

STUDENT NURSES SECTION

A Case Study of Acute Nephritis with Hypertension Encapalopathy

Name : Sunanda Laxman Prabhu.

Age : 16 years.

Patient was admitted to the hospital in an unconscious state; the relative of the patient stated that Sunanda had been suffering with severe headache for 8 days; she had swelling of the face and feet for the past four days and had passed very little urine. The evening before admission to hospital, Sunanda had fits and became unconscious.

On admission to the ward the patient had a convulsion lasting one minute involving the whole of her body. Temperature on admission 101.4°F; Pulse 140. Respiration 26. Patient was catheterised and 4 oz. of urine withdrawn; on examination it contained albumin, 10 gms. and R. B. C's plus plus, sugar nil.

Physical Examination

On examination of the pupils, it was found that they did not react to light, and were small. There was jerking but no rigidity of the neck.

Blood Pressure was 180/98.

Nursing treatment

The usual nursing care was given. Nasal feeds given. Fluid intake and output was recorded. Patient catheterised 6 hourly.

Medical Treatment

To control the convulsions, Injection of Paraldehyde 10 ml. was given, and repeated after 6 hours, Injection of Penicillin 5 lac, was given statum, and 1 lac continued every 6 hours. Injection Antistine 100 mg. 6 hourly. Blood was tested for blood urea, and non protein nitrogen, Blood urea 22.5. mg. and non-protein nitrogen 42.8. mg.

2nd day. The temperature, pulse and respiration was normal. The blood pressure had come down to 148/90. Injections continued, patient was still unconscious but did not have any convulsions. All feeds were restricted for 24 hours. The total amount of urine withdrawn was 18 oz. Patient had to be catheterised 6 hourly.

3rd day. The patient became conscious towards the evening. Temperature, pulse and respiration were normal. Blood pressure was coming down steadily. The urine was tested for albumin, which showed 6 gms of albumin.

The patient was given Dr Bull's modified diet, which is glucose 400 gm. olive oil 100 gms, and water 100 c.c. this was given by Intragastric drip, 5 ozs. of this solution every 3 hours.

Patient had to be catheterised and 18 ozs. of urine withdrawn, bowels opened, mouth and back attended. Patient's condition improved.

4th day. The same treatment. Nursing care was carried out. Diet was continued.

5th to 14th day. Temperature, pulse and respiration were normal, blood pressure had come down to 100/80. Oedema disappeared. Injections were continued till the 11th day. Dr. Bull's Diet was given. Patient passed 42 ozs. of urine for the first time since admission. On examination of urine it showed very little albumin, the R.B.C's were less and the blood urea was normal. General condition of the patient improved.

15th to 21st day. The patient was more active and cheerful, and was allowed to sit up in bed, light liquid diet was given, boiled vegetables, fruit

[Contd. on page 196]