

A Case Study

A Patient with Prostatectomy

By Mr. F. Crimson*

Mr. X, an agile, 76-year old man weighing 86 lbs., was admitted to the Men's Surgical Ward with symptoms of Benign Prostatic Hypertrophy.

A retired businessman of middle class Hindu Brahmin heritage, he was a vegetarian with regular and well-balanced habits.

History of Past Illness

He was apparently in good health until three years ago when he developed left direct hernia and did not seek medical assistance. He also had internal haemorrhoids which responded to native treatment.

Present Illness

On admission, Mr. X presented the following complaints :—

(i) Two years ago he developed pain around the lumbar region, which was colicky in nature and occurred intermittently.

(ii) Besides this, he also had complaints of dyspnea and breathlessness which occurs even now after a heavy meal. However, the pain is not severe and not associated with vomiting.

(iii) His main complaint was frequency of micturition and inability to void completely.

(iv) For the past two years he had been aware that the urinary stream was getting smaller and he encountered extreme difficulty in starting as time passed. He had no complaints of burning on micturition. Haematuria, pain and scalding on micturition were not evident.

(v) He had marked nocturia and had to micturate practically every two hours during the night. As a result of disturbed sleep, he complained of weight loss, weakness and tiredness.

(vi) A rectal examination done by the Surgeon revealed enlargement of the prostate gland.

Investigations

On admission Mr. X was assigned to a bed in the general ward and the routine admission procedure was carried out. His temperature, pulse, respiration and blood pressure and weight were taken and recorded in his chart.

(i) **Urine Analysis** : Later a routine urine analysis done revealed the following :—

S.G.—1.020 ; Reaction—acidic ; Sugar—Nil ; Albumin—Nil.

(ii) **Stool and Urine** : The next day a specimen of his stool and urine was sent for microscopic examination. In both specimens occult blood was present.

(iii) **Haemoglobin Determination** : A specimen of his blood was sent to the laboratory for determination of haemoglobin level and for grouping and cross matching.

His haemoglobin level was 12 gm/100 ml of

blood. His blood group was determined as Gr. O positive and arrangements were made for 2 pints of blood to be ready before the operation.

(iv) **BUN** : To rule out renal involvement a Blood Urea Nitrogen level was determined. Mr. X's BUN was within normal values—10 mgm/100 ml of Blood). (Normal values 10-20 mgm/100 ml of blood).

(v) **Post-Prandial Sugar** : To rule out diabetes a complication sometimes present in elderly patients, a specimen of his blood was sent to determine the level P.P. Sugar. Findings : 160 mgm/100 ml of blood.

(vi) **E.C.G.** : A normal Electro Cardiogram reading obtained ruled out coronary insufficiency and cardiac involvement.

(vii) **Radiological examination** : A chest and kidney Ureter Bladder X-ray was taken. Findings : Chest X-rays was normal : KUB X-ray revealed enlargement of the prostate.

(viii) **General Physical Examination** : A general physical examination was done by the Physician and Mr. X was certified fit to undergo surgery.

Pre-operative Nursing Care

All required investigations were carried out and on being certified fit for surgery Mr. X was posted for a Supra-public prostatectomy. During the pre-operative period, he was prepared psychologically. I explained to him briefly about the operation and why such an undertaking was necessary. He was reassured of arising doubts and fears and finally signed the consent form accepting surgery. His temperature, pulse, respiration and blood pressure were taken and recorded regularly. Personal hygiene and needs were attended to.

The day prior to the surgery a soap and water enema was given to cleanse the bowels and he was advised to fast after 10 p.m. Two doses of 500 mgm of Chloromycetin was given at 6 p.m. and 10 p.m. as initial antibiotic therapy. To assure a good night's sleep two tablets of Soneryl was given and Mr. X, though anxious, slept fairly well during the night, except for periodic disturbance to micturate.

Schedule for surgery

A soap and water enema was given at 9.30 a.m. on the day of the surgery. After bowel evacuation, Mr. X rested calmly and his relatives visited him to comfort and reassure him.

Skin preparation

The lower abdomen and pubic area, including the back, were shaved and cleaned as a spinal anesthesia was anticipated. Then he was dressed in operation clothing and dentures were removed.

