

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ



Shendi University



Faculty of Graduate Studies and Scientific Research

**The Concept about Performance of Nurses
Regarding Pre and Postoperative Nursing Care
of Patient Undergoing Hemorrhoidectomy in
Elmak Nimer University Hospital (2016)**

A thesis submitted as partial fulfillment requirement of
master degree in medical surgical nursing

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الآية

بسم الله الرحمن الرحيم

قال تعالى:

﴿ فَتَبَسَّمْ ضَاحِكاً مِّن قَوْلِهَا وَقَالَ رَبِّ أَوْزِعْنِي أَنْ
أَشْكُرَ نِعْمَتَكَ الَّتِي أَنْعَمْتَ عَلَيَّ وَعَلَى وَالِدَيَّ وَأَنْ
أَعْمَلَ صَالِحاً تَرْضَاهُ وَأَدْخِلْنِي بِرَحْمَتِكَ فِي عِبَادِكَ
الصَّالِحِينَ ﴾

صدق الله العظيم

سورة النمل - الآية (19)



Dedication

Happily I would like to dedicate this attempt to

My parents

Who learnt me first betic spring of chaity

My mother

The spring of love.

My father

The spring of love.

My lovely sister and brother

My husband:

Light of my life

My teachers

Who educated me letters of language

To all my fiends

Acknowledgment

*First the greatest thanks to God Almighty
Allah.*

*I would like to express my dearest full thanks and
deeply emotion to all contributed with me to the
accomplishment of this piece of work.*

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Dr. Sulman Alkamil

I must not forget to thank all my teachers.

All thank all my colleagues in the faculty.

ملخص البحث

هدفت هذه الدراسة الوصفية إلى معرفة مفهوم وأداء الممرضين حول العناية التمريضية للمرضى قبل وبعد عملية إزالة البواسير بمستشفى المك نمر الجامعي بمدينة شندي في الفترة من أغسطس إلى ديسمبر 2016م وتم اختيار مجموعة الدراسة باستخدام العينة العشوائية (70 ممرض) وتم جمع البيانات باستخدام استبانته، وتم التحليل عن طريق التحليل الإحصائي للحزم الإحصائية للعلوم الاجتماعية، حيث أثبتت الدراسة أن معرفتهم بمفهوم ومراحل البواسير والمراحل التي تحتاج لتدخل جراحي ضعيفة (24% و 47% و 10%)، ومعرفتهم بالإرشاد الصحي قبل العملية ضعيفة جداً (28%) وأيضاً أثبتت الدراسة أن أدائهم ومعرفتهم بما قبل العملية جيدة مثل صيام المريض (64%) وأخذ العلامات الحيوية (74%) ومحتوى فأيل المريض (71%) وارتداء المريض ملابس العملية (74%) وتوصيله إلى غرفة العمليات (94%) ومعرفتهم وأدائهم بعد العملية جيدة مثل تقييم مستوى الوعي (75%) وأخذ العلامات الحيوية (76%) وملاحظة مكان العملية (67%) وكيفية بداية العلاج (79%) وبداية الأكل (62%). وأيضاً أثبتت الدراسة أن معرفتهم وأدائهم حول العناية في المنزل ممتازة مثل الإرشادات التي تتجنب حدوث البواسير (84%) والمتابعة (74%) والنظافة اليومية (87%). لذلك أوصت الدراسة إلى زيادة معرفتهم بالإرشادات الصحية قبل العملية بالنسبة للمريض.

Abstract

This descriptive study aimed to identify the concept about performance of nurses regarding nursing care of patient undergoing hemorrhoidectomy in Elmak Nimer university hospital in period from Augustus to December 2016. Study group was selected by using simple random sampling and data was collected by questionnaire. The study showed that knowledge about concept of degree of hemorrhoid, and degree require removal (surgery) was poor (24%, 47%,10%) respectively. Knowledge about health teaching preoperative very poor (24%), also the study showed that the concept and performance about preoperative was good like (fasting (64%), vital signs (74%), patient file done (71%), patient gown done (74%), transfer patient to theater (94%), and performance and knowledge about postoperative was good like (assessing level of consciousness (75%), vital signs (76%), check site of operation (67%), start medication (79%), start diet (62%). And also the study showed that performance and knowledge about postoperative home care was excellent like (precaution (84%), follow up (74%) and hygiene (87%), the study recommended increase knowledge about identify preoperative teaching for the patient.

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Chapter One

Introduction

Justification

Objectives

1.1 Introduction

Hemorrhoids are common health problem but not too many people are willing to discuss or admit to having them openly. The good news is that hemorrhoids are totally treatable if proper treatment is administered at an early stage ⁽¹⁾.

The incidence of hemorrhoidal disease is difficult to quantify due to difference in health care access, and it is more common in white patient than in black patients in US with presentation peaking between the age of 45 years since the second half of the 20th century there appears to be an unexplained decreases in the prevalence of symptomatic hemorrhoidal disease in both the US and England⁽¹⁾.

Five hundred and seventy tow patients with hemorrhoid seen in the rectal clinic Khartoum teaching hospital. Pure internal piles were found in 39.86% of patients. Both internal and external component were found in 33.22%. only external component was found in 5.07% and there was miscellaneous group of 125 (20%) patients. Constipation was noted in 21% of patients suffering from hemorrhoids. Patient with pure internal piles were best treated conservatively 89% responded to local ointment, injection or rubber band ligation and 11% required surgery ⁽¹⁾.

The prevalence of hemorrhoids has been estimated at 4.4% US adults with the highest. Prevalence in those between 45-65 years of age factors that intra-abdominal pressure and prolapse of hemorrhoidal vascular tissue ⁽¹⁾.

The nursing role include education of client of all ages, maintain adequate intake of dietary fiber. Aiberal fluids intake and regular exercise to maintain stool bulk, teach appropriate constipation management including the use of bulk foaming laxative and packing may be in place for the first 24 hours, following procedure when removed, observe client bleeding, pain also sitz bath usually are ordered ⁽¹⁾.

1.2 Justification

The care of patient pre and postoperative hemorrhoid was important. The cares of patient preoperative with hemorrhoid do to prevent the complications of postoperative.

So (to assess the concept about performance regarding pre and postoperative nursing care of patient undergoing hemorrhoidectomy).

1.3 Objectives

1.3.1 General objective:

To assess the concept about performance of nurses regarding pre and postoperative nursing care of patient undergoing hemorrhoidectomy.

1.3.2 Specific objective:

1. To assess nurses knowledge about preoperative care.
2. To assess nurses knowledge about postoperative care of hemorrhoidectomy.
3. To assess nurses knowledge about postoperative home care.

2. Literature review

Hemorrhoids are varicose vein in the anal canal. They are caused by an increase in the pressure in the veins often from increased intra-abdominal pressure⁽³⁾.

Hemorrhoids develop when venous return from the anal canal is impaired. Straining to defecate increase venous pressure and it the most common cause of distended hemorrhoids ⁽⁷⁾.

2.1 Pathology:

The anal cushions are disrupted to produce piles by the forces of defecation. For many sufferers defecator habits and stool consistency are probably to blame. The Val Sava effect of excessive straining engorges the cushions, which have lost the support of the external sphincter as it relaxes. The shearing force of hard stools will increase the damage. In other patients who claim a lifetime of regular easy bowel actions, the anal cushions may be structurally deficient. Weakness arising from the influence of progesterone on smooth muscle and elastic tissue may explain the predisposition to hemorrhoids in pregnancy, though an increase in pelvic vascularity may contribute ⁽⁶⁾.

2.2 Types of hemorrhoids:

Hemorrhoids are classed ether internal or external. Internal hemorrhoids affect the venous plexus above the mucocutaneous junction of the anus, internal hemorrhoids rarely causes pain, usually presenting with bleeding from internal hemorrhoids is bright red and un mixed with the stool, it can vary in quantity from streaks on toilet tissue to enough to color the water in the toilet, recurrent bleeding of internal hemorrhoids may be sufficient to cause anemia. Mucous discharge and feeling of incomplete evacuation of stool also may be manifestation of internal hemorrhoids ⁽⁷⁾.

External hemorrhoids affect the inferior hemorrhoidal plexus below the macocutaneous injection. Bleeding is rare with external hemorrhoids and irritation feeling of pressure and difficulty cleaning the anal region may be manifestation of external hemorrhoids ⁽⁷⁾.

As they enlarge, hemorrhoids may prolapse or protrude through the anus initially, prolapse occurs only with the defecation and the hemorrhoids spontaneously regress back into the anal canal. Eventually, the client may need to manually replace internal hemorrhoids after defecation ⁽⁷⁾.

Normal hemorrhoids are not painful prolapsed hemorrhoids may become strangulated as result of congestion and edema leading to thrombosis, hemorrhoidal thrombosis causes extreme pain and may lead to infraction of skin and mucosa overlying the hemorrhoids. Internal hemorrhoids associated with portal hypertension in liver disease may bleeding profusely if ruptured. ⁽⁷⁾

2.3 Degree of hemorrhoid:

Physicians use grading system to describe the severity of hemorrhoids:

First degree: hemorrhoids that bleed but do not prolapse ⁽¹⁰⁾.

Second degree: hemorrhoids that prolapse and retract on their own (with or without bleeding) ⁽¹⁰⁾.

