Call for Editorial Board Members

As you are well aware that we are a medical and health sciences publishers; publishing peer-reviewed journals and books since 2004.

We are always looking for dedicated editorial board members for our journals. If you completed your master's degree and must have at least five years experience in teaching and having good publication records in journals and books.

If you are interested to be an editorial board member of the journal; please provide your complete resume and affiliation through e-mail (i.e. info@rfppl.co.in) or visit our website (i.e. www.rfppl.co.in) to register yourself online.

Call for Publication of Conference Papers/Abstracts

We publish pre-conference or post-conference papers and abstracts in our journals, and deliver hard copy and giving online access in a timely fashion to the authors.

For more information, please contact:

For more information, please contact:
A Lal
Publication-in-charge
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi – 110 091 (India)
Phone: 91-011-79695648
E-mail: info@rfppl.co.in

Free Announcements of your Conferences/Workshops/CMEs

This privilege to all Indian and other countries conferences organizing committee members to publish free announcements of your conferences/ workshops. If you are interested, please send your matter in word formats and images or pictures in JPG/JPEG/Tiff formats through e-mail attachments to sales@rfppl.co.in.

Terms & Conditions to publish free announcements:

1. Only conference organizers are eligible up to one full black and white page, but not applicable for the front, inside front, inside back and back cover, however, these pages are paid.
2. Only five pages in every issue are available for free announcements for different conferences.
3. This announcement will come in the next coming issue and no priority will be given.
4. All legal disputes subject to Delhi jurisdiction only.
5. The executive committee of the Red Flower Publication reserve the right to cancel, revise or modify terms and conditions any time without prior notice.

For more information, please contact:
A Lal
Publication-in-charge
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi – 110 091 (India)
Phone: 91-011-79695648
E-mail: info@rfppl.co.in

Win Free Institutional Subscription!

Simply fill out this form and return scanned copy through e-mail or by post to us.

Name of the Institution_____
Name of the Principal/Chairman_____
Management (Trust/Society/Govt./Company)_____
Address 1_____
Address 2_____
Address 3_____
City_____
Country_____
PIN Code_____
Mobile_____
Email_____

We are regular subscriber of Red Flower Publication journals.

Year of first subscription_____

List of ordered journals (if you subscriberd more than 5 titles, please attach separate sheet)

Ordered through

Name of the Vendor	Subscription Year	Direct/subs Yr

Name of the journal for which you wish to be free winner

Terms & Conditions to win free institutional subscription

1. Only institutions can participate in this scheme
2. In group institutions only one institution would be winner
3. Only five institutions will be winner for each journal
4. An institution will be winner only for one journal
5. The free subscription will be valid for one year only (i.e. 1 Jan – 31 Dec)
6. This free subscription is not renewable, however, can be renewed with payment
7. Any institution can again participate after five years
8. All legal disputes subject to Delhi jurisdiction only
9. This scheme will be available to participate throughout year, but draw will be held in last week of August every year
10. The executive committee of the Red Flower Publication reserve the right to cancel, revise or modify terms and conditions any time without prior notice.

I confirm and certify that the above information is true and correct to the best of my knowledge and belief.

Place: Signature with Seal
Date:

Revised Rates for 2022 (Institutional) **Title of the Journal**	**Frequency**	**India(INR) Print Only**	**India(INR) Online Only**	**Outside India(USD) Print Only**	**Outside India(USD) Online Only**
Community and Public Health Nursing	3	6000	5500	469	430
Indian Journal of Agriculture Business	2	6000	5500	469	430
Indian Journal of Anatomy	4	9000	8500	703	664
Indian Journal of Ancient Medicine and Yoga	4	8500	8000	664	625
Indian Journal of Anesthesia and Analgesia	6	8000	7500	625	586
Indian Journal of Biology	2	6000	5500	469	430
Indian Journal of Cancer Education and Research	2	9500	9000	742	703
Indian Journal of Communicable Diseases	2	9000	8500	703	664
Indian Journal of Dental Education	4	6000	5500	469	430
Indian Journal of Diabetes and Endocrinology	2	8500	8000	664	625
Indian Journal of Emergency Medicine	4	13000	12500	1016	977
Indian Journal of Forensic Medicine and Pathology	4	16500	16000	1289	1250
Indian Journal of Forensic Odontology	2	6000	5500	469	430
Indian Journal of Genetics and Molecular Research	2	7500	7000	586	547
Indian Journal of Law and Human Behavior	3	6500	6000	508	469
Indian Journal of Legal Medicine	2	9000	8500	703	664
Indian Journal of Library and Information Science	3	10000	9500	781	742
Indian Journal of Maternal-Fetal & Neonatal Medicine	2	10000	9500	781	742
Indian Journal of Medical and Health Sciences	2	7500	7000	586	547
Indian Journal of Obstetrics and Gynecology	4	10000	9500	781	742
Indian Journal of Pathology: Research and Practice	6	12500	12000	977	938
Indian Journal of Plant and Soil	2	7000	6500	547	508
Indian Journal of Preventive Medicine	2	7500	7000	586	547
Indian Journal of Research in Anthropology	2	13000	12500	1016	977
Indian Journal of Surgical Nursing	3	6000	5500	469	430
Indian Journal of Trauma and Emergency Pediatrics	4	10000	9500	781	742
Indian Journal of Waste Management	2	10000	9500	781	742
International Journal of Food, Nutrition & Dietetics	3	6000	5500	469	430
International Journal of Forensic Science	2	10500	10000	820	781
International Journal of Neurology and Neurosurgery	4	11000	10500	859	820
International Journal of Pediatric Nursing	3	6000	5500	469	430
International Journal of Political Science	2	6500	6000	508	469
International Journal of Practical Nursing	3	6000	5500	469	430
International Physiology	3	8000	7500	625	586
Journal of Animal Feed Science and Technology	2	8300	7800	648	609
Journal of Cardiovascular Medicine and Surgery	4	10500	10000	820	781
Journal of Emergency and Trauma Nursing	2	6000	5500	469	430
Journal of Forensic Chemistry and Toxicology	2	10000	9500	781	742
Journal of Global Medical Education and Research	2	6400	5900	500	461
Journal of Global Public Health	2	12500	12000	977	938
Journal of Microbiology and Related Research	2	9000	8500	703	664
Journal of Nurse Midwifery and Maternal Health	3	6000	5500	469	430
Journal of Orthopedic Education	3	6000	5500	469	430
Journal of Pharmaceutical and Medicinal Chemistry	2	17000	16500	1328	1289
Journal of Plastic Surgery and Transplantation	2	26900	26400	1954	575
Journal of Psychiatric Nursing	3	6000	5500	469	430
Journal of Social Welfare and Management	4	8000	7500	625	586
New Indian Journal of Surgery	6	8500	7500	664	625
Ophthalmology and Allied Sciences	3	6500	6000	508	469
Pediatric Education and Research	4	8000	7500	625	586
Physiotherapy and Occupational Therapy Journal	4	9500	9000	742	703
RFP Indian Journal of Medical Psychiatry	2	8500	8000	664	625
RFP Journal of Biochemistry and Biophysics	2	7500	7000	586	547
RFP Journal of Dermatology (Formerly Dermatology International)	2	6000	5500	469	430
RFP Journal of ENT and Allied Sciences (Formerly Otolaryngology International)	2	6000	5500	469	430
RFP Journal of Hospital Administration	2	7500	7000	586	547
Urology, Nephrology and Andrology International	2	8000	7500	625	586
Coming Soon					
RFP Gastroenterology International	2	–	–	–	–
Journal of Food Additives and Contaminants	2	–	–	–	–
Journal of Food Technology and Engineering	2	–	–	–	–
Journal of Radiology	2	–	–	–	–
Medical Drugs and Devices	3	–	–	–	–
RFP Indian Journal of Hospital Infection	2	–	–	–	–
RFP Journal of Gerontology and Geriatric Nursing	2	–	–	–	–

Terms of Supply:

1. Agency discount 12.5%. Issues will be sent directly to the end user, otherwise foreign rates will be charged.
2. All back volumes of all journals are available at current rates.
3. All journals are available free online with print order within the subscription period.
4. All legal disputes subject to Delhi jurisdiction.
5. Cancellations are not accepted orders once processed.
6. Demand draft/cheque should be issued in favour of "**Red Flower Publication Pvt. Ltd.**" payable at **Delhi.**
7. Full pre-payment is required. It can be done through online (http://rfppl.co.in/subscribe.php?mid=7).
8. No claims will be entertained if not reported within 6 months of the publishing date.
9. Orders and payments are to be sent to our office address as given below.
10. Postage & Handling is included in the subscription rates.
11. Subscription period is accepted on calendar year basis (i.e. Jan to Dec). However orders may be placed any time throughout the year.

Order from

Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi - 110 091 (India)
Mobile: 8130750089, Phone: 91-11-79695648, E-mail: info@rfppl.co.in, Website: www.rfppl.co.in

Journal of Emergency and Trauma Nursing

JETN

Corresponding address
Red Flower Publication Pvt. Ltd.
48/41-42 DSIDC, Pocket-II
Mayur Vihar Phase-I, Delhi - 110 091(India)
Phone: 91-11-79695648
E-mail: info@rfppl.co.in, Website: www.rfppl.co.in

Journal of Emergency and Trauma Nursing intends to publish research, Review and short articles related to Emergency care and Management. The Journal intends to aim in an area that is one of the most challenging area of medicine and invites research review, short articles and case studies

Subscription Information

India
Institutional (1 year) (Print+Online): INR 6000

Rest of the World
Insitutional (1 year) (Print+Online): $ 469
Payment instructions
Online payment link:
http://rfppl.co.in/payment.php?mid=15

Cheque/DD:
Please send the US dollar check from outside India and INR check from India made. Payable to 'Red Flower Publication Private Limited'. Drawn on Delhi branch

Wire transfer/NEFT/RTGS:
Complete Bank Account No. 604320110000467
Beneficiary Name: Red Flower Publication Pvt. Ltd.
Bank & Branch Name: Bank of India; Mayur Vihar
MICR Code: 110013045
Branch Code: 6043
IFSC Code: BKID0006043 (used for RTGS and NEFT transactions)
Swift Code: BKIDINBBDOS

Send all Orders to: Subscription and Marketing Manager, Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi - 110 091(India), Mobile: 8130750089, Phone: 91-11-79695648. E-mail: sales@rfppl.co.in.

