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NURSING CARE FOR A PATIENT DIAGNOSED WITH EATING DISORDERS IN THE FORM OF ANOREXIA

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ABSTRACT

Introduction: Nowadays, the problem of eating disorders is becoming more and more common in the society. It affects not only the youth but also adults. The canons of beauty presented by tabloids or advertisements become a benchmark of value for many people who, in pursuit of a perfect figure, are willing to make many sacrifices even at the expense of their own health and life. It is estimated that about 8 – 9% of the population is affected by eating disorders in the form of anorexia or bulimia. Mortality constitutes about 20% of diagnosed cases. A timely diagnosed disorder can be treated mainly with the help of appropriate therapeutic techniques, which allows symptoms to resolve in a significant number of patients.

Aim: The aim of the study is to present the tasks of a nurse in care for a patient with diagnosed eating disorders in the form of anorexia.

Methods and materials: The study was based on the individual case study method. The adopted research techniques were as follows: the interview, nursing observation, measurements and the analysis of the patient's medical record documentation. The following research tools were used for the study: the Individual Nursing Care Card, the NRS for pain assessment, the MNA for nutrition status and the Beck Depression Inventory.

Findings: During the research process, eight nursing diagnoses based on the patient's health issues were made.

Conclusions: Nursing problems in the care of a patient diagnosed with eating disorders in the form of anorexia arise from the disease and the accompanying complications.

Key words: eating disorders, anorexia, nurse, patient, nursing care

Introduction

Eating disorders are a group of mental disorders that give specific psychopathological symptoms closely related to eating, the consequence of which is the occurrence of physiological disorders and somatic complications [1]. Currently, this type of disorders is being diagnosed more and more frequently in the society. Peer pressure, ideal canons of beauty presented by the mass media influence many people's decision to change their current appearance for the one from the magazine cover. However, the decisions made very often destroy the system and threaten health and life.

Anorexia (*anorexia nervosa*) is a disorder characterized by intentional weight loss that is induced and perpetuated by the patient. Most often it affects adolescents and young women, however, it can also occur in boys, young men or even older menopausal women. This disorder is associated with psychopathological symptoms, manifested by excessive fear of weight gain, a change in silhouette shape, which in turn causes the patient to lose weight more intensely. The result of this is malnutrition causing systemic physiological, hormonal and metabolic changes [2,3].

The symptoms of anorexia are the following: sudden and restrictive diet resulting in weight loss with a body mass index of 17.5kg / m^2 or less, exhausting physical exertion, provoking vomiting, the use of laxatives as well as dehydrating and anorectic agents, disturbed perception of one's own body and absent menstruation in women. Most often,

anorexia may be accompanied by depressive disorders, anxiety disorders, obsessive-compulsive disorders, social phobias and the abuse of psychoactive substances [3].

It is stated that the development of anorexia nervosa can be affected by biological and genetic as well as non-biological factors such as family, socio-cultural and cognitive factors [4].

As a result of anorexia nervosa, endocrine, circulatory, digestive, genitourinary, skeletal or nervous system complications may occur. As a result of starvation, the hypothalamic -pituitary axis regulation is disturbed, which affects hormonal disorders. Circulatory complications constitute the most common cause of sudden death in patients. These complications occur in the form of bradycardia, orthostatic hypotension, vertigo, lowering of blood pressure and collapse. In addition, prolonged fasting may result in atrophy of the myocardium and damage to heart cells. Patients often suffer from hematological disorders in the form of anemia, thrombocytopenia and leukopenia. Gastrointestinal complications result from impaired motility caused by following restrictive diet as well as the abuse of laxatives, dehydrating agents and anorectic ones. They lead to chronic abdominal pain, bloating, constipation, nausea or vomiting. Women suffer from menstrual disorders and absent menstruation. Changes in the skeletal system may manifest themselves as bone mineralization disorders in the form of osteoporosis or osteopenia. In the nervous system, the volume of the brain decreases, which is associated with behavioral and psychosocial disorders such as reluctance, cognitive stiffness, emotional lability or problems with social communication [4].