Pre-medication

Injection Atropine 0.6 mgm/ml and injection Pethedine 50 mg/ml was given to allay apprehension. At 11 a.m. he was transported to the Operation Theatre in a trolley together with all the necessary articles, which included two sterile drainage bottles with rubber tubings and glass connections. Foley's catheter size 20, a blood transfusion set, intravenous infusions—one bottle of 5% glucose with normal saline and one bottle of 5% Dextrose and 1 pint of blood, the emergency injection box, his chart and X-rays.

(Contd.)

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Choice of Operations

Although Mr. X underwent a supra-pubic prostatectomy because there was an extremely large mass of obstructing tissue there were other surgical routes whereby the adenomatus soft tissue was removed which included :—

(a) Miller's retropubic prostatectomy ; (b) Wilson Hey's transversical supra-pubic approach ; (c) Endoscopic resection-transurethral resection and (d) Perineal prostatectomy.

Post-operative Nursing Care

On returning from the Operation Theatre at 1.15 p.m., Mr. X was received carefully into an Intensive Care Unit, where major post-operative cases are nursed. He was placed in dorsal, recumbent position with his head turned to one side so as to facilitate the maintenance of a clear air way. We took care to ensure that the drainage tubes were intact and remained patent. An extra blanket was used to keep the patient warm. The blood pressure, pulse, and respiration was checked and recorded half-hourly till it was steady and intermittently thereafter. His respiratory movement was carefully observed.

Blood and urine drained steadily and Mr. X came round at about 2.30 p.m. He felt thirsty and asked for water. Clear fluids were given orally a little at a time and gradually the amount was increased.

In the meantime, intra-venous infusions were continued as ordered. One pint of blood was transfused during surgery and after returning from the theatre he received a total of :

2160 cc IV fluids (Manitol 10%—540 cc
in the next GNS 5% —1080 cc
12 hours Dextrose 5% —540 cc)

He was encouraged to drink fluids liberally. The blood urea Nitrogen levels also rise after prostatectomy and if fluids are not taken sufficiently, uraemia may set in and patient may even die of renal failure. Assorted and flavoured drinks were given and Mr. X was very co-operative and managed to drink 1010 cc during the next 12 hours after the operation.

To prevent post-operative chest complications, he was frequently moved in bed and was later propped up. Steam inhalation was also given at night to relieve congestion in the upper respiratory tract. He was also encouraged to breathe deeply. The scrotum was well supported on a broad piece of elastoplast strapped across his thighs to lessen the risk of epididymis orchitis.

The pressure areas were attended to and passive exercises were given to the lower and upper limbs and every effort was made to keep him dry.

Medication

500 mgm of Chloromycetin was given Q6H till his discharge. For the first 3 nights 2 tablets of Sonalgin were given to ensure adequate sleep.

Injection Pethidine 50 mg was given PRN for pain during the first 24 hours followed by injection Novalgin 2 cc IM thereafter.

All medications were given as ordered and a strict

record of the intake and output was maintained.

Diet

For the first three days, Mr. X had a poor appetite and could only tolerate a fluid diet. However, his intake was satisfactory. Later he was given soft diet and gradually returned to normal diet.

The dressings were inspected frequently to detect bleeding and changed daily by the doctors.

The drainage tubes were changed every morning and an extra set of sterile bottles were kept ready when they needed changing.

Bladder irrigation was given once on the day of operation and twice the next day.

The supra-pubic tube was removed the following day. A Blood Urea Nitrogen level done revealed a slight increase to 16 mgm/100 ml of blood. Fortunately, there were no post-operative complications and Foley's catheter was removed on the 5th day.

He complained of difficulty in evacuating his bowels. Dulcolax suppository was inserted per rectum to relieve distress. Soon after he evacuated without difficulty. Blood pressure, temperature, pulse and respiration were checked and recorded four-hourly.

Till the 4th day of surgery he remained in the Intensive Care Unit. On his return to the general ward, the catheter was removed. He was made to void every hour during the day and every two hours during the night. For the first two days there was slight dribbling after which he was able to control and micturate normally.

On the 7th day Furadanti 100 mg was started and given I D till discharge. The sutures were also removed.

Mr. X recovered satisfactorily and was discharged on the 10th day. On discharge, he was advised to continue antibiotic therapy as directed and was advised to take fluids liberally for the next three months. He was further advised to restrain from heavy lifting and exertion and to return immediately to the hospital if any abnormal pain or fever develops and to keep with the appointments.

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