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ORIGINAL

Nursing care in post-surgical patient of adnexal cystectomy in the Obstetrics and Gynecology Service of a national hospital of Chincha, 2023

Cuidados de enfermería en paciente posquirúrgica de quistectomia anexial en el Servicio de Gineco Obstetricia de un hospital nacional de Chincha, 2023

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ABSTRACT

The ovarian cyst is a sac with a collection of fluid that forms in the ovary or the wall of adjacent organs. The objective was to manage the nursing care process (PAE) for a post-surgical patient of adnexal cystectomy with right salpingo-oopherectomy with release of adhesions. The study has a qualitative approach, a single case type, the methodology was the PAE, which included a 22-year-old patient, in which the five stages were applied: in the assessment stage, the guide with the 11 functional patterns was applied by Maryori Gordon, 6 altered patterns were found, three being prioritized: cognitive perceptual, exercise activity and metabolic nutritional; In the diagnosis stage, it was developed based on taxonomy II of NANDA-I, 10 nursing diagnoses were identified, prioritizing three: Acute pain, Risk of surgical wound infection and Obesity, according to the SSPFR format (signs and symptoms, problem, related factor/risk factor/associated); In the planning stage, the care plan was developed based on the NOC, NIC Taxonomy; In the execution stage, specific care was provided according to the plan; and in the evaluation the differe nce between the final and baseline scores respectively was assessed, resulting in a score of +2, +1 and +1. In conclusion, the nursing care process for the patient was managed, which allowed quality and holistic care to be provided.

Keywords: Nursing Care; Patient and Adnexal Cyst.

RESUMEN

El quiste ovárico es un saco con colección de líquido que se forman en el ovario o la pared de órganos adyacentes. El objetivo fue gestionar el proceso de atención de enfermería (PAE) a una paciente posquirúrgica de quistectomia anexial con salpingo-oferectomia derecha con liberación de adherencias. El estudio tiene enfoque cualitativo, tipo caso único, la metodología fue el PAE, que incluyo a un paciente de 22 años de edad, en el que se aplicó las cinco etapas: en la etapa de valoración se aplicó la guía con los 11 patrones funcionales de Maryori Gordon, se hallaron 6 patrones alterados, priorizándose tres: perceptivo cognitivo, actividad ejercicio y nutricional metabólico; en la etapa de diagnóstico se elaboró en base a la taxonomía II de NANDA-I, se identificaron 10 diagnósticos de enfermería, priorizándose tres: Dolor agudo, Riesgo de infección de herida quirúrgica y Obesidad, de acuerdo al formato SSPFR (signos y síntomas, problema, factor relacionado/factor de riesgo/asociado); en la etapa de planificación se elaboró el plan de cuidados en base a la Taxonomía NOC, NIC; en la etapa de ejecución se procedió a brindar los cuidados específicos de acuerdo al plan; y en la evaluación se valoró la diferencia entre las puntuaciones final y basal respectivamente, obteniendo como resultado una puntuación de +2, +1 y +1. En conclusión, se gestionó el proceso de atención de enfermería en la paciente, lo que permitió brindar un cuidado de calidad y holístico.

Palabras clave: Cuidados de Enfermería; Paciente y Quiste Anexial.

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INTRODUCTION

The incidence of adnexal cysts worldwide is 6,21 % in women younger than 20 years; the prevalence is estimated at 4,9 per 100 000 women.(Gonzalez-Menocal et al., 2019). Polycystic ovary syndrome (PCOS) is a common endocrine-metabolic abnormality, with a worldwide prevalence equivalent to 4 % to 21 %, according to diagnostic criteria.(Ordinola et al., 2022). It is estimated that 10 % of women will have an adnexal pathology in their lifetime; the highest percentage of lesions that are operated on are benign (Rodriguez et al., 2017).

Internationally, in the USA, the estimate of women undergoing surgery for adnexal masses is more than 200 000 women per year (De Matías et al., 2020). In Bolivia, they found cases in clinical stage III of the disease, where the main symptom was abdominal pain and increased abdominal perimeter; the histopathological type of adnexal masses were epithelial tumors with 43,75 % and germinal tumors in 17,85 % of cases (González, 2022).

According to Cano (2022), MINSA considers that there are associated risk factors such as obesity in more than 50 %, type II diabetes, glucose intolerance, metabolic syndrome, and dyslipidemia, with many alterations such as ovulatory dysfunction due to altered folliculogenesis and hyperandrogenism. In Lima, it is the most common disease in women of childbearing age (15 to 49 years), and 70 % of those who suffer from it have not been diagnosed. It is also said that this pathology affects 8 % to 13 % of the female population. At the Hospital

Virgen de Fátima, Chachapoyas, studied 300 medical records from 2018, finding a prevalence rate of PCOS of 52,6 per 100 patient records attended. Ultrasonography was a conclusive diagnostic tool for medical diagnosis (Ordinola et al., 2022).

Adnexal cysts are fluid collections in the pelvic area around the uterus, encompassing the ovaries, fallopian tubes, and other adjacent tissues. Simple ovarian cysts often form during the normal menstrual cycle and are not listed as a problem (Defaz, 2017).

The etiology is unknown, but studies show an association with increased concentrations of chorionic gonadotropin or abnormal ovarian response to this hormone. It is frequently asymptomatic and discovered accidentally, usually in acute abdominal pain or abdomen due to ovarian torsion or hemorrhage. On some occasions, it can be confused with malignant ovarian neoplasms (Reyna-Villasmil et al., 2020).

As for the pathophysiology, month, during the menstrual cycle, a follicle develops in the ovary; if this follicle does not rupture and release an egg, the liquid remains inside it, and a cyst is formed; this is called a follicular cyst and when a follicle makes the egg independent, it begins to produce estrogen and progesterone for fertilization. The follicle is now called the corpus luteum. Sometimes, fluid is stored within the follicle, which causes the corpus luteum to enlarge and form a cyst called a corpus luteum cyst (Martinez et al., 2022a).

The clinical picture manifests with intense pain in the hypogastrium (radiating to the flanks or lumbar region), nausea, vomiting, and thermal rise, which occurs rarely. On physical examination, a palpable mass can be perceived. Among the useful ultrasound findings described is the appearance of a cystic mass (solid or complex, with or without pelvic fluid) with wall thickening and hemorrhage. (Ramirez and Rengifo, 2019).

The fundamental point of treatment in ovarian tumors is to diagnose and differentiate between functional cysts (follicular), benign tumors, or malignant tumors. There are two possible approaches: control or surgery. Surgical treatment may include Cystectomy, Oophorectomy, or adnexectomy (Gomez et al., 2022).

The Nursing Care Process, as a scientific method, guides the nurse's work to provide scientific, humanistic, and systematic care. The main activity of the nurse is constant evaluation of the patient's pathophysiological changes and improvement, assessing their welfare from the care provided. The application of PAE quality and timely and safe care is essential to achieving prompt recovery of their health. (Martínez et al., 2022b).

Obstetrics and gynecology nursing care is important because it provides comprehensive care to people, supported by scientific evidence (Miranda-Limachi et al., 2019). This requires comprehensive and technical preparation in knowledge, procedures, and skills, including health education, from a biological, psychological, and social perspective (Borges et al., 2018). In this sense, they are an integral part of the multidisciplinary team, strategic and essential to protect the right to health of the female population.

METHOD

The present study took a qualitative, single-case approach, applying the nursing care process as a tool with a series of closely interrelated stages. To organize nursing work, it is necessary to gather information, formulate the diagnosis, plan the interventions, administer them to achieve the results, and then formulate the evaluation (Herdman et al., 2021).

