APOPLEXY series of symptoms resulting from interference with blood supply of the brain.

(a) Cerebral haemorrhage.
(b) cerebral thrombosis.
(c) cerebral embolism. } sudden onset.

Commonest site for cerebral haemorrhage is lenticular striate artery — one in every sphere. Usually in elderly people — 750 associated c. arteriosclerosis and hypertension.

Cerebral Haem.

S.+S. onset sudden - patient becomes unconscious
face flushed, stertorous breathing.
at onset pulse rapid, but becomes slow + full.
pupils dilated at first, later become unequal.
paralysis of opposite side of body to haemorrhage - flacid paral., becomes spastic
incontinence of urine and faeces.
large number die within 48 hours - may die from other things later on.

If patient survives, the paralysis becomes spastic, with increased tendon jerks, with +ve Babinski's sign (upper motor neurone effect, from spinal cord alone)
Some patients regain consciousness in few hours, but may remain in a confused state - may be unable to speak. Respiratory complications can occur quickly (br. pneum.)

Cerebral Thrombosis: clot in lenticular striate.
Assoc. c arteriosclerosis - usually occurs when p. at rest, and extent of paralysis depends on size of artery which is occluded. May be hemiplegia or monoplegia.

Cerebral Embolism.
Commonest site of embolism is left side of heart where there is mitral stenosis. (vegetations break up or clots) Poss. complication of bronchiectasis.
S.+S. Characteristic feature is sudden onset - unconsciousness, convulsions.
Mild - small artery - may not lose consciousness - becomes dazed and complains of headache. Extent of paralysis depends on size of artery occluded.

All three may cause haemiplegia. Throm. - for years. Haem. poss fatal.

APOPLEXY

Hemiplegia:

Caused by lesion on opposite side of brain, usually vascular. May also by cerebral tumours, head injury.

Admitted to Hosp. usually unconscious, -stert. breathing, flushed face-(one cheek blows in + out c̄ respiration as paralysed other side) incontinence of urine + faeces.

Management:

Admitted to well-protected bed - rubber - mattress or air-bed. Nursed on side with head + shoulders slightly raised to relieve congestion.

Paralysed limbs placed in good anatomical position - legs straight, slightly flexed at knee, heels protected. Arm abducted, wrist extended, and fingers extended.

Position changed from side to side every 2 hours - prevent br. pneum. + pr. sores.

Mouth + throat should be kept free from excess mucus + cleaned frequently.

Two hourly massage of pressure areas. Observation of bladder for signs of retention with overflow. - Catheterization necessary if this occurs - with strict aseptic precautions.

Care of bowels - small enemas on alternate days to regulate action. Bed changed as soon as necessary.

Diet - artificial while unconscious (Ryles')

When conscious, some voluntary movements lost, grad. some return of power to affected muscles may occur, so physiotherapy as early as possible.

Always an amount of residue paralysis.

S.O.O.B. as soon as poss. to encourage to exercise + walk.

Encouraged to exercise paralysed limbs, and occupational therapy must be [illegible].

Knitting + weaving best.

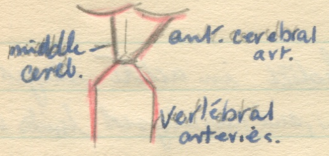
Patience + tact imp. (for nurse) in rehabilitation) + Speech therapy

May be allowed home if conditions there are satisfactory, otherwise an institution for the chronic sick.

APOPLEXY

Sub-Arachnoid Haemorrhage.

Circle of Willis : due to congenital weakness of blood vessels forming C. of W.
on surface of brain-base
or atheroma, aneurism or arteriosclerosis.



May occur at any age : as repeated small haemorrhages or one large fatal haem.

S+S. sudden onset of severe occipital headache (if survives)
vomiting.
stiffness of neck.
may become unconscious - coma.
possible Kernig's sign.
C.S.F. heavily blood-stained & under high pressure.
If p. regains consciousness c/o severe headache, may have strabismus
ptosis - paralysis of eyelids. Usually no paralysis (only squint & ptosis) Photophobia.

