Ulcerative colitis essay

The young gentleman I took part in his care had an underlying condition of ulcerative colitis but was admitted as suffering from acute nephritis. This is normally a condition that exhibits itself in the form of inflammation of the kidney’s glomeruli (Milly 2005, pg 234). The patient was admitted exhibiting symptoms like; cola-colored urine, high blood pressure, edema, increased proteins and electrolytes in urine, anemia and headaches (Greig 2000, pg 329). As a professional, I played an important role in getting the medical history of the client, undertook the anthropometric assessments before admitting him.

From the underlying medical condition the patient had ulcerative colitis and hence it was very likely that he had been on anti-cancer drugs used to control any abnormal proliferation of cells. The underlying conditions therefore called for careful planning of care so that the acute nephritis could be taken care of while keeping in mind that the underlying condition of ulcerative colitis could be responsible for most of the symptoms and even the acute infection hence must also be addressed properly.

In terms of assessment and testing, I undertook to establish the patient’s blood pressure, abnormal sounds from the heart and lungs as well as seeking to establish external signs like swellings on the face. When dispensing the care for the acute condition of acute nephritis, it should be done with the bigger picture of the underlying condition, which is ulcerative colitis. Because acute nephritis also presents with almost similar signs like ulcerative colitis, it was important to first review the details of ulcerative colitis before dispensing care.

The review of the underlying condition is as follows in the case review; Case review Ulcerative colitis can be both acute and chronic disease/disorder that brings with it extensive ulceration or inflammation or both in the colon. This mainly takes place in its mucosa or submucosa. It is just but one of the many conditions lumped together as inflammatory bowel disease. In most cases, the ulcers form in places where cells lining the colon have died due to the inflammation. It can happen to anyone regardless of age but mostly starts among the population between 15 and 30 years of age (Thomas 2006, pg 623).

The most common symptoms associated with this condition is bloody diarrhea and pain in the abdomen. In most severe cases, it is always necessary that the physicians offering care remove the colon! The term idiopathic is always used in reference to this condition because its etiology is really never known clearly. In several situations, this condition is always not just limited to pathological changes in the co0lon but also involves systematic degenerations of other parts of the body that involve joints hence resulting in migratory arthritis, ankylosing spondylitis and even sacroileitis (Jill 2008, pg 45).

Other organs like the liver, the skin and the eyes can also be affected and hypercoagulability is also exhibited. The clinical manifestations and complications of ulcerative colitis Emotional or physical stress is known to bring about bloody mucoid diarrhea among the patients. These are often acute attacks that can last from a few days to weeks or even a few months and are always followed by some periods of remission, which can extend from months to even decades!

This patient had already been having these remissions for three years according to his medical records. In some patients, the attacks are relatively few while in others it can take long, become more prolonged or even be more severe hence predispose the colon to even unforeseen malignant alterations. The diarrhea, whether acute or chronic, brings about severe alterations in electrolyte balance in the body system, interfere with the patient’s nutrition condition, and bring about severe fevers, weight loss and even stomach cramps (Ferguson 2000, pg 1120).

This patient exhibited most of these signs and if they were because of the acute nephritis for which he was admitted, it could not be accurately refuted that they were not due to the underlying condition of ulcerative colitis. In cases where the disease attack is severe and sudden, the patient may suffer from cessation of the bowel function, colon dilatation or bring about toxic megacolon. This normally takes place spontaneously but in some cases can be preceded with barium enema, anticholinergic narcotics or even hyperkalemia.

Bacterial growth characterized with the production of exotoxin can also take place like was the scenario in this case. Still when it is sudden, other complications like systemic toxicity, metabolic alterations and severe blood loss leading to anemia, are also exhibited. The sequela of long-term chronic ulcerative colitis is in most cases the colon carcinoma. This carcinoma occurs in approximately 5% of all the people suffering from ulcerative colitis (Hanauer 2001, pg 98). Those patients who suffer fewer relapses are always at reduced risk of this carcinoma compared to those who remain symptomatic over the years.

Colonoscopy has been accepted across the medical board as the most effective method of screening ulcerative colitis patients for this form of carcinoma and hence was what we used to screen this patient. Ulcerative colitis patients are therefore supposed to undergo colonoscopy at intervals of one or two years for a period of about 8 years especially for those who have had it for a period of 15 years. This patient had already undergone one colonoscopy and was negative. Patient care for ulcerative colitis

During the acute attacks, the patient always presents medical problems related to the deficit of fluid volume, changes in normal nutrition, electrolyte imbalance and even the potential of having skin breakdown in the anal region. Disturbances from rest and even sleep also occur. During care, it is important to note that long-term problems can also occur and are mostly related to anxiety, changes in one’s self concept and the fears of developing even more malignancies and social isolation. All these were put into consideration when designing and interacting with this patient.

