. The stains, however, may be removed with alcohol or Labarraque's solution. It is used in the form of powder, ointment, and in solutions of the strength of 1:500 and 1:1000.

*Labarraque's solution* is a solution of chlorinated soda, and is made from chlorinated lime and sodium carbonate. It is used as an antiseptic in solutions of 1:10, and for cleansing purposes.

*Chlorinated lime*, or chlorid of lime, is one of the best disinfectants for drains, infected clothes, bowel-

movements, sputum, and urine. It is also a powerful deodorizer. It loses its strength if exposed to the air. The standard solution contains 6 ounces to 1 gallon of water.

*Milk of lime* is made by slaking lime in water. The freshly made solution is used to disinfect typhoid stools or urine, but must be thoroughly mixed with the infected material to be effective. The disadvantage of this solution is its liability to clog the drain-pipes.

*Sulphuric* and *hydrochloric acids* are employed in 4 per cent. solutions for the disinfection of excretions, equal parts of the solution and the substance to be disinfected being used.

*Zinc chlorid* has some value in solution as a deodorizer.

*Ichthyol*, derived from fish scales, is a dark brown thick liquid, with a highly disagreeable odor; it is used extensively as an antiseptic, astringent, sedative, and alterative in many skin diseases, various inflammatory affections, wounds, and abscess-cavities. It is employed externally in the form of a thick liquid and ointment. Before the application of ichthyol the affected parts are washed with warm water and soap, and gently dried. After painting, or after inunction, the parts are covered with absorbent cotton or flannel and gutta-percha tissue. The applications are best employed morning and evening. Many patients object strongly to its use on account of the disagreeable odor. This may be disguised by the addition of oils of citronella and eucalyptus, 1 part of each to 50 parts of ichthyol—or ichthyol (9 parts) may be combined with oil of turpentine (1 part). Ichthyol is said to have a remarkably efficacious action upon recent burns in re-

lieving the pain and facilitating healing. It is also used in combination with the compound stearate of zinc. The stains of ichthyol may be removed by boiling the stained articles in soap and water, or by washing them with potash-soap or soap-spirit.

*Balsam of Peru* is used as an external application to wounds, 10 to 20 per cent. in castor oil, it having both an antiseptic and a stimulant action. Glycerin is sometimes used as a menstruum for ichthyol and balsam of Peru because of its dehydrating effect upon the granulation-tissues of a wound, whereby they are held more in check and do not form so rapidly.

*Orthoform* is an antiseptic and a local anesthetic having a decided action when applied to raw surfaces or exposed nerve-endings. It owes its antiseptic action to benzoic acid. It is a white, crystalline powder, without odor or taste, entirely non-poisonous, is slowly absorbed, and is used in the form of powder or ointment. In rare cases it causes severe inflammation and even sloughing of the skin.

*Orthoform hydrochlorid* is a combination of orthoform and hydrochloric acid, and is also an anesthetic.

Mustard, vinegar, and normal salt solution are also antiseptic.

*Sterilized vinegar* is said to be equal in antiseptic power to a 1 : 2000 solution of corrosive sublimate. It is less irritating to the tissues than bichlorid, and is said to stimulate the healing process in open wounds instead of retarding it, as mercury sometimes does. It is sometimes used during an operation for irrigation, especially if there is much capil-

lary hemorrhage, which, on account of its astringent action, it controls. It is also used for the disinfection of the hands, surgical operating-rooms and wards, and to remove blood-stains from the hands.

*Mustard* is used for the disinfection of the hands and arms of the surgeon and his assistants, and of the field of operation. After scrubbing the hands and arms with a stiff brush and green soap, the water used being as hot as can be borne, one teaspoonful of mustard is rubbed in very thoroughly for about three minutes, after which it is washed off with hot sterilized water. The field of operation is prepared in the same way.

*Resorcin* is an antiseptic and deodorant, used in the form of solution, powder, or ointment in strengths varying from 2 to 20 per cent. As a powder it is usually mixed with boric acid, 1 : 20 or 1 : 10. It is not absorbed by the unbroken skin and produces very little irritation on the cutaneous tissues.

*Dermatol*, also called bismuth subgallate, is used as a substitute for iodoform in the dressing of wounds. It is an antiseptic, sedative, and astringent.

*Protargol* is an albuminous compound of silver, containing about 8 per cent. of the metal. It is soluble in water to the strength of about 50 per cent., and forms a clear light-brown fluid.

*Listerine* is a proprietary antiseptic solution used extensively on wounds, for cleansing the mouth, throat, and nose.

*Bicarbonate of sodium* has been used with marked success as an antiseptic in the treatment of foul suppurating wounds and ulcers in a strength of 2 per cent. A 1-per-cent. solution has long been used in

which to boil surgical instruments. It is customary ordinarily to simply add sufficient soda to impart a greasy feeling to the fingers. The soda adds to the disinfectant power of the boiling water.

*Soaps* have some action as weak disinfectants.

There are numerous other antiseptics of proprietary nature, but it is hardly necessary to refer to them. Chemists are constantly adding new preparations to the long list already in use.

## PART II.

# SURGICAL TECHNIC.

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### CHAPTER VI.

#### **BANDAGING AND DRESSINGS.**

BELIEVING that nurses will be far more likely to practise and to understand the application of the various bandages if the directions are set down in a terse manner than when wordy descriptions are employed, the following section upon bandaging is intended to be read off while the nurse is actually engaged in applying the bandage described. With the bandage of proper size in hand she is to begin its active application while another directs her movements by reading from the text (a glance at the illustration before beginning will aid in securing a well-proportioned dressing). It is to be recalled when applying the complex bandages that but one edge is to show, the rest being covered up by subsequent turns. Fears that the bandage is not being correctly and neatly applied, because of wrinkles appearing, may be discarded if the upper or lower edge (as the case may be) is applied sufficiently taut. It may be added, too, that frequent turns, each applied moderately firm, will secure the patient's comfort better than a few turns tightly set.

Secure the initial end of a bandage when apply-

ing by making three circular (overlapping) turns about the limb or part which is to be covered. Fasten the extremity by means of another bandage, safety pins, by tearing up the end in two, reversing and tying about the part, narrow adhesive strap, or by stitching at the crossing points of the bandage.

**Head.**—For head bandaging use a roller 2 inches wide, 6 yards long.

*Circular Turns.*—This bandage may be used to cover the forehead, temporal regions, or the sides and base of the scalp.



FIG. 6.—Figure-of-eight of one eye.

FIG. 7.—Figure-of-eight of both eyes.

*Circular with Oblique Turns* (Figs. 6, 7).—Begin this bandage by laying the initial end beyond the site of the injury or upon the opposite side of the head. May be used to cover one or both eyes; scalp.

*Circular with Recurrent.*—Begin with circular turns, then apply the recurrent or refolding turns back and forth over the top of the head. Another hand is needed to hold the bandage until the final circular fixing turns are made. Is used to cover whole of scalp (Fig. 8).

*Circular of the Forehead.*—This bandage is used to cover the occiput, neck, or base of the skull.

*Circular of the Occiput and Forehead* (Fig. 9).—This bandage is applied by making a reverse over the temporal region from the crown to the under jaw after passing the first turns. It covers the lower jaw and the parotid region.



FIG. 8.—Recurrent bandage of the head.



FIG. 9.—Crossed bandage of the angle of the jaw.

*Circular*.—From the occiput to the forehead, reversed over the temporal region; then circular and oblique turns from the crown to the under jaw. It covers the cheek and side of the face.



FIG. 10.—Barton's bandage, or figure-of-eight, of the jaw.



FIG. 11.—Gibson's bandage.

*Barton's* (Fig. 10).—This is used for fracture and dislocation of the jaw. It is made with figure-of-eight turns, beginning just behind the mastoid proc-



ess with alternating circular turns from the occiput to the chin.

*Modified Barton's* is used to obtain greater security. Add circular turns from the occiput to the forehead.

*Gibson's* (Fig. 11) is used for fracture or dislocation of the lower jaw. Three circular turns are made from the crown (vertex) to the lower jaw; reverse and make three circular turns over the temporal region, from the occiput to the forehead, then three circular turns from the occiput to the chin; reverse and make a last turn from the occiput to the forehead.



FIG. 12.—Four-tailed bandage for the jaw.



FIG. 13.—Griffith's head bandage.

*Handkerchief or Four-tailed Bandage* (Fig. 12).—This is used for fracture or dislocation of the lower jaw, to retain dressings.

*Griffith's Head Bandage* (Fig. 13).—A simple retaining bandage for dressings about the angles of the jaw and adjacent neck region may be made from a yard length of a three- or four-inch roller. The bandage is applied by laying it against the dressing

in place. The ends are then drawn up upon each side of the patient's head. A two-tailed end is made from each by tearing down the middle until the level of the lobe of the ear is reached. The four tails are then to be drawn taut, crossed, and tied over the vertex.

**Neck.**—For this bandage use a roller 2 inches wide, 5 yards long.

*Circular.*—*Circular* with *oblique* turns. *Circular* with *figure-of-eight* turns about the *axilla* (Fig. 14).

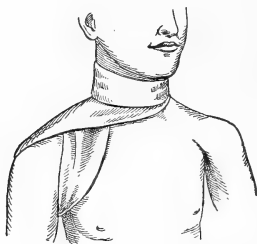


FIG. 14.—Figure-of-eight bandage of neck and axilla.

They are used to retain dressings to the neck or axilla.

**Chest.**—Roller 3 inches wide, 10 yards long.

*Spiral Bandage of the Chest.*—This bandage is used to secure dressings to the chest, temporary dressing for fracture of the ribs. It is made by applying circular turns with oblique (spiral) turns until the chest is covered; a final turn is made for support over the shoulder and down the front of the chest.

*Anterior Figure-of-eight Turns.*—This is used to cover the front and upper parts of thorax. It is formed by circular turns from the axilla across the chest (to fix the bandage); figure-of-eight turns from behind the shoulder up and over, crossing anteriorly to the other side of the body.

*Posterior Figure-of-eight Turns.*—Used for fracture of the clavicle or dislocation. To hold dressings to back of the chest. Oblique turns from one shoulder, across the back to the opposite axilla, thence anterior up and over the shoulder with figure-of-eight turns to the other side of the body.

*Bandage for Support and Compression of the Breast* (Fig. 15).—Circular turns (oblique) from the scapula of the sound side, across the back, to axilla, beneath the breast, over the shoulder to point of starting. Alternate with circular turns about the thorax. By repeating the turns for the other side both breasts may be supported.

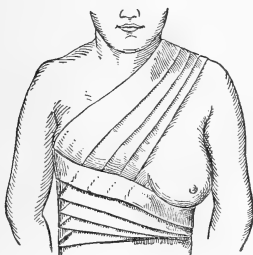


FIG. 15.—Figure-of-eight bandage of the breast.



FIG. 16.—Gauntlet bandage.

**Upper Extremity.**—For these bandages use a roller  $2\frac{1}{2}$  inches wide, 7 yards long.

Roller 2 inches wide, 6 yards long, for hands, wrist, and elbow.

*Fingers.*—Roller 1 inch wide, 3 yards long for fingers.

*Circular with Oblique (Spiral) Turns.*—Used to retain dressings or splints. For additional support apply one or two circular turns to the wrist.

*Gauntlet Bandage of the Hand* (Fig. 16).—It is

used to cover back of hand and all of the fingers. It is made by circular turns to the wrist (fixes), oblique turn across the back of the hand to the little finger; cover in by circular, oblique (spiral), and recurrent (refolding) turns; when necessary to cover up the ends of the fingers, return to the wrist by an oblique and circular turn; cover remaining fingers and the thumb. Complete by a circular turn to the wrist.

*Back of Hand (Demi-gauntlet)* (Fig. 17).—Used to secure dressings to either the back or palmar (by reversing) surfaces of the hand. Fix by circular turns about the wrist. Continue with an oblique turn

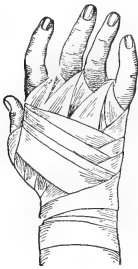


FIG. 17.—Demi-gauntlet bandage.



FIG. 18.—Spica of the thumb.

across the back of the hand to the base of the little finger, circle the finger, return to the wrist. Complete by similar turns to the remaining fingers and thumb with a final circular turn of the wrist.

*Spica of Thumb* (Fig. 18).—Used to retain dressings or splints to this part. Circular turns of the wrist to fix. Continue by an oblique turn to the tip of the thumb, circular with an oblique turn to the wrist. Continue by repeating until the thumb is entirely covered. Complete by a circular turn around the wrist. Cover the end of the thumb by recurrent (refolding) turns when necessary.

*Spiral Reversed of the Upper Extremity* (Fig. 19).—Used to cover the arm, forearm, and hand. Fix by circular turns at the wrist. Cover the hand by circular and oblique turns (spiral or spiral reversed); with figure-of-eight turns about the base of the thumb and the wrist. Cover the arm by ascending circular with oblique (spiral reversed and spiral) turns to the elbow which is covered in by figure-of-eight turns. Complete by circular (oblique, spiral, and spiral reversed) turns to the axilla.



FIG. 19.—Spiral reversed bandage of the upper extremity.



FIG. 20.—Figure-of-eight bandage of the elbow.

*Figure-of-eight of Elbow* (Fig. 20).—Used for dressings about the elbow. Allows motion without derangement of the dressing. Fix by circular turns just below the elbow. Continue by an oblique turn across the front of the joint to the upper arm. Complete by circular turn with a return across the joint to the starting-point. Continue, overlaying two-thirds of the previous turn laid down, until the parts are entirely covered.

*Spica of the Shoulder (Descending)*.—Used to retain splints and dressings about the shoulder. Circular turns about the arm at the level of the axilla (to fix); oblique turn across the shoulder, base of the neck, about the opposite axilla to the back. Complete the turn by crossing the first turn at the base of the neck.

Continue until the parts are covered (each turn overlapping two-thirds of the previous one).

*Spica of the Shoulder (Ascending)* (Fig. 21).—This bandage is made by circular turns around the arm at the level of the axilla (to fix). Continue by an oblique turn across the chest to the opposite axilla, return across the back to starting-point. Continue by repeating these turns (ascending by overlapping preceding turns two-thirds).

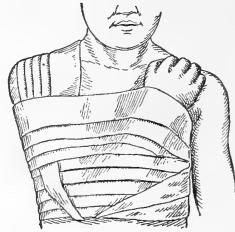
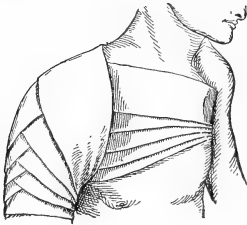


FIG. 21.—Ascending spica of the shoulder.      FIG. 22.—Velpeau's bandage.

*Velpeau Bandage* (Fig. 22).—This is used for fracture of the clavicle and scapula and for dislocation of the humerus. Place the fingers of the affected side upon the sound shoulder (prevent the skin surfaces coming in contact by means of gauze, towel, dusting-powder). Commence the application of the bandage from the scapula of sound side, continue with a turn over the shoulder of the affected side, anteriorly down the arm, behind the elbow; across the front of the chest to the sound axilla; thence to the point of starting. Repeat (to fix). After the second turn carry the bandage transversely around the chest, over the flexed arm, near the elbow. Continue by alternating circular turns (ascending spirally) with turns similar to the fixation turns.

*Desault Bandage.*—Used in fracture of the clavicle.

First roller (Fig. 23): Elevate slightly the arm of the affected side; place a pad in the axilla, secured by circular turns (spiral) with figure-of-eight about the opposite shoulder (to fix). Complete by covering in the chest with circular oblique turns.

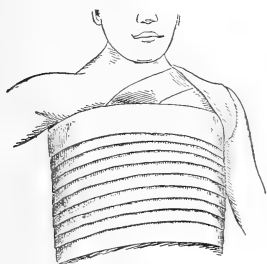


FIG. 23.—Desault's bandage, first roller.



FIG. 24.—Desault's bandage, second roller.

Second roller (Fig. 24): Lower the arm of the affected side; flex the forearm (to a right angle) across the front of the chest. Bind the arm to the chest by circular turns (spiral) from the shoulder to the elbow.

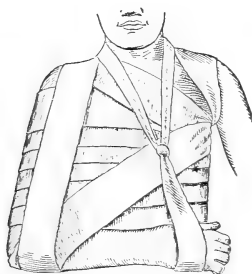


FIG. 25.—Desault's bandage, third roller.

Third roller (Fig. 25): Forms two triangles if correctly applied (an anterior and a posterior). Oblique

turns beginning in the axilla of the sound side, thence across the chest to the shoulder, around the shoulder to beneath the elbow. Return to starting-point. Repeat, alternating in front and behind. Complete the dressing by applying a sling.

**Abdomen.**—For abdominal bandages use a roller 4 inches wide, 9 yards long.

*Circular with Spiral Turns.*—Binder; many-tailed binder (9 to 18 inches wide, 1 to 2 yards long). Used to secure dressings, and for support of the parts.

**Lower Extremity.**—Use a roller 3 inches wide, 9 yards long.

*Spica of the Groin (Ascending).*—Used to secure dressings to the groin, upper portion of the thigh. Circular turns around the thigh (to fix). Continue by oblique circular turn just below the crest of the ileum of the sound side. Return to the starting-point. Repeat, ascending and covering two-thirds of the previous turn.

*Spica of the Groin (Descending).*—Made by circular turns about the thigh, high up (to fix). Continue by a circular oblique turn to the crest of the opposite ileum. Complete by returning to the affected side, crossing the first turn in the middle of the thigh. Repeat by circular oblique turns, descending by overlapping two-thirds of the previous turn.

*Figure-of-eight Bandage of the Groin* (Fig. 26).—An emergency or provisional bandage may be quickly applied to the groin by passing the end of a three-inch roller bandage about the body above the hips. Cross the ends over the center of the groin and reverse them, one passing above the thigh, the other behind to be tied upon the outer aspect of the limb.



*Double Spica of the Groins* (Fig. 27).—Made by circular turns about the abdomen above the crests of the iliac bones. Continue by an oblique circular turn to and around the left thigh, across to the back of the abdomen, anterior with an oblique turn to the inner

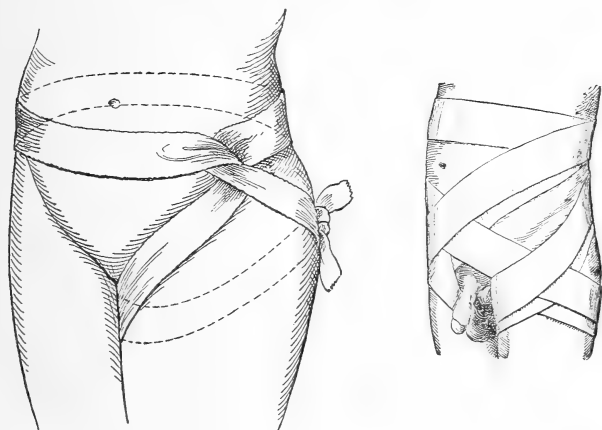


FIG. 26.—The Pryor inguinal bandage. FIG. 27.—Double spica of the groins.

side of the right thigh, circular turn ; mount obliquely to the opposite side of the abdomen. Repeat until both groins are covered, overlapping two-thirds of previous turn at the crossing line in the middle of the thighs.

**Knee.**—Roller  $2\frac{1}{2}$  inches wide, 5 yards long.

*Figure-of-eight Bandage of the Knee.*—Used for retaining dressings about the knee. Circular turns (3) about the leg below the knee (to fix). Continue by an anterior oblique turn across the front of the knee, mounting to the thigh ; circular turn about the thigh ; return by recrossing the knee, descending with an oblique turn. Repeat, overlapping previous turns two-

thirds at the midline. Complete by covering in the parts entirely, finishing with circular turns.

*Figure-of-eight Bandage of Both Knees.*—Used as a temporary dressing for fracture or dislocation of the thighs.

Circular turns about the legs at the level of the tops of the calves (to fix). Continue by rising obliquely across the front of the knees to the thighs; finish with a circular turn; return to the starting-point by a descending oblique turn across the front of the knees. Repeat, covering in two-thirds of the previous turns until the parts are entirely covered. Complete by right-angled turns about the bandage, by passing between the legs and thighs.

**Foot.**—Use a roller  $2\frac{1}{2}$  inches wide, 6 yards long.

*Spica of the Foot* (Fig. 28).—This bandage is used for sprains, and as a dressing to the foot. Circular



FIG. 28.—Spica of the instep.



FIG. 29.—Method of covering the heel.

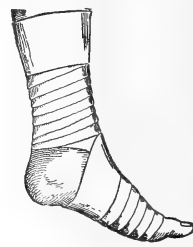


FIG. 30.—Figure-of-eight bandage of the instep.

turns (3) about the ankle (to fix); descend by an oblique turn across the back of the foot to the base of the toes, circular turn; cover the foot by ascending, oblique, spiral reversed turns until the instep is reached. Continue by oblique turns, covering in the

heel. Complete by ascending, oblique, circular turns above the ankle.

*To Cover the Heel (American Method)* (Fig. 29).—Circular turns (3) about the ankle (to fix); descend by oblique turn across the back of the foot; circular turn at the base of the toes. Continue by covering the foot with ascending spiral reversed turns until the instep is reached. Cover the heel by circular turns from the instep to the heel, alternating with figure-of-eight turns about the sides of the heel. Complete by circular turns, ascending the ankle.

*Bandage of the Foot Not Covering the Heel (French)* (Fig. 30).—Circular turns (3) at the ankle (to fix). Oblique turn across the back of the foot, descending to the base of the toes, where a circular turn is made. Cover in the foot to the instep with spiral reversed turns (ascending). Complete by circular turns about the ankle and lower leg.

*Complete Bandage of the Lower Extremity* (Fig. 31).—This bandage is used for applying compression to the leg to retain dressings. Circular turns (3) at the ankle (to fix); oblique turn, descending across the dorsum of the foot, with a circular turn at the base of the toes. Continue by covering in the foot and heel. Ascend the leg by circular, oblique, spiral, or reversed spiral, covering in the calf. Continue by figure-of-eight turns at the knee. Complete by ascending spiral or reversed spiral of the thigh.

*Figure-of-eight of the Leg*.—This bandage is used to secure compression; it is not easily disarranged. Circular turns (3) about the ankle (to fix). It is made by oblique turn across the dorsum of the foot; circular turn at the base of the toes. Continue by cover-

ing in the foot. Ascend the foot to the ankle with oblique, spiral reversed turns. Ascend the leg to the top of the calf by an oblique turn across the front of the shin. Continue with a circular turn just below the knee; return to the ankle, crossing the previous turn on the line of the shin. Complete by repeating the oblique turns, covering two-thirds of the previous turn as you mount the leg. Finish with a circular turn just below the knee.



FIG. 31.—Spiral reversed bandage of the lower extremity.

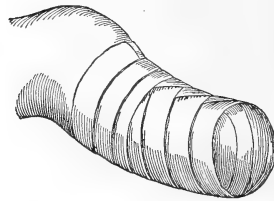


FIG. 32.—Recurrent bandage for a stump.

*Recurrent Bandage for a Stump* (Fig. 32).—Roller  $2\frac{1}{2}$  inches wide, 6 yards long. Circular turns near the lower end of the stump (to fix). Ascend with oblique circular turns. Continue by recurrent (refolding) turns, covering the end of the stump. Complete by ascending oblique, spiral, or spiral reversed turns, overlapping two-thirds of the previous turn.

*Spiral Reversed Bandage of the Penis*.—Roller 1 inch wide, 1 yard long. Circular turns at the penoscrotal junction (to fix). Continue by an oblique turn to the glans; circular turns. Ascend the body of the

penis by oblique, circular, or reversed spiral turns. Complete by circular and figure-of-eight turns about the base of the penis and scrotum.

*Bandage for Securing the Lithotomy Position.*—Roller  $2\frac{1}{2}$  inches wide, 4 yards long. Bring the patient's hand down to the side of his foot. Circular turns (3) around the wrist and ankle (to fix). Continue by alternating circular turns about the wrist and ankle. Repeat with the hand and foot of the opposite side. A rolled sheet twisted from opposite

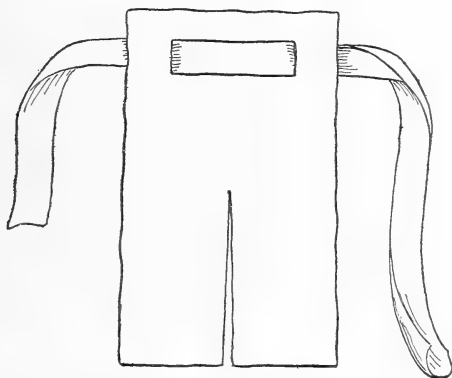


FIG. 33.—Perineal binder.

corners, passing under one shoulder, over the other, and beneath the patient's knees, drawn up to his chest and tied, will answer the same purpose.

*Perineal Binder for Retaining Dressings to Perineum* (Figs. 33, 34).—Roller 8 inches wide, 4 feet long.

*Liebreich's Eye Bandage* (Fig. 35).—Strip of flannel, white or black,  $2\frac{1}{2}$  inches wide, 8 to 10 inches long, fitted with tapes at the extremities. Apply to

one eye obliquely, reverse the tapes by crossing at the occiput, circular turn, and tying. Apply to both eyes transversely with circular turn of the tapes and tie.

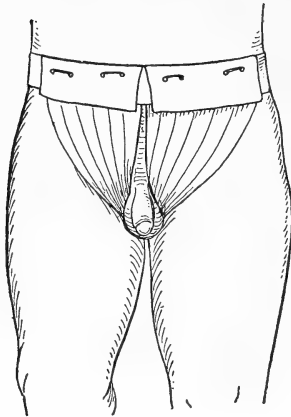


FIG. 34.—Perineal binder in position.



FIG. 35.—Modified Liebreich's eye bandage.

In addition to the well-known roller-bandage, special bandages find frequent employment, particularly after abdominal operations. The most important are the Scultetus and the T-bandages.

The *Scultetus*, or many-tailed, bandage is used for surrounding the abdomen. It is made of two pieces of flannel or of cotton, each 1 yard long and 4 inches wide, the two pieces being placed 4 inches apart; across them are sewed five other pieces of the same length and width, each piece being overlapped by the one above it by one-half its breadth. This bandage is placed under the patient's back, the cross-strips are folded over the abdomen from below upward, and the lower ends of the vertical strips are brought up between

the thighs and pinned to the front of the bandage. This keeps the bandage from wrinkling and retains it in position. Greater security will be obtained in male patients if the tail be torn half way down its middle, the two strips being then brought up over each groin space. A simple form of this bandage may be made from a width of flannel 1 yard long. Placed smoothly beneath the patient's back, its ends are torn nearly through in strips or tails, each 6 or 8 inches wide. It is applied by overlapping and alternating the tails, which are to be then snugly fastened with safety pins or adhesive straps.

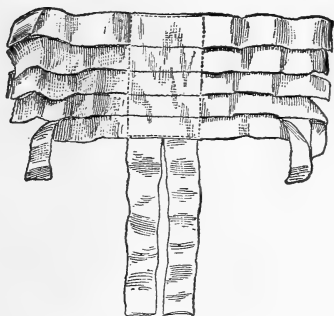


FIG. 36.—The Scultetus bandage.

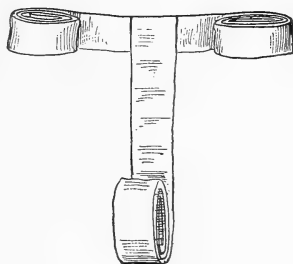


FIG. 37.—T-bandage.

*T-bandage.*—The T-bandage, which is used to secure dressings on the anus or the perineum, is made up of two strips of bandage, each about 5 inches wide. To the middle of one strip, which is to go around the waist, the end of the other strip is sewed, which forms a letter T. This latter strip is brought forward between the thighs and pinned to the front, thus securing the perineal dressing.

*Splints*, padded with cotton-batting, oakum, wool,

or hair, may be constructed from white pine, poplar, or willow wood,  $\frac{1}{8}$  to  $\frac{1}{2}$  inch (3–12 mm.) in thickness, cut to measured length and width; they may be of pasteboard or binder's board, molded to shape by soaking in boiling water, or of raw-hide similarly worked; of felt; plaster of Paris; starch (dissolved in cold water, after which boiling water is added until the proper consistence is secured) requires from twelve to forty-eight hours to dry thoroughly (Fig. 38); gum and chalk (equal parts of gum arabic and precipitated

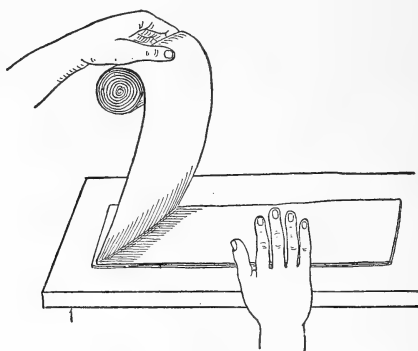


FIG. 38.—Splint made from plaster-of-Paris bandage. Complete by molding to the part; trim after setting has taken place.

chalk, add sufficient boiling water, stirring to obtain a proper consistence of solution), applied upon bandages; hatter's felt or binder's board may be softened in hot water and molded to the injured parts. The *coaptation splint* consists of thin and narrow board strips (of bass wood or pine) placed in position (side by side, with a slight interval) upon a sheet of adhesive plaster, or they may be quilted between two pieces of sheeting. The splint is held in position by bandaging or by adhesive straps, and may be em-



ployed in emergency or to reinforce the ordinary board or bracket splint. *Fracture-box* consists of a stout board 6 to 8 inches (15-20 cm.) wide by 18 to 30 inches (45-75 cm.) long, with hinged sides, a foot-board, upright, firmly attached at right angles to the bottom board, padded with a pillow, cotton-batting, or bran; may be used in treating fractures of the lower leg and knee. Bags made from stout muslin or light duck canvas cut 14 inches (35 cm.) wide by 3 feet (90 cm.) to 5 feet (1.5 m.) long, doubled, sewed, and inverted before filling with sand or bran, closed with a draw-string or by stitching, are employed in fractures of the leg and thigh. *Compresses* to prevent displacement may be made of cotton, lint (folded), oakum, and held in place by adhesive straps, bandage, or placed upon splints when padding.

Prevent infection of the soft parts from maceration of the skin surfaces after fracture by a thorough cleansing of the parts before applying the first permanent dressing and by "alcohol rubs" at each subsequent dressing. Neuralgic pain in the region after fracture is due to organized blood-clot or exudate. Treat by massage. Swelling, loosening, infection, malposition of the parts will demand an examination or change of dressings and correction by the surgeon.

## CHAPTER VII.

### CARE OF OPERATING-ROOM; METHODS OF STERILIZATION; CARE OF INSTRUMENTS.

IN almost all large hospitals there are three operating-rooms, one for general surgical, one for gynecologic, and one for septic operations.

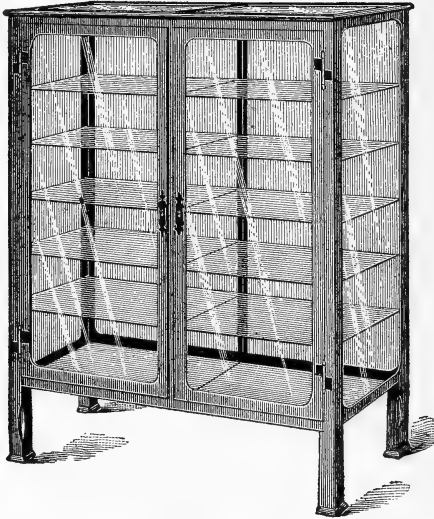


FIG. 39.—Kny-Scheerer instrument cabinet, having adjustable shelves and a plate-glass partition in the center, which practically divides it into two closets.

The operating-room for septic cases should be far removed from the others, and neither surgeon nor nurse attending this room should have anything to

do with the others. Rooms should also be set apart exclusively for dressing the cases, thus extending the benefit of an isolation of operating-rooms and adding greatly to the convenience of hospital work.



FIG. 40.—Griffith's hook for use in glass-shelved instrument cases.

These dressing-rooms are otherwise very desirable, for besides having everything at hand with which to do a dressing properly, the nurse in charge of the

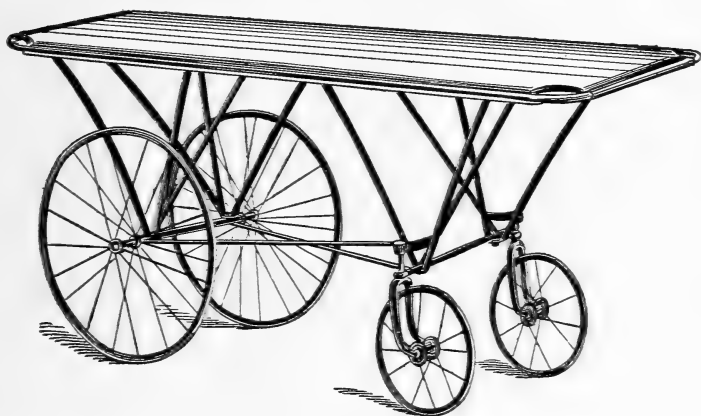


FIG. 41.—Wheeled stretcher.

patient has the opportunity to turn and make up the bed afresh during the patient's absence. Stretchers are used to convey patients to and from the operating- and dressing-rooms. The wheels generally have

rubber-tires, the top-board is detachable and has four handles, two at each end. At least four stretchers are necessary in a large hospital.

The material used in the construction and furnishing of an operating- and dressing-room should be of marble, metal, porcelain, and glass, all of which can readily be made aseptic. The water-faucets should be controlled by automatic foot- or elbow-valves, so as to avoid contamination by turning on the spigots with the hands after they have been rendered aseptic.

The operating-room should be kept clean, and



FIG. 42.—House-stretcher.

should be damp-swept and wiped every day ; in short, it should be in such a condition as to be ready for an operation at a few moments' notice. The supplies for dressings should not be allowed to run down, and the instruments should always be in a first-class condition. An emergency bundle, containing everything necessary for an emergency operation, should be kept in readiness.

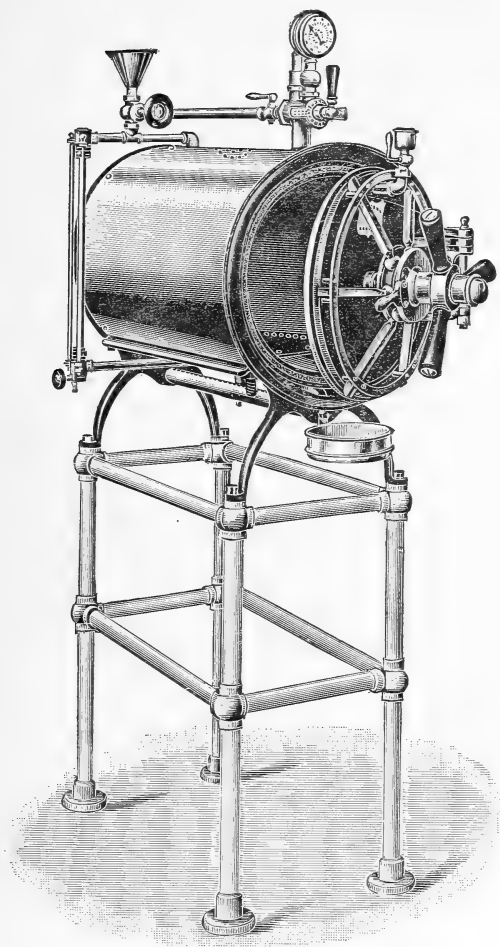


FIG. 43—Improved model sterilizer.

**Sterilization.**—Sterilization may be either dry or moist ; moist heat is preferable, because it is more thorough and more penetrating than dry heat. For

dry sterilization the towels and dressings are placed in covered tin pans in an oven the temperature in which ranges from  $160^{\circ}$  to  $212^{\circ}$  F. For moist or

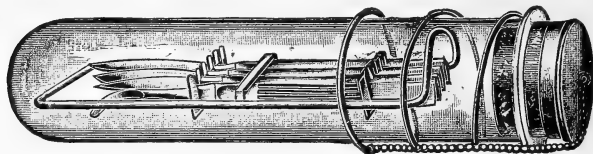


FIG. 44.—Sterilizing tube for edged instruments.

steam sterilization, a Kellogg, a Sprague, or an Arnold steam sterilizer is used. The heat must be continued for fully one hour before the operation.

Regarding the sterilization of instruments surgeons

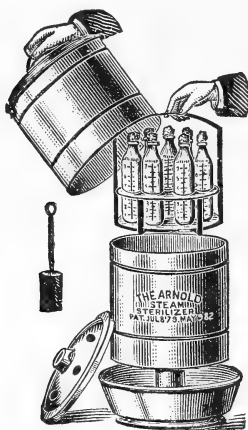


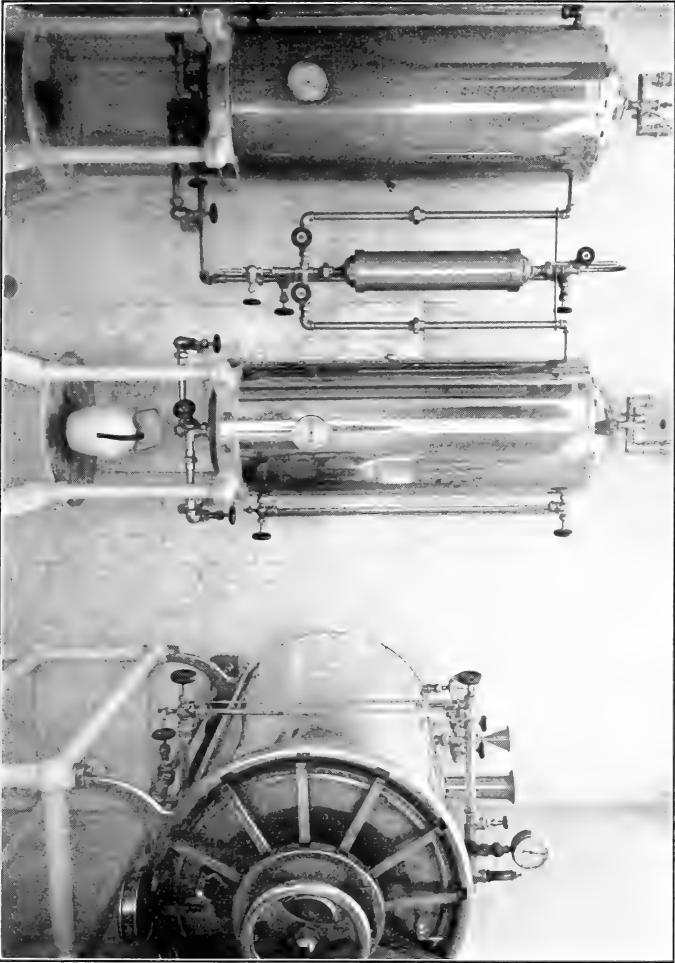
FIG. 45.—Arnold sterilizer.



FIG. 46.—Formalin lamp.

differ; some prefer to have their instruments wrapped in a towel and put into the Schimmelbusch or Arnold sterilizer and allowed to boil for half an hour in a 1 per cent. solution of carbonate of sodium to prevent

PLATE I.



Sterilizing Room, Medico-Chirurgical Hospital, Philadelphia.





their rusting. The water must boil before the instruments are placed in it. All edged instruments to be boiled in the soda solution should be wrapped in cotton and packed so firmly that they will not be tossed against one another by the solution as it becomes agitated in boiling. This agitation seems to be the reason why they lose their edge. Many operators prefer to have their edged instruments and needles placed in a dish containing 95 per cent. carbolic acid for half an hour; then just before the operation they are taken out and rinsed with sterilized water.

