

### NOODHULP: 'N NUWE BENADERING

Noodhulp is so belangrik dat ons die betekenis daarvan nie kan oordryf nie. Daarsonder kan ligte beserings ernstig word, en ernstige beserings noodlottig. 'n Hele reeks omstandighede wat deur bevredigende noodhulp in beheer gehou kan word, kan anders tot nadeel van die pasiënt ontwikkel. Om hierdie rede moet die uitstekende noodhulpwerk wat tans reeds deur persone gedoen word wat daarvoor opgelei is, ons nie lei tot selftevredenheid en selfingenomenheid nie. Ons moet 'n baie groot agterstand inhaal voordat ons resultate enigins goed kan vergelyk met, byvoorbeeld, wat in die Koreaanse oorlog bereik is.

As ons aan noodhulp dink, is die beheer van bloeding onmiddellik 'n prominente probleem. Tydelike beheer van bloeding, soos elke praktiserende chirurg weet, kan op die beste manier beheer word deur drukking op die bloeipunte. Hierdie prosedure laat die bloeding ophou en belemmer nie die distale sirkulasie nie. Maar, die beheer van bloeding deur die gebruik van 'n proksimale knelverband, deur drukverbande, en deur drukking op 'drukpunte', word nog in ons opleiding voorgeskryf as noodhulphandeling—oorblyfsels van die dae voor die gebruik van antibiotiese middels, toe enigiets anders beter beskou is as direkte drukking op 'n oop wond met al die moontlike komplikasies van besmetting. Direkte drukking kan maklik toegepas word, dit kan maklik geleer word, en, aangesien dit doeltreffend is, maak dit die behoud van 'n ledemaat moontlik ten spyte van vervoer en vertraging. 'n Paar rolle stywe kripverband op 'n depper kan omtrent enige bloeding beheer sonder om die pasiënt aan die marteling van 'n knelverband te onderwerp—met of sonder 'n klip in 'n sakdoek. Enige bloeding wat met 'n knelverband beheer kan word, kan veiliger en beter beheer word met 'n stywe kripverband wat direk op die wond geplaas word.

Ons stel nie voor dat daar nou drastiese veranderinge in ons noodhulpboeke gemaak word nie.<sup>1,2</sup> Hierdie boeke, wat onder die beskerming van organisasies soos die Rooi Kruis- en die St. John-ambulansvereniging uitgegee word, het die toets van die tyd weerstaan en het hierdie liggame in staat gestel om waardevolle dienste te lewer. Nogtans moet ons nie toelaat dat ons dinkprosesse 'versteen' en belemmer word deur bewondering van gevestigde gebruike nie. Verbeteringe kan gemaak word, en moet dus aan die hand gegee word.

Afgesien van die beheer van bloeding is die toepassing van kunsmatige asemhaling 'n ander voorbeeld van 'n gebied waarop verbeteringe aan die hand gegee kan word. Schafer se metode en Eve se metode moet plek maak vir intensiewe onderrig van die tegniek van die mond-tot-mond-metode (die inblaas van uitgeasemde lug)—die metode wat onlangs deur die Amerikaanse Rooi Kruisvereniging goedgekeur is. 'Safar'<sup>3</sup> en soortgelyke buise is in ons land verkrygbaar vir gebruik in noodgevallen van hierdie aard, en bevredigende propaganda vir hierdie metode moet gemaak word by ons noodhulporganisasies.

Nog 'n verdere saak wat opgehelder moet word, is ons metodes van spalk. As ons besluit om pasiënte te vervoer, dan moet ons ophou om net lippediens te lewer aan die uitspraak: 'spalk hulle waar hulle lê', en dan moet ons verder aandring op die meer algemene gebruik van Thomasspalke deur noodhulppersoneel, by frakture van die onderste ledemate. Hierdie palke is vandag nog die beste wat beskikbaar is, en die gebruik daarvan is onvergeljlik beter as enige ander eenvoudige metode van fiksasie, ook met die lang Listonspalk wat gewoonlik gebruik word. Liston is per slot van rekening al in 1847 dood, en hierdie spalk behoort inderdaad tuis in 'n museum van uitgediende instrumente, wat wel hul doel gedien het, maar nou nie meer gebruikswaarde het nie.

'n Laaste vraag in hierdie verband (wat ons met huiwering stel, maar tog nie sonder 'n mate van oortuiging nie), is die vraag of die tyd nie aangebreek het om ons ambulanspersoneel op die platteland op te lei om eenvoudige binnearse indruppeling met plasma toe te dien nie? Ons kan dit kategorieë stel dat enigeen wat voorheen gesond was, maar nou ernstig verwond is, niks anders nie as voordeel kan kry uit die druppelsgewyse binnearse toediening van 500 ml. plasma. Die tegniek is veilig en eenvoudig om te leer. Die Verenigde State se leer het sy ambulanspersoneel opgelei om bloedoortappings in die veld te doen. Miskien moet ons ook aandring op 'n bietjie meer positiewe denke en optrede.