The subject of the study was a 22-year-old patient diagnosed with a right adnexal cyst after immediate surgery of cystectomy with right salpingo-oophorectomy, release of adhesions, and placement of a drain pen rose and obesity, selected at the convenience of the researchers. For the assessment, we used observation technique, physical examination of the patient, interview, and documented review based on the clinical history; as a basic instrument, we used an assessment guide based on the 11 functional patterns of Maryori Gordon; after the critical analysis of the significant data, nursing diagnoses were formulated taking into account the NANDA-I taxonomy II; for the planning stage, we used the NOC and NIC taxonomy. After the nursing care execution stage, the process culminated with the evaluation, which was given with achievement scores obtained from the difference between the final and the baseline scores.

Nursing Care Process Assessment

General Data

Name: GALC Sex: Female Age: 22 years old

Days of nursing care: 24 hours Date of assessment: 7/10/22

Reason for admission: The patient is referred from the post-anesthesia recovery unit to the gynecology department on a stretcher accompanied by nursing staff, with a medical diagnosis of salpingo-pherectomy right+ release of adhesions+ dren pen rose. On assessment, the patient was lucid, oriented in time, space, and person, and ventilating spontaneously with a peripheral line perfusing fluids. The operative wound in the right flank quadrant of the abdomen, protected with a dry dressing and drain pen, rose with drainage in a colostomy bag, with little content of schematic secretion. Blood pressure control 100/60 mm Hg, pulse 78/minute, respiratory rate 17/minute and temperature 36.5 °C.

Assessment according to Functional Health Patterns

Functional Pattern I: Perception - Health Control. History of diseases, in February 2022 a giant benign cyst was detected in the right ovary, with hormonal treatment for 3 consecutive months and then the patient abandoned the treatment.

Surgical history: Cesarean three years ago, operated on right adnexal cyst by emergency 12 hours ago. She is not allergic to medications or food. Good hygiene status. No risk factors, with four doses of Sarcovid-19 vaccine.

He is currently receiving treatment with clindamycin 600 mg EV c/8 hours, ceftriaxone 2 g EV c/24 hours, metamizole 2 g EV c/8 hour.

Functional Pattern II: Metabolic Nutrition. Weight 105 kg, height 1,60, obesity III by BMI of 41 $^{kg/m2}$. Skin, warm, hydrated with mild pallor and normal temperature of 36,6 ° C, normal hair.

Soft and depressible abdomen, painful in the operative area, operative wound with Pfannenstiel incision, with presence pen rose drain and drainage to a colostomy bag, mild anemia with hemoglobin 10,7 mg/dl, normal basal glucose analysis of 110 mg/dl, has lost 3 kg of weight compared to the date of admission, tolerates soft diet and oral fluids according to medical indications. Diet with consumption of sugary drinks and fried foods.

Functional pattern III: Elimination. Patient did not have a bowel movement since the previous day, eliminates flatus normally, uses diaper for vaginal bleeding in small amount, colostomy bag hematic fluid content 20 ml. and dry dressing.

Functional Pattern IV: Activity - Exercise. Respiratory Activity: Normal respiratory rate with 20 breaths x min, no cough or secretions, spontaneously ventilating with normal oxygen saturation of 98 %. Circulatory activity: Presents normal levels of peripheral pulse with 80 x min, systolic blood pressure 110 and diastolic blood pressure 70mhg, normal capillary filling (<2 seconds), presence of invasive line, with peripheral catheter number 18 Gauges and 38 millimeters in left upper limb, there is operative wound in the right flank of the abdomen with the presence of drain pen rose and colostomy bag for collection of secretion, containing 20 ml of serohematic fluid. Exercise Self-care capacity: Dependent, manifests pain in operative wound 6/10 according to VAS scale that limits his mobilization to get out of bed.

Pattern V: Rest - Sleep. Patient reports that she had falling asleep due to the noises, she slept alertly for approximately 5-6 hours.

Functional Pattern VI: Perceptive - Cognitive. Level of consciousness, she is awake and oriented in time, space and person, conscious according to Glasgow scale (15 points). Pupils isochoric, manifests pain in the operative area, she is evaluated using the standardized pain instrument Eva scale with a score of 6/10.

Pattern VII: Self-perception - Self-concept Tolerance to stress. Patient receives support from her relatives. She is anxious due to pain in the surgical area, she says that she is very chubby, and this would make her recovery difficult, she also refers that she is a victim of bullying friends and neighbors.

She is concerned about her husband's income, which is not enough to cover the family's expenses because he will stop working until he recovers.

Pattern VIII: Relationships - Role. She has a good relationship with her relatives, who are attentive to her health situation; she lives with her husband and a 3-year-old son.

They have no addiction problems and deny having marital problems.

Pattern IX: Sexuality - Reproduction. Presence of sero-hematic secretions in genitals, with the use of disposable diapers due to the presence of vaginal bleeding in small amounts, she refers that her first menarche was 10 years of age.

Pattern X: Adaptation - Stress Tolerance. Patient is worried about her only who is not used to being without her.

Pattern XI: Values and Beliefs. Religion, she is baptized in the Christian religion. In her religious restriction she does not wear tight-fitting clothes, keeps her hair long, does not dance and does not drink liquor. Practicing Christian religion.

Prioritized Nursing Diagnosis

First Diagnosis

Diagnostic label: (00132) Acute pain.

Defining Characteristics. Facial expression and verbalization of pain, rating of 6/10 on Eva.

Related Factor. Physical injury agent, associated with operative wound.

Diagnostic Statement. Acute pain related to physical injury agent associated with operative wound evidenced by facial expression, verbalization of pain and rating of 6/10 on Eva.

Second diagnosis

Diagnostic Label (00266) Risk of surgical wound infection.

Risk Factors. Obesity.

Associated condition. Invasive procedure in abdominal area, presence of drain pen rose with colostomy bag.

Diagnostic Statement. Risk of surgical wound infection as evidenced by obesity, associated with invasive procedure and drain pen rose to colostomy bag.

Third diagnosis

Diagnostic Label (00232) Obesity.

Defining Characteristics. Morbid obesity with BMI> 41 kg/m2.

Related Factor. Consumption of sugar-sweetened beverages and frequent intake of fried foods and abnormal eating behavior patterns.

Diagnostic Statement. Obesity related to consumption of sugary drinks and intake of fried foods and abnormal eating behavior patterns evidenced by morbid obesity with BMI > 41 kg/m2.

Planning

Care Plan

First Diagnosis (00132) Acute pain.

Nursing Outcomes. NOC: (2102) Pain level.

Indicators

- Referred pain
- Facial expression of pain
- Concern
- Muscle tension

Nursing Interventions. NIC (1410) Acute pain management.

Activities

- Perform an exhaustive pain assessment, including pain localization
- Identify the intensity of the pain
- Ask the patient about the level of pain assessed on the Eva scale.
- Administration of analgesic according to medical prescription.
- Administer non-pharmacological interventions according to the patient's preferences.

Second Diagnosis (00266) Risk of surgical wound infection.

Nursing Outcomes. NOC (1842) Knowledge of infection control.

Indicators

- Signs and symptoms of infection.
- Infection control procedures.
- Importance of hand hygiene.

Nursing Interventions. IAS (6550) Infection protection.

Activities

- Observe for signs and symptoms of systemic and localized infection.
- Observe the patient's vulnerability to infection.
- Administer the indicated antibiotics: clindamycin and ceftriazone, complying with the five correct ones.
- Body temperature monitoring every six hours.
- Maintain asepsis in all procedures.

Third Diagnosis (00232) Obesity.

Diagnostic Label. NOC (1004) Nutritional status.

Indicators

- Nutrient intake.
- Food intake.
- Weight/height ratio.

Nursing interventions. NIC (5246) Nutritional counseling.

Activities

- To assist in the identification of the eating behaviors to be changed.

