A Case Study

Miracle of Surgery

By Miss E. S. Masih, Staff Nurse

Mr. MKV felt losing strength in his right hand fingers since July 1968 which continued decreasing gradually. On November 10, 1968 he had fever with cold. The temperature was 102 degree F. In the night he felt his right hand trembling to the extent that he could not even drink water himself. He tried to drink water with his left hand but felt that it was also trembling. The fever came down in the morning and the patient felt normal within three days. The trembling of hand did not occur again. But strength of his right hand fingers continued to decrease to the extent that on November 30, 1968 he could not take even a morsal of food to his mouth. In between November 10 and 30, 1968 various investigations were carried out and treatment taken but without any improvement.

In the night of December 10 he got an Epileptic type of attack. He felt that some sort of electrical shock was passing in the whole body with jerk during his sleep. He became unconscious and passed urine. Some froth was present in his mouth and uttered broken words. He regained consciousness after one hour but felt restless. After some medication he slept from 4.00 A. M. to 6.30 A.M. without any trouble. When he got up he felt severe pain in his left shoulder on a particular point across the dorsal vertebral region on account of which he could not bend. The pain persisted and he was admitted to the Hospital.

The lumber puncture, blood sugar, W.R., TLC and DLC, Hb% and B. P. were normal. The pain persisted for three consecutive days and disappeared on the fourth day. During the period from December 10 to 28, the strength of his right hand and leg particularly the grip of fingers got diminished, slowly. The tendency remained constant from December 28 to 31. Subsequently he felt gaining some strength gradually and for this reason left Carotid Angiogram was not done. He was discharged from the hospital on January 14.

Treatment continued. There was slow improvement. Sometimes he felt severe headache which persisted for 12 to 24 hours. On August 1,1969 at about 11.30 A.M. when he was taking rest, he got an attack of previous type or but was of lesser intensity. He remained unconscious for about half an hour and restless thereafter for some period. He was again admitted to the hospital. Neuro Surgeon advised left Carotid Angiography and it was done on August 19. A case of Meningioma. Advised operation. The patient and his relatives were explained the risk of surgery and written consent for surgical intervention was obtained form the patient (a nurse himself) and as well as his wife.

On September 3, the patient's head was clean shaven and covered with sterilised gauze. He was brought to the Operation Theatre at 8.45 A. M. and premedication *i. e.* Bellalolin 1 amp. given I.M.I. A foley's catheter was put into the urinary bladder for continuous drainage. The patient was placed in recumbent position. General Anaesthesia was started at 9 a.m. by injecting 2 cc Sodium Pentothal Intravenous and Scoline. An endotracheal tube was inserted into trachea and was connected with the anaesthesia trolly. His face was turned over right side. The area of operation was prepared with iodine and spirit. The operation started with the following procedures :

Incision was made in the left parietal frontal and temporal region and the scale was turned over to the occipital region.

Four Bur holes, two each in occipital and frontal region, were made.

Gigly-saw with director was passed through occipital and frontal holes and bone was cut from downwards to upwards and skull bone was removed and kept in normal saline.

Before opening the Dura 20% 100 cc Uniminital was given.

Dissection of tumour done with the diathermy and suction done with cotton strips.

Bleeding coagulated with cautery.

Excision of tumor done with cautery loop.

After removing the tumor the silver clips were applied and the area was washed with hydrogen peroxide with normal saline.

All the bleeding points were checked and coagulaled.

Dara closed with fine silk.

Bone flap replaced and tied with s.s. wire.

Skull closed in layers.

1000 c.c. 5% glucose and two bottles of blood was given during the operation. This was supplemented with 500 cc 5% Glucose and one bottle of blood in post-operative room.

The output of 530 c.c. of urine was satisfactory.

The whole process of operation was completed in five hours.

Patient was then transferred to post-operative room in fairly good condition and was kept in recumbent position on railing bed without pillow.

Sedation was strictly restricted.

Medication.

(*i*) Injection Terramycin 100 mg 8 hourly
(*ii*) Injection Decadon 1 cc, 8 hourly given for 2 days.
(*iii*) Vitamin C 500 mg. OD.
(*iv*) Betenlan 1 tab. B.D.
(*v*) Phenabarbitone 1 gr, TDS
(*vi*) Dilentin sodium 1 cap. TDS
(*vii*) Injection Bejectal 2 c.c. OD

Temperature pulse and respiration and blood pressure was recorded 1 hourly. Oral hygiene was maintained. On the 2nd day intravenous fluid was discontinued and fluids allowed orally. Dressing changed on the 2nd day. Toilet was attended with all nursing precautions until he was able to do it himself. On the 3rd day he could lift and move his right hand and right leg.

As the condition was improving day by day the antibiotics and cortisones were stopped on the 4th day and easy digestible diet was allowed. On the 5th day regular

(Contd. on page 316)