

Nurses Role in Plastic Surgery

By

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PLASTIC Surgery is a discipline, where the nurse plays a vital role in the care of patients. In order to analyse what qualities one should look for in such a nurse, I think, one should try to discern what her part will be in the ward and in the operating room. Let us now pay a visit to the nurse in the ward.

Care of Cleft Lips

We routinely perform paediatric check-ups and children are pronounced fit when the hemoglobin is over 10 Gms. and the weight over 10 lbs. There should also be, no upper respiratory infection.

It is very important to train these children to take spoon feeds, because no sucking is allowed for 3 weeks after the operation. We also advocate the use elbow splints, so that the child cannot meddle with the suture line. Elbow splints are easily constructed out of stiff cardboard, well padded and bandaged securely from the axilla to the wrist. If the child is started on spoon feeds and elbow splints one or two days before surgery, he does not resent the sudden change in his habits, as much.

Post-operatively, all children irrespective of age have rectal temperatures taken, unless old enough to have axillary thermometers. This is very important, since the integrity of the suture line, depends upon no strain being placed upon it for a few days. The child is sedated with Vallergran or Vistaril in appropriate dosages.

The care of the suture line forms one of the most important duties of the nurse. We advocate H_2O_2 : Water, 1 : 4 dilution for gentle cleansing of the suture line. Swab sticks are used for this purpose. The idea of suture line

care, is to gently clean each suture, till it is without any crusts. This allows for easier suture removal, as well as a better scar, since maceration is reduced to a minimum. After cleansing, the sutures are lubricated with liquid paraffin. A Band-Aid is placed over the suture line to absorb any discharge. This procedure is repeated every 6 hours. Sutures are removed on the 5th day, and the child is discharged, with the elbow splints in place for 2 weeks more and instructions to continue spoon feeding for the same period. The major share in the care of these infants, therefore, devolves upon the nurse. A nurse cognizant of these procedures is a valuable asset to the team.

Care of Cleft Palates

The optimum age for operation is 18 months. The other requirements are commensurate with the expected norms for the age of the child. Again, the child should be free of U.R.I. before surgery. The pre-operative care of these children, is similar to that of cleft lips.

In the post-operative period, these children should be well sedated. An antibiotic is also added to the medication, to reduce infection in the suture line. The child is preferably kept in the tonsillectomy position until fully conscious. In the early post operative period, a vigilant nurse will look out for respiratory obstruction. This may be due to the tongue falling back or due to commencing of laryngeal oedema. The latter condition usually manifests itself by stridor during inspiration and a crowing, husky sound, while crying. The doctor if immediately alerted, can give Decadron I.M. or I.V. and bring about a rapid subsidence of the oedema. Cold steam

given by blowing oxygen over ice in a tent, also helps a great deal. The ward nurse should have a tracheostomy set handy, just in case the procedure is necessary. In the last 15 years, only one tracheostomy has had to be performed following cleft palate repair. This I think is a tribute to the vigilant role of the nurses in our wards. In no other sphere is the adage "An ounce of prevention is better than a pound of cure" more appropriate.

Feeding, is again through the medium of spoon. In the first 48 hours after surgery, only clear fluids are allowed. These include water, glucose water, fruit juices, Naks solution etc. The idea is to withhold milk and milk-containing products, as they tend to form a white membrane in the raw areas on the palate and bring about a dissolution of the suture line, by virtue of the infection that would result. In 48 hours, the wound is given a chance to seal itself and thereafter, the child is free to take full liquids. Under this heading, Jello and custards also can be served. However, on discharge after a week or so post-operative, instructions regarding elbow splints and feeding, are again given to the parents, by the nurse in charge. A normal diet can be resumed 3 weeks after the repair and at this time the elbow splints can also be removed.

One other emergency that may crop up, during the care of these patients, is that of bleeding. This can be quite alarming. It usually occurs 5-8 days post-operative. The child should be turned on his side to prevent choking and immediate medical help sought. If in an older child, then he can be made to sit up and hold his head forward with his mouth held open

over a K-basin. A suction apparatus ought to be handy and adrenaline ampoules, syringes and a dressing tray available.