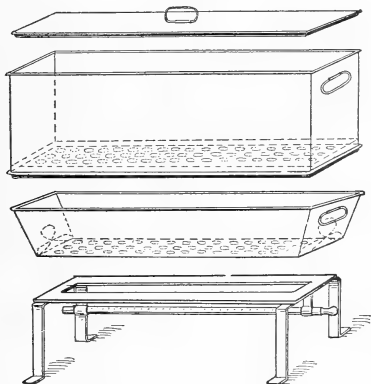


FIG. 47.—Sterilizer for instruments and dressings.

After sterilization the instruments are transferred to the instrument-table, or to shallow porcelain or glass trays, in which they lie covered with sterilized towels until required.

Instruments and dressings are now sterilized with formaldehyd with excellent results, one great advantage being that neither the solution of formalin nor the gas injures the instruments in any way or dulls

the edge of knives, scissors, or needles. A Schering lamp is usually used either with a 40-per-cent. solution of formaldehyd or with formalin pastils. The best results seemed to be obtained with the pastils. One pastil is constantly being evaporated in the upper cup of the lamp; but when rapid evaporation is required the upper cup is removed and the pastils are placed in the lower part.

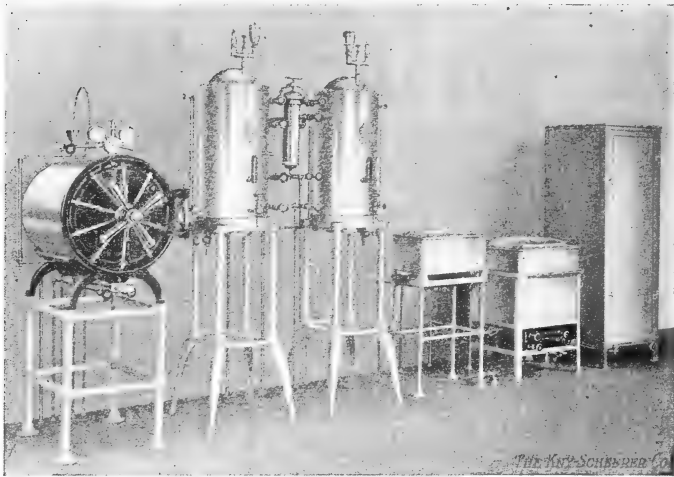
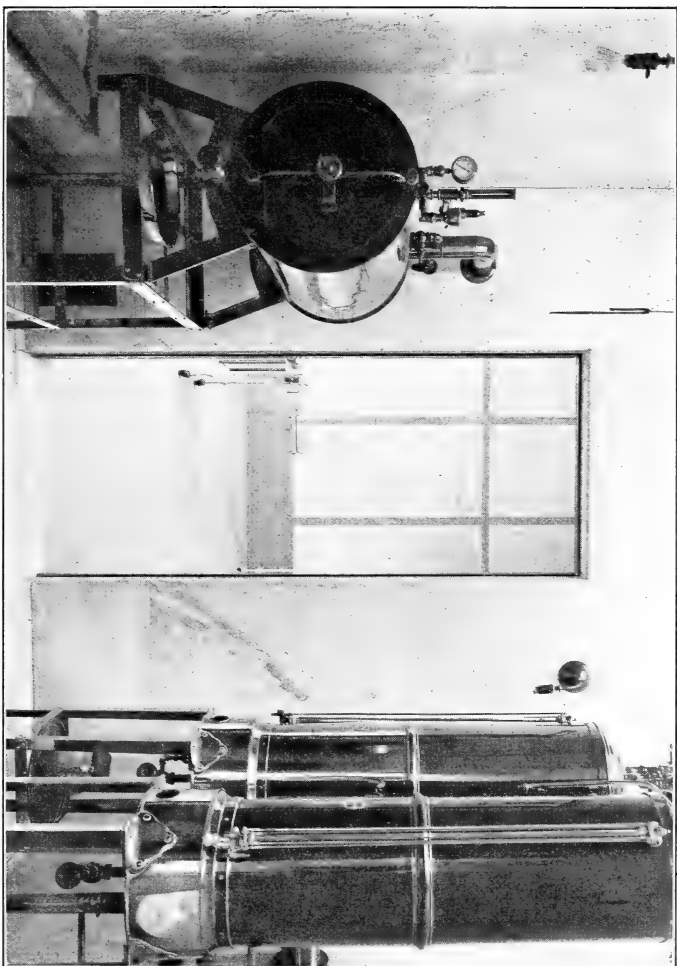


FIG. 48.—Latest form of complete sterilizing outfit for dressings, water, instruments, sheets, towels and operating gowns, basins, and trays.

After the operation the instruments should be taken apart, washed in cold water to remove all blood, pus, and tissue-particles, and then thoroughly scrubbed with green soap. Instruments with permanent joints, which fortunately are seldom seen now, must receive special attention, since it is difficult to get them surgically clean. After being scrubbed the instruments are rinsed in hot sterilized water, wiped



Sterilizing Room, Medico-Chirurgical Hospital, Philadelphia.



dry with a soft towel, locks oiled, and then laid away in the case. The knife-blades must be rolled in cotton. The important points to be remembered in cleaning instruments after an operation are:

First, all instruments that can be so dealt with must be taken apart and the rough catches thoroughly cleansed.

Second, they must be dried carefully in order to prevent rusting; for instruments once rusted seem always to have a tendency to return to that condition.

Instrument-trays are made of glass, porcelain, agate-ware, or hard rubber; and are rendered aseptic by being first scrubbed with green soap and warm water, after which they are filled to the brim with 1:500 corrosive sublimate, which is allowed to remain in them for half an hour. When needed they are rinsed with salt solution or sterile water. Many surgeons prefer the trays filled with enough sterile water to cover the instruments, while others again prefer the instru-

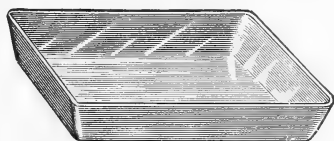


FIG. 49.—Glass instrument tray.

ments to be laid dry on the glass table, which has been previously covered with a sterilized sheet or towels.

Every operating-room nurse should be familiar with the names of the instruments necessary for each different operation, so as to be able to lay them out when occasion requires. Many nurses get to-

gether after school-hours and "make believe" an operation is to take place. Each nurse has her duty assigned to her, and each tries to fulfil it in a thoroughly professional, dignified, and quiet manner. Practice of this kind is never lost.

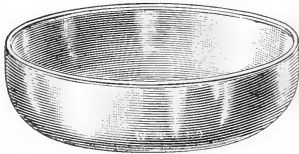


FIG. 50.—Glass hand bowl.



FIG. 51.—Pus basin.

In the operating-room should be kept two large ledgers, in one of which the house-surgeons, after making the morning rounds with the visiting surgeons, should record the number of operations to be performed the next day, the time, name of operator, etc. The operating-room nurse is thus made acquainted, by consulting the book, of the amount of work before her for the next day, and the character of the operations for which she has to prepare.

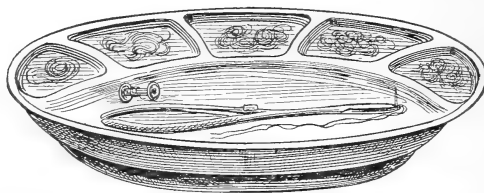


FIG. 52.—Robb's aseptic ligature-tray ; white porcelain.

On the morning of the operations she makes out a list of the floor and number of private room or letter of ward and number of bed, from which the patients are to be brought to the operating-room, and the order

in which the operator wishes them. This list is given to the male attendant, who brings up the patients in succession, in such a way that while one patient is being operated on the next is being anesthetized. The head nurse in the operating-room has two or three sets of instruments, and during one operation an assistant nurse is sterilizing the instruments and making preparations for the next operation. There is then no waiting on the part of the operator, for as the patient operated on is wheeled out of the operating-room the next patient is wheeled in. The following chart will give an idea as to the way the book is made out and the order in which the operations are written. The emergency-operations, accidents, etc., are also recorded, but after the performance of the operation.

Date.	Operation.	Floor. <sup>1</sup>	Time.	Operator.	Room	Ward.	Bed.	Floor.
Mar. 11.	Laparotomy.	4th.	8. A. M.	Dr. Murphy.	19			3d.
"	"	"	8.30 "	" "	21			"
"	Vaginal hysterectomy.	"	9.00 "	" Johnson.	24			"
"	Cholecystostomy.	"	9.30 "	" Fenger.	16			"
"	Appendicectomy.	"	10.00 "	" Morgan.		B	10	
"	"	"	10.45 "	" Kindig.		D	6	
"	Amputation, breast	"	11.30 "	" Carter.		D	9	
"	"	"	2. P. M.	" Andrews.	24			4th.
"	Appendicectomy.	"	3.00 "	" Fenger.	21			2d.
"	Cesarean section.	"	4.00 "	" Eyster.	21			4th.
"	Appendicectomy.	3d.	6.30 "	" Comegys.	29			2d.

The second book gives the date on which the patient was prepared for operation, by whom prepared, etc., as, for example—

<sup>1</sup> Clean operating-room, fourth floor; septic, third floor.

Date of Preparation.	Prepared by	Antiseptic used.	Operator.	Floor.	Room.
March 10.	E. A. S.	Corros. sub.	Dr. Eyster.	Fourth.	No. 21.

---

Date of Operation.	Hour.	Sutures used.	Length of time prepared.	Stitches removed.	Condition.
March 11.	4 P. M.	Silkworm-gut.	Two hours' boiling.	March 19.	Aseptic.

A book should also be kept in each dressing-room showing the number of cases dressed each day, the dressing used, and progress since the last dressing. It should be kept for the convenience of the dressing-room nurse in making an estimate of dressings for the next day, and for the convenience of the surgeon in knowing what patients are dressed, their condition, and in knowing when they are to be again dressed. It will also recall condition of last dressing.

Room or Ward.	Diagnosis.	Operated.	Operator.	Dressed.	Died or Discharged.	Remarks.
No. 29, 2d floor.	Appendicitis.	March 11.	Dr. Come-gys.	March 17.	Discharged April 2.	



## CHAPTER VIII.

### INSTRUMENTS NECESSARY IN DIFFERENT OPERATIONS, KEEPING OF CHARTS, SURGEON'S KIT, ETC.

IN many hospitals, small ones especially, where there are no medical students or house doctor, the nurse has more responsibility than in larger institutions, and becomes closely familiar with such details as taking the history of the patient; the arranging and sterilization of instruments; assisting the operator, giving the anesthetic, and writing out the report of the operation. The following charts will be of use in keeping the important features of this line of duty in mind. When taking the patient's history it is a good plan to allow her to describe her condition in her own words. Any peculiarities of the patient's manner and other points which may be observed can be noted, and afterward the questions necessary for making out the charts may be asked.

#### Family History.

Age.	Health.	Disease.	Cause of death if dead.
------	---------	----------	-------------------------

Father.

Mother.

Brothers (number).

Sisters (number).

Wife or husband.

Children (number).

Uncles or aunts with epilepsy, insanity, tuberculosis, or consumption.

**Personal History.**

When born. Where lived. Peculiarities of climate. Occupations. Habits (as to eating, drinking, sleeping, etc.). Appetite. Condition of bowels. Nervousness. Culture.

(When Female.)

**Sexual History.****I. Menstruation.**

(a) First at what age.

(b) Regularity. No. days.

(c) Duration. No. days.

(d) Amount.

(e) Character of discharge

{ Color.  
Consistency.  
Odor.

(f) Intermenstrual discharge.

(g) Dysmenorrhea—when.

II. *Pregnancies* { Number.  
Sickness or peculiarities.

III. *Miscarriages* { Number.  
Sickness.  
Fever.

**IV. Labors.**

(a) Number.

(b) Character

{ Easy.  
Difficult.  
Spontaneous.  
Instrumental.

(c) Peculiarities.

(d) Sickness post partum, if any.

**Previous Illness.**

Starting with childhood, give different sicknesses

and age at which same occurred, following life of patient to present time simply with reference to sickness, including appetite, bowels, urine, headaches, pains, coughs.

### Present Sickness.

Date.

Onset. Character. { Chills, pains, locations, severity, etc. Peculiarities.

Progress and changes to present time.

Changes. Appetite. Bowels. Urine, etc.

### Examination.

The packing of a surgeon's bag is often done by the operating-room nurse. Many surgeons use the telescope valise, or kit, as it is more commonly called; while others employ a regular surgeon's bag. Before the bag is packed the nurse makes out the list of necessary articles, and as each article is put in it is checked off the list. When packed, a copy of the list is securely pinned upon a towel inside, where the surgeon can see it on first opening the bag. The kit is packed by first laying in two large sterilized towels, the ends of which hang over the edges of the bag. Together with the instruments, which are placed in a linen instrument-roll, and the dressings, the kit should contain three new nail-brushes, soap, razor, oxalic acid and permanganate of potassium crystals in bottles, hypodermic syringes with tablets of strychnin sulphate (gr.  $\frac{1}{30}$ ), atropin sulphate (gr.  $\frac{1}{150}$ ), and morphin sulphate (gr.  $\frac{1}{6}$ ), cocain hydrochlorate (gr.  $\frac{1}{4}$ ), ether and chloroform (with cone and mask), tablets of corrosive sublimate and sodium chlorid, iodoform gauze, plain gauze, gauze sponges, white suits, caps and canvas shoes for the operator

and assistants, Kelly pad, rubber gloves, brandy, alcohol, safety-pins, absorbent cotton, twelve towels, a rubber apron, ligatures, sutures, and rubber and glass drainage-tubes. The glassware should be packed in the middle, to prevent breakage. When the kit is

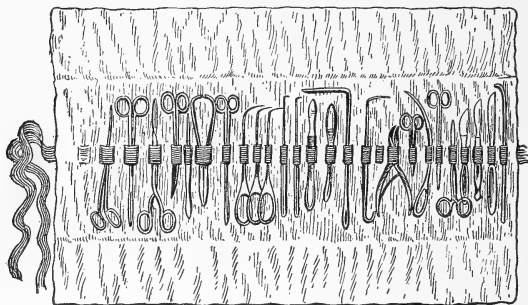


FIG. 53.—Canton-flannel roll for instruments.

packed a third towel is laid over the contents, the edges of the other two are brought up, and all pinned together with safety-pins.

The instrument-rolls are very serviceable in economizing space and in keeping the instruments aseptic.

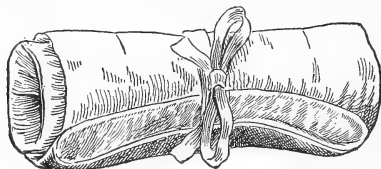


FIG. 54.—Instruments wrapped in canton-flannel roll.

They are made of linen, canton flannel, or toweling, one yard long; and through the middle of each are adjustable loops in which the instruments are placed. When soiled the rolls may be washed and sterilized.

## OPERATION BLANK.

---

*Service of Dr.*.....

*Date.* March 10, 1899.

*Name*.....

---

- I. PREPARATION OF PATIENT FOR OPERATION.
- II. ANESTHETIC. ANESTHETIST.  
Temperature.  
Before operation.  
After operation.  
Pulse and Respirations.—To be taken continuously during operation.
- III. PREPARATION OF FIELD OF OPERATION.
- IV. POSITION OF PATIENT DURING OPERATION.
- V. PRIMARY MANIPULATIONS.
- VI. INCISION AND HISTORY OF OPERATION.
- VII. TREATMENT OF WOUND.
- VIII. DRAINAGE.
- IX. CLOSURE OF WOUND.
- X. DRESSING.
- XI. RECOVERY FROM ANESTHETIC.
- XII. AFTER-TREATMENT.



**LIST OF INSTRUMENTS NECESSARY IN DIFFERENT OPERATIONS.**

*Instruments for General Anesthesia.*

Inhalers for gas, ether, chloroform.  
 Wooden mouth-wedge and gag.  
 Tongue forceps.  
 Hypodermic syringe and needle.  
 Anesthetizing stethoscope.  
 Throat swabs.

*Instruments for Local Anesthesia.*

Two glass hypodermic syringes.  
 Two medicine glasses, one to hold cocain solution, the other for weak, sterile soda solution.  
 Extra needles and cleaning wires.

*Instruments for Perineorrhaphy.*

Catheter, glass, small,	I
Catheter, glass, large,	I
Forceps, hemostatic, small,	6 pairs.
Forceps, hemostatic, intermediate,	3 "
Forceps, hemostatic, long,	3 "
Forceps, hemostatic, long dressing-,	I pair.
Forceps, hemostatic, tissue- (rat-tooth),	2 pairs.
Forceps, hemostatic, bullet-,	2 "
Forceps, hemostatic, volsella,	2 "
Scalpels,	2 "
Uterine sound and applicator.	
Tenacula, straight,	I pair.
Tenacula, curved,	2 pairs.
Tenacula, shepherd's crook,	I pair.
Scissors, straight,	I "
Scissors, right-angle,	I "
Scissors, left-angle,	I "

Sponge-holders,	6 pairs.
Needles. Sutures, silk of various sizes, and silkworm-gut.	
Needle-holder. Sims' speculum. Retractors. Leg-holder. Sterilized stockings.	
Glass nozzles. Irrigation dressings.	

Tenacula are used to catch and hold movable tissues which are being sutured, to hold the cervix uteri, etc. There are two kinds, the curved and the straight; and of the curved there are three varieties: the shepherd's crook, the simple curved, and the corrugated. The shepherd's crook is much used in vaginal operations, and has the advantage over the others that when once it is put in place it can be dropped without losing its hold on the tissues.

*Instruments for Trachelorrhaphy.*

Catheter, glass,	I
Two-way catheter,	I
Curette, dull,	I
Curette, sharp,	I
Curette, spoon,	I
Dilators, different sizes.	
Forceps, hemostatic,	8 pairs.
Forceps, volsella,	I pair.
Forceps, bullet-,	2 pairs.
Forceps, long dressing- (Kelly),	I pair.
Forceps, tissue- (rat-tooth),	2 pairs.
Scalpels,	2 " "
Speculum, Sims', small,	I
Speculum, large,	I
Shot-compressor and shot.	
Retractor, small,	I
Retractor, medium,	I





FIG. 56.—Skene's reflux catheter.

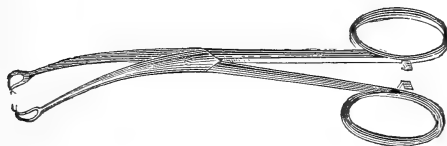


FIG. 57.—Volsella.



FIG. 58.—Curved tenaculum.

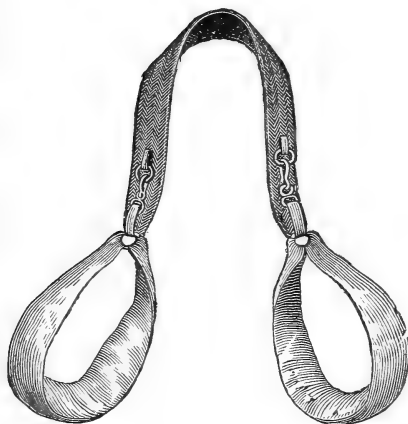


FIG. 59.—Kelly's leg holder.

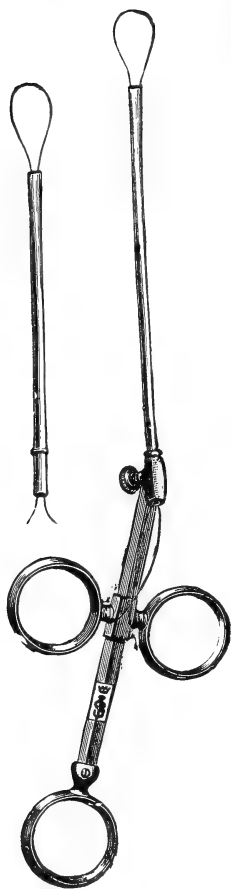


FIG. 60.—Snare.



FIG. 61.—Spoon curet.

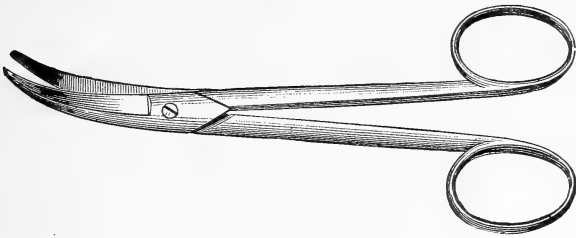


FIG. 62.—Curved scissors for performing trachelorrhaphy.



FIG. 63.—Sir J. Y. Simpson's sound.



FIG. 64.—Sharp curet.



FIG. 65.—Dull wire curet.



FIG. 66.—Gauze packer.

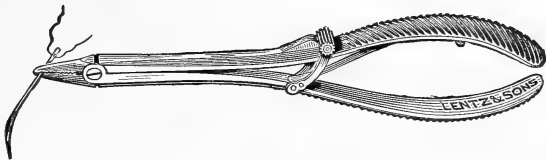


FIG. 67.—Reiner's needle-holder.

Scissors, straight,	1 pair.
Scissors, curved,	1 "
Tenacula,	2 pairs.
Needles, curved, various sizes, short, stout, straight.	
Needle-holders,	2
Uterine sound and applicator.	
Sterilized stockings. Leg-holder.	
Catgut and silkworm-gut sutures.	

*Instruments for Dilatation of Cervix and Curetting  
of Uterus.*

Catheter, glass, small,	1
Catheter, two-way, for irrigation,	1
Curet, sharp,	1
Curet, Martin's double blunt,	1
Curet, curved, sharp,	1
Dilators (Hank's rubber, all sizes).	
Dilator, Goodell's,	1
Forceps, long dressing-,	1 pair.
Forceps, bullet-,	1 "
Uterine sound and applicator.	
Sims' specula, large and small.	
Kelly perineal pad. Sterilized stockings.	
Irrigator. Glass nozzles. Dressings.	
Small sponges. Cotton pledgets.	
Churchill's tincture of iodine.	
Carbolic acid, 95 per cent. Leg-holder.	

*Instruments for an Abdominal Operation.*

Arrange for Trendelenburg position. Secure this by special table; elevation of one end of an ordinary table by means of blocks or upon two kitchen chairs or by placing a flat-backed chair upside down



FIG. 68.—Sims' speculum.

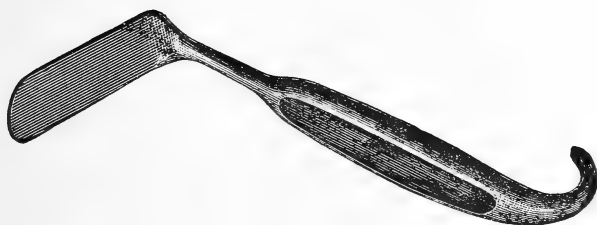


FIG. 69.—Schroeder's vaginal retractor.



FIG. 70.—Varieties of hemostatic forceps.

under the operating mattress ; secure the patient in position by tying with bandage, sheet, or towel.

Forceps, small, hemostatic,	6 pairs.
Forceps, medium,	6 “
Forceps, pedicle-,	4 pairs.
Forceps, long,	4 “
Forceps, long dressing-,	1 pair.
Forceps, for drainage-tube,	1 “
Forceps, Billroth,	2 pairs.
Forceps, bulldog,	1 pair.
Forceps, rat-tooth,	2 pairs.

Aspirator. Scalpels. Vaginal packer.

Uterine sound.

Paquelin's thermocautery.

Sponge-holders. 6

Scissors, long and small, 1 pair of each.

Retractors, Lange's large, 1 pair.

Volkman's 6-prong retractors, 1 “

Volkman's 4-prong retractors, 1 “

Long and small probe and director.

Needle, aneurysm-, 1

Needle, transfixion, right curved, 1

Needle, transfixion, left curved, 1

Needle, transfixion, pedicle, 1

Needles, large, small, and intermediate,  
curved and intestinal.

Murphy anastomosis button (sizes 1-4).

Murphy's forceps for holding button, 1 pair.

Murphy's forceps, intestinal clamp, 1 “

Murphy's forceps, introducing, 1 “

Flat dissector (Fenger).

Drainage-tubes, glass or aluminum, as-  
sorted sizes.

Needle-holders, 2

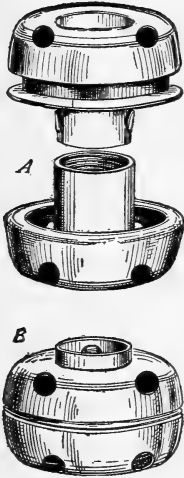


FIG. 71.—Murphy anastomosing button: *A*, open; *B*, closed.



FIG. 72.—Griffith's antiseptic irrigator tip holder.



FIG. 73.—Lange's retractor.

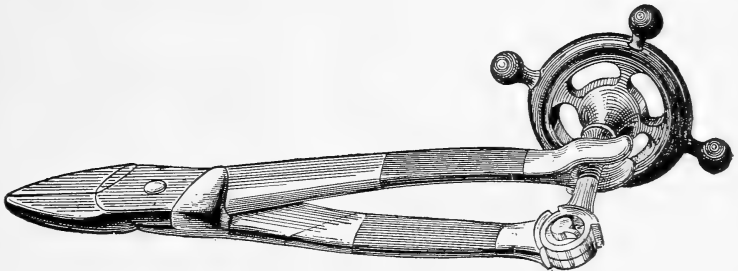


FIG. 74.—Angiotribe of Tuffier.



FIG. 75.—Bone-cutting forceps.

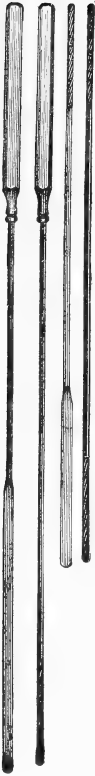


FIG. 76.—Cotton applicators for nose and ear work.



FIG. 77.—Eustachian catheter.



FIG. 78.—Periosteum knife.



FIG. 79.—Periosteal elevator.

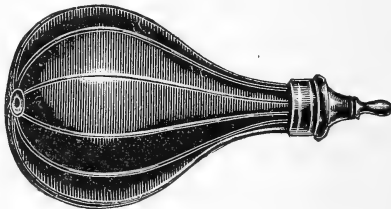


FIG. 80.—Poltzer's inflating bag.



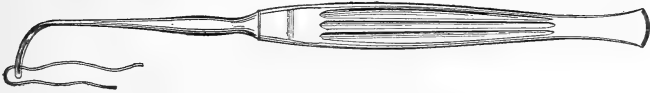


FIG. 81.—Aneurysm needle.

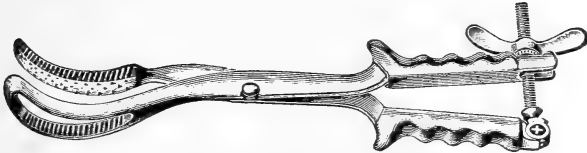


FIG. 82.—Braun's cranioclast.



FIG. 83.—Smellie's perforator.

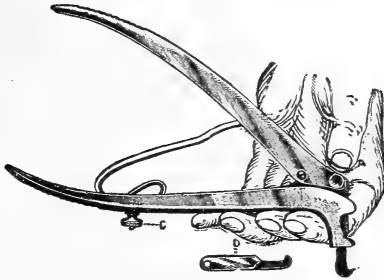


FIG. 84.—De Vilbiss bone-cutting forceps.

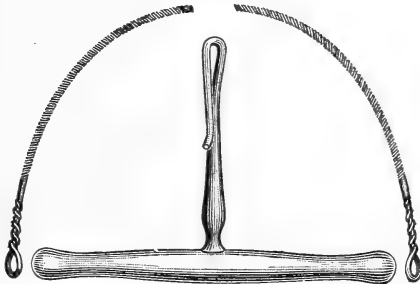


FIG. 85.—Gigli's chain saw.

Dressings, ligatures, and sutures of silk-worm-gut, and various sizes of silk and catgut.

Laparotomy sheet. Saline solution.

Small bolsters, made of non-absorbent cotton covered with gauze, six inches by three, to retain the intestines and to keep them from encroaching upon the site of operation.

*Extra, for Cysts or Tumors.*

Trocars, large and small. Rubber tubing.

Nélaton's forceps.

Billroth's tumor-forceps, 2 pairs.

Angiotribe or tumor-pedicle crushing forceps.

*Extra, for Vaginal Hysterectomy.*

Sterilized stockings. Leg-holder.

Clamp-forceps, 6 pairs.

Uterine sound. Dissecting forceps. Long and short tenacula. Speculum. Curet.

*Instruments for Operations on the Brain and Spine.*

Forceps, hemostatic, medium, 6 pairs.

Forceps, hemostatic, small, 6 "

Forceps, rat-tooth (tissue-), 2 "

Forceps, bone, three kinds; long-jaw forceps.

Trephine—three sizes, small and medium.

Chisels, various sizes. Hammer.

Scalpels, 2

Scissors, 2 pairs.

Curets, sharp and dull.

Needles. Sutures. Ligatures. Saline solution. De Vilbiss forceps.

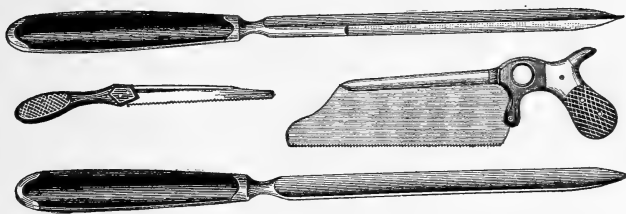


FIG. 86.—Catlin, knife, and saws for amputation.

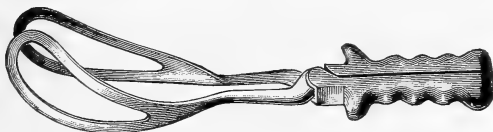


FIG. 87.—Simpson's forceps.

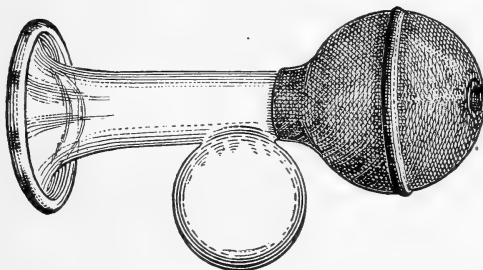


FIG. 88.—Breast-pump.



FIG. 89.—Modern combination of Baudelocque's and Oslander's pelvimeter.



FIG. 90.—Nipple-shield.

*Instruments for Amputation of a Limb.*

Esmarch bandages,	2
Periosteotome,	1
Long amputating-knife.	
Medium amputating-knife.	
Scalpels, large and medium.	
Bone-saw. Chain-saw.	
Forceps, small hemostatic,	6 pairs.
Forceps, medium hemostatic,	6 "
Forceps, bone-cutting, straight, curved, and angular.	
Forceps, gouging.	
Forceps, rat-tooth (tissue-),	2 pairs.
Forceps, retractor,	1 pair.
Scissors, large and small,	1 pair of each.
Bone-pins.	
Four-prong retractors,	2
Three-tailed gauze retractors,	2
Dressings. Sutures. Ligatures of silk, catgut (various sizes), and silkworm- gut.	

*Obstetrical Instruments and Appliances.*

Bed-pan.	
Fountain syringe.	
Glass catheter.	
Glass catheter, two-way, for irrigation.	
Scissors.	
Cranioclast.	
Perforator.	
Breast-pump.	
Nipple shield.	
Incubator, for premature-born children.	

*Instruments for the Mouth and Throat.*

Head-mirror.	Snare of silver wire.	
Volsella forceps for tonsils.		
Uvulatore.	Tonsillotome,	2
Sponge-holders,		6
Uvula scissors with and without claws.		
Tongue-depressor.		
A self-fastening mouth-gag.		
Trachea-dilator.		
Trachea-tubes.	Intubation-tubes.	
Long forceps,		1 pair.
Long curved forceps,		1 "
Long straight scissors,		1 "
Throat-mirror (laryngoscope).		
Angular forceps,		1 pair.
Angular scissors,		1 "
Long, slender curet.		
Gottstein knife (for adenoids).		
Gradle forceps (for adenoids).		
Bistoury.	Flexible probe.	
Esophageal sound and dilator.		
Fish-bone catcher for foreign bodies.		

*Instruments for the Nose.*

Polypus-snare.	Silver applicator.
Nasal curet.	
Saw with reversible blade for cutting up or down.	
Nasal scissors, with and without saw- teeth.	
Nasal bone-scissors.	
Nasal bone-scissors, turbinated.	

- Nasal polypus-forceps.  
 Septum-straightening forceps, 1 pair.  
 Nasal speculum.  
 Septum-knife.  
 Electrocautery for hypertrophied turbinates and for hemostasis.  
 Chromic acid. Applicators.  
 Iodoform-strips for packing.  
 Monsell's solution for hemostasis.

*Instruments for the Eye.*

- Lens (double convex).  
 Ophthalmoscope.  
 Speculum.  
 Cataract knife.  
 Strabismus hook.  
 Probes.  
 Iris forceps.  
 Fixation forceps.  
 Keratome.  
 Cystotome.  
 Horn or metal spoon.  
 Wire loop.

*Instruments for the Ear.*

*For Mastoid Operations.*

- Forceps, hemostatic, small, 8 pairs.  
 Scalpels, small and medium, 1 each.  
 Chisels and gouges, various sizes.  
 Mastoid drills and bone-trephines, 2  
 Mallet.  
 Ear-speculums, various sizes.  
 Diagnostic tube and otoscope.  
 Ear-syringe (hard rubber).



FIG. 91.—Septum compression forceps.



FIG. 92.—Probang for removing foreign bodies from the throat.

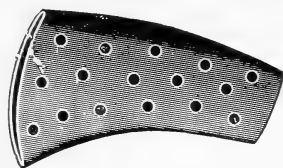


FIG. 93.—Nasal splint.

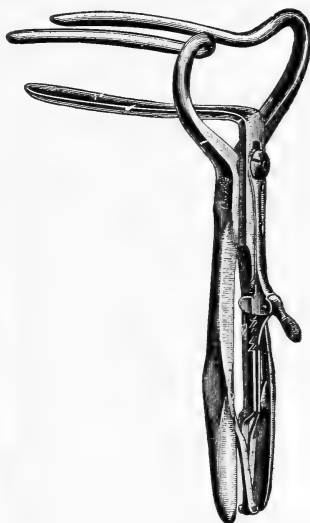


FIG. 94.—Ridal speculum.



FIG. 95.—Sharp-pointed retractor.

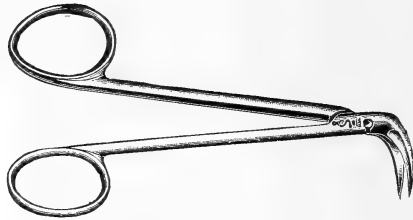


FIG. 96.—Curved sharp-pointed scissors.

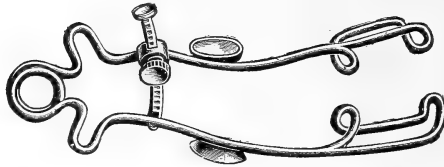


FIG. 97.—Eyelid speculum.



FIG. 98.—Rawhide mallet.

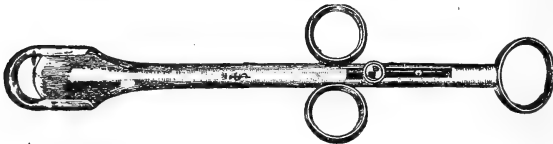


FIG. 99.—Tonsillotome.



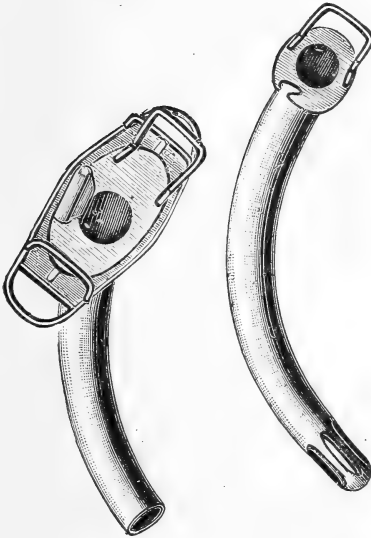


FIG. 100.—Tracheal tube.

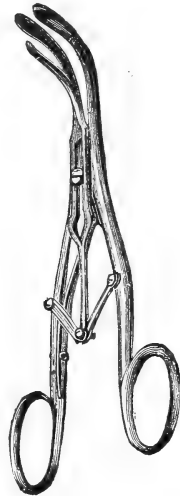


FIG. 101.—Tracheotomy forceps.

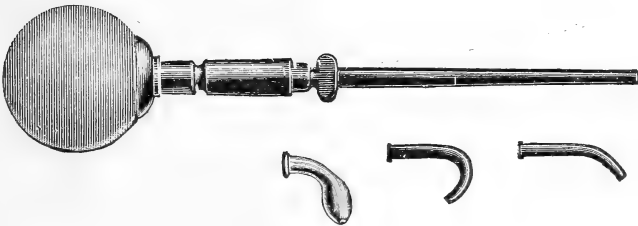


FIG. 102.—Powder-blower for nose and ear work.



FIG. 103.—Steel-eyed curet.

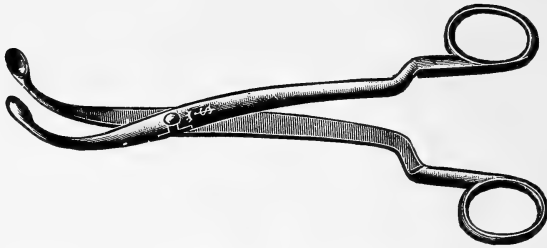


FIG. 104.—Adenoid forceps.

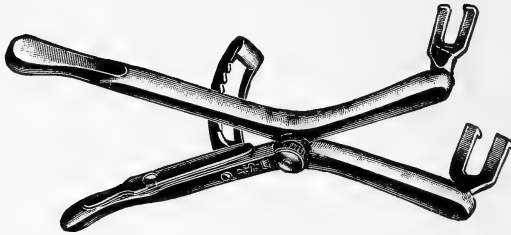


FIG. 105.—Mouth-gag.

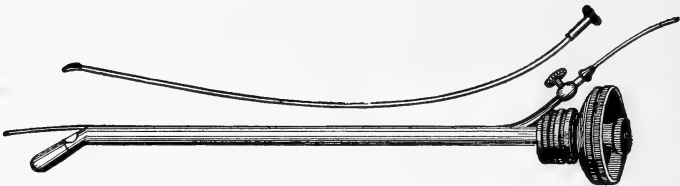


FIG. 106.—Brenner's ureter-cystoscope.

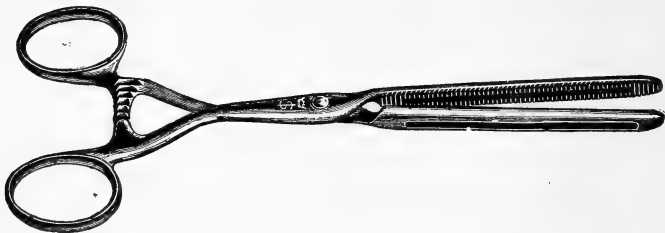


FIG. 107.—Phimosis forceps.



FIG. 108.—Cataract knife.



FIG. 109.—Cystotome.



FIG. 110.—Capsule forceps.



FIG. 111.—Metal spoon.



FIG. 112.—Wire loop for extraction of lens.

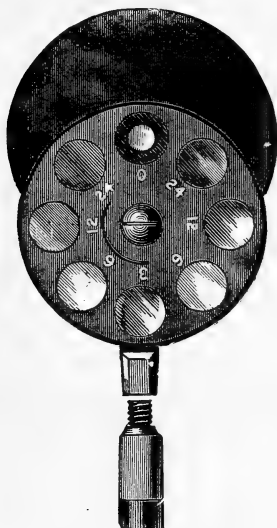


FIG. 113.—Loring's ophthalmoscope.



FIG. 114.—Griffith's one-piece wooden mallet.

