A Case Study

PSEUDO PANCREATIC CYST

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Pseudo pancreatic cyst is a collection of fluid in the lesser sac of the peritoneum. This may be due to either injury of the pancreas or pancreatitis or due to peptic perforation.

You must be interested to share my experience of nursing a patient with pancreatic cyst.

History : Mrs. S., 47, was admitted to the female surgical ward with complaints of upper abdominal pain and swelling on and off since 20 years. Occasionally the pain increased radiating to the back. The patient did not give any past history of injury of abdomen. She had neither vomitting nor bowel disturbance, or any urinary trouble. Other systems were normal.

On examination a large mass was visible in the epigastric region 4"×5". It was firm and not tender. No fluctuation was felt nor any peristalsis seen. Liver and spleen were not palpable.

Investigations : Hb—10.8 gms ; T.C.—9,800 ; Lymph—9% ; Eos—7% , Poly—74% : Group—'A' ; Rhesus Factor—negative ; Blood urea—33 mgm ; serum amylase—408 units ; Plain X-ray of abdomen showed scattered areas of calcification.

I.V.P.—Left kidney appeared bigger than the right kidney. Calycex was not well visible. Dye execretion was poor. Left pelvis and left ureter appeared to be normal in size and shape. Right kidney was normal.

Barium meal screening : No definite lesion was seen.

Treatment : Advised surgery.

Pre-operative care. The patient and relatives were explained the extent and risk of surgery and a written consent for surgery was obtained from the relatives. Blood was sent for cross matching and two bottles of blood were arranged to be given during the operation.

On the evening of the operation local preparation of the abdomen was done. The patient was taught deep breathing excercises before operation. Phenobarb gr i given at bed-time for a good night sleep and the patient was asked to fast from 9 p.m.

On the following morning a bed bath was given and toilet attended. Ryles tube was inserted. The patient was reassured. Premedication was given at 7 a.m. Patient was sent to operation theatre at 8 p.m.

The operation started under general anesthesia. Peritoneal cavity was opened by a left upper paramedium incision. The cyst was found to be coming through the lesser sac. There was no evidence of any peptic ulcer.

Cystogastrostomy was done as follows : The anterior wall of the stomach incised and the posterior gastric wall exposed. The contents of the stomach was sucked out (and a dry field obtained). A disc of the full thickness of the posterior gastric wall was excised and the contents of the cyst were sucked out. Catgut stitches put between the cyst and the cavity of the stomach. The anterior wall of the stomach was closed in two layers.

Post operative care : Intravenous fluids, dextrose 5% 2,000 ccs were ordered for 24 hours. An injection of Vitamin B complex 2 cc and Vitamin C 500 mgm were given in the drip. Terramycin 100 mg intramascularly BD given for the first 5 days to combat infection. Morphia 10 mg. intramuscularly was given to relieve pain. An intake and output chart was maintained. Blood pressure and pulse were recorded ½ hourly for two hours and then hourly. Ryles tube was aspirated every hour for 12 hours and then every 2 hours for 2 days. Since the patient had difficulty to pass urine, she was catheterised. The urine output was normal.

Position changed, back attended and oral hygiene performed 4 hourly. Patient was encouraged to have deep breathing and bed excercises to prevent chest complication and venous thrombosis. Ryles tube was removed on the 3rd day of operation. She was allowed to have oral fluids from the same day. Patient had an uneventful post-operative period. Stitches were removed on the 8th day. She was advised to come to out-patient department for follow-up.

Courage— *(Contd. from page 12)*

professional partners look at us. There is no need hiding the fact that there remains much to be desired in the Doctor-Nurse relationship in our hospitals. This is more evident in government institutions. Nurses in several countries enjoy equal status with Doctors.

In Canadian hospitals, as also hospitals in other advanced countries, Doctors and Nurses have their separate spheres, which are mutually respected. Nurses have wide attitudes and great authority in their wards, which doctors scrupulously avoid interfering with. Doctors often consult nurses and offer suggestions rather than merely issuing orders. The Doctor-Nurse relationship in those countries, therefore, is one marked by respect for one another and for one another's profession.

Working conditions of nurses in our country are still far from satisfactory. Their hours of work are too long *i.e.* from 8-12 hours a day ; housing inadequate and inferior ; equipments insufficient and in many cases outmoded ; remuneration low in relation to the nature of their work ; workload very heavy ; messing and uniform allowances very low in relation to the cost of living, besides over-crowded and under-staffed hospitals and non-nursing duties. We need courage to be able to serve well in the face of these formidable odds.

It will be the height of ingratitude to deny that several improvements have been brought about by the government at considerable cost. But these are quite inadequate in proportion to the problems faced by the profession. So long as Nursing is considered subordinate to the medical profession, there is little possibility that the nursing profession will be able to gain the status it deserves in the society.

While we in the profession silently endure and serve, our Association carries on its relentless fight to secure better conditions of service and higher status for us. We on our part must endeavour to do everything in our power to strengthen the hands of our Association. The least we can do, beside carrying out our duties sincerely is, to assure our Association, the public and the Government that we "Serve with Courage." □