THE NURSING OF DYSENTERY

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An epidemic of dysentery can defeat an army, as was proved in the Prussian campaign against the French Republicans, and also in our own ill-fated expedition to Walcheren. It is accordingly vitally important in this war that the nurse should be skilled in nursing the two forms of this disease.

Common as dysentery has been in peace and war, it was not till the beginning of the present century that it was recognised as not one disease but two. Their clinical resemblance is quite superficial, and the two varieties of dysentery are very distinct clinical entities.

1. *Bacillary Dysentery.*—This is caused by three varieties of bacilli: (a) Shiga's bacillus, (b) Flexner's bacillus, and (c) Sonne's bacillus.

It is characterised by sudden onset accompanied by a considerable degree of pyrexia, numerous stools containing blood and mucus, abdominal pain and straining with toxæmia and prostration varying a great deal in degree. When the disease is established, the number and character of the stools varies enormously. The patient may spend most of his, or her, time on the bed pan, or may have only five or six stools in the twenty-four hours.

Mild forms of bacillary dysentery are very common, especially in Egypt, India and the Far East. These have been given local names, and are known as "Gippy Tummy," "Simla Trots," and "Hongkong Dog." In this country outbreaks of the disease have for many years been common in asylums.

Recently it has been shown that the Sonne bacillus is not only responsible for many outbreaks of dysenteriform diarrhœa in the British Isles and in Germany, but is also the cause of some epidemics of "food poisoning". The infection has been carried by unusual vehicles, such as pease pudding, but only last year at Bedford an epidemic of Sonne dysentery was definitely proved to be milk-borne.

2. *Amœbic Dysentery.*—This form of the disease is caused by a minute animal parasite which lives in the intestines. It is endemic in most tropical and sub-tropical countries, and differs widely from the bacillary form of the disease.

This is the variety of dysentery which may be followed by the dreaded liver abscess. The condition is a disease of men only in the tropics. European women, although they are just as frequently subject to amœbic dysentery as their men folk, hardly ever suffer from liver abscess.

To save space and for future reference, it may be useful if I set out the characteristics of the two types of dysentery in tabular form:—

	Bacillary	*Amœbic*
1.	"Lying down dysentery."	"Walking dysentery."
2.	Acute.	Chronic.
3.	Epidemic spread.	Endemic.
4.	Incubation 7 days or less.	Incubation 14 to 90 days.
5.	Acute onset.	Insidious onset.
6.	Pyrexia,	No fever usually.
7.	Tenesmus very severe.	Usually no straining.
8.	Patient loses weight rapidly.	Emaciation is uncommon.
9.	Small numerous odourless stools. Bright red, gelatinous and viscid, Resemble red currant jelly.	Copious, very offensive stools. Blood and mucus mixed with fæces producing appearance of "sago grains" or sometimes "anchovy sauce".
10.	No reaction to emetine. Responds to saline aperients or castor oil in repeated small doses.	Almost immediate reaction to emetine, which acts as specific remedy.

Nursing of Bacillary Dysentery

Cases are infectious and to no one more so than the nurses who tend them; therefore you must be alive to the dangers you run and take every measure to avoid infection.

The patient, however mild the symptoms, must be promptly put to bed and kept there. He, or she, must be warmly clad and on no account allowed to get out of bed to defæcate. As much as possible of the stools must be kept for inspection by the doctor.

Solid diet is never permissible. Milk is usually badly tolerated, and jellies, beef tea, arrowroot, chicken broth or rice water are preferable. Food should be served slightly warmed and only in small quantities, otherwise it is likely to aggravate the tenesmus or griping.

Treatment is usually started with half an ounce of castor oil to which 15 minims of tincture of opium have been added.

Following this, the patient is given 60 grains of sulphate of sodium in half an ounce of peppermint water, every two hours for the first 24 hours, and subsequently every four hours till the stools become fæculent. Antidysenteric serum is usually given in addition and is, indeed, the mainstay in severe cases.

The nurse must be on the look-out for two rather serious complications: the so-called "dysenteric rheumatism", and eye complications which take the form of conjunctivitis in acute and irido-cyclitis in chronic cases.

Nursing of Amœbic Dysentery

Cases of this form of the disease reach the trained nurse much later than bacillary infections. She will probably only be concerned with the treatment of acute cases by means of emetine, which is the active principle of ipecacuanha. Eight to twelve grains are given to adults in the form of deep subcutaneous injections.

For chronic cases E.B.I., which is the iodide of emetine and bismuth of the B.P., is now usually combined with Yatren—a yellow powder containing 28 per cent. of iodine with bicarbonate of soda. It is given in the form of pills and retention enemata.

Both the bacillus and amœba are carried by flies and contaminated food and water, and too much attention cannot be paid to prevention.

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