A Case Study

Congenital Hypertrophy of the Pylorus

By

Sr. Mary Varkey, St. Ann's School of Nursing, Vijayawada

RAJA 26 days old baby was admitted with vomitings soon after feeds, and constipation. He belonged to a middle class Hindu family, and was much loved and cared for by his parents.

He was enjoying good health for 11 days after birth. Raja started having vomiting 15 days before admission to the hospital. He was being treated by a private practitioner, but there was no improvement. He was admitted with history of projectile vomiting since 15 days. He also had constipation for the last 6 days.

Typical Signs:

(i) Projectile vomitings; (ii) Deterioration of the general condition; (iii) Rapid loss of weight; (iv) Dehydration; (v) Palpable mass in the epigastrium; (vi) Visible peristalsis from left to right and fullness in the epigastic region were present and (vii) Constipation.

Provisional Diagnosis:

Congenital hypertrophy of the pylorus.

Medical Treatment Given:

1. Nasal feedings—3 hourly. The feed contained half to one ounce of citrated milk, glucose, water.
2. Intravenous fluids. Dextrose saline by slow drip.
3. Piptal drops—6 drops, 10 minutes before each feed.
4. Carmicide ½ teaspoon tid.
5. Propped up position.

But there was no improvement in his conditions; the projectile vomitings continued.

Investigations:

1. Heamoglobin Hb% was 11.1 gm%
2. Barium Series

After giving barium meal (20 cc of 1:3 Barium meal) films were taken at the intervals of 5 mts., 30 mts., 1 hour and 2 hours. The 1st film after 5 minutes showed defective filling in the mid-stomach and enlargement of stomach; the 2nd film after 30 minutes showed contracting stomach. No meal had passed through the pylorus; the 3rd film after 1 hour revealed that very little meal had entered the item; the 4th film after 2 hours showed stomach still containing appreciable quantity of the meal. Duodenal cap was not seen in all the films. His case was diagnosed as pylorus stenesis.

Pre-operative Nursing Care:

Raja's personal hygiene and needs were attended to. Intravenous fluids were given to correct dehydration and electrilyte imbalance. Urine output was checked and charted against the intake.

Consent for the operation was signed by his father. His parents were explained about the operation, their doubts were cleared and they were reassured. On the morning of the operation, stomach wash was given with normal saline.

Skin Preparation:

The area of the skin from nipple line above, to the thighs below, was cleaned and covered with sterile pad.

The baby was sent to the operation theatre with the Ryle's tube in situ and the I.V. fluids (5% Dextrose with normal saline) on flow.

Anaesthesia:

Local anaesthesia, Xylocaine infiltration 0.5% cc with very light open Ether was given.

Operation:

Right upper paramedian incision was made. Abdomen opened by splitting the rectus muscle. Distended stomach and pyloric hypertrophy were visualised. Pylorus was drawn out and the hypertrophied pylorus was demonstrated. The thickened pylorus was held in the surgeon's hands and incision was made between the superior and inferior borders in the long axis of the pylorus. Muscle layer was separated with a blunt forceps till the muscosa prolapsed through this muscle incision. Duodenal fornices were checked for leakage from the stomach. Haemostasis was checked. Pylorus returned and abdomen closed in layers. The suture line was covered with dry dressing and strapped.

Post-operative Care:

The patient was received in the ward after operation. The post-operative orders of the surgeon were:

1. Nothing orally for 24 hours.
2. Ryle's tube aspiration every hour.
3. Slow Intravenous drip for 24 hours.
4. Inj. Pencillin 1 mgm I.M. BD × 3 days.
5. Feeds after 24 hours—2 hourly feeds—sips of water and wean glucose water, citrated milk, and milk were introduced gradually.
6. For sedation Inj. largactil 2.5 mg I M.

Baby's position was changed frequently to prevent lung complications. Ryles tube aspiration was done hourly for 24 hours. First feed was given through the Ryles tube and then tube was removed. He was given small feeds every 2 hours. Since he tolerated his feeds, quantity of the feeds was increased gradually. His mother was allowed to carry him. His bowels were regular.

On the 9th day sutures were removed. The union was very good. His recovery was rapid and satisfactory. He was discharged on the 11th day. His parents were advised to bring the baby for follow up. Within a month after his discharge, his gain in health and weight was marvellous.

Bibliography:

1. James Moroney, **Surgery for Nurses,** page 506-408.
2. Katharine F. Armstrong, **Surgical Nursing,** page 276-278.
3. Kathreen Newton Shafer, **Medical Surgical Nursing,** page 603.

I C N NEWS

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The Board reviewed plans for the ICN meetings in Kenya. A special session is being planned during the CNR meeting for discussion of socio-economic welfare programmes for nurses.

A joint ICN/WHO workshop on primary health care is being held following the CNR meeting (September 30-October 1). The Board decided that participation in the workshop will be open to the two national representatives of each association attending the CNR and two additional nurses named by each member association, who have experience in primary health care.

The Board approved a procedure for establishing/maintaining/discontinuing relationships with international organizations, and for a regular periodic review of the total programme of relationships with international organizations.

The Board received committee reports on ICN finances, the 3M fellowship programme, ICN's relationships with international organizations, socio-economic welfare of nurses, ICN membership, and amendments to the ICN constitution. Staff reports to the Board covered field work and representation at international and regional meetings, ICN publications, and joint projects with other organizations.

Members of the ICN Board of Directors present were, Olive Anstey, President, Australia; Rebecca Bergman, First Vice-President, Israel; Verna Splane, Second Vice-President, Canada; Hildegard Peplau, Third Vice-President, USA; Ang Mun Moi, Singapore; Marie-Louise Badouaille, France; Annamma Cherian, India; Elouise Duncan, Liberia; Ingrid Hamelin, Finland; Eileen Jacobi, USA; Eunice Muringo Kiereini, Kenya; Syringa Marshall-Burnett, Jamaica; Sheila Quinn, United Kingdom; and Fe Valdez, Philippines.

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MISS REIMANN DEAD

CHRISTIANE Reimann, the first Executive Secretary of the International Council of Nurses (ICN), died in Siracusa, Italy, on April 12. Miss Reimann was 92 years of age.

Born in Denmark, Christiane Reimann graduated from Bispebjerg Hospital, Copenhagen, in 1916. She obtained her Bachelor of Science and Master's degrees from Columbia University, New York, USA. She became the first nurse instructor at Bispebjerg Hospital.

In 1922, Christiane Reimann was elected ICN's Honorary Secretary. In 1925, the ICN Grand Council voted to establish a permanent headquarters for ICN and to offer the post of the first Executive Secretary to Christiane Reimann. Miss Reimann held this position until 1934, when she resigned from ICN and moved to Siracusa, Sicily, to manage her farm estate there.

Miss Reimann devoted herself totally to ICN affairs during her 12 years in office, and personally financed many ICN activities.

Many essential ICN programmes were initiated by Miss Reimann and it was she who began publication of the **International Nursing Review.** She was determined that ICN should be recognised as the organization competent to speak for nurses and to represent nurses at international level. She made contact with as many nurses associations as possible; in fact, in one year, she paid visits to 20 European countries, at her own expense. Her initial work on the international exchange of nurses led to much future activity by ICN.