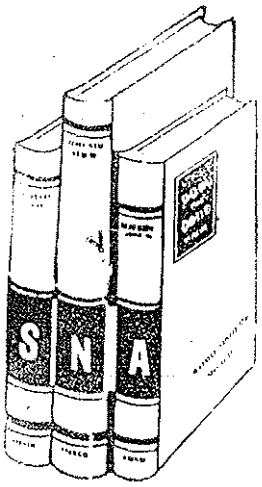
A Case Study—Ileocolostomy

By

K. PULLAMMA,

2nd Year Student Nurse, Govt. General Hospital, Guntur (AP)



A boy, aged 10 years, was brought to the Surgical out-patient Department with complaints of severe abdominal pain and irregular bowel action.

History

He was the son of a farmer and had been suffering with pain in abdomen and constipation off and on for the past six years. The pain was of a peculiar nature; colicky, the abdomen would be distended during the attack and the attack used to last for a day or two and would occur at an interval of 10 to 15 days. There was no vomiting, but had slight rise in temperature during the attack. Loss of appetite, but no appreciable loss in weight.

Clinical Findings

Patient slightly anaemic—Liver and spleen not palpable. No glandular swellings were seen. Examination of abdomen showed that there was tenderness and pain in the right iliac fossa. No lump or fluid was felt. On admission, temperature, pulse and respiration were normal. Blood pressure was 120/80 m.m. Hg.

Laboratory Investigation

Urine and stool were sent for examination. N.A.D.

E.S.R.—25 m.m., the first hour and 39 m.m. 2nd hour. Blood grouping and cross matching were done ('O' Group).

The case was provisionally diagnosed as Tubercular Enteritis. A course of Streptomycine injection 10 gms. was given once a day for ten days. Blood transfusion was given 200 c.c. a few days before operation.

The parents of the boy were informed of the nature of the operation and were reassured that it was necessary for the health of the boy.

Pre Operative Treatment

The skin was prepared for operation. Bowel evacuated by enemata, and all solid food stopped. Injection of Morphia 1/8 gr. with Atrophine 1/200 gr. was administered half an hour before the operation.

Operation

The operation wes done under General Anaesthesia. On opening the abdomen it was found that the obstruction was due to Tubercular lesion in the terminal part of the ileum and caecum, multiple intussusceptions throughout the ileum and stricture in the ileocaecal region were also noticed.

Ileocolostomy was done, the ileum was connected to the transverse colon by anastomosis and the abdomen was closed in the usual manner.

Post Operative Nursing Care

1st day. The patient was received in the Surgical Ward on a warm bed. He was given Intravenous Glucose and Saline 5% during the operation which was continued. Ryles Tube was inserted (to avoid vomiting) and aspirated every 1/2 hour. Temperature, pulse and respiration were taken 1/2 hourly. The patient was given injection streptomycine 1/2 grm. twice a day along with Injection Vitamin "C" 300 mgms. and Vitamin "B" Complex 2 c.c. were given intramuscularly.

Patient's mouth was kept moist and back attended. The patient was able to micturate of his own accord. For sleep at night the patient was given injection Pethedine—50 mg. intramuscularly. The patient's general condition showed improvement though he was weak.

2nd Day: Temperature, pulse and respiration were recorded 4 hourly. Ryles Tube aspiration done 4 hourly. Glucose water given orally, the usual nursing care given. No distension, and patient was given injection Pethedine 50 mg. intramuscularly for sleep. Injection streptomycine 1/2 grm. given along with the Vitamine "C" and "B" Complex the same dose as before.

3rd Day: Temperature, pulseand respiration recorded 4 hourly which were normal. Ryles tube removed, and glucose water and diluted milk feeds given. Patient was propped up in bed. Nursing care given. Condition better. Bowels opened by means of enema.

4th Day: General condition of the patient was improving. Soft light diet given. T.P.R. and B.P. normal. The abdominal dressings changed and sutures removed on 7th day. The wound healed with first intensions. The patient was discharged on the 10th day with instructions to continue with the streptomycine injections 1 grm. every alternate week for 3 months, till 30 grms. were administered. That he should attend the O.P.D. from time to time for the routine check up. He should eat his normal diet and keep his bowel movements regular and avoid constipation.

The patient, being a child, his adjustment to the hospital situation became a little difficult but this initial difficulty was overcome by the psycological and understanding approach on the part of the Nursing personnel.

Every opportunity was taken by the Nursing Staff to advise the patient and his relations on healthful living, personal hygiene and sanitation.

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