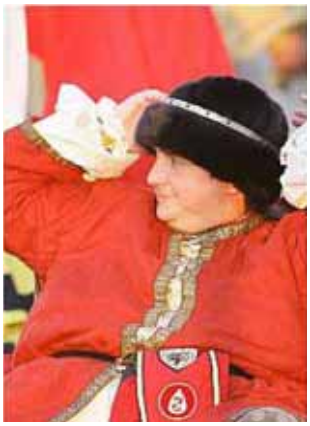
The Chirurgeon's Burden

Newsletter For An Tir Chirurgeons

ISSUE #14 – July, 2007 Editor: Lianna Stewart, MC, GdS

Your Kingdom Chirurgeon Speaks!



Greetings, all!

We are winding down to the end of my term. I'm going to have a lot of thank you's to say at the chirurgeon meeting at September Crown, I tell you!!

I missed July Coronation; it wasn't feasible for me to attend. Krystene of Blatha an Oir was Chirurgeon in Charge and represented me at Curia. I'm sending out mass mailings shortly, watch for that in your mailboxes. Remember, we need everyone on the email list and watching the message board for updates.

At May Crown, Zachariah led a team of Solveig, Buzzy, Krys, and Fjorlief (any others?) in a massive rip and grommet repair session for the Kingdom Chirurgeon Pavilion - be sure to make admiring noises when next you see it!

Please check your warrant status on the website; I need written (email) confirmation that you have read and accept the new Chirurgeon Handbook revisions. We do now have those new warrant letters from the website, we're working toward making it so you can print out your own if you misplace it... meantime, those who are current (including handbook) have already started receiving their warrant letters and the rest will be mailed this month.

We ran into a wonderful young lady at An Tir West War who was 12 and needed some job that would respect her caring and responsibility level. Remember there's no age limit for chirurgeon assistants? We made sure she understood the 3 rules: no touching the oogy stuff, no talking about patients and their care, do what the chirurgeon needs and try to stay out of the way if something exciting happens. We have a place in the chirurgeonate for spouses, interested teens, and people who want to be helpful and don't want to have to deal with hands on care. Make sure they know they're valued and valuable - it's a wonderful feeling, when you've got stuff on your gloves and need that one more 4x4, to have someone "clean" to get it from your kit for you! You can recognize a CA (or candystriper) by the red and white striped mantle or baldric. Make one for your handy helper, so we all know s/he belongs with us "cool kids" at point!

I would like to put out one treatment caution - we have seen lately how mundane-life suspicions - and their valid targets - lurk among our folks. Please remember to think in terms of appearances - just as we discuss in training, how will a parent react to returning from the bathroom to find you giving their child abdominal thrusts or CPR if the parent didn't know anything was wrong? Looking consummately professional is the first cue they have that we're there to help. Any time you're the least bit uncomfortable, ask for a witness. If it involves the opposite gender, a minor, or a dependent adult, *really* consider what the best strategy is to resolve patient privacy and your own liability - whether a friend of theirs, a chirurgeon or chirurgeon assistant, or someone else nearby at least, so everyone can feel more comfortable.

In service to the crown, you, chirurgery, and the dream,

THLord Tvorimir Danilov, MC, GdS, JdL, WOAW
Kingdom Chirurgeon, An Tir

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Six Steps to Better Breathing or Quick & Easy Means to Lower Blood Pressure

By Lianna Stewart

Consider taking only 10 minutes of proper breathing technique daily for 8 weeks to lower blood pressure. Here's a way to make this happen:

1. Lie flat on the floor.
2. Take a deep, slow breath. Imagine your lungs filling up with air. (This should take about 5 seconds.)
3. As you breathe in, your belly button should be moving away from your spine -- the result of your diaphragm pulling air into your lungs.
4. Toward the end of your inhalation, your chest also may expand.
5. When your lungs feel nice and full, exhale slowly. (This should take about 7 seconds.)
6. You should notice your belly button pulling toward your spine as you exhale.