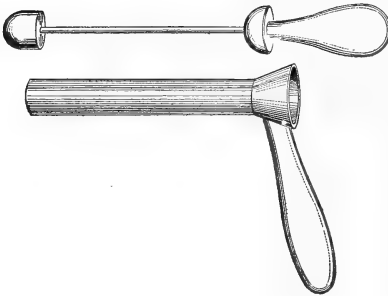


FIG. 115.—Rectal speculum, large size.

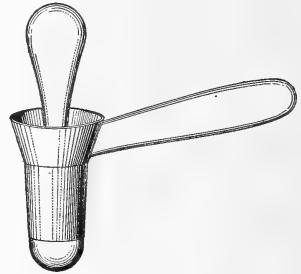


FIG. 116.—Rectal speculum, small size.



FIG. 117.—Probes.

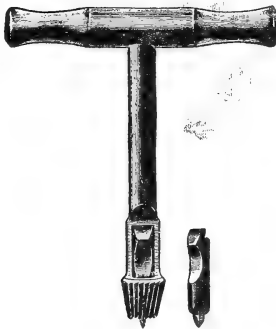


FIG. 118.—De Vibiss trephine.

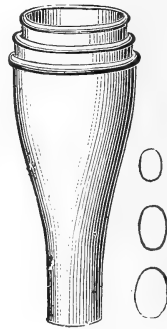


FIG. 119.—Gruber's ear specula.

Sponge- and cotton-holder.  
 Small curet.  
 Irrigator.

*For Middle-ear Operations.*

Eustachian catheter, and Politzer's air-  
 bag.  
 Curets. Ear-scoop.  
 Snare and wire.  
 Head-mirror.  
 Cotton-holder.  
 Tympanum-perforators.  
 Ear-aspirator for cleansing middle ear.  
 Case of tuning-forks and hammer.  
 Ear-scissors.  
 Ear-speculum, various sizes.  
 Slender polypus-forceps, 1 pair.  
 Slender scalpels.  
 Ear-probe. Irrigator.

*Instruments for Rectal Operations.*

Rectal speculum.  
 Forceps, small hemostatic.  
 Forceps, hemorrhoid.  
 Scalpel. - Paquelin's cautery.  
 Rectal bougies.  
 Sterilized stockings. Leg-holder.  
 Kelly perineal pad.  
 Irrigator. Dressings. Sutures. Liga-  
 tures.  
 Curets, sharp and dull, 1 pair of each.  
 Saw and chisels for Kraske's operation.  
 Metal probes for tracing fistulæ.

*Instruments for Urethral and Bladder Operations.*

- Set of sounds, curved and straight.  
 Catheters, various sizes.  
 Urethral forceps, 1 pair.  
 Artery-dilators, various sizes.  
 Endoscopes with calibrators, various sizes.  
 Urethral searcher.  
 Head-mirror. Return-irrigator.  
 Sounds and dilators (usually the same).  
 Scalpels, artery-forceps, lithotrites.  
 Stone-forceps, litholapaxy set.  
 Curets, etc., for suprapubic or perineal lithotomy, or for litholapaxy, operations on tumors, etc.

*Necessary for Dressings after Gynecologic Operations.*

- Sims speculum.  
 Bullet-forceps, 1 pair.  
 Long dressing-forceps (Kelly).  
 Applicator. Scissors, straight, 1 "  
 Churchill's tincture of iodine.  
 Carbolic acid, 95 per cent. Ichthyol.  
 Balsam of Peru and glycerin.  
 Glycerin (pure). Vaseline.  
 Tampons. Boric acid solution.  
 Irrigator. Kelly perineal pad.  
 Andrews stitch-cutter for the removal of silkworm-gut stitches from the vagina and cervix.



FIG. 120.—Canton-flannel legging (Hirst).

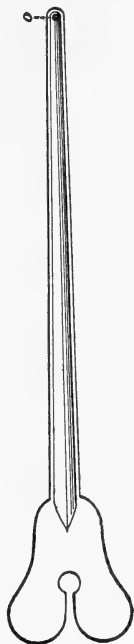


FIG. 121.—Griffith's director, eyed (to enter deep-seated pus collections by being passed down, the aspirating needle used as a guide).



FIG. 122.—Keyes' stone-searcher.



FIG. 123.—Gouley's tunnelled catheter threaded on a filiform bougie.

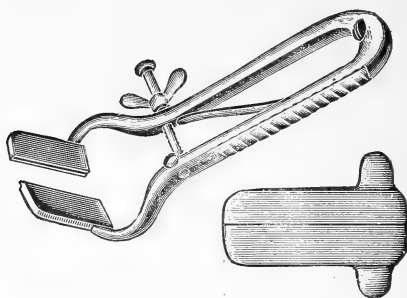


FIG. 124.—Gant's pile clamp.

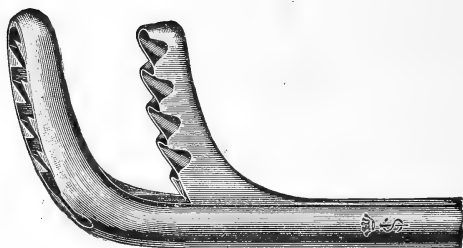


FIG. 125.—Lithotrite.

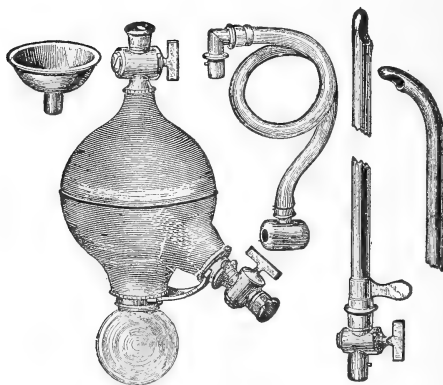


FIG. 126.—Bigelow's evacuator.



*For Cystoscopic Examination.*

Head-mirror.

Urethral calibrator and dilator.

Urethral searcher.

Vesical specula with obturators.

Evacuator for removing urine.

Long-mouthed toothed forceps.

Applicator.

Cocain solution, 10 per cent.

Boroglycerid to lubricate the speculum  
and dilator.

In private practice a head-mirror or reflector can be improvised with a lamp or candle and a mirror.

## CHAPTER IX.

### ANESTHESIA.

ANESTHETICS are divided into two classes, local and general. In local anesthesia the patient does not lose consciousness; but in general anesthesia consciousness is lost, the brain, together with the rest of the body, is narcotized, and there is profound sleep from which the patient awakens slowly. Both classes of anesthetics are used in surgery.

We have practically four general anesthetics, one a gas, nitrous oxid, and three in liquid form: ether, chloroform, and ethyl bromid. The first is employed in dentistry and as a preliminary anesthetic, while the last three are used in general surgical work. The administration of the anesthetic is a duty which may unavoidably fall to the nurse in emergency cases.

The anesthetic should be administered in a room apart from the operating-room, so that the patient may be spared the sight of the preparations for the operation and the necessary display of instruments. Before giving the anesthetic the urine, heart, lungs, and mouth are examined, the mouth because patients are apt to deny the presence of false teeth, and male patients have been known to go to the anesthetizing room with tobacco in their mouths. The patient's habits should be known. Alcoholic patients pass through the exciting stage of anesthesia with con-

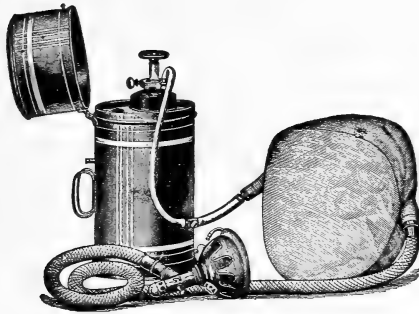


FIG. 127.—Portable apparatus for nitrous-oxid gas.

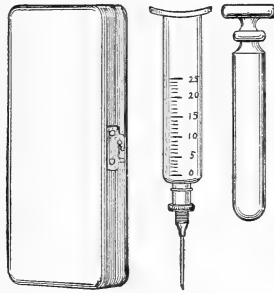


FIG. 128.—Luer's hypodermic syringe.



FIG. 129.—Hard-rubber oral screw.



FIG. 130.—Griffith's wooden mouth-wedge and gag.

siderable struggling; they are also more liable to congestions.

An anesthetic must never be given on a full stomach, because the patient may vomit, and particles of food may lodge in the larynx and trachea and result in strangulation. An interval of four to six hours should be allowed for, or in emergency the patient's stomach may require to be washed by use of stomach-tube and warm water siphonage. The bladder and bowels must always be emptied, or they may act involuntarily. False teeth must be removed, as there is danger of their being swallowed.

Absolute silence must be maintained while the anesthetic is being administered, as anything said may be heard by the patient and be repeated. Whatever is said by the patient during the anesthetic state, or while going into or coming out of it, must be kept absolutely secret. Family secrets and other things may be told which might make great trouble if they were repeated. So a religious silence must be observed by every one with regard to any statement that the patient may make while intoxicated. Care must also be taken that the operation is not discussed. Many patients have been made very unhappy through carelessness on this point; for they can often hear everything that is said by the doctors, students, and nurse, but are totally unable to make any sign by which a bystander may know that they can hear. These are about the first lessons that should be impressed upon a nurse when she begins her operating-room service. Oliver Wendell Holmes, in his *Medical Essays*, says: "It is a terrible thing to take away hope, even earthly hope, from a fellow-creature. Be very careful what names

you let fall before your patient. He knows what it means when you tell him he has tubercles, or Bright's disease; and if he hears the word carcinoma, he will certainly look it out in a medical dictionary, if he does not interpret its dread significance on the instant."

It is not always best that the patient should know that she has carcinoma; if she hears that word, she will feel that it is a sentence of death sooner or later, and her life will be made miserable, whereas, if she is not informed as to the nature of her condition, her life can often be made more comfortable.

The giving of the anæsthetic is by no means a subordinate duty. It requires a very skilled and trustworthy assistant, one who is competent to act in case of emergency, because the life of the patient is as much in the hands of the anæsthetist as in those of the operator. The anæsthetist's whole attention must be given to the administration of the drug. Consequently, he cannot also watch the operator.

The majority of patients are opposed to giving up consciousness, and often it costs a great struggle. It is here that a nurse should inspire her patient with confidence. Although we see many operations in the hospital in a single day, yet to the patient it is the one great event in his or her life.

Some patients have an idea that an operation is mere butchery; while others who have any control over themselves can be shown the operating-room in readiness for work. A few cheering words conveying the right meaning are all that is needed, but we should remember that these are needed.

In all operations in which an anæsthetic is em-

ployed, even in those of a minor character, it is well to be prepared for accidents, such as heart-failure, arrest of respiration, or hemorrhage. There should be a hypodermic tray, with bottles containing solutions of strychnin sulphate, atropin sulphate, digitalis, whiskey, nitroglycerin, morphin sulphate, and camphorated oil. Two hypodermic syringes in good order should be in readiness. An oxygen-inhaling apparatus is a valuable adjunct to an operating-room, and may prove useful in respiratory failure. It is also advisable to have a small faradic battery near at hand. A quantity of normal saline solution should always be in readiness for injection under the skin.

The Allis inhaler is generally used, and in its absence a cone is to be preferred to a sponge, since a cone is always fresh and clean. An ether cone is made by folding a newspaper; or a straw cuff may be shaped to fit over the nose and mouth, a stiff towel being folded around and secured with safety-pins, and a clean handkerchief or piece of cotton placed inside. Ether should be given slowly; the cone should not be filled with ether and put over the face, entirely smothering the patient. The patient should be instructed how to inhale it, slowly and deeply, and also to close the eyes, or cover them with a folded towel, because ether is an irritant to them. About two tablespoonfuls of ether are poured into the cone, which should be held a little distance from the patient's face, and as he becomes accustomed to the vapor and comes under its influence the cone may be brought nearer; the strangling sensation, of which so many patients complain, is then in a measure avoided. A little patience exercised at the beginning

obtains more satisfactory results and less shock than when the drug is crowded, and force is used to re-

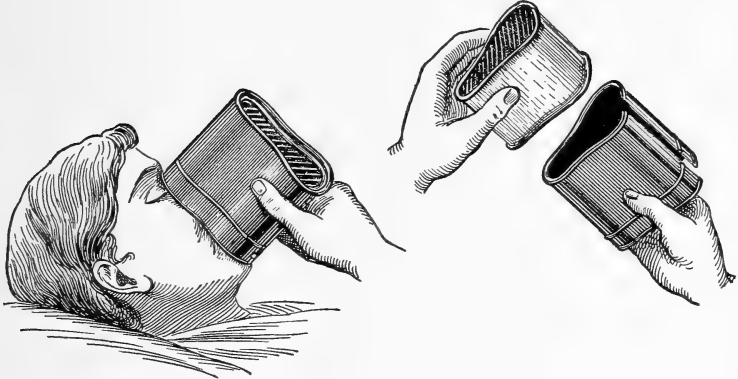


FIG. 131.—Allis's aseptic ether-inhaler.

strain the struggles of the patient. Ether generally first produces choking and coughing, followed by ex-

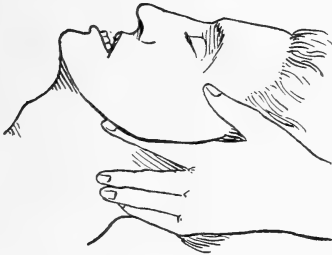


FIG. 132.—Method of pushing the lower jaw forward to prevent obstruction to breathing.

citement ; that is followed by the muscles becoming rigid, the face may be cyanosed, and the breathing stertorous or snoring ; this stage passes away, the muscles become relaxed, and the patient is in a state of insensibility.

The lower jaw must be kept forward by placing the thumbs behind the angles of the jaw. Gentle pushing of the jaw forward and upward, which brings the upper behind the

under teeth, keeps the tongue from slipping back and obstructing the larynx, and gives free access of air to the lungs. Should the tongue slip back, it may be pulled forward with the fingers or with a pair of forceps. Holding the tongue forward by means of passing a suture through the tongue with a needle is rarely required; neither should too much pressure be put on the tongue-forceps, for that will cause the tongue to become sore and swollen, and after the patient recovers from the anesthetic, about the first thing of which she complains is the soreness of tongue and jaws. Frequent inspirations of fresh air should be given. When completely etherized only a small quantity of the drug is needed to keep the patient under its influence. The eyeball should not be touched in order to ascertain if the patient is completely narcotized; it is liable to cause conjunctivitis. Press down the upper eyelid on the eyeball; if the patient makes no movement, and is perfectly relaxed, then insensibility is complete. Bronchorrhea (excessive mucus formation) usually occurs during the earlier stages of anesthesia; but if proper care is taken not to crowd the ether at the start, the mucus secreted will not be of sufficient amount to cause any distressing symptom. When it does occur, the head should be turned to the side and the mouth wiped with a gauze sponge in a sponge-holder. Bronchorrhea may prove to be a distressing complication to the administration of the anesthetic, inasmuch as the free secretion in the bronchi and bronchioles may interfere with thoroughly anesthetizing the patient, and the patient is more prone to nausea from swallowing the mucus, which is probably



soaked with ether. If the patient seems inclined to vomit, the ether should be pushed, which will generally ward it off; should she vomit, her head should be turned to one side, to allow the matter to escape more easily from the mouth. If the operation is about the neck or chest, the head must be turned to the opposite side, to prevent vomited matter from getting into the



FIG. 133.—Griffith's single-eared anesthetizing stethoscope, which will enable the anesthetist to have constant knowledge of the patient's heart and respiratory action while allowing the hands to be free.

wound. Vomiting is usually due to incomplete anesthesia and the admixture of too much air with the vapor. The anesthetic must be persistently given until the vomiting ceases and complete relaxation occurs.

The mucus should be constantly wiped from the patient's mouth. The pupils should remain contracted all through etherization, and dilate when the patient is returning to consciousness. Dilated pupils mean one of two things: either that the patient is coming out of the anesthetic influence, or that she is too deeply anesthetized. We can readily ascertain which condition the patient is in by pouring a little ether into the cone. If she is coming out, she will cough, stop breathing, and give other signs of discomfort;

while if too deeply etherized she will breathe on steadily and not notice the fresh supply of ether; and the pupils will remain dilated until the muscles of the eyes regain their tone, when they contract. The sudden dilatation of the pupils is generally a sign of imminent death. It is very important for the anesthetist to watch carefully the respirations, because ether kills by suffocation, the heart usually beating long after the respirations have ceased. The anesthetist should *speak out* if the pulse is growing rapid, feeble, irregular, or intermittent; if the respirations are becoming low, rapid, or gasping; if the face is becoming pale or blue; if the pupils are gradually dilating; or if the extremities are cold and there is profuse perspiration. In every case of continued doubt it is best to let the patient revive slightly. A very long anesthesia may lead to secondary prostration and collapse, and secondary shock from that cause alone. In other words, the prostration of the anesthetic is added to the effects of the operation.

Primary anesthesia is that moment of temporary unconsciousness which comes on after the patient has taken a few inhalations, before the stage of excitement.

In etherizing very young children it is best to put them on the back and at once to place the ether-cone over the mouth and nose without temporizing. If their pleadings to have the cone taken away are listened to (and they are hard to resist), their agony will only be prolonged and the operation delayed. Older children, once their confidence is won, may be gradually anesthetized as in the case of adults. Children are quickly etherized, and very rapidly recover from the influence of the ether.

Death from ether is slow, by paralysis of the respiration, the signs of danger being a blue and livid skin, and low, shallow, gasping respirations. It sometimes kills quickly by action upon the heart direct. Ether is very inflammable; hence the can should never be opened near a light or fire.

Nausea and vomiting are very common after ether, but are usually over at the end of eighteen hours. The smell of the anesthetic, due to saturation of the patient's hair with the vapor, in a woman may be prevented by protecting the individual's head by means of a towel held in place by use of safety-pins before going into the operating room. Postoperative vomiting may sometimes be overcome by applying an abdominal binder wrung out in cold water—the so-called Neptune girdle. Should vomiting persist until the following day, it may be due to shock or to some cause other than ether. It may be relieved by the inhalation of hot, strong vinegar fumes; a cloth wet with vinegar placed over the mouth and nose; teaspoonful doses of very hot water, either plain or with four grains of bicarbonate of sodium added to one ounce of water; crushed ice; champagne and ice; small doses of brandy and ice; black coffee; aromatic spirits of ammonia, or sometimes tea. Cocain, one-fourth grain every two hours for five doses, has been successful in severe cases; also a mustard-leaf applied over the stomach, and the washing out of the stomach. Oxygen gas is now frequently administered both to lessen nausea and to hasten consciousness. As a last resort, when all other treatment fails and there is danger that the severe retching will exhaust the patient, morphin, one-sixth grain, is injected over the epigastrium.

*Chloroform* is similar in its action to ether, and is often to be preferred to it, because it is pleasanter to

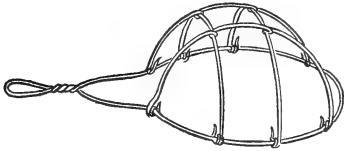


FIG. 134.—Griffith's wire-frame chloroform inhaler.

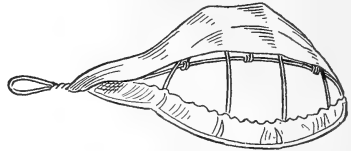


FIG. 135.—Griffith's chloroform inhaler covered with square of double-thickness gauze.

take, rapidly recovered from, does not produce excitement or subsequent vomiting, and the patient is

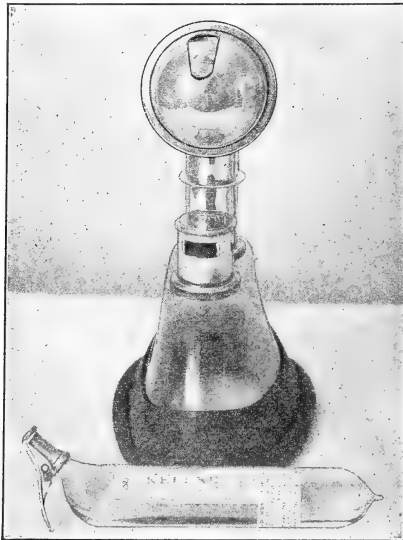


FIG. 136.—Mask and tube for ethyl chlorid (Hirst).

brought more quickly under its influence. It is, however, more depressing to the heart than ether,

and therefore more dangerous. The patient is not allowed to rise until all effects have passed off. To give chloroform, a few drops may be sprinkled on an Esmarch inhaler, a handkerchief, a towel, or a small wire framework covered with gauze. Where the operation is on the mouth, so that all available space and light is demanded, after the patient is fully anesthetized it is administered on a small gauze sponge clamped in forceps which are held several inches above the mouth. Vaseline should first be spread over the face, and especially around the lips and nose, to prevent the burning which might occur should any of the fluid drop. Acrid vomit sometimes causes superficial skin burns. Preventive treatment consists in cleansing with a wetted towel or one wrung out in weak soda solution. The same symptoms are to be watched for as in the case of ether. Death from chloroform is almost always sudden, from paralysis of the heart; the pupils become dilated, the face pale, and the pulse flickering. These symptoms usually come on with little or no warning.

*Ethyl bromid* is often used as a substitute for chloroform, which it resembles in its action, except that it is more prompt. It is employed in minor operations and gynecologic examinations. About half a dram is poured on a folded towel, or chloroform-inhaler, and held close to the mouth and nose. The same amount is added at intervals until the patient is completely narcotized. The stage of excitement is short, and its elimination is rapid. It leaves a disagreeable odor of garlic on the breath, which may last several days; but, on the other hand, the patient recovers rapidly, and may be able in a very little while to resume work.

Ethyl bromid is also used as a local anesthetic in the form of a spray.

*Schleich's anesthetic* consists of one and a half ounces of chloroform, one-half ounce of petroleum ether, and six ounces of ordinary ether. It is given in an Esmarch inhaler, and is considered to be safer than chloroform. Unconsciousness is obtained usually in one minute and a half; there is no excitement, and the reaction is rapid. There are three forms of this solution, the other two being weaker.

**Local anesthetics** are those which abolish the sensibility of the peripheral nerves of a particular area (Brunton).

*Cocain* is the best one that we have at present; the others are ethyl chlorid, eucaïn, menthol-chloral, orthoform, freezing with ice and salt, carbolic acid, alcohol, ether, the so-called infiltration-anesthesia.

*Ice.*—The disadvantage of using ice is that it is always followed by a reaction, the blood-vessels becoming filled with blood; and the patient suffers the pain and tingling sensation which follow intense cold. It is used in the following way: To a little, finely-chopped ice is added about a quarter the amount of salt; this mixture is placed in a piece of gauze and laid over the part, which in about ten minutes becomes white and numb.

*Eucaïn* is much used as a local anesthetic in surgery of the nose, throat, and ear in strengths of 2, 5, and 8 per cent. In the onset its action is slightly slower than that of cocain, from five to ten minutes elapsing before the patient is ready for operation, but when established the anesthesia is fully equal to that of cocain. The duration of the anesthesia is

from ten to twenty minutes, fifteen minutes being the most usual time.

*Cocain hydrochlorate* is a very good anesthetic. It is ordinarily employed in a  $\frac{1}{10}$  of 1 per cent. to a 4 per cent. solution, and is principally applied to the mucous membranes, such as the eye, the mouth, the nose, the urethra. It is not so effective when applied to the sound skin; in order to produce anesthesia there it must be injected subcutaneously, when it gives rise to a rapid edema of the tissues. It has the power of shrinking up the blood-vessels and temporarily driving the blood out of the parts, which is quite an advantage in minor operations.

One-half grain of cocain hydrochlorate dissolved in an ounce of water forms a  $\frac{1}{10}$  per cent. solution: eighteen grains of cocain hydrochlorate to one ounce of water is a 4 per cent. solution. One grain of boric acid added to the solution will prevent the development of fungi, and the solution remains aseptic. The solution should be kept in a cool spot, for if placed in a temperature higher than 60° F. it begins to lose its anesthetic properties.

The use of the cocain discoids enables the nurse to prepare a desired amount of a fresh solution at a moment's notice. They are convenient and safe, and contain accurately weighed quantities of pure cocain.

The *phenate of cocain* is a local anesthetic, used in from 5 to 10 per cent. solutions. It takes longer to act than the hydrochlorate; it also coagulates the tissues and lessens absorption.

*Ethyl chlorid* is a local anesthetic, acting by freezing the parts. It is put up in glass tubes. The cap is removed from the tip of the tube and the bulb held

in the palm of the hand, the warmth of which causes the liquid to escape in a vaporized stream. The tube is held a little distance from the part to be operated upon, which whitens and is ready for operation in about fifteen seconds.

The method of *infiltration-anesthesia* (local anesthesia by injection of solutions in the skin) was introduced by Schleich, who claims that a weak solution of cocain hydrochlorate, with common salt, and a small amount of morphin, will produce a thorough and prolonged anesthesia. There are three preparations, each of which is put up in tablet-form, containing the proper proportions :

No. 1. *Strong.*—

Cocain. hydrochlor.,	1 gr.
Morph. hydrochlor.,	$\frac{1}{8}$ gr.
Sodium chlorid,	1 gr.

No. 2. *Normal.*—

Cocain. hydrochlor.,	$\frac{1}{2}$ gr.
Morph. hydrochlor.,	$\frac{1}{8}$ gr.
Sodium chlorid,	1 gr.

No. 3. *Weak.*—

Cocain. hydrochlor.,	$\frac{1}{20}$ gr.
Morph. hydrochlor.,	$\frac{1}{8}$ gr.
Sodium chlorid,	1 gr.

The tablets should be dissolved in distilled sterilized water.

Alcohol and ether are local anesthetics, as is also any agent which evaporates rapidly and produces cold.

Cocain anesthesia has become an important factor



in modern surgical procedures. While generally confined to use in so-called minor operations, such as the laying open of abscesses and finger amputations, some surgeons have not hesitated to employ it successfully in operations for appendicitis, hernia, and glandular tumors of the neck. It has been determined that a  $\frac{1}{10}$  per cent. solution of the hydrochlorate of cocain will anesthetize the skin for a period of from forty-five minutes to one hour and a half.

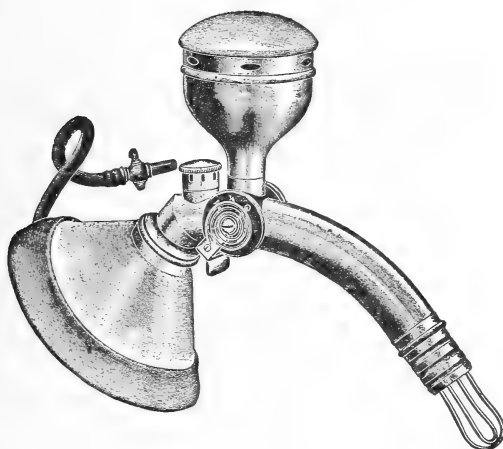


FIG. 137.—Griffith's combined inhaler for gas and liquid anesthetics.

Spinal cocainization produced by injecting a solution of hydrochlorate of cocain (mixed up with spinal fluid to form 1 to 4 per cent.) directly into the spinal canal has been employed. This procedure must be carried out with absolutely sterile implements. From its manifest dangers it is now believed to have a very limited usefulness.

Cocain poisoning may be avoided by never employ-

ing more than the amount of solution equalling one-third of a grain of cocain hydrochlorate. The symptoms of overdose are dryness of the mouth and throat, mental excitement, delirium, dilated pupils, with increased heart and respiratory action, convulsions. Treatment of oncoming symptoms consists in hypodermic injections of full doses of morphin sulphate. General anesthesia is now secured with greater despatch and with more comfort to the patient by means of the mixed gases of oxygen and nitrous oxid, the ill effects of the latter gas, whose action is that of mechanical suffocation, being overcome by the oxygen, or by the employment of nitrous oxid gas alone as a preliminary to ether. Owing to the more active properties of chloroform it is not generally employed in the combination anesthesia.

## CHAPTER X.

### ANTISEPTIC GAUZES, TAMPONS, THERMOCAUTERY, SALINE INFUSIONS, IRRIGATION, ETC.

**Surgical Dressings.**—Gauze and absorbent cotton are now almost universally used as wound-dressings. A dressing may be aseptic or antiseptic. An antiseptic dressing absorbs from the wound all discharges, prevents the access of germs to the wound from the outside, and also destroys all germs that may come in contact with it. An aseptic dressing has the same properties, with the exception that it cannot destroy germs.

In selecting gauze for dressings, that which possesses the greatest absorbent power should be secured. It should be soft, *pliable*, and free from irritating and gritty materials.

When applied to a wound, it should be unfolded and laid on loosely (fluffed); it thus forms a softer dressing and more readily absorbs the discharges.

*Absorbent cotton* is ordinary cotton deprived of its oil, in order to render it absorbent. Laid over gauze, it acts as a sieve through which germs cannot pass; also as a springy protective, by means of which the wound is protected from undue pressure.

*Antiseptic dressings* are made by impregnating gauze

with an antiseptic, such as bichlorid of mercury, iodoform.

To make *bichlorid gauze*, the gauze after the initial boiling is immersed in a 1 : 1000 bichlorid solution for twenty-four hours, after which it is dried, cut into dressings, and packed in glass sterilized jars.

*Iodoform gauze* may be made after the following formula :

Cheese-cloth,	5 yards.
Alcohol,	8 ounces.
Iodoform,	3 "
Ether,	7 "
Glycerin,	3 "

Shake the alcohol and iodoform together in a sterile bottle for fifteen minutes, then add the glycerin, and lastly the ether. Put all into a sterilized stone jar ; then rub the mixture into the gauze thoroughly, and cut the latter into strips two inches wide. Each strip is rolled up separately, and several strips are placed in a sterilized jar. When required for use a strip is taken out with sterile forceps.

In some cases an emulsion of iodoform is rubbed into the gauze. This emulsion, according to Wharton, is made by adding three drams of iodoform to six ounces of Castile soap-suds. This suffices to impregnate eighteen ounces of moist gauze.

The iodoform glycerin or oil which is used for injections into wounds is prepared by taking

Iodoform,	5 grams (75 grains).
Glycerin,	100 c.c. (3½ ounces).

Mix and place in a wide-mouthed flask of thin

glass, and sterilize for one hour, plugging the flask afterward with sterilized cotton.

*Potassium-permanganate Gauze.*—The formula for this is as follows :

Potassium permanganate,	160 grains.
Hot water (distilled),	33 ounces.

The gauze is cut and rolled as for iodoform gauze, and saturated thoroughly in the above solution. It should be preserved in colored glass jars.

*Bismuth gauze* is made after the subjoined formula :

Bismuth subiodid,	11	drams.
Glycerin,	7	“
Water (distilled),	4½	ounces.

Mix and rub thoroughly into the meshes of gauze, cut, and preserve the same as iodoform gauze.

In emergency cases old sheets and clean linen may be cut to the desired size and sterilized in an oven.

*Collodion Dressing.*—Collodion is a preparation of pyroxylin in alcohol and ether. On evaporation of the alcohol and ether a thin, impervious film of collodion is left. The collodion is either painted over the surface of the wound by means of a clean stick of wood or an applicator with sterile cotton fixed to the end, or thin layers of absorbent cotton are saturated with it, laid on the wound, and allowed to dry. Collodion is used only when the wound is aseptic. Various antiseptic agents, such as iodoform, boric acid, etc., may be dissolved or suspended in the collodion. The surface of the wound must be perfectly dry, or the collodion will not adhere. An ordinary dry

dressing may be applied over the collodion as a further protective.

*Horsley's wax* is made of seven parts of beeswax to one part each of almond oil and salicylic acid.

*Rubber adhesive plaster* is at times used in the later stages of wound-healing, for the purpose of drawing the edges together. The chief objection to its use is that it cannot be thoroughly sterilized. A protective dressing may be applied over it in the usual way. Rubber plaster is also used to take the place of bandages where these are inconvenient or difficult of application.

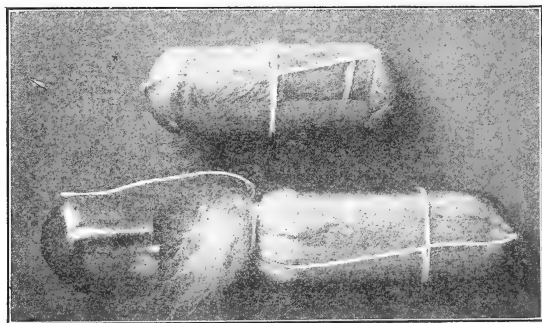


FIG. 138.—Vaginal tampon, sterilized and placed in a gelatin capsule ready for use (Hirst).

*Oiled silk* or *rubber protective* is used when it is desirable to prevent sticking of the dressings to the wound, as in ulcers, and skin-grafting. The material is applied in narrow strips which overlap each other like shingles. The strips are sterilized by washing in cold soap-suds and soaking them in a 1 : 250 solution of corrosive sublimate. They are then rinsed in sterile water or saline solution, in which they are allowed to float until needed by the surgeon.

*Tents* are small strips of rolled gauze used to keep a wound open for the escape of pus. They are rarely employed at present, having been replaced by the drainage-tube. The term tent more frequently designates a conical or cylindrical pencil of sponge, sea-tangle, and other substance, employed for dilating a narrow channel, such, for instance, as the cervical canal. When introduced, the tent expands from the absorption of moisture, and this dilates the part.

**Tampons** are made of absorbent cotton, lambs' wool, or gauze, and are about seven inches long, one and one-half inches wide, and one-half an inch thick. They are folded and tied in the middle with a strong white thread or fine twine, leaving long ends by which to remove the tampon. The so-called kite-tail tampon is made by fastening several of these pieces of cotton to a thread about two inches apart. The tampons may after sterilization be kept in a dry, sterile jar, or they may be thoroughly soaked in water and then kept in glycerin. Tampons are principally used for introduction into the vagina. Previous to introduction they may be dipped into various special solutions. They are generally removed from the vagina on the day after the application.

**Antiseptic Powders.** — Reference has already been made to these. Those most frequently employed are iodoform, boric acid, acetanilid, dermatol, and mixtures of these various kinds. Iodoform and boric acid are generally combined in the proportion of one of the former to seven of the latter. The powders are kept in sterilized glass salt-cellars with silver-tops, which are covered with gauze when not

in use, or in sterile wide-mouth bottles over which a piece of gauze is stretched. As the bottle may not be thoroughly clean on the outside, it should be handed to the surgeon wrapped in a sterile towel up to the top.

The **thermocautery**, known also as the Paquelin cautery, because of its invention by Paquelin, of Paris, is frequently employed in surgery to control

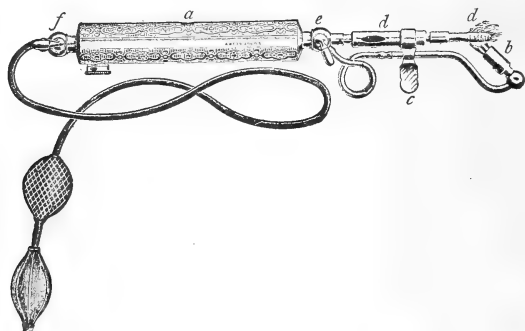


FIG. 139.—Paquelin's thermocautery: Connect point or tip (*d*, *d*) to the container at (*e*) after pouring a teaspoonful of benzine into the reservoir (*a*). Connect bulbs to the bottom of the reservoir at (*f*). Attach the blowpipe (*c*). Open stopcocks (*e* and *f*), press the bulb and apply a lighted match at *b*. Remove blowpipe (*c*) and continue incandescence after platinum has begun to glow by gently working the bulb.

bleeding, and also to produce counter-irritation. The efficacy of this instrument depends on the fact that when the vapor of some highly combustible carbon compound is driven over heated platinum its rapid incandescence is sufficient to maintain the heat of the metal. Platinum points of various shapes and sizes are attached to a rubber tube, which is connected with a metal container half full of benzine or alcohol, the vapor of which is pumped through



the tubing and holder into the platinum point. In order to prepare the instrument for use benzoin (above 65° Baume) is the best combustible, but wood-alcohol, naphtha, benzol, gasolene, ammonia-water, or ether may be used.

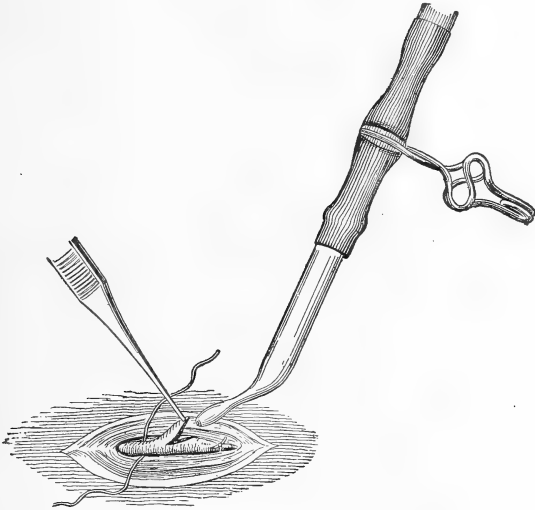


FIG. 140.—Intravenous saline infusion. Manner of incising vein and inserting glass tube (Senn).

After using, the container should be completely closed, and the points while hot must be removed from the handle and laid away to cool; they must not be put into water, but wiped perfectly clean. The handle when cool must be removed from the tubing, and each part must be carefully laid in its own compartment in the case.

**Normal saline solution** is made to correspond as nearly as possible in specific gravity with the normal serum of the blood. The formula suggested by Dr.

Locke of Boston and Dr. H. A. Hare, containing in one quart calcium chlorid 0.25 gm., potassium chlorid 0.1 gm., sodium chlorid 9 gm., is usually employed. It not only

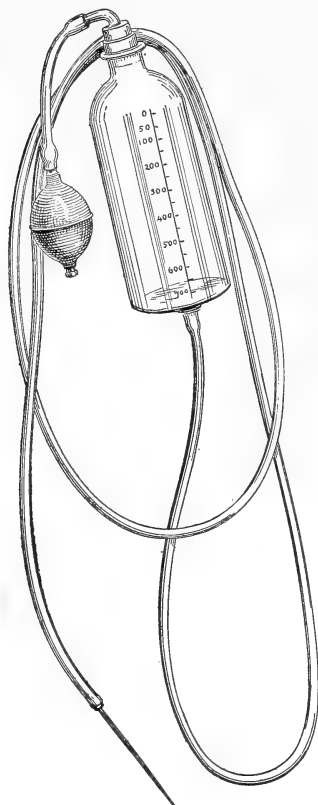


FIG. 141.—Apparatus for hypodermoclysis (Hirst).

gives the heart a better fluid to work upon, but it restores to the blood that coagulable quality which is diminished or lost by hemorrhage. Tablets containing this formula have been devised, and are usually used. One tablet added to one quart of water gives the correct strength. In absence of the tablets one teaspoonful of table salt is added to one pint of water. It is absolutely necessary whatever formula is used that the solution and all the apparatus used be properly sterilized. If the water contains particles that cannot be strained out and there is no filter at hand, the water should stand until the sediment settles, when the fluid can

be poured off, resterilized, and used. This solution is placed in an irrigator or a fountain-syringe which has been thoroughly sterilized with hot water and corrosive-sublimate solution, and subsequently rinsed with

boiled water. A long hypodermic needle, which has also been thoroughly sterilized, is fastened to the end of the rubber tube connected with the irrigator or fountain-syringe. The fluid may be kept in a pitcher and poured into a glass funnel to which the rubber tube is attached. The temperature of the solution should be about  $100^{\circ}$  F. The solution is introduced under the skin of either the chest, the abdo-

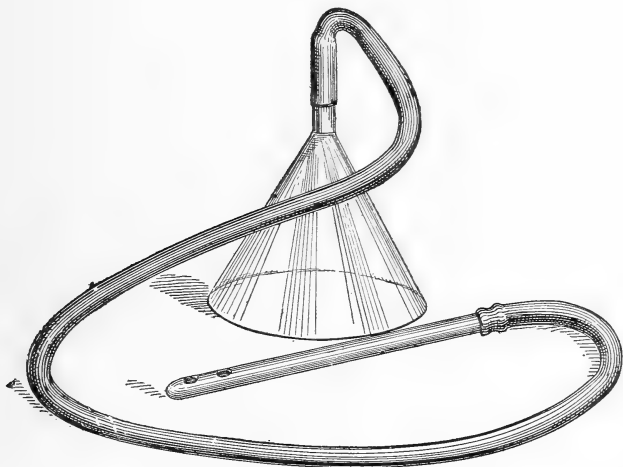


FIG. 142.—Apparatus for douching the abdominal cavity (Hirst).

men, the thigh, the arm, or between the shoulder-blades. From a pint to two quarts are injected at one time. The part selected for the injection is to be sterilized thoroughly in advance. Saline infusion is also given by the rectum, a long rectal tube being used.

