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Knowledge of Foot Care on Diabetic Patients

IJSN
Volume 8, Number 2

Moganaraman[1], Mala[2], Meera[3], Manikandan[4], S. Sridevy[5]

Abstract

Diabetes is the third leading cause of death by disease, people with diabetics are prone to foot problem because of the disease can cause damage to the blood vessels and nerve. This in turn may result in decrease ability to sense trauma or pressure on the foot. So it is important to create awareness about foot care among diabetic patients. The present study was to assess the knowledge of foot care among diabetic patients visiting selected government hospitals in Puducherry. The qualitative approach was used for the study. The study reveals that 40 (66.66%) of the subjects are belongs to the moderately adequate knowledge about the diabetic mellitus and also states that the Ages, sex, education, marital status, habits, diet, family history, duration, availability of treatment are non-significant to knowledge on diabetic foot care.

Keywords: Knowledge; Foot care; Diabetic; Selected government hospital.

How to cite this article:

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Introduction

Non communicable diseases are known as the one of important cause of mortality in the developed country and it is growing rapidly in the developing countries too. One of the major causes in increase of the disease in the world is the prevalence of diabetes mellitus. High blood sugar has numerous symptoms and many people are unaware of its outbreak. Most of the people would realize the outbreak when they experience heart attack, shock, and for diagnosis in the physical examination. Today, in developed countries one in every adult has Diabetes mellitus. Prevalence of diabetes mellitus in the urban was higher than the rural communities based on the factors such as lifestyle, food, environmental stress. Etc.,

Diabetes mellitus can lead to nerve damage in the feet and legs resulting in the loss of sensation. Any trauma or injury may not be felt and can even lead to serious problems such have ulcerations. Diabetic foot ulcers develop in approximately 15% of people with diabetes. Eighty percent of lower limb amputation in diabetic are preceded by the development of foot ulcer and is estimated than an annual incidence of lower limb ulcerations in patients with diabetes varies from 2.2 to 7.0 globally (WHO).

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Statement of the Problem

A study to assess the knowledge of foot care among diabetic patients visiting selected government hospitals of Puducherry.

Objectives

1. To determine the level of knowledge of the diabetic patients on foot care.

2. To associate the level of knowledge with selected demographic variables.

Methodology

The quantitative approach was followed to conduct the study and it is based on the concept of manipulation and control of phenomenon and the verification of results using empirical data gathered through senses. This study uses semi structured questionnaire to collect the data. The research design selected for the study was descriptive study design. A simple random sampling technique was adopted for the study.

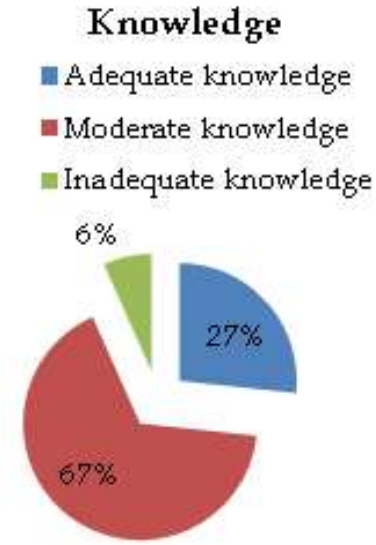

Fig. 1:

Scoring Pattern

0-9-Inadequate knowledge

10-17-Moderate knowledge

18-25-Adequate knowledge

The study shows Majority of samples 40(66.66%) have moderate knowledge, 16(26.66%) have adequate knowledge, 04(6.66%) have inadequate knowledge on diabetic foot care.