Journal of Emergency and Trauma Nursing **JETN**

July - December 2022
Volume 3, Number 2

Contents

Original Articles

Review Articles

Original Article

Journal of Emergency and Trauma Nursing
Volume 3 Number 2, July - December 2022

Role of Innovative Splints in Protecting Skin Grafts

Barath Kumar Singh P[1], Ravi Kumar Chittoria[2]

How to cite this article:
Barath Kumar Singh P, Ravi Kumar Chittoria/Role of Innovative Splints in Protecting Skin Grafts/Journal of Emergency and Trauma Nursing. 2022;3(2):47–49.

Abstract

Skin grafting are most common surgeries performed in field of plastic surgery. Post-operatively patient may need to maintain the particular position to preserve the viability of the Skin grafts to prevent the direct pressure application over the recently raised loco regional flap. Skin grafts over the back will be very cumbersome for the patient postoperatively to maintain the prone and lateral position to prevent the direct pressure over the Skin grafts. In this case report we will assess the role innovative splint to prevent the application of direct pressure over skin grafts in lower back.

Keywords: Flaps; Protective splints; Innovation.

INTRODUCTION

A Skin grafts is harvested when the surgeon needs to cover the raw area that needs to be covered, known as the recipient site in the local site. Skin grafts can be used to cover the raw area variety of body parts. The head, neck, chest, or breast areas, arms and legs, and the lower back, buttocks, or vagina are all examples. In this case report we will assess the use of innovative ring splints in post-operative care of the surgical site with skin grafts.

Author's Affiliations: [1]Senior Resident, [2]Professor, Department of Plastic Surgery, Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry 605006, India.

Corresponding Author: Ravi Kumar Chittoria, Professor, Department of Plastic Surgery, Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry 605006, India.

E-mail: drchittoria@yahoo.com

Received on: 11-07-2022

Accepted on: 14-08-2022

MATERIALS AND METHODS

In this case report, 32 year old male came to JIPMER Hospital with the chronic non healing ulcer over the lower back of size 5 X 5 cm for past 10 year post electrical burns. After wide local excision of the ulcer histopathology report came as Squamous cell carcinoma with all margins negative for tumor. After tumor removal size of the tumor ulcer size was around 8 x 8 cm. In view of scarred tissue all around the ulcer, local keystone flap based on the perforator on the right side of the ulcer and transposition flap on left side of the ulcer planned. The raw area created post local flaps from the donor site was covered with split skin grafting from the left thigh. Post-operative care for the flap and skin graft was done with innovative ring splint made from cotton roll and pad made into a ring and fixed around the flap site so that even if the patient lies flat flap site was protected by the splint from direct pressure over the skin grafted site. The cost of making the innovative splint is very minimal and is readily and easily applicable.

RESULTS

In this case report, patient was comfortable postoperatively with the splint, the patient compliance is good as patient can mobile in any direction in bed without any harm to the skin grafted site. The patient was very happy with splint as he feels less pain post-operative with well-padded splint even if the patient lies flat with the surgery over the lower back region.

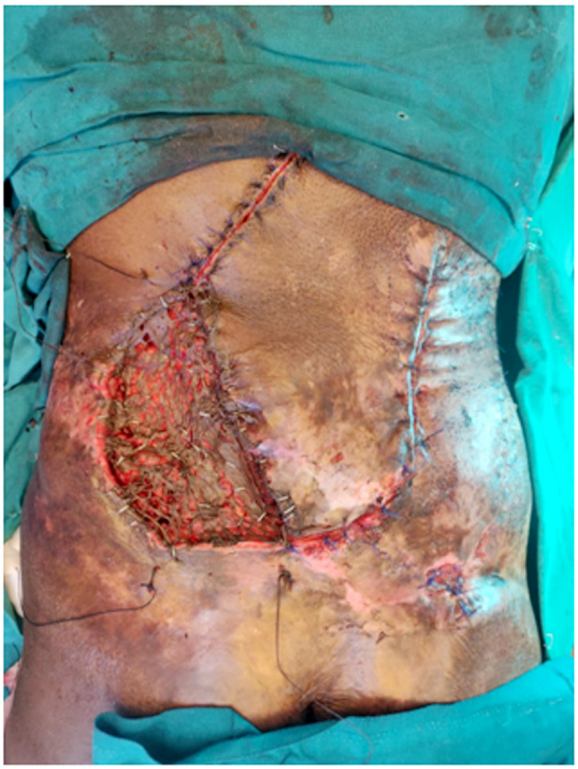

Fig. 1: Transposition flap.

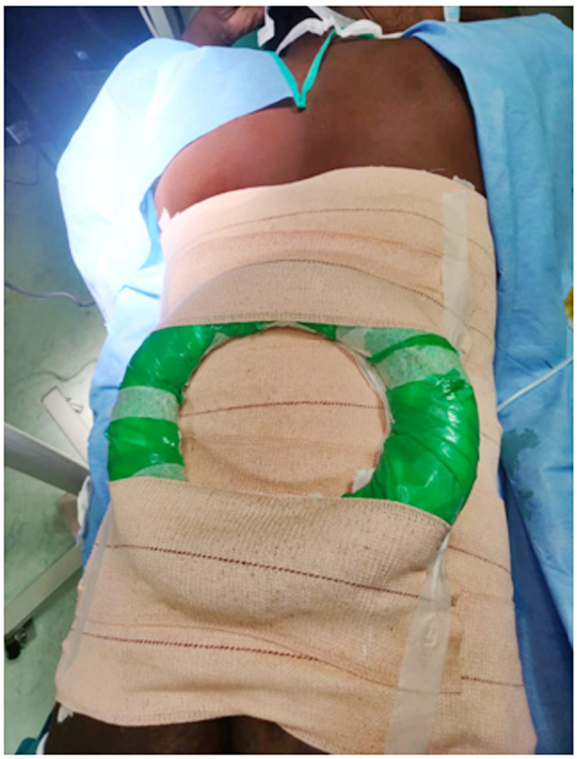

Fig. 2: Protective Ring splint for local flap

DISCUSSION

Skin grafts are to be protected post surgery, for monitoring and splinting we will splint the region with the customized splint or Plaster of Paris.[1] This method helps in a way to protect the skin grafts. The positioning and splinting should be important post surgery for skin grafting as it minimizes edema formation, prevent tissue destruction, maintain tissue in an elongated state to facilitate recovery and adopt the anti-contracture position. Physical therapy and splinting should immediately after the injury as they play an important role in different body parts function, especially in hand function. The splints are used to hold parts of the body so that the skin graft and flaps can be immobilized and protected while healing.[2] The skin can be prevented from shrinkage and contractures while healing. The new grafts and flaps are protected. The deformity is prevented and/or corrected. There are 3 types of splints usually used with namely static, static progressive and dynamic splints.[3,4] Static or Primary splints are used in the acute phase for skin graft protection after surgery or anti-contracture positioning. These splints are applied to adjacent intact skin. Static progressive or postural splints are used after the graft phase when there is no sufficient Range of movements (ROM) obtained with static positioning and exercise. These splints may be implemented for correction and contractures commonly used in burns patients. Dynamic or follow-up splints are used to increase function by providing a slow force to stretch a contracture or provide resistive force for exercisepost surgery or post burns.

CONCLUSION

Loco regional flaps, free flaps, Skin grafts are commonly performed procedures in plastic surgery department. In this study we can able to appreciate the role of Innovative Splint in Protection of skin grafts. This was based on single case report, so validity of the splints should be tested by using it widely in many patients in future. These splints can be easily adaptable and can be used in any hospital.

Conflicts of interest: None

Authors' contributions: All authors made contributions to the article

Availability of data and materials: Not applicable.

Financial support and sponsorship: None.

Consent for publication: Not applicable

REFERENCES

1. Caulfield, Robert H et al, A Novel Splinting Technique to Protect Free Flaps in Major Limb Trauma. The Journal of Trauma: Injury, Infection, and Critical Care. March 2008 - Volume 64 - Issue 3 - p E44-E46
2. Rrecaj S, Hysenaj H, Martinaj M, Murtezani A, Ibrahimi-Kacuri D, Haxhiu B, Buja Z. Outcome of Physical Therapy and Splinting in hand burns injury. Our last four years experience. Materio socio-media. 2015 Dec; 27(6): 380-382.
3. Dewey WS, Richard RL, Parry IS. Positioning, Splinting, and Contracture Management. Physical Medicine and Rehabilitation Clinics of North America. 2011 May 1;22(2):229-47.
4. Althoff AD, Reeves RA. Splinting. StatPearls. 2020 May 2.

SUBSCRIPTION FORM

I want to renew/subscribe international class journal "**Journal of Emergency and Trauma Nursing**" of Red Flower Publication Pvt. Ltd.

Subscription Rates:
• Institutional: **INR 6000 / USD 469**

Name and complete address (in capitals):_____
_____

Payment detail:
Online payment link: http://rfppl.co.in/payment.php?mid=15

Cheque/DD: Please send the US dollar check from outside India and INR check from India made payable to 'Red Flower Publication Private Limited'. Drawn on Delhi branch.

Wire transfer/NEFT/RTGS:
Complete Bank Account No. 604320110000467
Beneficiary Name: Red Flower Publication Pvt. Ltd.
Bank & Branch Name: Bank of India; Mayur Vihar
MICR Code: 110013045
Branch Code: 6043
IFSC Code: BKID0006043 (used for RTGS and NEFT transactions)
Swift Code: BKIDINBBDOS

Term and condition for supply of journals
1. Advance payment required by Demand Draft payable to **Red Flower Publication Pvt. Ltd**. payable at **Delhi.**
2. Cancellation not allowed except for duplicate payment.
3. Agents allowed 12.5% discount.
4. Claim must be made within six months from issue date.

Mail all orders to
Subscription and Marketing Manager
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India)
Phone: 91-11-79695648
Cell: +91-9821671871
E-mail: sales@rfppl.co.in

Instructions to Authors

Submission to the journal must comply with the Guidelines for Authors. Non-compliant submission will be returned to the author for correction.

