



This one Recovered . . .

My Patient with Tetanus

By

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AS I walked into the ward one morning, I found that my assignment included a patient with tetanus. I quickly read his case record before going into his room. I had had many patients with tetanus before this, but all of them had died. So, I was very nervous about taking care of this new patient.

When I walked into the darkened room, I found a small boy who was semi-conscious with a nasogastric feeding tube and who looked very ill. His mother, who was sitting beside his bed, looked very worried about her child. His name was Salim, and if he had not been hospitalized for tetanus that day, he would have been in school with his other eight year old friend.

I spoke to his mother and tried to reassure her. She told me that Salim had injured himself about one week earlier while playing. A nail had broken the skin just over the left kneecap. Thinking it to be only a minor injury, he did nothing about it. Then after a few days he began to show symptoms of being ill. He complained of pain in the neck and some difficulty in swallowing. Later he was unable to open his jaws or swallow and began to have convulsions. He was brought to the hospital acutely ill but conscious. At the time of admission, the mother did not realize that her son's illness was at all related to his earlier minor injury.

I knew from past experience that

I must care for this patient and at the same time, I must not do anything to bring on a convulsion. Therefore, I had to move quietly and handle him very gently being careful not to disturb him. Even the bright light could stimulate a convulsion so the room was kept in semi-darkness.

Like any other patient, the patient with tetanus should have all his needs met. Sometimes, however, it is best not to give a bath rather than cause a convul-



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sion. The nurse must decide what to do. I was able to give Salim a bath and mouth care without convulsions developing. He required frequent suctioning to keep his air-way clear. I had to keep in mind that any real respiratory difficulty might require a tracheostomy. Fortunately, Salim was in good nutritional status. His nutrition and fluid intake were maintained by nasogastric tube feedings. I gave small amounts of nourishing fluids at body tempera-

ture and let it run in by gravity. His feedings were supplemented by multivitamins. His eyes accumulated a lot of discharge and good eye care was necessary. His intake and output were carefully observed and recorded. Liquid paraffin was given to prevent constipation.

His medications included tetanus antitoxin 50,000 units intramuscularly on admission. This dose was divided and given in both buttocks. He was given crystalline penicillin every 12 hours and then some days later, Seclophen was started. His sedations and muscle relaxants included phenobarbital. The dose varied according to his convulsions. Largactil was given by tube every six hours. Myanesin elixir, Rubinex and paraldehyde were also given. During the febrile period of his illness, he was given aspirin by tube.

Although his convulsions had started at home, he did not have one while I was caring for him that first day. On the following day he began to have convulsions. At that time I gave him paraldehyde intramuscularly. I was worried because his condition seemed to be very serious. I could only give minimum physical care in order not to cause more convulsions.

In the afternoon his condition seemed to worsen. During a hard convulsion, his respirations stopped and he did not start breathing again. There was no pulse and I was very much frightened that the end had come as with all my other tetanus patients. The staff nurse came to my aid and quickly gave artificial respirations. I hastily got the oxygen cylinder and started nasal oxygen and kept his airway clear by suctioning. After some

minutes Salim began to breathe normally again. Micoren drops were given by tube and then every four hours for eight doses.

Not only did Salim need a great deal of emotional support, but also his mother who was very much worried. Salim was most apprehensive during and just following convulsions. After this bad day, Salim began to improve. A tracheostomy was not necessary. Some days later it was quite clear that Salim would recover. I was very happy to have had a part in all the efforts made to get him well.

During the days of Salim's improvement and recovery, I had an excellent opportunity to do health teaching with him and his family.

A student nurse's life is full of ups and downs, but is always a challenge. It was truly one of my happiest student days when Salim said goodbye as he walked out of the hospital only four weeks following his serious battle with tetanus.

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Eliason, E.L., Ferguson, L.K., Sholtis, Lillian A., *Surgical Nursing*, Philadelphia, J.B. Lippincott Co., 10th edition, 1955.

Planning for Nursing Service— A Must—(Continued)

from the beginning, so I can implement the improved methods from the start." The other point made by this energetic young nursing administrator was, like Mrs. Das' reaction, the value of hearing the other side of the story from the guest speakers. "Not only did it make me understand their problems", she said, "but it made me see mine in a wider perspective. It made me realize why administrators sometimes seem to make difficulties. I can now understand their limitations, and that will help me adjusting my demands to what is possible. In addition, the workshop has helped me in my budgeting and in

visualizing what posts should be created. It has been a most useful two weeks."

(WHO)

Nursing Care of a Paraplegic Patient—(Continued)

100 mg. was started to overcome this complication. Tab. ascorbic acid 100 mgm. t.i.d. and tab. fersolate 1, multivitamin 1, tab. Vitamin B Complex 1, and tab. ascriptin gr.x t.i.d. were started and continued. As he had severe spasms of both lower limbs tab. vallium 5 mgm. t.i.d. was given. Pulvis glyceris compound dr. 11 h.s. o.d. was given for constipation. Magnesium sulphate paste dressing was done to all bedsores.

As he was improving nicely he was referred to the surgical department. The bedsores were healing and all his toxic symptoms had subsided, so he was posted for skin grafting. This was done in various stages. The grafted area was treated by moistening the wound with saline and protected from the bedclothes by a cradle. A delay flap was also done. As he was having severe spasm he was treated with intrathecal phenol injection, para-vertebral block with procaine and epidural block.

Progress of the patient

Within a week his temperature settle down. As he was taking plenty of fluids his urine became very clear. It appeared reddish on admission. All the bed sores healed well. As he was doing active exercises daily with much interest within two months he was allowed to sit up in bed as well as in the wheelchair. He rolled the wheelchair himself and started to go out. He seemed to admire the natural sceneries and made his atmosphere pleasant. He was also taught type-writing as he was very interested in it. He also learned music.

Special braces were given for him to walk. He was taught to empty his bladder by the suprapubic pressure method (pressure on the suprapubic area every hour or two-hour to pass urine).

My hearty thanks to Dr. Mary

Verghese who allowed and helped me a great deal to write this nursing care study. My hearty thanks also to my Nursing Superintendent and to other Sisters who guided me in writing this case report.

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Tetany—(Continued)

There was marked improvement in his physical and mental condition while leaving the centre. He was advised to continue the diet rich in calcium and Vitamin D, with the medicines advised by the doctor. Ramu's uncle was also advised to take him to the Ophthalmologist for treatment of cataract.

Nursing has played a great role in saving the precious life of Ramu. Nurses should not lose heart at critical times, but should reassure the patient and his relatives to be optimistic. It is our responsibility to save precious lives at all costs.

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flight attitude. Placed in a small wind tunnel, it will fly if a gentle air flow is directed on to it. Wing-beat frequency is measured in two ways—by a piezoelectric pick-up attached to the pin and by a stroboscope. Mosquitoes have also been flown on a roundabout to measure speed and distance at the same time as wing-beat frequency, so that this could be related to speed changes. Frequencies vary, but mostly they are in the range of 24,000 to 30,000 beats a minute.

Such research should assist in the campaign against elephantiasis, but it may help against other mosquito-borne diseases. These include malaria, yellow fever and dengue fever, which affect millions of people in different parts of the world.

(B.I.S.)