- Establish executable short-, medium- and long-term goals for change in nutritional status.
- Facilitating care by a nutrition professional for information about the need for dietary modification for health reasons (weight loss)
- Participate with the patient in measuring fluid intake and elimination, blood pressure readings, weight gain and loss every day.
- Provide information about the need for dietary modification based on weight loss, fluid intake and recommended diet.

Execution

Table 1. Implementation of the acute pain management intervention for acute pain diagnosis

Intervention: Acute pain		
Date	**Time**	**Activities**
07/11/2022	8:00am 08:05am	An exhaustive pain assessment is performed, including pain location
	08.05am	Pain intensity is identified The patient is asked about the level of pain, assessed on the Eva.
	08.10am	Analgesic is administered according to the medical prescription.
	10:00am	Non-pharmacological interventions are administered according to the patient's preferences.

Note: prepared from the Nursing Intervention Classification (NIC) (Butcher et al., 2018a).

Table 2. Protection against infections for diagnosis Risk of infection in the surgical wound

Intervention: protection against infection		
Date	**Time**	**Activities**
07/11/ 2022	7:30 am 7.40 am 8.20 am 12.00 am.	Signs and symptoms of systemic and localized infection are observed. The patient's vulnerability to infections is observed. The indicated antibiotics are administered: clindamycin and ceftriaxone, complying with the five correct ones. Body temperature control is monitored every six hours. Asepsis is maintained in all procedures.

Note: prepared from the Nursing Intervention Classification (NIC) (Butcher et al., 2018b).

Table 3. Implementation of the intervention Nutritional status for the diagnosis of obesity

Intervention: helps to reduce weight		
Date	**Time**	**Activities**
07/11/2022	8:00 am 8:20 am	It helped in the identification of the eating behaviors to be changed. Short-, medium- and long-term executable goals were established for the change of nutritional status.
	2.00 pm 5.00 pm 3.00pm	Facilitated attention by a nutrition professional for information about the need for dietary modification for health reasons (weight). Fluid intake and elimination measurements, blood pressure readings, weight gain and loss were taken with the patient every day. Information was provided on the need for to modify the diet according to weight loss, fluid intake and recommended diet.

Note: developed from the Nursing Intervention Classification (NIC) (Butcher et al., 2018c).

Evaluation

Result: Pain level

Table 4. Baseline and final score of outcome indicators pain level

Indicators	**Baseline score**	**Final score**
Referred pain	2	5
Facial expression of pain	2	4
Concern	2	4
Muscle tensión	2	4

Note: prepared from the Classification of Outcomes. (NOC) (Moorhead et al., 2018a).

In table 4 fashion of the selected pain level outcome indicators for the diagnosis Acute pain, before the nursing interventions

the baseline score was 2 (substantial), after the, the fashion was 4 (mild), corroborated with the patient's verbal expression and improvement with the Eva scale assessment. The change score was +2.

Outcome: Knowledge: infection control

Table 5. Baseline and final score of the knowledge outcome indicators: infection control

Indicators	Baseline score	Final score
Signs and symptoms of infection	2	4
Infection Control Procedures Importance of	3	4
Hand Hygiene	3	4

Note: developed from the No Outcome Classification (NOC) (Moorhead et al., 2018b).

Table 5 shows that the mode of outcome indicators of knowledge of infection control: infectious problem, selected for the diagnosis Risk of infection of the operative wound before the nursing interventions was 3 (moderate knowledge) and after the interventions was 4 (substantial knowledge) with all the care provided, there was evidence of afebrile stage, decrease of secretions through the drain pen rose and better general condition. The change score was +1.

Result: Nutritional Status

Table 6. Baseline and final score of outcome indicators Nutritional status

Indicators	Baseline score	Final score
Nutrient intake	2	3
Food intake	3	2
Weight/height ratio	2	3

Note: *d*eveloped from the Classification of Outcomes (NOC) (Moorhead et al., 2018).

Table 6 shows that the mode of the adherence behavior outcome indicators: healthy diet, selected for the diagnosis Obesity, before nursing intervention was 2 (Substantial deviation from normal range), after care management was 3 (Moderate deviation from normal range), corroborated with the acceptance of the hypoglycemic, hypocaloric and hyposodium diet with fiber. The change score was +1.

RESULTS

As for the assessment phase, objective and subjective data were collected, the patient was the primary source of information, the clinical history was used, the data was corroborated with the cephalo-caudal physical examination, and then the information was organized with an assessment guide based on the functional health patterns of Maryori Gordon, which was adapted for the obstetrics and gynecology service, in this phase there were no difficulties in conducting the interview.

In the diagnostic phase, the analysis of the significant data according to NANDA-I was carried out, obtaining six altered nursing diagnoses, of which three were prioritized:

(00132) Acute pain, (00266) Risk of infection in the operative wound, and (00132) Obesity; at this stage, developing nursing diagnoses was not difficult.

In the planning phase, considering the NOC and NIC taxonomies, the analysis was carried out to determine nursing outcomes that were best related to the nursing diagnoses, and interventions that were consistent and/or coherent with the outcomes were selected. The difficulty in this phase was in the determination of the scoring of outcome indicators both at baseline and at final evaluation.

During the implementation phase, the care plan prepared for the patient's case was put into practice without major difficulties. New data continued to be evaluated, and at the same time, the care plan was updated and implemented in a comprehensive manner with quality and warmth.

The evaluation phase allowed us to provide feedback on each phase during the care provided to the patient until the patient was discharged without health risks or complications.

DISCUSSION

Acute Pain

Pain is a first line health problem and the physiological response of pain is a product of tissue damage, it is very important to take a complete and detailed clinical history (VAS scale) (León, et al., 2022).

Likewise, Diaz and Flores (2021a) report that pain is a symptom of major consultation in the emergency department. The physiological response of pain is the product of tissue damage generating a chemical response producing an electrical impulse, to

finally pain.

Next, we mention what Ardila et al. (2022a) indicate: pain persists in the presence of damage or disease and disappears when the cause or root cause is eliminated. Generally, acute pain is intense, and NSAIDs are first-line drugs for pain management.

The patient presented as a related factor: a physical injury agent associated with an operative wound. Pain persists in the presence of damage or disease and disappears when the cause is eliminated with the administration of drugs (Ardila et al., 2022b).

The patient under study showed defining characteristics: facial expression of pain, facial expression and verbalization of pain, a rating of 6/10 on the Eva scale; Diaz and Flores (2021b) mention that pain is a physiological response as a result of tissue damage, it generates a chemical response producing an electrical impulse, to finally perceive the pain, of which, the nursing plan would be to calm the patient's pain by assessing the level according to the standardized Eva scale instrument.

In relation to the verbalization of pain, Ferran (2021) mentions that there are accurate methods for assessing pain, and various instruments help to assess and measure the pain manifested by the patient.

Measuring pain is an activity of the nursing professional; it requires observation and humanized communication with the patient; in this case, the patient expressed the discomfort of pain. The visual analog scale (VAS) helps to assess the perception of pain considering that it is susceptible and valid to measure pain in people with different levels of reaction to the intensity of pain, it is reproducible among other professionals, and it is easy to use (Delgado, 2020). In this case, the VAS scale was applied, and the patient verbalized a score of 6 on a scale of zero to 10, obtaining a valuation of 6/10 as a result.

About the pain management intervention, the following activities were carried out:

The exhaustive pain assessment, which includes localization, was performed. This task allows the application of many assessment scales and questionnaires to validate the pain through an interview, observation, and exploration. However, all are valid; it will depend on the researcher which one to use according to the case, his experience, and the study objective (Vicente-Herrero et al., 2018).