Third degree: hemorrhoids that prolapse but must be pushed back in by finger ⁽¹⁰⁾.

Four degree: hemorrhoids that prolapse and cannot be pushed back in by finger. ⁽¹⁰⁾

2.4 Predisposing factors:

Most hemorrhoids are caused by straining during bowel movements. They are common during pregnancy. Prolonged sitting or standing, obesity, and chronic constipation also contribute to hemorrhoids. Portal hypertension related to liver disease may also be a factor ⁽⁴⁾.

2.5 Signs and symptoms:

2.5.1 Symptoms:

Although the underlying lesion in piles—disruption of the supporting and anchoring tissues of the cushions—means that prolapse is inherent in their nature, bleeding is more worrying and is the usual reason for seeing a doctor. Prolapse is, however, the other unequivocal symptom. Pain, itching, and anal dysfunctional effects are less reliable diagnostic criteria ⁽⁶⁾.

2.5.1.1 Bleeding:

The capillaries of the lamina propriety are only protected by a single layer of epithelial cells, and little trauma is required to breach them. Since it is the more lax-textured, upper part of the anal cushion which mainly prolapses, dragging the mucosa to the outside, trauma due to wiping or contact with clothes often occurs. Repeated trauma produces a chronic inflammatory response, making the damaged mucosa a brighter red, so more friable and likely to bleed ⁽⁶⁾.

2.5.1.2 Pain:

Pain is a contentious issue in pile symptomatology. Although claimed to be a prominent and attributable problem, there seems to be no good reason why a disrupted anal cushion should actually be painful. When trapped outside the closed anus, distortion combined with edema and congestion from lymphatic and venous impairment may well cause discomfort. In many cases pain on defecation is due to an easily overlooked fissure ⁽⁶⁾.

Episodes of painful irreducible swelling which last a week or so can be most unpleasant. Often called 'strangulated' piles or an 'attack of the piles', they are usually due to greater or lesser degrees of infarction resulting from obstruction of venous drainage by thrombosis and consecutive clotting in the sacculated venous plexus ⁽⁶⁾.

Infarction is used here in its proper sense, denoting an intravascular and interstitial 'stuffing with blood', and not in its common contemporary misuse implying necrosis. Although necrosis would supervene if circulatory impairment by venous blockage were sufficient, complete obstruction of venous return is in fact very rare and the usual outcome is spontaneous resolution as the clot shrinks and lyses and venous Itching ⁽⁶⁾.

When the patient's circulation is restored. Main concern is itching, piles are seldom to blame. A local skin condition is usually responsible ⁽⁶⁾.

Mucus discharge from a prolapsed pile, however, causes an all viable irritation in some patients ⁽⁶⁾.

2.5.1.3 Anorectal dysfunction:

Defecator derangement can be excited by disrupted anal cushions causing a sensation of incomplete evacuation, particularly when further engorged by fruitless straining. Of course a feeling of unsatisfied defecation—tenuous—may have a more serious explanation ⁽⁶⁾.

2.5.2 Signs:

There are several dynamic influences on a pile's presentation—the vigorous arterial supply, the presence and possibly changing diameter of the arterio venous shunts, the variability of cushion bulk due to the capacity of the venous saccules, and the effects of cushion displacement and anal sphincter contraction on venous and lymphatic drainage. As a result, not only does the appearance change from time to time in the same patient, but the same symptom may have different causes. For instance, whereas most people complaining of prolapse have simple displacement of the anal cushion, a 'lump' felt by others may be due to engorgement of the subanodermal veins from, one presumes, impaired drainage or transient but most uncomfortable post defecator anodermal edema. ⁽⁶⁾.

2.6 Management:

2.6.1 Medical management:

Hemorrhoids cause itching and pain and are the most common cause of bright red bleeding with defecation. External hemorrhoids are associated with severe pain from the inflammation and edema caused by thrombosis (ie, clotting of blood within the hemorrhoid). This may lead to ischemia of the area and eventual necrosis. Internal hemorrhoids are not usually painful until they bleed or prolapse when they become enlarged ⁽⁵⁾.

Hemorrhoid symptoms and discomfort can be relieved by good personal hygiene and by avoiding excessive straining during defecation. A high-residue diet that contains fruit and bran along with an increased fluid intake may be all the treatment that is necessary to promote the passage of soft, bulky stools to prevent straining. If this treatment is not successful, the addition of hydrophilic bulk-forming agents such as psyllium and mucilloid may help. Warm compresses, sits baths, analgesic ointments and suppositories, astringents (eg, witch hazel), and bed rest allow the engorgement to subside ⁽⁵⁾.

There are several types of non-surgical treatments for hemorrhoids. Infrared photocoagulation, bipolar diathermy, and laser therapy are newer techniques that are used to affix the mucosa to the underlying muscle. Injecting sclerosing solutions is also effective for small, bleeding hemorrhoids. These procedures help prevent prolapse. ⁽⁵⁾.

Preventing constipation, avoiding straining during defecation, and good personal hygiene relieve hemorrhoid symptoms and discomfort. Astringents, such as witch hazel, can be used for symptom relief. Sits baths increase circulation to the area and aid in comfort and healing. Stool softeners can be used to reduce the need for straining. Other anti-inflammatory medications may be tried, such as steroid

creams or suppositories. Alternating ice and heat helps relieve edema and pain with thrombosed hemorrhoids ⁽⁴⁾.

If hemorrhoids are prolapsed and are no longer reduced by palliative measures, more aggressive measures may be used. Sclero therapy involves the injection of a sclerosing agent into the tissues around the hemorrhoids, causing them to shrink. Rubber band ligation uses rubber bands placed around the hemorrhoids until the tissue dies and sloughs off. ⁽⁴⁾.

2.6.2 Surgical management:

A conservative surgical treatment of internal hemorrhoids is the rubber-band ligation procedure. The hemorrhoid is visualized through the anoscope, and its proximal portion above the mucocutaneous lines is grasped with an instrument. A small rubber band is then slipped over the hemorrhoid. Tissue distal to the rubber band becomes necrotic after several days and sloughs off ⁽⁵⁾.

Fibrosis occurs; the result is that the lower anal mucosa is drawn up and adheres to the underlying muscle. Although this treatment has been satisfactory for some patients, it has proven painful for others and may cause secondary hemorrhage. It has been known to cause per anal infection. ⁽⁵⁾.

Cryosurgical hemorrhoidectomy, another method for removing hemorrhoids, involves freezing the hemorrhoid for a sufficient time to cause necrosis. Although it is relatively painless, this procedure is not widely used because the discharge is very foul smelling and wound healing is prolonged. The Nd: YAG laser is useful in excising hemorrhoids, particularly external hemorrhoidal tags. The treatment is quick and relatively painless. Hemorrhage and abscess are rare postoperative complications ⁽⁵⁾.

The previously described methods of treating hemorrhoids are not effective for advanced thrombosed veins, which must be treated by more extensive surgery. Hemorrhoidectomy, or surgical excision, can be performed to remove all the redundant tissue involved in the process. During surgery, the rectal sphincter is

usually dilated digitally and the hemorrhoids are removed with a clamp and cautery or are ligated and then excised. After the operative procedures are completed, a small tube may be inserted through the sphincter to permit the escape of flatus and blood; pieces of Gel foam or Oxycel gauze may be placed over the anal wound ⁽⁵⁾.

Haemorrhoidectomy is therapy that can often be done under local anesthetic and seldom requires much more than an overnight stay. The excessively painful and prolonged experience of folk memory resulted mainly from the well intentioned use of wide-bore rubber drains or packs inserted in theater against the risk of hemorrhage ⁽⁶⁾.

The patient's rectum should be emptied prior to surgery by means of an enema administered about 2 h before. Whereas in the United Kingdom the patient is usually put 'in lithotomy' for the procedure, the prone jack-knife position is probably preferable for reasons both of access and local conditions, the anal canal's axis then being in a line with the surgeon's eye rather than, as in the lithotomy position, at an angle to it, and the vasculature not being unnaturally suffused with blood. However, the lithotomy position and the lateral position with buttocks taped apart, also useful, are easier to arrange ⁽⁶⁾.

Haemorrhoidectomy can be performed either open or closed and is done with scissors or diathermy (or for that matter, laser). Either way, the essential principle, emphasized by the reminder that surgery is the replacement of one lesion by another, is to keep the damage to the minimum required for symptomatic relief.

After haemorrhoidectomy, light dressings are placed over the anus, perhaps kept in place by elasticated pants for easy changing. If general anesthesia has been used the anal wounds should be thoroughly infiltrated with a long-acting local anesthetic. The anus should not be packed. Warm baths are comforting, with or without salt, and measures are taken to keep the stools soft and regular. There is no need for the patient to stay in hospital until the bowels have moved but if they have

not by the third day the patient should report back for an enema. Antibiotic cover is not required unless there is a particular predisposition to sepsis ⁽⁶⁾.

Surgical hemorrhoidectomy involves surgical removal of hemorrhoids, and is used in severe cases ⁽⁴⁾.