To access the online submission system and for the most up-to-date version of the Guide for Authors please visit:

http://www.rfppl.co.in

Technical problems or general questions on publishing with **JETN** are supported by Red Flower Publication Pvt. Ltd.'s Author Support team (http://rfppl.co.in/article_submission_system.php?mid=5#)

Alternatively, please contact the Journal's Editorial Office for further assistance.

Editorial Manager
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India).
Mobile: 9821671871, Phone: 91-11-79695648
E-mail: author@rfppl.co.in

Original Article

Journal of Emergency and Trauma Nursing
Volume 3 Number 2, July - December 2022

Impact of Computer Assisted Teaching Regarding Menopausal Transition among Women Residing at Rural Community Amritsar, Punjab

Vijayalakshmi

How to cite this article:
Vijayalakshmi/Impact of Computer Assisted Teaching Regarding Menopausal Transition among Women Residing at Rural Community Amritsar, Punjab/Journal of Emergency and Trauma Nursing. 2022;3(2):53–59.

Abstract

Context: Menopause is a significant life event affecting millions of women globally.Menopausal transition is a difficult process and has a considerable variation among women regarding the manifestation of menopausal signs and symptoms.

Aims: Evaluate the effectiveness of computer assisted teaching on menopausal transition among women residing at selected rural community.

Methods and Material: A double blind study was conducted among women aged 40-55 years residing at Tarsika rural community, Amritsar, Punjab. The research design was true experimental i.e. Randomized controlled trial design. Simple random sampling technique was used to select 300 samples for the study. The tool used for the study was menopause rating scale. Computer assisted teaching was given to the experimental group immediately after pretest. Post-test I and II was conducted after one month and third month respectively.

Statistical analysis used: The data gathered was analyzed by descriptive and inferential statistics.

Results: Results revealed that in the control group, majority of women (42.7%, 47.3% and 58.7%) had severe and moderate level of menopausal transition during pretest, posttest-I and posttest-II respectively where as in experimental group, majority of women (48.7%) had severe level of menopausal transition during pretest but there was a marked change observed in the posttest-I and II level of menopausal transition. After computer assisted teaching in the experimental group, majority of women had mild level of menopausal transition (70.7% and 72.7%) in post-test I and post-test II.

Conclusion: The findings revealed that the provision of computer assisted teaching has reduced the severity of menopausal symptoms and very effective during menopausal transition.

Keywords: Menopause; Menopausal transition; Computer assisted teaching.

Author's Affiliations: Principal, S.B.S Institute of Nursing, Amritsar 143601, Punjab, India.

Corresponding Author: Vijayalakshmi, Principal, S.B.S Institute of Nursing, Amritsar 143601, Punjab, India.

E-mail: Vijayal2006@gmail.com

Received on: 25-06-2022

Accepted on: 27-07-2022

INTRODUCTION

The menopausal transition is a natural process and a developmental phase of life. In many women menopausal transition is a troublesome period of life and is often associated with decreased well-being and number of symptoms.[1] Women going through the menopause transition may experience a variety of symptoms ranging from

vasomotor symptoms to sleep disturbance, mood disorders, loss of sexual desire and vaginal dryness. The symptoms can make it a considerable struggle for those who are already dealing with their hectic lives.[2] Large efforts are required to educate and make women to be aware of menopausal symptoms.

STATEMENT OF THE PROBLEM

Impact of Computer Assisted Teaching regarding Menopausal Transition among Women residing at Rural Community Amritsar, Punjab.

OBJECTIVES

- Assess the menopausal transition among women residing at selected rural community.
- Evaluate the effectiveness of computer assisted teaching on menopausal transition among women residing at selected rural community.
- Find out the association between menopausal transition andselected demographic variables of women.

HYPOTHESIS

HO1: There is a statistically significant change in menopausal transition between women those who attend the computer assisted teaching than those who do not.

HO2: There is a statistically significant association between menopausal transition and selected demographic variables among study group.

MATERIALS AND METHODS

Research approach : Evaluative approach.

Research Design : Randomized Control Trail; True Experimental Design.

Setting of the Study : Rural community, Tarsika, Baba Bakala, Amritsar, Punjab.

Target Population : Women with in the age group 40-55 years.

Sample Size : Total three hundred women with in the age group 40-55 years in that 150 samples were control group and the other 150 samples were study group.

Sampling Technique : Simple random sampling by lottery method.

DESCRIPTION OF THE TOOL

The tool consists of two sections.

Section-I

It is demographic variablesof women which consist of 2 parts.

- Part-A consists of Background variables such as age, marital status, educational status of woman, educational status of husband, occupational status of woman, type of family, family socioeconomic status, type of diet, Sources of health information and Distance of health care facility from house.
- Part-B consists of Clinical variables such as parity of woman, number of health visits per year, suffering from any menopausal symptoms, suffering from any chronic illness, taking hormone replacement therapy, taking calcium supplements and doing any exercise.

Section-II

- The Menopause rating scale consists of 11 symptoms of menopause. It includes 5 columns for responses (None, mild, moderate, severe and very severe) with a score of 0, 1, 2, 3 and 4 respectively.

SCORING PROCEDURE

Section-II

Menopause rating scale was developed by ZEG Berlin center for epidemiology and health research.3 MRS is used to assess the symptoms of menopause (Menopausal transition) consisting of 11 items. It includes 5 columns for responses (None, mild, moderate, severe and very severe) with a score of 0, 1, 2, 3 and 4 respectively. Total score is 44.

Menopause symptoms	Score	Percentage
No symptoms	0	0%
Mild symptoms	1-11	1-25%
Moderate symptoms	12-22	26-50%
Severe symptoms	23-33	51-75%
Very severe symptoms	34-44	76-100%

RELIABILITY

The reliability of the tool- menopause rating scale is standardized tool and found to be highly reliable.

Pilot Study

Pilot study was conducted for thirty women (15 as control group and 15 as study group) to find out the effectiveness of computer assisted teaching regarding menopausal transition in Tarsika rural community at Amritsar for a period of 30 days to find out the feasibility of the study and to plan for data analysis on the basis of pilot study. Written permission was obtained from the medical officer of Tarsika community health center and oral consent was obtained from the subjects after explaining the purpose of the study. Researcher has given training to one ASHA health worker about data collection.

Data was collected by one ASHA health worker who was trained by the researcher. First 15 samples were selected as control group for data collection. Pretest was conducted for each woman to collect the demographic variables and to assess the menopausal transition with structured tool. Then the investigator selected 15 samples for study group and pretest was conducted with same tool. Immediately after the pretest, computer assisted teaching on menopause for 45 minutes was given only to the study group by using laptop as small group teaching. After 15 days of pretest, posttest was conducted for both control group and study group with the same tool to assess the effectiveness of computer assisted teaching.

Data were analyzed and findings of the pilot study showed that there was a mild change found between pretest and posttest level of menopausal symptoms in study group. There is no significant association found between level of menopausal transition and selected background variables among study group. After the pilot study results concluded that it is feasible and practicable to conduct the main study.

DATA COLLECTION PROCEDURE

True experimental research study was conducted by using double blind study method. For double blind study researcher had selected 2 ASHA health workers as investigators and given training for taking survey and data collection procedure. Then researcher clarified their doubts and evaluated by asking questions. Written permission from the medical officer of CHC in Tarsikarural community was obtained.Investigators visited the selected rural community Tarsika and taken survey of women aged between 40-55 years. Three hundred Samples were selected randomly by lottery method from survey report on the basis of inclusion criteria. Oral consent from the samples were obtained. In that first 150 was considered as control group and next 150 as study group. Primly, validated menopause rating scale was administered for control and study group, followed by computer assisted teaching given only to the study group. Teaching was given as small group teaching with 2-3 samples. Posttest-I was conducted after one month with the same tools for both the group. Information booklet was given to the study group for reinforcement purpose immediately after posttest-I. After three months the same tools were administered for the same samples for posttest-II.Collected data were coded, tabulated and analyzed by descriptive and inferential statistics.

STATISTICAL ANALYSIS

Data were put to statistical inferences by using SPSS software package.

S. No.	Data analysis	Methods	Purpose
1.	Descriptive statistics	Frequency percentage mean Standard deviation.	To assess the pretest and posttest level of menopausal transitionamongstudy group and control group.
2.	Inferential statistics	Paired 't' test	To find out the differences in pretest and posttest level of menopausal transition amongstudy and control group.
		Independent 't' test	To find out the effectiveness of computer assisted teaching on menopausal transition between study group and control group
		Chi-square test ANOVA	To find out the association between demographic variables and posttest level of menopausal transition in study group.

RESULTS

Findings related to Demographic Variables of Women

In the control group, majority of the women were belonging to 40-45 years (45.3%), married (87.3%), having primary education (32.7%), house wife (76.7%) and vegetarian (72.7%). The data revealed that majority were belonging to nuclear family (72.7%), having 1-3 children (75.3%) and monthly family socio economic status up to 30000 and above

(30.7%). Clinical variables depicts that majority of women had menarche at the age of 13-15 years (58.7%), marriage at 19-22 years (61.3%) and not attained menopause (66%). Most of them were peri-menopausal (43.3%), suffering from no illness (47.3%), not taking hormone replacement therapy (93.3%), not taking calcium supplements (56.7%) and not doing any exercise (59.3%). Total 36% of women were not going for health checkup whole year. Distance of health care facility from the house was less than 5km for most of the women (64%). Majority of woman's husband (28.7%) were having secondary education. Majority of women (46.7%) got information from peer and family members.

In study group, majority of the women belonged to more than 52 years (44.7%), married (85.3%), illiterate (54.7%), house wife (63.3%) and vegetarian (77.3%). The data revealed that majority were belonging to nuclear family (50%), having 1-3 children (52%) and monthly family socio economic status up to 5000 (84%). Clinical variables depicts that majority of women had menarche at the age of more than 15 years (59.3%), marriage at 19-22years (69.3%) and not attained menopause (70.66%). Most of them were peri-menopausal (65.3%), not suffering from any illness (55.3%), not taking hormone replacement therapy (98%), not taking calcium supplements (81.3%) and not doing any exercise (82%). Total 52% of women were not going for health checkup whole year. Distance of health care facility from the house was less than 5Km for most of the women (72%). Majority of woman's husband (42.7%) were illiterate. Majority of women (58%) got information from peer and family members.

