

6TH AUGUST, 1980

EXAMINERS' GUIDE TO SURGICAL NURSING - SECTION B3795-17
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The following is forwarded as a general indication to examiners of the essential information expected in answers to the various questions. The suggestions are not intended to be either complete or inflexible, but it is hoped they may be of some guidance to examiners and to that extent lead to uniformity of marking.

- Question 1.
- (a) Anterior and posterior tibial arteries. - (2 marks)
- (b) Intermittent claudication - diminished arterial supply or tissue perfusion, - in legs on walking - muscles are ischaemic.
Coldness of extremities - arterial blood flow reduced.
Skin colour changes - pale - arterial blood flow reduced. Cyanosed - sluggish circulation. Distal pulses - weak or absent. Sensation diminished - blood supply to nervous tissue reduced. Ulceration - skin damaged due to anoxia. Gangrene - absence of blood supply to area, leading to gross tissue necrosis. - (4 marks)
- (c) Arteriography. Ultrasound blood flow detectors, Oscillometry.
Skin temperature studies. Reactive hyperaemia. Clearance measurements using isotopes. - (1 mark)
- (d) Position lower limb - horizontal. Head of bed may be raised. Special exercises. Analgesics. Vasodilator drugs. Warm clothing and environment. Skin hygiene and care. Avoid vasoconstricting factors, e.g., smoking, emotional stress, constricting clothing. Avoid trauma, local heat, rough handling, etc. - (3 marks)
- (e) Adequate explanation of operation, post-operative care and objectives of rehabilitation programmes. Reinforce explanation of physician and surgeon. Stress that amputation will eventually relieve pain and enable patient to walk again with aid of an artificial limb. Help patient to accept altered body image, accept limitations realistically, involve whole family in the preparation. Listen to patient and family - establish open and honest communication. Encourage patient to meet rehabilitation team and meet a well-established amputee. - (3 marks)
- (f) Wound Care - Observe for haemorrhage. Drain tubes - removed when drainage is minimal or ceases. Stump dressing suitable, adequate to give support. No pressure on wound. Adequate analgesics.
Stump Care - Position - flat on mattress - firm. No pressure on stump. Prevent flexion deformity, and abduction. Prone position - short periods, e.g., 1/2 hour twice daily. Proper bandaging technique - moulding of stump important. Start as soon as wound heals, help to mould limb for prosthesis - mould into a good cylindrical shape that will fit the prosthesis. Early limb fitting. Explain and reassure about phantom limb pain. Support, encouragement, understanding. - (7 marks)
- (20 marks)

Question 2.

- (a) The process of expanding the ostium uteri (cervix) to permit scraping of the walls of the uterus. -(2 marks)
- (b) 1. Diagnostic, e.g., infertility. 2. Amenorrhoea - endometrial biopsy. 3. Therapeutic abortion. 4. Remove remnants of tissue after an incomplete abortion. 5. Therapeutic - removal of a polyp. 6. Diagnostic, e.g., dysmenorrhoea or menorrhagia. -(2 marks)
- (c) 1. Permission for operation form. 2. Bowel preparation - e.g., aperients or small enema. 3. Bladder emptied, urine tested. 4. No skin preparation in most cases. 5. Fast. 6. Dress for theatre - tape rings - no hair pin; false teeth out. 7. Prea medication. -(4 marks)
- (d) Lithotomy position. Both legs lifted up at the same time - to prevent strain on the sacro-iliac joint. Legs should be bent at an angle of no more than 90° to the body. Lower legs should be supported along the whole of the calf to prevent D.V.T. -(2 marks)
- (e) 1. Vital signs - indicate the circulatory competence and any symptoms and signs of shock and haemorrhage. 2. p.v. loss - indicate any haemorrhage - a certain amount of p.v. loss is normal but large amounts or clots indicate haemorrhage. 3. Micturition should be normal after 8-12 hours and for adequate hydration - anaesthetic or pain may inhibit micturition. 4. Pain - a certain amount of pain which can be relieved by analgesia is expected, but if not relieved by analgesia it may indicate perforation of the urethra. 5. Temperature - elevation may indicate infection. -(3 marks)
- (f) Some vaginal loss until next period is normal. Do not resume sexual activity until after next period if profuse or frank bleeding occurs, see R.H.O. -(2 marks)
- (15 marks)

Question 3.

- (a) Investigations - chest X-ray, full blood examination, biopsy, mammography. -(2 marks)
- (b) Minimum area - shoulder - pubis,
- Axilla,
- bedline - opposite nipple line. -(2 marks)
- (c) (i) Promotion of drainage.
Limit movement.
Observations.
Diet.
No tension on suture line.
Asepsis.
- (ii) Position.
Exercises & movement.
Analgesia.
- (iii) Initially movement of wrist and fingers.
Later gradual shoulder movement and increase range.
Encouragement.
Position arm to help reduce oedema. -(6 marks)
- (10 marks)

Question 4.

Record T.P.R., B.P., frequently to detect haemorrhage and shock.
Urinalysis and urine specimen studies for degree of haematuria.
Observe area of flank for swelling, and abdominal rigidity.
Radiography.
Degree, position and type of pain.
Report nausea and vomiting.
Hb. - to detect anaemia.

-(10 marks)

Question 5.

- (a) Flail chest injury. -(1 mark)
- (b) Control paradoxical movement with large firm pad or binder.
Give mouth-to-mouth resuscitation if necessary. -(2 marks)
- (c) To drain blood from pleura and allow expansion of lung, while preventing the entry of air or bacteria from outside. -(1 mark)
- (d) Keep below chest level. Ensure secure connections. Allow sufficient slack in tube for normal movements. Pin tube securely to pillows or bed. Prevent pressure on or bending of tube. Clamp before changing bottle. (Controversial - accept reasonable regime). Milk tube at intervals. Observe and record drainage. Observe fluctuation in underwater seal container. Observe patient for signs of distress. -(4 marks)

-(6 marks)

Question 6.

- (a) Temporary paralysis of bowel causing cessation of peristalsis, due to interference to its nerve supply. -(1 mark)
- (b) Peritonitis. Haemoperitoneum. Shock. -(1 mark)
- (c) Copious vomiting/gastric aspirate. Patient feeling unwell. Abdominal distension. No flatus or faeces passed. -(2 marks)
- (d) Nil orally. Naso-gastric tube aspirated (continuously, intermittently - hourly). Replacement intravenous fluids, added electrolytes, antibiotics if ileus due to infection. Fluid balance chart. Observations for signs of improvement. Sedation to relieve anxiety. -(3 marks)

-(7 marks)