The patient should be instructed to consume a high-fiber diet and 2 to 3 L of fluid a day to promote regular bowel movements. The effects and side effects, proper dosage, and frequency of local or topical treatments should be explained. If the patient has surgery, analgesics should be given as needed because the many nerve endings in the anal canal can cause severe pain. Comfort measures such as a side-lying position and fresh ice packs should also be used to relieve pain. After the first postoperative day, sitz baths may be ordered. Unfortunately, a side effect of opioid analgesics is constipation, which needs to be avoided, especially in the immediate postoperative period. Because the first bowel movement can be painful and anxiety provoking, stool softeners are given and analgesics administered before the first bowel movement. ⁽⁴⁾.

2.7 Examination:

When a meticulous history suggests piles and the findings agree, examination can be confined to the ano rectum. The only equipment then required is proctoscope (anoscope), rigid sigmoidoscope (rectoscope), light source, and biopsy forceps. Many, however, would disagree and argue for routine adjunctive fiber-optic inspection of the distal colon, at least in those over 40 years of age for rectal bleeding, however described and whatever the anoscopic findings. Some workers in this field indeed advocate full colonoscopy in patients aged 40 or over presenting with rectal bleeding even when bright red, on the basis of the frequency of finding right-sided pathology in those of middle age and older, but in the author's view theirs is more an argument—still unresolved—for screening. ⁽⁶⁾

2.8 Diagnosis:

Your doctor may be able to see external hemorrhoids simply by looking. Tests and procedures to diagnose internal hemorrhoids may include examination of your anal canal and rectum ⁽¹¹⁾.

Digital examination. During a digital rectal exam, the doctor inserts a gloved, lubricated finger into your rectum. He or she feels for anything unusual, such as growths. The exam can suggest to your doctor whether further testing is needed.

Visual inspection. Because internal hemorrhoids are often too soft to be felt during a rectal exam, your doctor may also examine the lower portion of your colon and rectum with an anoscope, proctoscope or sigmoidoscope ⁽¹¹⁾.

The doctor may want to examine your entire colon using colonoscopy if:

The signs and symptoms suggest you might have another digestive system disease ⁽¹¹⁾.

Have risk factors for colorectal cancer ⁽¹¹⁾.

Middle-aged and haven't had a recent colonoscopy. ⁽¹¹⁾

2.9 Complications:

2.9.1 Pain:

Pain, some discomfort follows all the tissue ablative procedures but amounts in some patients to severe pain lasting as long as a week. Again, prior knowledge will prevent much needless worry and also allow the patient to plan in advance ⁽⁵⁾.

2.9.2 Hemorrhage:

Tissue destructive or excisional techniques will also leave a well vascularized, raw wet surface and so carry the irreducible risk of secondary hemorrhage. It is rare, but when it occurs, alarming, but once more if the patient is told of the possibility beforehand there will be less anxiety and disruption. In the author's experience only once in 20 years has continued bleeding required suture for hemostasis. In the other dozen or so instances the bleeding stopped

spontaneously and without resort even to attempted tamponed with a balloon catheter ⁽⁵⁾.

2.9.3 Infection:

Sepsis is an uncommon complication and will be treated on its merits. Fatal sepsis even after simple banding has been reported in immune compromised patients. Stories are handed down of portal pyemia following haemorrhoidectomy, and of necrotizing fasciitis complicating it. Both no doubt have occurred and will again but must be excessively rare. Neat surgery with the least trauma will surely reduce the possibility as will patient selection and judicious drainage rather than skin closure when the tissues have been compromised ⁽⁵⁾.

2.9.4 Urinary:

Haemorrhoidectomy is notorious for causing transient difficulty in voiding in men. Banding may also induce curious bladder symptoms. Inadvertent intra- or per prostatic injection of sclerosant may have serious sequelae, even impotence being reported ⁽⁵⁾.

2.9.5 Anal cushion thrombosis:

Occasionally, excessive pain seems to be attributable to thrombosis/clotting in the residual anal cushion after pile banding, the complication being detectable by the digital discovery of knobbly in duration within the anal canal ⁽⁵⁾.

2.9.6 Edema and tags:

Occasionally, however careful the excision, the intervening skin bridges may swell uncomfortably with edema to remain afterwards as tags. Though lymphatic impairment, perhaps from diathermy damage, is presumably responsible, the etiology of anal tags is obscure; furthermore, when the entire anal lining has dislocated to form a circular curtain at the anus, the intervening bridges will of necessity remain as tags. They can be improved later under local anesthesia if required ⁽⁵⁾.

2.9.7 Stricture:

The anal lining is extraordinarily forgiving; elastic, robust, and quick healing. Only inexcusably excessive excision will result in stenosis, or some other extraordinary circumstance. ⁽⁵⁾.

2.10 Preoperative care:

Clear liquids are taken and tolerated. This can be almost immediately following surgery, especially if local anesthesia was used. Sometimes general Preoperative tests may include blood and urine tests, a chest x-ray, and an EKG, depending on the patient's health. These tests are normally done a few days prior to surgery ⁽⁸⁾.

Medications that "thin" the blood, including aspirin, are usually discontinued before a scheduled surgery. Some drugs, such as the prescription medication Coumadin (warfarin), usually must be withheld at least 3 or 4 days prior to a surgical procedure to avoid excessive bleeding during the surgery ⁽⁸⁾.

If general anesthesia is going to be used, nothing may be eaten from midnight on the evening before surgery until the procedure is completed. This includes food, water, chewing gum, and candy. This necessary precaution decreases the possibility of vomiting during and after surgery ⁽⁸⁾.

For local and spinal anesthesia, dietary restrictions vary. The surgeon may require patients to abstain from eating after midnight, and that should be clarified in advance ⁽⁸⁾.

Hemorrhoidectomies are performed in a hospital or outpatient surgery center. The anesthesiologist performs a brief physical examination and obtains a patient history. It is important that the anesthesiologist is aware of all medications that the patient is taking, any allergies, and any prior adverse reaction to anesthesia. This information helps the anesthesiologist select the most suitable anesthetic agents and dosage and avoid possible complications. Two to 4 hours before surgery, a mild

laxative or enema may be ordered to clear out stool. A sedative also may be administered in the patient's room or in an area designed for patients who are about to undergo surgery. The sedative helps the patient relax and induces drowsiness ⁽⁸⁾.

Sometimes it is given as an injection about an hour before the surgery, and sometimes it is given intravenously ⁽⁸⁾.

All patients have an intravenous line (IV) to administer fluid and medication before, during, and after surgery. The intravenous may be started in the hospital room or in the preoperative area. Anesthesia is given in the operating room ⁽⁸⁾.

2.11 Postoperative care:

After surgery, the patient is taken to the post anesthesia care unit (PACU). Patients are closely monitored by the nursing staff and remain there until they are stable. The amount of time spent in the PACU depends on the patient's progress and the type of anesthesia received. General anesthesia must wear off and the patient must be awake and coherent before they leave the PACU.

Outpatients are transferred to another room to finish their recovery, and inpatients are taken to their hospital room. The intravenous line remains in until anesthesia induces nausea, which may delay taking oral fluids. Once clear liquids are tolerated, the diet progresses to solid foods.

Spinal anesthesia usually wears off within a few hours. During the first hour following surgery, patients lie flat on their back to decrease the risk for an anesthesia-induced headache, which can be painful and prolonged. Before being discharged, the patient must regain full sensation in the lower part of the body.

Because of swelling and the dressing, some patients have temporary difficulty urinating. If there is urgency, but the urine will not flow, a catheter is used to empty the bladder. Outpatients may need to stay overnight, if they are unable to urinate. Patients must be able to urinate on their own before being discharged.

Patients experience pain and discomfort during the immediate postoperative period (i.e., about 10 days). Pain medication is prescribed and should be taken as directed. Sometimes relief can be achieved with an over-the-counter preparation such as Tylenol®. If a pack was inserted into the rectum following surgery, the physician usually removes it in a day or two.

An ice pack can help reduce swelling. Soaking in a sit bath (a shallow bath of warm water) several times a day helps ease the discomfort.

It is important to avoid constipation at this time so; the physician will prescribe stool softeners and a laxative. Eating a high-fiber diet and drinking plenty of liquids also helps. A small to moderate amount of bleeding, usually when having a bowel movement, may occur for a week or two following the surgery. This is normal and should stop when the anus and rectum heal.

Complete recovery takes 6 weeks to 2 months. Most patients return to work within 10 days. Heavy lifting should be avoided for 2 to 3 weeks ⁽⁸⁾.

2.12 Prevention:

2.12.1 High fiber food:

Eat more fruits, vegetables, and grains, these soften the stool and increase its bulk⁽⁹⁾.

2.12.2 Plenty of liquids:

Should be consumed. The amount of daily fluid depends on age. Sex, health activity level ⁽⁹⁾.

2.12.3 Exercise:

Staying active helps to reduce pressure on veins which can occur with long periods of standing or sitting ⁽⁹⁾.

2.12.4 Avoid long period of standing or sitting:

Sitting in the toilet for long period can increase pressure on the vein in the anus ⁽⁹⁾.

2.12.5 Eliminating straining:

Straining and holding the breath when trying to pass a stool creates greater to hemorrhoids. ⁽⁹⁾

2.13 Nursing diagnosis:

Acute pain related to physical injury agent (surgical incision) ⁽¹²⁾.

2.13.1 Gal:

- Increased patient comfort.
- Pain control ⁽¹²⁾.