Learn more ways to breathe better -- including **pursed-lip breathing, deep breathing, and diaphragm breathing.**

Other Ways to Reduce Blood Pressure
Regular exercise and a low-fat/low-sodium diet do the job. Add some yoga, meditation, or biofeedback to your regime to aid in the process.

There was a knock at the pearly gates. St. Peter looks out and a man is standing there. St. Peter is about to begin his interview when the man disappears. A moment later, another knock. St. Peter opens the gate, sees the man open his mouth to speak then disappear again. Slightly annoyed, St. Peter calls after him: "Are you playing games with me?" "No" the man's voice anxiously replies. "They're trying to resuscitate me!"

Letters to the Editor

"A little clinical factoid about those pupils...
Is your patient is alert? Even if their pupils are unequal, it is not going to be a sign of impending neuro-catastrophe.

When unequal pupils are a sign of cerebral swelling, they're caused by pressure on the nerves which control the iris. For a brain to swell enough to put pressure on those nerves, it essentially *has* to press *first* on spinal cord centers which control breathing and alertness. (The only exception which comes to mind would be certain brain tumors in very precise locations -- and even then, those wouldn't cause abrupt pupil changes). A drowsy, somnolent, patient, one with altered alertness and thinking, on the other hand, ought to raise concern. (And a 911 call).

In the alert patient, other causes of unequal pupils include:

- Direct blow to the eye in question, with stimulation of the iris muscle.
- Topical medications such as scopolamine (from an anti seasickness patch; some of the scopolamine gets on the fingers, which then rub an itch near the eye, and then...)
- old/chronic injuries
- artifical eyes (beloved teaching trick of sadistic physical diagnosis teachers in med school labs...)

Cordially, G"

From Giovanni or "William Ernoehazy, Jr"
dedoc@mac.com

Also, there is a condition called anisicoria (unequal pupils) that is a normal condition for some folks. I caught me once with a ski injury patient. I was worried about a brain injury when his sister said,

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"Oh, his eyes have always been like that"! One of my questions when asking about illness or injury is now, "and is that normal for you?"."

Michael MacSeoin
(Mike Jones" bear@pyramid.net)

"But be careful. I had a fighter with severe pain in the right middle of the rib cage. Said he had been hit very hard in the side from behind by a Tuchuck. I listened to his lungs, motioned to an EMS guy (Porterville then), and mentioned it to the patient. This is a symptom of a punctured lung, but it could be other things.

He said his doctor had noticed it and it was normal for him. The EMS guy went away and I stayed for a while. Suddenly, he buckled over in pain. I listened again and it was very markedly different with the right lung producing almost no sound. I called for the ambulance. Dispatch later said they had never heard that amount of urgency in my voice before and we had an ambulance with two docs there in about 3 minutes.

They did a decompression in the back of the box and took him to the hospital. It was a tension pneumothorax. I don't know the outcome after that.

It may be normal for them, but that does not mean the condition you are looking for is not there also.

Be observant and don't assume much. Also, don't leave someone with a blow to the ribs until you are sure he is OK. Technically, you cannot leave him until he refuses further help or you pass him on to someone with equal or higher training/certs, but even if he dismisses you, watch him for a while or get someone else to do so (squire brother, girlfriend ...)"

Caelin on Andrede
(Richard Threlkeld rjt@acm.org)

It is really nice to get such appropriate feedback to our articles. Any feedback in the future will be added so that everyone gets a more complete picture. ***Editor***

In the 60's, people took acid to make the world weird. Now the world *is* weird and people take Prozac to make it normal.

Dental first Aid for ChirurgeonsPressure

By Lady Genevieve del Gamba

It's Crown Tournament and you are Chirurgeon in Charge. The Tournament has gone well, and you have been bored all day. As you watch the semifinals, you see Duke Rhino Hide hit Sir Robert the Handsome right in the grill of his helm. Sir Robert's chin strap was worn, but the marshals passed it anyway. With Duke Rhino's hit, the strap broke and the helm was forced right into Sir Robert's nose and mouth. The Marshals call "Hold!" and, horrified, Sir Robert realizes that he is now missing a front tooth and is bleeding profusely from his mouth and nose. "Chirurgeon!" he screams. The Marshall calls you onto the field. What do you do?