Tr. Patient is nursed in a quiet room - light shaded.
Bed well-protected - soft mattress, nursed in recumbent position.
Position changed from side to side. Don't flex head.
Careful nursing important. Unnecessary handling of p. avoided.
G. N. C. of unconscious p.
When conscious: analgesics necessary for headache.
Repeated L.P.'s to relieve pressure, some surgeons.
Sometimes Mag. Sulph. 50% retention enemas attracts fluids
(50% — 3ozs. Mag. Sulph. crystals to 6 ozs. water) Helps to relieve intra-cranial pressure.
In recent years surgery, with excellent results - selected patients (Ligation of ruptured blood vessel) prevents further attacks.

ANT. POLIOM. Poliomyelitis

virus - incubation period 12 days. Anterior poliom. - on fibres of motors - effect muscles.
At the beginning - whole nervous system involved. At onset - common cold, severe headache, aching limbs. Next stage - meningeal, photophobia, stiff neck, no retraction, sometimes +ve Kernig's, irritable. May recover now - abortive attack.
May develop to paralysis. Groups of muscles involved - in neck, - muscles of shoulder and arms, lumbar - lower limbs. Occasionally stem of brain - Medulla affected - Bulbar Polio - respiratory centre affected. Swallowing diffic. - pharyngeal muscles paralysis. May die from resp. failure if not in respirator.

Poliomylitis:

In fully developed polio - pain of affected limbs, and loss of voluntary power.
Diagnosis confirmed by Exam. of C.S.F. - proteins.

Tr. isolation to prevent spread.
all secretions + excretions disinfected in acute stages.
nursed in good anatomical position, and paralysed limbs well supported in position of rest.
Artificial respirator necessary if respiratory centre effected.
G.G.N.C.
unaffected muscle may spasm - cause shortning. Careful managment ∴ to prevent it. Physiotherapy important from beginning, but fatigue of muscles should be avoided.
Analgesics for pain, sedatives nocte.
In a few days, some recovery of muscle tone, if recovery slow - some paralysis will result.

Physio. excercise under water (no atmos. pressure - avoids muscle fatigue)
appliances - splints - calipers, to aid movement.
When resp. muscles involved, if any resp. residue paralysis - taught automatic breathing - like frogs (frogmen) When older - few years - breathe automatically.

Preventative - Salk vaccine.

When p. over acute stage + muscles restored as much as poss. - re-education may be necessary to fit them for suitable occupation.

PARKINSON'S DISEASE.

Progressive degeneration of brain, charactirised by lack of facial expression, intension tremor, shuffling gait. Later stage - saliva dribbles from the mouth, and usually become mentally deteriorated.
Causes: often history of Encephalitis Lethargica - virus inf. of brain - 10-20 yrs. avant.
Artane given to control tremor - may lead fairly useful life for many years, but R.P.B. - good nursing care later stages.

Aphr 247.

DISSEMINATED SCLEROSIS.

Scattered areas of degeneration of brain & cord. Begins at any age. Progress may be arrested at variable periods, but invariably fatal.

S+S. Onset - usually some disorder of muscles - weakness of leg muscles, awkward unsteady gait, diplopia, nystagmus (tremor when looking upwards) Speech slurred and slow & intentional tremor. Often remission of symptoms, sometimes for a few months, then s+s. becomes worse. Confined to bed later. Ambulant as long as poss.

Occupational therapy important in tr.

Well balanced diet.

When bedridden - prevent pressure sores, urinary infection & pneumonia.

No known cure.

Encephalitis Lethargica.

Inflammation of brain caused by virus.

S+S. drowsiness during day - restless and delirious at night.
headache, miserable, irritable, pyrexia during acute stages.
changes of personality often when recovers.
Maybe - Mental Home.
or may recover then 10-15 yrs Paralysis Agitans.

Tr. Isolation
G.N.C.
Sedatives may be necessary for delirium.
Re-education for change of personality.

GASTRO-ENTERITIS. (Infants) Thought to be due to virus. Dangerous condition, causing severe dehydration and toxaemia.