Results and Discussion

There were 60 clients with diabetes from selected government hospital were selected for this study and their major finding are dicussed as follows:

- Majority of samples 26(43.33%) belongs to 50–70 years of age.
- Regarding sex majority of samples 34(56.66%) were male patients.
- According to educational status, 23(38.33%) falls between primary education to secondary education.
- Regarding occupation majority of samples 20(33.33%) were Heavy workers.
- Regarding monthly income majority of samples 26(43.33%) had family income of Rs.3000–6000 per month.
- According to marital status majority of sample 50(83.33%) were married.
- Regarding the personal habits majority of samples 31(51.66%) have no ill habit.
- Out of 60 samples, majority of samples 43(71.66%) were Non–Vegetarian.
- According to family health history that majority of samples 23 (38.33%) parents have diabetes mellitus.
- According to duration majority of samples 27(45%) have 2 to 5 years of illness.
- Majority of samples 29(48.33%) had Type 1 diabetes mellitus.
- According to place of treatment majority of samples 39(65%) takes treatment at govt. general hospital.

Recommendation

- This study may be replicated on larger samples.
- The study can be done by using experimental designs.
- The same study can be conducted for longer duration.
- The experimental study can be done by pretest and posttest method.

Implication

The nursing implication includes the specific suggestion for Nursing Practice, Nursing education, Nursing administration and Nursing services. Nursing students should be educated thoroughly about diabetes and their causes, prevention and treatment. Demonstration should be done on how to do the foot care diabetic clients to prevent diabetic foot related complications. Administration involves private and government nursing colleges should take initiation to implement various teaching strategies to increase knowledge and awareness

among public regarding the prevention of diabetic and diabetic complications through mass media, video assisted technologies, journals, magazines, etc., Nursing students should know the important of diabetic foot care and complications. Properly doing foot care prevents various complications in diabetic patients and also prevents early death in diabetic patients.

Conclusion

Regarding knowledge 40(66.66%) of the subjects are belongs to the moderately adequate knowledge about the diabetic mellitus. Remaining 16(26.66%) of the clients are having adequate knowledge about diabetic and 04(6.66%) have inadequate knowledge on diabetic foot care. It evident that majority of the diabetic patients had moderately adequate knowledge about the diabetic mellitus. As health personnel, it is our duty to promote and create awareness to the diabetic patients about the knowledge on foot care to prevent the complications of diabetes mellitus.

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ICU Psychosis

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Neethu Jose

Abstract

Advances in the field of technology and sciences improved the patient care by using highly sophisticated machines. Application of these machines in the intensive care units created a serious problem that has been recently attracted much attention of the health care providers. The patients in ICU experiences a cluster of serious psychiatric symptoms named as ICU psychosis. ICU psychosis is also a form of delirium, or acute brain failure and is also known as ICU syndrome.

Keywords: Psychosis; Delirium; Sensory deprivation.

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Introduction

Advances in the field of technology and sciences improved the patient care by using highly sophisticated machines. Application of these machines in the intensive care units created a serious problem that has been recently attracted much attention of the health care providers. The patients in ICU experiences a cluster of serious psychiatric symptoms named as ICU psychosis. As the number of intensive care units and the number of people in them grow, ICU psychosis is perforce increasing as a problem.

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ICU psychosis is an acute organic brain syndrome involving impaired intellectual functioning and occurring in patient treated within a critical care unit.

Definition

"ICU Syndrome"/"ICU psychosis" as an acute organic brain syndrome involving impaired intellectual functioning and occurring in patients treated within a critical care unit.

-A/C Eisendrath

Incidence

It is commonly found in the critically ill with a reported incidence of 15-80%. By some estimates, 80% of elderly intensive-care patients develop the condition.

Etiology

Pre Disposing Factors

- *Sensory deprivation:* A patient being put in

a room that often has no windows, and is away from family, friends, and all that is familiar and comforting.

- *Sleep disturbance and deprivation:* The constant disturbance and noise with the hospital staff coming to check vital signs, give medications, etc.
- *Continuous light levels:* Continuous disruption of the normal biorhythms with lights on continually (no reference to day or night).
- *Stress:* Patients in an ICU frequently feel the almost total loss of control over their life. Lack of orientation: A patient's loss of time and date.
- *Medical monitoring:* The continuous monitoring of the patient's vital signs, and the noise monitoring devices produce can be disturbing and create sensory overload.