First objective- Assess the menopausal transition among women residing at selected rural community

Data analysis showed that during pretest in both control and study group, most of the women (42.7% and 48.7%) had severe level of menopausal symptoms respectively. The mean score of pretest level of menopausal symptoms in the control group and study group were (13.53 ± 4.739) and (22.65 ± 6.921) respectively and the 't' value 2.400 was significant at 0.05 level.

During posttest-I in control group, majority of women (47.3%) had moderate level of menopausal transition where as in the study group, majority of women had mild symptoms (70.7%). The mean score of posttest-I level of menopausal transition in the study group (8.60 ± 4.197) was lower than the control group (18.25 ± 8.516) and the 't' value -12.445 was significant at 0.05 level. Hence there is a statistically significant change in menopausal transition between menopausal women those who attend the computer assisted teaching than those who do not. So hypothesis (H01) is accepted.

During post-test II in control group, majority of women (58.7%) had moderate level of menopausal transition where as in the study group, majority of women had mild symptoms (72.7%). The mean score of post-test II level of menopausal transition in the study group (8.34 ± 4.068) was lower than the control group (20.87 ± 6.672) and the 't' value -19.644 was significant at 0.05 level.So hypothesis (H01) is accepted.

In the control group, majority of women (42.7%, 47.3% and 58.7%) had severe and moderate level of menopausal transition during pretest, posttest-I and posttest-II respectively. In study group, majority of women (48.7%) had severe level of menopausal transition during pretest where as in posttest-I and II, marked changes were observed in the level of menopausal transition after computer assisted teaching. Majority of women had mild level of menopausal transition (70.7% and 72.7%) in posttest I and posttest II.

Second objective- Evaluate the effectiveness of computer assisted teaching on menopausal transition among women residing at selected rural community

The mean score of pretest and posttest-I level of menopausal transition in the control group were (20.51 ± 8.403) and (18.25 ± 8.516) respectively. The mean score of pretest and posttest-I level of menopausal transition in the study group were (22.65 ± 6.921) and (8.60 ± 4.197) respectively. The post test-I mean score (8.60 ± 4.197) was lower than the pretest mean score (22.65 ± 6.921), the 't' value 24.322 was significant at 0.05 level in the study group. The post test-I mean score (18.25 ± 8.516) was slightly lower than the pretest mean score (20.51 ± 8.403) the 't' value 2.580 was significant at 0.05 level in the control group. The mean posttest-I scores of menopausal transition in the study group (8.60 ± 4.197) was significantly lower than the mean posttest-I scores of menopausal transition in the control group (18.25 ± 8.516). Hence there is a statistically significant change in menopausal transition between menopausal women those who attend the computer assisted teaching than those who do not. So hypothesis (H01) is accepted.

The mean score of pretest and posttest-II level of menopausal transition in the control group were (20.51 ± 8.403) and (20.87 ± 6.672) respectively. The mean score of pretest and posttest-II level of

menopausal transition in the study group were (22.65 ± 6.921) and (8.34 ± 4.068) respectively. The post test-I mean score (8.34 ± 4.068) was lower than the pretest mean score (22.65 ± 6.921), the 't' value 23.153 was significant at 0.05 level in the study group. The post test-II mean score (20.87 ± 6.672) was slightly higher than the pretest mean score (20.51 ± 8.403) the 't' value -0.452 was not significant at 0.05 level in the control group. The mean posttest-II scores of menopausal transition in the study group (8.34 ± 4.068) was significantly lower than the mean posttest-II scores of menopausal transition in the control group (20.87 ± 6.672).So hypothesis (H01) is accepted.

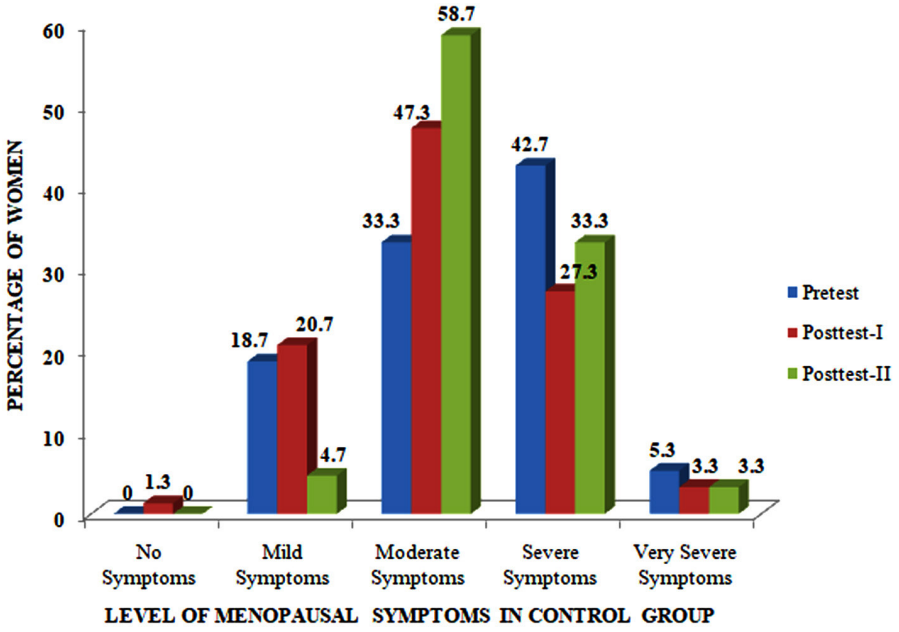

Fig. 1: Comparison of level of menopausal symptoms between pre-test and post-test in control group

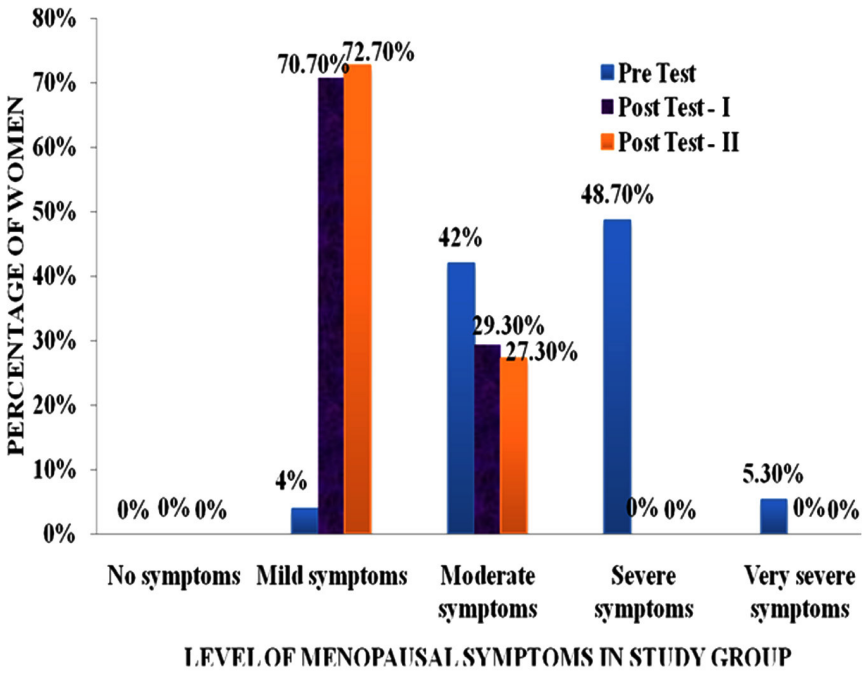

Fig. 2: Comparison of level of menopausal symptoms between pretest and posttest in study group

Table 1: Frequency, percentage, mean, standard deviation and't' value distribution of posttest-I symptoms level of women regarding menopause in control and study group

(n^1=150; n^2=150)

S. No.	Group	Posttest-I Symptoms level	F	%	Mean	Standard deviation	't' value	P value
1	Control group	No symptoms	2	1.3				
		Mild symptoms	31	20.7				
		Moderate symptoms	71	47.3	18.25	± 8.516		
		Severe symptoms	41	27.3				
		Very severe symptoms	5	3.3			-12.445 (S)	0.000
2	Study group	No symptoms	0	0				
		Mild symptoms	106	70.7				
		Moderate symptoms	44	29.3	8.60	± 4.197		
		Severe symptoms	0	0				
		Very severe symptoms	0	0				

S= Significant; NS=Not significant; P≤0.05 level

Table 2: Frequency, percentage, mean, standard deviation and't' value distribution of posttest-II symptoms level of women regarding menopause in control and study group

(n^1=150; n^2=150)

S. No.	Group	Posttest-II Symptoms level	F	%	Mean	SD	't' value	P value
1	Control group	No symptoms	0	0				
		Mild symptoms	7	4.7				
		Moderate symptoms	88	58.7				
		Severe symptoms	50	33.3	20.87	± 6.672		
		Very severe symptoms	5	3.3			-19.644 (S)	0.000
2	Study group	No symptoms	0	0				
		Mild symptoms	109	72.7				
		Moderate symptoms	41	27.3	8.34	± 4.068		
		Severe symptoms	0	0				
		Very severe symptoms	0	0				

S= Significant; NS=Not significant; P≤0.05 level

Third objective- Find out the association between menopausal transition with selected demographic variables of women

Results showed that there was significant association found between posttest-II level of menopausal transition of women with their selected demographic variables, when compared to age (=6.387) and education status of woman (=11.853). So hypothesis (H02) is accepted.

There was no significant association found between posttest-II level of menopausal transition of women with other demographic variables such as marital status, education status of the husband, Occupation, type of family, monthly family socio economic status, type of diet , sources of health information, distance of health care facility from house, age at menarche, age at marriage, age at menopause, parity of women, number of health visit per year, menopausal symptom status, chronic illness status, taking HRT, taking calcium and doing exercise.

DISCUSSION

The study findings are congruent with the study conducted by Leena D Souza and Anitha C Rao (2012) in Karnataka to assess the health problems among 50 urban and 50 rural menopausal women which revealed that 50% of the rural menopausal women had experienced moderate symptoms, 16% had severe symptoms while 14% had mild symptoms and remaining 20% had not experienced symptoms. The study concludes that menopausal health problems were more prevalent among

women residing in rural area when compared to the women residing in urban area.