Pain intensity was also identified. The health professional must use scales that measure pain intensity and indicate whether the treatment was effective or not. The VAS scale is the most appropriate pain intensity assessment. In this case, the patient was reevaluated using the same VAS scale, with a thorough exploration of the history and a rethinking of the nursing care plan to address this symptom (García et al., 2022).

In addition, the patient was asked about the level of pain assessed according to the Eva scale because pain is a subjective phenomenon (symptom) that will affect other dimensions of the organism (sensory, physiological, affective, cognitive, and sociocultural). Therefore, it is necessary to evaluate each dimension and ask the patient how much she measures the level of pain on the EVA scale, considering from no pain (zero points) to extreme pain (10 points), and to determine the patient's perception of pain (Sanz, 2021). The patient reported a score of 6/10 on the VAS scale, considering it as severe pain.

Analgesic treatment was administered with metamizol 2 g EV every 8 hours and tramadol 100 mg conditional to pain greater than seven on the VAS scale. Analgesics are drugs that inhibit cyclooxygenase, block the production of prostaglandins that are responsible for the inflammatory response and pain at peripheral and central levels, helping to alleviate or suppress pain, the

WHO suggests the gradual use of analgesic medication about the patient's response, i.e., the use of a peripheral analgesic (NSAID) or an opioid will depend on the intensity of the pain (Maria-Josep Divins, 2023).

Non-pharmacological interventions, such as postural changes, deep breathing, antalgic position, etc., were also performed according to the patient's preferences, which helped to reduce pain. Ruiz et al. (2021) demonstrated that the non-pharmacological actions contributed to reducing pain as assessed with the VAS scale, decreased analgesic consumption, better attitude to life and the disease, decreased anxiety, improved sleep time, better pain control, and above all, acceptance of pain.

Risk of Infection in the Operative Wound

Surgical site infections are a frequent complication worldwide.

It increases morbimortality in patients with risk factors such as age, gender, chronic pathologies (diabetes mellitus, obesity, immunological diseases, etc.), or wound contamination (Gutiérrez et al., 2023).

Surgical wound infection is manifested by the presence of microorganisms such as staphylococcus aureus, escherichia coli, or enterococci. It is necessary to treat with broad-spectrum antibiotics. Infection depends on endogenous and exogenous factors, and therefore, antibiotic prophylaxis appropriate to the patient's clinical signs is necessary (Cajamarca et al., 2023).

Rodriguez et. al (2020) studied the risk factors and prevention of infections in the surgical site and concluded that it is important to protocols and practices of asepsis and antisepsis measures and the use of antibiotics to prevent infections. Obesity is a factor three times the risk of causing infection in the operative wound. The patient has obesity III due to a BMI of 41 kg/m2 and is therefore at risk of presenting an infection in the operative wound.

In the nursing intervention of protection against infections, health professionals must comply with good practices of preventive measures to reduce nosocomial infections; they should have knowledge and professional experience associated with this preventive practice (Yagui et al., 2021). The preventive actions implemented by the health professional were to maintain good biosafety practices and to provide personnel with experience in the care of gynecological patients.

The nursing activity is to observe the signs and symptoms of systemic and localized infection. In an infectious operative wound process, it is necessary to intervene early to expect it to develop into a complication and consequent disruption to routine incisional healing post-surgery, including surgical site infection, tissue dehiscence, hyper granulation, peri-injury skin maceration or adhesive skin damage (International Surgical Wound Complications Advisory Panel [ISWCAP], 2020). During the patient's surgical wound assessment, signs and symptoms of no localized or systemic infection were evident, evidenced by typical vital signs and characteristics

of the incision site with no changes in its structure.

Observing the patient's vulnerability to infections is an activity that allows the assessment of endogenous and exogenous factors to determine the state of vulnerability to infections. Exogenous factors are external causes that expose the patient to an infectious focus, and endogenous factors or internal causes derive from the pathophysiology, immunity status, and the presence of metabolic or carcinogenic diseases to acquire an infection. Anamnesis and biosafety measures are important if the patient is not infected.

The patient's endogenous conditions are present (MINSA, 2021). Due to obesity III, the patient is considered vulnerable to infections, and biosecurity has been applied.

Antibiotics were administered: clindamycin 600mg every 8 hours and ceftriaxone 2g every 24 hours, meeting the five correct ones. Clindamycin is a macrolide that acts at the level of bacterial protein synthesis for treating severe infections caused by Staphylococcus aureus, group A streptococcus (S. pyogenes), skin and soft tissue infections (complicated and uncomplicated). Ceftriaxone is a third-generation cephalosporin used in complicated skin and soft tissue infections and prophylaxis of postoperative infections. The action of both antibiotics is broad-spectrum; they eliminate the action of bacteria, reducing their growth and multiplication (Vera, 2021).

Body temperature monitoring every six hours. It is a preventive and alert activity for detecting sub-febrile states that indicate the increase of organic defense against the invasion of microorganisms. It is a safety measure care in the postoperative period that alerts states of infection in the surgical site, considering that a patient with infection in the operative wound has five times more mortality risk than a non-infected patient (Martinez et al., 2022).

Likewise, asepsis was maintained in all procedures to avoid transmitting germs from one place to another; it is a preventive and promotional measure in health care. Hand washing is a habit that saves lives, especially in patient care, to prevent transmission, spread of infections, and nosocomial infections WHO, 2022).

Obesity

Obesity is considered a chronic non-communicable disease, is associated with other comorbidities, and becomes a negative and relevant factor in the performance of surgical procedures due to postoperative complications (Añez et al., 2021).

Obesity is an abnormal state of the organism caused by excessive accumulation of body fat that is detrimental to health. It is very easily associated with other chronic diseases. Worldwide, more than 3 % of the population is morbidly obese. WHO considers obesity as a body mass index (kg/m) greater than 30 (Nazar et al., 2018).

The patient under study showed the following characteristics: morbid obesity with a BMI> 41 kg/m2. The WHO (2021), in its publication Obesity and Overweight, states that obesity is linked to the intake of high-calorie and high-fat foods and a sedentary lifestyle. The consequences are non-communicable diseases such as diabetes, cardiovascular diseases, and locomotor system disorders. Obesity in the postoperative period has a high risk of presenting coagulopathies, infections, and renal insufficiency, generating serious complications and more extended hospital stays.

In turn, the consumption of sugary drinks, frequent fried foods, and abnormal eating behavior patterns were considered as related factors. For Zila-Velasque et al. (2022), negative patterns in eating behavior are related to psychiatric alterations in eating and weight control with physical, social, and psychological affection; the person experiences dissatisfaction with the perception of food, body image, fear of weight gain and obsessive thinking about eating. This abnormal eating behavior problem is a public health problem.

Obesity is a risk factor for diseases such as type 2 diabetes, cardiovascular pathologies, cancer, and psychological conditions. The increase in adiposity in obesity becomes a risk factor for surgical wound infection; the nurse's role is important because he/she must identify complications early (Kaufer-Horwitz et al., 2022). The patient presented a BMI > 41 kg/m2; the probability is high of presenting infection at the incision site; however, personal hygiene measures and healing of the surgical wound twice a day are continued.

The nursing intervention to help reduce weight is necessary to include the patient in a dietary program based on vegetables and physical exercise, which will help control obesity, reduce body fat, reduce anthropometric perimeters, reduce blood pressure values, and above all, reduce the high risks of acquiring chronic diseases (Cari, 2022). The actual conditions of the patient are related to a sedentary lifestyle and uncontrolled food consumption without a dietary regimen and control of chronic diseases.

The activity to determine the patient's desire and motivation to reduce weight or body fat is related to the commitment to solve the problem of obesity, to propose eating habits that promote education on diet quality and exercise to reduce obesity, improve the quality of life and reduce the onset of metabolic diseases at an early (Morocho & Llallahui, 2022). In the case of the patient with obesity III, it will be necessary for her to provide nutritional instruction with a feeding program according to her occupational conditions to reduce her body weight and adipose tissue.