In hospitals it is customary to keep on hand flasks of saline solution. These flasks are sterilized before

filling; afterward they are stopped with sterile cotton-plugs and sterilized again by boiling for one hour on three successive days.

Normal salt solution is used for irrigation and for injections in cases of shock, in acute diabetic and uremic coma, hemorrhage, puerperal infection and eclampsia.

**Irrigation.**—Irrigation, or flushing, is employed to cleanse wounds and wash out cavities, such as the uterus, the abdomen. The solutions employed are various. Many surgeons use sterile salt-solution or plain boiled water. Antiseptic solutions, such as bichlorid solution (1 : 10,000 to 1 : 1000), boric acid solution, are used especially for septic wounds and surfaces. For purposes of irrigation a conical glass vessel, with a tube at the bottom to which a rubber tube is attached, is commonly employed; a fountain-syringe will also answer the purpose.

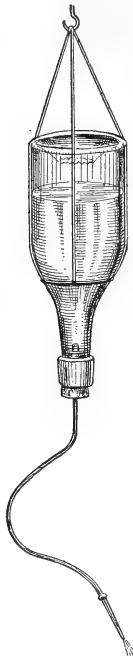


FIG. 143.—Improvised apparatus for the irrigation of a wound (DaCosta).

The irrigating-nozzle is usually of glass. The solution should be warm; when it is desired to check hemorrhage, it is used quite hot (110°–120° F.).

## CHAPTER XI.

### SUTURES AND LIGATURES; SPONGES; DRAINAGE; DRAINAGE-TUBES; GAUZE DRAINS; RUBBER DAM; RUBBER AND COTTON GLOVES.

**Sutures**, which are used to bring together the edges of a wound, may be of silver wire, silkworm-gut, twisted Chinese silk, kangaroo-tendon, catgut, and horse-hair. Of these, silkworm-gut, catgut, and silk are most commonly used.

*Catgut* is made from the intestine of the sheep. It is largely used for suture-material within the abdominal cavity or deeper layers of tissues, because it is absorbed by the fluids of the body, and does not remain after the healing of the external wound to constitute a foreign body.

*Kangaroo-tendon* is prepared from the split sinews of the tail of that animal, and was intro-

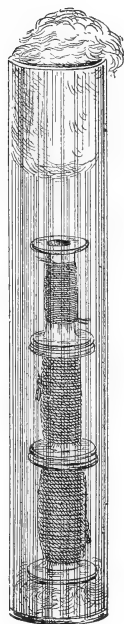


FIG. 144.—Silk in glass tube, on glass reels; the tube is stoppered with cotton (Hirst).

duced by Dr. H. O. Marcy of Boston. It is obtainable in any size, and comes in pieces of about twenty inches in length. Its advantage over catgut consists in its greater strength. It is more easily sterilized, and does not lose its strength during perfect sterilization. It is particularly of value in buried sutures and ligatures and continuous sutures at the surface.

To prepare the kangaroo-tendon the following method may be used: The tendon having been soaked in absolute ether for forty-eight hours, is heated to a temperature of  $100^{\circ}$  C. in alcohol under pressure in a closed receptacle for one hour. This temperature is maintained by means of a water-bath. It is then put in mercuric chlorid solution, consisting of mercuric chlorid 40 grains, tartaric acid 200 grains, and alcohol 12 ounces, for ten minutes. It is then placed with sterilized forceps in sterilized glass-stoppered jars containing bichlorid of palladium  $\frac{1}{16}$  grain to 1 pint of absolute alcohol.

*Silkworm-gut* is prepared for use by soaking for forty-eight hours in ether and one hour in 1 : 1000 corrosive sublimate; it is then kept in a long tube of alcohol, though many surgeons prefer it made aseptic by boiling two hours before the operation. It is seldom used as a buried suture, but chiefly in closing wounds with interrupted sutures.

*Catgut.*—There are various methods of sterilizing catgut, among them the methods of Leavens and Fowler, by which catgut is kept in alcohol in sealed tubes, the preparation by formalin recently proposed by Senn, cumol catgut, all equally effective if judiciously carried out. The gut used should be of the very best quality. The following are the most popular methods of preparation:

1. Six strands of catgut, each fourteen inches long, are wound on glass reels and soaked in ether for twenty-four hours to remove all fatty substances. The spools are then removed with sterilized forceps and dropped into covered glass jars, containing 95 per cent. alcohol, care being taken that the catgut is completely submerged and that allowance is made for evaporation. The mouth of the jar is covered with

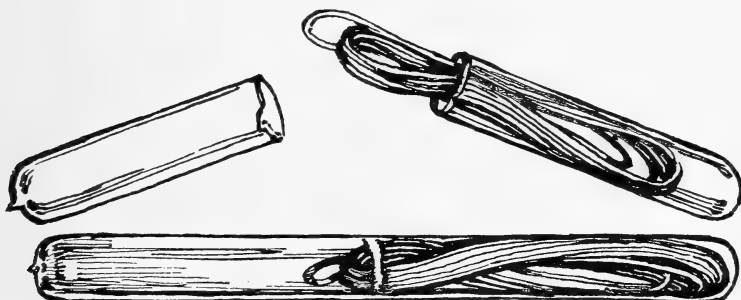


FIG. 145.—Sterile catgut in glass tubes ready for use.

absorbent cotton and the jar placed on a water-bath, the water of which is gradually heated until the alcohol boils, when the jar is removed. This operation is repeated on two successive days. On the third day of sterilization the absorbent cotton is removed, and a glass cover, fitted with a rubber protective to prevent evaporation, is screwed on.

2. The catgut is soaked for twelve hours in a corrosive sublimate solution (1 : 1000), and afterward from twenty-four to forty-eight hours in oil of juniper. The spools are then transferred to covered glass jars, containing sufficient absolute alcohol to cover the catgut completely. The alcohol is changed every two weeks.

3. Strands of catgut are soaked for twenty-four hours in oil of juniper, after which they are wound upon glass reels, and placed in covered glass jars containing absolute alcohol.

*Iodized Catgut.*—Ordinary catgut placed for eight days in the following solution :

Iodin,	1 part.
Potassium iodin,	1 “
Water,	100 parts.

Tensile strength not affected up to six months.

When used externally irritation to the skin may result (due to the action of iodin).

*Bichlorid Catgut* (said to keep indefinitely).—Place the gut strings in ether for twenty-four hours (dissolves out fat), then in a solution of :

Bichlorid of mercury,	1 part.
Alcohol (95 per cent.),	500 parts.

Ordinary sized gut strings are sterile after eight days ; large sizes, after fourteen days.

The method used by Dr. F. W. Johnson, of Boston, Mass., is as follows: The gut is soaked in ether for several days. It is then cut into the desired length, each length being thoroughly stretched (the stretching prevents kinking and twisting). The gut is then soaked for twenty-four hours in absolute alcohol, to take out as much of the water as possible. It is then covered with a solution of bichromate of potassium in absolute alcohol (fifteen grains to the pint), and remains in this twelve hours. Each length is coiled up, wrapped in waxed paper, and put in an envelope, which is sealed. The sealed envel-



opes are put in a dry oven, and baked for one hour at a temperature of  $100^{\circ}$  C. This removes all moisture. On the following day the sealed envelopes are baked three hours at a temperature of  $140^{\circ}$  C. The gut is now ready for use. The envelopes are kept in a glass jar. An assistant tears open one end of an envelope, undoes the wax paper without touching the catgut, and hands it to the operator. In this way the gut is touched by no one, and touches nothing until picked up by the fingers of the operator.

*Formalin Preparation.*—Formalin is also used in the preparation of catgut. The catgut is wound on a glass spool, not too tightly, and soaked for two days in equal parts of ether and alcohol, after which it is rinsed in pure alcohol for a few moments and transferred to glass bottles with tightly fitting covers, and which have been previously sterilized, containing equal parts of formalin and alcohol, more than enough to cover the catgut. After one week the catgut is taken out and boiled for half an hour in normal saline solution, and is then placed in sterilized bottles containing alcohol until needed.

Silk is sterilized by being boiled for two hours before the operation. Five yards each of various sizes of twisted Chinese and pedicle silk are wound on glass spools and allowed to boil for two hours before the operation. When called for by the operator the pan containing the silk is handed to him, and he takes out the required size with sterilized forceps. In this way the sutures and ligatures are touched by no one but the surgeon himself. It is always a good plan to sterilize fresh silk for each

major operation. By so doing we are sure of it being perfectly aseptic.

To sterilize horsehair, first wash thoroughly in green soapsuds; rinse several times; soak in ether for twenty-four hours. Boil in sterile water for twenty minutes. Preserve in alcohol, 95 per cent.

Silver wire is sterilized by means of dry heat or by boiling in a 1 per cent. soda solution with the instruments. Usually the latter is preferred.

The *interrupted suture* is made by passing catgut or silk through the skin from one side of the wound

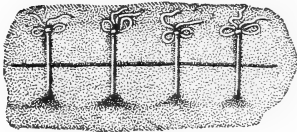


FIG. 146.—Interrupted suture (Bernard and Huette).

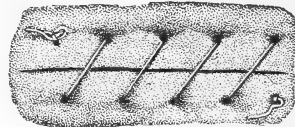


FIG. 147.—Continued or Glover's suture (Bernard and Huette).

to the other; then both ends are drawn together and tied in a double knot. The *continuous suture* is the ordinary over-and-over stitch from one end of the wound to the other. The *button suture* is made by passing wire across the bottom of the wound, bringing out the ends about one inch from the edge of the

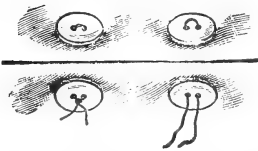


FIG. 148.—Button suture (Bryant).

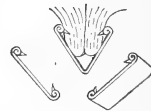


FIG. 149.—Metal suturing clamps.

wound, and securing each end with a button. The *shotted suture* is one in which the ends of the suture,

after it is introduced, are passed through a perforated shot, which is then clamped.

*Metal Suturing Clamps.*—Modified serrefines, made of block tin, they have been successfully employed as sutures, being readily applied or detached by dissecting forceps. Infection through the skin or stitch-hole abscess does not occur from their use, as the retaining spur does not deeply puncture. Scarring is decreased by their employment, and claims for value in intestine sewing have been made.

*Stitch abscesses* are usually produced by unclean suture-material. They may be caused by tying the stitches too tightly; but, as a rule, they occur when the sutures are not carefully sterilized. This is the reason why so many operators prefer their silk and silkworm-gut boiled immediately before using. It cannot be denied that a sterile suture may become infected when passing through the deeper layers of the epidermis, and so give rise to a stitch-hole abscess.

**Sponges.**—Sponges are used to wash wound-surfaces and to absorb or soak up fluids. The sponges most commonly employed are in the form of the gauze pads, the cut edges being folded over and loosely hemmed, and of square pieces of gauze, each piece being rolled loosely in the form of a ball, the free end being twisted and tucked in. The marine sponges are not often used at the present time. Gauze sponges are never employed more than once. Those used in operations are afterward destroyed; those not used are resterilized, placed in sterilized towels, and deposited in covered glass jars, which are not uncovered until called for at an operation.

The great advantage of gauze over a marine sponge is that it can be thoroughly sterilized.

If marine sponges are required for an operation, the dark-colored ones should be bought. They do not look so attractive, but they are the finest sponges; they are "uncut" and "unbleached," and give more service than the clearer-looking ones, which are partly or wholly bleached. The bleached and cheaper sponges have been made by cutting one large sponge into several small ones; or by cutting off portions that were torn in taking the sponges from the ocean.

Marine sponges should be prepared as follows: 1. Lay them in a stout cloth and pound sufficiently to break up grit and lime. 2. Rinse with warm water until it remains clear. 3. Immerse in hydrochloric acid solution (two drams to one quart of water) for twenty-four hours. 4. Immerse in saturated solution of permanganate of potassium, followed with oxalic acid, then pass them through lime-water to take out all the oxalic acid, and rinse well in plain sterile water; after which they are immersed for twenty-four hours in a 1:1000 corrosive sublimate solution. They are preserved until used in a 3 per cent. carbolic acid solution.

When wanted for use the sponges are lifted out of the jar with long dressing-forceps and rinsed in plain sterile water.

**Gauze pads** for abdominal operations are made of eight thicknesses of gauze about eight inches square, with the edges tucked in and hemmed to prevent fraying.

Pads are usually made in sets of five, seven, or nine for purposes of identification. As a further precaution to prevent a pad being left within the abdominal cavity the first pad should have a stout threaded cord

attached to it. Additional pads may now be threaded upon the cord, all being removed without fear from miscount. A weighted or gravity pad made by quilting flat bits of lead within the layers of gauze may be useful at times to act as a retractor of the intestines.

**Gauze**, now considered the most valuable of dressings for wounds, is cut into sections of four thicknesses and folded into dressings. A large number of these are sterilized for two hours, when they are removed with perfectly aseptic hands and placed in sterilized jars.

**Absorbent cotton** used in dressing cases is prepared in the same way.

Some hospitals find it expedient to sort, wash, re-sterilize, and use over soiled bandages and gauze. Cotton waste, after being boiled, sterilized, and dried, is used in place of absorbent cotton and gauze for the *filling of pads*.

To sterilize oils or glycerin, place in a water-bath and boil for two hours.

**Needles** of various shapes and sizes required for an operation are sterilized with the instruments. Many operators prefer the needles to be threaded, then attached to a towel, which is folded, enveloped in another towel, and securely fastened. These bundles are sterilized and are not opened until called for by the operator or his assistants. After the operation is completed the sutures and ligaments which have not been used are carefully dried and re-sterilized. In choosing the needles care must be taken that only sharp needles and strong sutures and ligatures are selected for use.

Sheets, gowns, and towels used in operations are all made into convenient bundles and sterilized for two hours prior to an operation. Bundles once opened are not used again for other operations until they are resterilized.

**Emergency bundles** containing everything necessary for an emergency operation are stored in cases provided for them; but if not used for forty-eight hours, are again sterilized before being used.

**Brushes.**—Small hand brushes having a strong wooden back and stiff bristles are used for scrubbing the hands, field of operation, and the instruments. They should be boiled two hours before the operation, then placed in a jar containing a 1 : 1000 corrosive sublimate solution. A separate brush should be reserved for the patient, and should be so marked. A separate brush should also be used for the cleansing of the vagina or rectum. Brushes used in purulent wounds and cancer should be destroyed after the operation. The same brush should never be used twice by the same person without being resterilized, and no two persons should use the same brush.

**Drainage.**—The object of drainage is to carry off to the surface the secretions and discharges of wounds and cavities. The retention and accumulation of these would interfere with healing, and, in the case of septic discharge, involves the danger of general infection. Drainage may be secured by means of rubber or glass tubes, or by strands of gauze, catgut, silkworm-gut, horse-hair, or silk. In case of abdominal section the glass drainage-tube is usually preferred to gauze drainage, because it gives freer drainage, does not require a large opening in the

abdominal walls, and is less likely to cause hernia; a sinus is more apt to follow the use of gauze drain-

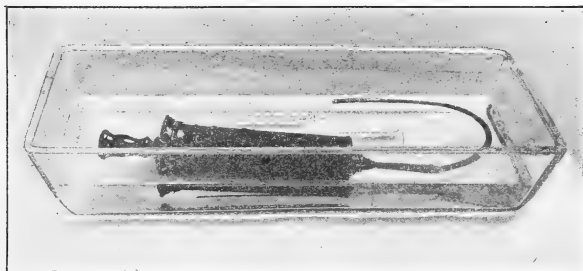


FIG. 150.—Drainage-tubes and syringe for sucking them out (Hirst).

age, and without anesthesia its removal is painful. Gauze soils the dressings and edges of the wound. With the glass drainage-tube, if properly taken care of, the dressings can be kept as sweet and clean as when put on. By bacteriologic examination the secretions in the glass drainage-tube have been found on the third day free from pathogenic bacteria. The "cigarette drain" is made by rolling a loose twist of gauze in rubber tissue. The chief objections to drainage of dependent pockets in the pelvis or abdomen, as formulated by Dr. J. G. Clark, of the University of Pennsylvania, are, first, that the fluids are frequently not removed, but, on the contrary, are pent up by the gauze drain; and, second, instead of removing infection, the gauze or tube may be the means of introducing it from the outside into the degenerated fluids. To overcome the dangers of dependent pockets and dead spaces in the pelvis, Dr. Clark suggests the elevation of the patient's body after operation to a sufficient height to start the flow of fluids from the

pelvis toward the diaphragm, and thus promote the rapid elimination, by the normal channels of exit from the peritoneal cavity, of infectious matter, and of vital fluids that may stagnate in these pockets and form a culture-medium for pyogenic organisms.

The technic of *postural drainage* through the abdomen, which has met with such good results, is very simple. After the operation proper a large quantity of normal saline solution is poured into the abdomen and allowed to remain, and the foot of the patient's bed is raised twenty inches for about thirty-six hours after the operation. The result is that the exudate, if infected, is greatly diluted and may all be absorbed by the peritoneum; if inflammatory, it is kept liquid, and organized exudates are avoided. The pressure of the viscera is removed, intestinal adhesions are avoided, peristalsis does not cause pain by irritation, the patient suffers less distress and discomfort, and convalescence is naturally more rapid; Fowler's position seeks, by elevating the head of the patient's bed and slinging the individual from the shoulders, to prevent the spreading of a local peritoneal infection upward toward the vital organs.

Closure of the abdomen without drainage after thoroughly drying out the cavity is the rule of some operators, who believe that so-called drains for the most part act as foreign bodies.

*Care of Drainage-tubes.*—If a glass drainage-tube is in the abdomen, the care of it is usually left to the nurse. She must, each time before drainage, thoroughly scrub and sterilize her hands. A syringe is used to withdraw any fluid remaining and for injecting irrigating solutions. The syringe must be washed first



with boiling water, the water being passed through it several times, then with corrosive-sublimate solution (1 : 1000), followed with boiling water; the syringe is then to be laid in the corrosive solution until the nurse has washed her hands a second time and unpinned the dressing covering the tube. The rubber tube attached to the syringe is passed down the center of the drainage-tube to the bottom, then withdrawn a little, so that only the fluid will be drawn up, and not the tissue of the pelvis. The syringe-piston is to be slowly and steadily drawn up. When removing the syringe the nurse should be careful that blood does not drop on the dressing. The mouth of the tube is to be covered while the syringe is being emptied, and the corrosive and hot water are to be passed through the syringe before again putting it down the tube.

Some surgeons place a piece of twisted gauze into the tube, which sucks up the fluid. This gauze is changed at stated intervals, and the tube is cleaned with a small piece of sterilized cotton or gauze fastened on the end of a pair of long forceps; then a fresh twist of gauze is inserted. The amount of fluid drawn and its character must always be reported by the nurse. When the drainage-tube is to be removed, the nurse should observe the same precautions as she would for a dressing.

Glass drainage-tubes are made aseptic by boiling for two hours before the operation.

*Preparation of Rubber Drainage-tubes.*—Cut tubing into desired lengths, slip each piece over a glass rod, and scrub with a stiff brush and green soap. Rinse in sterile water until entirely free from soap. Boil for

one hour in a 1 per cent. solution of sodium bicarbonate (enough to impart a greasy feel to the water); rinse again several times in sterile water, and put into

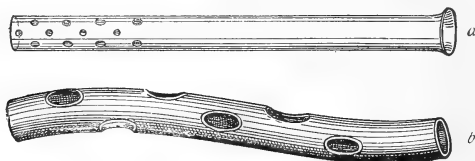


FIG. 151.—Drainage-tubes: *a*, glass; *b*, rubber.

sterile jars and cover with alcohol or carbolic acid, 1 : 20. The jar is kept covered except when the tubes are being put in and taken out by sterilized forceps.

**Rubber Dam.**—Rubber dam is sterilized by boiling in 1 per cent. soda solution, and is afterward transferred to a glass jar containing 1 : 20 carbolic acid solution.

Cargile membrane, tissue made from the peritoneum of the ox, is used as a protective against adhesion formation, particularly in operations upon the bowels.

Several years ago the reviser discovered a similar material to be very cheaply and easily obtained from sharks.

**Gloves.**—Rubber and cotton gloves are much employed in surgical work, and with very good results. They prevent infection by the surgeon's and assistants' hands, which even with the greatest care cannot be rendered completely sterile. The cotton gloves are sterilized by dry heat. The rubber gloves

are sterilized by boiling one hour in a 1:20 solution of carbolic acid, after which they are transferred to a basin of sterilized water until required for use. To put them on, they are filled with sterile water until the whole glove becomes distended, after which they are easily slipped on. Some surgeons wear the gloves to protect the hands after they have been

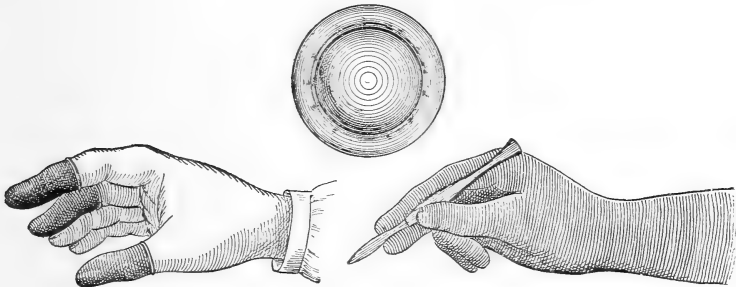


FIG. 152.—Finger cots.

FIG. 153.—Rubber glove.

sterilized and remove them when all is ready for the operation. The disadvantage of rubber gloves lies in their causing the wearer's hands to perspire, thereby increasing the danger of infecting the wound in cases of accidental puncture of the glove by knife or needle during operation. The same care must be used in scrubbing hands when rubber gloves are used as when they are not. Careless regard of this rule will end up sooner or later in infection from a punctured glove.

*Rubber-glove Solution.*—Murphy suggests an aseptic film covering sufficiently tenacious to last during several hours' work, to be made by dipping the hands and arms into a 4 per cent. solution of pure gutta-percha chips dissolved in sterile benzine or acetone

(use chloroform or carbon tetrachlorid in place of these, owing to inflammability). The solution must not be boiled. Apply by immersion, allowing excess to drip from the fingers; the acetone solution dries in a few seconds, that of benzin requires two or three minutes. Remove from the skin, which is left pliant, by washing in benzin.

**Green Soap.—**

Caustic potash,	13 ounces.
Linseed oil,	40 “
Alcohol,	4 “

Heat the oil in a vessel to 140° F. or till it is too hot for the fingers. Dissolve the potash in 67 ounces of hot water. Add the alcohol and let it cool. Then add the heated oil, stirring constantly until mixed. Let the mixture stand twelve hours and add alcohol.

To make a tincture of green soap:

Green soap,	3 parts.
Alcohol, 95 per cent.,	2 “
Ether,	1 part.

To prepare cold, mix and stir for a few minutes every hour until a clear solution is formed; or the soap may be melted first over a slow fire. Remove to a safe cool place, stir occasionally, and just before complete hardening recurs, add the alcohol and ether.

## CHAPTER XII.

### INFLAMMATION.

INFLAMMATION is the reaction of a part to an irritant.

The first changes are in the vessels and circulation; second, a passing out of fluids and solids from the vessels; and third, changes in the perivascular tissue—*i. e.*, the tissues about the blood-vessels. These

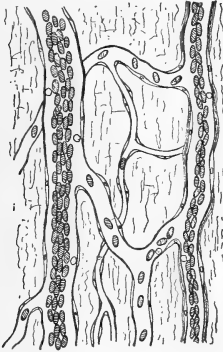


FIG. 154.—Normal vessels and blood-stream.

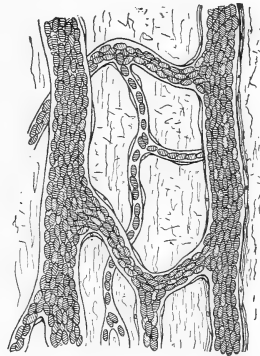


FIG. 155.—Dilatation of the vessels in inflammation.

(American Text-Book of Surgery.)

three changes produce the characteristic phenomena of inflammation—heat, redness, swelling, pain, and loss of function.

The first change in an inflamed area is a dilatation of all the vessels—the arterioles, capillaries, and venules. As a result, there is an increased activity in the circulation and an increased flow of blood to

the part, a condition known as active hyperemia. After a time the blood-current begins to slacken; then the white cells approach the vessel-wall and

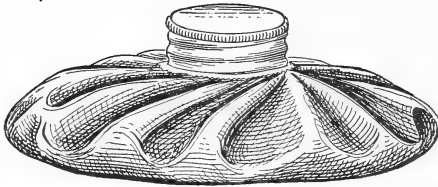


FIG. 156.—Ice-bag (Ashton).



FIG. 157.—Water coil.

begin to pass through it (emigration of white cells). There is also a passing out of plasma or fluid from the blood, and in severe cases of inflammation the red cells may also pass out. If we now examine the inflamed area with a microscope, we find an enormous number of cells, chiefly white blood-cells, in the tissues about the vessels. Fibrin in the form of delicate granules and fibrils may also be present.

Inflammation is a process which is directed to the removal of an irritant, which may be either a portion of an injured tissue or a foreign body or material. After this result has been accomplished healing or regeneration takes place. If the inflammation was caused by bacteria, suppuration is likely to follow. In that case the tissues will liquefy and the cells will be thrown off suspended in a liquid (liquor puris), the whole being known as *pus*. In suppuration there is always loss of tissue, and healing, if it occurs, is

brought about through the formation of a scar. In order to produce healing granulation-tissue is formed.

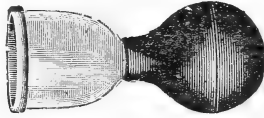


FIG. 158.—Bier's vacuum treatment apparatus for boils.

Granulation-tissue consists of new cells and tiny capillary loops. It is sometimes called "proud flesh," and bleeds very easily. The scar has a marked tendency to contract and may cause great deformity.

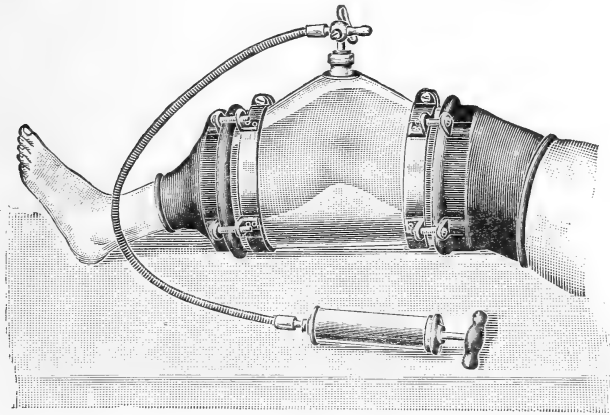


FIG. 159.—Bier's air suction apparatus for treating stiff knee.

Among the causes of inflammation are injuries, chemical irritants, heat and cold, and bacteria.

## CHAPTER XIII.

### **CATHETERIZATION; DOUCHES; ENEMATA; WASHING OUT THE BLADDER; LAVAGE.**

THE use of the catheter is ordinarily very simple, and yet it may truthfully be said that there is no operation which is performed with so little regard for asepsis. Asepsis and antisepsis are as important here as they would be in preparing for an abdominal operation.

Cystitis is often caused by the introduction of germs into the bladder by means of a dirty catheter, or by not cleansing the external genitals, vestibule, and meatus before the operation. Normal urine is to be considered sterile unless there is some disease of the kidneys or bladder; and when infection occurs we may assume that the germs have gained entrance from without. The catheter may be of glass. When a glass catheter is not at hand, a silver or rubber one may be used. When of glass or silver or rubber it should be boiled twenty minutes before being used.

Glass catheters are the best; they are easily rendered aseptic, and show whether they are or are not perfectly clean. Sterilization is most important before using the catheter and immediately afterward. There is no danger of the catheter breaking, as so many patients fear, if it is not cracked before being introduced. Besides the catheter, which is taken to the bedside in a basin of very hot water, there are



needed a basin of corrosive sublimate solution (1 : 1000), sterilized gauze or cotton, and a vessel to receive the urine. A lubricant of sterilized oil

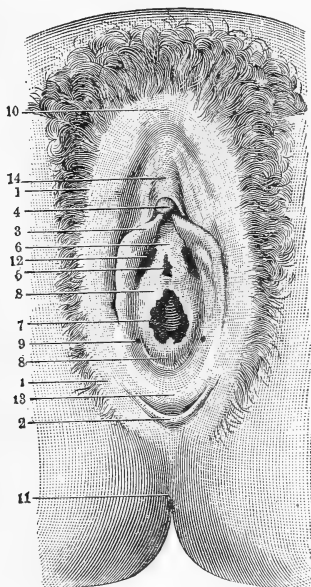


FIG. 160.—Virginal vulva : 1, Labia majora ; 2, fourchet ; 3, labia.minora ; 4, glans clitoridis ; 5, meatus urinarius ; 6, vestibule ; 7, entrance to the vagina ; 8, hymen ; 9, orifice of Bartholini's gland ; 10, anterior commissure of labia majora ; 11, anus ; 12, blind recess ; 13, fossa navicularis ; 14, body of clitoris. (Modified from Tarnier.)

to render the entrance of the instrument as easy as possible is used only when a gum-elastic or rubber catheter is employed. A mixture of carbolic acid solution (1 : 40) and glycerin serves for this purpose.

**Introduction of the Catheter.**—The patient lies on her back with the knees drawn up and separated, the upper clothing being divided over each knee to guard against unnecessary exposure. The

labia are separated with sterilized sponges and the parts washed with the corrosive solution. The catheter is inserted into the urethra, the opening of which is just above the vaginal entrance. If there is any difficulty, the catheter should be withdrawn a little, and gently pointed a little downward or upward, to the right or to the left. If the flow should cease before enough urine has been drawn, the catheter is withdrawn a little or is inserted a little farther than before. Before removing the catheter a finger should be placed over its end, to prevent any drops of urine wetting the bed. After the operation the parts are again washed, and the catheter boiled and placed in a bottle containing a solution of carbolic acid (1 : 20), unless the catheter is of rubber; for carbolic acid ruins rubber.

When the bladder is partially paralyzed from result of an operation, or otherwise, a rectal injection of very warm water will often cause the bowel and bladder to empty themselves at the same time, thus doing away with the necessity of using a catheter.

The urine for examination by the physician is best drawn with the catheter, to prevent contamination from vaginal discharges.

A distended bladder must be emptied gradually; several sittings, at intervals of four or six hours, may be necessary in some cases; and as the last amount of urine is being drawn the flow should be slowed, to prevent any injury to the mucous membrane of the bladder from drawing it into the eye of the catheter.

**Irrigation of the Bladder.**—To irrigate the bladder a fountain-syringe, cleansed with boiling water and a disinfectant, is needed; also a glass catheter, which is sterilized in the same way as for

catheterizing. The parts, of course, are cleansed in the manner described. The patient is first catheterized; the catheter is then rinsed with boiling water and attached to the rubber tubing of the syringe which contains the irrigation solution (boric acid or salt solution), the temperature of the latter being about 100° F. The solution must run warm before the catheter is inserted. The rapidity of the flow is regulated by raising or lowering the irrigator. The quantity of solution introduced is governed by the feelings of the patient; usually 200 c.c. is all that can be tolerated, after which the tube is disconnected and the fluid is drawn off. If a double catheter is used, the tubing is not removed. The irrigation is repeated until the washings come away perfectly clear and clean.

**Examination of Stomach-contents.** — Many times the nurse is called upon to give a test-breakfast and to send the stomach-contents to the laboratory for examination.

A test-breakfast usually consists of a cup of tea without milk or sugar, and two soda-crackers; or instead of the crackers a small piece of rare steak or small piece of bread without butter is given. One hour after, the stomach-contents are obtained by passing the stomach-tube. As soon as the tube comes in contact with the walls of the stomach they contract and force out the contents. If vomiting does not occur, it may be excited by pouring down the tube about two drams of lukewarm water. The contents are measured, and placed in a clean bottle labelled with the patient's name, the date, quantity, and hour that the breakfast was given and contents secured; the bottle is then sent immediately to the laboratory.

In cases where revulsion does not occur, pour a measured quantity of warm water (one pint) into the stomach, remove it, and secure the test meal by siphonage (lower the mouth of the stomach-tube below the level of the patient's stomach, when gravitation will cause the fluid to flow).

**Douches.**—Properly given, the vaginal douche relieves inflammation, checks hemorrhage, acts as a stimulant and cleansing agent, and checks secretion. The amount of water used is from five to six quarts, of a temperature of 110° F. The temperature must always be tested with a bath-thermometer (Fig. 161), not with the hand. The Baker douche apparatus (Fig. 162) is an excellent contrivance. In its absence a fountain-syringe may be used.

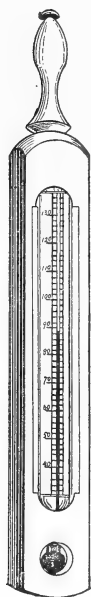


FIG. 161.—Bath-thermometer.

When taking a douche the patient should lie on her back, with the thighs flexed on the abdomen and the legs flexed on the thighs. In this position the water comes in contact with the whole vagina.

The pail or fountain-syringe must be hung about four feet above the bed, so that it will take about twenty minutes for the water to run out. Air must be expelled, and the water must run warm before the tube is inserted into the vagina. The vaginal tube must always be sterilized before and after using, and every patient should have her own tube.

Many patients in private practice object to taking douches, and will neglect them on account of the inconvenience; but this they can overcome by

taking the douches in the bath-tub. Half-way across the bottom of the tub a piece of board is placed, on which the patient can lie. The douche-board designed

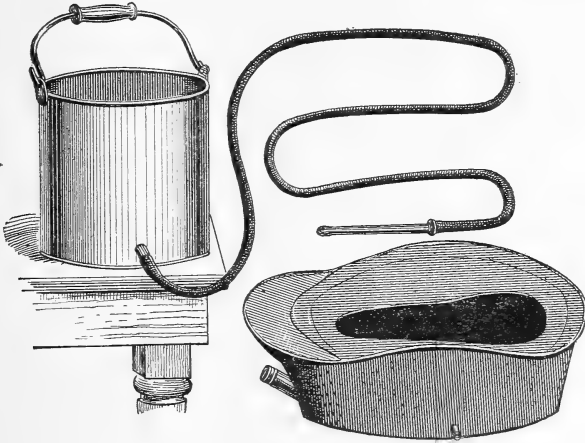


FIG. 162.—Apparatus for vaginal douche.

by Prof. Byron Robinson, of Chicago, has proved very beneficial and convenient to patients by giving them a comfortable and simple method of taking a douche.

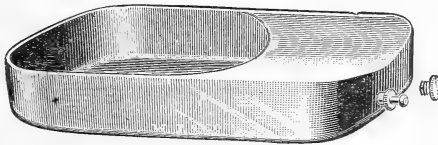


FIG. 163.—Douche-pan.

It can be used without legs, on a bath-tub, and with legs (some twelve inches long) may be used in any room.

*Antiseptic Douches.*—Corrosive sublimate, carbolic acid, creolin, and boric acid are used for antiseptic

douches; and to prevent absorption and irritation a plain water douche is often given after any of these antiseptics.

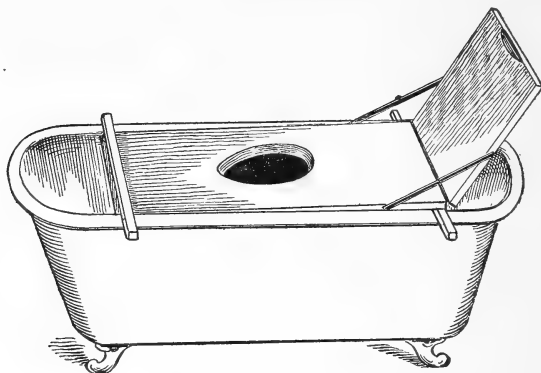


FIG. 164.—Douche-board.

After any intra-uterine douche too forcibly given uterine colic with dangerous collapse may occur.

A patient should lie quietly for one hour after taking a douche; if only one is used a day, it is best to give it at night, because then the uterus is most congested and needs the hot water most, and the temporary weak feeling which follows a douche will be gone before morning.

**Rectal Injections (Enteroclysis) and Irrigation.**—The therapeutic range of this procedure is not confined to the treatment of local troubles. It has long been used as a means of cleansing the lower bowel of accumulated feces. In the treatment of rectal ulcers and inflammations it has been employed both to relieve the irritation produced by fecal matter and to apply various medicaments to the parts. For the prevention of shock normal saline solution is

injected—one or two pints. This, by filling the blood-vessels, enables the patient to withstand the loss of blood from the nerve-centers. After the operation shock and hemorrhage are counteracted by its use, and at the same time the thirst is relieved and restlessness quieted. In septic conditions, both local and general, by diluting the toxic materials in the circulation and promoting their excretion by the skin, kidneys, and bowels, saline rectal injections play an important part in the treatment.

In patients whose digestive tracts are too weak to hold food or medicine rectal feeding or rectal medication is employed. The rectum should be washed out thoroughly before the injection is given. If the rectum is intolerant and will not retain what is injected, it is well to turn the patient on her left side and raise the hips on a pillow or a folded blanket. A long rectal tube should be used as for a high enema. The physician will give directions as to the temperature of the solution. In fever patients and in the hemorrhage of typhoid fever great relief and comfort are afforded by using very cold or iced water. In shock or hemorrhage a temperature of 100° F. is usually preferable. In long-continued lavage for local trouble the patient's preference as to the temperature is generally consulted.

A stimulating and nutrient enema, black coffee, or hot saline solution is given when symptoms of shock appear either during or after an operation; it should be injected high up into the colon. The rectum should be thoroughly cleansed at least once daily with warm saline solution, which will also aid the absorption of the nutrient enema. When

feeding by rectum in gynecologic cases, it should be remembered that tight tamponing of the vagina may interfere with absorption in the rectum. If the presence of hemorrhoids is a drawback, a 2 per cent. solution of cocain may be used before injecting the fluid.

*Stimulating enema :*

Whiskey,	2 ounces.
Ammonium carbonate,	15 grains.
Beef-tea,	4 ounces.

Or

Brandy,	2 ounces.
Tincture of digitalis,	20 minims.
Milk,	4 ounces.

*For tympanites :*

Tincture of asafetida,	2 ounces.
Spirits of turpentine,	1 ounce.
Magnesium sulphate (Epsom salt),	2 ounces.
Warm water,	1 pint.

*Purgative enemata :*

1. Warm soap-suds,  $\frac{1}{3}$  pint.
2. Common black molasses, 12 ounces.  
Warm soap-suds, 16 "
3. Molasses, black, 4 ounces.  
Glycerin, 4 "  
Magnesium sulphate, 1 ounce.  
Spirits of turpentine, 1 "  
Warm soap-suds, 8 ounces.