These findings are consistent with a study conducted in Israel by Rotem M. et. al., (2005) to examine the impact of psycho-educational program for improving woman's attitudes and coping with menopause symptoms revealed that participants reported significant improvements in attitudes and reductions in symptom severity compared to their own baseline scores and compared with the control group.

CONCLUSION

Results revealed that in the control group, majority of women (42.7%, 47.3% and 58.7%) had severe and moderate level of menopausal transition during pretest, posttest-I and posttest-II respectively where as in study group, majority of women (48.7%) had severe level of menopausal transition during pretest but there was a marked change observed in the posttest-I and II level of menopausal transition. After computer assisted teaching in the study group, majority of women had mild level of menopausal transition (70.7% and 72.7%) in post-test I and post-test II respectively. Thus computer assisted teaching was effective in reducing menopausal symptoms.

Acknowledgement

I would like to acknowledge the study participants for their cooperation and responses. My sincere thanks to all those who have helped me directly and indirectly for the successful completion of this study.

Conflict of interest

This study is self-funded research work. So there is no conflict of interest.

REFERENCES

1. Jayabharathi, B. (2012) Knowledge of menopause among menopausal women. Nightingale nursing times, 7 (12), 14-16.
2. Mackey, S. (2009) Menstrual change during the menopause transition: do women find it problematic? Maturitas, 64(2), 114-8.
3. www. Zeg-berlin.de
4. Leena D. Souza. and Anitha C. Rao. (2012) Health problems among menopausal women in Udupi district, Karnataka. The Nursing Journal of India, CIII(2), 62-64.
5. Rotem, M., Kushnir, T., Levine, R. andEhrenfeld, M. (2005) A psycho- educational program for improving woman's attitudes and coping with menopause symptoms. J Obstet Gynaecol Neonatal Nurs, 34(2), 233-240.

Original Article

Journal of Emergency and Trauma Nursing
Volume 3 Number 2, July - December 2022

Role of Cyclic Negative Pressure wound Therapy in the Management of Thermal Burns

Barath Kumar Singh P[1], Ravi Kumar Chittoria[2]

How to cite this article:

Barath Kumar Singh P, Ravi Kumar Chittoria/ Role of Cyclic Negative Pressure wound Therapy in the Management of Thermal Burns/Journal of Emergency and Trauma Nursing. 2022;3(2):63–73.

Abstract

Burns are one of the leading cause of morbidity and death in children. Every physician and surgeon should always have a basic knowledge about the care of thermally injured child. Burn injury is a chronic disease requiring long term treatment and supervised rehabilitation, reconstructive surgery and psychosocial support.

Keywords: Thermal injury; Cyclic Negative Pressure; Wound Therapy.

INTRODUCTION

Since the introduction of the cyclicnegative pressure wound therapy (NPWT) system by Morykwas and Argenta, it has been applied to a number of wounds and has become an influential and effective technique for healing simple and complex wounds. The conventional cyclic NPWT system adopts either 'intermittent' or 'continuous' mode.

While the continuous mode constantly applies a sub-atmospheric pressure of 125 mmHg, the intermittent mode creates a sub-atmospheric pressure of 125 mmHg for 5 minutes and a 2 minutes resting phase of 0 mmHg.

In experiments performed on animal models, the intermittent mode showed increased perfusion level and formation of granulation tissue in the wound area compared with the continuous mode.[1,2] Despite the effectiveness of intermittent mode in wound healing, it has been avoided in clinical application because of the pain occurring every few minutes during the initiation phase of the system to reach 125 mmHg. [3–6]

The cyclic NPWT system is similar to the intermittent mode in terms of using the same maximal sub atmospheric pressure, but the pressure never reaches zero in the cyclic mode. So, it continuously creates certain pressure gradient that oscillates between 125 mmHg and the preset sub atmospheric pressure. The cycle runs based on the changes in sub atmospheric pressure, not time, and thus its frequency reflects the wound volume. In this article we present a case of a one year old male child who presented with second degree superficial burns over the chest, abdomen and right upper limb and the use of cyclic NPWT.

Author's Affiliations: [1]Senior Resident, [2]Professor, Department of Plastic Surgery, Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry 605006, India.

Corresponding Author: Ravi Kumar Chittoria, Professor, Department of Plastic Surgery, Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry 605006, India.

E-mail: drchittoria@yahoo.com

Received on: 18-07-2022

Accepted on: 18-08-2022

MATERIAL AND METHODS

This study was conducted in the Department of Plastic Surgery in a tertiary care institute. Informed consent was obtained from the patient under study. Department scientific committee approval was obtained. It is a single center, non-randomized, non-controlled study. The patient under study was a 1 year old male child, with no other known comorbidities. Patient was analyzed systematically and was found to have second degree superficial burns to his chest, abdomen and right upper limb. Wound bed was prepared in accordance with TIME concept mentioned in the guidelines, the ulcer was serially assessed and documented according to bates – Jensen wound assessment tool. Non-viable necrotic tissue was managed with multiple sessions of surgical & hydro debridement. Infection was managed with local antimicrobials & antibiotics according to culture sensitivity. As wound was wet in nature, moisture control was done using cyclic negative pressure wound therapy. Cyclic negative wound pressure therapy sittings was applied twice. (Fig. 1)

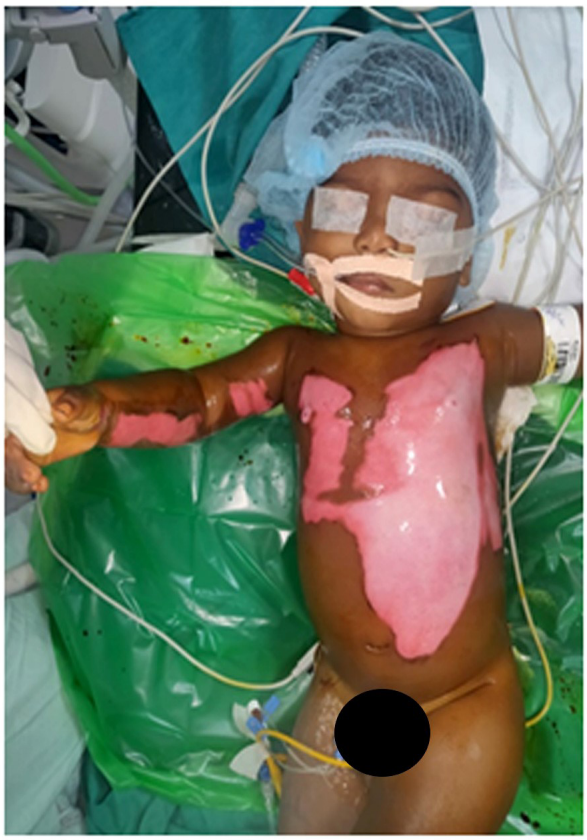

Fig. 1: Superficial burns at presentation.

RESULTS

Wound bed gradually improved, clinical decision was taken to reconstruct with skin grafting. (Fig. 2).

Fig. 2: Cyclic negative pressure wound therapy applied on wound.

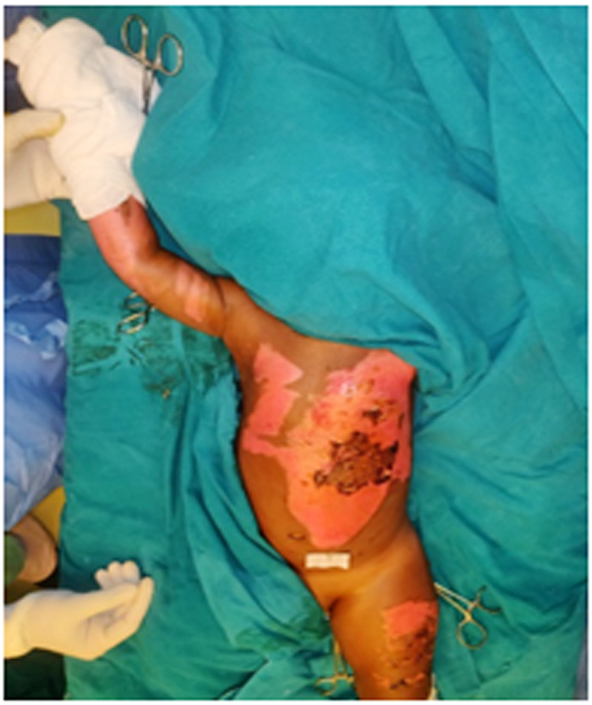

Fig. 3: Wound underwent skin grafting following wound bed preparation after cyclic negative pressure wound therapy

DISCUSSION

The cyclic mode operates its negative pressure in a manner similar to the sine wave by cycling through the designated negative pressures. Once it hits the upper target pressure of 125 mmHg, the pressure system shuts off and the pressure slowly drops till the lower target pressure is reached, regardless of time. As the change in the intralesional pressure is measured, the drop velocity of the pressure is closely associated with the defect volume in the cyclic mode. In other words, the larger the volume of defect, the shorter the time taken for completing one cycle of the system.

Improved tensile strength in in vivo research has previously showed increased collagen I production in wound healing. This rise could be owing to the pro-angiogenic effect of increased vascular endothelial growth factor and fibroblast growth factor levels. Both growth factors are involved in the wound healing process, namely in the stages of hemostasis, proliferation, and repair, and so influence wound healing. VEGF also controls cell proliferation, differentiation, and migration during angiogenesis. This encourages the creation of new capillaries, allowing for better circulation to the wound site and hence the delivery of critical nutrients and oxygen. The increased expression of certain mediators, such as IL-1 and monocyte Chemo attractant Protein-1, causes VEGF to be stimulated (MCP-1).[3]

Human and animal's studies have shown increased growth of granulation tissue, increased blood flow, diminution of the wound area, and regulation of inflammatory response with VAC therapy.[7] VAC causes wound contraction, stabilization of the wound environment, decreased edema with removal of wound exudates, and micro deformation of cells. These effects allow VAC to accelerate wound healing by virtue of increase blood flow; reduced bacterial load; and improved wound bed preparation for subsequent coverage. The compression of tissue by negative pressure causes tissue hypoxia due to decreases perfusion beneath the foam which stimulates angio-neogenesis, and local vasodilatation due to release of nitric oxide.[8,9,10]

Micro deformation/micro strain of cells due to VAC causes tissue expansion effect with release of growth factors. This tissue expansion effect is due to the differential pressure in the tissues after negative pressure application. The pressure within the cells is positive; while the pressure outside the cells and beneath the dressing is negative. This may lead to expansion of cells, growth of granulation tissue and pulling of wound edges closer to one another reducing wound size.