It was necessary to provide more luxurious sleeping bedding to make the patient get some sleep. Counseling him to assure that his condition was under control and that he would receive the best management that would relieve his pain and return him to normalcy helped to ease out his anxiety. This counseling was also important in alleviating the fears that he was at risk of developing malignancies. An arrangement was made to make a family member come and stay with him in the hospital and as such stress associated with social isolation was reduced.

The care involved the observation of the stool character as well as the number, the auscultation of the bowel sounds, weight monitoring, and establishment of the nutrition intake and output. This was done every day and sometimes periodically in a day depending on the severity of the symptoms exhibited. Other activities involve checking for any signs of bleeding and anemia, monitoring the blood gases and electrolytes, assessing the PH at specific time intervals to ascertain the acid-base balance in the body due to the electrolyte imbalance.

It was also important at this point in time to check for any abnormal changes in the patient’s joints or even for any forms of lesions on the skin. It was good nursing practice to inform the patient of the diagnostic procedures involved so that he gets to know the purposes of each and every test. The tests included sigmoidoscopy, stool analysis and barium enema. Informing the patient is necessary since it helps him to know what is expected of him before they are executed, during and even after they have been done (Scholmerich 2006, pg 203).

Concerted effort should always be made to ensure that certain long-term goals like ensuring that the patient has the knowledge and skills to adhere to the medical regimen prescribed for him, are also taken care of. These medical regimens normally consist of the anti-diarrheic agents, some mild sedative as well as low fiber diets that produce low residue (Tracy 2006, pgs 123). Others are the anticholinergic drugs that were used to help the patient relieve his abdominal cramps and bland foods that provide sufficient calories and proteins.

Antibiotics were also used to control the other forms of infections that may infect the stomach. These antibiotics also came in handy as an intervention against acute nephritis. However, in cases where the other conservative treatments have failed, a surgical intervention can always be done. The surgery if undertaken is always not devoid of medical complications because it always involves the creation of a permanent ileostomy. Disease severity It is always important to assess and classify the severity of the patient’s condition since it guides the formulation of the care program.

Ulcerative colitis presents different cases depending on how severe it is in an individual. If the patient is having a mild case of the disease, it is always characterized by less than four stools per day, which may or may not have blood stains. It is also without any systemic forms of toxicity and the patient also always has a normal and regular erythrocyte sedimentation rate (ESR). The patient also suffers fewer and mild abdominal cramps and sometimes the patient has a false feeling of being constipated when in real sense, the feeling is due to tenesmus (Truelove 1988, pg 389).

Tenesmus is the feeling that makes one to continually feel like emptying the bowel most of the time and is accompanied by elements of involuntary straining, pain as well as cramping without any fecal output but rectal pain is not common. At its moderate state, the patient releases more than four stools per day only that there is almost no sign of toxicity. The patient presents mild forms of anemia at this stage but does not need a transfusion; there is also moderate abdominal pains and mild fever of about 38 and 39 degrees Celsius.

When the condition gets to the severe stage, one presents more than 6 stools in a day, there is evidence of toxicity with an outward sign of fever, elevated ESR, instances of tachycardia and even anemia. In certain instances, the disease gets to the stage of being a fulminant disease. Here, the patient experiences extreme signs of everything one experiences in the less severe stages. The patient experiences more than 10 bowel movements per day; there is continued bleeding and toxicity as well as abdominal tenderness and distension (Orholm 2000, pg 1076).

It is also at this stage that colonic expansion or dilation is experienced and blood transfusion is always very necessary in this stage. At this stage, the patient may always have the inflammation going beyond the layer of the mucosa hence causing impaired colonic motility bringing about toxic mega colon. The perforation may always occur especially if the serous membrane is involved. At this stage of fuminant disease, the patient is always at high risk of even dying and therefore a lot of care was taken in this case (Carding 2007, 1630).

During the care of the patient, the nurse should always pay attention to the extraintestinal features of ulcerative colitis. Due to the fact that this condition always comes with a variety of comorbidities, it can present various complications external to the colon like the aphthous ulcers in one’s mouth. One can also have inflammations of the eyes like iritis for the iris as well as episcleritis. In the musculoskeletal region, the patient may exhibit seronegative arthritis, which can affect two big joints of the leg or even the smaller joints in the hand.