- |                   |                                  |                      |
|-------------------|----------------------------------|----------------------|
| 4.                | Glycerin,                        | 4 ounces.            |
|                   | Turpentine,                      | 1 ounce.             |
|                   | Magnesium sulphate (Epsom salt), | 2 ounces.            |
| 5.                | Inspissated ox-gall,             | $\frac{1}{2}$ ounce. |
|                   | Warm water,                      | 1 quart.             |
| 6.                | Spirits of turpentine,           | 10 drops.            |
|                   | Mucilage of acacia,              | $\frac{1}{2}$ ounce. |
| To be given high. |                                  |                      |
| 7.                | Senna,                           | $\frac{1}{2}$ ounce. |
|                   | Magnesium sulphate,              | $\frac{1}{2}$ "      |
|                   | Olive oil,                       | 1 "                  |
|                   | Boiling water,                   | 1 pint.              |

Infuse the senna in the water. Then dissolve the magnesia, add the oil, and thoroughly mix by stirring.

## CHAPTER XIV.

### MINOR SURGICAL PROCEDURES.

**Hypodermic Injection.**—This procedure is employed to secure rapid medication or in obtaining local anesthesia by the injection method. When used in the latter capacity it is called interdermic injection.

The aseptic method of employment requires that the syringe, needle, and solution should be sterile. To cleanse the skin about the point of intended

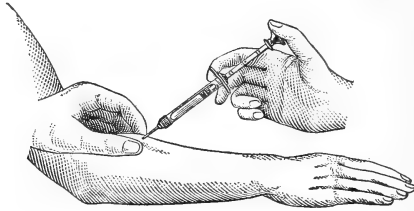


FIG. 165.—Method of reducing primary puncture pain in cocainization or hypodermic injection.

puncture use first soap and water. Apply ether, alcohol, or tincture of iodine to render the site sterile.

Insert the needle-point at the summit of a pinched-up fold of the sterilized skin (Fig. 165). For hypodermic medication the skin of the arm, forearm, or the thigh may be selected, fleshy parts favoring rapid absorption. Avoid superficial veins and deeper vessels, as direct entry of the drug into the blood-current might give rise to a too rapid effect.

**Counter-irritation.**—Counter-irritation or revulsion is a method of producing artificial irritation upon one portion of the body surface to alter the progress of disease in distant parts. It acts directly by drawing blood away from the diseased area or through the nervous system, and may be used in cases of localized inflammation or congestion to overcome neuralgic pain and in conditions of general depression or shock.

The methods employed may be mild or severe in their effects. Of the milder means used for the purpose the mustard foot-bath is one of the best. It consists in soaking the feet and legs of the patient in a bucket two-thirds full of water at a temperature of from 110° to 140° F., to which has been added one to two tablespoonfuls of ground mustard. The patient's body should be protected by blanketing during the bath, which may continue for from ten to twenty minutes. Tincture of iodine is used for a similar purpose in chronic inflammation of joints or glands. It may be applied with a swab or brush to the parts. Application must not be made oftener than once in two to four days to patients having tender skins.

*Mustard-plaster*, made by mixing up one part of ground black mustard to five parts of wheat flour or flaxseed in a little water, and applied upon a cloth or folded newspaper to the parts, will often prove useful in widespread inflammation or irritations. A fresh mustard-plaster should not be applied for a longer period than twenty or thirty minutes, else it may give rise to local injury to the skin and directly underlying tissues.

*Turpentine Stupe.*—This method of producing counter-irritation consists in the application to the inflamed parts of a flannel cloth which has been wrung out in hot water and sprinkled or dipped and wrung out in either the spirits or oil of turpentine. The skin should be anointed with vaselin if the application causes too much pain or irritation. Spice-plasters or bags are often ordered in the treatment of children. The mixture consists of equal parts of ground ginger, cloves, cinnamon, allspice, to which add and thoroughly mix one-fourth part of Cayenne pepper; wet with hot water, alcohol, or whiskey before applying. The so-called warming plaster consists of Burgundy pitch 12 parts, cantharides cerate 1 part.

**Heat and cold** are identical in effects.

*Use.*—(1) Locally as a stimulant (if of moderate intensity and applied but for a short time and if followed by immediate reaction); also as a sedative (if of long application, very intense, and if no reaction occurs). (2) Constitutional: (a) Heat may be used as a pyretic in shock, collapse, insanity; (b) cold as an antipyretic in acute fever, sunstroke.

*Application.*—(1) *Heat.*—(a) *Dry* (in the form of hot-water bags or bottles, hot bricks, hot sand or salt bags, heated stovelids, hot-air-oven apparatus (Fig. 166), hot blankets); (b) *Moist*, poultice (flaxseed, oatmeal, or hops, mixed with water, is sterilized by boiling); hot bath; hot pack; hot douche; hot fomentation (gauze, flannel, or towel wrung out in hot water, hot antiseptic solution; change when cooled). A ready method of producing diaphoresis (sweating) is by pouring water upon hot bricks wrapped in flannel.

(2) *Cold*.—(a) *Dry* (applied in the form of crushed ice in thin rubber bags, bladders, ice water passed through coils of rubber tubing); cold air (by exposure); (b) *Moist* (irrigation, ice-water compresses, cold pack—wringing sheet out in ice water and wrapping it around the patient. Keep it wet by sprinkling);

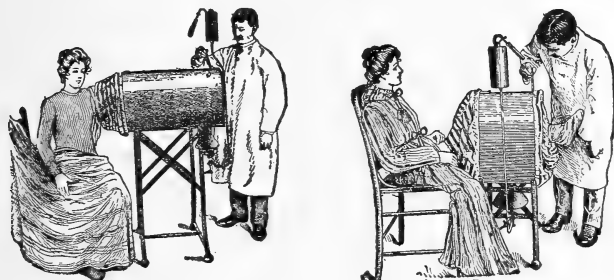


FIG. 166.—Hot-air oven.

tepid bath (gradually reduced); sponge-bath (keep the patient's body-surface moist, fanning him all the time); alternating douche of hot and of cold water.

**Vaccination.**—Vaccination is the inoculation of an individual with the virus of cow-pox.

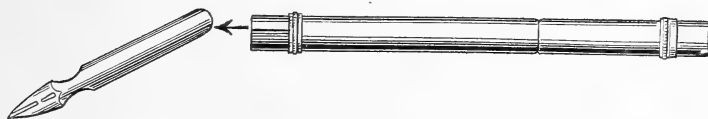


FIG. 167.—Mareschal's individual vaccination stylet.

The implements needed are a needle, lancet, or ivory point (Fig. 167); fresh virus (bovine or humanized).

Vaccination is performed as follows: (a) Render skin surface aseptic (select by choice upper and outer third of arm, inner side of thigh); (b) abrade the skin

until serum exudes; (*c*) carefully work in the moistened virus; (*d*) protect surface of spot until dry. Avoid exposure.

The times to perform vaccination are: (1) About the third month; (2) seventh year; (3) at puberty; (4) repeat whenever small-pox is prevalent.

**Liniments.**—These are local stimulants useful in mild neuralgic or rheumatic pains: (*a*) Ammonia; (*b*) chloroform; (*c*) camphor; (*d*) turpentine. Apply upon a cloth or by rubbing into the parts for a period of from five to twenty minutes; anoint with vaselin after each application to prevent abrasion.

**Ointments.**—Mildly stimulating and emollient: (*a*) Mercurial (blue ointment); (*b*) ichthyol; (*c*) belladonna; (*d*) boric acid; (*e*) resorcin; (*f*) iodin. Do not use iodin locally where there will be a possibility of a future cutting operation, because the skin becomes like leather and heals badly.

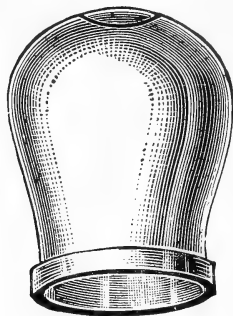


FIG. 168.—Dry cup.

Ointments should be applied upon gauze or lint, nicked to allow for the escape of discharge if present.

**Cupping.**—I. *Dry Cups.*—In dry cupping no blood is lost (Fig. 168). The operation is performed

by means of special cupping-glasses or wineglasses. Exhaust the air by burning a little roll of paper, piece of lint, or paper dipped in alcohol and lighted. Before the flame is extinguished rapidly invert the glass upon the skin surface.

2. *Wet Cups*.—(a) Prepare the skin by cleansing with soap and water, dry thoroughly, and apply dry cups; (b) scarify with a bistoury or by means of a spring scarificator upon the cupped sites; (c) reapply the cups to the incised areas; (d) treat the scarification wounds antiseptically.

Cupping is employed to produce local depletion; wet cups are better in serous inflammations.

**Leeching**.—(a) American leech (draws about a teaspoonful—4 c.c.—of blood).

(b) Swedish leech (draws three or four—12–16 c.c.—teaspoonfuls).

A mechanical leech consists of a scarifier, cup, and exhausting air-pump attachment.

*Method*.—Prepare the skin surface by cleansing with soap and water; dry thoroughly; apply the leech to the area moistened with blood or milk; confine the leech to the moistened area by means of an inverted glass tumbler. To remove the leech sprinkle a little salt upon its head. To preserve the life of the leech, strip it of the sucked blood and replace in a jar of water having a perforated cork. Dress the wound antiseptically; apply a compress, nitrate of silver torsion (acupressure), for continuous bleeding.

Leeching is employed to secure local depletion.

**Scarification**.—This consists in the making of small linear incisions through the skin and subcutaneous or mucous tissues for the purpose of securing local depletion to relieve tension.

**Puncturation** is the operation of making punctures with a sharp-pointed bistoury through the skin or mucous tissues. It is performed to secure local depletion or to relieve pressure.

**Deep puncture and incision** with a sharp-pointed bistoury is sometimes performed—(a) To relieve tension; (b) to secure drainage.

**Plasters.**—(a) Belladonna (use as a local sedative in neuralgia, mastitis, adenitis; remove if dryness of throat or disordered vision occurs—the first symptoms of belladonna-poisoning); (b) mercury (used for its resolvent effect upon indurated glands, chronic arthritis); (c) adhesive, “American surgeon’s adhesive plaster” (contains rubber, and adheres without heating); (d) resin plaster (requires heating to adhere).

**Collodion** and **cotton** are used to support and seal external flaps and wounds.

**Massage.**—Massage consists of manual manipulations of a part for the purpose of stimulation. May be applied twice daily, once daily, or every other day; each application may last from twenty minutes to one hour.

The movements of massage are—(1) Rubbing (stroking movements, gentle at first, afterward of increasing firmness); (2) kneading (rolling, circular, pinching movements); (3) tapping (percussion over the surface with the leveled finger-tips produced by flexion, ulnar side of the hand, or by the use of a mechanical muscle-beater); (4) passive motion (elevation, flexion, and contraction of the parts produced by the operator).

**Clinical Thermometer.**—May be of Fahrenheit (common form) or Centigrade scale. To reduce read-



ings—(1) Fahrenheit to Centigrade: Subtract 32 from the number of Fahrenheit degrees and multiply the

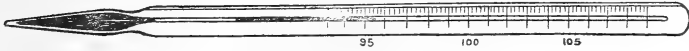


FIG. 169.—Clinical thermometer.

remainder by  $\frac{5}{9}$ ; (2) Centigrade to Fahrenheit: Multiply the number of Centigrade degrees by  $\frac{9}{5}$  and add 32.

Thermometers may be—(a) straight, self-registering ( $90^{\circ}$  to  $110^{\circ}$  F.— $33.3^{\circ}$  to  $44.4^{\circ}$  C.); (b) surface, coiled or bulb ( $80^{\circ}$  to  $110^{\circ}$  F.— $26.6^{\circ}$  to  $44.4^{\circ}$  C.).

Temperature may be taken in—(a) Mouth; (b) axilla; (c) rectum; (d) vagina. Most exact in vagina and rectum. Mouth-temperature is higher than that of the axilla and less than that of the rectum. Axilla-temperature is somewhat less than a degree below the rectal.

**Electricity** is used—(a) As a muscle tonic; (b) for nerve-sedative action employ that form of electricity



FIG. 170.—Electric brush.

which gives the best contractions with the least amount of pain and discomfort to the patient; for



FIG. 171.—Electrolysis needles.

implements required see Figs. 170, 171; (c) electrolysis (used in the treatment of aneurysm, tumors, for the

removal of superfluous hair); (*d*) cautory, ecreaseur (is followed by least hemorrhage when used at a dull red heat).

### POISONS AND ANTIDOTES.

*Acids, Mineral.*—Give chalk, flour, white of egg, magnesia (plaster torn off the wall may be used in an emergency); a solution of carbonate of soda; emollient drinks; fixed oils (sweet oil, olive oil, cod-liver oil). Give plenty of water to dilute the acid.

*Acid, Carbolic.*—Any soluble sulphate (magnesia), alcohol acts as a direct antidote if given during the first ten or fifteen minutes; whiskey may be employed for the purpose.

*Acid, Hydrocyanic.*—Secure plenty of fresh air; carry on artificial respiration; apply cold affusion; ammonia—inhalation and intravenously in a vein of the leg.

*Aconite.*—Give emetics; stimulants (external and internal); keep up the body-heat; patient is to be placed flat on his back.

*Antimony Tartrate.*—Give vegetable acids—tannic acid (gr. v-xv—0.333-1 gm.), catechu (fʒj-ij—4-8 c.c.).

*Arsenic.*—Give freshly precipitated hydrated sesquioxid of iron (made by adding magnesia to any iron solution).

*Atropin, Belladonna, Stramonium.*—Emetics (mustard flour in water); apply cold to the head; give physostigma (gr.  $\frac{1}{10}$ - $\frac{1}{5}$ —0.006-0.013 gm.) or pilocarpin (gr.  $\frac{1}{8}$ —0.008 gm.).

*Cantharides.*—Give emetics; emollient drinks; opium (gr.  $\frac{1}{4}$ - $\frac{1}{2}$ —0.016-0.033 gm.) by mouth and

rectum; large draughts of water to flush the kidneys.

*Chlorin-water*.—Give albumin (white of egg, milk, flour).

*Chloroform*.—Secure plenty of fresh air, carry on artificial respiration (inclining head down, pull the patient's tongue forward); brandy and ammonia intravenously in leg; hypodermic injection (15 min.—1 c.c.) of tincture of digitalis; gr.  $\frac{1}{80}$  (0.001 gm.) of atropin.

*Colchicum*.—Give emetics, followed by demulcent drinks; keep up external heat. If coma is present, brandy, ammonia, coffee. Opium in large dose.

*Conium*.—Give emetics; stimulants (external and internal).

*Copper Sulphate*.—Give yellow prussiate of potash (may be given freely if pure); soap.

*Corrosive Sublimate*.—Give albumin (white of egg—4 gr. (0.266 gm.) of sublimate requires the white of one egg); flour; milk; equal parts of lime-water and milk; emetics or stomach-pump.

*Croton Oil*.—Give emetics; wash out the stomach; mucilaginous fluids containing opium.

*Digitalis*.—Give emetics; recumbent position; tincture of aconite (1–5 drops—0.066–0.333 c.c.); opium (gr.  $\frac{1}{4}$ – $\frac{1}{2}$ —0.16–0.033 gm.).

*Elaterium*.—Give demulcent drinks; enemata of opium; external heat.

*Hyoscyamus*.—Stomach-pump; give emetics; stimulants (external and internal); physostigma (gr.  $\frac{1}{10}$ —0.006 gm.); pilocarpin (gr.  $\frac{1}{8}$ —0.008 gm.).

*Illuminating-gas*.—Hypodermic injection (1 min.—0.066 c.c.) of nitroglycerin; carry on artificial respiration.

*Iodin.*—Give emetics; demulcent drinks (starch or flour in water); opium (gr.  $\frac{1}{4}$ — $\frac{1}{2}$ —0.016—0.033 gm.); external heat.

*Lead Salts.*—Give any soluble sulphate (magnesia or soda). Follow with emetics, opium (gr.  $\frac{1}{4}$ — $\frac{1}{2}$ —0.016—0.033 gm.), and milk.

*Lobelia.*—External and internal stimulation.

*Morphin; Opium.*—Atropin (gr.  $\frac{1}{100}$ —0.006 gm.) hypodermically until respirations number eight a minute; stomach-pump; stimulants (external and internal); brandy; strong coffee; cold affusion; ammonia to nostrils; galvanic shocks; compelling patient to move about; artificial respiration; permanganate of potassium; cocain (gr.  $\frac{1}{4}$ — $\frac{1}{2}$ —0.016—0.033 gm.); repeat if necessary.

*Oxalic Acid.*—Give lime (plaster, lime-water, milk of lime).

*Phosphorus.*—Sulphate of copper in emetic dose as a chemic antidote; emetics; purgatives. No oils.

*Potash and Soda Salts.*—Dilute acetic acid; citric acid; lemon-juice; vinegar; fixed oils; demulcent drinks.

*Silver Nitrate.*—Solution of common salt; demulcent drinks; emetics.

*Strychnin; Nux Vomica.*—Give 30 grains (2 gm.) of chloral and 60 grains (4 gm.) of bromid of potassium; nitrate of amyl.

*Tobacco.*—Emetics; stimulants (external and internal); strychnin (gr.  $\frac{1}{30}$ — $\frac{1}{15}$ —0.0022—0.0044 gm.).

*Zinc Salts.*—Carbonate of soda; emetics; warm demulcent drinks.

*Poisonous Fish.*—Emetics to wash out the stomach; purgatives; stimulants.

## CHAPTER XV.

### OBSTETRICAL NURSING, CARE OF INFANTS, ETC.

PROFESSOR HIRST has employed printed slips containing the following directions to the nurse :

#### BEFORE LABOR.

I. Have ready towels ; ether,  $\frac{1}{2}$  lb. ; brandy, 2 oz. ; vinegar, 4 oz. ; hot water ; a bottle of antiseptic tablets ; a large, new sponge ; a roll of narrow tape or skein of bobbin ; a fountain-syringe ; bed-pan ; new, soft-rubber catheter ; 4 dozen small, 2 dozen large, pads ; small package of salicylated cotton ; absorbent cotton.

II. Give a rectal injection (a pint of soapsuds with teaspoonful of turpentine) as soon as labor-pains are well established.

#### AFTER LABOR.

III. No vaginal injection to be given unless ordered.

IV. Take the temperature three times a day—morning, noon, and evening.

V. Place large pad under patient. Occlusive bandage to be used as directed.

VI. The external genitals to be washed off four or five times a day with a warm corrosive sublimate solution, 1 : 2000. Use absorbent cotton.

VII. If, at the end of twelve hours, the bladder

cannot be emptied naturally, use a catheter. Afterward, if necessary, catheterize patient three times a day.

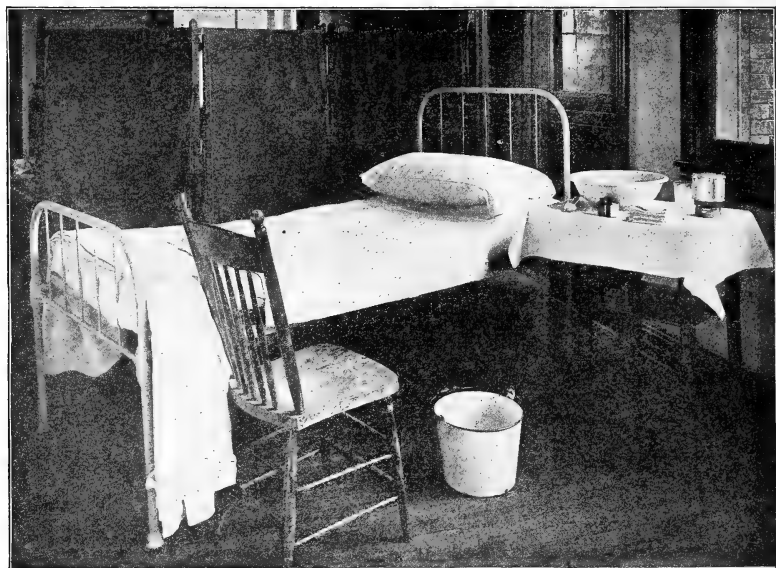


FIG. 172.—Bed arranged for childbirth : The mattress is protected by a mackintosh, over which a clean sheet is spread. The upper bedclothes are rolled up at the foot of the bed. The woman's buttocks rest upon a square yard of nursery cloth. The chair is for the obstetrician; at his feet is a waste-bucket, into which the pledgets of cotton used to clean the anus are thrown. The table, in easy reach, has upon it a large basin of sublimate solution, 1 : 2000, in which are many large pledgets of cotton; a small tin cup on an alcohol lamp to boil the scissors for the cord; a half dozen clean towels; a pot of carbolated vaselin; a tumbler of boric-acid solution with squares of clean soft linen in it for the child's eyes and mouth; a tube of sterile silk for the cord (Hirst).

VIII. The patient is to lie on her back; she may be moved from one side of the bed to the other several times a day; her limbs may be rubbed with alcohol and water or bathing whiskey once a day.

IX. The nurse's hands are to be washed with nail-brush, soap and water, and rinsed in a 1 : 3000 sublimate solution before catheterizing the patient, cleansing the genitals or breasts.

**Diet.**—*First 48 Hours.*—Milk,  $1\frac{1}{2}$ –2 pints a day, gruel, soup, one cup of tea a day, toast and butter.

*Second 48 Hours.*—Milk-toast, poached eggs, porridge, soup, corn starch, tapioca, wine jelly, small raw oysters, one cup of coffee or tea a day.

*Third 48 Hours.*—Soup, white meat of fowl, mashed potatoes ; beets in addition to above.

After sixth day return cautiously to ordinary diet. In addition to three meals a day give three or four glasses of milk through the day.

**Child.**—I. After being well rubbed with sweet oil, the child is to be bathed in water of  $90^{\circ}$  F. ; this should be the temperature of the daily bath. Use a bath thermometer, or else the water will often be too hot.

II. The cord is to be dressed with salicylated cotton. Observe carefully for bleeding.

III. It should be bathed daily, about mid-day, in the warmest part of the room. Use Castile soap and a soft sponge ; avoid the eyes.

IV. The bowels of a healthy infant are moved four times a day, the urine voided six to twenty times. It is usually necessary to change the diapers eighteen to twenty-four times a day. Use compound or borated talcum powder, lycopodium, zinc oxid, or rice flour. In case of chafing, cold cream and borated talcum flour. Note the color of stools.

*Nursing.*—The child is to be put to the breast every four hours during the first two days. No other

food is to be given it. After the second day it should be nursed every two hours, from 7 A.M. to 9 P.M., and twice during the night (1 A.M. and 5 A.M.). After every nursing the nipples are to be carefully washed with a piece of absorbent cotton, warm water, and Castile soap, and then smeared with a little sweet oil.

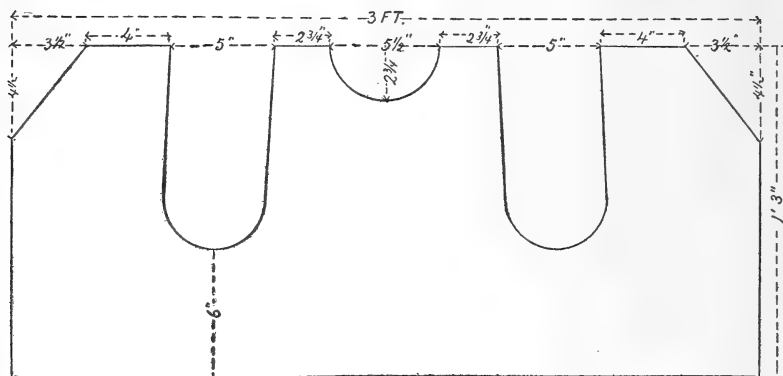


FIG. 173.—The Murphy breast-binder.

*Clothing.*—If born during the winter season a baby should be clothed as follows: A binder of flannel or knit wool twice around abdomen, a knit shirt, diaper, knit woollen shoes, and two skirts, the first flannel (in midsummer, linen), and finally its dress. The skirts should be supported from the shoulders by sleeves or tapes. A knit jacket may be worn over the dress. A light flannel shawl or cap will protect the child from attacks of head cold (coryza).

*Feeding.*—The average stomach capacity of a newborn infant is one ounce, and it increases one ounce per month up to six months. A child should never be nursed while it lies in its crib, but be taken up in



the arms. Young mothers experience great pleasure in suckling a child, and may put it to the breast every fifteen or thirty minutes, giving rise to derangement of the infant's bowels which may become serious.

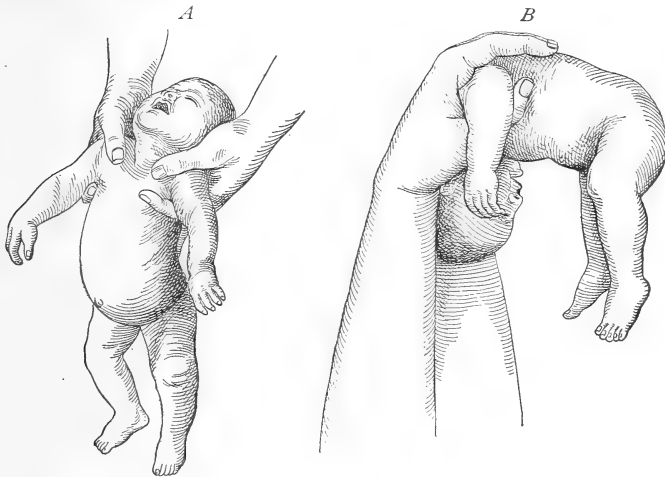


FIG. 174.—Schultze's method of artificial respiration: *A*, Inspiration; *B*, expiration (Hirst).

*Artificial Feeding.*—Asses' and goats' milk are most like human milk. An infant cannot begin to digest starchy foods under nine months of age, hence all prepared foods are injurious according to the amount of starch contained.

*Milk Mixtures.*—(a) For first twelve or fourteen days take :

Condensed milk,	1 teaspoonful.
Boiled water,	3 tablespoonfuls.
Cream,	1 teaspoonful.
Lime water,	1 “
Stir.	

(b) After fourteenth day up to third month the following may be used:

Milk,	1	tablespoonful.
Boiled water,	5	teaspoonfuls.
Cream,	1	teaspoonful.
Lime-water,	1	“
Maltine (Merck's),	10	grains.

Stir.

After the third month increase the amount of milk to 5 teaspoonfuls, and reduce the boiled water to 4 teaspoonfuls.

(c) A mixture for general use may be made according to the following formula:

Milk, 1 ounce,	2	tablespoonfuls.
Boiled water, 1 ounce,	2	“
Cream,	2	teaspoonfuls.
Lime-water,	2	“
Malt sugar (malt extract),	1	coffeespoonful.

Stir together.

Absolute cleanliness of all milk bottles, spoons, dippers, and rubber nipples is necessary, or deranged digestion if not serious bowel disorders will assuredly result.

## CHAPTER XVI.

### OPERATIONS; PREPARATION OF THE OPERATING-ROOM; THE SURGEON AND HIS ASSISTANTS.

SURGERY has two objects, to prolong life and to relieve suffering. If it accomplishes either of these objects it succeeds. To prolong life or to relieve suffering divides operations into several classes, because they occur with more or less urgency according to the condition the patient is in.

We often hear it said of an operation that it is one of necessity; of another, that it is one of emergency; and of another, that it is one of expediency. For convenience, operations are divided into two classes. First, operations of necessity; second, operations of expediency; and the first class may be subdivided into emergency and elective operations.

Operations of *expediency* are those which it would be well to perform for the health of the patient, as, for instance, the removal of a malignant growth of the breast. If left to itself, the growth will slowly and gradually invade the internal organs and in a very few years will end life; while if removed, the patient will in all probability live a number of years, and there may be immunity for a long period before the disease returns.

Operations of *necessity* are performed to save the life of the patient, as, for example, in cases of intestinal obstruction, in hemorrhage from rupture of an extra-uterine pregnancy, etc.

*Emergency* operations are those which must be performed immediately, without any choice, such as tracheotomy.

An *elective* operation is at the choice of the patient; if done at all, it is only as a last chance and forlorn hope.

**Preparation of the Operating-room.**—The operating-room should be made as aseptic as possible; the walls and floor should be washed with corrosive-sublimate solution (1:2000). The operating-table, stands, chairs, and other furniture, which are usually of glass and iron, should be washed with the sublimate solution. The sterilizer, which has been packed with the dressings, blankets (2), sheets (2), towels, caps, suits, and gowns for the operator, assistants, and nurses, should be started two hours before the operation. The instruments should boil half an hour before the operation in a 1 per cent. soda solution. Everything that will be needed for the operation and for possible accidents must be in the operating-room, and within easy reach. The solutions used should be quite warm, both for the surgeons and patient. We often come across a nurse who when she has filled the basins will put in her dirty hand to see if the water is too hot or too cold. We can readily tell from the outside of the basin if the water is of the proper temperature.

At all major operations four nurses are necessary—the head nurse, who has charge of the instruments;

a second nurse, to take charge of the sponges; a third nurse, to keep ready for the operator a basin of sterile water to enable him at any time to quickly rinse his hands to remove septic fluid or to free his fingers from blood and clots, and attend to the irrigation, etc.; a fourth nurse, to handle unsterilized articles. Each nurse should have a clear idea of her duties, and discharge them without undertaking the duties belonging to another. If the dry technic is used, the head nurse can hand the sponges as well as the instruments, and this gives a nurse to wait on her exclusively. Under no consideration should the head nurse be left alone for a single moment, as the operator might call for something which she, being "surgically clean," could not touch, and so cause a probable delay in the operation.

The duties of the nurses in the operating-room are the same for all operations. The dress must be of washable material, preferably white; it should be fresh for the operation and as far as possible sterilized. A dress that has been through the wards is not clean; neither is one that has been worn a day or half a day. The dress-sleeves should be unbuttoned, so that they can be rolled up above the elbow, to allow the arms to be made as sterile as possible, and so that the sleeves may not come in contact with anything used in the operation itself. The finger-nails must be cut short. On first going to the operating-room the hands and forearms should be scrubbed with a brush and green soap and running water as hot as can be borne for ten minutes by the clock. The cleaning of the finger-nails is very important, as many of us would be surprised to find the large number of germs

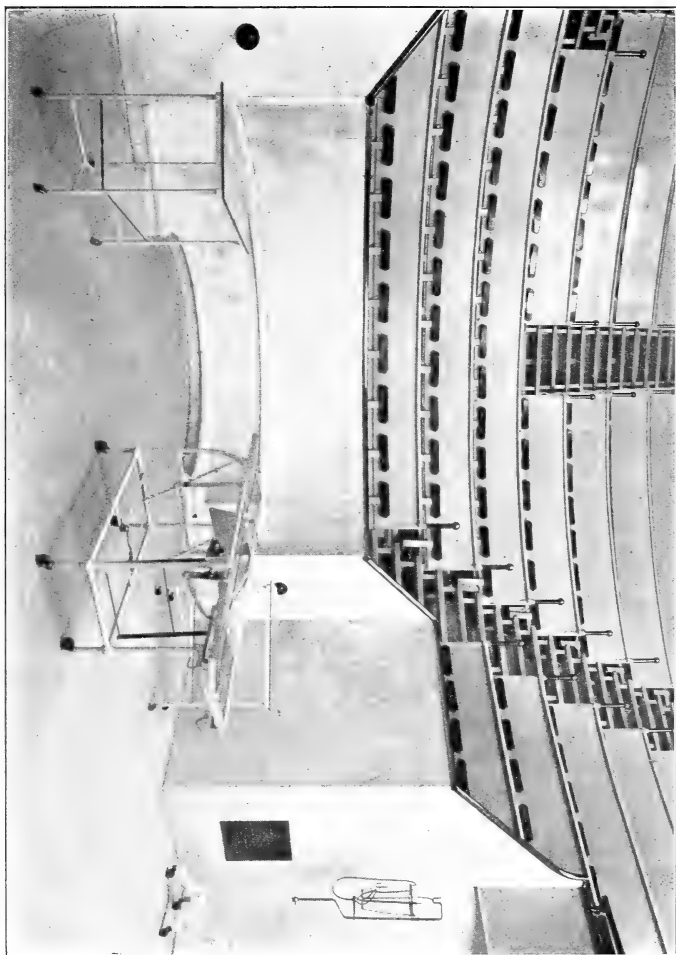
taken from under the finger-nails as the result of one cleansing.

The hands and forearms are then rendered absolutely sterile by putting them first into a saturated solution of permanganate of potassium until they are of a deep-brown color from the tips of the fingers to the elbow, then into a hot saturated solution of oxalic acid until all the permanganate stain has been removed; they are then washed in sterilized hot water, and finally are soaked for three minutes in a solution of corrosive sublimate (1 : 1000). The solutions reach those corners and crevices in the finger-nails that cannot be reached by the brush.

Some surgeons prefer ether and alcohol for cleansing the skin. After the hands have been scrubbed thoroughly in hot soap-suds and the finger-nails cleaned, the hands are washed in ether, which removes from the skin all oily and fatty substances; they are next washed in pure alcohol for one minute, and finally soaked for three minutes in a solution of corrosive sublimate (1 : 1000). The field of operation is cleansed in the same manner with ether, alcohol, and the sublimate solution.

The nail-brushes used should be absolutely sterile. They must be new, and need to be boiled for two hours on the day before the operation, and then put into a glass jar containing corrosive sublimate (1 : 1000). A dirty nail-brush is the haven of myriads of germs and their spores, and by using such a one we place more germs on our hands than were there before they were touched.

In some hospitals it is the custom to put on sterilized rubber gloves, to protect the hands from con-



Clinical Amphitheater, Medico-Chirurgical Hospital, Philadelphia.





tamination until the operation begins. The nurses next put on sterile caps and gowns. After making the hands aseptic it is essential that they do not come in contact with anything that has not been made aseptic before the operation is commenced, for such is very easy to occur unless the nurse is constantly on her guard against it.



FIG. 175.—*a*, Long-sleeved gown; *b*, the same, showing glove with gauntlet turned up over wristband of gown (Hirst).

The surgeon and his assistants prepare for the operation very much the same as does the nurse. Many surgeons before operating take a corrosive-sublimate bath (1 : 500), after which they put on

clean linen suits or long gowns and prepare their hands and forearms, after which they put on sterilized suits. The suits, which have been sterilized in bags or folded in a sheet, are taken from the sterilizer by the head nurse, and placed in the dressing-room about one hour before the arrival of the surgeons, so that they may be perfectly dry when required for use. They should not be hung over the back of a chair, or laid over a table for dust to collect upon them. We must bear in mind that after sterilization there is always the danger of contamination, and the articles must be carefully protected as soon as they are removed from the sterilizer. To avoid confusion, each suit and bag should be distinctly marked with the owner's name, as should also the white canvas shoes which some surgeons wear. The caps must be laid in the dressing-room, together with long strips of sterilized gauze to cover the beard and mustache.

Spectators should remove their coats and wear long linen gowns. The nurses should not leave the operating-room unless it is absolutely necessary, and there should be no unnecessary opening of doors, which allows cold air to enter. Constant moving also causes dust to become stirred up. The temperature of the operating-room should be 80° F., and the air kept perfectly pure by thorough ventilation, which should be so arranged that draughts will be avoided.

With the kind permission of Dr. F. W. Johnston, of Boston, I extract the following from his paper on "Two Years' Work with the Sprague Sterilizer in the Gynecologic Department at St. Elizabeth's Hospital, Boston, Mass.," which shows the great neces-

PLATE 4.



Surgical Operating Room, Medico-Chirurgical Hospital, Philadelphia.



sity of absolute cleanliness and how easily infection takes place from dust in the room :

“I was especially anxious to ascertain if any pus-producing organisms should be found in the dust.

“The operating-room is kept as clean as soap and water and corrosive sublimate can effect the cleanliness of its floor and walls.

“The following is the report of E. A. Darling, Assistant in Bacteriology, Harvard Medical School :

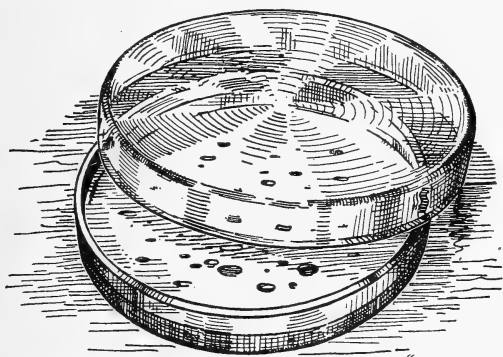


FIG. 176.—Petri dish with colonies (Warren).

“Four Petri double dishes containing films of sterilized and coagulated blood-serum were exposed in various parts of the operating-room during a celiotomy, the period of exposure varying from one hour and twenty minutes to one hour and fifty minutes.

“The plates were exposed during the middle of the forenoon of December 28, 1897.

“One dish was placed on the floor, where we supposed the dust would be kept in the most active motion by our feet and the nurse’s dress ; one was placed on the stand holding the sponge-pails ; one

was placed on the patient's knees raised in the Trendelenburg position ; and one was placed on the table beside the instrument-tray. The dishes were uncovered just as the knife went through the skin.

"At the conclusion of the operation the dishes were covered, conveyed to the bacteriologic laboratory, and placed in the incubator at 37° C. for several days.

"After twenty-four to seventy-two hours the plates were opened and the colonies counted.

"At the same time an attempt was made to determine the varieties of bacteria present, and particularly to demonstrate the presence or absence of the pyogenic forms.

"Cover-glass preparations and cultures were made from as many different kinds of colonies as could be distinguished.

"The results are, in brief, as follows :

"Plate A. *Sponge-table*, exposed 1 hour 50 minutes: after 24 hours showed 216 colonies; 72 hours, 296 colonies.

"Plate B. *Knees of patient*, exposed 1 hour 20 minutes: after 24 hours showed 156 colonies; 72 hours, 280 colonies.

"Plate C. *Floor*, exposed 1 hour 50 minutes: after 24 hours showed 296 colonies; 72 hours, 428 colonies.

"Plate D. *Instrument-table*, exposed 1 hour 40 minutes: after 24 hours showed 216 colonies; 72 hours, 256 colonies.

"The varieties of bacteria present were studied minutely on Plate B (the one on the patient's knee), less carefully on Plate D (the one on the instrument-

tray). Of the recognized pyogenic cocci, two varieties were found—the *Staphylococcus albus* (15 colonies on Plate B, 20 colonies on Plate D) and the *Staphylococcus aureus* (3 colonies on Plate B, 4 colonies on Plate D).

“The remaining colonies on both plates were sarcinæ of several kinds, yellow, orange, and white moulds, and several varieties of unrecognized bacilli and cocci.

“As would be expected, the plate from the floor showed the largest number of colonies. Plate B (the one on the patient's knee) most interested me.

“The finding by Dr. Darling of fifteen colonies of the *Staphylococcus albus* and three colonies of the *Staphylococcus aureus* on this small plate within a few inches of the opened abdominal cavity was certainly a grand object-lesson, and has given lots of food for reflection.”

## CHAPTER XVII.

### TRANSPORTATION; PREPARATION OF PATIENT FOR OPERATION; CARE OF PATIENT DURING AND AFTER OPERATION.

**Transportation.**—The entire duty of attending to the transfer of a patient to or from home and hospital may fall upon the nurse. The following suggestions are made by Mr. Scully, who conducts a private ambulance business in New York. The transportation of a patient, in order that it may be safely and pleasantly accomplished, requires attention to detail. The nurse or friends of the patient should attend to the requirements for admittance by the hospital authorities, such as the hours of admission, financial details, and presentation of a written statement of diagnosis by the family physician. Other things being equal, it is better in the summer months to remove a patient early in the morning or toward evening; in the winter, near midday. Give as much notice as possible in order to secure the best attention from the ambulance service. Have the patient ready at the hour arranged. Nothing is more trying to the patient than to be delayed, either by friends or by non-arrival of the ambulance. Do not disturb the patient by insisting on a perfect toilet; an ample supply of covering is the chief necessity. The nurse should accompany the patient in the ambulance, to give any



needed attention and complete the arrangements with the hospital authorities. Jewelry and valuables should be checked at the hospital office. In transporting to and from railroads and steamships ample notice must be given to make connections. For all distances up to thirty-five miles, direct transportation by ambulance is preferable to train service, especially in cases of very sick patients.