CONCLUSION

Cyclic application of "negative pressure" results in a superior local enhancement of cutaneous microcirculation with regards to blood flow and consecutive tissue oxygenation. Beyond that, repeated alterations between different levels of "negative pressure" due to cyclic application represent a greater stimulus for remote conditioning effects, indicating a superior local interaction with the underlying tissue. Hence we were able to manage superficial burns using cyclic NPWT successfully however it needs large scale randomized trials for application in clinical practice.

REFERENCES

1. Argenta LC, Morykwas MJ. Vacuum-assisted closure: a new method for wound control and treatment: clinical experience. Ann PlastSurg 1997; 38:563–76 discussion 577.
2. Morykwas MJ, Argenta LC, Shelton-Brown EI, McGuirt W. Vacuum-assisted closure: a new method for wound control and treatment: animal studies and basic foundation. Ann PlastSurg 1997; 38:553–62.
3. Glass GE, Nanchahal J. The methodology of negative pressure wound therapy: separating fact from fiction. J PlastReconstrAesthet Surg. (2012) 65:989– 1001.
4. Kairinos N, Voogd AM, Botha PH, Kotze T, Kahn D, Hudson DA, et al. Negative-pressure wound therapy II: negative-pressure wound therapy and increased perfusion. Just an illusion? PlastReconstr Surg. (2009) 123:601– 12.
5. Borgquist O, Ingemansson R, Malmsjö M. Wound edge microvascular blood flow during negative-pressure wound therapy: examining the effects of pressures from−10 to−175 mmHg. PlastReconstr Surg. (2010) 125:502– 9.
6. Kairinos N, McKune A, Solomons M, Hudson DA, Kahn D. The flaws of laser Doppler in negative-pressure wound therapy research. Wound Repair Regen. (2014) 22:424–9.
7. Argenta LC, Morykwas MJ. Vacuum-assisted closure: a new method for wound control and treatment: clinical experience. Ann PlastSurg 1997; 38:563–76 discussion 577.
8. Timmers MS, Le Cessie S, Banwell P, Jukema GN. The effects of varying degrees

of pressure delivered by negative-pressure wound therapy on skin perfusion. Ann PlastSurg 2005; 55:665–71

9. Saxena V, Hwang CW, Huang S, Eichbaum Q, Ingber D, Orgill DP. Vacuum assisted closure: micro deformations of wounds and cell proliferation. PlastReconstr Surg. 2004; 114:1086e1098.
10. Wilkes RP, McNulty AK, Feeley TD, Schmidt MA, Kieswetter K. Bioreactor for application of sub atmospheric pressure to three-dimensional cell culture. Tissue Eng. 2007; 13:3003e3010.

Review Article

Journal of Emergency and Trauma Nursing
Volume 3 Number 2, July - December 2022

Need for more Clinical Training for Improving the Fifth Vital Signs Assessment Skill of Oncology Nurses

Rajendra Kumar Sahu[1], Avadhesh Kumar Yadav[2], Meena K Krishnan[3], Raman P[4]

How to cite this article:

Rajendra Kumar Sahu, Avadhesh Kumar Yadav, Meena K Krishnan, *et al.*/Need for more Clinical Training for Improving the Fifth Vital Signs Assessment Skill of Oncology Nurses/Journal of Emergency and Trauma Nursing. 2022;3(2):69–73.

Abstract

Pain is a subjective feeling, and there are no physical tools or instruments available to measure pain. Pain assessment in the clinical setting is a crucial step in the management of pain in inpatient as well as outpatients setting. Pain is accepted as a fifth vital sign in the healthcare setting, like other vital signs, pain can not be measured by any instrument because of a subjective nature as other vital signs are objective in nature. Adequate and accurate assessment and documentation, and thereupon management of pain ensures that each and every patient, from acute to chronic illnesses including terminal ill patients, hasbenefitted from efficacious pain-relieving measures. It has been estimated that 18 million people globally have cancer pain, and in that proportion, approximately 60% to 90% of the pain is caused by advanced tumors and 30% caused by mild and/or moderate tumors that can be treated by medical surgical or other therapy. Pain is classified as nociceptive and neuropathic based on the fundamental pathophysiology of pain. Assessment of pain can be done in three ways, Self-report, Behavioural how the patient behaves, and Physiological clinical observations.

Conclusion: Pain is a worldwide health issue. Pain assessment & Management requires the attention of health professionals. Pain is one of the most common under evaluated vital signs in the health care sector. Under evaluation causes, discomfort to the patient as well as psychiatric problems, Better evaluation of pain stimulates good therapeutic management of it which improves the quality of life among patients pain assessment & management is complex, there are varieties of factors that affect pain assessment and management services thus a deeper understanding of the barriers and overcoming to this barrieris required for proper and effective pain management services.

Keywords: Pain Assessment; Pain; Pain management; Fifth Vital Sign.

Author's Affiliations: [1-2]Nursing Officer, [3]Nursing Suprintendent, [4]Assitant Nursing Suprintendent, Department of Nursing, Mahamana Pandit Madan Mohan Malviya Cancer Centre, Varanasi 221005, Uttar Pradesh, India.

Corresponding Author: Avadhesh Kumar Yadav, Nursing Officer, Department of Nursing, Mahamana Pandit Madan Mohan Malviya Cancer Centre, Varanasi 221005, Uttar Pradesh, India.

E-mail: avadheshkumar1382@gmail.com

Received on: 28-05-2022

Accepted on: 30-06-2022

INTRODUCTION

Pain is a subjective feeling, and there are no physical tools or instruments available to measure pain. Pain is whatever they felt by individuals, say it as like as felt by them, and where ever they experience pain.[1] Pain assessment in the clinical setting is a crucial step in the management of pain in inpatient as well as outpatients setting. In the health care sector, nurses have a notable role and responsibility in the assessment of pain, undoubtedly nurses perform it better because they have more association with the patients as well as

their families in the hospital as well as community.[2]

Pain is accepted as a fifth vital sign in the healthcare setting, like other vital signs, pain can not be measured by any instrument because of a subjective nature as other vital signs are objective in nature. Adequate and accurate assessment and documentation, and thereupon management of pain ensures that each and every patient, from acute to chronic illnesses including terminal ill patients, has benefitted from efficacious pain-relieving measures.[3]

CANCER AND PAIN

Pain is a usual symptom in patients diagnosed with any type of cancer patients. There are no doubts that it is usually a feared symptom, and thought to be linked with distress and inability. It has been estimated that 18 million people globally have cancer pain, and in that proportion, approximately 60% to 90% of the pain is caused by advanced tumors and 30% caused by mild and/or moderate tumors that can be treated by medical surgical or other therapy.[3]

As per who data, Cancers are the major cause of morbidity and mortality globally, accounting for 18.1 million new occurrences and 9.6 million deaths in 2018. It is a remarkably raising burden on patients as well as families, communities, and health services.

Pain is encountered by 55% of patients receiving anti-cancer treatment such as chemotherapy, radiation therapy, or surgery and 66% of patients diagnosed with an advanced, metastatic, or terminal disease experience pain.

Cancer pain is mainly caused by the growth of tumors or destroying nearby tissue, press on nerves, bones, or organs, and chemicals released from tumors. Another cause of pain in cancer patients is oncological treatments, such as surgery, radiation, chemotherapy, and various diagnostic as well as a therapeutic procedure such as biopsy, frequent iv cannulation, and major or minor surgical procedures.

The pain felt by cancer is generally round o clock in nature. The quality of life of amay be improved by better management of pain. Better pain management can improve better sleepingat night which makes them more energetic during the day. Improving activity may also decrease the risk of ailments such as pneumonia, pressure soreness, blood clots, and various type of infections, which are linked to immobilization of patients due to pain.

The basics of pain management in an oncology setup are regular medication, including antipyretics (acetaminophen) and opioid drugs. Appropriate selection of drug ensure the safety of patients and minimize side effects of the drug.

TYPES OF PAIN

Pain is classified as nociceptive and neuropathic based on the fundamental pathophysiology of pain.

The Nociceptive pain transmits from nociceptor response to noxious stimuli, that may be found in thesuperficial tissues, or in the deep tissues (Called somatic pain). It may also occur in the visceral organs (Called visceral Pain). Superficial somatic pain is produced by external factors which may be the mechanical cause, chemical cause, or thermal cause such as surgery, burns, abrasions, cuts, contusions, injections, or dermatological problems causing injury. Deep somatic pain may be stimulated by mechanical injury, inflammation, or ischemia. When the pain occurs in the visceral organ called visceral pain. Some examples of visceral pain in oncology include cancer of gastrointestinal organs such as the stomach, gall bladder, intestine liver, genitourinary cancer, cancer of the bladder, ureter, prostate, and inner genital organ.

Neuropathic pain is also known as pathologic pain, this type of pain may be caused by injury and impairment of the central (Brain & Spinal cord) or Peripherally distributed nerves (peripheral nervous systems). This produces abnormal pain stimulus which can cause diffuse pain, this characteristic makesit difficult to recognize the source such as diabetic neuropathy, neuralgia, phantom limb pain, post-stroke, or autoimmune disorders.

Based on duration, Pain is classified as acute or chronic

Acute pain – It comes suddenly and is generally sharp in nature, it is mostly caused by a specific factor, pain caused by diagnostic and therapeutics in the oncology sector are an example of acute pain. Acute pains last less than 3 months to 6 months.

Chronic pain persists beyond the expected course of acute pain. Chronic pain disrupts the work pattern of the individual as well as activities of daily living and sleeping quality. Identification of fundamental pathophysiology presence and/orextent of chronic pain is a difficult task for healthcare personnel. There are some other factors such as psychological that are not associated with the cause of pain but affect the nature of pain. Chronic pain may exist without physiologic signs and it can be continuous

orperiodic, with or without acute exacerbations. When an acute pain episode comes from achronic disorder, called "breakthrough pain."