Unfortunately, the above scenario is based on a true story. Dental injuries in the SCA are more common than most chirurgeons think. The most common injury is

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described above, whether the tooth is completely knocked out or only loosened. Very few fighters, whether chivalric or fencing, wear custom fitted sports mouth guards. Dental accidents can also happen to bystanders where a fall can knock out a tooth just as easily as a hit during a tournament. So what would you do in the scenario above?

The first thing to do is to act calmly and calm the patient, just like any other call. Put on gloves, obtain consent for treatment, and start paperwork. If the tooth is missing and is not in the oral cavity, look on the ground or in the helm for the tooth. Ask the patient if he thought he swallowed the tooth.

Once you find the tooth, check its condition. Does it look whole and have all its roots? How clean is it? If the tooth is dirty, do not scrub the tooth. This is extremely important. Rinse the tooth off in milk, saline, or water. Do not scrub the tooth. There are important cells and tissues that will still be attached to the avulsed (knocked out) tooth that are vital for the tooth to reattach to the bone when re-implanted.

Next, help to control the bleeding. Many times the lip will be lacerated or the nose will be bleeding after an accident like this. Control that bleeding as well. Put some gauze (2x2 size is perfect) folded into a square over the bleeding socket and have the patient bite to control the bleeding.

While the patient is doing this, you can rinse off the tooth (remember, only rinse gently) and find a container (clean) for the tooth. Place the tooth in milk or saline and make sure the patient takes it with them to the hospital. The patient needs to see a dentist within 90 minutes of the tooth being knocked out or they will lose the tooth.

Most major hospitals will have an oral maxillofacial surgeon who can re-implant this tooth when they get to the hospital. Any general dentist can also do this. A kit can be ordered from your local dentist that has pre-made solution and container to carry the tooth to the dentist. It's called Save-A-Tooth and is a great addition to your kit.

If the patient cannot make it to a dentist or hospital within 90 minutes, it is within the scope of first aid to re-implant the tooth. Make sure the tooth is rinsed of visible dirt, debris, etc. Gently hold the tooth with two fingers and place the tooth in the socket. There will be discomfort, so advise the patient before you replace the tooth. Push the tooth gently into place and caution the patient not to disturb the tooth. The patient must still see the dentist as soon as possible to stabilize the tooth.

Sometimes the tooth is only partially knocked out or loosened. Obviously, do not pull it the rest of the way out. First aid in this situation is to gently reposition the tooth. This will be uncomfortable for the patient, so inform them what you are doing. Most dentists would rather see the tooth put gently back in place as closely as possible rather than have it dangling two hours later. Bleeding will likely be present, so help to control that as well by using a gauze bandage and pressure. Highly encourage the patient to go to the hospital or see a dentist as soon as possible (within 90 minutes preferably). Caution the patient not to eat or drink until they see the dentist so they don't disturb the tooth further.

Custom fitted sports mouth guards or football-type mouth guards will prevent most of these injuries. However, chirurgeons and marshals cannot prevent a fighter from fighting because they don't have a mouth guard. Encourage your local fighters to wear a mouth guard. Most other dentally related calls are fairly mild.

Occasionally folks will have fillings that come out or will have a toothache. When a filling comes out, recommend that they can get a temporary filling material at most drug stores that can cover the hole or they can wait to see their dentist when they get home. Toothaches (especially if they are swollen) need to be

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referred directly to a dentist or ER for antibiotics. Swellings in the gum should also be treated like a toothache. Remember that the teeth and gums are located very close to the brain and any infections in them should be handled with care.

The topics included in this article should cover the dental emergencies chirurgeons may face at events. If there are further questions, please contact the author at the contact information below or talk to your local dentist.

