

Case Report: Evaluation of Patient Diagnosed Perianal Fistula According to Abdellah's 21 Nursing Problems Model

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Abstract:

This case report aimed to provide nursing care to the patient diagnosed with Perianal Fistula for the nursing diagnoses in Faye Abdellah's "21 Nursing Problem Theory and North American Nurses Association (NANDA) classification system. Material and Methods: Verbal and written consent was obtained from the patient and the attending physician for the research. Results: He was married at the age of 62. The patient, who has four children and had perianal fistula surgery in 2002, was admitted to the Gastroenterohepatology Polyclinic of a training and research hospital due to increased rectal discharge and constipation recently. disease. There is no known disease in the family history. There is no known history of drug use and known allergy. Conclusion and Suggestions: The case was examined based on Faye Abdellah's "21 Nursing Problem Theory" and the North American Nurses Association (NANDA) Nursing care was given by using the nursing diagnoses in the classification system.

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INTRODUCTION

The abnormal connection between the anal canal and the perineal skin is called a perianal fistula and is twice as common in men as in women. It is usually a complication of recurrent anorectal abscesses (Liang et al., 2014). Although pain is common, the most common finding is known to be discharge (Włodarczyk et al., 2021). Fistula can be diagnosed clinically. The aim of clinical assessment is to determine the fistula anatomically. For this purpose, the location of the external and internal hole, the primary course of the fistula, secondary courses or blind ends, and any secondary diseases should be determined (Akcal et al., 2011). Among anorectal imaging techniques, "Fistulography" and "MR Fistulography" can be used for cases of perianal fistula (Şentürk and Acar, 2015). Symptoms of perianal fistula include: Irritation of the skin around the anus, foul-smelling discharge that contaminates the linen, persistent and throbbing pain that increases during defecation or coughing while moving or while sitting, granulation around the external hole, pus or blood during defecation, discoloration, swelling and temperature increase around the anus if an abscess is present.

Treatment is usually surgical, but the recurrence rate due to surgical failure is quite high. Perianal fistula is a condition that has always been diagnosed and treated mostly by surgical methods (Erşen et al. 2019). Good preoperative assessment is a prerequisite for successful surgical treatment (Chappe et al., 2000; Sivri et al., 2017). When caring for patients, it is important to benefit from theorists who form the basis of the nursing profession (Soydan et al., 2020).

Abdellah mentioned 21 nursing problems in his book "Patient-Centered Approaches to Nursing" written in 1960 (Basavanthappa, 2007; Allam et al., 2016; Alligood, 2017). These include; ensuring good hygiene and physical comfort, providing activities such as exercise, sleep and rest, ensuring safety by preventing accidents, injuries or trauma, preventing the spread of infection, ensuring good body mechanics to prevent or correct deformities, ensuring oxygen supply to all cells of the body, ensuring the nutrition of all cells of the body, ensuring elimination, ensuring fluid-electrolyte balance, recognition of physiological, pathological and compensatory responses of the body against the disease, ensuring the continuity of the body's regulatory mechanisms and functions, ensuring the continuity of sensory functions, positive or negative expression, identification and validation of emotions and reactions, identification and validation of the relationship between excitement and organic diseases, effective use of body language and verbal communication, ensuring continuity, development of effective interpersonal relationships, ensuring that the individual can achieve his/her spiritual goals, creating and maintaining a therapeutic environment, ensuring that the individual develops awareness in terms of physical, emotional and developmental needs, acceptance of possible optimum goals taking into account physical and emotional conditions, utilization of social resources in solving problems caused by the disease, understanding that social problems may be the cause of the disease (Pektek, 2013). In this case report, the data of the patient diagnosed with perianal fistula was collected according to Gordon's Functional Health Patterns and a care plan was developed using the nursing diagnoses of the North American Nursing Diagnostic Association (NANDA). Verbal and written informed consent were obtained from the patient and the facility for the study.

CASE PRESENTATION

The patient was 62 years old and married with four children. The patient underwent perianal fistula surgery in 2002 and was admitted to the gastroenterohepatology outpatient department of a teaching and research hospital with complaints of increased rectal discharge and constipation. The patient was admitted to the gastroenterohepatology department to evaluate the clinical picture.

The Assessment of the Case According to Abdellah's 21 Nursing Problem Model

1. Basic Requirements

1) Hygiene and Physical Comfort

The patient can independently meet his or her individual needs, such as cleaning and dressing.