Matching diets to lifestyle and activity levels, including fiber, requires a healthy lifestyle program that includes a design.

They recommend the consumption of fruits and vegetables of all colors in five portions, which provide fiber, vitamins, and minerals; avoid consumption of packaged or processed products; and reduce the consumption of reused fats. They recommend the consumption of fruits and vegetables of all colors in five servings, which provide fiber, vitamins, and minerals; avoid consuming packaged or processed products; and reduce the consumption of reused fats. (Lopez, 2021). The patient's eating problem requires developing a dietary plan according to the accessibility of products and the process of unlearning the consumption of foods harmful to her health.

To encourage the substitution of undesirable habits for favorable habits by giving priority to proteins, vitamins, and iron, it is necessary to plan healthy food schemes with professional specialists that contain macro and micronutrients to cover physiological needs, so they must be varied, balanced in proportions, and healthy. Bad eating habits such as fasting, standing up, frequent meals, skipping meals, or eating in abundant volume increase body weight. These habits can be improved if we practice the approach

of reflecting on eating, replacing unhealthy foods with healthier ones, and reinforcing our new eating habits (Centers for Disease Control and Prevention [CDC], 2021). In this case study, the patient has not yet become aware of initiating a dietary plan to replace unhealthy habits with healthy ones.

Placing written indications and encouragement to achieve behaviors that favor health instead of eating is an activity that will allow one to achieve a healthy life; it is a priority to change eating behavior and to know how to face stress and anxiety situations, especially to maintain a good mood because it is the ingredient of life and wellbeing. The behaviors to modify requires a list of activities that should be posted in a visible place; it should include meal times and portions, frequency of water consumption, physical exercise, mental exercise, walking, social gatherings, sleeping or resting hours, maintaining a positive attitude and feelings (Basque Government, 2022). To help the patient improve her eating behavior, she will have strict supervision and control the activities to be considered in the calendar, trying to keep her in good spirits to comply with it strictly.

CONCLUSIONS

The human care based on the PAE allows us to provide nursing care from assessment, diagnosis, planning, execution, and evaluation of the planned actions, which allows us to provide comprehensive, continuous, and permanent care during 24 hours, as to rethink the care required by the patient at different times. During the care, an interactive relationship was maintained between the patient and the nursing professional, which allowed us to offer constant monitoring with the possible detection of complications. As a whole, the interdisciplinary work allowed the patient's prompt recovery.

The use of the NANDA, NIC, and NOC relationship allows for analyzing the choice of the nursing diagnosis, then determining the results and the interventions with their respective activities related to the case study, with the purpose of using a unified language based on scientific knowledge.

Finally, the nursing care administered to the patient in her postoperative stage had favorable results for our patient that contributed to an early recovery without complications.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORSHIP CONTRIBUTION

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ANNEXES

Appendix A: Care plans

Diagnosis nurse	**Planning**				**Execution**			**Evaluation**	
Domain:12 Comfort Class 1: Physical comfort Diagnosis: Acute pain (00132) related to damaging agent physical injury associated with operative wound as evidenced by expression of facial, verbalization of pain and rating of 6/10 on Eva's scale	Results and Indicators	Baseline score (1-5)	Target score	Interventions activities				Final score	Score of change
	Result NOC: Pain level (2102)	2	Maintain at Increase to: 4	NIC: Acute pain management (1410)	M	T	N	4	+2
	Scale: Serious (1) None (5)			Activities	→	→			
	Indicators:								
	Referred pain	2		Perform a comprehensive pain assessment, which include the location	→	→		5	Refers to a decrease in the pain
	Facial expression of pain	2		Identify the intensity of the pain	→	→		4	No facial expression of pain
	Concern	2		Ask the patient about the level of pain assessed on Eva scale	→	→		4	Mild, tolerable pain
	Muscle tension	2		Administration of analgesic according to medical prescription.	→	→		4	Partially effective analgesic for pain
				Administering interventions according to the patient's preferences.	→	→			Antalgic position

Nursing diagnosis	**Planning**				**Execution**			**Evaluation**	
Domain:11 Security and Protection Class: 1 (00004) Risk of infection in the surgical wound as it is evidence by the obesity, associated with invasive procedure and drain pen rose to colostomy bag.	Results and Indicators	Score basal (1-5)	Score diana	Interventions activities				Score end	Score of change
	NOC result Knowledge of infection control (1842)	3	Keep in Increase to: 4	Intervention: NIC Protection against infections (6550)	M	T	N	4	+1

	Scale: No knowledge (1) knowledge extensive (5)			Activities:					
	Indicators:								
	Signs and symptoms of infection	2		Observe them signs and symptoms of infection systemic and located	→	→		4	Wound tissue operation without sign of alteration.
	Procedure infection control	3		Observe the vulnerability of the patient to the infections	→	→		4	The staff practices the measures of biosecurity Receives the antibiotic prophylactic indicated
	Importance of the hygiene of hands	3		Manage the antibiotics indicated: clindamycin and ceftriazone, complying with the five correct	→	→		4	
				Body temperature monitoring every 6 hours	→	→			Stable body temperature
				Maintain asepsis at all times procedure	→	→			Decrease in the transmission of microorganisms.

Nursing diagnosis	**Planning**				**Execution**			**Evaluation**	
Domain:2 Nutrition Class: 1 (00232) Obesity related to consumption of sugar-sweetened beverages and fried food intake and abnormal patterns of conduct morbid obesity with BMI > 41%. kg/m2	Results and Indicators	Baseline score (1-5)	Target score	Interventions activities				Final score	Change score
	NOC result State nutritional (1004)	2	Keep in Increase to: 4	Intervention: NIC Nutritional counseling 5246) Activities	M	T	N	3	+1
	Scale: 1 Severe deviation from normal range (1) to No deviation from the range normal (5)			Assist in identification of desired eating behaviors change.	→	→	→		Identifies healthy foods
	Indicators:			Establish enforceable goals short, medium and long term for the change of the nutritional status.	→	→	→		Establish status nutritional in the medium term

	Nutrient intake	2		Facilitate attention by a nutrition professional for information about the need for dietary modification by health reasons (loss of weight)	→	→	→	3	Consume a low-sodium, low-fat diet and vegetables.
	Ingestion of food	3		Participate with the patient in the measurement fluid intake and elimination, blood pressure readings, fluid intake elimination, blood weight every day.	→	→	→	2	Consumes three meals per day
	Weight/height ratio	2		Provide information about the need for dietary modification based on weight loss, fluid intake and diet. recommended	→	→	→	3	Obesity III

Appendix B: Nursing Assessment

GUÍA DE VALORACIÓN DE ENFERMERÍA

SERVICIO DE GINECOLOGÍA

DATOS GENERALES

Seguro: SIS_____SOAT_____ PARTICULAR_____ Historia Clínica: _____
Nombre del usuario: _____ Fecha nacimiento: ___/____/_____ Edad: _____
Fecha de ingreso al servicio: _____ Hora: _____ Centro de referencia: _____ Telf._____
Procedencia: Consulta Externa_____Emergencia_____ URPA _____ Otro _____
Forma de llegada: Ambulatorio _____ Silla de ruedas _____ Camilla _____
Fuente de Información: Paciente _____ Familiar/amigo _____ Otro_____ N° Celular_____
Alergias a medicamento y/o alimento_____
Motivo de ingresso: _____ Dx. Médico: _____
Familiar responsable_____telefono_____
Funciones vitales: P/a_____ P:_____ R:_____ t°_____ SAT O°: _____
Fecha de valoración _____ y Hora_____: _____