Precipitating organic factors

- Drug intoxication
- Alcohol withdrawal
- Metabolic disturbances
- Acute cerebral disorders
- Infection
- Hemodynamic disturbances
- Respiratory disorders
- Epilepsy

Facilitating factors

- Sustained anxiety
- Sleep deprivation
- Sensory deprivation and overload
- Immobilization
- Unfamiliar environment
- Pain

Medical Causes

- Pain that is not effectively treated in ICU
- *Critical illness:* The pathology of the disease, illness or traumatic event and its effects on body can lead to a variety of symptoms.
- *Medication and side effects:* medication which are new to the patient
- Infection creating fever and toxins in the body.
- *Metabolic disturbances:* electrolyte imbalance, hypoxia, and elevated liver enzymes.
- *Cumulative analgesia:* inability to feel pain while still conscious

Clinical manifestations

- Sudden onset of impairment in cognition
- Disorganized thinking
- Difficulty in concentrating
- Problems with orientation in time and/or place and/or person
- Altered perception of external stimuli
- Impairment of memory
- Changes in sleep–wake cycle
- Hallucinations
- Agitation or change in activity levels

The cluster of psychiatric symptoms of ICU psychosis includes:

- Extreme excitement
- Anxiety
- Restlessness
- Hearing voices
- Clouding of consciousness
- Hallucinations
- Nightmares
- Paranoia
- Disorientation
- Agitation
- Delusions
- Abnormal behavior
- Fluctuating level of consciousness which include aggressive or passive behavior.

In short, patients become temporarily psychotic. The symptoms may change according to the patient and his disease condition. The onset of ICU syndrome is very rapid, upsetting and threatening to patient and even to his family.

Duration

ICU psychosis vanishes magically. It may last 24 hours or up to two weeks with fluctuations in the level of consciousness and behavior patterns

of patients. But it usually worst at night (sun downing). Usually ICU psychosis resolves when the patient leaves the intensive Care Units.

Diagnostic evaluation

- Bedside diagnosis
- Mini mental status and neurologic examination and explore other organic causes
- Nursing record –mental status, behavior and fluctuations of symptoms and signs
- Identify the precipitating organic factors and facilitating factors by history and physical examination and lab test
- Presence of past psychiatric illness or drug dependency-from family member

ICU psychosis can be diagnosed only in the absence of any underlying medical conditions which mimic the symptoms of the ICU psychosis. A medical assessment of the patient is important to search for other causes of mental status abnormality such as:

- Stroke.
- Low blood sugar,
- Drug or alcohol withdrawal, and
- Any other medical condition that may require treatment.

The patient's safety must be considered at all times.

Management *"wait and watch"*

Management includes mainly Non drug management, clear communication of the health care personal, repeated verbal reminders for orientation to time, place and person.

Pharmacological Management

- An Antipsychotic agent such as haloperidol (for resistant cases) is commonly used.
- Olanzapine and Respiridone have been used as sedating and have few side effects.
- Benzodiazepine would be beneficial, and lorazepam is the drug of choice.

Other Therapeutic measures

- Adequate pain management.
- Avoid offending drugs.
- Correct fluid and electrolytes.
- Treat infection.
- Administer oxygen.
- Correct hypoglycemia and.
- Treat underlying cardiac problems.

Treatment

Treatment is based on the underlying causes. Firstly review the patient's medications to identify whether these medications are influencing the delirium.

- Allowing family members, familiar objects, and clam word may help to reduce the symptoms.
- Providing a quiet environment enhances sleep as sleep deprivation is a major contributing factor in delirium.
- Increase the visiting time to stimulate the patient
- Adequate hydration to be maintained.
- Early identification and treatment of the infections.
- Sedation with anti-psychotic agents may help.

Prevention

General principles

- Prevention of ICU psychosis is desirable
- Early detection and treatment reduces the morbidity and death
- Consider patient's family, ICU staffs, environment and his disorders for optimal management.
- Therapeutic endeavors do not stop with ICU discharge
- A trusting relation with the treating physician facilitates early recovery.