S.+S. vomiting and diarrhoea (up to 20 stools daily)
stools yellow & greenish or yellow & watery.
Then marked dehydration skin inelastic, eyes sunken, sunken fontanelle.
child has worried expression with wizened appearance
also - upset of electrolyte balance of sodium & potassium.

The younger the baby - the more serious the condition. pyrexia at onset, but later subnormal when dehydration.

GASTRO-ENTERITIS. Tr. Hospital - isolated in separate room to avoid spread of infection.
Nurses should wear gowns & masks.
Clothing, stools & napkins thoroughly disinfected before laundry - carbolic 1:20 - 2 hours
Hands - thoroughly washed after attention to child.
Nurse should not prepare feeds for other children or attend them.
Replace lost fluids - I.V. if possible, or sub-cutaneously.
- Hartmann's or Darrow's Solutions - (Sod. Pt. chlor., Sod. lactate, chlor., & Glucose)
If given subcutaneously - Rondase given also to aid absorption.
Nil orally until vomiting has stopped.
As condition improved - Hartmann's or Darrow's Solution orally, then fluids, etc.
Spec. Drugs Antibiotic course to prevent pneumonia.
Chloramphenicol sometimes used. 50mg / Kilogramme (2 lbs.) of body weight.

HYPERTROPHIC PYLORIC STENOSIS (congenital) obstruction to flow of food due to congenital thickening. More common in healthy boys. 2-3 weeks of age, the vomiting of more than one feed projectile - no bile in vomitus. (intussusception has bile in vomit)
Dehydration loss of weight, constipation.
Visible peristalsis - lumps in epigastrium.
If untreated - die from dehydration.
Tr. Restore lost fluids - IV. or sub-cutaneously
Surgical - Ramstedt's pyloromyotomy. - L.A. Xylocaine
Baby kept warm & supported on T-shaped splint - abdomen exposed
Pre-med. - 1/300 gr. Atropine.
Post-op. In fairly good condition.
Careful observation of baby. Teaspoon sterile water after 4 hours - given hourly - increased as tolerated. Normal feeding 3rd day if progresses.
If home conditions satisfactory, home on 4th or 5th day, Mother to bring back to have sutures removed on 8th day.
Medical Tr. Eumydrine (Atropine) by mouth to dilate sphincter (20 m a/c) for several months. Gradually dose decreased as dose improves. - if bad chest, etc.

BACILLARY DYSENTERY.

Sonne, dysentery – mild form, but can be dangerous in infants, or elderly
Shiga " " – severe.

Sonne Dysentery.

S/S. diarrhoea, abdominal pain
vomiting.
blood + mucous in stools
Pyrexia. 101–103°
Sweating, headache + malaise. – Tenesmus, sometimes.

Diagnosis confirmed – ex. of stool for organism.

Tr. isolation – gowns, hands, linen, excreta., until stool free from infection
fluids – nourishing.
non-residue diet (milk, eggs, custards, junkets) then, more solids later.
If dehydration marked – I.V. may be necessary.

Spec. drug Sulphaguanadine }
Sulphasuccadine. } in large doses.
Sulphathaladine. }
G.N.C.
3 negative stools before cured (stools after disappearance of symptoms)

Shiga dysentery.

Confined to tropical countrys.

S/S. similar to Sonne Dysentery, only worse.
Pain severe – mucous + blood passed.
Toxaemia
Loss of weight
Dehydration.
Tenesmus.

Diagnosis – stool.

Tr. similar to Sonne.
I.V. necessary.
G.G.N.C.
May get severe anaemia – extra iron given.

Bacterial food poisoning.

Fungi, tinned, but majority due to bacteria. - Salmonella Bacillus (7 types) & Staphylococcus (toxin)

Botulism.

Reheated or pre-cooked food (carriers) pies, milk foods, synthetic creams, custards.

S.+S. 4-6 hours after eating infected food:
- abdominal pain
- vomiting
- diarrhoea,
- shivering
- rigors & collapse
- T — 102-104°
- weak, rapid pulse.

