colostomy may be necessary. Furthermore, episodes of acute diverticulitis are often recurrent, and the client may fear future problems.

- Assess and document level of anxiety. Severe anxiety or panic states can interfere with the ability to respond to instructions and assist with care. Low to moderate anxiety levels enhance learning and compliance with prescribed interventions.
- Demonstrate empathy and awareness of the perceived threat to health. It is important to recognize and respect the client’s feelings and perceptions as reality.
- Attend to physical care needs. This provides reassurance that these needs will be met and relieves concerns about them.
- Spend as much time as possible with the client. Presence of a caring nurse helps relieve fears of abandonment or that help will not be available if needed. It also enhances trust and provides opportunity for expression of fears or concerns.
- Assess level of understanding about disease and condition. This allows misperceptions that may contribute to anxiety to be corrected.
- Encourage supportive family and friends to remain with the client as much as possible. This provides a supportive environment for the client and also distracts from physical concerns.
- Assist the client to identify and use appropriate coping mechanisms. Coping mechanisms provide immediate relief of anxiety while the client adapts to the situation.
- Involve the client and family (as appropriate) in care decisions. This increases the client’s sense of control over the situation.

Using NANDA, NIC, and NOC

Chart 24–7 shows links between NANDA nursing diagnoses, NIC (McCloskey & Bulechek, 2000), and NOC (Johnson et al., 2000) when caring for the client with diverticulitis.

### CHART 24–7 NANDA, NIC, AND NOC LINKAGES

#### The Client with Diverticulitis Nursing Diagnoses

<table>
<thead>
<tr>
<th>NURSING DIAGNOSES</th>
<th>NURSING INTERVENTIONS</th>
<th>NURSING OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>• Nutrition Management</td>
<td>• Symptom Control</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>• Bowel Management</td>
<td>• Bowel Elimination</td>
</tr>
<tr>
<td></td>
<td>• Diarrhea Management</td>
<td>• Symptom Severity</td>
</tr>
<tr>
<td>Deficient Knowledge</td>
<td>• Teaching: Prescribed Diet</td>
<td>• Knowledge: Diet</td>
</tr>
<tr>
<td>Pain</td>
<td>• Pain Management</td>
<td>• Comfort Level</td>
</tr>
<tr>
<td>Risk for Deficient Fluid Volume</td>
<td>• Fluid Management</td>
<td>_ Fluid Balance</td>
</tr>
</tbody>
</table>


---

### Nursing Care Plan

#### A Client with Diverticulitis

Roseline Ukoha is a 45-year-old married school teacher who has two children. For the past 2 days, she has experienced intermittent abdominal pain and bloating. The pain increased in severity over the past 9 to 10 hours, and she developed nausea, lower back pain, and discomfort radiating into the perineal region. Mrs. Ukoha reports having had no bowel movement for the past 2 days. The emergency department nurse, Jasmine Sarino, RN, completes her admission assessment.

#### ASSESSMENT

Mrs. Ukoha relates a 10-year history of chronic irritable bowel symptoms, including alternating constipation and diarrhea and intermittent abdominal cramping. She states that she thought these symptoms were due to the stress of teaching middle school, and that they never became severe enough to seek medical advice. When questioned about her diet, she calls it a typical American high-fat, fast-food diet, usually consisting of a sweet roll and coffee for breakfast, a hamburger or sandwich and soft drink for lunch, and a balanced dinner, usually including meat, a vegetable or salad, and potatoes or pasta, “except on pizza night!”

Physical assessment findings include T 101°F (38.3°C), P 92, R 24, and BP 118/70. Abdomen is slightly distended and tender to palpation. Bowel sounds are diminished. Diagnostic tests include the following abnormal results: WBC 19,900/mm³ (normal 3500 to 11,000/mm³) with increased immature and mature neutrophils on differential; hemoglobin 12.8 g/dL (normal 13.3 to 17.7 g/dL); hematocrit, 37.1% (normal 40% to 52%). Abdominal X-ray films show slight to moderate distention of the large and small bowel with suggestion of possible early ileus. A small amount of free air is noted in the peritoneal cavity.

The diagnosis of probable diverticulitis with diverticular rupture is made, and Mrs. Ukoha is admitted to the medical unit for intravenous fluids, antibiotic therapy, and bowel rest.
**ANORECTAL DISORDERS**

Anorectal lesions include hemorrhoids, a normal condition common to all adults that may become enlarged and painful; anal fissure; anorectal fistulas; anorectal abscess; and pilonidal disease. Fecal incontinence also may be considered an anorectal disorder.

**THE CLIENT WITH HEMORRHOIDS**

The anus and anal canal contain two superficial venous plexuses with the hemorrhoidal veins. When pressure on these veins is increased or venous return impeded, they can develop varices, or varicosities, thus becoming weak and distended. This condition is commonly known as hemorrhoids, or piles. When asymptomatic, hemorrhoids are considered to be a normal condition found in all adults.

**PATHOPHYSIOLOGY**

Hemorrhoids develop when venous return from the anal canal is impaired. Straining to defecate in the sitting or squatting position increases venous pressure and is the most common