The primary goal is to correct any imbalance, restore the patient's health, and return the patient to normal activities as quickly as possible. To help prevent ICU psychosis, many critical care units are

now:

- Liberalization of visiting policies
- Adequate time for rest and sleep
- Prevent unnecessary excitement of the patient
- Minimize the shift changes in nursing staff who cares for the patient
- Adequately and repeatedly orient the patient to time, person and place
- Explain adequately about the medical procedures.
- Asking the patient if there are any questions or concerns.
- Adequate communication with the family about the religious and cultural beliefs.
- Co-ordinate the lighting with the normal day-night cycle, etc.

Pre –ICU prevention

- If ICU admission is elective identify and treat the predisposing factors if possible.
- Decrease surgical organic precipitating factors if possible.
- Diminish facilitating factors.
- Treat depressive disorders before admission or surgery if at all possible, because of the increased risk of morbidity and deaths.

ICU prevention and treatment

1. Staff- patient relationship

Presence of familiar staff or family members helps to improve orientation, decrease anxiety about strangers and builds trust.

An empathic, humane, respectful approach and direct communication decrease patient frustration and anxiety.

Autonomy in self care should be encouraged as soon as it is feasible.

2. Early recognition of delirium and psychosis

Determine attention span, orientation, memory and perceptions aids diagnostic and orientating activities.

Patient can be encouraged to report distressing symptoms as soon as possible.

3. Organic precipitating factors

Can be prevented or treated when delirium is diagnosed.

4. Facilitating factors

Decrease anxiety by adequate staff/patient relationship, presence of trusted relative, adequate information and reassurance about symptoms, procedures and orientating activities.

Reduce sleep deprivation – arrange nursing, investigational and visiting schedules.

Improve sensory environment by removing unnecessary machinery from the patient's immediate environment and providing familiar sounds. Windows, natural lighting, a night light and privacy are all desirable. Use eye patches.

Patient should be mobilized as early as possible.

Pain mgt- Adequate amounts of analgesics; avoid unnecessary painful procedures and using distraction and staff reassurance.

Enhance patient communication by an interpreter, writing tablet or alphabet board, if required.

Patient/ family counseling

- Counselor reinforces the patient's and family's strengths.
- Promotes reality testing, reassures, encourages optimism where possible.
- Reassured about the origins of delirium.

Staff well being

- Stress may be alleviated by using team support.
- In-service teaching, patient follow up and the availability of regular consultations improve morale and confidence.

ICU discharge and follow up

- Common problems following hospital discharge include depression, cognitive impairment, stress response syndromes and illness behavoiur reinforced by a variety of family interactions.
- Individual, group and family counseling.
- Administer antidepressant or other pharmacotherapy.

Conclusion

Delirium is a reversible syndrome, and its occurrence is associated with long term cognitive dysfunction. Early identification, risk factor assessment and prompt treatment is more important in dealing with psychosis. A multidisciplinary approach can enhance the recognition of delirium. For early intervention a validated delirium bedside tool can be used by the ICU team on daily basis. Prevention of delirium is the responsibility of all the health care providers who will have the ability to avoid precipitating factors. Further studies are needed on effective treatments, differences between the motor subtypes, and long-term consequences of ICU delirium.

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Review Article

DOI: http://dx.doi.org/10.21088/ijsn.2277.467X.8219.3

Bleeding Varices

IJSN
Volume 8, Number 2

Seema Varghese

Abstract

Esophageal and gastric varices are one among many complications of Cirrhosis of liver. It occurs in 1/3rd of patients with cirrhosis. First bleeding episode has mortality of 30–50%. Bleeding varices are due to structural changes in the liver from cirrhosis. Esophageal varices are a complex tortuous veins at the lower end of the esophagus, enlarged and swelled due to portal hypertension. Gastric varices are located in the upper portion (cardiac and fundus) of the stomach. Manifestations include hematemesis, melena, general deterioration and shock. Patients with varices must undergo screening endoscopy every two years. Management of bleeding varices includes emergency, therapeutic and prophylactic interventions.