Diag. confirmed by exam. of stool

Tr. isolation
- restore lost fluids
- chloramphenicol for salmonella.
- + P also given.
- palliative Tr. of symptoms - analgesics & sedatives.
- free from infection after 3 negative stools.

Botulism.

Caused by toxins of Clostridium Botulinus, normally lives in soil. Harmless unless deprived of air, then liberates toxins (aerobic) food - unless antitoxin given - fatal.

S.+S. difficulty c̄ resp., swallowing
- diplopia.
- die from respiratory failure.

In tinned root vegetables, potted meats & pastes, if food not adequately sterilised before sealing can.

(20 died of wild duck paste)

TYPHOID or ENTERIC FEVER.

Bacillus typhosus (Eberth. belongs to Salmonella group) in intestine - inflames the Peyer's Patches of ileum - into then blood stream
Infectious disease transmitted by infected food - water, milk, pre-cooked food, ice-cream, fish - esp. shell-fish in river where sewerage emptied.
Incubation period 14 days
S.ts. Onset gradual - malaise, headache, abdominal discomfort.
Constipation at first.
Gradual rise in temp. - staircase pattern. (2° up E., 1° down M.) then continuous
S.ts. become worse as temp. rises - take to bed.
Diarrhoea - pea-soup stool. Severe toxaemia - delirium, restlessness, insomnia
2nd week agglutination test on blood (Widal) +ve - antibodies - agglutinins formed in the blood - specific to B. typhosum - isolated in stools & urine. rose-coloured spots.
3rd If progresses untreated - p. becomes worse - L.I.B. - lying in delirium. picking at bedclothes. critical week - may die from toxaemia, perforation of wall of intestine or br. pneumonia. Haemorrhage may also occur P.R.
Tr. isolation - sputum, urine & faeces infectious.
nursed in well-ventilated room on rubber mattress.
semi- or recumbent position - changed side to side QQH.
Pressure-areas, mouth scrupulously clean.
Sponging daily. Tepid sponging frequently to soothe & ↓ T.
Diet fluids & low residue diet during acute stage - nourishing.
Chloramphenicol (3G daily - 50 mg/Kg body weight for child)
Dramatic response - few days temp. subsides. S.ts. gradually subside but occasionally sudden rise of temp, which will gradually settle. (Chloramphenicol - toxins liberated by Chl. killing orgs)
G.G.N.C.
Nourishing diet important when recovery - ravenously hungry.
Encouragement, and reassurance.
P. may remain a carrier for quite a long time. B. Typhosus remains in G.B., and occasionally outpouring of bile into intestines.
Cholecystectomy sometimes done.
Saline every morn to empty G.B., then Chloramphenicol
Complications Perf. haem, br. pneum., occas. - fem. thrombosis, pericarditis & heart failure.

Ca BREAST may occur in both sexes.

S/S. early - painless lump.

2nd - lump becomes fixed to surrounding tissues - pectoralis major muscle - to axilla glands - hard + enlarged masses in axilla. Skin covering breast becomes roughened - orange peel.

3rdly - may ulcerate + bleed, or evidence in 2ndies in lungs, brain, spine.

Tr. Radical mastectomy, followed by deep X-Ray therapy.

Prep. of P. - gen. health investigated - X-Ray chest to exclude metastases.
Exam of blood - Hb, grouping + X-typing.
Admitted few days before, taught deep breathing exercises.
Gen. pre-op. care - shave axilla + arm on affected side, etc.

Local skin prep. - all ant. aspect of chest + affected side of post. asp. + arm.

Op. includes removal of all breast tissue, pectoralis major muscle, axillary glands, + any neighbouring glands which can be removed.

Skin flap sutured + 2 drainage tubes in situ - 1 in front of axilla to drain large dead space - large amount of serum oozing - axilla may be attached to bottle (under water drainage) or low pressure sucker + gentle suction applied. Other corrugated tube near lower end usually removed on third day.

Axilla tube in situ until no further drainage of serum - 7-8 days.

Sutures - alternate 10th day, rest 11th day.

