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CONTRIBUTIONS OF AMBULATORY NURSING IN THE POST-OPERATIVE DISEASES OF ANORRECTA

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Abstract: Introduction: Nursing work is carried out through processes of organized, sequenced, evaluated and objective activities. Nursing work process is a scientific method designed to identify nursing problems, determine the basic needs affected and prescribe or recommend care to the person, family or community through the systematization of patient care. ambulatory in anorectal abscesses, anal fistula; hemorrhoids and pilonidal cysts. Objective: To discuss nursing care in the outpatient postoperative period of anorectal disorders. Method: To reach the proposed objective, we opted for a literature review where we searched in reference books on surgical nursing that contained this theme and in books that dealt with the nursing process, focusing on outpatient care. A qualitative analysis of the collected data was carried out; in order to explain the work process of outpatient nursing aimed at these clients. Result: It was observed that the focus of attention in care is on the management of constipation; in the reduction of anxiety in the surgical result; in pain management it may still exist; pay attention to the risk of urinary retention; for the fear of an ineffective treatment and finally the biggest field of action of outpatient nursing: the healing of these postoperative wounds that are mainly by second intention, they take a long time to close and that, due to their location, are usually dirty wounds with a risk of infection; thus, they need the performance of outpatient nursing in a more intensive way. Conclusion: With this study it was possible to trace the path to exercise the specific nursing work process for this interest group. And we realized that health education is essential for the success of postoperative treatment.
Keywords: Anorectal Disorders; outpatient clinic; Nursing; Postoperative Assistance.

INTRODUCTION

Perioperative nursing is the term used to describe nursing care during the surgical phases: preoperative, intraoperative and postoperative; in the case of outpatient care, the nursing team will welcome this patient in the preoperative and postoperative phases. However, our research focuses on the late postoperative phase, that is, after hospital discharge. With the guiding question of this research: how outpatient nursing works in the postoperative care of patients with anorectal disorders; then we sought to discuss nursing care in the outpatient postoperative period of anorectal disorders.

Nursing work is carried out through processes of organized, sequenced, evaluated and objective activities. Nursing work process is a scientific method designed to identify nursing problems, determine the basic needs affected and prescribe or recommend care to the person, family or community through the systematization of care (CUMING, 2021). your work process to investigate the health problems that need your action.

Brunner; Suddarths (2013) say that patients with anal pain and bleeding constantly seek medical care; however, other complaints such as protrusion of anal varicose veins, anal itching and difficulty or emergency in evacuating also lead the patient to seek help.

Clients with anorectal diseases are generally not hospitalized, spending a maximum of 24 hours in the hospital after surgery; the nurse must instruct the client to keep the anal region as clean as possible, free of hair, washing it with warm water and neutral soap; not using toilet paper and drying with compresses, in addition to care with food, hydration, defecation, urination and pain relief (PELLICO, 2021).

Efficient care is one that guarantees the improvement of health conditions without wasting personal and material resources. Patient-focused care allows for respectful

and responsive care to individual needs (TANNURE; PINHEIRO; 2019).

Brunner; Suddarths (2013) remind us that every contact between the nurse and the health service user, whether the person is sick or not, is an opportunity for health education and the professional has the responsibility to inform and motivate the other to learn.

In the nursing consultation, the professional will provide health education. It is in this meeting that the bond can be established in the perspective of joint solutions. The ability to listen to the user must be considered a fundamental element for the establishment of bonds of trust and bond (VASCONCELOS, GRILLO; SOARES, 2009).

Here we will detail outpatient nursing care in approaching patients with the following anorectal conditions: anorectal abscesses, anal phistula; hemorrhoids and pilonidal cysts.

METHODOLOGY

To reach the proposed objective, we opted for a literature review where we searched in reference books on surgical nursing that contained this theme and in books that dealt with the nursing process, focusing on outpatient care. A qualitative analysis of the collected data was carried out; in order to explain the work process of outpatient nursing aimed at these clients.

DATA ANALYSIS AND DISCUSSION

PERIOPERATIVE NURSING

Perioperative nursing comprises a wide variety of nurse roles associated with the patient's surgical experience. (BRUNNER; SUDDARTHS, 2013).

Cuming (2021) defines as perioperative nursing the nursing care provided to patients before, during and after surgical or invasive procedures using the structure of the nursing process; from collecting data, organizing information, prioritizing problems, establishing nursing diagnoses, identifying goals, planning and implementing care and evaluating results on an ongoing basis. In addition, the perioperative nurse collaborates with other health professionals, makes appropriate nursing referrals, in addition to delegating and supervising the care provided to the patient.