Keywords: Esophageal varices; Variceal ligation and transjugular intrahepatic portosystemic shunt (TIPS).

How to cite this article:

Seema Varghese. Bleeding Varices. Indian J Surg Nurs. 2019;8(2):51–53.

Introduction

Acute gastrointestinal bleeding is a potentially life-threatening abdominal emergency that remains a common cause of hospitalization. Upper gastrointestinal bleeding (UGIB) is defined as bleeding derived from a source proximal to the ligament of Treitz. UGBI can be categorized as either variceal or non-variceal. Variceal is a complication of end stage liver disease. While non variceal bleeding associated with peptic ulcer disease or other causes of UGIB. Varices are dilated blood vessels usually in the esophagus or stomach. They cause no symptoms unless they rupture and bleed. Management also involves a combination of drug therapy and endoscopic therapy.

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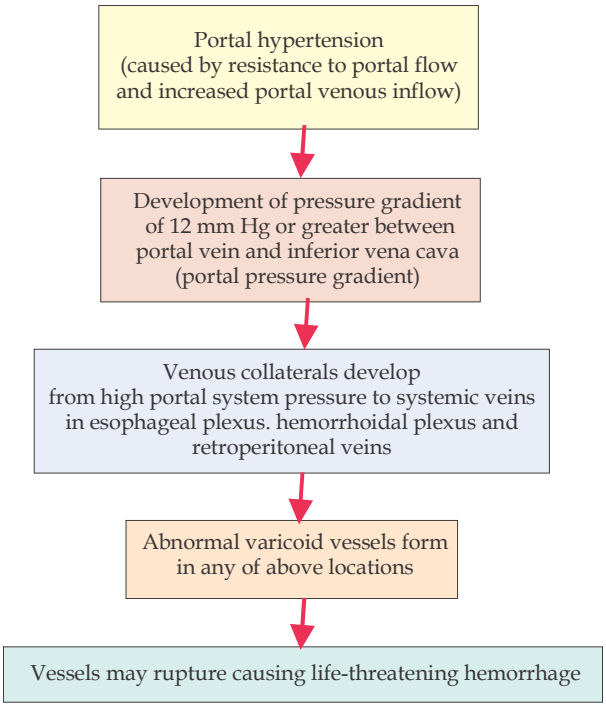
Sign and Symptoms

Non bleeding varices are generally asymptomatic. Once varices are bleeding, patients classically present with symptoms of an upper gastrointestinal hemorrhage such at hematemesis, passage of black or bloody stools, lightheadedness, or decreased urination. Associated signs of variceal hemorrhage include decompensated liver function manifested as jaundice, hepatic encephalopathy, worsened or new-onset ascites.

Physical examination will likely reveal hypotension or shock (in severe cases), pallor and stigmata of chronic liver disease such as spider angiomatas, palmar erythema, gynecomastia, or splenomegaly. A rectal examination should be performed on all patients without obvious bleeding. A black tarry stool on the gloved finger suggests an upper gastrointestinal source, and further workup needs to be pursued. Hemoccult testing is not necessary

because clinically significant bleeding should be apparent with visual inspection of the stool alone.

Pathophysiology of Bleeding varices



Pharmacological management

- Somatostatin analog octeriotide- vasoconstrictors
- Nitroglycerin may be used in combination with vasopressin - to reduce coronary vasoconstriction Beta adrenergic blockers (Propranolol and nadolol) -to decrease portal pressure
- Vitamin supplementation (A, C, K, folic acid) - to stop bleeding
- Histamine receptor blockers (cimetidine/ ranitidine)
- Proton pump inhibitors (pantoprozole)
- Antibiotics- (Ciprofloxacin)
- Lactulose and Neomycin - to prevent hepatic encephalopathy from breakdown of blood and the release of ammonia in the intestine

