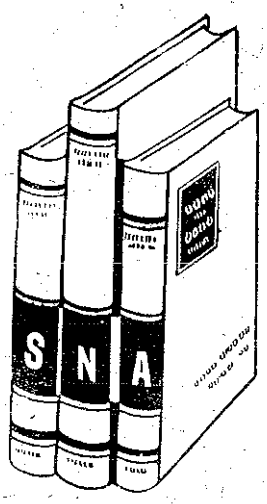

A Case Study

Stricture of the Stomach caused by Corrosive Poisoning

By

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MISS Haleena, 18 years, was admitted to the Surgical Ward for treatment of vomiting after meals, for the past four months, pain in the abdomen, and high fever of unknown origin for the last 8 days.

Four months ago the patient accidently took some kind of acid and was treated in the Medical Ward of this hospital. She was not completely cured but discharged and asked to attend the O.P.D. Later she developed more severe symptoms and was re-admitted for pain in the epigastric region, vomiting, constipation and high temperature.

Personal and family history showed that the patient had an unhappy home life ; she had a step-father who ill-treated her ; she had to look after her younger sisters and brothers, and cook the meals.

Physical examination showed, that the patient was under-nourished but there were no other visible abnormalities.

Investigations. Laboratory examinations included blood, urine, stool, and gastric analysis ; nothing abnormal was discovered.

It was decided that a laparotomy should be done and the patient was accordingly prepared. On the morning of the operation the final preparation and the usual pre-medication was given, the patient was sent to the Operation Theatre accompanied by a nurse.

The patient was given general anaesthesia and right a paramedian incision was made and the abdomen opened. The liver was enlarged, gall bladder was smooth and normal, stomach was small and contracted five inches in length and three inches in width. A small area around the fundus of the stomach looked normal, and in places it was white in colour, the lymph nodes were felt along the greater and lesser curvature. Partial gastrectomy and gastrojejunostomy was done. The abdomen was sutured in layers.

Post-Operative Care : The patient was received in a post-operative bed ; temperature, pulse and respiration were recorded ½ hourly. Intravenous infusion of glucose 50% and normal saline, 0·9% was given continuously, Intra-gastric suction continued. Condition of patient fair ; patient put into Fowler's position after regaining consciousness. No post-operative complications occurred. The usual post-operative nursing care given. At night the patient was given an injection of Pethidine 50 mgm., with effect.

1st day : General condition of the patient was fair. Intravenous glucose/saline continued ; intra-gastric suction continued. Urine passed, no distention of the abdomen ; patient afebrile ; the usual nursing care given and the patient made comfortable.

2nd day : General condition better, intravenous infusion of glucose and saline was continued Intra-gastric suction continued. T.P.R. normal ; nursing care given.

3rd day General condition improving, T.P.R. normal. Blood pressure : 100/70 ; no vomiting, abdomen soft ; Ryle's Tube was removed. Sips of glucose water given 250 c.c. Intravenous glucose, 1,000 c.c. given.

4th day : General condition better : T.P.R. normal ; gradually the patient was given light, soft diet. Bowels opened normally ; nursing care given.

10th day : Mitchell's clips removed. Wound healed by first intention, dry dressings applied. Patient's condition improving and she was allowed to sit up. Diet increased ; usual nursing care given.

12th day : Tension sutures removed. Patient was allowed to walk about. Full diet given ; patient was told that she would be discharged in a day or two. As Haleena is returning to an unfortunate home situation, we tried to reassure her and we hope to talk with her family.

We shall ask her to return for a check-up at some later date.