Netinna (2021) describes the three phases of perioperative nursing:

- **preoperative phase**– moment when the decision to perform the surgical intervention is made; what is necessary for the procedure to be carried out.
- **intraoperative phase**– the moment the patient enters the operating room until he is admitted to the anesthetic recovery room.
- **postoperative phase**– from the post anesthetic recovery room to outpatient follow-up after hospital discharge.

In post-operative nursing care, activities are focused on patient recovery and teaching care for a successful recovery and rehabilitation after hospital discharge (BRUNNER; SUDDARTHS, 2013).

The view of nursing as a process allows acting from a system that is developed through critical thinking for decision making. This process outlines the focus in which perioperative nurses must employ their clinical skills and knowledge, to provide care with autonomy and safety (CUMING, 2021).

The nursing process establishes phases for carrying out care in an organized manner, but to avoid being reduced to a methodological means of grouping information unrelated to the subject's subjectivity, it is necessary to be based on a theory of the area. And with the use of critical thinking focused on the skills of the professional, it is possible to analyze, develop actions and obtain appropriate results (TANNURE; PINHEIRO; 2019).

The nursing process promotes coherence between theoretical knowledge and critical clinical reasoning. Within the nursing process, it must contain some skills (CUMING,2021):

- Provision of nursing care;
- Provision of cultural and social care according to the patient's age;
- Maintenance of a safe environment;
- Patient and family guidance;
- Ensuring continuity of care through care planning

Thus, the nursing process can be defined as a scientific method designed to identify nursing problems, determine the basic needs affected and prescribe care through the Systematization of Nursing Care (SAE) (NISHIO; FRANCO, 2011).

SAE is a theoretical system for problem solving and decision making; allowing an organized, individualized care, with each patient as unique and requiring constant attention during their treatment process (COFEN, 2009).

The care plan must be developed with the client and his family, the establishment of goals is an important element to engage the patient and his family in home care and outpatient follow-up; for this, the performance and degree of independence of the patient and the commitment of the family or caregiver in maintaining the treatment must be observed (KAWAMOTO, 2021).

SURGICAL WOUNDS

Timby (2001) says that surgical wounds are those resulting from a tissue incision with a laser or a sharp instrument known as a scalpel.

Care for surgical wounds involves the use of some technologies such as dressings, drains, sutures, staples, bandages, among others (TIMBY; 2001).

Anorectal conditions are classified as dirty or infected wounds, which include old, traumatic wounds with retained devitalized tissue and those involving an existing clinical infection; therefore, in most cases there is no suture of tissues and healing occurs by 2nd intention (BAK, 2021).

As for their etiology, the wounds can be surgical, which are caused by incision or excision; traumatic, which are caused by mechanical, thermal, or chemical tissue destruction and chronic, which is caused by a pathophysiological condition such as systemic hypertension or diabetes. For this article, the type of healing of surgical wounds was discussed.

Bak (2021) exemplifies the types of wound healing:

- **First Intent:** healing by first intention is only possible when the wound was created aseptically, with minimal tissue destruction. These wounds are closed by sutures, staples, tape, or surgical adhesive. When this wound is created in a sterile situation, healing is rapid.

Timby (2001) recalls that healing by first intention is also called primary intention and occurs when the ends of the wound are very close to each other.

- **Second intention**: when the surgical wound is made with considerable tissue loss and without the possibility of approximation of edges. This type of wound is usually not closed in the operating room and healing occurs from the inside of the wound to the external surface. In infected wounds, it allows adequate cleaning and the dressing adapts to the wound healing phase.

Healing by second intention is seen in chronic wounds, dirty wounds, and traumatic wounds. Anorectal disorders fall into this category.

In this type of healing, the edges are quite separated and the tissue to granulate needs to come from the inside to the outside and

from the ends towards the center; resulting in a larger and deeper scar. It is a slow process that can be prolonged by drainage, infection or residues in the wound, so it needs a lot of care (TIMBY, 2001).

- **Third Intention:**When there is a delay in primary closure, it is delayed. The reasons for delaying wound closure are as diverse as removal of an inflamed organ or significant wound contamination.

ANURETAL DISORDERS

ANORECTAL ABSCESSES

It consists of an infection in the pararectal space, it can happen in or around the rectum. When it is superficial, it causes swelling, redness and sensitivity. When deep, it causes pain in the lower abdomen and fever. Palliative care to manage pain and the inflammation process is sitz bath and analgesics. Surgical treatment is to cut and drain the abscess when it is out. Being deep there is the possibility of fistula. The fistula path and the cut and drained abscess must be removed (BRUNNER; SUDDARTHS, 2013).