Occasionally B.Trans. in progress on return from O.T. - When consc. - propped upright grad. + arm on affected side elevated on pillow. Analgesics, etc.

On 2nd day - p. encouraged to move fingers + hand of affected arm, then end of day - full arm - elbow + shoulder joint. By 5th day - should be able to comb hair with affected arm.

If cond. satisfactory 2nd day S.O.O.B. - breathing + leg exercises encouraged. and 12-14 days home if satisfactory.

Post.-op. complic.s :- Haemorrhage.
Haematoma.
Collections of serum in pockets, or sloughing of wound - breaks down.
Broncho-pneumonia.
Oedema of arm (due to interference of lymph drainage.
Paralysis of one or more arm muscles. (pressure on br. plexus on op. table)

Further tr. Deep X-Ray therapy + this tr. causes distress to some patients - cannot tolerate - attacks of vomiting.

Skin graft sometimes on wound during operation. - Dressing untouched for 10 days.

Advanced Ca breast ½ secondaries — Ovaries - bi-lat. salpingoophorectomy + bi-lat. adrenalectomy (adrenal glands)
Arrests progress of spread + sometimes improvements in deposits.
This alleviates pain.

FIBRO-ADENOMA — Benign tumour. Small, painful + mobile lump. (Ca fixed)
All breast tumours should be removed for biopsy, so shelled out (in capsule)

BR. ABSCESS. — in nursing mothers, due to infection through abrasion.
S+S. pain + swelling.
redness, tenderness.
often loss of function -
gen. s. toxaemia - ↑T, hot dry skin, anorexia, malaise.
as condition progresses - localised area of redness + fluctuating c̄ fluid (pus)
Tr. early stages - rest, support. antibiotics (usually P.)
when abscess develops - incision and drainage.
Post-op. some Doc.'s order irrigation of cavity, or drainage tube, which is removed when no further discharge.
Analgesics for pain + sedation.

CHRONIC MASTITIS — usually bi-lateral.
S+S. pain + tenderness. Develops into cystic nodules often.
Tr. support and if any suspicion of Ca - send nodules for section + analysis.

HERNIAS. — protrusion of contents of abdomen through some weakness of muscular wall.
Common sites - inguinal canal;
femoral canal - more common in females.
umbilical. - corpulent patients - children.
hiatus, diaphramatic.
incisional.

Inguinal Hernia

Common site - more common in males.

S+S. lump in inguinal region - enlarged during lifting or coughing - reducable.
if severe pain - vomiting, severe pain, abdominal distension - strangulation.
- acute intestinal obstruction - Same S. + S.

Tr. surgery - herniorrhaphy - opening of canal, excise hernial sac, abdominal contents back in position and repair of canal - catgut, silver wire, silk, steel gauze or Gallie's fascia lata graft. (hernioplasty - for recurrent hernias).

Same tr. for other hernias.

STRANGULATED HERNIA.

S.+S. colicky intermittent pain.
Severe abd. pain + distension
vomiting - stomach, bile then faecal.
absolute constipation
dehydration ↓ B.P., weak rapid pulse, etc.
palpable mass - tender - irreducable - no cough impulse - over inguinal region.

Tr. urgent - immediate op.
When diagnosed - analgesic - Pethidine.
Ryles' tube + aspirated.
Blood - group + X - matched - tested for chlorides.
If dehydrated I.V. before taken to O.T.
Laparotomy - loop of intestine released. Gangrenous - black + does not return to normal colour - anastomosis + repair of canal.

Post-op. Aspiration of stom. contents.
I.V.
Analgesics.
Antibiotic course - P. + Str. or Terramycin.
Etc.

Strangulation occurs more often c̄ femoral hernia, ∴ should be repaired as soon as possible.

Umbilical - in baby - folds of skin from either side + Elastoplast.
- in adult - repaired - transverse incisions, contents back repair muscle.

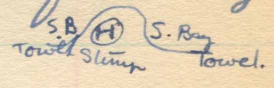
Post-op. care of hernias. S.O.O.B. 2nd day. unless comp. – strangulation, and gen. post op care. Leg excercises. Gallie's graft requires longer convalescence.