About the Author

Lady Genevieve del Gamba is a 12th Century Norman woman who has a morbid and unseemly fascination with other peoples' teeth. She is a Chirurgeon, Master Waterbearer, ER Deputy Kingdom Chirurgeon and Kingdom Waterbearer. She is an Apprentice / Protégé to Mistress Xene Theirane, OL, OP. In her free time she enjoys the gentle pursuits of embroidery, cooking, archery, and hunting.

Grimbold's Rules of Chirurgy

By Grimbold

Grimbold here,

If you think about it, most rules can be traced back to someone doing something either dumb or just wrong. "Do this", "Don't do that", "If this happens then you must do <x>", we have many of these, great for a basic structure and we do need them.

Mine aren't that sort of rules, they're more general, derived from watching things go both wrong and right, and are a personal attempt to distill that experience into something easy to transmit to others. You might actually have to think about them before they can work for you. No doubt someone with more of a gift for words could do better; this seems to work for me so far.

Grimbold's Rule #1:
Don't become part of the problem

Take care of yourself first. When you go down, you not only add to the patient load, but you've just taken out one of the rare people who fix things, which is much worse. This means: meals, hydration, take your meds, get sleep when you can, wear hat/sunblock/heavy cloak/real shoes when you should, talk to someone trusted if you need to de-stress, line up help to take over before you collapse, etc.

In short, all the stuff you tell patients to do is even more important for you to do. Monitor yourself first; you're supposed to be helping patients. Not creating new ones.

Grimbold's Rule #2
Know your <digestive end product> & do it right

Doesn't matter what your cert is, we do first aid, so do the best first aid you can. If you're SFA, be a really *good* first aider, if you're an EMT, be at the head of your class (or at least learn enough afterwards that you would be now), and do good first aid. Much the same for other certs, keep learning and practicing those "basic" first aid skills until you can do them half-asleep in the dark at least partially underwater with completely panicked people screaming at you - Because sooner or later you may have to.

When you think you really know what you're doing, work on 'why', that should keep you busy for quite some time.

Grimbold's Rule #3
Panic is contagious, calm less so. Work on it

It's hard to overstate the importance of staying calm in mid-crisis, but really easy to see the bad results of not doing so. Most of us arrive at a crisis situation and gradually reduce it through hard work; a few of us walk in and everyone gets crazier, a very few of us walk in

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and not only help, but everyone *else* gets calmer and more effective.

Want to start becoming more like the last type? Look to your own knowledge and behavior, watch how others react to you, and like the book says, in an emergency, take your own pulse first.

Grimbold's Rule #4
Never trust patients

Sounds mean and paranoiac? True, but you'll remember it easily. Some patients will 'forget' to tell you little things like "I'm dehydrated and on Lithium" or "I didn't eat in the last 3 days", unless you ask them the right questions. Patients with what you think are minor complaints (e.g. finger cut) will wait until your back is turned grabbing a Band-Aid, to silently faint to the floor.

They'll leave their meds at home, fail to let anyone else on the planet know about their poorly-controlled seizure disorder or heart condition and generally do the worst, most unexpected things a particularly vengeful deity could dream up on a bad day. It's not intentional, it's not personal it's just reality. We never see people at their best; we see them when they're sick or hurting, upset or confused.

Not all patients will do this, but a dismayingly large percentage do, and you can't tell which ones will do so in advance. So keep a very aware eye on each patient in your care and do your best to be ready if they do something unexpected - Because all too often, they will.

Grimbold's Rule #5
One chirurgeon per non-emergent patient

Goes along with rule #6, never swarm the patient, doesn't do good for anyone. Obvious exceptions, one apprentice works while being observed, lifting or assisting patient movement where more than one helper would be safer, when you need a witness, etc.

Not that there's nothing wrong with asking for help if you need it and it's available, just don't overwhelm the patient. "He/she knows a lot more about <this problem>, I'd like to ask them to look at you too, OK?" is how I usually hear it done.