The methods given here for preparing the patient for abdominal operations may serve as a reliable guide to the nurse, who is more or less responsible for preparatory treatment. The methods of preparation of all kinds are subject to change in detail, because surgical methods are constantly advancing and changing, though the general principles remain. It should be remembered that patients rally much better from an operation when they have been properly prepared both externally and internally.

**Day Before Operation.**—The patient receives a full bath and the hair is washed. A cathartic is given—castor oil, citrate of magnesium, or salts. The diet should be nourishing and light. Milk is not given before an abdominal operation, because the stomach may not digest it thoroughly, and its curds may remain in the intestines and act as an irritant. Gruel is nourishing and easily digested. No food is given after midnight.

#### PREPARATION OF FIELD OF OPERATION.

1. Scrub the parts with green soap and stiff brush.
2. Shave from nipples to rectum. Chemical hair remover may be used; acts by dissolving the hair, but may prove too irritating to some skins.

3. Scrub again and rinse thoroughly with sterile water.

4. Rub well with alcohol, followed with ether, to remove fats.

5. Wash with corrosive sublimate (1 : 1000), and put on an antiseptic dressing, consisting of five dressing-pads, one layer of common cotton, one dressing over that, then abdominal binder. The patient must be instructed not to put her fingers underneath the dressing nor to disturb it in any way.

*Prepare the vaginal canal* by giving a warm douche (lysol, 1 per cent.), and cover the vulva with a dressing. Use perineal straps to keep the dressing and abdominal binder in position. See that the dressings are kept wet with the antiseptic ordered until the patient is taken to the operating-room. This preparation should be made twelve hours before an operation.

Some surgeons will direct the application of a *poultice of green soap*, which is removed early on the morning of the operation, the part being scrubbed with hot water and a brush to remove the soap, a warm corrosive-sublimate poultice (1 : 1000) being then applied. A green-soap poultice is a thin layer of green soap spread over a pad of gauze, absorbent cotton, or a towel, and covered with a dry towel and a bandage. The antiseptic pad, or the poultice, thoroughly softens the scarf-skin, which in about twelve hours can be scrubbed off, leaving the true skin.

Biniodid of mercury is sometimes dissolved in the ether, making a solution of 1 : 1000, which, besides removing all fatty substances from the skin, is also a disinfectant. When the skin is very dirty it is scrubbed with turpentine, then with alcohol, and then with the biniodid solution. The nose and mouth should be thoroughly sprayed with a saturated solution of boric acid every three hours.

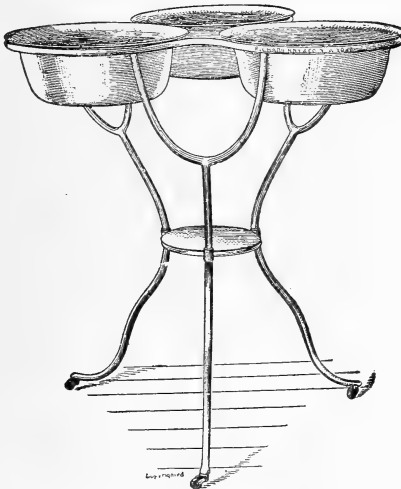


FIG. 177.—Solution basins stand.

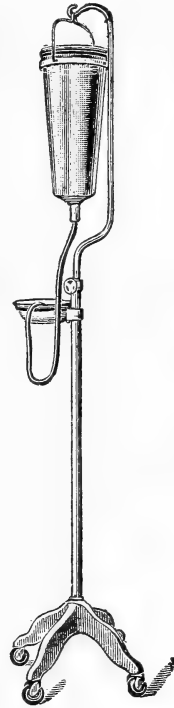


FIG. 178.—Irrigator.

**Day of Operation.**—Flush out the colon and give a bath; take off all flannels, put on a gown open at the back, and cotton-flannel stockings. Cleanse teeth, mouth, nose, and throat with a boric-acid solution and brush. Catheterize just before sending the patient to the anesthetizing-room if the operation is

on the uterus or its appendages. Always catheterize in other operations if the patient is unable to urinate. Envelop the hair in a sterilized towel.

Remove all rings and ear-rings; also false teeth, whether a whole or a partial set, as there is danger of their being swallowed, and put them in a tumbler of cold water. Envelop feet and lower limbs in a warm blanket securely pinned around the hips with safety-pins. Besides preserving the heat, this arrangement will prevent the patient from tossing the limbs about while taking the anesthetic. Many operators give morphin (grain  $\frac{1}{4}$ ) and atropin ( $\frac{1}{100}$  of a grain), hypodermically, half an hour before the operation, to stimulate the heart and prevent vomiting.

#### **Arranging the Patient for the Operation.—**

The patient having been placed on the operating-table, the clothes are removed from the part to be operated upon, and sterilized blankets are tucked about the chest, the edges being tucked under the back to reduce as far as possible the loss of body-heat, and the bandage and pad are removed from the field of operation, which is again thoroughly cleansed with soap and water and disinfectants. An assistant nurse hands the sterilized water, green soap, and scrubbing-brush to the assistant surgeon. The soap-suds are rinsed off with sterile water, after which the part is sponged with permanganate of potassium, oxalic acid, lime-water, and sterile water, or with ether, alcohol, and bichlorid solution. This final scrubbing should be done in the anesthetizing-room if possible, while the patient is being anesthetized, to avoid delay in the operating-room. A sterilized

sheet, having an oval opening in the center through which the section is made, and towels are then arranged around the field of operation. One towel is laid along the side, turned over and fastened with

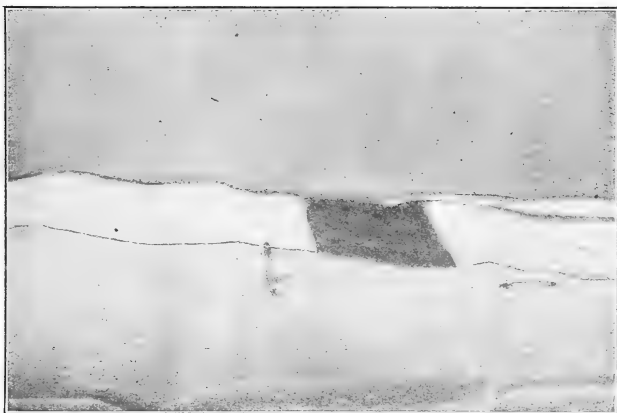


FIG. 179.—Towels pinned over rubber-dam, leaving no skin surface exposed (Hirst).

clamps to the sheet, so as to form a pocket in which the surgeon places the instruments he needs to have close at hand. The instruments are taken from the sterilizer and laid in trays containing sterile water or laid upon dry sterile towels.

Some surgeons use the prepared sponges. These must be reliably counted before the operation by the operator and assistants, and the number written down, so as not to trust to memory. Sponges must be squeezed almost dry before they are handed to the surgeon, because it is only in an almost dry condition that they are of service. The nurse should not, while waiting to hand a fresh sponge, rest her hands

or forearms on the pail. She should count the sponges before the surgeon begins to sew up the wound, and then should be very sure that she has the exact number employed in the operation. The large

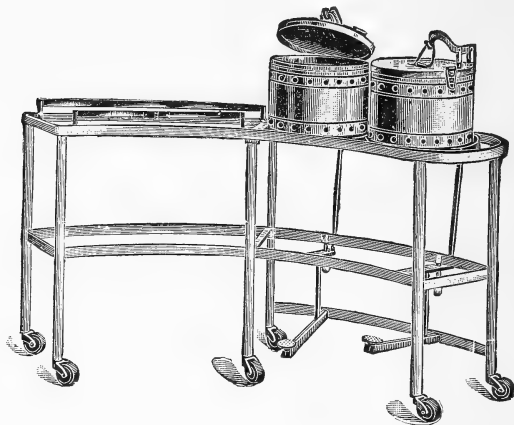


FIG. 180.—Dressing table.

square sponges used for covering the intestines, or walling off small areas, should have a long piece of silk attached, and to this a forceps, so that if one should slip out of sight it can be readily located and recovered without undue handling of the bowel. After being used, the sponges are put into a pan or basin, and should not be disposed of until they have been accounted for before the abdomen is closed.

Whatever has been removed from the body must be placed in a basin and laid aside in a safe place until the surgeon gives his directions as to whether or not he wishes it to be sent to the laboratory for examination to make sure of its character, with a view to clearing up some obscure point about the nature of the disease.

The head-nurse attends to the instruments, sutures, and ligatures. If the dry technic is used, a basin of dry gauze sponges is placed on a table within easy reach of the operator's assistants.

The assistant nurses must be on the alert to change the hand solutions when necessary, and to wipe the moisture from the face of the operator and his assistant with a sterilized towel, to prevent drops falling into the wound, and this must be done at a moment when the surgeons are not bending over the wound. They must move about the room very quietly but quickly. If asked to do anything that they do not understand, they should always inform the head nurse, who will make the duty clear. When emergencies arise and the operator is dealing with exceptional difficulties, the nurses must be on the alert to do quickly anything they may be called upon to do, each nurse discharging her duties without undertaking those belonging to another. It is absolutely necessary on such occasions to exercise self-control, and to follow the directions given without excitement or confusion.

Just before the wound is closed the soiled towels are removed and replaced by fresh ones. After the dressing has been applied the patient is raised, wiped perfectly dry, and a bandage put on. While the patient is waiting to be transferred to bed, hot-water bottles, well covered, should be applied to all parts of the body. The blankets used to cover the feet and chest of the patient during the operation should be tucked closely about the body and underneath, and not merely be thrown over.

Pneumonia and pleurisy after operation may follow as the result of chilling when in the operating-

room, or exposure during the removal from the operating-room to the patient's room.

When the patient is replaced in bed, which has been thoroughly warmed during the operation, the nurse should be present to take charge. The pillow should be removed, and a towel placed for the head to rest upon. The foot of the bed is elevated, this posture being maintained for twenty-four hours, after which the bed is lowered. The heaters are placed about the patient's body, one thing being kept constantly in mind—not to burn the patient. A towel should be placed under the chin of the patient, and a small basin should be at hand to receive the vomited mucus, and this should be removed during quiet intervals. Nausea and vomiting may be relieved by saturating a towel with fresh, strong vinegar and holding it a few inches from the patient's face, laying it over the nostrils, or hanging it from the bedstead so that it will be near the patient's head. Oxygen hastens the recovery of consciousness and lessens the nausea. If administered with the anesthetic, there is almost complete absence of nausea—usually none as soon as the patient is fully conscious.

Dryness of the mouth and lips, and thirst (which is often a troublesome feature), may be relieved by placing wet cloths on the lips, by allowing the patient to rinse out the mouth with cool water, and by frequent bathing of the hands and face with alcohol and tepid water or with plain water. If thirst is extreme, an enema of saline solution (one pint) is given slowly.

The patient should not be left alone for a single



moment during the first thirty-six hours after an abdominal section if it can be avoided. The patient can do nothing for herself, and every want should be instantly supplied. I have known patients so eager to allay their thirst that they would get out of bed and drink water from the water-pitcher on the wash-stand and reach down for the hot-water bottle at the feet and drink part of the contents. One ward patient drank the water from an irrigator standing by the side of the next bed; another patient while in a semiconscious condition took the drainage-tube out of the abdomen, and when found by the nurse after a moment's absence from the room was sitting up on the edge of the bed. Watching a patient recover from anesthesia is often monotonous; but if this duty is closely attended to, many dreadful accidents will be avoided.

A roll should be placed under the knees, so as to relax the abdominal muscles and also to remove the strain the patient would have to make in order to keep up the knees. A small flat pillow placed under the hollow of the back will relieve the backache of which so many patients complain.

**Bladder and Bowels.**—The catheter should be passed every six or eight hours if necessary, according to directions, the most rigid aseptic precautions being taken. Flatulence may be very distressing; consequently passage of gas by the rectum is of good omen, as it shows that the bowels have regained their normal tone and there is no obstruction. After an abdominal operation the muscular walls of the intestines share in the weakness of the patient, and are not strong enough to overcome the contraction of the sphincter muscle. The accumulation of gas distends

the muscular fiber of the intestines, and, if not relieved, would soon result in paralysis of the intestines. To prevent this a rectal tube is inserted to keep the sphincter dilated and to allow the gas to escape when it reaches that point. Purgatives, such as calomel (grain  $\text{x}$  every hour until 10 grains have been taken), are usually given as soon as possible after the patient has recovered from the anesthetic, to stimulate the intestines, and keep up peristaltic action.

Much fluid is not given for a certain number of hours after the operation, as it might cause vomiting, and also because, as we have seen, bacteria require heat and moisture for their development. If they can lie in a small pool of fluid, they will develop rapidly. We cannot deprive them of warmth unless we almost freeze the patient, but we can deprive them of moisture. Should any bacteria have found their way during the operation into the abdominal cavity, they will be rendered inert by the absence of moisture, and will be taken by the leukocytes into the lymphatic vessels and glands and be devoured.

After twelve hours, if there is no vomiting, very hot water, or toast-water is given in teaspoonful doses every fifteen or twenty minutes, the quantity being gradually increased and the intervals lengthened. The familiar cup of freshly made tea is sometimes the best drink to begin with; it is always a pleasure under the circumstances to see the patient enjoy it, since it is not only refreshing but stimulating. If the stomach behaves well, tablespoonful doses of gruel or beef-essence may be given every

half hour. Milk is not given as a rule, as the curd may pass along the intestines and act as an irritant. For the first three days, and if there is no vomiting, nothing but liquids is given; and after the third day soft and easily digestible food, which is gradually changed to a more solid diet.

The external genitals should be kept perfectly clean, the body bathed, the bed and body-linen kept sweet and clean, the teeth brushed, and the hair combed. Every want of the patient should be anticipated, and she should be made as comfortable as possible. Sponging the palms of the hands, the arms, and the legs will add to the comfort of the patient. The luxury of a change into a fresh bed will often secure a good night's rest. Under no consideration should morphin be given except by the surgeon's directions, and every moral influence should be exerted to induce the patient to endure pain rather than resort to the drug.

The nurse should not ascertain whether the patient is comfortable by continual questioning, but by unobtrusive observation. Questioning may alarm a patient and lead her to think too much about herself.

No visitors should be admitted without the surgeon's consent. The mind of the patient is to be kept perfectly free from worry and excitement, and the whole atmosphere of the room should be bright, pleasant, and cheerful, no matter what trouble is going on outside.

A slight rise of temperature the day following operation usually marks reaction from shock. On the eighth day the dressings are removed and the stitches taken out. The following week the patient sits up, and at the end of the third week she goes home.

The following diet-list, dating from the third day, will be of assistance in varying the food.

#### FIRST DAY.

*Breakfast.*—Mutton-broth with bread-crumbs.

*Lunch.*—Milk-punch.

*Dinner.*—Raw oysters, thin bread (with crust removed) and butter, sherry wine.

*Lunch.*—Cup of hot beef-tea.

*Supper.*—Milk-toast, jelly.

#### SECOND DAY.

*Breakfast.*—Oatmeal with sugar and cream, cup of cocoa.

*Lunch.*—Soft custard.

*Dinner.*—Small piece of tenderloin steak, chewed but not swallowed, baked potato.

*Lunch.*—Glass of milk.

*Supper.*—Buttered milk-toast (crust removed), jelly, cocoa.

#### THIRD DAY.

*Breakfast.*—Soft-boiled egg, bread and butter, coffee.

*Lunch.*—Milk-punch.

*Dinner.*—Chicken-soup, tender sweetbreads, Bavarian cream, light wine.

*Lunch.*—An egg-nog.

*Supper.*—Tea, raw oysters, bread and butter.

#### FOURTH DAY.

*Breakfast.*—Oatmeal with sugar and cream, a tender sweetbread, creamed potatoes, coffee, graham bread and butter.

*Lunch.*—Glass of milk.

*Dinner.*—Chicken panada, baked potato, bread, tapioca-cream.

*Lunch.*—Cup of hot chicken-broth.

*Supper.*—Buttered dry toast (crust removed), wine jelly, banquet crackers, tea.

#### FIFTH DAY.

*Breakfast.*—An orange, scrambled egg, oatmeal with sugar and cream, soft buttered toast, coffee.

*Lunch.*—Milk-punch.

*Dinner.*—Cream of celery soup, a small piece of tenderloin steak, baked potato, snow pudding, wine, bread.

*Lunch.*—An egg-nog.

*Supper.*—Calf's foot jelly, soft-boiled egg, bread and butter, cocoa.

#### SIXTH DAY.

*Breakfast.*—Oatmeal, poached eggs on toast, coffee.

*Lunch.*—Cup of chicken-broth.

*Dinner.*—Chicken-soup, small slice of tender roast beef, baked potato, rice-pudding, bread.

*Lunch.*—Glass of milk.

*Supper.*—Baked apples, raw oysters, bread and butter, orange-jelly, tea.

#### SEVENTH DAY.

*Breakfast.*—Orange, mush and milk, scrambled eggs, cream-toast, coffee.

*Lunch.*—Cup of soft custard.

*Dinner.*—Mutton-soup, small piece of tender beef-steak, creamed potatoes, sago-pudding, bread, wine.

*Lunch.*—Cup of beef-tea.

*Supper.*—Sponge-cake with cream, buttered dry toast, wine-jelly, cocoa.

#### EIGHTH DAY.

*Breakfast.*—Broiled fresh fish, oatmeal, graham bread, coffee.

*Lunch.*—Chicken-broth.

*Dinner.*—Potato-soup, breast of roasted chicken, mashed potatoes, macaroni, blanc mange.

*Lunch.*—Cup of mulled wine.

*Supper.*—Cream-toast, lemon-jelly, chocolate.

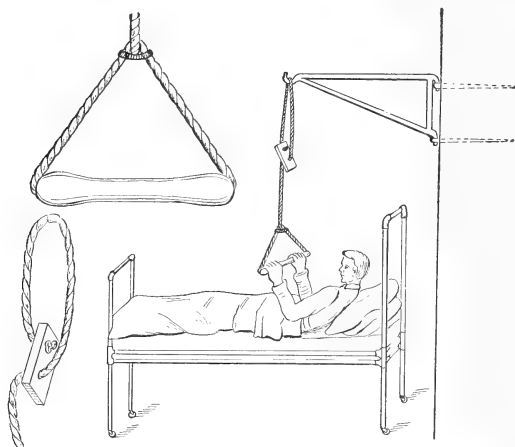


FIG. 181.—Griffith's bed-grapple for patient's comfort during convalescence.

The diet for other days may be selected from previous ones. The change of diet may cause a temporary rise in the temperature and pulse.

## CHAPTER XVIII.

### SEQUELÆ OF OPERATIONS; SHOCK, HEMORRHAGE, SEPTIC PERITONITIS, ACCIDENTS DURING OPERATION, ETC.

As a rule, the average abdominal case passes into convalescence, especially when the case is in skilled hands and the operation has been performed in a finished surgical way. Complications, however, are liable to arise in the simplest case, and throw great responsibility on both surgeon and nurse. It is in these cases that the knowledge and skill of the nurse mean so much, and where the greatest triumphs of surgery are scored.

A nurse has no moral right to take charge of a surgical case unless she has at her finger-ends the complications liable to arise, their symptoms and the various means of meeting them until the arrival of the surgeon.

**Shock** is great depression of the vital functions of the body brought on by injury or surgical operation. It is produced through the agency of the nervous system. The greater the injury, the longer the anesthesia, the greater the shock. The anesthetic enables the patient to undergo the operation without consciousness, but it does not prevent shock coming on afterward from the opening of the abdomen, the uncovering of the viscera, the handling of the intestines, and the exposure of the delicate sympathetic

nerves in that part to the air and to touch. If to all this is added a long anesthesia, then the prostration produced by the anesthetic is added to the effects of the operation.

Different individuals are differently affected: most persons are more susceptible to shock after months of hard work, or when the system is run down after an illness. Invalids stand shock very well, and indifferent persons stand it better than those who are despondent. The mental influence is very great: anything that depresses the mind aggravates shock. It is here that the offices of the Church have such an effect on some patients, in quieting apprehension and in adding fortitude.

Age modifies shock. In old people shock is usually more severe and prolonged, especially if there is any organic disease. Children recover readily from shock if there has been very little loss of blood. Shock is combated to a certain extent by the patient's drinking a large amount of fluid for forty-eight hours before the operation, so that the blood-vessels of the vital organs will be well supplied with fluid during the operation. Experiments have been made which show that when the abdomen is opened the abdominal veins dilate, and as a consequence a large amount of the blood in the body flows into them, thus leaving the heart and the vessels conveying blood to the important nerve-centers at the base of the brain with very little fluid to work upon, and shock ensues. The output of the heart, as we know, is in proportion to the venous pressure, and if this is lowered the heart and the important nerve-centers at the base of the brain will be supplied



with a diminished amount of blood. The intravenous injection of saline solution causes a rise in the venous pressure and an increase in the output of the heart. The signs of shock may be and have been mistaken for those of hemorrhage on account of the two presenting so many points of likeness; but in shock the symptoms are present from the first, while in hemorrhage they do not come on for some hours after the operation.

Two very important points to be considered in case of shock or of hemorrhage are the temperature and the condition of the patient's mind. In shock the temperature at first is normal or very little below normal, and the senses are dull in proportion to the degree of shock present; in hemorrhage the temperature is subnormal, the mind is bright, keen, and alert, and there is an anxious expression on the face, as if the patient were anticipating danger.

The *symptoms of shock* are a weak, rapid, and irregular pulse; sighing, rapid, irregular, and shallow respiration; a normal or slightly subnormal temperature; a pale face with a pinched look; a cold, clammy skin, and dulness of the mind. There may be involuntary movements of the bowels and urine as a result of loss of muscular power; nausea and vomiting may also be present.

The *treatment of shock* consists in lowering the patient's head and raising the foot of the bed, to increase the supply of blood to the vital centers; in the application of heat to all parts of the body, particularly the sides, between the legs, and to the feet; in placing a mustard-plaster over the heart; in administering whiskey, brandy, or nitroglycerin

hypodermically; in giving hot black coffee by the rectum, or saline solution hypodermically or by the rectum. Strychnin is a powerful stimulant, and should be given in doses of  $\frac{1}{20}$  grain every half hour for four doses. Tincture of digitalis in 15-minim doses may be given every half hour for four doses. As a rule, in cases of shock there is a disposition on the part of nurses to do too much. Everything must be done in a prompt, quiet manner. For immediate stimulation in threatened collapse nitroglycerin is valuable. It is used for quick effect only, and not for prolonged stimulation of the heart's action. Stimulants must be given carefully, and time allowed to observe the effects produced, other measures being determined accordingly. An enema of one-half ounce of turpentine, a well-beaten raw egg, and three ounces of warm water constitutes a powerful stimulant.

It must be remembered that in severe shock the function of absorption by the stomach and intestines is almost wholly suspended, and anything given by the rectum must be introduced high up. When the respiration of the patient is fast failing, everything depends on maintaining the heart's action. To this end artificial respiration must be persistently practised. A serious danger in performing artificial respiration is that in our hurry we may make the motions too rapidly and not give the lungs time to fill thoroughly nor allow the air to be expelled before filling the lungs again. The motions should not be more frequent than sixteen to eighteen in the minute, so as to imitate as nearly as possible the natural rhythm of respiration. External heat is a most

powerful heart-stimulant, and often when the heart's action fails it may be restored by heat over the heart and by hot fluids taken into the stomach.

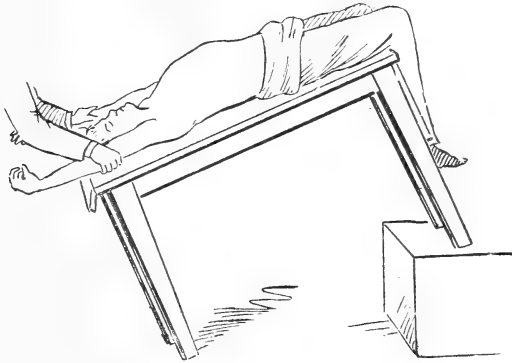


FIG. 182.—Sylvester's method of performing artificial respiration (inspiration)

Recovery may be rapid or very slow; it is manifested by "reaction"—the pulse becomes more full,

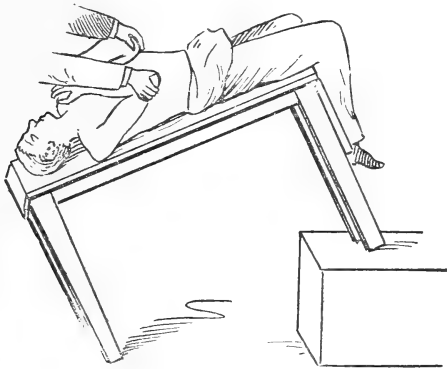


FIG. 183.—Sylvester's method of performing artificial respiration (expiration).

slow, and regular, the temperature rises, the body becomes warm, and a general improvement takes

place. In rare cases the reaction becomes excessive and develops into *traumatic delirium*, which may be mild, low, and muttering, or of the wildest character. The skin is hot and flushed, the pulse full and regular, and the temperature above normal. This condition may subside and recovery take place, or it may be followed by collapse.

**Hemorrhage** may be caused by the slipping of a ligature or by the displacement of clots, as the result of restlessness or reaction of the circulation, and generally occurs within the first twenty-four hours

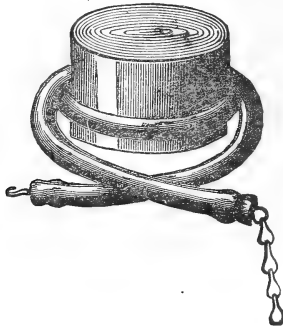


FIG. 184.—Esmarch's tourniquet, consisting of 9 feet of elastic webbing  $2\frac{1}{2}$  inches wide, 3 feet tubular strap with chain.

after the operation. The hemorrhage which comes from torn adhesions and bleeding surfaces is a free oozing, and seldom affects the pulse. When a drainage-tube has been used, it will usually indicate that there is hemorrhage by a flow of blood through the tube. This, however, cannot be relied upon, as only a moderate quantity of blood may flow through the tube, the abdomen being filled with clots.

The *symptoms* of internal hemorrhage are restlessness, thirst, faintness, an anxious expression, pale face, dilated pupils, cold skin, frequent and irregular



FIG. 185.—Bellocoq's canula, used for passing a cord through the nose, to be drawn out of the mouth, and gauze or cotton plugs attached for packing the nasal cavity for hemorrhage.

or sighing respiration, subnormal temperature, and a weak, rapid pulse (120–140). In rare cases the pulse is not greatly accelerated.

*Treatment.*—The patient must be kept perfectly quiet on her back, the head being lowered and the foot of the bed elevated. If symptoms of shock supervene, heat is to be applied to all parts of the body by warm blankets and hot-water bottles. Stimulants are given only when the pulse is failing, as they excite the heart's action and increase the hemorrhage. When the hemorrhage has been excessive, infusion of saline solution is resorted to, the fluid that the body has lost being thus replaced. Bandaging the limbs from their extremities upward is sometimes of use in keeping the blood in the vital organs. When the hemorrhage comes from a slipped ligature with large vessels pouring blood into the abdominal cavity, the abdomen is reopened and the vessel ligated. Everything should be ready for operative interference when the surgeon arrives, the same aseptic precautions being observed as in the original operation. For the free oozing from torn

adhesions the tube is emptied frequently—every ten minutes. The drier the pelvic cavity is kept, the sooner will the hemorrhage cease.

A noted surgeon has said that if an abdominal case escapes shock or hemorrhage, there is still a third danger to which the patient is liable, that of septic peritonitis. This is due to the entrance of germs into the peritoneal cavity, either from without or from ruptured abscesses or wounds. It may set in at any time from a few hours to six days after operation. The symptoms are pain in the abdomen and exquisite tenderness, distention, vomiting, constipation, icterus, restlessness, sleeplessness.

The temperature rises a little, rarely going for a few days above  $100^{\circ}$  or  $101^{\circ}$  F.; but the pulse creeps up rapidly to 115, 120, or 130 beats per minute, and is weak and thready; although sometimes it is hard and "wiry" in the beginning. Then the temperature rises to  $103^{\circ}$  F. or above. The rectal or vaginal temperature may show a much higher rise than that of the mouth or axilla. In one typical instance the temperature taken in the mouth ranged between  $101^{\circ}$  and  $102^{\circ}$  F., the skin was cold and clammy, and the patient complained of intense thirst and a "burning up" feeling. The vaginal temperature was  $108^{\circ}$  F. In some of the worst cases the writer has seen the temperature was below normal, but the prostration was severe. The abdomen is distended, due to distention of the transverse colon by gas. There are nausea and vomiting. First the contents of the stomach are vomited, then bile, then a dark coffee-colored fluid which becomes more and more fecal in odor; a cold perspiration appears; the patient has a

very anxious, pinched expression, and is restless and talkative; the eyes are unusually bright, and there is a faint yellowish look about the skin and conjunctivæ. As the disease continues the general system becomes poisoned.

The *treatment* consists in ridding the system of the poison through the skin, bowels, and kidneys. High enemata of turpentine, glycerin, oil, salts, or molasses are usually given until the bowels are thoroughly moved or large quantities of gas are passed, because it is by putting the bowels into an active state that the threatened paralysis of the intestines can be overcome, and they can take up from the peritoneal cavity the poisonous materials that are causing the disturbance. It is only when the intestines are so paralyzed that they cannot be moved that a fatal result ensues. Strychnin, being a powerful heart-stimulant, is given in doses of grain  $\frac{1}{25}$  every hour until its physiologic effects are produced. It must be stopped at the first appearance of twitching of the muscles of the face or of the limbs and stiffness of the neck. Vomiting may be relieved by washing out the stomach, by the application of a mustard-plaster over the region of the stomach, or by cocain in  $\frac{1}{4}$ -grain doses for four doses. If improvement does not follow, the surface of the body becomes cold and clammy; the face pinched and sunken and of a dusky hue; the restlessness increases, also the thirst, which becomes very great, and to the last the patient calls for water, which is vomited immediately after being taken, but which it is cruel to withhold. The mind usually remains clear to the end.

Antistreptococcic serum has been used with fairly good results. It comes in glass tubes, sealed hermetically, and is injected hypodermically with antiseptic precautions into the thigh or the side of the breast, where there is considerable loose subcutaneous connective tissue. Another procedure of value is infusion of normal saline solution for the purpose of diluting the toxins in the blood and of removing them by the increased flow of urine which infusion brings about.

**Tympanites** is often one of the earliest signs of septicemia, and when accompanied with a high temperature is usually a cause for anxiety, though it may be due to constipation, and in such cases is usually without significance. The treatment consists in the application of turpentine stupes, the use of brisk purgatives or high enemata, and the insertion of the rectal tube for about ten inches.

**Fermentation-fever** is due to the absorption of fibrin-ferment and the products of aseptic tissue-necrosis. It causes a slight rise in temperature which need occasion no anxiety.

**Intestinal obstruction** may be due to strangulation of a knuckle of intestine beneath inflammatory bands, or to its enclosure between the sutures in the wound. There is usually distention of the abdomen. Note should always be made if gas is heard rumbling in the intestines, and also if gas is passed and how often; also the result of the enemata which are administered to relieve the distention.

**Hernia** is a sequel rather than a complication of abdominal operations, and is due to a failure of union between the cut edges of the muscles and fasciæ.



As a rule, it does not occur until some weeks after the patient has returned home. It is to prevent this accident that such stress is laid upon not allowing the patients to help themselves in any way without the surgeon's permission, so that the abdominal muscles may have sufficient time to become firmly united. This is also the reason why patients

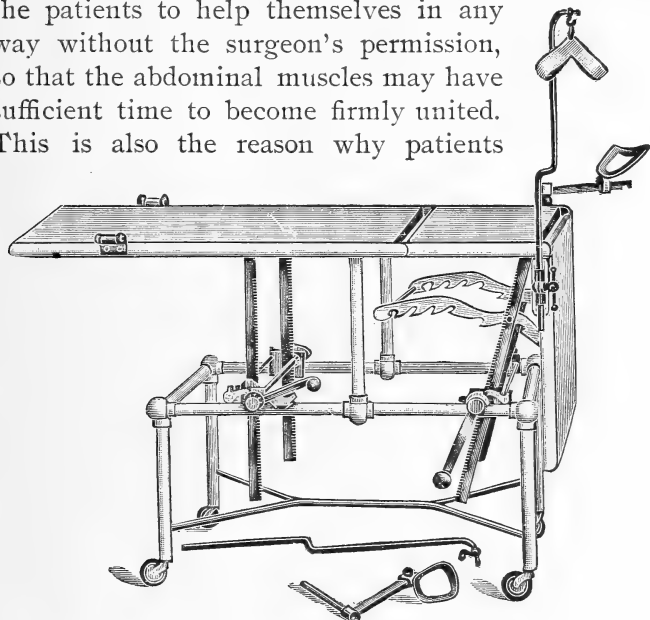


FIG. 186.—General operating table.

should wear an abdominal supporter for some months after their discharge. If hernia occurs, it is usually treated by a secondary operation.

A **sinus** is often caused by imperfectly sterilized ligatures, which may cause an abscess around the point of ligation. This abscess may discharge itself into the intestine or vagina, or into the tract occupied by the drainage-tube through the abdominal wall. The sinus keeps open until the ligature is discharged or removed by another operation.

**Accidents during Operation.**—Many times in difficult abdominal or vaginal operations the walls of the bladder may be torn, or one of the ureters or the intestine may be injured. When the ureter or bladder is injured, the urine sometimes passes through the incision to the dressing. This is called a urinary fistula. When the intestines are injured, fecal matter is discharged through the wound. This is a fecal fistula.

**Vaginal hysterectomy** is the most serious of vaginal operations, but the nursing is the same as every operative case requires. If clamps are used, they usually remain attached for forty-eight hours. The handles are usually supported on a pad of absorbent cotton. In the handling of the clamps great care must be used, as, for instance, when the patient is lifted on the bed-pan one nurse should lift the clamps.

**Hysterectomy** is the complete removal of the uterus and ovaries, either through the vagina (vaginal hysterectomy) or through the abdomen. Regarding the question of insanity which may follow a hysterectomy or the removal of a large fibroid tumor, one must know that a large amount of blood is taken from the body; that the cutting and tying of the large blood-vessels alter the circulation; and that the operation is also more or less a shock to the nervous system, and may affect the brain. Insanity is *not* a complication of this operation, the recovery from which is usually rapid; but when insanity does set in, this is commonly the cause, and the patient generally recovers.

## CHAPTER XIX.

### SPECIAL OPERATIONS.

**Operations Upon the Head.**—Nursing after operations upon the brain calls for special diligence in watching the patient during the first hours subsequently. Unlooked for symptoms may arise, and a change for better or worse in those accompanying the condition for which operation was performed; delirium, acute mania, or paralysis of some part or of the half of the body may develop, or, having been present, become rapidly altered in degree and aspect. Care to prevent the patient from injuring himself, falling from the bed or disturbing the dressing and doing direct injury after a trephining is necessary. Especially should the nurse be on her guard to prevent such patients being burned by hot-water bottles. Head operations being often long ones, or done for acute conditions in which the degree of shock is marked, the efforts to revive can easily be overdone in the matter of temperature of the hot-water bag with a subsequent further complication of the case from a bad body burn. As a general rule, it is safest to never put a bag directly against the patient's body, but to place it outside the blanket.

*Eye, ear, nose, and throat* cases, besides the general care and watchfulness necessary, require to be observed for shock or hemorrhage, where, as in the case

of the eye, serious functional injury might be done; or special symptoms complained of relating to the particular sense-organ operated upon.

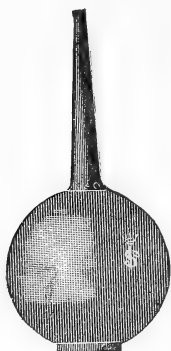


FIG. 187.—Soft-rubber nasal and ear syringe.

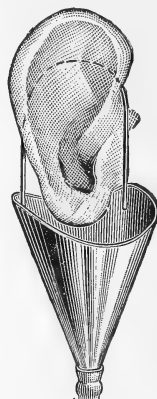


FIG. 188.—Syringe cup to hang upon patient's ear to catch the drip when irrigating the aural canal.

**Operations upon the neck** generally require the patient to assume the supine position. The chief danger is from accidental postoperative secondary hemorrhage, and this contingency may occur up to the third or fourth day when due to slipped ligatures. After intubation and tracheotomy operations, the nurse must be watchful lest the tube becomes displaced, coughed out, or clogged by exudate or false membrane shreds. Rapid cyanosis or a blowing-bellows action sounding through the tracheal slit are the signs calling for immediate correction of the difficulty, to avoid an immediate fatal termination of the case from total closure of wound or tube. If the case is one of tracheotomy with a displaced tube, the nurse

should make no attempt at readjustment, but quickly loosening or cutting the tapes, must, after withdrawing the tube, insert and set the tracheal forceps, which instrument must be ever at hand at the patient's bedside for such emergency use. Afterward the surgeon may be sought, who will replace the tube; but there will not be time to send for the physician to perform the former vital office.

**Operations upon the thorax** include those opening the chest for draining the pleural cavity and the mediastinum, suturing the heart, as after a stab or gunshot wound, removal of tumors within or upon the chest-walls. Shock and hemorrhage must be particularly watched for. Besides, in operations involving the pleura, collapse of the lung from disturbance of the internal chest, vacuum may occur, calling for a prompt treatment of the associated rapid sinking and cyanotic state generally accompanying it, depending upon the physical state of the organ. Efforts tending to a re-establishment of the normal state of vacuum carried out by the surgeon includes the attempt at production of artificial vacuum by means of an air-pump or by use of the Bier apparatus, consisting of a pump and having a bell-glass connection. The nurse's efforts in face of such complication would include the careful but rapid withdrawal of the drainage-tube, if there be any, and the sealing of the opening in the chest-wall by means of rubber tissue and adhesive-plaster strips, or by use of a plug of sterile cotton, held in place by adhesive straps.

**Abdominal operations** must also be observed for the first signs of a developing general peritonitis.

In **the extremities**, after operation for pus infec-

tion, elevation of the parts so affected goes far to prevent the lymph stasis or blocking up of the lymph spaces, with consequent squeezing, too, of the arterial and venous capillaries, thus aiding pus development; whereas, if free circulation is permitted, even at the cost of increasing pressure from elevation, recovery is aided. Further benefit in this connection is obtainable by the frequent applications of water as hot as can be borne. Finally, where the nurse applies the gauze and bandages, she must remember and use the minimum amount, else, in thus putting germs to bed in her bulky dressings, she assists in retaining heat at the surface wound of a temperature at which they develop quickest.

Fractures, whether the patient be confined to bed or not, always require the most careful attention from the nurse in charge. A slight displacement following a misstep in going about the wards, if unreported and not looked after, may decide the future functional value of a fractured arm. But if the danger is so great, why not keep all fracture cases in bed? For the reason that most patients, even fractures of the thigh, when a proper sustaining splint can be applied, improve more rapidly when they are up and about, a bed being oftentimes too sedative in effect for the patient's best interest.

## CHAPTER XX.

### OPERATIONS IN PRIVATE PRACTICE.

IN private practice the preparation of the patient is just the same and should be carried out as thoroughly as in a hospital. If it is not possible within twenty-four or thirty-six hours to make the preparation, then we cannot say that our attempts to obtain asepsis approach perfection. In emergency cases when there is not sufficient time to permit a thorough cleansing, freedom from sepsis is not so certain, and these cases do not cause the same anxiety as those that are sent to a hospital, where every effort to obtain complete asepsis is made. We must remember, in making the preparations, to make as little bustle and noise as possible, and to carry on the preparations in a quiet and cheerful manner, so as not to frighten the patient and family. When the surgeon and his assistants arrive they must be shown to a room in which they can change their clothing. The patient is not anesthetized until everything is in readiness.