Non-pharmacological management

- Sclerotherapy: the sclerosing agent (eg. scleromate) is introduced via endoscopy, leading to thromboses and obliterates the distended vein.
- Ligation of varices/ banding: a small rubber band (elastic o-ring) is slipped around the base of varix.
- Balloon tamponade: mechanical compression of the varices. The Minnesota/ Sengstaken Blakemore tube is used for this purpose.
- Glue: Cyanoacrylate glue is injected into the varices and has been found to achieve haemostasis in nearly 100% of cases. Re-bleeding rates have been documented to be as low as 2%. However, this technique requires technical expertise to avoid harming the patient, endoscopist, or equipment.

Surgical management

- Shunt therapy: Transjugular intrahepatic portosystemic shunt (TIPS) is a non surgical procedure in which a tract between the systemic and portal venous system is created to redirect portal blood flow. A catheter is placed in the jugular vein and then threaded through superior and inferior vena cava to the hepatic vein. Currently, the surgical shunts most commonly used are the portocaval shunt and the distal splenorenal shunt.

Nursing management with rationale

- Manage the airway- to prevent from complication.
- Initiate IV therapy, volume expanders, and electrolytes - to prevent hypovolemic shock.
- Saline Lavage - to remove blood from the stomach, this helps to prevent the blood from degrading to ammonia.
- The esophageal blood must be deflated every 8-12 hours -to avoid necrosis.
- The NG lumen may be connected to suction - to remove blood and keep the stomach empty to reduce the risk of aspiration.
- If gastric balloon breaks / deflates, the esophageal balloon may slip upward, obstructing the airway and causing asphyxiation. If this happens nurse must cut the tube / deflate the balloon. Scissors must be kept at the bedside.
- Oral and pharyngeal suctioning and keep

the patient in a semi- fowler's position- to minimize regurgitation.

- Administration of blood products (fresh frozen plasma, packed RBCs)- to prevent shock.
- Bed rest and activities can be modified according to signs of improvement- to reduce fatigue.
- Monitor Intake output chart- to detect early deterioration of health.
- Monitor and manage hemodynamic and renal parameters as well as glucose, electrolytes and acid base status.
    a) Close monitoring of vital signs
    b) Monitor patient's condition frequently, including emotional responses and cognitive status.
- Observe signs of bleeding (hematemesis/ melena) - early detection of hypovolemic shock.
- Encourage the patient for expectorate and should provide emesis basin and tissues- to reduce discomfort.
- Frequent oral and nasal care provides relief from the taste of blood and irritation from mouth breathing.
- Avoidance of alcohol, minimize or reduce aspirin, acetaminophen and NSAIDs-to prevent deterioration of health.
- Involve patient in regular physical, emotional and social climate (without exertion).
- Advise patient to take High-calorie diet, low sodium, low protein diet (1-1.5 gm /kg/ day) - to prevent hepatic encephalopathy.
- Small, frequent meals may be better tolerated.
- Consider patient preferences.
- Quiet, calm environment and reassuring manner.
- Monitor for associated complications such as hepatic encephalopathy resulting from blood breakdown in the GI tract and delirium related to alcohol withdrawal.
- Teaching and support of patient and family.

Complications

Bleeding-related complications include vascular collapse and hypotension, encephalopathy, aspiration, and sub-acute bacterial peritonitis.

Conclusion

Mortality from a variceal haemorrhage is high (25–50%).Prophylaxis against haemorrhage is crucial. If patients survive a variceal bleed, there is approximately a 70% risk that they will have a further bleed within the following two year. The management of esophageal varices is with a multidisciplinary team that consists of a gastroenterologist, internist, surgeon, invasive radiologist, and an intensivist. The treatment selected depends on the severity of the disease and patient status. Unless the primary cause of portal hypertension is controlled, recurrence is common with all treatments. The prognosis for patients with esophageal varices is guarded. Multiorgan failure, complications from procedures and infections often lead to premature death.