Grimbold's Rule #6
Emergency care for real emergencies

'Emergency care'. Really helps if there's an actual major emergency before we start treating one. Not every bee-sting is anaphylaxis, not every patient needs us leaping into action like Olympic hurdlers.

Signs and symptoms *rule*, it's that simple. If you don't know what an emergency is then you obviously need to train more, if you don't know what to do in an emergency you need to train a *lot* more. If your patient is emergent, deal with their problem efficiently as your training dictates and ship them out to get the care they need. If not, treat them as calmly as if you were treating yourself, "I know what this is and I'm fixing it, OK, all done, how do you feel now?" Both you and your patients will last a lot longer this way.

Grimbold's Rule #7
Work with patients, not on them

It's all too tempting to focus only on the problem, patch that, and completely ignore the person under the bandage. Bad chirurgeon, no coffee! Unless you have actual emergencies to tend to right now, talk to your patient like you're a person, not a textbook, and take the same about of time you'd want someone to take with you. OK, maybe a bit more, some of us get pretty jaded and clinical about our own care.

Remember, a patient who can talk to you is a godsend, and might be cooperative and give you good information if you let them. Keep in mind that a calm tone and a gentle pat on the hand can sometime have as good an effect as some pretty major meds, don't ever neglect the

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human element in healing. Hey, you might even get thanked, but don't get spoiled, it won't happen often

Grimbold's Rule #8
We save lives occasionally, we help all the time.

Face it now, the majority of our calls are not going to be life or death cutting-edge EMS, it does happen, but not often. And would you really want it to? Considering that rural events can be over an hour to the nearest hospital on a good day?

What does happen every day is people arrive with something wrong that could ruin their event/week/month if untreated or poorly treated and we make a positive difference, sending them out again doing better. That's what we do most, improving health and safety in small but effective ways. Train for the really nasty stuff but don't expect it all the time, all the care we provide is important, not just the exciting bits.

Grimbold's Rule #9
Seer, shmeer. Analyze and anticipate.

Think ahead. All the time. What you don't think of can bite you. If someone arrives shaky, they sit down immediately with someone next to them making sure they don't fall. If you think they might need to lie down later, start them sitting on a cot if you have one, or blankets on the ground if you don't. Treat what you find is wrong, but also think about what could happen based on what's happening now, plan your response(s), and you may be better prepared for 'surprises' that could otherwise bite you. Nobody can anticipate everything, but surprises shouldn't be all that surprising once you're doing this really well.

Grimbold's Rule #10
That was a fun learning experience

OK, your patient has been cared for and is gone now and you have a minute. In your head go back over the whole thing, both where you did everything perfectly and where it could have been better, less stressful, faster, etc.

Don't beat yourself up about it, just learn from it. Every experience is a learning experience, triumphs to repeat or minor glitches to learn from.

Note that nothing was said about other 'experts' second-guessing your call for you in hindsight, it was your patient and your decisions, so it's your job to review it, Ask questions of someone you trust who has more experience or training if you like, but don't broadcast things, preserves both confidentiality and your sanity.

Rule #2 is about general training, Rule #10 is about developing a personal 'scenario file' to keep you sharp for the next time.

Hoping you found the above useful.

Grimbold

Author's Note

I happened to remember this list of rules and annotations I put together over a decade ago, and thought it might be a small contribution to the list [the SCA-Chirurgeons Yahoo list – *Ed.*]. It is a personal view, not any kind of official one, drawn from experience and perhaps reflecting those early folks I followed around and learned from. If you're wondering, these would be Samirah, Anna, Theodor, Rannveigr, Brusten, Amaryllis and Devon among others, in no particular order. I'm sure they'd disavow any responsibility. I know I would.

Use this as you will, though I'd prefer if you think about these "Grimbold's Rules" as a basis, add that thinking to your own ideas and experience, and arrive at something useful and customized for your own work. I've been doing that in my work and teaching for a good long time.