VALORACIÓN SEGÚN PATRONES FUNCIONALES DE SALUD

PATRÓN I: PERCEPCIÓN y CONTROL DE LA SALUD

Describe su estado de salud

Buena _____ Regular _____ Mala _____
Da importancia a su salud: Si ___ No___
Acepta su estado de salud: Si ___ No___
Sigue el plan terapéutico: Si ___ No___
Motivo: _____
Antecedentes familiares

Antecedentes de enfermedad y quirúrgicas:

HTA___ DM___ Gastritis/úlcera___ TBC___ Asma ___
VIH_____ ITS_____
Covid-19 _____
Otros _____ Sin problemas importantes___
Cesárea _____Fecha_____
Qx _____Fecha_____
Qx _____Fecha_____

Alergias y otras reacciones

Fármacos: _____
Alimentos: _____
Signos-síntomas: _____
Otros _____

Factores de riesgo

Consumo de tabaco No_____ Si _____
Consumo de alcohol No_____ Si _____
Consumo de drogas No_____ Si_____

Medicamentos (con o sin indicación médica)

¿Qué toma actualmente?	Dosis/Frec.	Última dosis

Estado de higiene

Buena _____ Regular_____ Mala _____

Estado de Vacunación

Tipo de vacuna Dosis/Frec.
Antitetánica _____
Anti influenza _____
Covid-19 _____

Estado de higiene bucal: Mala___ Regular ___ Buena___

Apetito:

Normal _____ Anorexia _____ Bulimia _____
Dificultad para deglutir: Si ___ No ___
Nauseas ___ Pirosis ___ Vómitos ___ Cantidad: ____
SNG: No ___ Si ___ Alimentación ___ Drenaje ___
Número de comidas al día_____, Dieta: _____
Menú típico: (especificar tipo y cantidad)
Desayuno: _____ Hora _____
Almuerzo: _____ Hora _____
Cena: _____ Hora: _____
Alimentos que le desagradan: _____

Abdomen: Blando ___ Distendido___ Doloroso ___
Ruidos hidroaéreos: Aumentados___ Normales ___
Disminuidos ___ Ausentes ___
Dolor abdominal: no____ sí_____ distensión___ otras (especifique)_____

Drenajes: No ___ Si ___ Especificar: _____

Comentarios adicionales:

laboratorio

¿Qué sabe usted sobre su enfermedad actual?

¿Qué necesita usted saber sobre su enfermedad?

PATRÓN II: NUTRICIONAL – METABÓLICO

T°: _____Peso: _____ Talla: _____
Cambio de peso durante los últimos meses o días:
Si_____ No_____
Especificar: _____
IMC = _____

Diagnóstico nutricional (IMC)		
	ESCALA	**EVALUADO**
Delgadez severa	< 16	
Delgadez Moderada	16.00 – 16.99	
Delgadez Aceptable	17.00 – 18.49	
Normal	**18.50 – 24.99**	
Pre-obeso (riesgo)	>25.00-29.99	
Obeso Tipo I (riesgo moderado)	30 – 34.99	
Obeso Tipo II (riesgo severo)	35.00 – 35.99	
Obeso Tipo III (riesgo muy severo)	➢ 40.00	

Piel:
Coloración: Normal _____ Pálida _____ Cianótica _____
Ictérica _____
Hidratación: Turgente _____ Sq de deshidratación:
_____ _____
Integridad: Intacta _____ Lesiones _____
Herida quirúrgica: Apósitos: _____ seco___ limpio_____
Secreción serosa_____ sec. Serohemática_____
Purulenta_____ Dehiscencia de herida_____
Problemas de cicatrización: _____
Especificar: _____

Cavidad bucal:
Dentadura: Completa _____ Incompleta _____
ausente ____ Prótesis _____ Sup. _____ Inf. _____
Mucosa oral: Intacta _____ Lesiones _____
_____
Hidratación: Si_____ No _____

Ruidos respiratorios: _____
Tos ineficaz: ___ Eficaz ___
Reflejo de la tos: presente ___ disminuido___ ausente___
Secreciones: No ___ Si ☐___
Características: _____
Oxigenoterapia: No___ Si_____
Dispositivo: _____ a _____ l/min/FiO2: _____
Traqueotomía: _____ desde: _____

Actividad Circulatoria

Pulso: _____ Regular___ Irregular ___
Pulso periférico: normal___ disminuido___ ausente___
P/A_____/_____mmHg
Edema: No___ Si___ Localización: _____
_____
+(0-0.65cm) ++(0.65-1.25cm) +++(1.25-2.50cm) Anasarca
Equimosis No Si localización_____
Riego periférico:
MI I ___ Tibia___ Fría ___ Caliente ___
MID ___ Tibia___ Fría ___ Caliente ___
MSI ___ Tibia___ Fría ___ Caliente ___
MSD ___ Tibia___ Fría ___ Caliente ___
Presencia de líneas invasivas:

Estado de higiene bucal: Mala___ Regular ___ Buena___

Apetito:

Normal _____ Anorexia _____ Bulimia _____
Dificultad para deglutir: Si ___ No ___
Nauseas ___ Pirosis ___ Vómitos ___ Cantidad: ____
SNG: No ___ Si ___ Alimentación ___ Drenaje ___
Número de comidas al día_____, Dieta: _____
Menú típico: (especificar tipo y cantidad)
Desayuno: _____ Hora _____
Almuerzo: _____ Hora _____
Cena: _____ Hora: _____
Alimentos que le desagradan: _____

Abdomen: Blando ___ Distendido___ Doloroso ___
Ruidos hidroaéreos: Aumentados___ Normales ___
Disminuidos ___ Ausentes ___
Dolor abdominal: no____ sí_____ distensión___ otras (especifique)_____

Drenajes: No ___ Si ___ Especificar: _____
_____
Comentarios adicionales:
_____
_____
laboratorio

PATRÓN III: ELIMINACIÓN

Hábitos intestinales

Nº de deposiciones/día: _____ Normal _____
Características: _____
Estreñimiento _____ Diarrea___ Incontinencia ___

Hábitos vesicales

Frecuencia: _____ / día
Oliguria: _____ Anuria_____
Características: _____
Otros: _____

Sondaje: _____ motivo_____
Fecha de colocación: _____
Pañal_____

Menstruación: SI NO
Comentarios adicionales: _____

Valoración de la continencia urinaria:

INCONTINENCIA URINARIA DE ESFUERZO - MUJERES		
a. ¿Tiene sensación de peso en la zona genital?	Si	No
b. ¿Al subir y bajar escaleras se le escapa la orina?	Si	No
c. ¿Cuándo ríe se le escapa la orina?	Si	No
d. ¿Si estornuda se le escapa la orina?	Si	No
e. ¿Al toser se le escapa la orina?	Si	No

VALORACIÓN: Al menos 4 preguntas afirmativas tienen valor predictivo del 77% para incontinencia urinaria de esfuerzo

INCONTINENCIA URINARIA DE URGENCIA - MUJERES		
a. Si está en la calle y tiene ganas de orinar ¿Entra a un baño público, si está ocupado, se le escapa la orina?	Si	No
b. Cuando abre la puerta de casa ¿ha de correr al servicio, y alguna vez se le escapa la orina?	Si	No
c. Si tiene ganas de orinar ¿Tiene sensación que es urgente y ha de ir corriendo?	Si	No
d. Cuando sale del ascensor, sube o baja escaleras ¿tiene que ir a prisa al servicio porque se le escapa la orina?	Si	No

VALORACIÓN: Al menos 3 preguntas afirmativas tienen valor predictivo del 58% para incontinencia urinaria de urgencia.

