

Example of challenges in the assessment of the abdominal and neurological system ...

[Family](#), [Children](#)



Question 1.

- Location of pain, intensity and duration of pain can be misleading. Various causes of acute abdomen include appendicitis, cholecystitis, hernia and other gynecological causes may be difficult to distinguish and diagnose.
- Uncertainty of diagnosis and difficulty to identify abdominal pathology owing to the many organs within the abdominal viscera. An examiner will occasionally miss a diagnosis by mistaking the affected organ with an adjacent organ.
- Pregnancy – pregnant women are usually difficult to examine per abdomen owing to the physical and physiological changes e. g. enlarged uterus.
- Small children might be difficult to examine – they are usually uncooperative and their systems are not well developed.
- Use of narcotics and strong analgesia may hinder definitive diagnosis of both abdominal and neurological systems.
- Mental status, dementia and decreased sensation of peripheral nervous system in older patients can reduce perception of pain.
- CONCLUSIONS ABOUT K. B's DIETARY RECALL ON THE FOOD PYRAMID
- K. B's dietary recall includes many unhealthy foods contrary to recommendations and objectives of food pyramid to prevent obesity, chronic diseases and dental caries
- She takes highly refined foods, fatty foods, free sugars and all have very high glycemic load that expose her to health problems. Her diet predisposes her to lifestyle diseases e. g. type II diabetes, heart diseases, hypertension, cancer etc. owing to her genetic relationship with these diseases and the sedentary lifestyle that she leads.

- She does not balance the food she eats with physical activity to help maintain or improve her weight. Her BMI indicates that she already obese.
- Her foods do not include vegetables and fruits which are highly recommended in people at risk of developing lifestyle diseases.
- Her meals do not include the right portions or servings for every major food group. For adult women living a sedentary life 1600k/cal is what is required per day compared to her meals, which includes too much unrefined sugars, carbohydrates and saturated fats.

- ELEMENTS OF NUTRITIONAL ASSESMENT

- These include; anthropometric, biochemical, clinical and dietary assessments.
- Anthropometric assessment includes; weight, height and skin fold measurements e. g. Mid upper arm circumference. Weight and height are also used in calculation of body mass index (BMI)
- Biochemical assessment, involves laboratory test and food analysis.
- Clinical assessment involves collection of data and information about individuals' medical history and examination.
- Dietary assessment – documentation of data on the type of food, food portion and frequency.

- CONCLUSSION ABOUT CLIENT'S DIET.

The client has a very unhealthy diet that comprises of mainly refined foods, saturated fats, carbohydrates and free sugars. She has some hereditary/ genetic relationship that predisposes her to diabetes and hypertension and therefore must be very particular about her diet to avoid her diet developing these diseases.

- ORDER OF ASSESMENT TECHNIQUE
- Inspect – palpation – discussion – percussion

This applies to gastro- intestinal system and genital urinary systems.

- ASSESMENT, FINDINGS DURING ABDOMINAL EXAMINATION
- Inspection – abdominal distension, rate of respiration, visible peristalsis, scalps, veins enlarged liver and spleen.
- Palpation – tenderness localized organized, enlarged organs, mass, herms, pulsating vessels.
- Percussion – extent of liver and spleen enlargement, detecting peritoneal fluid, resource and dullness.
- Auscultation – bowel sounds, continuous murmurs.
- NURSING DIAGNOSIS:

Nutritional imbalance – related to poor dietary planning and increased risk of lifestyle diseases

FACTORS CONTRIBUTING TO CLIENT’S PROBLEMS.

- Sedentary life style work environment gender, age, physical activity, and other environmental factors.

A NEUROLOGICAL ASSESSMENT IN CEREBRAL VASCULAR ACCIDENT.

- Glasgow coma scale
- History taking – history of seizures, headaches, vision, and hearing problems.
- Mental status assessment – state of consciousness, orientation, mood,

thought process, memory, practical skills etc.

- Assessment of the peripheral and motor nerve function- reflexes, tetany, sensory evaluation etc

(B) CEREBRAL, COGNITIVE AND NEUROLOGICAL ASSESMENT AND THE RATIOANALE

- CVA disease is a risk factor to cognitive functioning of an individual, patients of CVA will usually present with dementia and attention deficit. Deficits in memory, circulation, reasoning and orientation are greatly affected.
- Neurological based anomalies that one may observe include developmental disabilities, muscle weakness & numbness. Others develop flaccidity, spasticity, hemiplegic, reduction of sensation, decreased reflexes balancing problem, dropping of the tongue.
- Cerebral deficits – breathing problem, difficulty with verbal expression, hearing, motor speech disorder, altered voluntary movement, memory deficits.