The treatment of anorexia is a multi-stage, long-term process involving various consultants – an internist, psychiatrist, dietitian, psychotherapist and depending on possible complications a cardiologist and endocrinologist. The main purpose of treating anorexia is to restore normal body weight and treat complications of long-term malnutrition, treat mental problems associated with eating disorders and work with a consultant trying to change thinking and perception of one's own body as well as to improve relationships with other people [5,6]

Aim

The aim of the study is to present the tasks of a nurse in care for a patient with diagnosed eating disorders in the form of anorexia.

Methods and materials

The individual case study method was used in the study. The interview, nursing observation, measurements and the analysis of the patient's medical record were adopted as research techniques. The following research tools were used for the study: the Individual Nursing Care Card, the NRS for pain assessment, the Mini nutritional assessment - MNA for nutrition status and the Beck Depression Inventory. The study was conducted in the patient's home environment between the 24th-26th of July 2019. The subject of the study was a patient diagnosed with eating disorders in the form of anorexia - anorexia nervosa. The patient was presented with the principles, aim and course of the study. She was informed about the anonymity and voluntary participation. The patient agreed to undergo the study and have her medical record accessed.

Description of the patient

The study included 20 years old patient, living in the city with his mother and brother. The patient describes the housing and financial condition as good. Secondary education, currently not studying or working. No problems in the family.

The patient is diagnosed with anorexia nervosa, anorexia. She has been under the close supervision of a psychiatrist and psychotherapist for about 2 months. Between the 18th and the 24th of June 2019, the patient was admitted to hospital due to loss of consciousness and dehydration. The patient currently resides in the home environment. The patient's blood pressure is 90/52 mmHg, heart rate 62 beats / min, 18 breaths / min and the body temperature 35.4 degrees Celsius. The patient is 168 cm tall and weighs 41 kg. The BMI indicator is 14.53. The patient reports amenorrhea. Her skin is pale, dry, without bruising, odema or skin lesions. No residual phlegm, rhinitis or cough. The patient did not report any cardiovascular complaints. She reported a decrease in immunity and greater susceptibility to diseases. The patient's diet is easily digestible, appetite and thirst disturbed due to illness. The patient suffers from abnormal bowel movements manifesting itself in a form of constipation due to past abuse of laxatives. Currently, the patient is trying to eat meals as ordered, i.e. per os, she does not take any laxatives. Daily fluid intake amounts to about 1-1.5l. No disorders of the nervous and skeletal-muscular system have been recorded. The patient moves independently, without restrictions. No sensory disorders. The patient remains apathetic and her mood is

lowered. No sleep disturbance. She complains of distorted perception of her own body. She is willing to cooperate and is well-oriented towards the treatment process despite adversities. The patient reports pain of 3/4 in the NRS in the abdominal cavity, exacerbating after food intake. In the scale of the Mini Nutritional Assessment - MNA to assess the nutritional status, the patient obtained 16 points, which indicates malnutrition. In the Beck Depression Inventory, the patient received 17 points, which indicates mild depression.

Findings

Based on the collected empirical data, the following nursing diagnoses were made:

1. Malnutrition of the patient due to eating disorders.
2. The risk of dehydration due to insufficient fluid and food intake.
3. Constipation caused by impaired gastrointestinal motility resulting from abuse of laxatives.
4. The risk of depression due to disturbed perception of her body.
5. Abdominal pain after a meal intake.
6. The risk of infection due to reduced systemic immunity.
7. Menstrual disorders caused by endocrine disorders due to malnutrition.
8. Knowledge deficit of the disease and the effects of its disregard.

Diagnosis 1: Malnutrition of the patient due to eating disorders.

Aim: Applying appropriate diet and nutrition control.

Care plan:

- Discussing the dangers of malnutrition with the patient.
- Regular measurement of body weight and girth.
- Allowing contact with a dietitian and consultants.
- Checking the quality and quantity of meals consumed.
- Praising the patient.
- Allowing contact with relatives during meals.