1. Die goedgekeurde handboek van die St. John-ambulansvereniging, St. Andrew-ambulansvereniging, en die Britse Rooi Kruisvereniging (1960): *First-Aid*, 12e druk.
2. Irvine, L. G., red. Mathews, R. A. (1958): *Manual of First-Aid*. Suid-Afrikaanse Rooi Kruisvereniging: Kaapstad.
3. Safar, P. en MacMahon, M. (1958): *J. Amer. Med. Assoc.*, **166**, 1459.

### A NEW LOOK AT FIRST-AID

The importance of first-aid can hardly be exaggerated. Without it, a whole train of circumstances, which can be held in check by proper first-aid, is set in motion to the great detriment of the patient; minor injuries become major ones and serious injuries become fatal. The splendid first-aid work that is already being done by our trainees should not lead us to smugness and self-satisfaction. There is a very big leeway to make up before our

figures are as good as those achieved in, for example, the Korean war or in mine accidents.

When considering first-aid, the first subject that leaps to mind is the control of haemorrhage. Temporary control of haemorrhage can best be done, as every practising surgeon knows, by direct pressure on the bleeding vessels; this stops the bleeding and does not compromise the distal circulation. But control by proximal tourniquet,

by pressure bandage, and by pressure on 'pressure points' are still taught as first-aid manoeuvres — doubtless as a relic of the times before antibiotics and control of infection, when most other methods of control were better than direct pressure on an open wound with all its risks of possible contamination. Direct pressure is easy to apply, can be taught quickly and, while it is effective, it permits a limb to survive transport and delay. A few turns of a firm, crêpe bandage applied over a pad can control any haemorrhage without subjecting the patient to the agonies of a tourniquet — with or without a stone in the handkerchief and a turnbuckle. Any haemorrhage that is controllable by tourniquet can be better controlled by a firm, crêpe bandage that is applied directly over the wound and is a far safer form of treatment.

While it may be unthinkable at the moment to make any drastic alteration in the first-aid manuals<sup>1,2</sup> (which, sponsored by such world-wide organizations as the Red Cross and the St. John Ambulance Association, have stood the test of time and have enabled these bodies to render splendid services), it is not right that our mental processes should become ossified and immobilized by admiration for old-standing institutions. Improvements can be made and should be suggested. Undoubtedly another such improvement is in the teaching of artificial respiration. Schafer's method, Eve's method and others should give way to intensive teaching of the mouth-to-mouth or the expired-air-insufflation method which has recently won the approval of the American Red Cross Association. 'Safar'<sup>3</sup> and similar tubes are readily available in this country for use in this emergency, and this method must be properly

propagandized among our first-aid organizations in South Africa.

Other accepted first-aid procedures that also require consideration are our methods of splinting. If we are going to move patients with safety, we should stop paying lip service only to the dictum 'splint them where they lie', and start pressing for the more extended use of the Thomas' splint among first-aiders for fractures of the lower limb. This splint is, to date, the best available and is incomparably superior to any other simple means of fixation; and the long Liston splint, which is usually used (Liston, after all, died in 1847), should perhaps be relegated to the surgical junkyard and museum to join the other implements that have served their purpose and are no longer recommended or in use.

And finally, though this is put forward rather diffidently, has the time not arrived for us to consider whether it would not be possible to train ambulance men in country districts to set up a simple intravenous drip with plasma? It can be categorically stated that no seriously injured, but previously healthy, adult can derive anything but benefit from 500 ml. of plasma administered intravenously, drop by drop. The technique is safe and simple to learn. The U.S. Army has trained its ambulance-corps men to set up blood transfusion in the field. Perhaps we, too, should press for a little more positive thought and action.

1. The authorized manual of St. John Ambulance Association, St. Andrew's Ambulance Association, and the British Red Cross Society (1960): *First-Aid*, 12th impression.
2. Irvine, L. G., ed. Mathews, R. A. (1958): *Manual of First-Aid*. Cape Town: South African Red Cross Society.
3. Safar, P. and MacMahon, M. (1958): *J. Amer. Med. Assoc.*, **166**, 1459.

## CARDIAC TECHNOLOGISTS

Elsewhere in this issue are published the proceedings of the first graduation ceremony, which was held recently at Groote Schuur Hospital, Cape Town, to grant diplomas to successful candidates for the Diploma of Associate Membership of the Society of Cardiological Technologists of South Africa. This was indeed a happy occasion and a natural result of the rapid development of cardiological practice in this country.

Full credit must go to the Southern African Cardiac Society and to the other members of the Cardiological Technologists Society of South Africa for the success of this project.

There is no doubt that in modern cardiology a great part of the success of the investigations is owed to the

technologist. Cardiac catheterization, angiocardiology, and open-heart surgery could not take place without the attention and scientific training and help that the cardiac technicians now give to the cardiologist.

Advance courses are now to be held for the Fellowship of the Society of Cardiological Technologists which will further enhance the efficiency and training of technicians. More and more demand will arise for technicians in every branch of medicine, because clinical medicine cannot progress without laboratory help in the very necessary special investigations.

We congratulate all those concerned in this worth-while project and wish them success for the future.