

A Case Study

Infective Hepatitis

By Sr. Antoneto

Sr. L., 30, was admitted to the medical ward in a delirious condition.

History: The patient had vomiting, fever, headache and loss of appetite since ten days. She had noticed yellowish discolouration of the urine since five days and that of the conjunctiva since three days. She felt impaired sensation since the previous day.

At the beginning of the illness she was treated by a local doctor. When jaundice was recognized, she was given Ayurvedic medicine. The vomiting persisted and her general condition became worse. She responded poorly to stimuli and was brought to the hospital.

Examination: The patient was delirious and restless. There was yellowish discolouration of the conjunctiva, pulse 76/mt, regular, volume and tension were good. B.P. 104/70 mm hg., Dehydration ++ Temp. 97°F. Cardio Vascular System (C.V.S.)—N.A.D. Respiratory System: Lungs were clear. **Abdomen:** Tenderness over the right hypocondrium ++, Spleen not palpable. No distention of abdomen. Blood sample was sent for test.

As she was delirious and restless inj. paraldehyde 4 cc i.M. was given. She was quiet for some time but started to struggle again. So inj. phenobarbitone 60 mg. i.M., I.V. 5% glucose with Bejectal 2 cc, Vit. C 500 mg. I.V. Inj. Vit. K. 20 mg. od and inj. Betnesol i.ml. Q. 6 hourly were given. Cap. Ampicillin 500 mg. and cap. Neomycine 1050 mg. (3 cap.) Q. 6 hourly were given by nasal tube. Continuous bladder drainage was maintained.

After about seven hours the patient became fully unconscious. Suction was used to remove secretions. The patient was responding

to painful stimulations only. 2000 cc of I.V. fluid was given in 24 hours. Pulse rate 40/54 mt., volume and tension (V.T) good. Resp. 16/18. mt. Blood test showed S.G.P.T. 470 units, Alkaline phosphate, 12.6 K.A., units. Serum Bilirubin, total 14 mg.% and direct 9.4 mg.%

On the second day her condition remained the same. I.V. infusion 1000 cc with inj. Vit. C 500 mg. and inj. B. complex 2 cc were given. kcl. 2 Gms. was given with I.V. infusion. Other treatment and nursing care were repeated. Bowel wash was given to eliminate toxins. Urine output during 24 hours was 300 cc. The patient was getting spasms 1-2 seconds on and off and responding to painful stimulations.

On the third day no change was noticed in her condition. Temp. normal, Pul: 50/54 mt., V.T. Good, Resp. 16/18 mt. Treatments and nursing care were repeated. 2500 cc I.V. fluid and 3 Gms. kcl were given. Urine output of 1600 cc was considered satisfactory in 24 hrs. At 11 P.M. the patient had one large brown coloured vomit. Her pulse and B. P. were 50-52 per mt, 80/40 mm hg. So inj. Betnesol $\frac{1}{2}$ cc I.V. was given. After that B.P. was raised to 110/70 mm hg.

On the fourth day at 3 A.M. the patient vomited about 150 cc brown coloured fluid. After some time she started responding to calls. By the following morning she answered questions. Treatments and nursing care were continued as before. 2000 cc I.V. fluid and 4 Gms. kcl were given. Urine output in 24 hrs, was 3100 cc. Patient felt very weak.

On the fifth day the patient started to talk. Tab. Vit. K. 10 mg. od. was started instead of inj. Vit. K., I. V. fluid 2500 cc and 3 Gms.

kcl were given. 800 cc barley water was given through nasal tube. Urine output was 3500 cc in 24 hrs. Blood test showed S.G.P.T. 460 units, serum electrolytes—Na. 104. mEq/L k. 4.6. mEq/L.

On the sixth day the patient felt better. Ryles tube was removed and oral fluid was started. Treatment and nursing care continued as before. 3000 cc I.V. drip and 4 grms. kcl were given. 1000 cc fluid was given orally. Urine output in 24 hrs. was 4000 cc. The patient slept fairly well during the night.

On the seventh day a general improvement in her condition was noticed. Treatment and nursing care were given as usual. 3000 cc I.V. fluid and 4 Gms. Kcl. were given. 1025 cc fluid was given by mouth. Urine output was 4900 cc.

On the eighth day medications were repeated. But inj. Betnesol was reduced to 1 cc Q. 8 hourly. 4000 cc I.V. fluid and Kcl. 4 grms. were given. 2485 cc fluid were given by mouth. Urine output in 24 hrs. was 7740 cc. Serum electrolytes were Na. 129 mEq/L and K. 4.4. mEq/L.

On the ninth day Tab. Esidrex 50 mg. was given. The patient developed polyuria. Total intake—7470 cc (5000 cc. I.V. and 2470 cc oral). Urine output in 24 hrs. was 9740 cc. By evening the patient had abdominal distention. Therefore, flatus tube was passed, and the result was good. To find out the cause of polyuria blood, and urine were tested. Blood sugar was 306 mg. %. Blood urea 22.5 mg. %, serum calcium 7.8 mEq/L. K. 4.6 mEq/L. Sp. gravity of urine was 1012. As the Blood sugar was high inj. soluble insulin 8 units Q. 6 hourly was started. After that the output decreased.

