Case Report

A Case of Nursing Experience of an Adult Abdominal HSP

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Abstract

The incidence of adult abdominal HSP is relatively low, and the early symptom is abdominal pain [1], therefore it is often misdiagnosed as acute abdomen. By summarizing the manifestations, stating the treatment and nursing, and reviewing the domestic and foreign literature in recent years of abdominal HSP, we found the rate of misdiagnosis of abdominal HSP is relatively high, especially in primary hospitals [2]. The recognition and identification of abdominal HSP in adults is still insufficient. In order to raise people’s awareness of the disease, reduce the misdiagnosis and missed diagnosis of the disease, and strengthen the nursing care, further study needs to be done.

Introduction

HSP is a common vasculitis allergic hemorrhagic disease. According to the location and clinical manifestations of the disease, it can be classified into simple type, abdominal type, joint type and renal type. Abdominal HSP is the most potentially dangerous type [3]. A combination of two or more types of the disease that occurs simultaneously is mixed type. In addition to skin petechiae or purpura, the most common symptom of abdominal HSP is abdominal pain. It mostly occurs in the periumbilical, lower or whole abdomen, showing paroxysmal colic with nausea, vomiting, diarrhea and other symptoms. Renal purpura is the most severe type [4], hematuria and albuminuria may occur in a week after the onset of purpura, and edema probably occurs in a few patients.

Case Analysis

A case analysis of abdominal HSP admitted in our department is as follows:

The patient developed pain in the epigastric and periumbilical region without obvious inducement three days before hospitalization. He developed continuous swelling pain, which is paroxysmal increasingly severe, with nausea, vomiting, diarrhea. One day later, the pain metastasized to the right lower quadrant. There was no obvious abnormality in blood routine. Ultrasonography of the epigastrium and appendix indicated a small amount of effusion in the right lower intestinal space. After treatment the pain is getting severe, and then hospitalized. Pelvic cavity CT scan showed effusion of small intestine in pelvic cavity, the part intestinal wall became edematous and thicker. No abnormality was found in urinary color ultrasound, the sonogram showed thickening of the appendix, so the patient was treated with acute appendicitis.

The patient underwent emergency appendectomy on the same day, intraoperative findings: there was 200 ml pale red clear effusion in perihepatic, right sulci paracolici and pelvic cavity, and no obvious displacement of greater omentum. The appendix lies in the inferior position of the cecum, which is about 7cm in length and 0.6cm in diameter. The appendix is full of hyperaemia and edema. Ileal hyperemia and edema were obvious in 20-50 cm from the ileocecal valve. Anti-inflammatoray therapy was given after operation.

The patient still had pain and weakness in the epigastric and periumbilical region after surgery, gurgling sound was regular. Six days after surgery, the patient developed petechiae, pruritus and no pain in the lower limbs, and gradually developed symptoms of swelling in the limbs, lower back, and face. It is concluded to be abdominal HSP. After the treatment of intravenous injection of 10mg/qd dexamethasone, VC and calcium gluconate, 10 mg/qd/po loratadine purpura was alleviated, but abdominal pain and anasarca were not.

12 days after surgery, the urine showed a dark brown color. 24-hour urinary protein quantity is 4800.5mg/d, the urine volume was 3830 ml in 24h. Urine protein was 1253.4 mg/L. Albumin was 32.1 g/L, urea was 4.55 mmol/L, creatinine was 57.2 mmol/L, and leukocyte was 7.11 ×109/L. The patient was transferred to nephrology department for further treatment 20 days after operation. The anti-allergic, anti-inflammatory and other treatment was continued to given.
The patient developed pain in the epigastric region without obvious inducement. CT image shows the appendix enlarged in diameter. Appendix was excised under laparoscopy, and then purpura symptoms appeared, hormonotherapy was given. The patient developed irreversible kidney damage. In the course of nursing after surgery, it was found that the abdominal pain was not alleviated, the incision pain and complications were excluded, purpura and edema appeared in the observation of the condition, and then the abdominal HSP was treated symptomatically. 24-hour urine volume was checked and the changes of urine volume and body weight were recorded.

Discussion and Conclusion

In order to reduce the occurrence of missed diagnosis and misdiagnosis and strengthen the observation and discrimination ability of nurses. Through the collection and integration of literature, this paper lists the common symptoms, treatment and nursing process of adult abdominal HSP.

Abdominal HSP is more common in children, and rare in adults [5]. IL-34 may be involved in the pathogenesis of HSP, this may be related to the abnormal expression of proinflammatory factors in HSP [6], which promotes the occurrence and development of vascular inflammation. Studies have shown that ligustrazine combined with urbason has good clinical effect in the treatment of adult abdominal HSP [7].

The initial symptoms of abdominal HSP in adults are usually acute abdomen without obvious inducement [8]. Anaphylaxis may or may not occur prior to the illness onset. Symptoms could not be alleviated after routine treatment of acute abdomen [9], typical symptoms of HSP such as rash appeared along with the course of disease.

In clinical treatment and nursing, nurses should handover and take physical examinations strictly, and observe the changes of abdominal physical signs, systemic symptoms, rashes, edema regression, urine color, character, quantity and other changes [10]. These could reduce the long-term impact of HSP on patients.

References