There can also be arthritis of the spine known as ankylosing slondylitis (Sandborn 2007, pg 1650). On the skin, the patient may present signs of inflammations of the subcutaneous tissue known as erythema nodosum. There can also be a painful ulceration of the skin known as pyoderma gangrenosum. All these were taken into consideration when offering care for this patient. It is important to know and let the patient know that there is no cure for the condition (Ulcerative colitis) because it is always a debilitating disorder that brings with it several physiological as well as psychological and social problems for the affected persons.

Normally the frequent bouts of diarrhea that one experience bring about discomfort and can as well are very embarrassing and depressing too. It is therefore very pertinent in care that the patient is emotionally supported and listened to in a very empathic nature. The problems that the patient suffers should be solved in a cooperative manner such that the intervener and the patient are all involved. Prior to being admitted, it was obvious that the patient had undergone a lot of economic stress because his condition took him out of employment and the high costs of healthcare was also taking a toll on him.

He was not having an active lifestyle due to his condition. The embarrassing episodes of diarrhea were too much for him and hence he could not even hang out with friends anymore. This means he was under intense social and psychological stress due to the loneliness that the disease had brought upon him. All these were to be taken into consideration when formulating the care plan. Causes of Ulcerative colitis This condition is not linked to any direct causes but have several possible factors linked to it.

The first is genetic factors. Ulcerative colitis is believed to be highly likely to occur in families where there is an aggregation of the ulcerative colitis, where identical twins with a concordance rate of about 10% or even among dizygotic twins with a concordance of about 3%. Issues of genetic markers as well as linkages also make up important determinants on issues pertaining to genetic causes of ulcerative colitis. It is believed that there are about 12 regions making up the genome that are linked to ulcerative colitis.

They are chromosomes sixteen, twelve, six, five, fourteen, one and three among others. The chromosome band 1p36 is for instance believed to be linked to the inflammations that occur in the stomach. Transporter proteins like OCTN1 and OCTN2 are also encoded from certain putative regions. The other cell scaffolding protein also believed to play an important role in the genetic contribution in ulcerative colitis is that of the MUGUL family (John 2005, pg 91). It is also believed that the human leukocyte antigens linkages also play an important role in ulcerative colitis.

The second is environmental factors. There are several hypotheses that have been raised in regards to the environmental contribution to the pathogenesis of ulcerative colitis. Diet is believed to play an important role in here. Dietary substances in the colon are believed to bring about inflammation even though little scientific evidence has been generated to support this end. It is believed that diets that are low in fermentable fiber have an effect on the incidence of ulcerative colitis.

There are studies that have held that certain practices like breastfeeding have the effect of being protective against the incidence of inflammatory

bowel conditions. Some scientific studies have also linked Accutane to the development of ulcerative colitis (Kane 2010, pg 145). It has also been thought that ulcerative colitis could be an autoimmune disease where the malfunctioning of the immune system results in attacks on certain parts of the body. The disease has a ‘ backwash ileitis’ that can occur in s10% to 20% of all the patients who are suffering from pancolitis (Porro 1998, pg 530).

The effect is however believed to have very little clinical significance in the pathology of this condition. The condition has also been linked to comorbidities that come with various symptoms outside the digestive system and often call for surgical removal of the large intestine. In terms of disease pathology, ulcerative colitis has been characterized by elements of colonic bacteria that have the effect of reducing sulfate. This has ensured that in most cases, the toxic hydrogen sulfide gas increases to higher levels (Levitt 1998, pg 1378).

The role played by the hydrogen sulfide in the pathogenesis of ulcerative colitis is however unknown (Ardozzone 2002, pg 487). In patients who smoke, some element of protection against this toxic gas has been reported mainly due to what is believed to be the reaction between the hydrogen cyanide in cigarettes smoke with the gas (hydrogen sulfide) resulting in a non-toxic compound known as isothiocyanate. Some studies have also linked the sulphur contained in red meats as well as alcohol with the relapse risk among the patients who are in remission.

Drug therapy in ulcerative colitis Patients with ulcerative colitis always undergo drug therapy mainly to help in inducing and maintaining remission

and to also be able to play a role in improving the quality of life of the patients. In most cases, the drugs used are always those classified as aminosalicylates, the corticosteroids and the immunomodulators. The Aminosalicylate drugs are believed to play a role in controlling the inflammation associated with ulcerative colitis due to the 5- aminosalicyclic acid/ 5-ASA it contains.