One difficulty which a nurse will have to encounter in private practice is likely to trouble her a great deal, inasmuch as she will find surgeons who conduct details of cases in a way to which she is not accustomed, and which may appear to her wrong, and which indeed may very often be crude and unscien-

tific. In these cases she should not be too ready to show her superior wisdom and instruct the surgeon, and inform him under whom she received her training, because there is not the slightest likelihood that he will act upon her suggestions, but will naturally be offended.

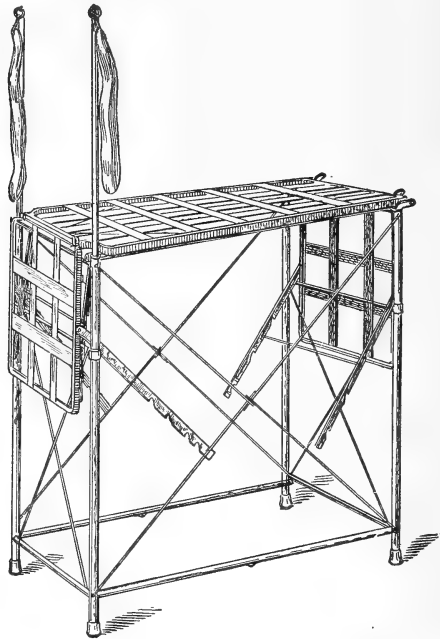


FIG. 189.—Portable operating-table set up for a vaginal operation (Hirst).

The directions for preparing for the operation will be given by the surgeon in charge. Have the temperature at about  $75^{\circ}$  F. In some houses there may be a separate room for the operation, while in others the nurse will have to prepare the patient's bedroom. In the latter case the bright-



est end of the room must be selected for the operation, to afford the surgeons plenty of light. A screen must be put up before the bed, so that the patient will not see the preparations. The nurse should remove from the room all movable furniture; sheet any large piece, as piano; lay oilcloths or newspapers covered with a damp sheet on the carpet, and pin them securely to it, and fasten a curtain across the window, so that the operation cannot be viewed from the opposite side of the street; or the panes may be frosted by lathering with soapsuds or sapolio. The remaining furniture and window-frames should be washed with carbolic-acid solution (1 : 60), and on the morning of the operation should be mopped with a cloth wrung out of the solution. The articles necessary for the operation can be placed on the operating-table, covered with a sterile sheet, and be left outside the room until the patient is partly etherized, when they may be carried in.

Have everything ready the night before, when possible. If a separate room can be had, one with a northern light is to be preferred; and if possible it should be near the bath-room and convalescent chamber. Fill the bath-tub half full with 1 : 1000 bichlorid solution for washing pitchers, plates, wash-bowls. Unless the nurse has twenty-four hours' notice in which to prepare the room for operation, it should not be disturbed, because if swept and dusted immediately before the operation dust is stirred up and the air is so filled with germs that it would not be safe to open the abdomen in the room. If the nurse has a few days in which to prepare for the operation, all unnecessary furniture should be re-

moved, the hangings taken down, the room thoroughly swept, and the walls and remaining furniture washed with carbolic-acid solution (1:60) and exposed to the action of the sun and air for about twelve hours, when the windows are to be closed,

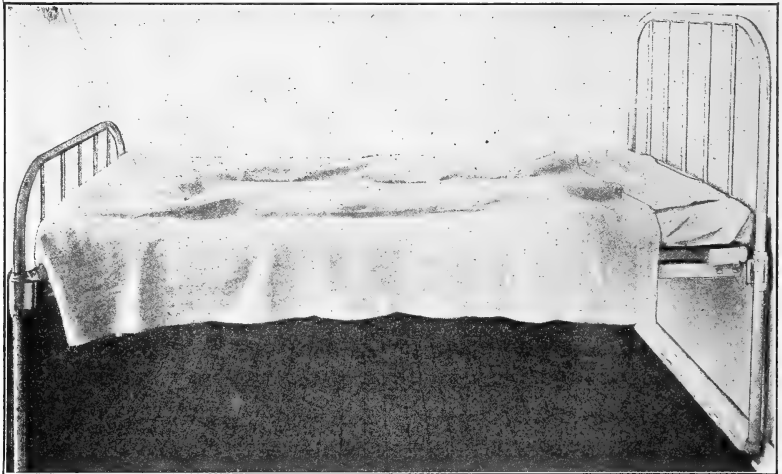


FIG. 190.—Bed arranged for reception of patient: A trough is made under the blanket by hot-water bags on either side. A towel is pinned to the lower blanket under the patient's head (Hirst).

the room thoroughly dusted with a damp cloth, and not again disturbed. The *kitchen*, if not too remote, makes the best operating-room; it is warm, hot and cold water are close at hand, and there is no danger of soiling carpets or hangings. Plug the drain-pipe openings with gauze or towel-pads soaked with bichlorid solution 1:1000.

When the operation must be performed in the patient's bedroom, push the bed up in one corner.

A word regarding the bed. If possible, it should

be an iron bedstead with a fresh horsehair mattress and pillow. The tall wooden bedsteads which we so often find are perhaps heirlooms which have wit-



FIG. 191.—Kitchen table prepared for gynecologic operation, showing Kelly draining-pad and leg supports (Hirst).

nessed every illness that has visited the family, and also the deaths. They cannot be disinfected so thoroughly as can iron bedsteads.

The operating-table should not be wider than twenty-five inches nor higher than thirty-seven inches. because if low and wide the surgeon will have to stoop and bend forward. A kitchen-table, or a dining-room table with the leaves hanging, and a small table at one end for the patient's head, or two dressing-tables, one placed across the head of the other, will make a good narrow operating-table; or three chairs, with two planks; a leaf from an exten-

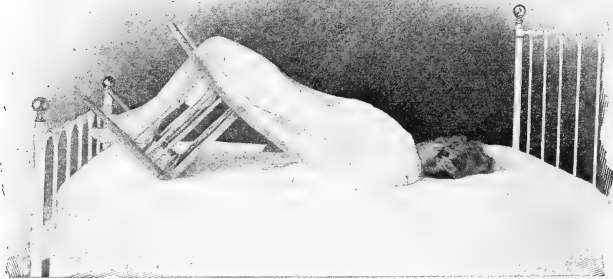


FIG. 192.—The Trendelenburg posture in bed, using a chair to elevate the pelvis (De Lee).

sion-table, or an ironing-board laid across them, may suffice.

A word of caution here: the nurse should not use any old blanket or comforter to cover the operating-table, for it is likely to be filled with germs. The top cover may be rubber bedcloth, oilcloth, or folded sheet, tied to the table by means of a muslin bandage. A Kelly pad may be improvised by means of a blanket rolled army fashion and covered with a piece of rubber cloth.

A square-backed wooden chair should be at hand

in case the Trendelenburg position is necessary, and two wooden boxes for the surgeons to stand upon when using this posture.

The lithotomy position can be quickly obtained by using a well-padded cane or broom handle placed under the patient's knees and bound in place by means of a twisted sheet passed around the patient's neck, over one shoulder, beneath the other.

Improvise a sterilizer for instruments and dressings by using a wash-boiler fitted with a light wood inside crate to hold the dressings above the water. Sterilize glass tips and syringe bags by placing in a towel hammock or muslin sling hung from the handle of the boiler.

The evening before the operation the nurse should boil a washboiler full of water and then fill covered pitchers, the washboiler and pitchers having first been made thoroughly aseptic. The water is conveyed from the boiler to the pitchers by means of a perfectly clean pitcher or tin ladle.

On the morning of the operation there should be sterilized in the boiler or in an oven six sheets, two blankets, twelve towels (not new). The heat should be kept up for fully one hour before the operation. The dry technic, by which is meant the use of dry sponges and gauze, is usually employed in private practice, especially when the water-supply is at all questionable.

There will be needed several clean recently boiled basins for the various solutions, etc. Two tables will be needed—one for the instruments, the other for the assistant. They should be covered with freshly washed and ironed sheets or towels. There will also

be needed a pail or a washtub for the soiled water, a tin dish or a flat bake-pan for the instruments, brandy, a hypodermic syringe filled with the required solution, usually strychnin sulphate ( $\frac{1}{25}$  grain), a small tumbler, a Davidson or a fountain-syringe,

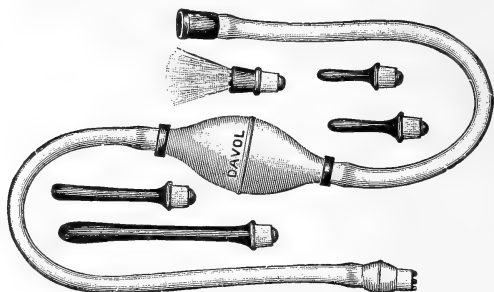


FIG. 193.—Household bulb-syringe (Davidson's).

table-salt for salt-solution, safety-pins, two new nail-brushes, ready for use in a 1:40 carbolic acid solution, castile soap, green soap, a razor, hot-water bottles, two blankets, alcohol, vinegar, and matches.

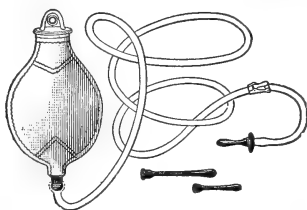


FIG. 194.—Fountain-syringe.

The surgeon will bring the necessary dressings with the instruments, which must be sterilized in the same way as in the hospital.

The instruments are to be wrapped in a towel and

allowed to boil for ten minutes in a saucepan, tin pail, or a fish-kettle of boiling water, to which have been added two teaspoonfuls of washing-soda to each pint of water, to prevent rusting. One end of the towel must be left hanging out of the kettle as a handle by which to lift out the instruments. The pail of water should be on the fire and the water boiling when the surgeon arrives, so that the instruments can be put in at once.

If the nurse is asked to give the anesthetic, she should not attempt anything else. None but novices give the anesthetic and watch the operation. The experienced anesthetizer constantly watches the patient. If the nurse is asked to assist the surgeon, she must be neither too enthusiastic, nor too quick, nor too slow. When the operation is over her duties will have nothing peculiar about them. She must see the patient safely out of the anesthetic influence, and carry the case along as she would any other.

Sometimes a nurse is called to an emergency operation in a very poor family, where there are no conveniences. In such instances the kitchen can be cleaned and prepared as an operating-room in a few minutes. If she is called in the night and goes to the case with the surgeon, she should, while the surgeon is making his examination of the patient, start a fire and put on the washboiler, to make sure of plenty of boiling water. She should then get six sheets and twelve towels, if possible. There may be no clean towels, and the nurse will have to wash some dirty ones. The sheets and towels can be soaked first in boiling water and afterward placed in corrosive-sublimate solution (1:1000), until the surgeon is ready

to use them. Boiling water is one of the best antiseptics, as it kills germs on contact. Unfortunately it cannot be used in rendering our hands and the field of operation aseptic, but it can be used in the preparation of the sheets, towels, sponges, and instruments.

The kitchen should be rendered as clean as possible. The kitchen-table should be prepared for the operating-table, and there should be two small tables, one for the instrument-tray and one for the sponges. If small tables cannot be had, chairs covered with a sheet or towels wrung out of the corrosive solution will answer the purpose. If there is no gaslight, as many lamps as can be obtained should be arranged near the surgeon, but not too near the ether, because ether is inflammable.

To fasten a sheet gown upon the operator, fold the sheet to a proper length, standing in front of the surgeon, so that the top of the fold is on a level with the axilla; draw ends up under the arms behind. Cross each end to the opposite shoulder and pin in front to form sleeves.

Improvise a stretcher by means of two curtain poles passed through a folded and pinned sheet and double blanket.

After the surgeon has made the examination, the part must be shaved, washed, and a towel wrung out of corrosive sublimate solution applied, an enema given to clear the bowels, and the urine drawn. While the patient is being anesthetized the nurse may arrange the tables and wash a flat bake-pan or meat-pan for the instruments. If sponges have been forgotten, a clean sheet can be torn up and



folded into flat sponges. China basins can be used for the antiseptics, the sponges, and the surgeon's hands; china pitchers for hot and cold water; a washtub for the soiled water; and hot bricks, plates, stove-lids, or beer bottles for heaters.

Cool boiling sterile water for immediate use during operation by pouring out in pitchers, which are then to be set in vessels containing ice-water and cracked ice.

In cases of contagious diseases, place all cleaning cloths and left-over dressings in paper bags or newspaper cornucopias to burn.

## CHAPTER XXI.

### GYNECOLOGIC EXAMINATIONS AND OPERATIONS.

PERFECT asepsis is of special importance in gynecologic examinations and operations, because in many instances the peritoneal cavity, which is highly susceptible to septic influences, is invaded by them. We must bear in mind that the whole genital tract communicates directly with the peritoneum, and infection at any point may cause peritoneal sepsis. Infection has taken place through the introduction of a dirty sound, and fatal peritonitis has followed perineorrhaphy and trachelorrhaphy.

The technic for major operations is usually perfect, but for minor operations carelessness is liable to creep in. We have no right to expose a patient to danger no matter how small the operation to be performed; and if our technic is not as perfect as we can make it with the means at our command, then we expose the patient to the greatest of all dangers, that of peritoneal sepsis, which usually means death. Success in surgery is due to minute attention to a careful technic, and a careless nurse may be the means of introducing sepsis, which may result in death after a most brilliant and skilfully performed operation. The most skilful surgeon is dependent upon his assistants for the perfection of his technic, and only those nurses

who have been thoroughly instructed in the practice of asepsis and antisepsis should be allowed to assist at an operation or examination, however small.

#### GYNECOLOGIC EXAMINATIONS.

The positions which a patient may occupy when undergoing an examination are the knee-chest, dorsal, Sims, and the upright.



FIG. 195.—Examination in the erect posture (Hirst).

The **upright**, or the erect, position is rarely used for the purpose of making a diagnosis, but is some-

times preferred in verifying a diagnosis, especially that of uterine displacement, previously made with the patient in another position. Around the waist is pinned a sheet, which extends to the floor, under which the clothing of the patient is drawn up. The patient stands with limbs separated, one foot resting on a stool or the rung of a chair.

**Dorsal Position.**—The patient lies on her back with the knees drawn up and separated; the hips are brought down near the edge of the table, leaving sufficient room for the heels to rest together comfortably, eight or ten inches apart, without slipping from the table. A sheet having an

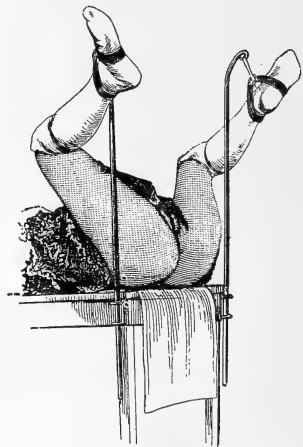
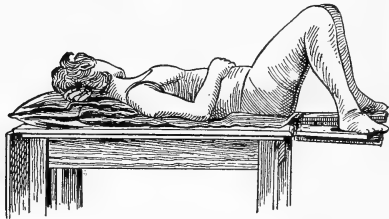


FIG. 196.—Dorsal recumbent posture. FIG. 197.—Edebohl's dorsal posture.

oval slit in the center long and wide enough to expose the parts is thrown over the patient. In this position there is naturally a certain amount of flexion of the pelvis upon the trunk, and almost complete relaxation of the abdominal muscles is secured.

**Sims' Position** (*also called the Latero-abdominal Position*).—In the Sims position the patient lies on the left side of her chest, with her head and left

cheek resting on a low pillow, and the left arm is drawn behind the body or hangs over the edge of the table. The hips are brought down to the left-hand corner of the table, so that her body lies diagonally across it, the head and shoulders being at the right-hand side, with the right hand and arm hanging over the table-edge. The thighs are flexed upon the abdomen, the right thigh being so flexed that it lies just above the left knee, and the feet rest upon a board extending from the right-hand corner of the table. This



FIG. 198.—Sims' posture, anterior view.

position is one in which there is a tendency for the intestines to ascend, and this causes the vagina to be filled with air and thus brings the uterine cervix within easy reach.

**The lithotomy position** is used when operating upon the rectum and in some conditions of the bladder. The position is obtained by placing the patient upon his back, knees and thighs flexed and separated, the hands being drawn down and attached by bandaging to the patient's feet and ankles.

The **knee-chest**, or *genupectoral*, position is much used for inspection of the rectum, bladder, vagina, and cervix of the uterus. In some cases of displacement of the uterus the patient may have to take

this position many times daily. The patient first kneels on the edge of the table, then bends forward and rests her chest on a low pillow, her head lying

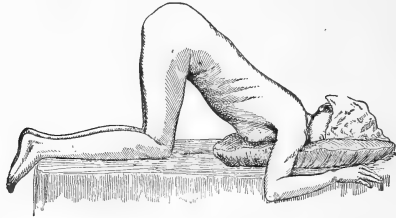


FIG. 199.—Knee-chest, or genupectoral, posture.

just beyond, so that her back slopes down evenly, her arms clasping the sides of the table. In this position the abdominal organs are thrown toward the diaphragm; the air enters the vagina and balloons it out, so to speak, so that there is an unobstructed view of the canal and the cervix.

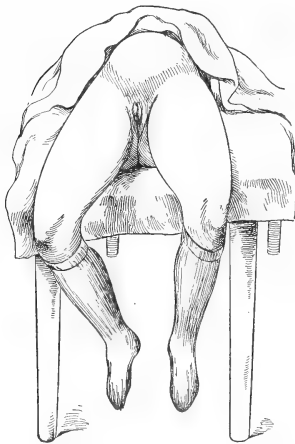


FIG. 200.—Walcher posture.

The **Walcher position** for increasing the size of the outlet of the pelvis during childbirth; action is secured by means of elastic and body weight extension.

**Examination of the Rectum.**—The patient is usually placed in the knee-chest position. Either the rectal speculum, or in its absence a Sims speculum (small blade), is used. When the instrument is introduced the rectum becomes distended

with air so that its walls are well exposed. If the patient is not in such a position that the buttocks are in a good light, a head-mirror, or an electric head-light may be needed. It is well to have these at hand in case they should be called for.

For an examination of the bladder the knee-chest position is sometimes used; though, as a rule, the dorsal position is chosen, with the hips elevated high above the abdomen by means of cushions or pillows, which allows the intestines to gravitate toward the chest; and when the urethra is opened the bladder becomes distended with air and its interior is thus easily seen. Sometimes the patient is anesthetized for the examination, since it is usually very painful; but local anesthesia of the urethra is often sufficient.

**Preparation for Gynecologic Examination.**—

To prepare a patient for examination the genital parts should be cleansed, so that there will be no danger of carrying septic material to the upper part of the genital tract; the bladder and bowels should be emptied. The uterus lies between the bladder and the rectum, and the distention of either of these organs will alter the position of the uterus. As a rule, no douche should be given before the examination, since the surgeon may want to see the character of the discharge. All bands around the waist must be loosened, also the corsets; a single tight band around the waist will crowd down the contents of the abdomen and displace the uterus. Around the patient is thrown a sheet, beneath which she can raise her clothing above the waist, and then step upon a chair and thence to the operating-table without there being the slightest exposure.

For examination in private practice the patient may lie on a small table covered with a shawl, a comforter, or blanket. There must be at hand a table, covered with a towel, on which are placed two bowls, one containing corrosive-sublimate solution (1 : 1000), and the other containing warm water, green soap, vaselin, and towels.

The speculum should be warmed by placing it in the warm sterile water. The same aseptic precautions are used during an examination as during an operation. The instruments should be sterilized. Sometimes a cleansing douche of corrosive sublimate (1 : 2000) is administered after an examination.

#### PREPARATION FOR OPERATION.

The preparation for gynecologic operations, such as perineorrhaphy, etc., are the same as for an abdominal operation, excepting the difference of the field of operation to be prepared. In case the operation is a minor one upon the uterus or vagina, the preparations may be somewhat modified according to the individual preference of the operator; but the general rules of asepsis are always the same; and they must be the more strictly observed in these operations because the dangers of infection are increased by our inability to get the genital tract thoroughly clean. In abdominal surgery there is not this difficulty.

The preparation of a patient in a private house for a minor gynecologic operation should be as thorough as in a hospital. If the operation is to be performed with the patient in bed, there will be needed a wide board or an ironing-board for insertion between the



mattress and sheet, thus making a hard surface for the patient to lie upon.

**Griffith's Operating Table-bed.**—Elevation is secured by means of blocks each four inches square

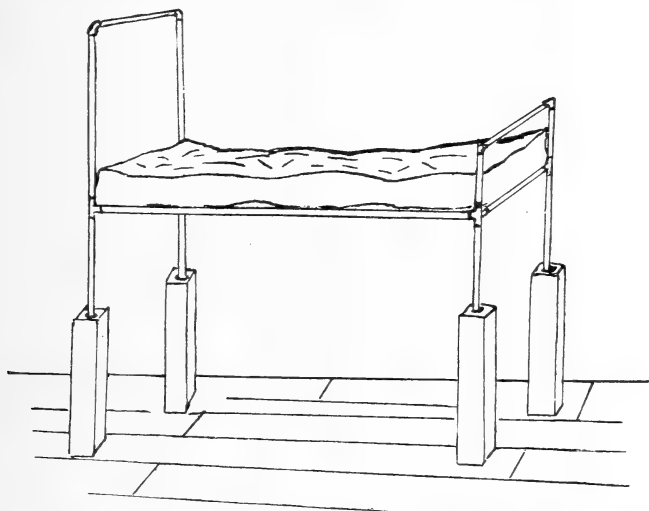


FIG. 201.—Griffith's operating table-bed.

by fourteen inches in length and having a hole two inches square and six inches long cut in one end.

**Trendelenburg's position** is secured by removing the extensions from the head legs after applying a broad binder or shoulder straps to the patient. Fowler's position for securing gravity drainage of the peritoneal cavity is obtained by removing the foot pieces after slinging the patient by means of shoulder straps.

A piece of rubber cloth or oilcloth will serve for the pad. The material used is folded at the top and

sides, covered with a towel, and the unfolded end draped into a pail or wash-tub. When the patient is

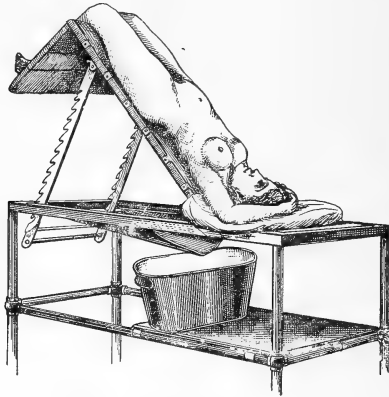


FIG. 202.—Trendelenburg posture.

anesthetized the bed is turned toward the window to afford the surgeon a good light—a northern light if possible. A bay window should be avoided, because it gives cross-lights.

The limbs are flexed, the hips brought to the edge of the bed, and the pad placed under them, so that the water used in bathing the external parts is conducted by the cloth into the pail or tub. When holding the patient's limbs the nurse should let the heel of one foot rest in the palm of her hand; the knee of the patient will then rest against the chest of the nurse, whose free hand is passed over and holds the other limb in position at the knee. If the nurse is asked to hold the speculum, she should grasp the handle from below with her right hand; the angle of the speculum will thus lie in the

hollow between the thumb and forefinger, and the convexity of the blade will rest on the dorsum of the hand. The upper labia and buttocks are raised by the left hand. If the speculum or regular retractors cannot be obtained in the emergency, retractors can be improvised by bending the handles of four large spoons to the appropriate angle. Two are used to retract the lateral walls, the other two being applied to the anterior and posterior parts of the vagina.

**After-care.**—After a vaginal operation, trachelorrhaphy, the patient will probably be catheterized for a few days. We must always remember the risk of cystitis. Many patients have fully recovered from the operation proper, but convalescence has been delayed by this complication.

After passing the catheter the nurse should be careful that when removing it the urine does not drop on the stitches; the parts are afterward sprayed with the ordered solution and dried. When giving douches the nurse must insert the tube carefully away from the stitches; and after the douche is over she should separate the labia and wipe the vagina dry with sterilized cotton or gauze held in dressing-forceps. The same care must be used when giving enemas, in order that the rectal and vaginal stitches be not broken by the tube. The patient must be instructed not to strain when the bowels are moved, or the stitches may break. When dressings are applied, they may require frequent changing in order to keep them clean and free from discharges. Strict antisepsis must be observed, the genital parts must be kept perfectly clean, otherwise septic material will readily find access and probably result in infection of the

wound and suppuration, or a stitch-abscess. If the uterus is packed with gauze, the pulse and temperature are usually taken every two hours ; and should the temperature rise to  $101^{\circ}$  F. the packing is removed.

**Diet.**—A liquid diet is usually ordered until after the third day, when the bowels will have been moved; after which, if all is well, the amount of food is increased until it attains its customary proportions.

The patient is generally kept in bed two weeks, and the sutures removed on the ninth day in the order in which they were introduced. After the removal of the stitches many operators order a vaginal douche two or three times a day, the amount of water varying from four to six quarts. This treatment is successful only when the douches are given at the proper time and temperature.

## CHAPTER XXII.

### DIET RECIPES.

FROM the following carefully prepared and long-used foods for the sick the nurse will be enabled to quickly choose a change of diet from day to day, enabling her to secure the fresh, dainty daily surprise for her patient:

**Water.**—Boiled water is the safest and best for the sick. Reaërated by pouring out in flat receptacle. It may be cooled by keeping in ordinary milk bottles set on ice.

**Albumin Water.**—Beat up the white of one egg very light; strain through a cloth; add a glass of water. Stir in a teaspoonful of lemon juice, one of sugar, and a pinch of salt. Serve set in a bowl of cracked ice.

**Apple Water.**—Bake two apples soft, mash; pour a cup of boiling water over the mass; cool; strain; sweeten to taste. Serve with shaved ice, or set in a bowl of cracked ice.

**Lime Water.**—Take a lump of unslaked lime the size of an egg, and place it in a half-gallon bottle of pure cold water. Keep the bottle corked; after a few moments the lime water is ready for use, the clear liquid being poured off as needed. So long as any lime remains the bottle may be restocked by the mere addition of cold water.

**Barley Water.**—Stir two ounces of pearl barley in a pint and a half of cold water; boil for half an hour over a slow fire in a covered vessel; strain. Add thin cuts of lemon, or pieces of sugar rubbed over the lemon to flavor.

**Lemonade.**—Cut a lemon in half after rolling; squeeze one-half into a glass, removing the seeds; add a little water and stir in a heaping dessertspoonful of sugar. Fill up the glass with water; stir in more sugar if necessary.

**Effervescing Lemonade.**—Add half a teaspoonful of bicarbonate of soda to the above; or may use Vichy water to make.

**Egg Lemonade.**—Shake up the white of one egg in a cup of water, to which add two teaspoonfuls of lemon juice and sugar; shake. Serve at once.

**Imperial Drink.**—Add a teaspoonful of cream of tartar to a pint of boiling water; squeeze and add the juice of half a lemon; add a dessertspoonful of sugar. Serve cold.

**Tamarind Water.**—Stir a tablespoonful of preserved tamarinds up in a cupful of boiling water; allow to cool; strain. Serve with shaved ice.

**Currant Juice.**—To a tablespoonful of currant jelly add a cupful of boiling water, stirring; sweeten to taste; set aside to cool. Serve with ice.

**Orangeade.**—Peel an orange; pour a cupful of boiling water over the peeling; squeeze and add the juice of the orange and a dessertspoonful of sugar; let cool; strain. Serve cold with shaved ice. A teaspoonful of lemon juice may be added to vary the taste.

**Milk Diet.**—This consists of two or three quarts of milk daily.

**Koumyss.**—Dissolve a third of a cake of compressed yeast in a little lukewarm water; add this to a quart of fresh, warm milk; stir in a tablespoonful of sugar. Put the mixture in stoppered bottles; cork and set away for twelve hours in a temperature of about 70° F. Then put the bottles upside down on ice till ready for use.

**Toast Water.**—Remove the crust from a slice of stale bread; toast without burning. Break the slice up and put the fragments into a small crock or pitcher; add a couple of pieces of orange peel or lemon. Pour over all a pint of boiling water; cover with a napkin; let cool; strain for use. Must be made fresh.

**Toast Soup.**—Toast a thin slice of stale bread. While hot, spread butter over it, having no excess. Break into fragments and place in a pitcher; add three-quarters of a pint of boiling water; add a pinch of salt and pepper. Serve hot.

**Flaxseed Tea.**—Add one-half cup of flaxseed to one quart of boiling water. Boil for one-half hour over a slow fire. Allow to set near the fire for fifteen or twenty minutes; add a teaspoonful of lemon juice; sweeten to taste; strain. Serve hot or cold.

Slippery elm bark may be added to the above mixture, allowing half an ounce of the bark to a pint of liquid.

**Milk and Cinnamon.**—To half a pint of new milk add enough broken cinnamon sticks to flavor; add to this a teaspoonful of sugar; strain. Serve cold or hot.

**Arrowroot Gruel.**—Stir up half a tablespoonful of arrowroot flour with a little cold water; add a cupful of water, stirring in half a dessertspoonful of sugar

and a pinch of salt. Boil slowly for twenty minutes, stirring constantly; add a cupful of milk; boil; strain. Serve hot.

**Barley Gruel.**—Stir up a tablespoonful of barley flour in a little water; add a cupful of water in which has been mixed half a dessertspoonful of sugar and a pinch of salt; heat; bring to a boil, continuing it for twenty minutes; stir constantly; add a cupful of milk; bring to a boil; strain. Serve hot.

**Cracker Gruel.**—Dissolve half a teaspoonful of sugar and a pinch of salt in a cupful of water; apply heat. Mix up two tablepoonsfuls of grated cracker in a little water and add to the heated water. Boil for five minutes; add a cupful of milk and again bring to a boil. Serve hot.

**Flour Ball.**—Tie up half a pint of flour in a square of cheese-cloth very tight; place in a pot of boiling water; cook for five hours. After removing the cloth peel the outside of the ball and grate; dry in the oven and keep in a closed jar. This may be used for making gruels; also to dilute milk for young children.

**Tapioca Jelly.**—Soak a cupful of tapioca for two hours; when soft, place in a saucepan; add a dessertspoonful of sugar; the rind and juice of one lemon; a pinch of salt and a pint of water; heat, stirring the mixture until boiling; turn into a mold and set out to cool before serving.

**Tapioca Soup.**—Boil a pint of meat broth; stir in an ounce of washed tapioca. Set on the back of the stove to simmer, covering the vessel. Skim and serve hot.

**Eggs.**—Boil eggs by dropping them into boiling water, and continue for three minutes.



**Poached Eggs.**—Bring water to a boil in a saucepan; add a pinch of salt; slip the egg carefully broken in a saucer into the salted water. Cook until the white is firm but jelly-like; remove with a skimmer and serve on a thin piece of buttered toast; sprinkle a little salt and pepper on the top; garnish with parsley sprig. Serve at once.

**Scrambled Eggs.**—Beat up two eggs thoroughly; add two tablespoonfuls of milk; a pinch of salt. Pour into a very hot frying pan, buttered; stir constantly for about two minutes. Serve on buttered toast at once.

**Shirred Eggs.**—Heat up the shirring cups. Put in each cup a bit of butter; break into each an egg. Allow to remain on the stove for a moment, then serve hot in the cup, adding a pinch of salt.

**Panado.**—Take a slice of wheat bread and break up into fragments; sprinkle a teaspoonful of ground cinnamon over the whole; add a pint of boiling water; boil for five minutes; add a teaspoonful of sugar and a little grated nutmeg. Serve hot.

**Milk Toast.**—Prepare two slices of crisp toast. Heat a cup and a half of milk to the boiling point; add a pinch of salt and a small bit of butter; thicken the milk by adding one-half teaspoonful of cornstarch; stir well and boil for five minutes. Pour the milk mixture over the toast in a closed dish. Serve hot.

**Rennet.**—One pint of milk warmed, sweetened, and flavored with nutmeg, cinnamon, or lemon; add one large teaspoonful of liquid rennet; stir for one minute; set aside to cool and set. Serve with sugar and cream.

**Boiled Rice.**—Rice must continue to boil until

every grain is softened without dissolving into a shapeless mass.

**Plain Rice.**—Two tablespoonfuls of rice are to be washed and placed in a shallow baking dish; add two tablespoonfuls of sugar; flavor with lemon peel or vanilla; add one quart of milk. Bake for three hours in a moderate oven, stirring every twenty minutes. Cool for an hour before using. Serve cold.

**Tapioca Pudding.**—Soak one-half cup of tapioca over night in cold water; put it over the fire and heat to clearness. Mix up one pint of milk and two eggs to form a custard by heating the mixture until almost boiling, then stir in two tablespoonfuls of sugar and cook for three minutes in a double boiler, stirring gently all the time. When done it should be as thick as cream. If allowed to cook too much it separates and is spoiled. Add the milk custard to the tapioca; sweeten and flavor to taste; bake in a quick oven. Set aside to cool. Serve cold.

**Cornstarch.**—To one tablespoonful of cornstarch add cold water enough to make a smooth paste. Add to this half a pint of milk; boil for five minutes, stirring all the time; add a pinch of salt; sweeten to taste, and add a flavoring extract. Serve cold.

**Beef Essence.**—Cut up one pound of fresh lean beef from the neck into small pieces; sprinkle a little salt over the mass; place the cut-up meat into a stout stone jug; place the jug in a vessel of cold water and bring to a boil; cork the jug tightly when steam begins to issue from the mouth. Continue boiling for at least four hours; strain through a cloth, and season the meat juice obtained with pepper and salt to taste.

**Invalid's Soup.**—To one pint of beef essence made

quite hot add half a pint of cream, likewise hot, to which the yolk of a fresh egg has been stirred up. Mix carefully together in a lined saucepan; season and serve.

**Beef Broth.**—Take a pound of beef (neck or shoulder) and slice it up; place in a pan and salt, then pour on a quart of cold water; place on the fire and bring to a simmer; keep so over a slow fire an hour and a half; set back on the range for half an hour; strain; serve.

**Mutton Broth.**—Cut up a pound of good mutton into small pieces and sprinkle with salt; allow to simmer over a slow fire, after adding one quart of cold water, for an hour and a half; boil for half an hour; strain; serve.

**Beef Juice.**—Take half a pound of lean beef and cut it up in pieces of about the size of a pigeon's egg; toast the pieces over hot coals; squeeze out the juice with a meet presser or lemon squeezer; add a pinch of salt before serving.

**Chicken Broth.**—Take a small chicken, removing skin and fat between the muscles; divide it in two down the back; remove the lungs as well as everything adhering to the side-bones and back; cut up the halves in thin slices; place them in a pan and sprinkle with salt, then add a quart of cold water; bring to a simmer over a slow fire; allow to remain for an hour and a half. Then remove from the fire to a place where the heat will still be kept up for half an hour longer; strain; serve hot. During the cooking a sprig of celery may be added, or a clove, or half a dozen pepper-corns to give it a flavor.

## CHAPTER XXIII.

### SIGNS OF DEATH; AUTOPSIES.

WINSLOW, one of the professors at the University of Paris, and who had twice been taken for dead, was the first to make a scientific investigation of the signs of death. After Winslow came Louis, and since their time eminent men, especially in countries prescribing rapid burial, have endeavored to find certain and reliable signs of death before decomposition begins.

#### SIGNS OF DEATH.

Absence of respiration is not a sure sign of death, as it may be due to syncope or to the person being in a trance; nor is absence of the heart-beat, unless determined by means of a stethoscope in experienced hands. Coldness and rigidity may be due to collapse or catalepsy or in persons who are frozen stiff.

In doubtful cases of apparent death which occur suddenly or from external violence the following tests are usually applied :

1. The absence of the heart's action is carefully determined by a stethoscope or phonendoscope.

2. Absence of the circulation is ascertained by tying a string tightly around a finger or a toe; if the tip becomes blue, life is not extinct, though this may occur in cases where there has been great loss of

blood, and in other cases where the heart is too weak to send the arterial blood into the capillaries of the fingers.

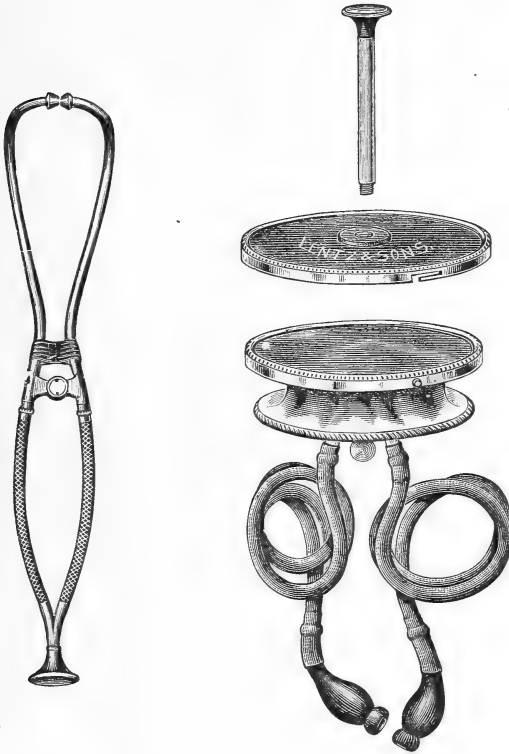


FIG. 203.—Stethoscope.

FIG. 204.—Bazzi-Bianchi's phonendoscope.

3. Absence of respiration is determined by placing the surface of a mirror before the mouth ; if the surface becomes moist, respiration has not ceased.

4. If a subcutaneous injection of aqua ammonia is given a red or purple spot will form if life still exists.

5. If a needle is inserted into the flesh of a living person blood will escape, but not if life is extinct ; still, if there has been a large loss of blood, there will be no escape of blood in the living.

**Rigor mortis** (post-mortem rigidity or stiffness of death) begins in the upper part of the body, usually in the maxillary muscles, and spreads gradually from above downward. It disappears in the same order. It comes and goes quickly after great muscular effort or excitement, and when once it has been broken up it does not return. The time it sets in after death varies from ten minutes to twelve or even twenty-four hours. Rigor mortis is considered the most positive sign of death, because it indicates death of the muscle itself.

Death of the body as a whole takes place first, and at intervals of an hour or even several hours death of one or other of the involuntary muscles follows.

Hypostasis, cadaveric lividity, or congestion of blood in the capillaries, which forms in all the dependent parts of the body, is considered a valuable sign of death, but this purple color may be due to contusion, and has been seen in cholera patients before death.

The body-temperature at and from one to two hours after death may be very high,  $107^{\circ}$  or  $112^{\circ}$  F. Patients dying from cholera and yellow fever have high temperatures for several hours after death; but, as a rule, the body is cold to the touch in from six to ten hours.

#### AUTOPSIES.

Every nurse should do all in her power to assist the physician or surgeon to obtain autopsies, and

with a little tact the necessary permission can usually be obtained. Every well-conducted autopsy adds more or less to medical knowledge. It verifies the diagnosis of the illness, and in many cases it explains or shows the cause of symptoms the explanation of which could not be determined before death. In surgical work, when a patient dies in less than twelve or fourteen hours after an operation, the autopsy, when made by a competent bacteriologist and pathologist, will show whether death was due to sepsis or to some organic disease over which the surgeon had no control.

In a private house the autopsy should be held in the room giving the best light, and if possible in the daytime in order to obtain the correct color-interpretation; for if made in artificial light the observations will not be entirely trustworthy.