2.13.2 Expected outcomes:

- Patient reported decrease pain, pain scale 2-3.
- Calm facial expression and can rest, sleep.
- Vital signs are within normal limits ⁽¹²⁾.

2.13.3 Nursing intervention:

- Pain assess comprehensively including location, characteristics, duration, frequency, quality, factor and precipitation.
- Observation of nonverbal reactions inconvenience.
- Use therapeutic communication techniques to determine the client's experience of pain before.
- Reduce pain precipitation factor.
- Teach non pharmacological techniques (relaxation, distraction, etc.) to overcome the pain.
- Give analgesics to reduce pain.
- Evaluation of pain reducers, control pain.
- Collaboration with the doctor if there are complaints about the administration of analgesics were not successful.
- Monitor patient acceptance of pain management. ⁽¹²⁾.

2.14 Impaired tissue integrity related to surgery procedures:

2.14.1 Goal:

Maintain skin integrity ⁽¹³⁾.

2.14.2 Expected outcomes:

Patient will have intact skin with no signs or symptoms of rectal prolapse or bleeding ⁽¹³⁾.

2.14.3 Nursing Intervention:

- Assess patient for presence of hemorrhoids, discomfort or pain associated with hemorrhoids, diet, fluid intake, and presence of constipation.
- Administer topical medication as ordered.
- Administer stool softeners as ordered.
- Assist with procedures for treatment of hemorrhoid.
- Instruct patient and or family regarding all procedures required.
- Instruct patient and family in dietary.
- Instruct patient and family regarding causes of hemorrhoids, methods of avoiding.
- Instruct patient and family regarding the use of bulk producing agents, such as psyllium husk.
- Instruct patient and family in comfort measures to use with the presence of hemorrhoids. ⁽¹³⁾.

3. Methodology

3.1 Study design:

This research was descriptive cross sectional, hospital based study done to assess the concepts about performance of nurses regarding pre and postoperative nursing care of hemorrhoidectomy in Elmak Nimer university hospital during period from August to October 2016.

3.2 Study area:

The study was done in Shendi town, Shendi town bounded by Khartoum state to south Eiddamer locality to the north River Nile west and Gadarif state to the east Shendi town is located 172K north to Khartoum city. Most of the people in Shendi working agriculture and some in industrial works and other work. The town considered as center. Shendi has two big hospitals, the teaching hospital and Elmek Nimer university hospital. Elmek Nimer hospital was established in 2002 and there are 121 nurses in hospital and consist of general units of medicine, pediatric, obstetric, cardiac unit, dialysis units, and surgery, oncology, minor and major theater, ENT. There is also blood bank and pharmacy and laboratory.

3.3 Study population:

Including all nurses in Elmak Nimer hospital during 3 shifts working for one year at least excluding nurse's who work to less than one year.

3.4 Sampling:

The sampling was selected by convenience simple.

3.5 Sample size:

70 nurses were selected from total number of nurse's working during all shift.

3.6 Data collection tool:

By using questionnaire designed by the researcher based on available literature review composed of 40 questions.

3.7 Scoring system:

Scoring system was established by researcher the data was distributed in three categories to assess the concepts about performance of nurses regarding pre and postoperative nursing care of hemorrhoidectomy: if the nurse respond to (4-3 choice it consider good knowledgeable), (2 choices consider faire knowledge); (1-0choice consider poor knowledge).

3.8 Data collection technique:

Data was collected during period of one week in the morning shift and afternoon night shift every nurse was filled the questionnaire and toke about 5-10minutes, there was no missing and no refusing.

3.9 Data analysis:

The data was analyzed by SPSS (statistical package for social science) and presented in form of tables and figures.

3.10 Ethnical consideration:

The study was approved to by the conducted by the research institute board of the faculty .Permission has been taken after explanation clearly and verbally to the responder and the information should be used only of the purpose of study, and they have chance to stop any time they wish.

4. Results

Part 1: Personal characteristic

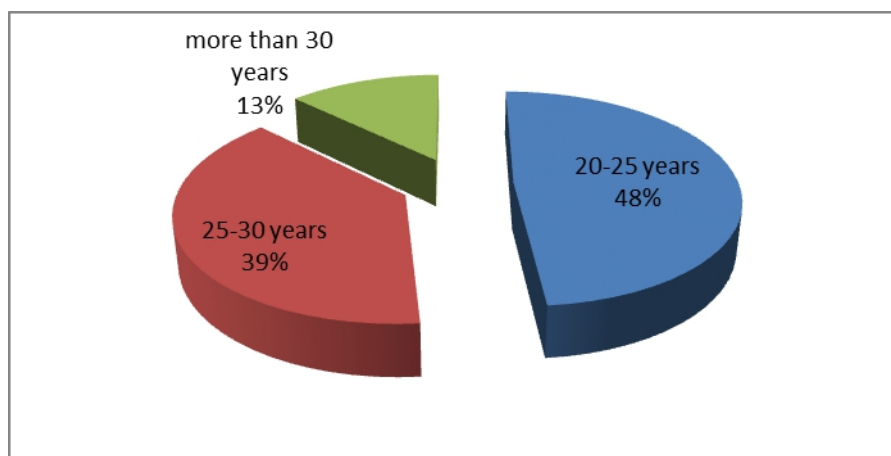


Figure No (1): Distribution of study group according to their Age.

The above figure showed (48%) of nurses their age range between (20-25) year, (39%) range (25-30) years and (13%) more than 30 years .

Table No (1): Distribution of study group according to their Sex:

Sex	Frequency	Percent
Male	13	19%
Female	57	81%
Total	70	100%

The above table Showed (19%) of nurses male and (81%) of nurses female.

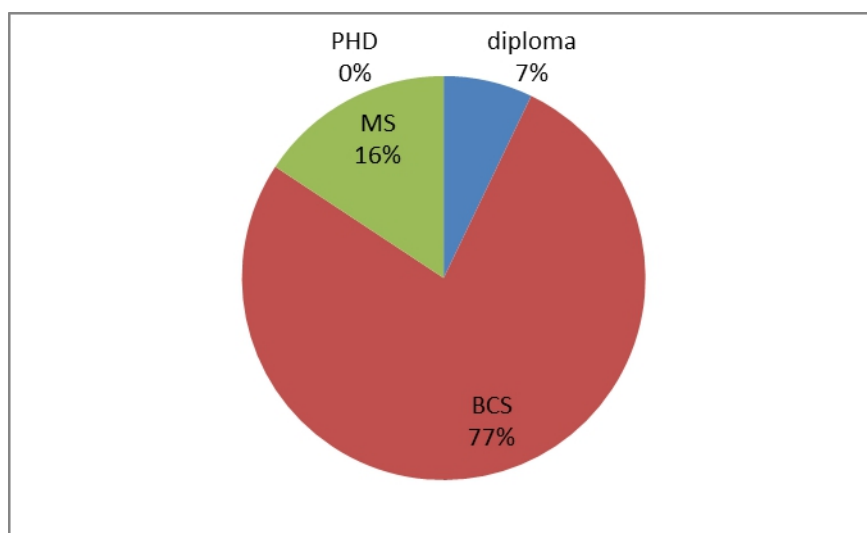


Figure No (2): Distribution of study group according to their qualification.

The above figure Showed (7%) of nurses had diploma, (77%) of nurses had bachelor, (16%) nurses had master and there is no nurses had PHD.

Table No (2): Distribution of study group according to their years of experiences:

Years of experiences	Frequency	Percent
1 – 3 years	43	61%
4 – 7 years	19	27%
8 – 11 years	8	12%
Total	70	100%

The above table Showed (61%) of nurses had (1-3) years of experiences, (27%) of nurses had (4-7) years of experiences and (12%) of nurses had (8-11) years of experiences.

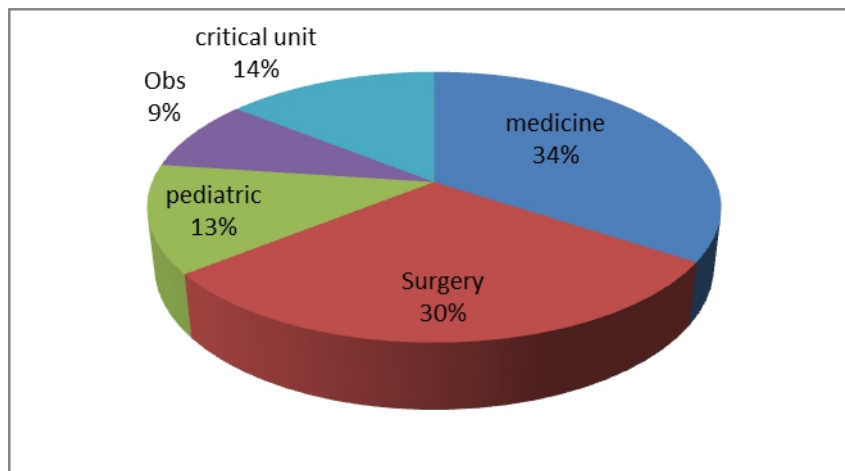


Figure No (3): Distribution of study group according to their department of work.

The above figure Showed (34%) of nurses working in medicine, (30%) of nurses working in surgery, (14%) of nurses working in critical unit, (13%) of nurses working pediatric and (9%) of nurses working in obs.