PATRÓN IV: ACTIVIDAD – EJERCICIO

Actividad Respiratoria

FR_____ Sat O2: _____
Respiración: superficial___ profunda___
Disnea: en reposo___ al ejercicio ___
Se cansa con facilidad: No___ Si ___
Ruidos respiratorios: _____
Tos ineficaz: ___ Eficaz ___
Reflejo de la tos: presente ___ disminuido___ ausente___
Secreciones: No ___ Si ☐___
Características: _____
Oxigenoterapia: No___ Si_____
Dispositivo: _____ a _____ l/min/FiO2: _____
Traqueotomía: _____ desde: _____

Actividad Circulatoria

Pulso: _____ Regular___ Irregular ___
Pulso periférico: normal___ disminuido___ ausente___
P/A_____/_____mmHg
Edema: No___ Si___ Localización: _____
_____
+(0-0.65cm) ++(0.65-1.25cm) +++(1.25-2.50cm) Anasarca
Equimosis No Si localización_____
Riego periférico:
MI I ___ Tibia___ Fría ___ Caliente ___
MID ___ Tibia___ Fría ___ Caliente ___
MSI ___ Tibia___ Fría ___ Caliente ___
MSD ___ Tibia___ Fría ___ Caliente ___
Presencia de líneas invasivas:
Cateter periférico: _____fecha_____
Cateter venoso central: _____fecha_____

Ejercicio: Capacidad de Autocuidado

1= Independiente
2= Parcialmente dependiente
3= Totalmente dependiente

	1	2	3
Movilización en cama			
Deambula			
Ir al baño/bañarse			
Tomar alimentos			
Vestirse			

Aparatos de ayuda: ninguno___ muletas___ andador
Bastón___ S. ruedas____ Otros _____
Movilidad de miembros_____:
Conservada___ Flacidez ___ Contracturas___
Parálisis ___ Fuerza muscular: Conservada_____
Disminuida ____
Comentarios adicionales: _____
_____

PATRÓN V: SUEÑO - DESCANSO

Horas de sueño: _____ Se levanta:
descansado_____ Somnoliento_____ durante el día
Problemas para dormir: Si _____ No _____
Especificar: _____
¿Usa algún medicamento para dormir? No___ Si____
Especificar: _____

PATRÓN VI: COGNITIVO - PERCEPTIVO

Despierto__ Somnoliento__ Soporoso___ inconsciente ___
Orientado: Tiempo___ Espacio___ Persona___
Desorientada__ confusa____ agitada__ convulsiona__
estado de estupor__ coma__ letárgico__
Comunicativa_____ poco comunicativa_____
Presencia de anomalías en:
Audición: _____
Visión: _____
Habla/lenguaje: _____
Otro: _____
Cefalea _____ Dinámica Uterina _____
Dolor: No _____ Si_____ Localización:_____

Ecala Visual Analógica (EVA)

Descripción:

_____

_____

_____

Escala de coma de Glasgow:	**Puntaje total:** _____	
Apertura Ocular	**Respuesta Verbal**	**Respuesta motora**
4 espontáneamente	5 orientado mantiene una conversación	6 Obedece órdenes
3 A la voz	4 Confuso	5 Localiza el dolor
2 Al dolor	3 Palabras inapropiadas	4 Sólo se retira
1 No responde	2 Sonidos incomprensibles	3 flexión anormal
	1 No responde	2 Extensión anormal
		1 No responde

Pupilas: Isocóricas OD____ OI____
Anisocorias OD____ OI____
Reactivas OD____ OI____
No reactivas OD____ OI____
Tamaño de pupilas: OD____ mm OI____ mm.
Comentarios adicionales: _____

PATRÓN VII: AUTOPERCEPCIÓN-AUTOCONCEPTO

Estado emocional:
Tranquilo _____ ansioso _____ Negativo _____
Temeroso _____ Irritable _____ Indiferente _____
Signos de ansiedad: temor _____ Nerviosismo_____
Cefalea _____Tensión muscular_____ Mareos _____
Movimientos inquietos _____ Insomnio _____
Somnolencia_____ Cansancio_____
¿Qué opina sobre su enfermedad?
_____
_____

PATRÓN VIII: ROL/RELACIONES (ASPECTO SOCIAL)

Ocupación: _____
Estado civil: Soltero _____ Casado/a _____
Conviviente _____ Divorciado/a Otro _____
¿Con quién vive?
Esposo___ Solo ____Con su familia ___ Otros _____
Fuentes de apoyo: Familia ____Amigos ____ Otros _____
Comentarios adicionales: _____
_____
Ambiente laboral

PATRÓN IX: SEXUALIDAD y REPRODUCCIÓN

Datos ginecológicos:
N° Gestaciones_____ N° hijos_____
N° abortos _____Motivo_____
Semanas de embarazo _____ FPP _____
FUR_____
Menarquia: (edad)_____ días/ciclo_____ _____
ciclo menstrual: regular____ irregular _____
Dismenorrea____ Menorragia_____ Metrorragia_____
Sangrado vaginal no menstrual (fecha y cantidad):
_____
_____
Inicio de vida sexual:_____ N°s parejas sexuales: _____
Uso de algún método de planificación familiar: no_____
sí_____ especificar _____
tipo y tiempo de uso_____

Fecha y Resultados de:
PAP _____
Colposcopía_____
Histerosonografía_____

Mamas:
Mama Derecha: presente _____ Ausente _____
mama Izquierda: presente _____ Ausente _____
Blanda____ turgente_____ congestiva____ dolorosa____
sensibles ___No sensible___ blanda___ duras___
secretantes ___ no secretantes _____ masa dura_____
absceso ___ Lugar _____ curación___ vendaje___
color de secreción_____
piel: congestiva_____ flogótica_____ equimosis_____
Pezones:
Formados __ planos__ invertidos__ agrietados ___
Antecedentes de lactancia materna: Exitosa____ Fallida___
Motivos _____No procede___
Prácticas de autoexamen mamario mensual: sí____ no____
Motivo: _____
Mamografías o ultrasonido mamario: sí_____ no____
Motivo: _____fecha ultima_____
Resultados _____ No aplica_____

Útero:
Grávido_____ semanas_____ No
grávido_____ contraído_____
Altura Uterina _____Tono_____ Intensidad_____
Movimientos Fetales Presentes: Si ___ No ___
Genitales:
Normal_____ edema_____ hematoma____
lesiones _____ otros _____
Presencia de flujos: no___ si___ características: blanco___
amarillo___ verde___ maloliente___
Volumen sangrado vaginal (N° de toallas): M:
_____T: _____N: _____
Tapón vaginal: Si ___ No ___ N° de gasas:_____
Líquido amniótico: _____ cant: _____ color: _____ olor:
_____
Sangrado vaginal: _____ cant:
_____ color:_____ olor:_____
Otras molestias: _____
Comentarios adicionales: _____
_____
Observaciones:
_____
_____
_____
_____
_____

PATRÓN X: AFRONTAMIENTO y TOLERANCIA AL ESTRÉS

Preocupaciones fundamentales en relación con:
Hospitalización y/o enfermedad___
Económicas__ De autocuidado__ De empleo_____
Apetito disminuido _____
Usa tranquilizantes prescritos: _____
Imagen corporal_____ Especificar:
_____
_____
¿Te sientes satisfecha consigo misma?