AMPUTATION

<u>Indications</u>
- Gangrene
- Severe crushing injuries.
- Sarcoma.
- Severe deformity (congenital.) – below knee.

Pre-op. care – general.

<u>Post-op. care</u> – Divided bed – so that stump can be observed for haemorrhage. Stump flat on bed, immobilised between sandbags. to prevent painful contractions of muscles – nerves severed.



R.P.A.O. – B.P. & P. Etc.

Tourniquet kept in readiness in case of severe haemorrhage. I.V. of blood often in progress, esp. if for crushing injury. When conscious, p. complains of severe pain of amputated limb (– phantom limb) – analgesics given as soon as possible.

<u>Care of stumps</u>: Dressing only changed if absolutely necessary (eg. haemorrhage, infection or bandages loose.) Bandaging important – in an endeavour to shape the stump so that artificial limb may be worn comfortably. Bandages tight and firm near tip of stump then gradually relaxed ⋃ shape.

Alternate sutures out 9th day – remainder 10th, depends on Dr.

<u>Physiotherapy</u> as soon as possible gentle movements of the stump, and 3-4 days p. encouraged to do active excercises to keep thigh muscles in good condition.

Before discharge, fitted with artificial limbs – may be several weeks before they can wear them (suture line painful)

→ If p. has has severe crushing injury – on admission to B.B.H. treat for shock and A.T.S & anti gas gangrene serum, blood grouped and X-typed – transfusion usually necessary, and prepared for Theatre. Post-op. further tr. for shock – careful explanation by surgeon of operation and T.L.C by nurse. Careful observation of urinary output, as badly crushed muscles release chemical substances which may cause renal failure – F.B.C.

AMPUTATION.

Haemorrhage: secondary, may occur if any infection. Direct pressure ̄c pad + extra pressure bandage.

If blood pours out – direct pressure ̄c hands on bleeding point – send for Doc. + cover blood. If absolutely necessary – tourniquet + treat for shock.

Rheumatoid Arthritis.

More common in women, exact cause unknown

Predisposing causes: general ill-health.
endocrine disorders
chronic infection (ch. t''itis)
worry + anxiety over period of years.
nutritional – lack of vitamins.

Usually occurs early adult life 20–40 yrs.
Early S.+S. stiffness of joints, sweating, pallor.
Acute symptoms develop – pyrexia, malaise, anorexia, sweating.
Affected joints – several – painful + swollen. Most common joints – wrists, fingers, elbows, knees, ankles.
E.S.R. raised.

As acute stage subsides – stiff joints – muscles on affected sides are wasted. – spindle-shape appearance. May get ankylosis of joints, and gross deformity. Aim of treatment to prevent the deformity. Ulnar deviation of fingers.

Tr. during acute stages – R.I.B. well balanced diet ̄c extra vitamins.
limbs in position of rest, but full range of movement daily

As acute stage subsides – physiotherapy – massage, exercise, application of heat to joints before exercises – liniments – Methy Sal.
– Packs
– Infra-red, or Diathermy.
– Wax baths. (120°F)

Drugs. Analgesics: Aspirin gr. 10–15. q.q.h.
Cortisone – effective for short time only – swelling of joints subside, pain relieved, but tr. can only be continued for 3 months only (Side effects – oedema, etc.)
A.C.T.H. – stimulates adrenals to produce Cortisone

Rheumatoid Arthritis.

Butazolidine: swelling down, relieves pain, but danger of agranulocytosis.
Gold salts – 12 weekly injections, causes agranulocytosis, renal failure, etc. Not often used.

Give p. encouragement to exercises – show them that not an incapacitating disease if exercise.
If crippling occurs despite tr. – orthopaedic surgery may be necessary – cutting muscle tendons, and reduction of deformity under G. A. Skin traction, or plasters to keep limb in position.
Still's Disease – Rh. Arth. affecting young children. Tr. the same. Does not affect heart – gross deformity & ankylosis complication.