ANAL PHISTULA

Opening on the side of the anus with a thin, tubular and fibrous path. It can develop from an infection or trauma; pus or feces may leak from this opening. Surgical treatment is recommended because natural healing is rare ((BRUNNER; SUDDARTHS, 2013).

It is a tiny tubular fibrous communication that extends from an orifice located on the side of the anus to the anal canal. They are usually formed by an infection, or by trauma, fissures or regional enteritis. Pus and feces may leak from the orifice. Depending on the path, fistulas can cause systemic infections (PELLICO, 2021).

Surgical treatment is always recommended because few fistulas heal spontaneously. Fistulectomy is the name of the surgical procedure where the fistula is dissected or opened by an incision from the rectal orifice to its proximal end. The wound closes by second intention (PELLICO, 2021).

HEMORRHOIDS

They are regions with dilated veins of the anal canal; didactically they are divided into two types: internal, which develop above the anal sphincter, and external, which appear outside the anal sphincter. Its prevalent symptoms are itching and pain. Bright red bleeding after defecation is a hallmark of this anal condition. The symptoms of hemorrhoids with the hygiene of the place, laxative feeding to avoid excessive force in the evacuation. The surgical treatment of internal hemorrhoids is the rubber band ligation procedure; In the case of thrombosed veins with advanced involvement, a more extensive procedure, hemorrhoidectomy, is required. (BRUNNER; SUDDARTHS, 2013).

Hemorrhoids are dilated veins in the anal canal, it is very common from the age of 50. Laceration of the mucosa during defecation causes slippage of structures in the wall of the anal canal, including tissues and blood vessels. There are external hemorrhoids that form outside the anal sphincter and internal hemorrhoids that form above the internal sphincter in the anal canal. They cause itching and pain, bright red bleeding during defecation (PELLICO, 2021).

PILONIDAL CYSTS

It is found in the Intergluteal fold, theories say that these cysts are the result of hair penetration into the epithelium and subcutaneous tissue; but it can also occur from a fold of epithelial tissue beneath the skin that communicates with the surface through one or more open sinuses, hair is

usually seen coming out of these openings. At first, the infection can be treated with antibiotic therapy, but after the abscess has formed, surgery is indicated. The abscess is removed and drained with a local anesthetic; Surgical intervention is to remove the cyst and the secondary path. Wound healing is by granulation (2nd intention); gauze dressings are placed on the wound to keep the edges separate while the healing process takes place.

They suggest that these lesions are the result of local traumas that allow the penetration of hairs into the epithelium and subcutaneous tissues. Pilonidal cysts can also be congenital, forming due to the invagination of epithelial tissues over the skin, which may communicate with the skin surface through one or several small fistular orifices. Sweating and friction easily irritate this area and can cause inflammation, infection and abscess, the latter must be surgically treated with incision and drainage under local anesthesia. To excise the cyst and its secondary paths, a major surgical procedure is necessary. The wound must heal by second intention with the stimulation of granulation tissue formation. The edges must be covered and kept away by sterile gauze (PELLICO, 2021).

HEALTH EDUCATION IN THE POSTOPERATIVE OF ANORECTAL DISORDERS

Saúde (2007) defines health education as a systematic, continuous and permanent process that aims at the formation and development of the citizen's critical awareness, stimulating the search for collective solutions to the problems experienced and their "real participation" in the exercise of social control.

Health education requires critical and reflective thinking to reveal the reality and propose actions that lead the individual to understand himself as a subject of doing and capable of having an opinion in decisions about his health, his family and his collectivity(VASCONCELOS, GRILLO; SOARES, 2009).

Patient education is essential for recovery from anorectal diseases (BRUNNER; SUDDARTHS, 2013):

- Keep the perineal area as clean as possible, washing it with warm water and gently drying it, if necessary with cotton swabs;
- Avoid cleaning the area with toilet paper;
- Instruct how to do the sitz bath and this must be done after each elimination for at least the first two weeks;
- Emphasize the importance of following the diet guided by the team and the importance of a laxative diet for the recovery of the condition.

Main problems to be assisted by the outpatient nurse:

- **relieve constipation**– by not meeting the need to defecate due to fear of pain, some patients develop constipation. (BRUNNER; SUDDARTHS, 2013).