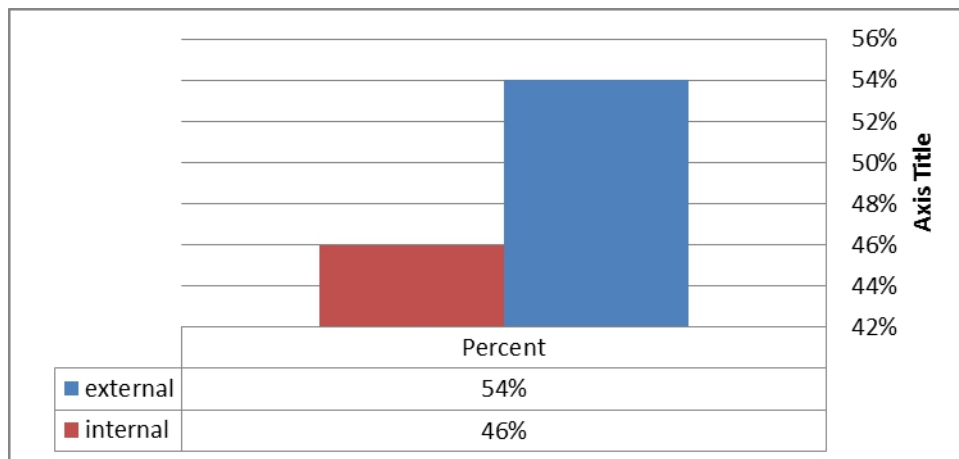


Figure No (4): Distribution of study group according to their knowledge about types of hemorrhoid.

The above figure showed (54%) nurses knowledge of external hemorrhoid and (46%) of internal hemorrhoid.

Table No (3):Distribution of study group according to their knowledge about definition of hemorrhoidectomy.

Definition of hemorrhoidectomy	Frequency	Percent
Good	6	8%
Fair	9	13%
Poor	55	79%
Total	70	100%

The above table showed (8%) of nurses had good knowledge about definition of hemorrhoidectomy (13%) had fair knowledge and (79%) had poor knowledge.

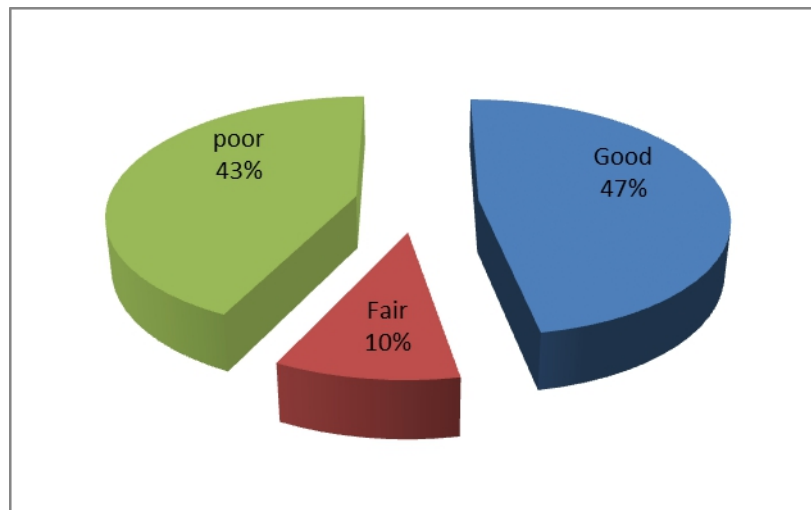


Figure No (5): Distribution of study group according to their knowledge about degrees of hemorrhoid.

The above figure Showed(47%) of nurses had good knowledge about degrees of hemorrhoid, (10%) of had fair knowledge and (43%)and had poor knowledge about degrees of hemorrhoid.

Table No (4): Distribution of study group according to their knowledge about degree of hemorrhoid required Surgery:

Degrees require removal	Frequency	Percent
Good	7	10%
Fair	29	41%
Poor	34	49%
Total	70	100%

The above table showed (10%) of nurses had good knowledge about degree of hemorrhoid required removal (Surgery),(41%) had fair knowledge and (49%) had poor knowledge.

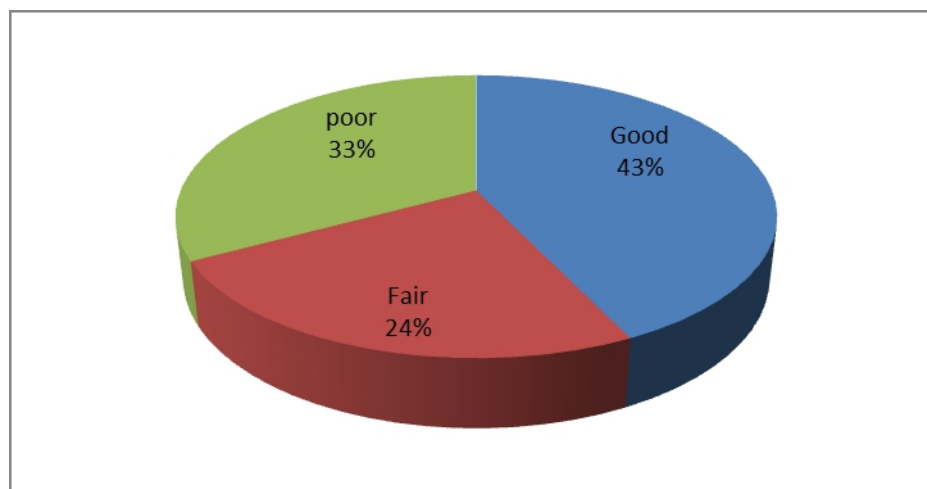


Figure No (6): Distribution of study group according to their knowledge about causes of hemorrhoid.

The above figure showed (43%) of nurses had good knowledge about causes of hemorrhoid, (24%) of nurses had fair knowledge and (33%) of nurses had poor knowledge.

Table No (5): Distribution of study group according to their knowledge about signs and symptoms of hemorrhoid.

Sings and symptom of hemorrhoid	Frequency	Percent
Good	30	43%
Fair	22	31%
Poor	18	26%
Total	70	100%

The above table showed(43%)of nurses had good knowledge about signs and symptoms of hemorrhoid, (31%) of nurses had fair knowledge and(26%)of nurses had poor knowledge.

Table No (6): Distribution of study group according to their knowledge about signs and symptoms of hemorrhoid required surgery.

Sing sand symptom require removal	Frequency	Percent
Good	26	37%
Fair	7	10%
Poor	37	53%
Total	70	100%

The above table showed (37%) of nurses had good knowledge about signs and symptoms of hemorrhoid required removal, (10%) had fair knowledge and (53%) had poor knowledge.

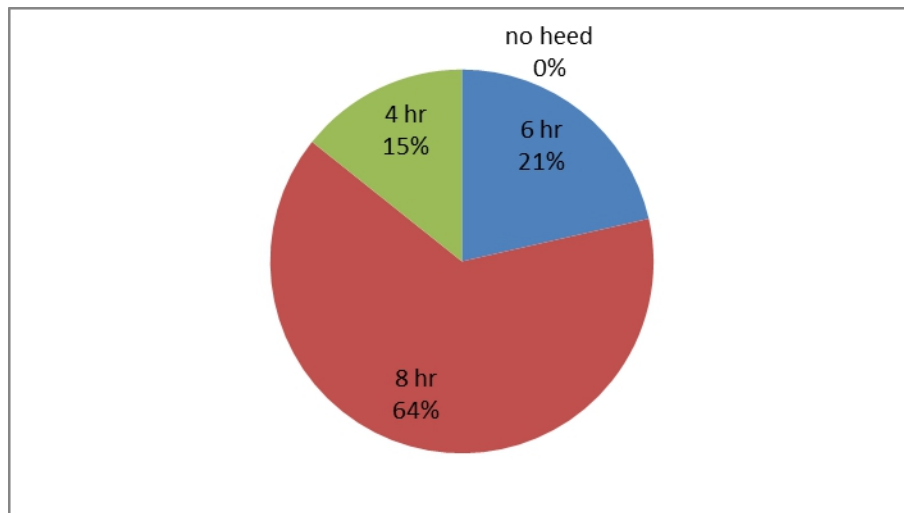


Figure No (7): Distribution of study group according to their knowledge about accurate time of fasting in preoperative period.

The above figure showed (21%) of nurses had knowledge about accurate time patient fasting 6hrs, (64%) had knowledge about accurate time of fasting 8hrs, (15%) had knowledge about accurate time of fasting and 4hrs there is no nurses had knowledge about accurate of fasting no need.

Table No (7): Distribution of study group according to their knowledge about consent form.

Consent form	Frequency	Percent
Nurse	18	26%
Doctor	52	74%
Total	70	100%

The above table showed (26%) of nurses had knowledge about consent form by nurse and (74%) of nurses had knowledge about consent form by doctor.

Table No (8): Distribution of study according to their knowledge about bowel preparation in preoperative period:

Bowel preparation	Frequency	Percent
Good	25	36%
Fair	7	10%
Poor	38	54%
Total	70	100%

The above table showed (36%) of nurses had good knowledge about bowel preparation, (10%) had fair knowledge and (54%) had poor knowledge.