When there is a generalised ooze from the raw area, in the palate, adrenaline packs usually control the bleeding. These need to be held with great caution, for fear of disrupting the suture line. If bleeding occurs from a small area, injection of 1 : 60,000 adrenaline solution in procaine, brings about a prompt arrest. Of course, it may recur. Occasionally, the child may have to be taken back to the operating room. There have been no fatalities due to this complication in our Hospital. This again attests to the teamwork that exists between the doctors and the nurses, that makes for efficient care of such emergencies.

Care of Actual Burns

The nurse contributes a great deal in the care of these patients. When a patient is brought to the ward, the very first thing that needs to be done is a cutdown. For children, a pediatric I.V. set-up with a Burette type arrangement to give measured quantities of fluid, is essential. An indwelling catheter, needs next, to be inserted. If there is a burn of the face and neck, a tracheostomy may have to be done. With the help of an efficient nurse, these procedures can obviously be performed in the minimum amount of time.

The patient is placed on a sterile sheet and all who take care of him, are masked to prevent infection of the burn wound. Sedation should be given intravenously, for the first 48 hours. This is to prevent pooling of sedative in the subcutaneous or intramuscular plane, during the shock phase.

In such patients, after adequate replacement of the fluid requirements, the blood pressure may rally round and this may cause a sudden, fatal, absorption of accumulated sedative.

If the burn is left exposed, a mosquito net placed around the bed is a good idea. If a close method is preferred, then a burn pack is something useful to have handy. In a burn pack, sterile gauze pieces, gauze bandages, and large pads are readily available. Such burn packs, make dressings of these patients, a quick and efficient procedure.

Once the emergency measures have been carried out, the responsibility for continued monitoring of the patient, rests very heavily on the nurse. The I.V. needs to be watched closely. Vital signs have to be recorded frequently and a chart giving the hourly output of urine is absolutely vital. If the hourly output is low, the drip rate has to be increased and if high the reverse is indicated. In enumerating some of early measures in burns, I hope to bring out the enormous contribution, a nurse interested in plastic surgery, can render the patient.

Obviously, the examples that can be quoted are legion and I do not propose to go into a detailed description, of all the situations, that may call for the skilled services of a nurse. The examples cited above, I hope, will give one a fair idea of the role of the nurse in the ward. We now move to the operating room.

In the operating room, a plastic surgeon needs a scrub nurse who is really very proficient with her hands. The time in the operating room, for each case, depends

as much on the surgeon, as on the nurse who is assisting him. When a scrub nurse is aware of the steps in a particular procedure, the case is bound to go smoothly. This brings to light what one needs in such a nurse; it is that one quality ANTICIPATION. When equipped with this quality, she is able to hand out the right instrument at the right time, and this naturally makes the case go without a hitch.

The range of instruments is not very great. Since a great many of the procedures are rather delicate in nature, the instruments necessarily have to be fine. Playing a prominent role in the plastic surgeon's armamentarium are fine Adson forceps, mosquito clamps, small needle holders, and fine hooks. We tend to use 3/0 or 4/0 chromic catgut for deep sutures and fine (5/0) atraumatic sutures of silk or nylon for the skin.

Nearly all proposed incisions are marked out with an orange stick dipped in methylene blue. We also use an injection of dilute adrenaline mixture, before making incisions, in order to cut down on the blood loss. We prefer 1 : 60,000 adrenaline in saline or 1% Xylocaine and it is prepared by adding $\frac{1}{2}$ c.c. adrenaline (1 : 1000) to 30 c.c. of the solution. It is pointless to further elaborate on minutiae. I trust a panoramic glimpse of the role of a nurse interested in our specialty, both in the ward and in the operating room, has been given.

In undertaking to write this article, my motive was mainly to attract nurses to take up this speciality, as their life work. If I have succeeded in stimulating a spark of interest, I deem it well worthwhile.

London Concert in Aid of Vellore Hospital

Sir Adrian Boult and one of his proteges, Vernon Handley, are to conduct the London Philharmonic Orchestra and Choir in this year's Vellore Concert at the Royal Albert Hall, London, on May 2.

The annual event, which raises funds for the Christian Medical College and Hospital at Vellore, South India, will be given in the presence of Princess Alice Countess of Athlone.

Last year's concert raised £1, 250, but this is only part of the continuous contribution made by the Friends of Vellore and a variety of other organisations in Britain. These include grants made for specific research project at Vellore, and the financing of staff working at the hospital.