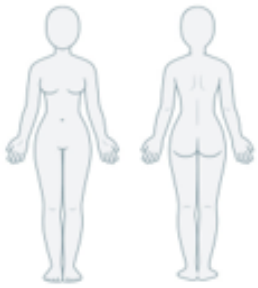
PATRÓN XI: VALORES Y CREENCIAS

Religión: _____
Existen restricciones por parte de su religión para seguir indicaciones médicas y/o de enfermería:
sí ____ no____ ¿cuáles?
_____
Solicita visita de capellán: _____
Comentarios adicionales: _____
_____
_____
_____

Exámenes Auxiliares

Prueba Covid-19 _____ ( )
Grupo sanguíneo y Factor RH _____
Hemoglobina_____ Fecha _____
Hemoglobina_____ Fecha _____
Hemoglobina_____ Fecha _____
Hemoglobina_____ Fecha _____
_____
_____
Hematocrito_____ Fecha _____
Plaquetas_____ Fecha _____
Glucosa _____ Fecha _____
_____
_____
_____
_____
_____
_____

Resultado de ecografía:
De: _____Fecha_____
Resultado_____
De: _____Fecha_____
Resultado_____



Ubicar: lesiones, cicatrices, hematomas, catéteres, sondas, etc
_____
_____
_____
_____
_____

Tratamiento Médico Actual:

Cloruro de sodio 9‰ 1000cc con agregados de:
_____
_____
_____
Dextrosa 5% AD 1000cc, con agregados de:
_____
_____
_____vía _____c/_____
_____vía _____c/_____
_____vía _____c/_____
_____vía _____c/_____
_____vía _____c/_____
_____
_____

_____

Interconsultas:
A _____Fecha_____
A _____Fecha_____
A _____Fecha_____

Nombre del enfermero:
_____
CEP: _____

Sello y firma

Appendix C: Informed Consent

Universidad Peruana Union Graduate School
UPG of Health Sciences.

Informed Consent Purpose and procedures

I have been informed that the present study has the objective of determining the role of nurse in the care of the post-surgical patient of adnexal cystectomy in the Gynecological Obstetrics Service of a national hospital in Chincha. This academic work is

carried out by Vilma Leonor Chumpitaz Saravia and Blanca Gloria Franco Villaverde, under the advice of our course teacher. The information provided through the assessment guide, interview and physical examination will be confidential and will be used only for the purposes of the study.

Risks of the study

I have been told that there is no physical, chemical, biological, and psychological risk associated with this academic work. But since some personal information will be obtained, there is the possibility that my identity may be discovered from the information given. However, precautions such as identification by numbers will be taken to minimize such a possibility.

Benefits of the study

There is no monetary compensation for participation in this study.

I have been informed that my participation in the study is completely voluntary and that I have the right to withdraw my consent at any point before the report is finalized, without penalty. The same applies for my initial refusal to participate in this project.

Having carefully read the consent form and having listened to oral explanations of the investigator, I voluntarily sign the present document.

First and Last name: G. A. C_____

DNI: _____ Date: 07-10-2022_____

Signature_____

Appendix D: Evaluation scale

Scale of normal temperature levels

Clasificación de temperatura	
Hipotermia	<35.0 °C (95.0 °F)
Normal	36.5–37.5 °C (97.7–99.5 °F
Hipertermia	>37.5 o 38.3 °C (99.5 o 100.9 °F)
Hiperpirexia	>40.0 o 41.0 °C (104.0 o 105.8 °F)

Scale of body mass index values

Clasificación	IMC (kg/m²)	
	Valores principales	Valores adicionales
Bajo peso	**<18,50**	**<18,50**
Delgadez severa	<16,00	<16,00
Delgadez moderada	16,00 - 16,99	16,00 - 16,99
Delgadez leve	17,00 - 18,49	17,00 - 18,49
Normal	18,5 - 24,99	18,5 - 22,99
		23,00 - 24,99
Sobrepeso	**≥25,00**	**≥25,00**
Preobeso	25,00 - 29,99	25,00 - 27,49
		27,50 - 29,99
Obesidad	**≥30,00**	**≥30,00**
Obesidad leve	30,00 - 34,99	30,00 - 32,49
		32,50 - 34,99
Obesidad media	35,00 - 39,99	35,00 - 37,49
		37,50 - 39,99
Obesidad mórbida	≥40,00	≥40,00

Scale of hemoglobin values

Población	Normal (g/dl)	Anemia por niveles de hemoglobina (g/dL)		
		Leve	Moderada	Severa
Niños de 6 a 59 meses de edad	11,0-14,0	10,0-10,9	7,0-9,9	<7,0
Niños de 6 a 11 años de edad	11,5-11,4	11,0-11,4	8,0-10,9	<8,0
Adolescente 12 a 14 años de edad	12 a más	11,0-11,9	8,0-10,9	<8,0
Mujer no embarazada de 15 años a más	12 a más	11,0-11,9	8,0-10,9	<8,0
Varones 15 años a más	13 a más	10,0-12,9	8,0-10,9	<8,0

Blood glucose value scale

EDAD	EN AYUNAS, AL DESPERTAR O DESPUÉS DEL AYUNO NOCTURNO	HASTA DOS HORAS LUEGO DE CONSUMIR ALIMENTOS	ANTES DE ACOSTARSE O DESPUÉS DE 4 HORAS DE COMER
Bebés: 0-5 años de edad	100-180 mg/dl	Máximo 200 mg/dl	100-200 mg/dl
Infantes: 6-12 años de edad	90-180 mg/dl	Máximo 200 mg/dl	100-180 mg/dl
Adolescentes: 13-19 años de edad	90-130 mg/dl	Máximo 180 mg/dl	90-150 mg/dl
Adultos jóvenes: 19-35 años de edad	90-130 mg/dl	Máximo 140 mg/dl	90-150 mg/dl
Adultos: 35-60 años de edad	90-100 mg/dl	Máximo 150 mg/dl	100-140 mg/dl
Adultos mayores: más de 60 años de edad	80-110 mg/dl	Máximo 160 mg/dl	100-140 mg/dl

frutasparadiabeticos.com

Levels from respiratory rate

Niveles de Saturación de oxigeno

- 95 – 99% Normal
- 91 – 94 % Hipoxia leve
- 86 – 90 % Hipoxia moderada
- < 86 % Hipoxia severa

Blood pressure levels

CATEGORÍA	SISTÓLICA (mmHg)	DIASTÓLICA (mmHg)
HIPOTENSIÓN	MENOS DE 90	MENOS DE 60
NORMAL	90 - 129	60 - 84
PREHIPERTENSIÓN	130 - 139	85 - 89
HIPERTENSIÓN GRADO 1 (ligera)	140 - 159	90 - 99
HIPERTENSIÓN GRADO 2 (moderada)	160 - 179	100 - 109
HIPERTENSIÓN GRADO 3 (grave)	MÁS DE 179	MÁS DE 109
HIPERTENSIÓN SISTÓLICA AISLADA	MÁS DE 139	MENOS DE 90

Heart rate levels per minute

Etapa	Latidos / min.
Feto	120 – 160
Recién nacido (hasta 28 días)	130 – 140
Infantes (menos de 1 año)	110 – 130
Niños	90 – 110
Adolescentes	80
Adultos	70
Ancianos	65

ESCALA DE COMA DE GLASGOW

Abertura Ocular	Resposta Verbal	Resposta Motora
Espontânea 4	Orientado 5	Obedece 6
Ao chamado 3	Confuso 4	Localiza 5
À dor 2	Palavras 3	Flete 4
Ausente 1	Sons 2	Flexão Anormal 3
	Ausente 1	Extensão 2
		Ausente 1

Soma dos critérios avalia o nível consciência = 3 a 15

INTERPRETACIÓN

- 15 PUNTOS: CONSCIENTE
- 13-14 PUNTOS: ESTUPOR LIGERO
- 11-12 PUNTOS: ESTUPOR MODERADO
- 9-10 PUNTOS: ESTUPOR PROFUNDO
- 7-8 PUNTOS: COMA SUPERFICIAL
- 5-6 PUNTOS: COMA MODERADO
- 3-4 PUNTOS: COMA PROFUNDO

Pain Rating Scale