2) Movement and Rest

The patient stated that he had exercised regularly in his life before hospitalization. It was observed that he often went out for walks during his hospital stay on the ward.

3) Safety

The patient has no safety requirements. The "Itaki Fall Risk Scale" was applied to the patient at regular intervals to determine the risk of falls. The Itaki Fall Risk Scale score was 0 when the patient was first admitted and the Itaki Fall Risk Scale score ranged from 0 to 2 during the hospital stay on the ward (The Itaki Fall Risk Scale ranges from 0 to 51 points. A score below 5 is considered low risk and a score above 5 is considered high risk). The "Itaki Fall Risk Scale" was used to determine the patient's fall risk. The patient's scale score was between 4 and 5 during his stay in the clinic. (The fall risk scale ranges from 0 to 51 points.

Below 5 is considered low risk and 5 and above is considered high risk) (SHGMKALİTEDB, 2021).

Nursing Diagnosis: 'Infection Risk' against the Possibility of Encountering Endogenous or Exogenous Microorganisms

Objective: To minimize the risk of infection in the patient

Interventions:

- (1) Patient and his/her companion were trained on aseptic techniques.
- (2) The patient was monitored for signs and symptoms of infection.
- (3) Life signs were measured as 2*1. During the time the patient was hospitalized in the ward, vital signs were heart rate: 70-84/min, blood pressure: 100/60-130/80 mm/Hg, body temperature: 36.1-37.2oC (tympanic region).
- (4) Invasive methods were avoided unless necessary.
- (5) Drugs prescribed by the physician were administered to the patient.

4) Body Mechanics

Nursing Diagnosis: Illness-related Fatigue

Objective: To minimize patient fatigue

Interventions:

- (1) Energy planning was made together with the patient, in such a way to fit the hospital environment.
- (2) The patient was supported to exercise at certain intervals in accordance with hospital conditions. It was observed that the patient took walks in the hospital garden with his relatives during the day.
- (3) The patient was informed of the necessity of eating little and often and drinking plenty of fluids.

2. Need for Supportive Care

1) Oxygenation

No problems were noted with the patient's vital signs during his hospitalization on the ward. The patient's vital signs during his stay on the ward were: heart rate: 70-84/min, blood pressure: 100/60-130/80 mm/Hg, body temperature: 36.1-37.2o C (tympanic area). There were no problems in maintaining oxygenation in all body cells.

2) Nutrition

The patient was asked to eat spice-free foods so as not to affect the perianal fistula area during elimination. During the hospital stay, the patient was asked to eat fat-free, salt-free and spice-free food. It was noted that the patient maintained his restricted diet.

3) Elimination

Before hospitalization, the patient had 1 bowel movement per day and bowel sounds were 4/min.

Nursing diagnosis: Risk of rectal bleeding due to disease.

Objective: Eliminate signs and symptoms of bleeding that may occur in the patient and minimize the risk if it cannot be eliminated.

Interventions:

- (1) The patient and his relatives were informed about protecting the patient from trauma. Signs and symptoms of bleeding were not observed.

(2) Vital signs were measured as 2*1. During the patient's stay in the ward, the vital signs were heart rate: 70-84/min, blood pressure: 100/60-130/80 mm/hg, body temperature: 36.1-37.2 C (tympanic membrane region).

(3) The patient's laboratory values were checked at intervals. (Hb:10.8, Hct:24, MCV:68, Plt:146 Thous, Wbc: 9660, Neut: 6600, INR: 1).

4) Fluid-Electrolyte

Monitoring the patient's intakes and outputs revealed that the patient was in a balanced state and that the electrolyte values in the laboratory values did not deteriorate during the hospital stay.

Nursing Diagnosis: "Impaired Urinary Excretion" due to BPH (Benign Prostatic Hyperplasia)

Objective: To enable the patient to maintain bladder control

Interventions:

- (1) It was ensured that diuretic fluids (coffee, etc.) were taken less.
- (2) It was ensured that he wore clothes that could be opened easily without buttons.
- (3) It was recommended to go to the toilet before meals, then before going to bed and every two hours.
- (4) When the patient asked for help to go to the toilet, he was assisted immediately.
- (5) The patient's privacy and safety were fully ensured in all these and similar interventions.
- (6) Efforts were made to ensure the patient gained the habit of regular urination.
- (7) The displeasure caused by inadequate urinary excretion was emphasized.
- (8) Tamsulosin (Flomax 1x0.4), prescribed by the doctor, was administered to treat benign prostatic hyperplasia.