Guide the fluid intake with at least 2 liters of water a day and foods rich in fiber to facilitate the formation of the fecal cake and its exit through the rectum; taking care with renal and cardiac patients, whose water intake must be guided by a specialist doctor. The client must set aside time for defecation and attend to the urge to defecate as soon as possible; in addition to doing relaxation exercises in the abdominal and perineal muscles before defecation (PELLICO, 2021).

- **alleviate anxiety**- related to fear of surgery and post-surgical embarrassment (BRUNNER; SUDDARTHS, 2013).

Patients undergoing rectal surgery are uncomfortable due to discomfort, pain and embarrassment. The nurse must identify the patient's needs and make a care plan according

to the problems encountered in order to bring safety and comfort. (PELLICO, 2021).

- **pain management**– related to sensitivity of the anorectal area and anal sphincter spasms. (BRUNNER; SUDDARTHS, 2013)

During the first 24 hours after rectal surgery, painful spasms of the sphincter and perineal muscles may occur. The patient must be instructed to stay in a comfortable position with pneumatic cushions over the buttocks when he/she is going to sit down; in addition to the application of ice and analgesic ointments. Sitz baths must be used to relieve irritability and pain, as it works by relaxing muscle spasms. Wet dressings can be used in the immediate postoperative period and placing the patient in a supine position at predetermined intervals helps to reduce tissue swelling.

- **facilitate urination**- related to postoperative reflex spasm and fear of feeling pain when urinating (BRUNNER; SUDDARTHS, 2013).

Urinating can be a postoperative problem as a result of the reflex spasm of the sphincter in the bladder outlet tract and the muscular defense caused by apprehension and fear. The nurse must guide methods of stimulating voluntary urination (liquid ingestion, noise of running water, warm water in the urinary meatus). Urinary output must be monitored in the rectal postoperative period (PELLICO, 2021).

- **Monitor and treat complications**- The nurse must evaluate the client for systemic signs of excessive bleeding (tachycardia, hypotension, agitation and thirst) (PELLICO, 2021).
- **Guide home care for surgical wounds**–Wound care at home requires the collaboration of the patient, family or caregiver; the nurse must guide the interested parties regarding wound care and finally the client must answer 03 questions satisfactorily: What is my main problem, what do I need to do and why is it important for me to do this. It aims to encourage the client to integrate into care (BAK, 2021).

Patients with open wounds, whether surgical or trauma, must be monitored for early detection of signs of infection such as increased pain at the site, temperature elevations, and foul-smelling and/or purulent drainage (VAUGHANS, 2012).

It is up to the outpatient nurse to guide and, if necessary, monitor the evolution of the healing of the surgical wound; developing together with the client a care plan for the daily dressing.

Netinna (2021) lists the importance of patient, family or caregiver adherence in performing the appropriate dressing in ideal time and conditions:

1. Protect the wound from mechanical damage;
2. Contain or immobilize the wound;
3. Absorb exudate drainage;
4. Avoid contamination by body fluids such as feces and urine;
5. Promote hemostasis as is done in compressive dressings;
6. Debride the wound when necessary;
7. Inhibit or kill microorganisms with the correct use of dressings;
8. Provide a physiological environment for wound healing;
9. Allow physical and mental comfort for the patient.

Netinna (2021) recalls the need for a good diet (rich in calories and proteins and low in nitrogenous foods so as not to compromise the wound healing process.

The objective of nursing actions is to make the person independent of this assistance as quickly as possible by teaching self-care, promoting and maintaining health recovery

(NISHIO; FRANCO, 2011).

CONCLUSION

The potential problems that patients undergoing surgery to treat anorectal disorders may develop and which will be the focus of attention in care were raised: management of constipation; reduced anxiety about the surgical outcome; pain management if it still exists; pay attention to the risk of urinary retention; for the fear of ineffective treatment and the healing of these postoperative wounds which are mainly by second intention, can take time to close; due to characteristics and location. They are dirty wounds with risk for infection and bleeding; they need the perspective of outpatient nursing more intensively.

All nursing care must be based on technical and scientific knowledge through the systematization of care and developed in a unique and individual way according to the information provided by the patient and family members, respecting the social context in which the client is inserted.

It was noticed that health education is an important tool in outpatient nursing care; being responsible for customer loyalty in the continuity of treatment until the problem is cured or controlled; because these conditions can be recurrent if the patient does not assimilate changes in their daily routine.

With this study, it was possible to trace the path to exercise the specific nursing work process for this interest group.

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