For instance the sulfasalazine drug is made up of 5-ASA and the compound sulfapyridine. It is the sulfapyridine that is used to 5-ASA to the intestine to bring about an anti-inflammatory effect. This carrier (sulfapyridine) always comes with certain side effects on the patients like heartburns, nausea, throbbing headaches, vomiting and even diarrhea. Because of this, drug therapy management of patients always utilizes other agents with 5-ASA like mesalamine, balsalazide and even olsalazine because they have fewer side - effects hence can even be used by those patients who cannot use sulfasalazine.

All these 5-ASA containing drugs are administered orally via an enema and sometimes as a suppository based on the exact location of the inflammation in the colon. The aminosalicylate drugs are mostly used by patients with mild to moderate ulcerative colitis hence is always the first to be used but can also be used in case of a relapse (Podolsky 2002, pg 105). The other group of drugs used for drug therapy is the corticosteroids. Examples of corticosteroids include prednisone and methylprednisone, which also play a role in reducing inflammation (Salim 2006, pg 312).

This drug are mostly used by those patients who do not respond to the 5-ASA drugs and are hence mostly used by persons who have moderate to severe cases of ulcerative colitis. These drugs can also be given orally, in suppository, intravenously or even through an enema depending on the location of the inflammation in the colon (Feller 2005, pg 45). The side-effect associated with these steroids include increase in weight, hypertension, set in of diabetes, the loss of bone mass and the patient's increased risk of more infection among other social and psychological effects like having mood swings.

They have been seen as effective when applied for short-term use but are not encouraged for long-term use due to the degree of their side-effects (Lashner 2009, pg 320). The patient we admitted was using these drugs. The other most commonly used group of drugs is the immunomodulators. These drugs mainly reduce the inflammation by acting on the immune system. Examples of this type of drugs include azathioprine and the 6-MP (6-mercapto-purine) (Baron 2006, pg 149).

These drugs are the last resort and are used by those patients who do not respond to both 5-ASAs and the corticosteroids. The immunomodulators are always slow in acting and may always take up to six months to bring out their full benefit on the patient. If the patient is put on this group of drugs, they have to be monitored closely for side-effects like pancreatitis, hepatitis as well as increased risk of getting infections due to the low levels of white blood cells (Calkins 1989, pg 1849).

Spiritual care According to the Joint Commission for Accreditation of Health Organizations (JCAHO), all patients admitted for acute interventions need to be offered spiritual care based on their individualized spiritual assessment. This spiritual care was offered to the patient and documented in the medical records since it contained the patient's beliefs, denomination as well as religious practices that may affect healthcare delivery.

By taking care of the patient's spirituality, we played a significant role in providing meaning to the life of the patient, increased his hopes in life and restored a sense of inner peace in him (Greg 2006, pg 178). A patient suffering from ulcerative colitis always undergoes several stressful experiences that come with pain, disability to perform certain tasks as well as social exclusion in the hospital set up. The pain linked to this disease brings with it an element of distress that makes the patient to miss love, hope and even the much needed comfort in life.

This care was offered by constantly seeking to share spiritual beliefs with the client. The first intervention was used as the assessment of the patient's religious beliefs since the concerns and doubts expressed in the first case were all incorporated to come up with the final spiritual care plan. Referral to a spiritual leader was often made and the spiritual leader came to assess and share with the patient at his place of admission in the hospital. Most evenings, the bible was read out to the client as a way of spiritual encouragement.

In the room where he was stationed, he was allowed to keep the picture of Jesus Christ whom he considered his Guru. Inspiring verses of the bible were

read out to the client especially those that linked the cure of diseases to the abilities of a supreme deity (God). This was integrated in the care so that in some instances, before therapy could be administered, the spiritual leader would be involved in praying for the sick. Most aspects of the spiritual care were based on the fact that the human soul lives forever and that even among those who die, they have a place to go (heaven) so long as they believe.

It was also based on the argument that everyone was created by God, belongs to him and is under his care all the time and therefore everything that happens is due to the wish of God. In evaluating the effect of this intervention, personal effort to perpetuate this act was used and the patient was found to have adopted the method of praying every day before taking his medication. He also appeared happier from the belief that everything that was happening to him was because of God and that he had no role to play in it.