Result: The patient was put on light diet, nutrition control ensured.

Diagnosis 2: The risk of dehydration due to insufficient fluid and food intake.

Aim: Minimizing the risk of the patient dehydration.

Care plan:

- Observation of the patient in concern with dehydration (*the skin, mucous membranes*).
- The use of fluid therapy following the doctor's order.
- Encouraging the patient to consume fluids per os.
- Fluid balance control.

Result: The patient was hydrated, no symptoms of dehydration.

Diagnosis 3: Constipation caused by impaired gastrointestinal motility resulting from abuse of laxatives.

Aim: Regulating bowel movements.

Care plan:

- Recommending more fluid intake to the patient.
- Fiber-rich, easily digestible foods intake.
- Encouraging moderate physical activity.
- Informing the patient on the negative effects of laxatives abuse.
- Allowing contact with a consultant.
- The use of pharmacotherapy following the doctor's order.

Result: The patient defecated.

Diagnosis 4: The risk of depression due to disturbed perception of your body.

Aim: Providing support to the patient.

Care plan:

- Ensuring contact with family and relatives.
- Contact with a psychologist, psychotherapist and psychiatrist.
- Organizing free time for the patient.
- Enabling the patient to develop her passions and interests.
- Conversation and providing support.
- Control and observation of the patient's behavior.
- The use of pharmacotherapy following the doctor's order.

Result: The patient received support from medical staff and the family.

Diagnosis 5: Abdominal pain after a meal intake.

Aim: Minimizing pain.

Care plan:

- Slow introduction of meals, use of small portions.
- Ensuring the patient comfortable body position while eating a meal.
- Control of the patient's pain intensity.
- The use of pharmacotherapy following the doctor’s order.
- Allowing rest after food intake.

Result: Pain complaints have decreased.

Diagnosis 6: The risk of infection due to reduced systemic immunity.

Aim: Minimizing the risk of infection occurrence.

Care plan:

- Informing the patient about the right choice of clothes for the weather to prevent the body from overexposure to cold or heat.
- Observation and care of cannulas and catheters, if any are in use.
- Change of patient's personal underwear and bed linen.
- Observation of the patient for developing infection.
- Control of temperature, breaths and secretions.
- Ensuring an adequate room microclimate.
- Administering medication following the doctor’s order if necessary.

Result: No infection occurred.

Diagnosis 7: Menstrual disorders caused by endocrine disorders due to malnutrition.

Aim: Normalizing the patient's hormonal balance.

Care plan:

- Proper nutrition for the patient.
- Performing body and girth measurements.
- Allowing contact with a gynecologist and the other consultants.
- Administering medication following the doctor’s order.

• Informing the patient about health recommendations.

Result: Normalizing the patient's hormonal balance requires long-term processes.

Diagnosis 8: Knowledge deficit of the disease and the effects of its disregard.

Aim: Raising the patient's level of knowledge.

Care plan:

• Presenting the nature of the disease and its complications to the patient.

• Answering the patient's questions.

• Allowing contact with consultants.

• Providing psychological support.

• Explaining treatment methods and cooperation with the therapeutic team.

Result: The patient gained knowledge of the disease entity and the effects of its disregard.

Conclusions

1. In caring for a patient with eating disorders in the form of anorexia, the problems encountered by the nurse are malnutrition, the risk of dehydration, abdominal pain, constipation, decreased immunity, hormonal disorders including menstrual disorders, disturbance in perception of one's own body and low mood that might result in developing more severe depression.
2. The main problem of the patient diagnosed with eating disorders in the form of anorexia is malnutrition, the risk of dehydration due to exhaustion of the body and the pathological picture of her own body.
3. The patient has insufficient knowledge of coping with anorexia as well as compliance with dietary and physical activity recommendations.
4. During the illness, the patient is affected by many emotions. She tends to be apathetic and in low mood. She has a disturbed body image, accompanied by fear of weight gain. There is also anxiety about her health and life, uncertainty about the future.

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