At the present time an autopsy is preferably held almost immediately after death, and before putrefactive changes have taken place. The undertaker should always be warned not to inject the body, because the fluids usually employed, which contain among other things corrosive sublimate and arsenic in large quantities, change the color and consistency of the organs to such an extent that it is difficult to recognize the pathologic processes. Then, again, the punctures made during the embalming process may open an abscess or other cavity, and thus distribute the contained pus or exudates. Embalming-fluid has been poured into the mouth, and having found its way into the lungs and stomach, has greatly changed the appearance of those organs.

The clothing on the body should be removed and

a large sheet spread over it; or if preferred, a night-dress or skirt open down the middle may be put on.

If the corpse is female, braid the hair in two plaits after combing a part extending from ear to ear over the crown. Coil each plait securely with hair-pins.

The things a nurse should provide are:

1. Large rubber sheet, old oil-cloth, old quilts, or papers to put under trestle to protect the floor.

2. Small table for instruments, a marble-top table if possible, unless there is a marble-top stationary bowl in the room.

3. Three washbowls: one for corrosive sublimate, one for dirty instruments, and one for organs removed.

4. Two pails for dirty water.

5. Old towels and a number of old sponges.

6. Plenty of hot and cold water.

7. About four quarts of fine sawdust, or oakum, or excelsior packing, absorbent cotton, or common cotton for filling up cavities; any one of which will prevent fluid oozing through the incisions. When these are not obtainable, bran, cloth, or newspapers may be used. Fine sawdust is the best material, as it packs easily, does not interfere with the sewing by getting into the stitches, and keeps the needle dry.

8. Six wide-mouthed bottles in which to place specimens from the various organs, and which can be securely corked.

9. Mucilage and labels on which to write the history of each specimen in the bottle.

10. About three yards of fine twine or carpet-



thread, and a large darning-needle or a large curved needle.

Should the autopsy take place in a house where there are no conveniences, the body can be left lying on the undertaker's stretcher covered with a sheet, the clothing removed, and a large napkin put on. There should be several old newspapers to protect the floor, and on which to place the dirty instruments and organs removed; an old sheet, a pail, a wash-bowl, and a pitcher of warm water can always be obtained.

The sheet is torn into four pieces. Two pieces are used, one for each side of the neck and trunk, covering the arms, leaving the chest and abdomen free for the surgeon to operate; the third piece is placed beneath the head; and the fourth piece is tucked in below the genitals, thus covering the lower extremities. The bowl contains the large dampened sponge, and, together with the pail, should be placed within convenient reach.

Absolute cleanliness is essential at a private autopsy. Blood-stains must be washed from the walls, floor, dishes, the rubber or oil-cloth; the papers, old sponges, and cloths should be burned, and the body must be washed perfectly clean. The room must be left in perfect order—just as it was before the post-mortem. Ground coffee thrown on a few live coals will remove all odor from the room.

For removing the odor from the hands, turpentine will be found serviceable, or a solution of permanganate of potassium and oxalic acid, or a dilute solution of formaldehyd. The result of the autopsy must be kept secret and revealed to no one.

## CHAPTER XXIV.

### HYGIENE; PERSONAL CONDUCT OF A NURSE'S LIFE; OF THE REWARDS; SUCCESS.

THE care of her own person must not be forgotten by the aspiring nurse, else she may gain the coveted post of trusted helper to physicians at the price of loss of her bodily health. Rest and regularity in conducting her mode of life are the chiefest factors for securing a continuation of the sound health conditions which every nurse should possess who attempts the work of caring for the sick. Futile as it may seem to suggest rest and regularity to one whose professional life is largely made up of activity and irregularity of mode of personal life, it is nevertheless essential for a good nurse to learn how to save up energy during ordinary times that she may have sufficient vital capital force to meet the emergency demands.

Sufficient sleep and a regular time for eating is as important for the well as the sick, and in the matter of eating it must be recalled that a mouthful of food which has been well masticated before swallowing will give much greater return in energy than many of the hurried mouthfuls which nurses are too prone to take.

Attention to the calls for emptying of the bladder and the bowels is for the most part made a matter of convenience rather than considered as most im-

portant functional activities to be attended to without delay.

Daily stimulation of the skin of the entire body by bathing, even if but a sponge bath taken from a wash-bowl or a basin, is to be recommended, for while the average nurse may be forced to scrub her hands and arms too often for either health or comfort, there is seldom allowed time enough for sufficient body bathing.

A nurse who spends a day a month in bed during the beginning of her monthly sicknesses will often be considered selfish, and she may now and then lose a position temporarily by following such a course, but her increased value to herself and to the profession she serves during the rest of the month will far outweigh the apparent disadvantage.

The presence of decayed teeth, corns, bunions, varicose veins in the legs, and hemorrhoids are all common affections which may be borne a long time, but the nurse who has such things may come to a time of final failure in her professional career. Upon the very first appearance of the handicapping conditions mentioned she must seek relief, for the best that medical and surgical advice and treatment can give is hers by right. Aside from the ordinary affections which arise from ill-fitting shoes, nurses are particularly liable to the condition called "foot sore," student nurses being special sufferers. While the hard floors of modern hospitals are responsible for the condition during the earliest days of a nursing career, later its control is a matter of proper care of the feet themselves. A nurse must seek foot comfort and health not by wearing her oldest, run-down

shoes, but always during working hours a well-fitting, ample sized shoe which allows her toes to lie uncramped. The other essential for comfort is to keep the feet dry. Perspiration quickly softens the skin of the feet, and allows swelling in the soft cellular tissue beneath to take place. While a perspiring foot is by no means unhealthy, the relaxation which accompanies it calls for treatment. To overcome the effects of excess the following measures will be found useful: A daily change of shoes; one or more changes of stockings during the day; stimulating foot baths, alternating hot and cold water, accompanied by rubbing with a coarse towel and massage; alcohol bath and rub; painting the soles of the feet with a 10 to 20 per cent. formalin solution once or twice a week; talcum powder, rice flour, fuller's earth dusted in the shoes; paper insoles, made from newspaper after folding several leaves, and cut to the size of the stockinged foot, will be found invaluable in keeping the feet both dry and warm. A daily change may be made at the time of dressing. In general, high laced shoes with low heels will prove more comfortable than the low light-weight ties. Rubber heels are restful, as they greatly reduce body-jarring. Tendency to flattening of the arches of the feet, manifested by a continuous ache upon standing, may be overcome by massage, strapping and bandaging, or supported by sole-plates.

The continual scrubbing and immersions in the various antiseptic solutions of hands and arms which the modern nurse is compelled to undergo often gives rise to discomfort, if not to well-marked skin disease. Drying up of the normal oil of the skin is the earliest

direct cause of roughness, cracking, and scaling skin. A peculiar sensitiveness of certain individuals' skins for such drug solutions as carbolic acid, bichlorid of mercury, and oxalic acid, which act toward them as special irritants, and which is known by the term idiosyncrasy, is not considered. In general, to keep the hands pliant by massage and the free use of cold cream, lanolin, or some such bland ointment, will suffice. In cases which fail of relief, rubber gloves must be worn.

The importance of cultivating her powers of observation can hardly be estimated, so much will the nurse's reliability be thereby increased. After making the first general observation, her duty is to note changes, to see and jot down facts, not bias her observing faculty by evolving opinions.

A good nurse makes no noise herself, and acts as a perpetual noise preventer in and around the sick-room.

The stricter a nurse holds herself to the prescribed uniform of her school the better, thus fancy collars, and neckwear, jewelry, and hair ornaments, finger-rings, detract her personality from the rôle she plays.

The calling of a nurse demands that she be always neat and trim in the matters of her personal appearance and in clothing effects, and that her professional relationship with the patient, his family, and the physician call for but the ordinary dignity which becomes a woman's greatest charm when least assumed.

While the mental caliber of the successful nurse is from necessity large, she will do well not to continually tax herself with the requirements of her art.

Proper amusements have their place, and will the better equip her for the serious work hours.

Nurses will do well to study surgical supply catalogues, so as to know the cost of supplies and keep abreast of what is new. A postal request will suffice to supply her.

No matter how physically well a nurse may conduct her life, it becomes a necessity for her to secure a change of scene during a month or two of the year, which may be obtained by means of a "travelling case," by connecting herself with work in some distant part of the country through correspondence, or the channels of a medical journal's advertisement columns, or by expending part of her year's savings for board in the country or at the seashore. Every nurse's bureau should have its correspondence department to provide for this "exchange" system in practice over the country. Besides rest in change of environment the results will be better, because broader, educated nurses. Of the rewards for conscientious work the nurse's outlook is a bright one, for better salaries are offered and more may be expected to be paid in the future for high class work than ever before. The matter of money loss to nurses, which occurs between "cases," is to be overcome by a mutual division of expenses, as is customary in large communities. Five or six nurses "keep house" in a few rooms, the one who is professionally unemployed acting as "housekeeper." By this means direct communication is kept up between doctors and nurses. While the agency system for hiring nurses is good, a sure plan for a nurse to gain cases is by periodic personal visitations upon doctors. A nurse who calls upon a

physician and tells him what she can do and the scale of her prices for her work has made an impression, and she will be remembered by the doctor when in need of a nurse's aid.

Individual success for the nurse, as in any other vocation, must be the sum-up of her whole life's work. If at the commencement of her career she learns to know herself as a helper—one whose life's work is dedicated to the sick and to a loyal devotion to the medical profession, of which she is herself a most important part—such a one is well started in her career, and is on the high road toward success and honor.





## GLOSSARY.

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### A.

- Abdominal binder.** A wide bandage dressing used to support the walls of the abdomen after open operations or the womb after childbirth. Muslin, flannel, or towelling may be used, and is applied snugly by overlapping tails and fastening or by safety-pins.
- Abdominal operation.** An operation which involves opening the abdominal cavity as a preliminary.
- Abdominal section.** An operation in which the belly cavity is opened.
- Abscess.** A circumscribed collection of pus.
- Acetic fermentation.** Souring with the production of acetic acid or vinegar.
- Actinomycosis.** A disease of cattle which may be transmitted to man; it is due to the ray fungus.
- Active hyperemia.** Steady increase of the quantity of blood in the vessels of a part.
- Acupressure.** Compression of a blood-vessel by twisting with an inserted needle.
- Acute disease.** One active in onset, energetic in course, and of short duration.
- Aërobic.** Requiring the presence of oxygen for development.
- Albumose.** A substance formed during the digestion of albumin.
- Alimentary canal.** The digestive tube extending from the mouth to the anus.
- Alterative.** A medicine having a gradual and general tendency toward the production of health.
- Anaërobic.** Requiring absence of oxygen for growth to take place.
- Anesthetic.** Producing unconsciousness to pain.
- Aneurysm.** A disease of blood-vessels due to stretching or rupturing of one or more of the coats.
- Aniline derivative.** An agent prepared from coal-tar.
- Anthrax.** A contagious disease of cows and sheep often transmitted to man, due to the Anthrax bacillus.
- Antiseptic.** An agent by whose action germs are destroyed or their growth prevented.
- Antiseptic agent.** One which inhibits the growth or destroys germs.
- Antiseptic surgery.** The various procedures which are carried out with the idea of preventing or destroying germ contamination.
- Antistreptococcic serum.** A protective blood-water taken from an animal which has successfully recovered from graded injections of virulent pus germs.

**Antitoxin.** A defensive proteid developed in a body for its protection from microbic assaults; a curative blood serum.

**Aqua ammonia.** Ammonia-water.

**Arterioles.** Smallest branching arteries.

**Artificial inoculation.** Attempt to produce a disease by injection or local application of the germs, their products, or the virus producing it.

**Artificial media.** An agent capable of supporting germ life outside of the body.

**Asepsis.** Freedom from septic poisoning; clean.

**Aseptic.** Free from germs; sterile.

**Astringent.** An agent which causes contraction of tissues and the lessening of secretions.

**Atomizer.** An appliance for spraying.

**Aural.** Pertaining to the ears.

**Aural canal.** The ear passage.

**Autopsy.** The examination of a dead body, a post mortem.

**Autopsy room.** A room set aside for the examination of dead bodies.

**Axilla.** The arm-pit.

## B.

**Bacilli.** Rod-shaped germs, as tubercle bacilli, the cause of consumption.

**Bacteria.** Minute organisms; microbes.

**Bacteriologist.** One who studies and experiments with germ life.

**Bacteriology.** The study of germs.

**Bed heater.** An appliance for heating a bed, as with a hot-water bag, hot bricks, etc.

**Beef essence.** Concentrated beef extract.

**Bistoury.** A sharp narrow-bladed surgeon's knife; may be sharp or dull pointed; curved.

**Blastomycete.** Yeast-forming germ.

**Blood serum.** The watery portion of animal fluids.

**Boroglycerid.** A pasty compound made by slowly dissolving two parts of boric acid in three parts of hot glycerin.

**Bouillon.** Strained beef soup; a culture-medium.

**Bronchi.** The first division of the windpipe.

**Bronchioles.** The finest divisions of the windpipe.

**Bronchorrhœa.** Excessive flow of mucus from the windpipe.

**Bubonic plague.** An acute, contagious disease characterized by a malignant type of fever and formation of buboes or glandular swellings throughout the body.

**Buttocks.** The fleshy parts back of the hips.

## C.

**Cancer.** A morbid growth whose tendency is to spread and to cause ultimate death.

**Capillaries.** The finest divisions of the blood-vessels.

**Capillary hemorrhage.** Oozing of blood.

**Carcinoma.** One form of cancer; common seat is the female breast.

**Catalepsy.** Condition of partial or complete suspension of will and consciousness, with rigidity of voluntary muscles.

**Catheterization.** The act of drawing off the urine.

**Catheterize.** To draw off the urine.

**Cellular tissue.** Loose fatty spaces beneath the skin and between organs.

**Cerebrospinal fluid.** Serous fluid contents of the cavities of the brain and spinal cord.

**Cervical canal.** Channel in the neck of the womb connecting the vagina with the body cavity of the womb.

**Chemic.** Chemical; relating to chemistry.

**Chill.** A nervous symptom usually marking the onset of disease, in which the patient has rigors and complaints of being cold; in malarial fever the temperature is really highest at this time.

**Chlorinated soda.** Soda which has been combined with chlorin.

**Chlorin-water.** A saturated solution of chlorin in distilled water.

**Citronella.** A fragrant Asiatic grass from which is obtained a volatile oil, useful, when applied to the person, in driving away mosquitoes.

**Clammy.** Moist and cold.

**Clamp.** An instrument with detachable handles to apply to the broad ligament; in operations for removal of the uterus through the vagina, six or eight are applied upon each side. A hemostatic forceps to control hemorrhage from vessels that cannot be reached to apply ligation.

**Clostridium.** A bacillus distended at its center by a large spore.

**Coagulable quality of blood.** The power to clot.

**Cocainization.** The act of producing cocain anesthesia.

**Collapse.** General failure of the vital powers without loss of consciousness.

**Colony.** A localized, unmixed growth of micro-organisms.

**Complication.** A disease appearing during the course of another, which may modify the termination.

**Contagious.** Capable of being transmitted from one individual to another; catching.

**Contagious affection.** A disease directly transmissible from one person to another.

**Contagious disease.** One which may be directly transmitted from one to another.

**Convalescence.** The period of uninterrupted recovery from illness.

**Convulsion.** A nervous condition giving rise to violent, continued, or intermittent muscular contractions.

**Corrosive sublimate.** Bichlorid of mercury.

**Coryza.** Cold in the head.

**Cranioclast.** An obstetrical instrument to aid in the delivery of a child's head by crushing.

**Crystalline.** Colorless; clear as crystal.

**Culture-media.** Substances upon which germs are experimentally grown.

**Cumul catgut.** Catgut sterilized for surgeon's use by superheating in a solution of cumol, a product of coal-tar.

**Curetting of uterus.** Clearing out of the contents of the womb or scraping the membranous lining of its cavity.

**Cyanosis.** The symptoms arising when the supply of oxygen is greatly lessened, as in strangulation.

**Cyst.** A circumscribed membranous cavity occurring abnormally and containing fluid, semifluid, or solid contents.

**Cystitis.** Inflammation of the bladder

**Cystoscopic examination.** A study of the bladder by the use of an instrument which brings its surface directly into view.

## D.

**Decomposition.** Act of decaying; rotting; separation into elements.

**Delirium.** Mental state in which there is a rapid flight of ideas which are incoherent and often unintelligible.

**Depletion.** Reduction of the amount of fluid, as blood or serum, in a part.

**Diabetic coma.** Loss of consciousness due to the action of poisons in diabetes.

**Diaphragm.** The great breathing muscle separating the chest from the abdomen.

**Dilatation of cervix.** Act of stretching the mouth and neck of the womb.

**Disinfectant.** An agent capable of destroying microbes or the products of their growth.

**Disinfection.** The act of rendering free from micro-organisms or their effects; purifying.

**Distillation.** The act of heating a solid or liquid in an apparatus, so that the vapors given off may be collected.

**Douche.** A more or less forcible flushing of a cavity or part of the body for purposes of cleansing and stimulation.

## E.

**Eclampsia.** Convulsions during the childbearing period caused by kidney disease.

**Ecraseur.** An instrument used to squeeze its way through tissue causing least amount of bleeding by employing a gradually tightening wire or string.

**Eczematous condition.** One in which peeling and crusting of the skin occurs with more or less itchiness.

**Edema.** Swelling due to excess of serous fluid within a tissue.

**Effervescence.** Bubbling.

**Elaborated.** Developed; produced

**Electrolysis.** Decomposition by electricity.

**Elimination.** The act of throwing off; expelling.

**Emergency operation.** One made necessary by the serious condition of the patient.

**Emesis.** Vomiting.

**Emetic.** A substance causing vomiting.

**Emulsion.** A fluid containing fat suspended in very fine particles, forming an opaque, milky white mixture.

**Endocarditis.** Inflammation of the lining membrane of the heart. The process is usually confined to the valves.

**Endometritis.** Inflammation of the lining of the womb.

**Enemata.** Rectal injections; solutions used to cleanse the lower bowel.

**Enteroclysis.** The administration of a rectal injection.

**Epidemic.** A general invasion of a community by a given disease.

**Epidemic cerebrospinal meningitis.** A microbic disease giving rise to inflammation of the lining membranes of the brain and spinal cord with convulsions, irregular fever, and a rash.

**Epidermic.** Injected; relating to the skin.

**Epidermis.** The surface-covering of the body; the skin.

**Epithelial cells.** Microscopic units; flat upon the skin, goblet-shaped on mucous membranes, forming the surface layers of these tissues.

**Epithelium.** Skin covering.

**Eruptive fever.** One attended with a rash; scarlet fever.

**Erysipelas.** An acute contagious skin disease caused by streptococci, giving rise to irregular fever, and with a tendency to relapse.

**Erythema.** Redness of the skin; blushing.

**Eucalyptus.** An Australian gum tree from which is obtained an oil used in medicine. This oil produces sweating, is tonic, stimulant, and antiseptic.

**Eustachian catheter.** A tubular instrument designed to pass through the nasal cavity to the opening of the *Eustachian tube*. This latter is a canal leading from the back of the mouth to the middle ear.

**Evaporation.** Loss of water by the action of heat.

**Excretions.** Products of body waste; urine.

**External jugular vein.** The largest superficial vein in the neck, running downward midway upon both sides.

## F.

**Fallopian tubes.** Two trumpet-shaped pipes, each about four inches long, connecting the womb with the abdominal cavity, through which ova pass.

**Fascia.** Strong, glistening fibrous sheaths separating muscles.

**Feces.** Body and food waste from the bowels.

**Fermentation.** The change effected by the action of a ferment; souring.

**Fetus.** A young child within or taken from its mother's womb before it has fully developed.

**Fibrils.** Thread-like connective tissue.

**Fibrin.** Fine elastic strands formed during clotting and inflammation.

**Fibrin-ferment.** A substance causing the formation of fibrin.

**Fistulæ.** Disease tracts indisposed to heal.

**Flacherie.** A contagious disease of silkworms caused by micrococci.

**Flat wines.** Wines spoiled by beginning acid fermentation.

**Flatulence.** Excess of gas in the stomach or bowels; wind colic.

**Fuller's earth.** A finely powdered earth used as an absorbent.

**Fumigate.** To free from infection by the use of vapors.

**Fungi.** The lowest order of non-flowering plants living upon animal matter; in bacteriology, a micro-organismal moss.

## G.

**Gangrene.** Local death of the part.

**Germ theory.** The theory that all specific disease is due to the presence or action of micro-organisms.

**Germicidal solution.** A germ killer.

**Glanders.** A disease of horses caused by the bacillus mallei which affects the air-passages and skin and is transmissible to man.

**Globulins.** A form of albumin.

**Gonococcus.** The germ that causes the venereal disease called

gonorrhœa; consists of a double, dumbbell coccus.

**Gonorrhœa.** A sexual disease caused by the transfer and activity of a germ called the gonococcus from one individual to another.

**Granulation tissue.** Reddish, bud-like projections found upon the surface of a healing wound.

**Gynecologic.** Relating to the sexual organs of a woman.

## H.

**Heart paralysis.** A condition in which the heart's action is rapidly weakened or ceases.

**Hemorrhage.** Bleeding; generally used to designate a profuse loss of blood from the vessel affected.

**Hemorrhoids.** Dilated and elongated blood-vessels about the opening of the lower bowel; piles.

**Hernia.** An abnormal protrusion of an organ or tissue.

**High enemata.** An injection made high into the bowel by aid of gravity and a rectal tube.

**Hives.** Common name for a skin disease giving rise to an evanescent eruption associated with severe itching.

**Hydrophobia.** A disease of dogs and kindred animals communicated to man by direct inoculation; rabies.

**Hypodermic injection.** Deposit of a solid or fluid beneath the skin by means of a syringe and hollow needle.

**Hypostasis.** The settling of blood or fluid to the lowest parts of the body by gravitation after death, or loss of pressure-controlling power in a given set of blood-vessels.

**Hysterectomy.** Removal of the womb by operation.

## I.

**Icterus.** Bile-stained; jaundiced.

**Immunity.** A condition in which a body resists the development of micro-organisms or the action of their poisons.

**Immunizing unit.** A standard strength agent to subdue the powers of a given quantity of micro-organisms or their products.

**Infectious disease.** One capable of being transmitted from one person to another.

**Infective.** Likely to produce disease.

**Infective puerperal endometritis.** Purulent inflammation of the lining of the womb after childbirth.

**Inflammation.** Reaction of a part to an irritant.

**Infusion.** Charging the veins with fluid by injection.

**Inoculation.** The act of directly implanting disease.

**Inoculous.** Rendered sterile.

**Insomnia.** Unable to sleep.

**Inspissated.** Dried and thickened from loss of water.

**Intestinal adhesion.** Union of two peritoneal surfaces of the bowel caused by inflammatory action.

**Intestines.** The bowels.

**Intracerebral injection.** Deposit within the cavities of the brain.

**Intravenous.** Within the veins.

**Intravenous injection.** An injection forced directly into a vein or cellular tissue.

**Intubation.** Operation of passing a tube through the larynx when closed by disease, as in diphtheria.

**Isolation.** Setting apart from all communication with others.

**K.**

**Knuckle of intestine.** A short length of gut sharply bent upon itself.

**Kraske's operation.** Operation devised by the surgeon whose name it bears for the removal of cancer growing high up in the rectum. The diseased area is exposed by chiselling away the coccyx and portions of the sacrum.

**L.**

**Lanolin.** A bland, fatty substance prepared from sheep's wool and used as the base of many ointments.

**Laparotomy sheet.** Linen sheet covering containing a longitudinal opening through which patient's abdomen is exposed.

**Lavage.** Washing by irrigation.

**Leprosy.** A chronic obscurely contagious disease caused by the bacillus of leprosy, and giving rise to various inflammatory lesions of the skin and internal organs.

**Leprous nodules.** One form of skin lesion caused by leprosy consisting of firm, irregular elevations, which later break down and become ulcers.

**Leukocytes.** Unit masses of protoplasm or the physical life principle.

**Ligation.** The tying off of blood-vessels, the ovarian tubes, the appendix, or a tumor by means of a gut or silk string.

**Liquefied.** Changed from a solid to a liquid state.

**Listerism.** Antiseptic surgery according to the principles first laid down by Sir Joseph Lister.

**Litholapaxy.** The operation of

removal of stone from the bladder by crushing and washing out the fragments.

**Lithotomy.** The operation of cutting for stone.

**Lithotrite.** An instrument for crushing stones within the bladder.

**Lubricant.** A substance used to diminish friction; rendering slippery.

**Lymphatic vessels and glands.** The great system of absorbents with their connecting channels.

**M.**

**Malady.** Sickness, disease.

**Malignant tumor.** One which has undergone cancerous change.

**Masticated.** Chewed.

**Meatus.** Anatomical name for the mouth of a canal.

**Media.** The means of transmission; substances favorable for the growth of bacteria.

**Mediastinum.** The middle space of the chest cavity between the lungs, and containing the heart and great blood-vessels.

**Medicaments.** Medicines.

**Menstruum.** A fluid carrier or solvent for a drug.

**Miasm.** Infection carried in the emanations from the soil.

**Miasmatic.** Caused by infectious particles rising in vapors from the soil; said of malaria before its cause was known.

**Micrococci.** Germs having a spherical shape.

**Micro-organisms.** Any form of germ life.

**Minim.** A fluid drop.

**Monomorphous.** Having but one form.

## N.

**Narcotized.** Poisoned by the action of a narcotic, as opium.

**Natural rhythm of respiration.** Normal breathing.

**Nerve-center.** One of the countless impulse generators or reflectors in the body.

**Neutralization.** The act of rendering free or open.

**Nidus.** Center of activity.

**Nutrient.** Having food value.

## O.

**Occlusion.** Closing up.

**Ophthalmic.** Relating to the eye.

**Organic ferment.** The microbic action which gives rise to souring.

**Organized exudate.** A fluid discharge made solid by the formation of fibrin.

**Otitis media.** Inflammation of the chambers of the middle ear.

**Ova.** Eggs.

**Ovaries.** The two egg-bearing organs in the female.

**Oxidation.** Burning up.

**Oxygenation of the blood.** Refreshing of the blood by the action of the red cells in taking up oxygen.

## P.

**Parasitic organisms.** Dependent upon other forms of life for their food; may live in or upon the sustaining organism. Gonococci are parasites, as are also tapeworms and lice.

**Pasteur chamber and filter.** An apparatus for sterilizing and filtering by the action of superheated steam, varied in pressure by means of an air-pump.

**Pathogenic bacteria.** Disease producers.

**Pathologist.** One engaged in the study of the causes and results of disease.

**Pebrin.** A hereditary contagious disease of silkworms consisting of the development of peculiar parasitic corpuscles which invade the eggs, blood, and tissues of the worms, causing black spots to appear externally.

**Pedicle.** An elongated support.

**Pedicle silk.** Strong silk used to tie off the base of tumors before removal for security against bleeding.

**Pellicle.** Surface scum; an outer limiting membrane.

**Pelvic cavity.** Space within the pelvis.

**Pelvimeter.** Curved dividers used by the obstetrician in calculating the size of a woman's pelvis.

**Pelvis.** The bony framework at the base of the spinal column supporting the trunk and affording attachment for the thighs.

**Perforator.** A sharp, spear-headed instrument used by obstetricians to pierce the skull (to facilitate delivery) of a dead infant or one whose life must be sacrificed for the good of the mother.

**Perineal lithotomy.** The breech operation of cutting for stone.

**Perineorrhaphy.** The operation of sewing up a torn breech of a woman.

**Peristalsis.** The muscular wave-motion of the bowels.

**Peristaltic action.** The motion which propels the contents of the bowels.

**Peritoneal cavity.** The space occupied by the abdominal organs.

**Peritoneum.** The lining mem-



brane of the belly cavity and covering of the organs contained.

**Peritonitis.** Inflammation of the lining membrane of the organs and cavity of the abdomen.

**Petri dishes.** Small double dishes for the cultivation of micro-organisms.

**Phagocytes.** Body cells whose supposed function is to devour other cells as micro-organisms.

**Phagocytosis.** The function of active destruction by devouring or englobing of one cell by another.

**Pharyngeal paralysis.** Loss of voluntary power of swallowing, with dropping of the soft palate.

**Placenta.** The late womb connection between a fetus and its mother.

**Plague.** An acute contagious disease commonly appearing in epidemic form due to micro-organisms characterized by bubo formation and high death-rate.

**Plasma.** The fluid portion of blood or lymph.

**Pleurisy.** Inflammation of the pleura or membranous covering of the lungs and lining of the chest walls.

**Pneumonia.** Inflammation of the lungs.

**Precipitated.** Thrown down by chemical action.

**Preparatory treatment.** Making a patient ready for an operation, consists in local cleansing, attention to bowels and bladder, food, etc.

**Prone.** Lying upon the abdomen.

**Prophylaxis.** Preventive measures.

**Protective dressing.** A waterproof material placed next to a wound according to the direction of Sir Joseph Lister.

**Puerperal.** Relating to childbirth.

**Puerperal fever.** Elevation of body temperature occurring in infection after childbirth.

**Puerperal infection.** Systemic poisoning by the action of micro-organisms in a child-bearing woman.

**Pure culture.** Containing but one variety of germs.

**Purgative.** A substance which moves the bowels.

**Pus.** Matter given off from an open sore.

**Putrefaction.** Separation of an organic compound into the elements of which it is composed by the action of micro-organisms; rotting.

**Pyroxylin.** Gun-cotton; made by immersing raw cotton in nitric and sulphuric acids.

## R.

**Raw surface.** An open wound or abrasion; a condition in which the skin or outer lining of a part or organ is broken through.

**Reaction.** The restoration of vitality after shock.

**Rectum.** The lower extremity of the large intestine.

**Recurrent.** Returning again.

**Regurgitation.** A back flow.

**Respiration.** Breathing.

**Retention of urine.** That condition in which the urine, while it continues to be formed by the kidneys, cannot be passed from the body; inability to pass water.

**Revulsion.** A rejection; counter-irritation.

**Rigor.** Sense of coldness accompanied by a superficial convulsive seizure.

## S.

**Salicylated.** Containing a given amount of salicylic acid.

**Saliva.** Spitte.

**Saprophytic organisms.** Those living in or on decaying organic matter.

**Sarcoma.** A form of cancer of rapid growth and occurring most often in the young.

**Saturated.** Fully filled; soaked.

**Scapula.** The shoulder-blade.

**Scarify.** To cut into.

**Scarlet fever.** An acute contagious disease of childhood giving rise to high fever, rapid pulse, a rose-red rash, and with a marked tendency to be followed by kidney disease.

**Scultetus bandage.** An overlapping many-tailed bandage dressing.

**Secretions.** Special substances thrown off by functionally active organs.

**Sedative.** Soothing; softening.

**Septic.** Relating to putrefaction or pus-germ infection.

**Septic discharge.** Purulent; containing pus germs.

**Septic peritonitis.** Inflammation of the lining membrane of the organs and cavity of the abdomen caused by the action of pus germs.

**Septicemia.** A severe form of blood-poisoning in which both germs and their products are current in the blood.

**Sequelæ.** After-effects of disease.

**Sequestrum.** A dead mass, as a fragment of a dead bone.

**Serum.** The watery part of drawn blood separating on standing; the fluid in a blister.

**Shock.** The constitutional effect of a disease or injury.

**Sinus.** A disease tract or channel left after the discharge of a purulent collection.

**Specific bacteria.** Germs directly responsible for the given disease.

**Sphincter muscle.** Anatomical name for muscles whose actions are to close openings, as at the mouth and anus.

**Spica.** A spiral bandage done with a roller in a series of figure eights. Most used for the shoulder, groin, thumb, and great toe.

**Spirilla.** Spiral-shaped germs, as the spirillum of cholera (also called the comma bacillus).

**Splenic fever.** Disease due to the anthrax bacillus; wool-sorter's disease.

**Spore.** A germ seed.

**Spotted fever.** Epidemic cerebro-spinal meningitis or cerebrospinal fever; a specific infectious disease of the membranes of the brain and spinal cord and accompanied by a peculiar dusky rash.

**Sterilization.** Act of rendering free from germs.

**Sterilize.** To kill all germ life.

**Stethoscope.** An instrument for listening to the flow of air or blood inside the body.

**Stimulation.** Arousing to greater action; urging.

**Subcutaneous injection.** One made beneath the skin.

**Subnormal temperature.** Degree of body heat below 98° F.

**Supine.** Outstretched upon the back.

**Suppression of urine.** A condition in which the kidneys cease to act, no urine being formed.

**Suppuration.** The last stage of inflammation, manifested by destruction of tissue with pus formation.

**Suprapubic lithotomy.** Cutting operation for stone in the bladder attacked from above.

**Surgically clean.** As nearly as is possible to be free from germ life.

**Sutures.** The material with which a surgeon sews; the stitches themselves.

**Syncope.** Sudden loss of power and consciousness; fainting.

## T.

**Tampon.** A gauze or cotton plug; may have a string or tape attached for withdrawal.

**Technic.** The mode of working; plan or method of work.

**Tepid.** Moderately warm.

**Tetanus.** Lockjaw; a very dangerous germ disease characterized by locking of sets of muscles due to the presence of a poison developed by tetanus bacilli.

**Therapeutics.** The science of the application of medicines for the cure of diseases.

**Thoracic cavity.** The chest.

**Toxicity.** Degree of poison.

**Toxin.** Poison formed by germ life.

**Trachelorrhaphy.** Operation for the repair of a torn mouth of the womb.

**Tracheotomy.** Operation of cutting open the windpipe below the larynx for the purpose of admitting air to the lungs; done for closure of the upper air-passages.

**Traumatic delirium.** Brain excitement following serious body injury.

**Trikresol.** A refined mixture made from carbolic acid.

**Tubercles.** Local effects of the action of tubercle bacilli consisting of cheesy masses.

**Tuberculosis.** An infectious disease giving rise to general or local disorganization caused by the tubercle bacillus; consumption.

**Tumefaction.** A swelling.

**Turpentine stupe.** A piece of cloth or flannel dipped in spirits of turpentine after wringing out in hot water.

**Tympanites.** Distention of the abdomen caused by excess of gas in the stomach and bowels; may become drum-like.

## U.

**Ulcer.** A sore, attended by discharge.

**Ulceration.** Superficial death of a part.

**Ulcerative endocarditis.** A severe inflammation of the heart, ending with destruction of the valve leaflets.

**Undertaker's stretcher.** A portable board and trestle inclined table upon which a corpse is laid during the process of embalming.

**Uremic coma.** Loss of consciousness and physical condition following the absorption of urinary poisons in the late stages of kidney disease.

**Ureter.** The tube leading from the kidney to the bladder. It is of the diameter of a goose quill and about sixteen inches in length.

**Urethra.** The water pipe from the bladder.

**Urethral calibrator.** An instrument for determining the size of the canal.

**Urination.** The act of passing water.

**Uterine appendages.** The ovaries, Fallopien tubes, broad and other attaching ligaments of the womb.

**Uterus.** The womb; the hollow, pear-shaped pelvic organ which is destined to retain the child from the moment of its conception until the time of its expulsion at birth.

## V.

**Vaccination.** Inoculation of cow-pox lymph into the arm as a protection from small-pox.

**Vacuum.** Space in which there is no air.

**Vagina.** The female genital canal.

**Vaginal discharge.** A flow from the genital canal.

**Vaginal hysterectomy.** Removal of the womb through the lower genital canal.

**Vascular.** Pertaining to vessels.

**Venesection.** Bleeding; opening a vein to let out blood.

**Venom.** Animal poison.

**Venous pressure.** The weight and flow power of the blood stream in the veins.

**Venules.** Smallest branching veins.

**Vertex.** The crown of the head; highest point of the skull.

**Vestibule.** The beginning of the female genital canal.

**Virulence.** Poison-strength.

**Virulent.** Highly poisonous; destructive.

**Virus.** Any form of organic poison.

**Viscera.** The contents of the large cavities of the body.

**Viscosity.** Stickiness.

**Vulva.** The external genitals, private parts, the female external organs of generation.

## W.

**Wound drainage.** A method of providing for the escape of pus or serum drip from a wound.

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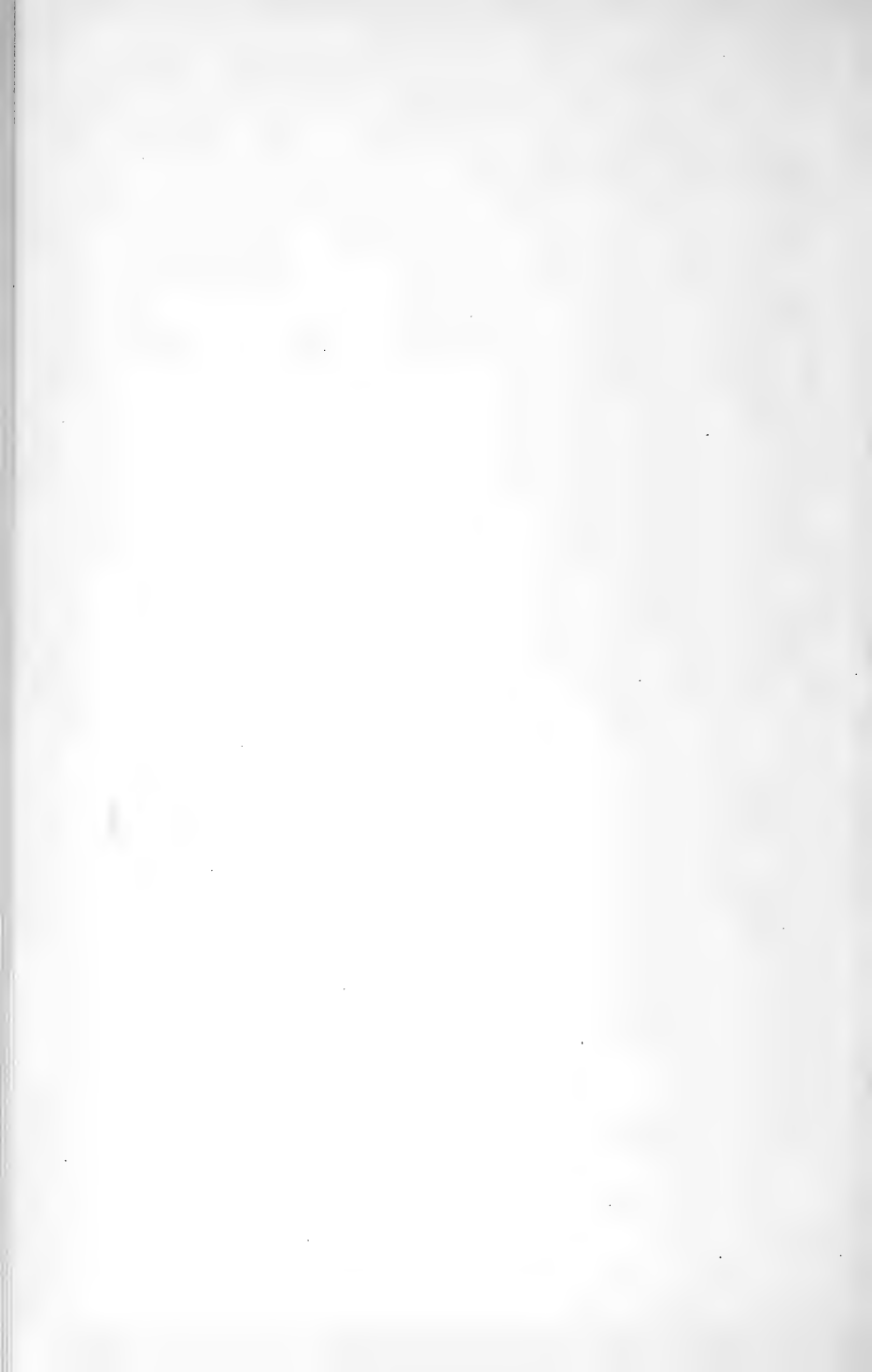
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