Table No (9): Distribution group according to their knowledge about preoperative teaching.

Preoperative teaching	Frequency	Percent
Good	20	28%
Fair	15	22%
Poor	35	50%
Total	70	100%

The above table showed (28 %) of nurses had good knowledge about preoperative teaching,(22%) had fair knowledge and (50%) had poor knowledge .

(B) Care at the day of operation:

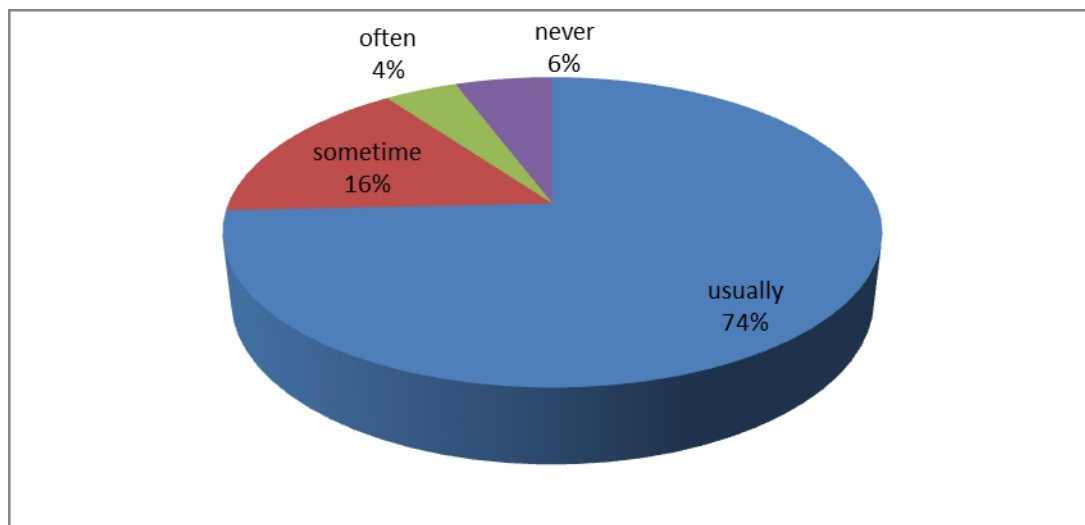


Figure No (8): Distribution of study group according to their knowledge about checking vital signs.

The above figure showed (74%) of nurses had knowledge about vital signs checking usually, (16%) had knowledge about sometime, (4%) had knowledge about often and (6%) had knowledge about never.

Table No (10): Distribution of study group according to their knowledge about assessing urine output.

Last urine output	Frequency	Percent
Usually	31	45%
Sometime	17	24%
Often	5	7%
Never	17	24%
Total	70	100%

The above table showed (45%) of nurses had knowledge about assessing urine output usually, (24%) had knowledge about sometime, (7%) had knowledge about often and (24%) have knowledge about never.

Table No (11): Distribution of study group according to their knowledge about common investigation in preoperative period.

Common investigation	Frequency	Percent
Good	14	20%
Fair	28	40%
Poor	28	40%
Total	70	100%

The above table showed(20%) of nurses had good knowledge about common investigation, (40%)had fair knowledge and (40%) had poor knowledge.

Table No (12):Distribution of study group according to their knowledge about medication should be discontinued.

Medication should discontinued	Frequency	Percent
Aspirin	39	56%
Warfarin	31	44%
Total	70	100%

The above table showed (56%) of nurses had knowledge about aspirin discontinued and (44%) of nurses had knowledge about warfarin discontinued.

Table No (13): Distribution of study group according to their knowledge about wearing gown.

Gown wearing	Frequency	Percent
Usually	52	74%
Sometime	15	21%
Often	2	3%
Never	1	2%
Total	70	100%

The above table Showed (74%) of nurses had knowledge about wearing gown to the patients usually, (21%) had knowledge about wearing gown to patient sometime, (3%) had knowledge about wearing gown to patient often and (2%) had knowledge about wearing gown to patient never.

Table No (14):Distribution of study group according to their knowledge about content of patient file.

Patient file	Frequency	Percent
Good	50	71%
Fair	11	16%
Poor	9	13%
Total	70	100%

The above table showed (71%) of nurses had good knowledge about patient file content, (16%) had fair knowledge and (13%) had poor knowledge.

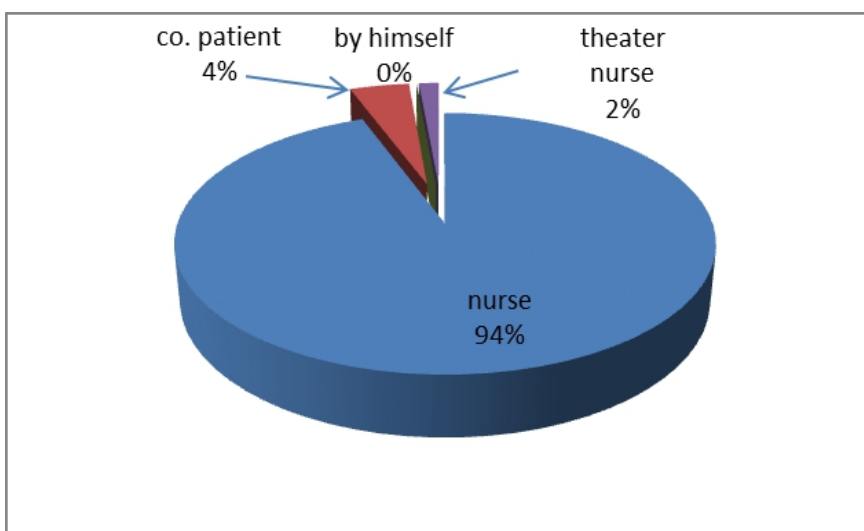


Figure No (9): Distribution of study group according to their knowledge about who transfer patient to operation.

The above figure showed (94%) of nurses had knowledge about transfer patient to operation with nurse,(4%) had knowledge about transfer with co. Patient, (2%) had knowledge about theater nurse and (0%) by himself.

Part 4: Postoperative nursing care of heamorrhoidectomy.

Table No (15): Distribution of study group according to their knowledge about position in postoperative period:

Position	Frequency	Percent
Supine	26	37%
Side lying	40	57%
Semi fowler	4	6%
Semi setting	0	0
Total	70	100%

The above table showed (37%) of nurses had knowledge about patient position is supine,(57%) side lying,(6%) semi fowler and(0%) semi setting .

Table No (16): Distribution of study group according to their knowledge about assessment of consciousness level.

Assess level of consciousness	Frequency	Percent
Usually	52	75%
Sometime	12	17%
Often	3	4%
Never	3	4%
Total	70	100%

The above table showed (75%) of nurses assess level of consciousness usually, (17%) sometime, (4%) often and 4% never.

Table No (17): Distribution of study group according to their knowledge about checking vital signs in postoperative period.

Check vital sings	Frequency	Percent
Usually	53	76%
Sometime	10	14%
Often	3	4%
Never	4	6%
Total	70	100%

The above table showed (76%) of nurses check vital sings usually, (14%) sometime, (4%) often and 6% never.

Table No (18): Distribution of study group according to their knowledge about Checking site of operation:

Check site of operation	Frequency	Percent
Usually	46	67%
Sometime	17	24%
Often	5	7%
Never	1	2%
Total	70	100%

The above table showed (67%) of nurses check site of operation usually, (24%) sometime, (7%) often and (2%) never.

Table No (19): Distribution of study group according to their knowledge about accurate time for starting Medication in postoperative period.

Medication	Frequency	Percent
As prescribe	55	79%
Immediately	12	17%
Alert patient	3	4%
Total	70	100%

The above figure showed (79%) of nurses had knowledge about medication start as prescribe, (17%) immediate and (4%) alert patient.

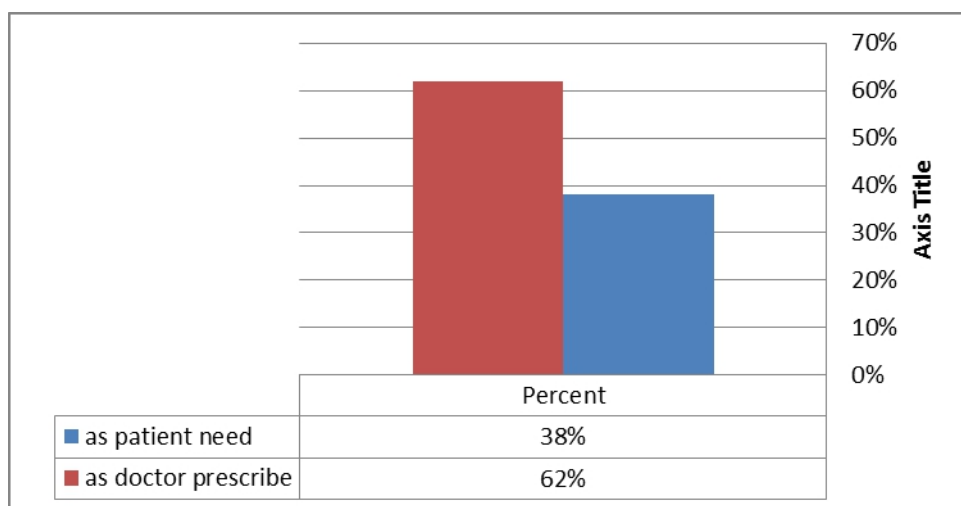


Figure No (10): Distribution of study group according to their knowledge about accurate time of starting diet.