Challenges and need more clinical training

Appropriate assessment and management of pain is a challenging task for nurses employed in an oncologic setting. Appropriate management of the pain of necessary because it distresses the patient, due to frequent diagnostic and therapeutic procedures. Follow-up assessment is also a key phase assessment for the patient to ensure them pain-free living in a home as well as society. Nurses should be clinically competent in recognition or identification of the "pain hints" given by patients. Undoubtedly, assessment of pain hints is also not easy work because patients and health care people may have varieties of perceptions of pain.

It is known that despite advances in the clinical setting, pain is still a poorly evaluated issue and intermittently underestimated by health care professionals. In adequate knowledge and clinical competency to assess pain are major and frequent obstacles observed in pain management services another barrier to adequate pain assessment and management concerns about opioid adverse effects, and the fear of drug addiction (dependence).[3] Numerous published source suggests Health care workers' knowledge and attitudes in terms of pain is lacking that causing undertreatment of pain.[4] HCPs have misconceptions & myths regardingthe pain that impedes satisfactory pain management.[4] Lacking Pain management knowledge is not the single factor that affects patients' well-being but perceptions and satisfaction about pain management followed post-surgery patients were also found low.[4] In-Service Education Program on Nurses' Knowledge and Attitudes towards Pain Management showed improved knowledge and attitude towards pain management.[5] Another study indicates that staff nurses have poor knowledge and negative attitudes about pain assessment and management which affects patient pain control measures.[6] To overcome the barrier of pain assessment nurses need to be clinically competent in the assessment and management of pain.

Inclusion of pain as vital signs

In 2000, an organization named the Joint Commission on Accreditation of Health Care Organizations (J.C.A.H.O) had recommended including pain as a vital sign. The organization suggested that pain should be assessed and documented with all vital signs, they validated it as the fifth vital sign.

WAYS TO ASSESS PAIN

Assessment of pain can be done in three ways, Self-report, Behavioural how the patient behaves, and Physiological clinical observations.

There are different scales available for the assessment of pain, the numeric scale, the Wong-Baker scale (also known as the FACES scale), and The FLACC scale is most commonly recommended for pain assessment.

In the clinical area, Numeric Scale is a widely applied pain scale in adult patients, it is a type of rating scale which include a rating of pain on a scale ranging from 0 to 10. In this scale nurses ask the patient for a verbal reply to the question, this scale providesa more accurate result with the visual analog scale. This scale maybe applied to the conscious patient who can reply verbally and patients minimum having 9 years of age and older.[7]

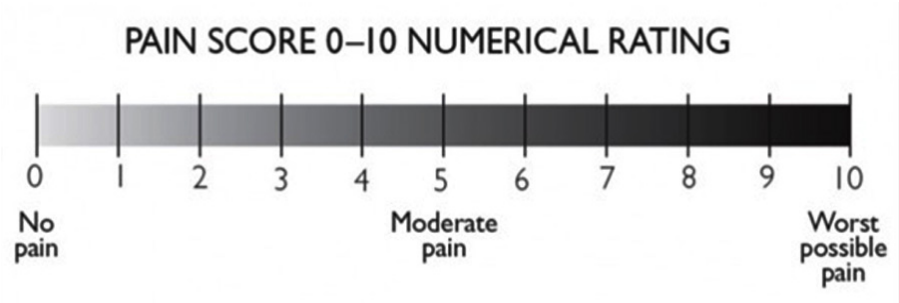

Fig. 1: Pain assessment numeric scale
Source: https://www.physio-pedia.com/Numeric_Pain_Rating_Scale

The Wong-Baker FACES Scale is used by observing the facial expression of the patient. The facial expression is linked with numbers as mentioned on a scale that isranged from 0 to 10. This scale is generally applied onchildren. This scale is thought to be appropriate for patients ages three and older. This scale is also used for adults who have developmental or communication challenges.[7]

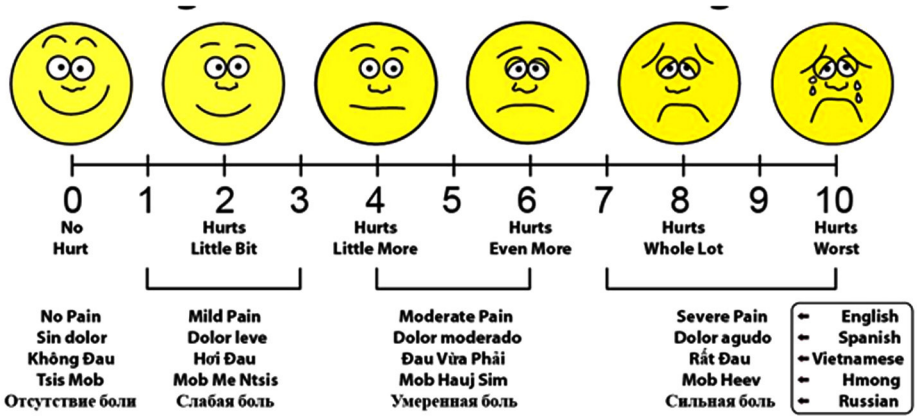

Fig. 2: Wong Bakers Scale
Source: https://www.ahutton.com/cgw/pain-scale-options.htm

FLACC scale is based on observation of behaviors, andit is generally used in pediatric patients less than three years of age and patientswho can notreport themselves.

The full name of FLACC is Face, Legs, Activity, Cry, and Consolability. In this scale behaviors that are explained are linked with a number; each unit is computed, in this scale pain score is displayed in a number ranging from 0 to 10. This scale is also recommended for developmentally delays patients and patients who have cognitive impairment.[7]

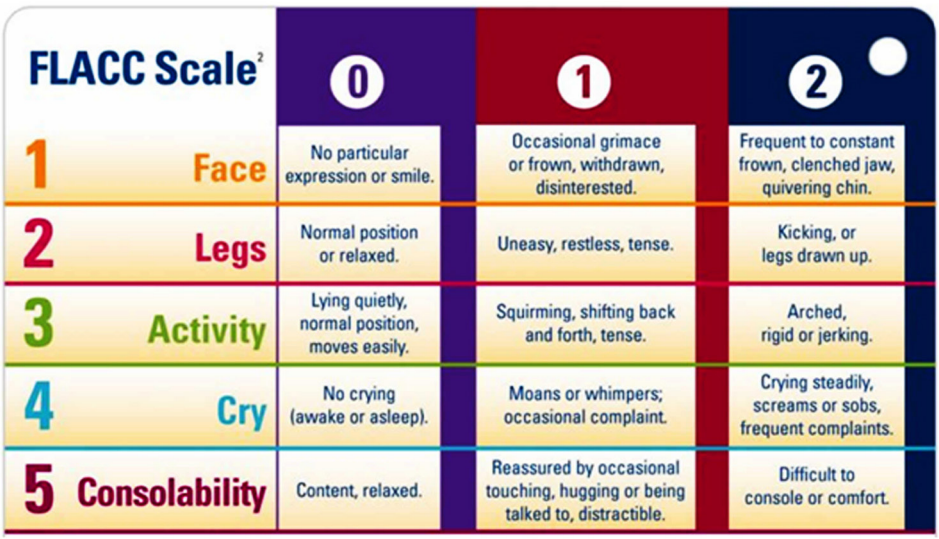

Fig. 3: FLACC Scale
Source: https://healthjade.net/flacc-scale/

A large number of a patient diagnosed with cancer, encounter anxiety and depression, therefore, the aim of pain management in a cancer patient should be a focus on the patient's comfort and function while preventing unwanted adverse effects from medications.[8]

PHYSIOLOGICAL INDICATORS

Some physiological indicators may alter by pain perception

- Elevation of Heartrate

- Shifting of Respiratoryrate and pattern from normal ie: increase, decrease, or change pattern
- Elevation of Blood pressure
- Reduction of Oxygen saturation[9]

But it is thought that physiological indicators alone cannot be applied as a measurement tool for assessing pain. A tool that includes physical, behavioral, and self-report should be preferred when possible. However, in certain conditions, such as mechanically ventilated patients and patients on sedation, physiological indicators (hints) of pain can be useful to evaluate a patient's feeling of pain.

CONCLUSION

Pain is a world wide health issue. Pain assessment & Management requires the attention of health professionals. Pain is one of the most common under-evaluated vital signs in the health care sector. Under evaluation causes, discomfort to the patient as well as psychiatric problems, Better evaluation of pain stimulates good therapeutic management of it which improves the quality of life among patients Pain assessment & management is complex, there are varities of factors that affect pain assessment and management services thus a deeper understanding of the barriers and overcoming to this barrieris required for proper and effective pain management services. The barrier needs to be addressed to remedy the deficiencies among HCPs and improve the quality of patient care.

REFERENCES

1. Caffery M. [Online].; 1968 [cited 2021 November 01. Available from: www.holycrosshealth.org › assets › documentsPain Management Cases in Palliative Care - Holy Cross Hospital.
2. Melbourne TRCH. The Royal Children's Hospital Melbourne. [Online].; 2020 [cited 2022 March 05. Available from: https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Pain_assessment_and_measurement/.
3. Romero LCdAB. Pain: evaluation of the fifth vital sign. A theoretical reflection. 2015 Oct-Dec; 16(4).
4. Nuseir K KMAB. Healthcare Providers' Knowledge and Current Practice of Pain Assessment and Management: How Much Progress Have We Made? Pain Res Manag. 2016.
5. Effect of a Nursing In-Service Education Program on Nurses' Knowledge and Attitudes towards Pain Management in a Governmental Hospital in the United Arab Emirates: Experimental Random Assignment Study. Dubai medical Jpurnal. 2019;: p. 146–152.
6. Moceri J, DD. Journal of emergency nursing: JEN : official publication of the Emergency Department Nurses Association. Nurses' Knowledge and Attitudes Toward Pain in the Emergency Department. 2012 July 26 ; 40.
7. AMN Healthcare Education Service. https://lms.rn.com/getpdf.php/1999.pdf. [Online].; 2014 [cited 2022 April 30. Available from: https://lms.rn.com/getpdf.php/1999.pdf.
8. Nersesyan HaKVS. Current aproach to cancer pain management: Availability and implications of different treatment options. Therapeutics and clinical risk management. 2007; 3(3): p. 381-400.
9. The Royal Children's Hospital Melbourne. The Royal Children's Hospital Melbourne. [Online].; 2019 [cited 2022 April 30. Available from: https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Pain_assessment_and_measurement/.

