FOR STUDENT NURSES

A Case Study of Partial Hepatectomy

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GIRIYA Soma, aged 20 years, was admitted to the surgical ward, complaining of pain in the epigastric region.

Giriya is one of a family of eight, he is the third son ; his parents and sisters and brothers are alive. He was working in a Tea-Shop when he became ill.

Physical Examination

Heart and lungs normal ; pain in the epigastrium and on examination a lump was felt in this region which moved with respiration ; the umbilicus was irregularly averted.

Laboratory Examination

Routine examination of stool and urine was done. The report of the stool showed that it contained the ova of the ankylostoma duodenales. Urine—normal.

Blood taken for icteric index, showed 7 units ; Van den bergh reaction negative. Blood Urea : 8 mgs ; bleeding and clotting time normal.

X-Ray of the abdomen showed an enlarged shadow on the liver ; the chest was clear. A second X-ray plate was taken after barium sulphate meal showed that there was a lump in the epigastric region lying outside the stomach and causing pressure on the lesser curvature of the stomach.

Treatment

On admission the patient was put on fluid diet. As the pain was not connected in any way with food taken, the patient was given his usual diet. A course of Emetine Hydrochloride ½ gr., injections of Liver Extract 1 c.c. and B Complex 1 c.c. was ordered daily for a week. It was decided by the surgeon that a laparotomy should be done to investigate the nature of a lump.

The patient was prepared for operation in the routine way. His blood pressure was taken 120/70. Injection of Atropine Sulph 1/100 gr. given and he was taken to the operation theatre. Under a general anæsthetic, a laparotomy was performed. Findings : that the lump on the left lobe of the liver was an hæmangioma of the liver. The right lobe of the liver was normal. A small section was taken for biopsy from the left lobe. The abdominal wound closed and the patient returned to the ward.

Post-operative Treatment

Temperature, pulse and respiration was recorded hourly, the maximum temperature : 100°F. pulse : 120, and respiration : 24. Patient was given fluids by mouth and intravenous inj. glucose saline. 500 c.c., 5% glucose 1,000 c.c., Vit. 1,000 mgs., and calcium gluconate 10% 10 c.c. was given. Penicillin 5 lac 6 hourly and streptomycine ½ gn. given 12 hourly.

The usual post-operative nursing care was given and the patient was made comfortable. He was able to pass urine naturally.

Giriya's condition improved day by day and he was given the usual nursing care. His back and mouth was attended to 4 hourly. As the temperature came to normal, the penicillin and streptomycine injections was discontinued. On the 9th day the sutures were removed. His wound healed and he was asked to walk about for a short period every day.

The patient progressed satisfactorily, but was weak. The biopsy report showed an hæmangioma of the left lobe. Giriya was advised to have hæmangioma removed as it may rupture due to trauma. This being a major operation, Giriya was asked to stay in hospital for a month whilst he was given nourishing diet. Giriya agreed to have the operation. Multi-vitamin tablets were given 1 three times a day. Injections of Liver Extract 1 c.c. with B Complex 1 c.c. and of imferon 1 c.c. were given daily.

Pre-Operative Treatment

Three days before the operation Giriya was given vitamin K 2 tablets—T.D.S. to raise the prothombine index of blood. Blood was taken for grouping and cross matching. The usual pre operative treatment of the skin done. Injection of Achromycine 100 mgs., intravenous glucose 25% 500 c.c. Vit C. 500 mg., calcium gluconate 10% 10 c.c. was given on the evening prior to the operation. One capsule of Nembutal 1½ gr. was given at night to give the patient good sleep.

On the day of the operation the intravenous injections of glucose, Vit. C 500 mgs. and calcium gluconate 10% 10 c.c. was given. The skin was prepared surgically, and the doctor in-charge gave an injection of Pethedine 50 mgs. and Atropine 1/100 gr. intramuscularly.

Operation

The patient was given spinal and general anæsthesia and placed in a supine position, on the operation table. Thoracic-abdominal incision was made across the mid line. The pleura was opened, the 8th rib removed and the thoracic cavity opened. The diaphgram was cut so as to expose the left lobe. The left branch of the Portal vein and left Hepatic artery, were disected and a sling put around them. The main structures such as the bile duct, and the hepatic duct were clamped loosely by special clamps. A rubber tourniquet was around the right lobe away from the hæmangioma, and stitches applied with an atraumatic needle, and the hæmangioma excised. The raw surface was

coagulated. The clamps on the blood vessels were removed ; there was no bleeding from the liver. Two drainage tube were inserted one in the abdomen and the other in the thorax. The wound was sutured in layers, and the drainage tubes were connected to under-water seal drainage. The patient was given blood transfusion 1.250 c.c. The whole operation took five hours.

Post-Operative Treatment

Giriya was placed on a prepared bed in a special ward. Temperature was recorded ½ hourly ; temp. 100°F, pulse 146, and resp. 40 ; his blood pressure was 124/70. After he came out of the anæsthetic, an intravenous drip of glucose/saline 500 c.c., glucose 25% 500 c.c. and Vit C 1,000 mgs. were given ; antibiotics : Achromycine 100 mgs given 6 hourly ; Penicillin 5 lac 6 hourly and Streptomycine ½ gn. given 12 hourly. Continuous oxygen given and gastric aspirations through Ryle's Tube was done every two hours.

Patient had a disturbed night ; was able to pass urine ; care of mouth and back done and his mouth was kept moist.

The next day patient had a high temperature, 103°F, pulse 140 and resp. 40. He developed pulmonary congestion and the anæsthetist had to do intratracheal suction which relieved him and his temperature settled down. He showed slight improvement on the third day and so glucose water and plain water was given by mouth which he retained.

Daily nursing care given ; his bed, back and mouth was attended to 4 hourly ; he was given light fluid diet of fruit juice and milk. Giriya's condition gradually improved. After 48 hours the drainage tube from the thoracic cavity was removed. The drainage tube from the abdomen was removed on the 5th day. His temperature gradually came down to normal and the antibiotics stopped.

As Giriya was making steady progress he was allowed to sit up on the 7th day, on the 10th day his abdominal sutures were removed. The wound had healed by first intention, and he was allowed to move about. He was allowed to have solid food Injection of B. Complex 1 c.c. with Liver extract 1 c.c. were continued.

Giriya was discharged on the 15th day, and was asked to report to the outpatient Department of the hospital every week.

For yesterday is but a dream
And tomorrow is only a vision ;
But today well-lived makes
Every yesterday a dream of happiness
And every tomorrow a vision of hope.

Osler