During the next five days the patient's general condition improved. Polyuria came down and I.V. fluid was discontinued. Nursing care was given as usual. The patient slept well during the nights. Her urine output was between 2000-3000 cc. Catheter was removed.

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Club Foot—(Contd. from page 237)

2. Exercise : In younger children passive movements are given. In older children active exercise to strengthen the evertors is very essential. The child is examined every 3 months.

Nurses' Role :

Prevention : Though the cause of this particular deformity has not been established, there are some genetic factors which are respon-

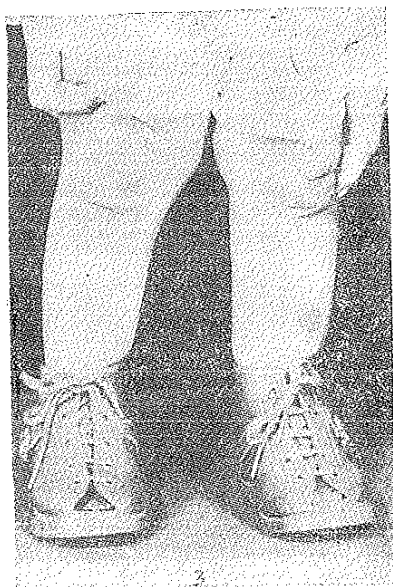


Fig. 3. The same child with Club Foot Boots

sible for this deformity. Therefore the usual measures such as discouraging marriages among close relatives and preventing irradiation of the pregnant mothers be emphasised.

Early recognition : Nurses are the first professional people to come in contact with a child. They should have a true appreciation of the problem and educate the parents about the need for proper scientific treatment. They should help the family to seek early medical treatment.

Education of the Parents : The parents should be educated on the line of treatment. Correction of club foot is a long process which needs continuous treatment. The parents should be motivated to

accept this method in preference to some "quick remedial methods" which are often not successful.

Nurses should obtain adequate knowledge in the process so that they can help the orthopaedic surgeon in the therapy.

Observation : The child is observed after the correction in the out-patient centres of orthopaedic clinics. A child need not be ordinarily admitted to the ward but should be observed for at least half an hour after manipulative correction for blood circulation and oedema of the toes. Printed instructions about plaster casts, the observations they should make and the care of the child will be of great help. The nurse can also make use of the time for discussing these topics and also educating them, on child care, nutrition and immunisation.

Rehabilitative Nursing : After full correction is obtained, a club foot boot should be given and the child periodically observed. The calf muscles and peroneal muscles must be developed by exercises, games and massages. The child as well as the parents need emotional support. They should not feel that they are burdened with the deformed child. The child should not be made to feel that he is different from others in any respect.

Bibliography :

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ved. Blood test showed S.G.P.T. 158 units, serum Bilirubin 4.7 mg., direct 2.4 mg. Blood sugar fasting was 135 mg. %. Inj. Betnesol was reduced to 1 cc Q. 12 hourly. Cap. Mandelamine 1 Gm. T.D.S. was started and cap. Ampicillin was discontinued. Urine for sugar was tested 4 times daily, and it was

negative. The patient was put on soft solid (fat and salt-free) diet. Potassium chloride was given instead of sodium chloride to prevent edema as a safety measure.

During the next three days urine output became normal. Cap. Neomycine was reduced to 700 mg. Q. 6 hourly and soluble insulin 8 units bd. Tab. Mandelamine was reduced to 1 Gm bd and cap. Neomycine 700 mg. Q. 8 hourly. Tab. B Ascorvit iod and lactisyn i amp. od was started. The patient complained of headache and sore throat and a slight rise in temp. was noticed.

On the 18th day the patient had erythematous popular rash. It started on the face and spread to the trunk. The patient had slight itching. So lotion calamine with phenol 1% was applied externally, and Tab. Periactin—4 mg. T.D.S. was started as advised by the Dermatologist. Inj. Betnesol was reduced to $\frac{1}{2}$ cc Q. 12 hourly.

Blood test for serum electrolytes showed-Na. 150 mEq/L K 3.6 mEq/L. S.G.P.T. 112 units, serum Bilirubin total 2.4 mg, direct 1.14 mg.

During the next 8 days the patient's general condition improved. She started to walk and had proper diet. Inj. Betnesol $\frac{1}{2}$ cc od was discontinued after two days. Cap. Neomycine was reduced to 350 mg. bd. The patient had good sleep during the nights. Her urine output was normal.

Blood test showed S.G.P.T. 83 units, Blood sugar 185 mg. %, serum protein—total 6.3 mg. Alb. 4.1, Gl. 12.2.

On the 27th-28th day the patient was febrile. Cap. Neomycin 350 mg. bd. Tab. Mandelamine 1 Gm bd. Tab. Periactin 4 mg. T.D.S., Tab. Vit. K 10 mg. od and Tab. B—Ascorvit iod were given. X-ray of the chest and urine examination were N.A.D.

On the 29th day groups of vesicles appeared on the trunk and back of the right side of the body and some on the hand and face. According to the Dermatologist,

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