OSTEO-ARTHRITIS

degenerative condition of articulating hyaline cartilage. Occurs usually after age of 45 years. Spikules of bone protrude through hyaline cartilage, friction and pain caused.
Predisp. causes – overweight, trauma & advancing years.
S. & S. pain in joint on movement.
no change in general health (us. only one joint involved)
Diagnosis confirmed by X-Ray.
Tr. exercise & massage during early stage to prevent stiffness
analgesics.
severe cases, esp. hip – arthrodesis or arthroplasty.

ANKYLOSING SPONDYLITIS

Inflam. of sp. column causing fixation of vertebrae. Progressive disease and eventually spine becomes rigid. Usually confined to men – often young, progresses over years.
Physiotherapy helps to slow progress of condition. Breathing exercises important to help chest movements. Often die from chest complications.

SHEURMAN'S DISEASE

between 2-3 vertebrae, not progressive.

GOUT

Disease of metabolism – accumulation of uric acid in toes, – tophi. – collections of crystals – Purine bodies in liver, sweetbreads, port.
Pain & swelling of joint – subsides after about 10 days. Drug Colchicum

CATARACT. opacity of lens (normally transparent)

Causes: 1. Diabetes.
2. arteriosclerosis - advancing age.
3. Trauma.
4. Congenital.

S.+S. Impairment of vision - progressive.
Whitish mass behind pupil.

Tr. Extraction of lens, when completely opaque.

Pre-op. care Usually elderly - admitted to B.B.H. few days before to get used to surroundings. 1/ General health investigated. Urinalysis for sugar, chest for respiratory infection / cough - prolapses iris post-op.) 2/ Smear of ear secretions to Path. Lab. for pathogenic secretions. 3/ Mental state - confusion, etc.

Immediate pre-op. care - often done under L.A., but some do G.A.
Eyelashes cut - smear vaseline on scissors, so no lashes in eye.
Sedative some hours before (Largactil + sedative, Nembutal)
Pupil dilated - Atropine 1% or Homatropine 2% (less toxic)
Under L.A. — Cocaine or Decicaine drops instilled. (Hour before op. - the few drops in every 5 minutes)
General Prep. similar to any operation (Retrobulbar block)

Post-op. care Both eyes are covered - gently lifted off table onto trolley - nurse supporting head. Gently returned to ward. R.I.B. semi-recumbent position - head well supported. First two days - kept quiet. Nurse should approach bed gently, but talk to patient from foot of bed (don't get fright / jump.)
Easily masticated food given & during movements in bed - one to support head.

Local tr. of eye After 24 hours - eyes uncovered & gently irrigated & covered again, after instilling 1cm. Atropine instilled in affected eye. Repeated daily.
2-3 days - 3rd eye uncovered. 7th day - suture removed, p. given dark glasses to avoid glare. S.O.O.B. usually 3rd day - not walk about.
Two nurses helps in & out of bed.

Complications: 1. Haemorrhage.
2. Prolapse of iris.
3. Confusion & delirium - may be due to Atropine (toxic - deliriant) - or caused by both eyes covered - uncover unaffected eye & instil Homatropine.

GLAUCOMA. Increase in intra-ocular pressure – acute or chronic. Blockage of Canal of Schlemm (maybe caused by iritis, shallow anterior chamber)

S/S. Sudden onset – pain in eye, headache.

Acute Impairment of vision.
Vomiting.
O/E eye-tension increased.
pupil oval, instead of round.

Tr. urgent – pupils contracted – Eserine 1% or Pilocarpine – thins iris & relieves pressure
analgesics – Morphine often necessary.
surgery – trephine to allow escape of fluid.

Chronic Gradual impairment of vision.
Usually no pain
O/E eye-tension hard.

When diagnosed – operation, though not urgent. If p. not fit enough – pin holes to relieve + eserine.
Also given diuretic to limit formation of aqueous humour – Dianox.

→ CONGENITAL CATARACTS Cataracts soft. Tr. "needling" – needle to lens, contents escape to inside of eye & absorbed. Impairment of vision, even with treatment, and special glasses necessary.

STRABISMUS. Inability to focus both eyes on one object, due to weakness of muscles moving one or both eyes. Slight squint – Tr. successfully by special spectacles and excercises – orthoptics.