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Case Report

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Thromboangiitis Obliterans or Buerger's Disease : It's A Life Thretening Disease

IJSN
Volume 8, Number 2

Pravin Gopal Pande

Abstract

Buerger's disease is a Nonatherosclerotic, segmental, recurrent inflammatory vasoocculusive disorder of the small & medium sized arteries, veins & nerves of the upper & lower extremities. Smoking or tobacco plays a central role in the initiation & progression of the disease. Initial symptom is pain typically begins in the extremities but may radiate to other part of the body. There is no laboratory or diagnosis test specific to Buerger disease. It is diagnosed on the basis on age of onset, history of tobacco use & clinical symptoms. There is a complete cessation of tobacco use in any form including second hand smoke also is only the prevention of Buerger's disease.

Keywords: Thromboangiitis Obliterans Buerger's Disease; Peripheral arterial disease

How to cite this article:

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Introduction

Buerger's disease is first reported by Felix von Winiwarter in 1879 in Austria & in 1908 detailed description of 11 amputated limbs at Mt. Sinai with endarteritis & endophlebitis.[1] Buerger's disease is a nonatherosclerotic, segmental, recurrent inflammatory vaso occulusive disorder of the small & medium sized arteries, veins & nerves of the upper & lower extremities. The disorder occurs predominantly in younger men (< 40 years of age). It is typically begins with ischemia of the small, distal arteries & veins, progressing to more proximal arteries. There is a very strong relationship between buerger's disease & tobacco use.[2]

Incidence: Buerger's disease is found worldwide, the prevalence among all patients with peripheral arterial disease ranges is low 0.5 to 5.6% in Western Europe & high as 45 to 63% in India.[3]

Causes: The exact cause cause of buerger's disease is unknown. Although is a type of vasculitis & it is distinct from other vasculitis. Smoking or tobacco plays a central role in the initiation & progression of the disease. By using an antigen-sensitive thymidine-incorporation assay, that patients with TAO have an increased cellular sensitivity to types i & iii collagen compared to that in patients with arteriosclerosis obliterans or healthy males. Then genetic, hypercougulability also responsible but some studies have failed to demonstrate any correlation.

Sign & symptoms: The initial symptoms of Buerger disease often include claudication (pain induced by insufficient blood flow) in the feet/or hands. The pain typically begins in the extremities but may radiate to other part of the body. Other sign & symptoms of the disease may include numbness &/ or tingling in the limbs.[4]

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Diagnosis: There is no laboratory or diagnosis test specific to Buerger disease. It is diagnosed on the basis on age of onset, history of tobacco use & clinical symptoms, imaging studies, x-rays, & blood investigation if necessary.[2]

Treatment: There is a complete cessation of tobacco use in any form including second hand smoke. Nicotine replacement products should not be used. Other therapy can be considered but have limited success the most commonly used medication are Antiplatlet agents, followed by calcium channel blockers, adrenergic agent, & anticoagulants. Surgical option includes revascularization & sympathectomy. Amputation below the knee may be necessary in advanced cases. The amputation rate on patient who continues tobacco use is 84.3% compared to only 30.6% in patient who discontinue to tobacco use.[2]

Differential diagnosis: The differential diagnosis of Buerger disease are PAD & variety of other inflammatory or autoimmune disease.

Case study

A case study showed that 37 year old male was admitted in hospital in critical condition; he had a history of current or recent smoking. His medical history revealed the presence of distal extremity ischemia indicated by claudication, severe pain in lower & upper extremities, severe hypertension, & weakness of lower extremities & right side upper extremities. Examination done i.e. MRI, Doppler, & blood investigation revealed that blockage in the artery & vein of the upper & lower extremities, increased TLC count, increased Hb%, decreased platelet count, & increased serum creatinine & blood urea level. After the investigation & condition of the patient emergency amputation was done of both leg, after that septicemia occurs & patient death in the hospital.

Conclusion

Early diagnosis & complete cessation of smoking is only to prevent Buerger disease & proper motivation, psychological support for cessaection of smoking & maintain the healthy life styles is utmost important.

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