Instructions to Authors

Submission to the journal must comply with the Guidelines for Authors. Non-compliant submission will be returned to the author for correction.

To access the online submission system and for the most up-to-date version of the Guide for Authors please visit:

http://www.rfppl.co.in

Technical problems or general questions on publishing with **JETN** are supported by Red Flower Publication Pvt. Ltd.'s Author Support team (http://rfppl.co.in/article_submission_system.php?mid=5#)

Alternatively, please contact the Journal's Editorial Office for further assistance.

Editorial Manager
Red Flower Publication Pvt. Ltd.
48/41-42, DSIDC, Pocket-II
Mayur Vihar Phase-I
Delhi - 110 091(India).
Mobile: 9821671871, Phone: 91-11-79695648
E-mail: author@rfppl.co.in

Subject Index

Author Index

Guidelines for Authors

Manuscripts must be prepared in accordance with "Uniform requirements for Manuscripts submitted to Biomedical Journal" developed by international committee of medical Journal Editors

Types of Manuscripts and Limits

Original articles: Up to 3000 words excluding references and abstract and up to 10 references.

Review articles: Up to 2500 words excluding references and abstract and up to 10 references.

Case reports: Up to 1000 words excluding references and abstract and up to 10 references.

Online Submission of the Manuscripts

Articles can also be submitted online from http://rfppl.co.in/customer_index.php.

I) First Page File: Prepare the title page, covering letter, acknowledgement, etc. using a word processor program. All information which can reveal your identity should be here. use text/rtf/doc/PDF files. Do not zip the files.

2) Article file: The main text of the article, beginning from Abstract till References (including tables) should be in this file. Do not include any information (such as acknowledgement, your name in page headers, etc.) in this file. Use text/rtf/doc/PDF files. Do not zip the files. Limit the file size to 400 Kb. Do not incorporate images in the file. If file size is large, graphs can be submitted as images separately without incorporating them in the article file to reduce the size of the file.

3) Images: Submit good quality color images. Each image should be less than 100 Kb in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 400 pixels or 3 inches). All image formats (jpeg, tiff, gif, bmp, png, eps etc.) are acceptable; jpeg is most suitable.

Legends: Legends for the figures/images should be included at the end of the article file.

If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks from submission. Hard copies of the images (3 sets), for articles submitted online, should be sent to the journal office at the time of submission of a revised manuscript. Editorial office: Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091, India, Phone: 91-11-79695648, Cell: +91-9821671871. E-mail: author@rfppl.co.in. Submission page: http://rfppl.co.in/article_submission_system.php?mid=5.

Preparation of the Manuscript

The text of observational and experimental articles should be divided into sections with the headings: Introduction, Methods, Results, Discussion, References, Tables, Figures, Figure legends, and Acknowledgment. Do not make subheadings in these sections.

Title Page

The title page should carry

1) Type of manuscript (e.g. Original article, Review article, Case Report)

2) The title of the article should be concise and informative;

3) Running title or short title not more than 50 characters;

4) The name by which each contributor is known (Last name, First name and initials of middle name), with his or her highest academic degree(s) and institutional affiliation;

5) The name of the department(s) and institution(s) to which the work should be attributed;

6) The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence about the manuscript; should be mentoined.

7) The total number of pages, total number of photographs and word counts separately for abstract and for the text (excluding the references and abstract);

8) Source(s) of support in the form of grants, equipment, drugs, or all of these;

9) Acknowledgement, if any; and

l0) If the manuscript was presented as part at a meeting, the organization, place, and exact date on which it was read.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (of no more than 150 words for case reports, brief reports and 250 words for original articles). The abstract should be structured and state the Context (Background), Aims, Settings and Design, Methods and Materials, Statistical analysis used, Results and Conclusions. Below the abstract should provide 3 to 10 keywords.

Introduction

State the background of the study and purpose of the study and summarize the rationale for the study or observation.

Methods

The methods section should include only information that was available at the time the plan or protocol for the study was written such as study approach, design, type of sample, sample size, sampling technique, setting of the study, description of data collection tools and methods; all information obtained during the conduct of the study belongs in the Results section.

Reports of randomized clinical trials should be based on the CONSORT Statement (http:// www. consort-statement. org). When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) and with the Helsinki Declaration of 1975, as revised in 2000 (available at http://www.wma. net/e/policy/l 7-c_e.html).

Results

Present your results in logical sequence in the text, tables, and illustrations, giving the main or most important findings first. Do not repeat in the text all the data in the tables or illustrations; emphasize or summarize only important observations. Extra or supplementary materials and technical details can be placed in an appendix where it will be accessible but will not interrupt the flow of the text; alternatively, it can be published only in the electronic version of the journal.

Discussion

Include summary of key findings (primary outcome measures, secondary outcome measures, results as they relate to a prior hypothesis); Strengths and limitations of the study (study question, study design, data collection, analysis and interpretation); Interpretation and implications in the context of the totality of evidence (is there a systematic review to refer to, if not, could one be reasonably done here and now?, What this study adds to the available evidence, effects on patient care and health policy, possible mechanisms)? Controversies raised by this study; and Future research directions (for this particular research collaboration, underlying mechanisms, clinical research). Do not repeat in detail data or other material given in the Introduction or the Results section.

References

List references in alphabetical order. Each listed reference should be cited in text (not in alphabetic order), and each text citation should be listed in the References section. Identify references in text, tables, and legends by Arabic numerals in square bracket (e.g. [10]). Please refer to ICMJE Guidelines (http://www.nlm.nih.gov/bsd/uniform_ requirements.html) for more examples.

Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540–7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, *et al*. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003; 61: 347–55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone-iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3–9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792–801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O,

Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. pp 7–27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

More information about other reference types is available at www.nlm.nih.gov/bsd/uniform_ requirements.html, but observes some minor deviations (no full stop after journal title, no issue or date after volume, etc.).

Tables

Tables should be self-explanatory and should not duplicate textual material.

Tables with more than 10 columns and 25 rows are not acceptable.

Table numbers should be in Arabic numerals, consecutively in the order of their first citation in the text and supply a brief title for each.

Explain in footnotes all non-standard abbreviations that are used in each table.

For footnotes use the following symbols, in this sequence: *, ¶, †, ‡‡,

Illustrations (Figures)

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files of minimum 1200x1600 pixel size. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of the side.

Original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay.

Type or print out legends (maximum 40 words, excluding the credit line) for illustrations using double spacing, with Arabic numerals corresponding to the illustrations.

Sending a revised manuscript

While submitting a revised manuscript, contributors are requested to include, along with single copy of the final revised manuscript, a photocopy of the revised manuscript with the changes underlined in red and copy of the comments with the point-to-point clarification to each comment. The manuscript number should be written on each of these documents. If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks of submission. Hard copies of images should be sent to the office of the journal. There is no need to send printed manuscript for articles submitted online.

Reprints

Journal provides no free printed, reprints, however a author copy is sent to the main author and additional copies are available on payment (ask to the journal office).

Copyrights

The whole of the literary matter in the journal is copyright and cannot be reproduced without the written permission.

Declaration

A declaration should be submitted stating that the manuscript represents valid work and that neither this manuscript nor one with substantially similar content under the present authorship has been published or is being considered for publication elsewhere and the authorship of this article will not be contested by any one whose name(s) is/are not listed here, and that the order of authorship as placed in the manuscript is final and accepted by the co-authors. Declarations should be signed by all the authors in the order in which they are mentioned in the original manuscript. Matters appearing in the Journal are covered by copyright but no objection will be made to their reproduction provided permission is obtained from the Editor prior to publication and due acknowledgment of the source is made.

Approval of Ethics Committee

We need the Ethics committee approval letter from an Institutional ethical committee (IEC) or an institutional review board (IRB) to publish your Research article or author should submit a statement that the study does not require ethics approval along with evidence. The evidence could either be consent from patients is available and there are no ethics issues in the paper or a letter from an IRB stating that the study in question does not require ethics approval.

Abbreviations

Standard abbreviations should be used and be spelt out when first used in the text. Abbreviations should not be used in the title or abstract.

Checklist

- Manuscript Title
- Covering letter: Signed by all contributors
- Previous publication/ presentations mentioned, Source of funding mentioned
- Conflicts of interest disclosed

Authors

- Middle name initials provided.
- Author for correspondence, with e-mail address provided.
- Number of contributors restricted as per the instructions.
- Identity not revealed in paper except title page (e.g. name of the institute in Methods, citing previous study as 'our study')

Presentation and Format

- Double spacing
- Margins 2.5 cm from all four sides
- Title page contains all the desired information. Running title provided (not more than 50 characters)
- Abstract page contains the full title of the manuscript
- Abstract provided: Structured abstract provided for an original article.
- Keywords provided (three or more)
- Introduction of 75-100 words
- Headings in title case (not ALL CAPITALS). References cited in square brackets
- References according to the journal's instructions

Language and grammar

- Uniformly American English
- Abbreviations spelt out in full for the first time. Numerals from 1 to l0 spelt out
- Numerals at the beginning of the sentence spelt out

Tables and figures

- No repetition of data in tables and graphs and in text.
- Actual numbers from which graphs drawn, provided.
- Figures necessary and of good quality (color)
- Table and figure numbers in Arabic letters (not Roman).
- Labels pasted on back of the photographs (no names written)
- Figure legends provided (not more than 40 words)
- Patients' privacy maintained, (if not permission taken)
- Credit note for borrowed figures/tables provided
- Manuscript provided on a CDROM (with double spacing)

Submitting the Manuscript

- Is the journal editor's contact information current?
- Is the cover letter included with the manuscript? Does the letter:

1. Include the author's postal address, e-mail address, telephone number, and fax number for future correspondence?
2. State that the manuscript is original, not previously published, and not under concurrent consideration elsewhere?
3. Inform the journal editor of the existence of any similar published manuscripts written by the author?
4. Mention any supplemental material you are submitting for the online version of your article. Contributors' Form (to be modified as applicable and one signed copy attached with the manuscript)