NURSING CARE SYSTEMATIZATION FOR PATIENT WITH FOURNIER SYNDROME

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ABSTRACT

Descriptive study of type experience report, which refers to nursing care for a user with Fournier syndrome admitted to a Surgical Clinic Unit of a university hospital in southern Brazil. The nursing assistance systematization (NAS) proposed by NANDA (2009-2011), used in the institution, guided the care plan established for the user. Nursing care aimed at a service with effective assessment, with actions of health education preparing for discharge, in addition, nursing care exists in the relationship of interaction between the nurse, multidisciplinary team and user, requiring professional technical training, knowledge and sensitivity in the care. It is concluded that the role of a nurse when taking care of the individual must plan and implement appropriate assistance to the client from the Nursing care systematization, contributing significantly to the evolution of the patient.

Keywords: Nursing Care; Surgical nursing; Fournier Syndrome.
INTRODUCTION

The French dermatologist Fournier, in 1883, described five cases of spontaneous genital gangrene called idiopathic scrotal gangrene or fulminating gangrene, which affected male genitals. There were in common, to cases, rapid progression, lack of apparent cause (assigned or associated), genital location, sex and commitment toxic considerable ¹.

Fournier Syndrome or gangrene Founier is defined as an affection polymicrobial, synergistic necrotizing of acute onset involving the superficial fascia and, frequently, deep fascia of the perineal and genital region, coursing with severe mutilations and high mortality rate.

This is a severe infectious pathology, rare, of rapid progression, which affects the genital region and adjacent areas, which leads to thrombosis of small subcutaneous vessels, progressing to necrosis and characterized by an intense tissue destruction involving the subcutaneous tissue and fascia because of the combined action of aerobic and anaerobic bacteria. ¹, ²

Predisposition to Fournier gangrene is associated with states of immunosuppression, chronic diseases, alcoholism, senility, obesity, mechanical trauma, insect bites, surgical procedures, urologic system abnormalities and colorectal diseases. ³

In the clinical condition of Fournier syndrome is observed the presence of pain, fever, edema that evolves to necrosis, which may lead to septicemia, becoming thus a dramatic picture even for health professionals.⁴

In the perineal and genital area occurs development of bruising, blistering, crepitus, gangrene, necrosis and fistulae with drainage of purulent secretion with a fetid smell, accompanied by discomfort, pain, paresthesia, warmth, swelling and redness.

OBJECTIVE

Report nursing care, based on the Nursing Care Systematization (NCS) provided to the user with Fournier Syndrome in a Clinical Surgery Unit.
Descriptive study of type experience report, which refers to nursing care for a user with Fournier syndrome admitted to a Surgical Clinic Unit of a university hospital in southern Brazil. The Nursing Assistance Systematization (NAS) proposed by NANDA used in the institution guided the care plan established to the user.

The user was followed on day-shift by unit nurses and members of a study group of skin lesions, which were met to discuss the case and for the standardization of approaches taken.

The NCS developed in the morning shift was accompanied by other shifts, and proposals were made at duty change from one shift to another.

**DISCUSSION / RESULTS**

The user internal in clinical surgery unit for clinical picture treatment of Fournier syndrome, post-debridement of the perineal region, post exploratory laparotomy to making colostomy protective in order to prevent infection of the perineal region.

On admission to the unit were elaborated the following nursing diagnoses and their respective plan of cares: pain related to perineal injury, knowledge deficit related to the diagnosis and colostomy, imbalanced nutrition: less than body requirements, risk of infection due to the large extension of affected area in the perineal area, anxiety and the severity of the disease by the use of colostomy.

The care plan started with pain relief, keeping analgesics fixed and before the start of curative, dressings three times a day, the same being realized with 6% Papain for the cleaning of the lesion due to the presence of dead tissue and purulent discharge. It was also used activated carbon with silver that absorbs exudate, filters the odor and performs bacterial action.

The user was accompanied by a multidisciplinary team, being encouraged improvement in caloric intake according to nutritionist recommendation and nursing monitoring, seeking improved healing.

The user was taken on two occasions for debridement in the surgical ward, and after the curative was reassessed and activated carbon was replaced by Vaseline gauze. The user was taken on two occasions for debridement in the surgical ward, and after the curative was reassessed and was replaced by activated carbon Vaseline gauze, which is a non-adherent wound dressing indicated for lesions with presence of granulation tissue, where it is
necessary to avoid grip of the cover to the wound bed, resulting in an exchange without pain and with tissue protection.

After 34 days of hospitalization with specific care to this patient, was performed graft in the perineal region, being the donor area the left inferior member of the anterior region of thigh.

The care dispensed to the donor area consists of daily application of PVPI until there is epithelialization of the donor area and consequent detachment of nonadherent bandage placed on this area, the receiving area of the graft was hydrated with TCM, which promotes chemotaxis (attraction of leucocytes) and angiogenesis (formation of new blood vessels), maintains the humidity and accelerates the process of granulation tissue.

In the care plan during all the hospital stay, were prepared the following nurse prescriptions: vital signs monitoring, documenting and recording changes; accompanying of food and hygiene self-care; Performance of bandages once a day by Nurse (being evaluated in other shifts the change needs); laboratory tests accompanying by the nursing team, guidance and monitoring of cleaning the colostomy, and the importance of stoma care, maintenance of care with invasive procedures for the infections prevention.

The nursing staff performed the discharge planning, a week after the graft, being conducted the orientation and training of the patient and family about colostomy related care, the need of it due to risk of infection, temporary maintenance and return to normal life after treatment.

At hospital discharge was performed against - reference to the basic health unit of reference for the user, in order to contribute to the continuity of home care in the context of comprehensive health care.

**CONCLUSIONS**

After analysis of this clinical case is concluded that early diagnosis of this syndrome can prevent progression of the disease, with its consequent tissue destruction, anatomical and functional impairment of the affected areas, in addition to preventing the risk of progression to sepsis and death of the user.

Health education given to the user during the hospitalization allowed a good recovery of the health situation of it, besides contributing to the reduction of anxiety about the situation experienced, encouraged their participation as active subjects to improve the quality of life.
Nursing care was essential for the good prognosis of the user. The nurse should plan and implement appropriate assistance to the client from the Nursing Assistance Systematization (NCS), contributing significantly to the clinical course and continuity of reflexive actions. It is understood that the actions planning through the SAE is essential for team critical reflective thinking about the care to be provided to the user in the health system.

During patient hospitalization, his case was discussed by the multidisciplinary team, what was essential for the good prognosis of him.

REFERENCES