ON GIVING INTRAMUSCULAR INJECTIONS

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We know all about using one needle for withdrawing the material for injection from the bottle and then using another for the actual injection. That very sharp needle can soon be blunted by pushing it through the rubber stopper, or even against the glass inside of an ampoule, so there should be a new needle for the injection, and a long needle for intramuscular injections into the buttock (one and a half inch) that will reach through the thick adipose tissue into that muscle.

Clean the skin with surgical spirit first. Then it is kind to allow the cold injection; just removed from the cool box, to warm up in one's hand to almost body temperature. A freezing cold inoculation straight into muscle can be a source of pain.

It is noticeable that not all healthcare professionals seem to know how to give these injections. Photographs in the newspapers show whoever bunching up the flesh so that there is a nice soft cushion of skin, then they plunge or push the needle in. That is quite painful for the patient.

Far better then, to stretch the skin tightly between the finger and thumb of the opposite hand and then quickly pop the sharp needle between. The tightly-stretched skin will then display fewer pain receptors and the recipient will notice only the pressure of that finger and thumb – no pain, no crying. Occasionally of course one goes through one's own thumb or finger so take care! Why some doctors ask the patient to "Cough!" at the moment of injecting is not known.

In choosing the site for intramuscular injections, it has become fashionable in hospitals to choose the front of the thigh. This is thoughtless and unkind to the patient since this makes for very uncomfortable movement and walking. During the last war, it was said that the Japanese doctors injected into the pectoralis major muscle. Far better to select the "upper outer quadrant" of the buttock and the articles of clothing must be "pulled down"; very often they will not go far "up" enough! There is ample room for an injection with no fear of hitting any sciatic nerve. Stand the patient sideways or lying recumbent and aim.

If the upper arm is chosen for such, then one must know exactly where lies the insertion of the multi-pennate deltoid muscle. It is lastingly panful to inject into its tendinous part so one must aim well above into the circumflex humeral nerve which appears from round the back!

It should be the common practice to cover the injection site then with a tiny plaster. Quite severe bleeding has been known to occur; which can spoil the only office shirt. SMA