Severe – may require surgery – tenotomy on affected muscle
or tenotomy c̄ advancement – forward into sclera
or tenotomy c̄ recession – moving further back.

Child usually > 7 years (more co-op.) gen. Anaesthetic.

Post-op. care: Both eyes covered – at least 7 days.
restrain & occupy child.
gentle irrigation daily.
8th day – sutures removed & spectacles are worn.

HAEMOPTYSIS. Causes 1. Pulmonary tb.
2. Ca lung.
3. Bronchiectasis.
4. Injury.
5. Mitral Stenosis.

Tr. Reassure.
Raise head + shoulders - 3 or 4 pillows.
Incline to infected side.
Send for Doc.
Cover blood + give bowl.
Swab mouth.
Prepare hypo. tray. - Morph. small dose (1/6) resp. depressant.
If severe - Blood transfusion.
If doesn't stop - artificial pneumothorax

Ca. Lung. Non. prod. cough.
When prod. later - streaked c̄ blood.
X-Ray - bronchoscopy.
Tr. pneumonectomy.

Tb Lim. rest in plaster to immobilize joints - 6-12 months.

H. Cause: arteriosclerosis, renal failure.
Tr. Serpasil ·25 - ·5 mgm. } together at first.
Ansolysen. 40 mgm. }
As B.P. <'s. Serpasil + Amytal.
Overweight - reduce + quieter life.

EPILEPSY To reduce fits - Drugs - Pb anticonvulsants
Epanutin + Dilantin. (less toxic than barbiturates)
Status Epilepticus - may die from heart failure.
Tr. Sodi. Phenobarbitone gr. iii I.M.
Employment of Epileptics - not steeplejacks, open machinery, kitchens (no safe occups.)
Low mentality - work on farms, gardens, etc.
Petit Mal no loss of consciousness Grand Mal - aura, chronic, coma.

ECZEMA

Tr. remove cause.
weeping stage - emulsion of calamine
dry stage - zinc cream + calamine.
antihistamine drugs., phenergan, anthisan.

MIGRAINE

Contraction of branch of cerebral artery, then dilatation, causing pressure on one side of brain-oedema - causing vomiting, headache on one side, visual disturbances.
Tr. quiet room.
Codein.
~~Femergin~~ Ergotamine tartrate - prevent cerebral artery contracting.

POISONINGS.

Corrosives.

Irritants: arsenic lead phosphorus.
pain in throat, chest + epigastrium - vomiting later + abdominal pain - griping.
Emetic, aperient, demulcent (albumin, no oil for phosphorus)
stimulants + O_2

Convulsants: strychnine, prussic acid (cyanide in dry state - gives off prussic acid with fluid)
pain quickly - severe convulsions, death in minutes.
Small amounts of strychnine lethal.
Tr: emetic, S.W.O. — Doc.
Aperient + sedative.
Light G.A. for convulsions, if possible.
Prussic Acid - not much - shock, antidote — inhale ammonia?
Kerosene: Doc - or Cas.
Warmth + reassurance.
S.W.O. (long tube to funnel)
MILK - then Hosp. + Ward.
$\uparrow T^o$
Petrol, etc. Antibiotics (br. pneum.)

BARBITURATE POISONING.

S. + S. drowsy or comatose (effects resp. system)
Respirations slow + shallow
If conscious - pupils small.
" unconscious - pupils dilated.
May die from circulatory or respiratory failure - no B.P., pulse weak.
If survives for few days - poss. { hyperpyrexia - effects heat-reg. centre. { hypostatic pneumonia

Tr. S.W.O. c̄ warm water.
Picrotoxin may be given (> causes convulsions) 5-20cc. I.V.
To Ward - nurse flat, from side to side.
O_2 mask for cyanosis.
I.V. - usually Dextrose 5% - Megimide 10cc.'s } into IV. every 5 minutes
Daptazole 15 mgm }
Methidrine 30 mg. may be used to elevate B.P.
X-P. given to cover hypostatic pneumonia.