The above figure Showed (38%) of nurses had knowledge about resume normal diet as patient need and (62%) as doctor prescribe.

Table No (20): Distribution of study group according to their knowledge about type of diet should be given after operation.

Diet	Frequency	Percent
Good	12	17%
Fair	19	27%
Poor	39	56%
Total	70	100%

The above table showed (17%) of nurses had good knowledge about taking diet, (27%) had fair knowledge and (56%) poor knowledge.

Table No (21): Distribution of study group according to their knowledge about type of hemorrhoidectomy required warm sit bath .

Warm sit bath	Frequency	Percent
Good	6	9%
Fair	5	7%
Poor	59	84%
Total	70	100%

The above table showed (9%) of nurses had good knowledge about warm sit bath, (7%) had fair knowledge and (84%) poor knowledge.

Table No (22): Distribution study group according to their knowledge about Exercise in postoperative period.

Exercise	Frequency	Percent
Usually	35	50%
Sometime	25	36%
Often	7	10%
Never	3	4%
Total	70	100%

The above table showed(50%) of nurses had knowledge about exercise postoperative done usually, (36%) sometime,(10%) often and(4%) never.

Table No (23): Distribution of study group according to their knowledge about Complication.

Complication	Frequency	Percent
Good	18	28%
Fair	24	34%
Poor	28	40%
Total	70	100%

The above table showed (28%) of nurses had good knowledge about complication, (34%) had fair knowledge and (40%) poor knowledge .

Part 5: home care:

Table No (24): Distribution of study group according to their knowledge about bowel habit.

Bowel habit	Frequency	Percent
As sometime patient	53	76%
On patient need	13	18%
Urgency defecation	4	6%
Total	70	100%

The above table showed (76%) of nurses had knowledge about bowel habits sometime patient, (18%)on patient need and (6%) urgency defecation.

Table No (25): Distribution of study group according to their knowledge about diet:

Diet	Frequency	Percent
Good	22	31%
Fair	13	19%
Poor	35	50%
Total	70	100%

The above table showed (31%) of nurses had good knowledge about diet in home care, (19%) had fair knowledge and (50%) poor knowledge.

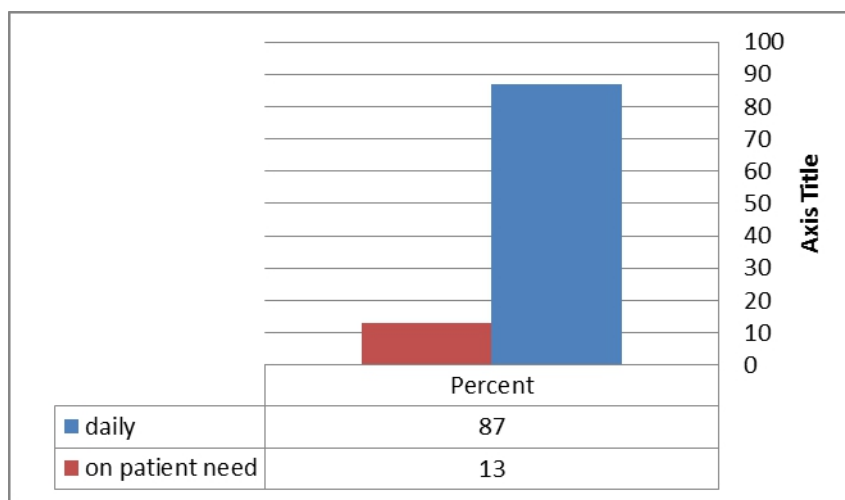


Figure No (11): Distribution of study group according to their knowledge about hygiene.

The above figure showed (87%) of nurses had knowledge about hygiene daily and (13%) on patient need .

Table No (26): Distribution of study group according to their knowledge about bath.

Bath	Frequency	Percent
Good	4	6%
Fair	13	18%
Poor	53	76%
Total	70	100%

The above table showed (6%) of nurses had good knowledge about bath, (18%) had fair knowledge and (76%) had poor knowledge.

Table No (27): Distribution of study group according to their knowledge about precautions.

Precautions of hemorrhoid	Frequency	Percent
Good	45	64%
Fair	12	17%
Poor	13	19%
Total	70	100%

The above table showed (64%) of nurses had good knowledge about precautions of hemorrhoid, (17%) had fair knowledge and (19%) had poor knowledge.

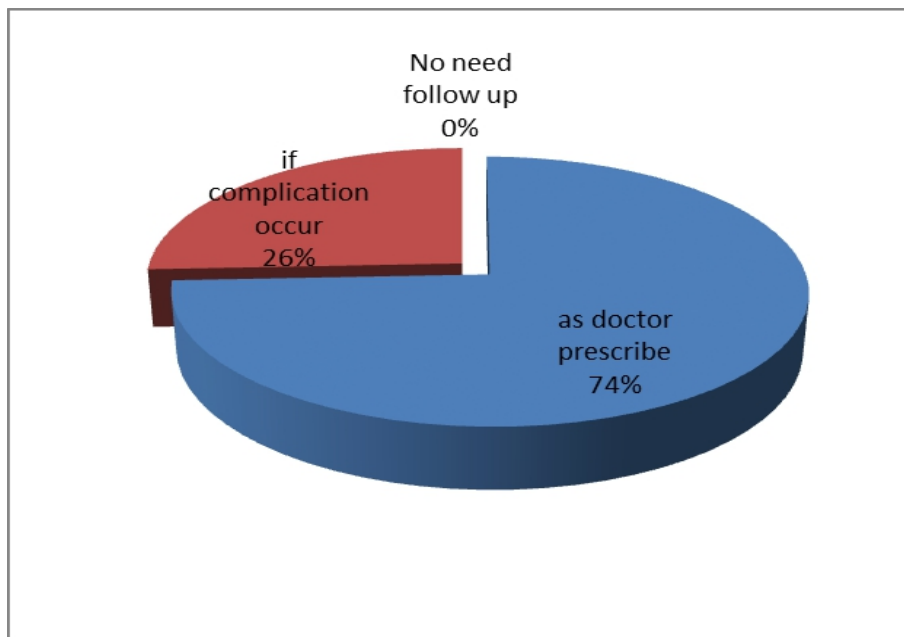


Figure No (12): Distribution of study group according to their knowledge about Follow up:

The above figure showed (75%) of nurses had knowledge about follow up as doctor prescribe,(25%) if complication occur and(0%) no need follow up.

Part 6: Correlation:

Table No (28): Cross tabulation between academic qualification and knowledge about Degree of hemorrhoid:

Academic Qualification		Knowledge about degree of hemorrhoid			Total	p-value
		Good	Fair	Poor		
Diploma	Count	3	0	2	5	.284
	% of Total	4.3%	0.0%	2.9%	7.1%	
BCS	Count	22	7	25	54	
	% of Total	31.4%	10.0%	35.7%	77.1%	
MS	Count	8	0	3	11	
	% of Total	11.4%	0.0%	4.3%	15.7%	
Total	Count	33	7	30	70	
	% of Total	47.1%	10.0%	42.9%	100.0%	

P value 0.284.

Table No(29): Cross tabulation between Years of experiences and Definition of hemorrhoid:

years of experiences		Definition of hemorrhoid			Total	p-value
		varicose vein in the anal canal	Develop when venous .	1+2		
1-3 years	Count	29	5	9	43	.447
	% of Total	41.4%	7.1%	12.9%	61.4%	
4-7 years	Count	9	5	5	19	
	% of Total	12.9%	7.1%	7.1%	27.1%	
8-11 years	Count	4	1	3	8	
	% of Total	5.7%	1.4%	4.3%	11.4%	
Total	Count	42	11	17	70	
	% of Total	60.0%	15.7%	24.3%	100.0%	

P value 0.447.

Table No (30): Cross tabulation between definition of Hemorrhoidectomy and degree of hemorrhoid required Surgery:

hemorrhoidectomy		Degree of hemorrhoid required Surgery			Total	p-value
		Good	Fair	Poor		
Good	Count	1	4	1	6	.139
	% of Total	1.4%	5.7%	1.4%	8.6%	
Fair	Count	2	5	2	9	
	% of Total	2.9%	7.1%	2.9%	12.9%	
Poor	Count	4	20	31	55	
	% of Total	5.7%	28.6%	44.3%	78.6%	
Total	Count	7	29	34	70	
	% of Total	10.0%	41.4%	48.6%	100.0%	

P value 0.139.

5.1 Discussion

This study was done in Elmak Nimer universal hospital in Shendi from August to December 2016, to assess the concept of nurses about performance regarding pre and post-operative nursing care of patient undergoing to hemorrhoidectomy. The data were collected through the questionnaire included in the study 70 nurses. This study confirmed that (48%) of nurses had 20-25 years and most of them were females (81%) and majority of them had bachelor degree (77%), more than half (61%) of study group had 1-3 year of experience . Neither the nurse's knowledge about definition of hemorrhoid was near quarter (24%).

