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**Different disorder of the prostate gland with their etiologies, therapeutic intervention as well as surgeries and nursing care plan and health education.**

The prostate gland is a male reproductive organ that produces fluid that feed and protect sperm cell. The 3 most common forms of prostate disorder are ;

 a] prostatitis.

 b] benign prostatic hyperplasia.

 c] prostate cancer.

 A. **PROSTATITIS** is the inflammation of the prostate. The types of prostatitis are acute bacterial infection [bacterial prostatitis] which can be treated with antibiotics drugs and chronic pelvic pain syndrome [non-bacterial prostatitis ] which is the most common and more difficult to manage. Its **ETIOLOGY** is bacteria found in the prostate gland from the urinary tract and from direct extension or lymphatic spread from the rectum, it can also result from sexually transmitted organisms such as Neisseria gonorrhea, HIV etc. Signs and symptoms include pain, difficult or frequent urination, blood in urine, fever and chills, urethral discharge , sexual dysfunction. Risk factors are it can affect men of any age but common in men of 30 to 50 years of age, urinary catheter, enlarge prostate gland. **MEDICAL MANAGEMENT** depends on the underlying cause and the type of prostatitis. Antibiotic are prescribed if the cause is a bacterial infection such as NSAIDs for inflammation and alpha blockers to reduce bladder outlet obstruction and improve voiding dysfunction. **SURGICAL MANAGEMENT** we have transurethral microwave heat treatment, which is the application of heat to prostatic tissue. **NURSING MANAGEMENT** IS

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| **NURSING DIAGNOISE** | **NURSING OBJECTIVE** | **NURSING INTERVENTION** | **SCIENTIFIC** **RATIONALE** | **EVALUATION** |
| Acute pain related to bladder distension evidence by patient verbalization of pain | Patient will verbalize reduced pain after 45 minutes of nursing intervention. | 1. Assess pain characteristics ;
2. Quality e.g burning, aching, sharp etc
3. Severity; use a mood scale or a number scale.
4. Location of pain.
5. Duration e,g long, intermittent, continuous
6. Establish interpersonal relationship.
7. Repositioning
8. Administer drugs
 | 1. These are all carried out to provide a baseline data.
2. Creating an interpersonal relationship between a nurse and a patient helps the patient to be more open minded.
3. Reposition can help make the patient comfortable.
4. Due medications are served to block the pain receptors
 | Patient verbalized less pain within 30 minutes of nursing intervention. |

 **CLIENT EDUCATION** should be carried out to reduce the risk of prostatitis. Client should be advised to maintain personal hygiene, hydrate, limit caffeine and alcohol, have safe sex and regular check up.

 B. **BENIGN PROSTATIC HYPERPLASIA** is a non-cancerous enlargement of the prostatic. It is more common in older men and it isn’t life threatening but can affect your quality of life significantly. The enlargement of the prostate gland [which surrounds the top of the urethra] causes the urethra to narrow and this puts pressure on the base of the bladder which can lead to an obstruction in the flow of urine [acute or chronic urinary retention]. Its **ETIOLOGY** is not well understood but testicular androgen have been implicated. BPH generally occurs when men have elevated estrogen levels and when prostate tissues become more sensitive. Sign and symptoms are urinary retention, fatigue, discomfort, anorexia, dysuria. The risk factors are age, smoking, family history, obesity, DM. **MEDICAL MANAGEMENT** can be drugs but for only patient who have mild or moderate symptoms of BHP. Approaches are blockade of alpha-adrenoreceptors and suppression of androgen. Drugs such as alpha –receptors blocker usually improve urinary symptoms and peak urinary flow rate 2-4 weeks after the introduction to therapy. **SURGICAL MANAGEMENT** include prostatectomy which involves the surgical removal of the inner portion of the prostate via to suprapubic. **NURSING MANAGEMENT**

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| **NURSING DIAGNOISE** | **NURSING OBJECTIVE** | **NURSING INTERVENTION** | **SCIENTIFIC** **RATIONALE** | **EVALUATION** |
| Impaired urinary elimination related to bladder outlet obstruction evidence by patient verbalization of dysuria. | Patient will verbalize relief after 40 minutes of nursing intervention. | 1. Assess voiding pattern [frequency and amount].
2. Palpate for bladder distension and observe for overflow.
3. Promote continued mobility.
4. Catheterize as indicated.
5. Teach kegel exercise.
6. Administration of drugs
 | 1. Assessing helps to identify characteristics of bladder function.
2. Bladder dysfunction is variable but may include loss of bladder contraction and inability to relax urinary sphincter , resulting in urine retention and reflux incontinence.
3. Mobility decreases the risk of developing UTI.
4. Catheterization helps to empty the bladder.
5. Kegel helps improve the pelvic floor muscle tone.
6. The prescribed drug should be administrated.
 | Patient verbalized relief 20 minutes after nursing intervention. |

 **CLIENT EDUCATION** should be done to reduce the risk of BHP. One should avoid delaying urination, alcohol consumption and practice a healthy lifestyle habit.

C. **PROSTATE CANCER** affect men over the age of 50 years. In the early stages, the cancer cells are confined to the prostate gland. If is an aggressive type of prostate cancer , the cancer cell enter the vascular and lymphatic system early and spread to other parts of the body where they develop secondary tumors, particularly in the bones. Its **ETIOLOGY** is unknown. It is only known that the cancer begins when some cells in the prostate becomes abnormal [mutation]. Signs and symptoms are dribbling, excessive urination at night, weakness, dysuria. Risk factors are age, race, sex, family history. **MEDICAL MANAGEMENT** require palliative care and watchful waiting, radiation, hormone therapy, chemotherapy, urinary retention medication. **SURGICAL MANAGEMENT** are laparoscopic radial prostatectomy which is the removal of the prostate gland and surrounding tissues, radiosurgery which focuses high power energy on a particular area of the body, prostatectomy, radical retropubic prostatectomy. **NURSING MANAGEMEMNT**

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| **NURSING DIAGNOISE** | **NURSING OBJECTIVE** | **NURSING INTERVENTION** | **SCIENTIFIC** **RATIONALE** | **EVALUATION** |
| Fear related to knowledge deficit evidence by patient asking a lot of questions. | Patient will report and demonstrate reduced fear after 30 minutes of nursing intervention. | 1. Asses the patient’s level of anxiety.
2. Assess for influences e.g cultural beliefs, norms, values.
3. Establish a nurse and patient relationship.
4. Reassure patient.
5. Explain or show patient other successful cases and involve the relatives.
 | 1. Assessment is done to know the nursing intervention to take.
2. Some patient’s stress may be based on cultural perception.
3. This relationship can help gain the patient’s trust.
4. Reassurance helps place the patient in a calm state.
5. It helps to reduce anxiety.
 | Goal met. Patient was less anxious within 20 minutes of nursing intervention. |

**CILENT EDUCATION** should be done to reduce risk such as avoiding over consumption of supplement and vitamin [folate and calcium], avoid smoking and excessive alcohol consumption, consume a balance diet and exercise well.