5) Reaction to Illness

The patient verbally expresses that he does not have enough information about his disease and asks questions about his condition.

Nursing Diagnosis: "Lack of knowledge" about his disease

Objective: Providing the patient with information about his illness

Interventions:

- (1) The patient's disease was explained to him in an understandable language as well as the interventions performed on him. The patient was informed before each intervention.
- (2) The patient was informed about the treatment.
- (3) The patient was encouraged to ask questions. It was observed that the patient asked questions to other team members about his disease and treatment during his stay in the ward.

6) Regulating Mechanisms

As the patient has no limitations in maintaining physical functions, there is no need for regulatory mechanisms.

7) Emotional Functions

The patient was examined regarding his vision, hearing, tactile functions and memory and no current problems were found. The patient's Glasgow Coma Scale score was 15.

3. Remedial Care Requirements

- 1) Emotions and Reactions: Identifying and Accepting Positive and Negative Expressions, Feelings, and Reactions

Nursing Diagnosis: "Anxiety" associated with embarrassment due to the diagnostic tests in the perianal region during treatment and a non-familiar environment

Objective: To reduce the patient's anxiety

Interventions:

- (1) Encouraged to openly express his feelings about the disease diagnosis.
- (2) Anxiety symptoms were observed to plan appropriate interventions.
- (3) All interventions to reduce the patient's anxiety were shared with the patient.
- (4) Attention was paid to the limits of privacy.

Nursing Diagnosis: "Distortion of Body Image" due to essential tremor

Objective: To enable the individual to gain healthy coping methods related to the situation in which he is in

Interventions:

- (1) Valid and reliable information was given about the patient's disease.
- (2) The individual was encouraged to express his feelings, thoughts, and self-perspective.
- (3) Tamsulosin (Flomax 1x0.4), prescribed by the doctor, the patient was administered 'Primidone' (Mysoline 1x250), a barbiturate drug used to treat essential tremors.
- (4) A reassuring patient-nurse relationship was established.
- (5) The patient was supported with physical activities he was capable of performing.
- (6) The patient was encouraged to perform activities that could increase self-esteem (such as eating alone).
- (7) The patient was involved in decisions concerning his care.

- 2) Communication: Maintaining and Facilitating Effective Verbal and Nonverbal Communication

No communication problems were observed during the patient's hospitalization in the ward.

- 3) Interpersonal Relationships: Ensuring the Development of Productive Interpersonal Relationships

The patient's companion said that the patient was on good terms with himself and his siblings, that he frequently met with them and that the patient had positive relations not only with himself but also with his environment.

Nursing Diagnosis: "Disruption in the continuity of intra-family processes" due to the patient's prolonged perianal fistula treatment

Objective: To ensure the continuity of family ties

Interventions:

- (1) Effective communication of family members was ensured.
- (2) Problems between family members were identified.
- (3) Attempts were made to establish a bond of trust between family members.

- 4) Spirituality: Facilitating the Achievement of Personal Spiritual Goals

The patient stated that the disease came from God and that the process he was in would end one day. It was observed that the patient frequently prayed and read religious books.

5) **Therapeutic Environment: Creating and/or Maintaining a Therapeutic Environment**

The patient stated that he had slept 8 hours/day before hospitalization and had short 30-45 minutes of sleep during the day. He stated that his sleep pattern had deteriorated since he was hospitalized and he slept 6 hours/day. It was observed that the patient slept during the day and could not sleep at night.

Nursing Diagnosis: 'Disruption of Sleep Patterns' due to Hospitalization

Objective: To ensure that the patient gets efficient sleep

Interventions:

- (1) The patient's sleep hours were organized. Daytime sleep was restricted and the patient was supported to sleep at night.
- (2) A calm, quiet, and dimly lit environment was provided for the patient to sleep.
- (3) The medical treatment to be applied to the patient was planned in accordance with sleep hours.

6) **Self and Personality Awareness: Making the Individual Aware of Their Changing Physical, Emotional, and Developmental Needs**

No problem was observed in the individual's self-awareness during his hospitalization in the ward.

4. Vital Care Needs

It was observed that the patient met his vital needs by himself during his stay in the ward and did not want visitors to stay with him most of the time.

CONCLUSION

Patient care is a very important component of the nursing profession. Nursing care is also essential in patients diagnosed with perianal fistula. The present study found that planning the patient's care according to Abdellah's 21 nursing problem model and analyzing the data according to the sub-dimensions of the model solved the patient's problems in a short time and the nursing care given to the patient took on a systematic nature.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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