More than half of nurses had knowledge about external hemorrhoid (54%), near half of nurses had knowledge about internal hemorrhoid (46%) internal hemorrhoids affect the venous plexus above the mucocutaneous injection of the anus and external hemorrhoids affect the inferior hemorrhoidal plexus below the mucocutaneous injection ⁽⁷⁾.

The nurses knowledge about degree of hemorrhoid near half (47%) agree with first degree is pain and bleeding, second degree is prolapse spontaneously reduction, third degree is prolapse manual reduction, four the degree is prolapse do not reduction and require surgical reduction ⁽¹⁰⁾.

Near half of nurses had warfarin discontinued (44%) before surgery and more than half of nurses had aspirin discontinued (56%) agree medication that (thin) the blood, including aspirin, are usually discontinued before scheduled surgery and warfarin discontinued at least 3-4 days before surgery ⁽⁸⁾.

Also instead nurses knowledge regard definition of hemorrhoidectomy poor (8%) the knowledge about signs and symptoms of hemorrhoid near half (43%), the study was clarify the knowledge about degree of hemorrhoid require surgery was poor (10%), the signs and symptoms of hemorrhoid require surgery also poor (53%), neither just more than half (54%) nurses had poor knowledge about bowel

preparation, their knowledge about accurate time of fasting in preoperative period was near two third (64%), instead study group had poor knowledge (28%) regard preoperative teaching, near three quarter of nurses had checking vital signs in preoperative period and below half of nurses (45%) assessing urine output.

Neither nurses knowledge about common investigation in preoperative period was poor (20%) but the nurses had knowledge about wearing of gown near three quarter (74%) and content of patient file also near three quarter (71%), and transfer the patient by nurse majority (94%).

This study also confirm the importance of post-operative nursing care by three quarter (75%) of nurses had knowledge about assess the level of consciousness and more than three quarter (76%) had knowledge about checking vital signs usually in postoperative period. More than two third (67%) had checking the operation site and more than half (57%) putting the patient in side lying position. This study clarify more than third (79%) had knowledge about accurate time for starting medication as prescribe in postoperative period and near two third (62%) accurate time of starting diet as doctor prescribed. Poor (17%) of nurses were unknowledgeable about fluidity of diet, also poor (9%) of nurses had knowledge about type of hemorrhoid required sit bath warm. Just half (50%) of study group had teaching the patient about post-operative exercise agree exercise staying active helps to reduce pressure on veins which can occur with long periods of standing or sitting ⁽⁹⁾.

The majority (84%) had good knowledge about hemorrhoid precautions and majority (87%) had the client about hygiene daily.

Also this study clarify that poor (18%) of nurses had knowledge about teaching client about bowel habit, near third (31%) had knowledge about teaching about diet types, and poor (6%) had knowledge about bath in their home, just more than quarter (28%) had observe the complications.

Near three quarter (74%) of nurses had good knowledge about follow up. There was no significant between academic certification and degree of hemorrhoid, p-value 0.05 (0.284).

There was no significant between years of experience and definition of hemorrhoid, p-value 0.05 (0.447).

There was no significant between definition of hemorrhoidectomy and degrees require removal, p-value 0.05 (0.139).

Open excisional hemorrhoidectomy under local anesthesia is feasible, safe and well tolerated in our environment and may encourage early presentation of patients with piles to hospital. ⁽¹⁴⁾

Stapled hemorrhoidectomy is an effective treatment for third and fourth degree hem- Orchids with significant advantages for patients compared with traditional hemorrhoidectomy. ⁽¹⁵⁾

5.2 Conclusion

This study was done throughout to identify the concept about performance of nurses regarding pre and postoperative nursing care of patient under going to hemorrhoidectomy in Elamk Nimer university hospital, this study it was concluded that:

Most of study group had bachelor degree (77%) and most of them work in departments about more than quarter of study group had knowledge about definition of hemorrhoid.

About near half (47%) of study group had good knowledge about degree of hemorrhoid and more than tow third had good knowledge about preoperative nursing care (vital sing (74%), gown done (74%), content of patient file (71%), more than half (54%) had poor knowledge about bowel preparation, more than tow third had good knowledge about postoperative nursing care and performance (assess level of consciousness (75%), check vital sings (76%), accurate time of starting medication (79%).

The majority of study group had good knowledge about patient health teaching for postoperative home care (hygiene (87%), precaution of hemorrhoid (84%).

5.3 Recommendations

Depend on the research result the study recommended to the nurses:

- Identify preoperative teaching for the patient.
- Encourage patient about important of follow up.
- Nurses must encouraged patient to do exercise.
- Nurses must know than the sitz bath can be done for both internal and external haemorrhoid.

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Shendi university

Faculty of graduate of Nursing sciences

Questionnaire about the concept about performance of nurses regarding pre post nursing care of patient under going hemorrhodectomy in Elmak Nimer hospital

Part one: personal characteristic:

1) Age:

a. 20 – 25 years { } b. 25 – 30 years { } c. more than 30 years { }

2) Sex: a. male { } b. female { }

3) Academic certification:

a. Diploma { } b. Bachelor { } c. Master { } d. PDH { }

4) Years of experiences:

a. 1 – 3 years { } b. 4 – 7 years { } c. 8 – 11 years { }

5) Department:

a. medicine { } b. surgery { } c. pediatric { } d. obs { }
e. critical unit { }

Part two: knowledge about heamorrhoidectomy:

6) Definition of hemorrhoid is:

a. varicose vein in the anal canal { }
b. develop when venous return from the anal canal is impaired { }

7) Types of hemorrhoid:

a. external { } b. internal { }

8) Heamorrhoidcomtomy is:

a. removal of varicose vein in anal canal { } b. therapy that can open or closed { }
c. therapy can often be done under local anesthetic { }

9) Degree of hemorrhoid:

a. First degree { } b. second degree { } c. third degree { } d. four degree { }

10) Degree of hemorrhoid required removal (surgery):

a. First { } b. second { } c. third { } d. four { }

11) Causes of hemorrhoid:

a. straining { } b. hard stool { } c. irregular bowel habits { } d. unknown { }

12) Signs and symptoms of hemorrhoid:

a. pain { } b. bleeding { } c. anorectal dysfunction { }

13) Signs and symptoms of hemorrhoid required removal:

a. pain { } b. bleeding { } c. prolapse { }

Part three: (A) preoperative nursing care of hemorrhoidectomy:

14) Fasting:

a. 6 hr { } b. 8 hr { } c. 4 hr { } d. no heed { }

15) Consent form: a. nurse { } b. doctor { }

16) Bowel preparation:

a. enema { } b. fluid diet { } c. Laxative drug { }

17) Preoperative teaching:

a. coughing exercise { } b. breathing exercise { }

c. extremity exercise { } d. pain management { }

(B)Care at the day of operation care:

18) Checking vital signs :

a. usually { } b. sometime { } c. often { } d. never { }

19) Assessing urine output:

a. usually { } b. sometimes { } c. often { } d. never { }

20) Common investigation in preoperative period:

a. straining test { } b. sigmoidoscopy { } c. digital rectal examination { }

d. stool general { }

21) Medication should be discontinued:

a. aspirin { } b. warfarin { }

22) Wearing gown:

a. usually { } b. sometimes { } c. often { } d. never { }

23) Content of patient file:

a. consent form { } b. investigation { } c. documented chart { }

24) Who transfer patient to operation :

a. Nurse { } b. co. patient { } c. by himself { } d. theater nurse { }

Part four: Postoperative nursing care of hemorrhoidectomy:

25) Position:

a. supine { } b. side lying { } c. semi fowler { } d. semi sitting { }

26) Assessment of consciousness level :

a. usually { } b. sometimes { } c. often { } d. never { }

27) Checking vital signs:

a. usually { } b. sometimes { } c. often { } d. never { }

28) Checking site of operation:

a. usually { } b. sometime { } c. often { } d. never { }

29) Accurate time for starting Medication:

a. as prescribe { } b. immediately { } c. alert patient { }

30) Accurate time of starting diet:

a. bowel movement { } b. as patient need { } c. as doctor prescribe { }
d. immediately post-operative { }

31) Type of Diet should be given after operation :

a. fluid diet { } b. semi solid diet { } c. fibers diet { } d. solid diet { }

32) Type of hemorrhoidectomy required warm sit bath:

a. for internal hemorrhoid { } b. for external hemorrhoid { }
c. for both { } d. I don't know { }

33) Exercise in postoperative period:

- a. usually { } b. sometime { } c. often { } d. never { }

34) Complication should observed postoperative:

- a. bleeding { } b. wound infection { } c. anemia { } d. thrombosis { }

Part five: homecare:

35) Bowel habit:

- a. as sometime patient bowel habit { } b. on patient need { }
c. urgency defecation { }

36) Diet:

- a. fluid diet { } b. take fiber diet { } c. take laxative { }
d. take semi-solid { } e. take solid diet { } f. take normal diet { }

37) Hygiene:

- a. daily { } b. on patient need { }

38) Bath:

- a. partial bath { } b. complete bath { } c. avoid continuous sixth bath { }
d. avoid clean site of operation only { }

39) Precautions :

- a. avoid long setting { } b. avoid long standing { } c. elimination straining { }
d. constipation { } e. do exercise { }

40) Follow up:

- a. as doctor prescribe { } b. if complication occur { } c. no need follow up { }