(C) FINDINGS THAT WILL DEVIATE FROM THE EXPECTED FINDINGS IN A NORMAL PERSON

- Patient present with face dropping, arm weakness and speech difficulty
- Sudden numbness or weakness of the leg
- Mental confusion and a problem understanding
- Vision with one or both eyes may be affected
- Loss of balance and coordination, trouble walking
- Severe headache of unknown origin
- Hemiplegic

(D) WHY IS IT NECESSARY TO INCLUDE MUSCULO SKELETAL ASSESMENT

- CVA is a physically disabling neurological condition that result in secondary musculoskeletal complications of the patient.
- Assessment of the muscular skeletal system will help to recognize and treat complication of CVA and improve patient functioning
- In order to plan for rehabilitation of patients and to to avoid development of secondary musculo skeletal complications and degenerative disorders of the system.
- Treatment and rehabilitation focuses on improving and helping the patient to regain function and prevent secondary disability.

(A) INSPECTION

- Yellowish discoloration of the eyes/sclera
- Patient presents with abdominal distension
- Lying supine, the flanks are pushed further upwards due to excess fluid
- Visible bulging abdominal veins.

(B) AUSCULTATION

- Reduced bowel movements.
- Tachycardia in case of an infection
- High blood pressure related to portal hypertension
- Tarchypnoa, due to increased respiratory activity and pressure on diaphragm

(C) PERCUSSION

- Direct percussion on the abdomen – there is direct transition from tymphani to dullness as you precise further downwards.
- Shifting dullness - when patient lays on the side these is a shift of tymphani

to the top and dullness to the bottom of the belly.

- Fluid wave – when you tap one side of the abdomen with your finger tips there is a shock wave felt on the opposite side of the abdomen.

(D) PALPATION

- Palpate the liver for enlargement and spleenomegally. The liver can be palpated 2 – 3 cm below the lower costal margin. If there is a liver pathology you can feel the texture of the liver i. e. softness, hardness, nodular swelling etc.
- It might be impossible to palpate for other organs in the abdomen owing to the large amount of fluid in the cavity.

(A) HEALTH QUESTIONS I WILL ASK THE MOTHER WHO BROUGHT HER CHILD TO THE ER WITH VOMITING AND DIARRHOEA

- For how long has the child been vomiting and passing diarrhea
- History of fever and other symptoms related for infections
- The color and consistency of stools.
- Type of food given to the child lately.
- Is the child drinking water? Are there signs of thirst

(B) ORGANS AND SYSTEM TO FOCUS ASSESMENT ON

- Check the child's general condition – is the child lethargic, restless or irritable
- Look at the eyes; are they sunken
- Are the fontanel's of the head bulging or sunken
- Check for skin turgor and dryness push the skin on the abdomen and check whether it goes back easily

(C) ASSESSMENT RESULTS

- Inspection – child general condition, whether lethargic, irritable inspect the eyes for jaundice, pallor, dryness or sunken are the fontanel's of the skull sunken or bulging. Check the skin for dryness, edema, and turgor.
- Auscultation – auscultation of the chest for respirations, cardiovascular system for rate of heart beat, murmurs etc. check the abdomen for bowel sounds
- Percussion – percussion of the chest, abdomen for tympany and resource
- Palpation – palpate the abdomen for tenderness, liver and spleen for enlargement.
- COMPLICATIONS
- Several dehydration
- Metabolic hypo kalemia and hyponatraemia
- Shock acidosis
- Electrolyte imbalance
- hypoglycemia
- Malnutrition
- Death

REFERENCES

- <http://connection.lww.com>

American Journal of Gastroenterology.

- American Academy of Nursing Practice. By Ambrose, M., & Decker, H. M. (1996)

- Healthy Eating Plate and Healthy Eating Pyramid. (Harvard School of Public Health)

<https://assignbuster.com/example-of-challenges-in-the-assessment-of-the-abdominal-and-neurological-system-and-why-case-study/>

[www. hsph. harvard. edu/nutritionsource/pyramid](http://www.hsph.harvard.edu/nutritionsource/pyramid)

Boston 2013

- Textbook of Clinical Neurology. 3rd Edition

Saunders Elsevier.(2007) chapter 45.

- [www. paediatrics. about. com](http://www.paediatrics.about.com)

Treatment of vomiting and diarrhea in children