Case Study:

Samantha Custodio: Digestive Disorder

As the mother of four young boys ages 1 to 10, Samantha Custodio didn't have time to be sick. But last fall, there she was, sidelined with severe abdominal pain, diarrhea, bleeding, and stomach cramps.

"I couldn't go anywhere without the constant fear that I would be struck with sudden severe twisting in my guts," says the Milton, Pa., resident. "I was miserable. My husband — who's an emergency nurse— and I both thought it was food poisoning."

Her primary care doctor thought so, too. But after weeks of testing for bacteria, parasites, and infection — which were all negative — she was referred to a gastroenterologist.

Samantha felt relieved.
"I was so sick for so long. All I wanted were answers," she says. "I felt confident a specialist could help."
At her first appointment with the gastroenterologist, Samantha described her symptoms and reviewed her history with the doctor.

"She was amazing. Before doing any tests, the doctor suspected she knew what it was," says Samantha.
Two days later, the doctor performed a colonoscopy procedure that confirmed her suspicions. Samantha had ulcerative colitis, an inflammatory bowel disease that causes inflammation and ulcers in the lining of the large intestine or colon. There is no cure for ulcerative colitis, but medicine can help. Samantha was immediately prescribed medication to calm the inflammation and allow the tissue to heal. Within days, her symptoms began to subside. "I felt so much better," she says.

Samantha continues to see the doctor every three to four months for careful management of her disease.
"Now that it's diagnosed and being managed properly, everything has changed," she adds. "I can take long walks with the kids, go bike riding, shopping — without any worry."

Bowel elimination is an essential function for the human body. Clients are often embarrassed about needing help with these functions.

Reflect on ways you can help your client (Samantha) to be more comfortable accepting help while getting their needs met. What could you say? What could you do?

To help Samantha, I will educate that bowel elimination is a normal part of the human experience and that it is a natural process. I would provide privacy and listen attentively and actively. Encouragement to seek help through support groups, dieticians, and family and friends. Regular checkups with her primary care doctor and gastroenterologist should be encouraged to maintain adequate health promotion and to monitor ulcerative colitis progression. Also, the checkup can be used to make sure that the medication regimen is controlling the inflammation, or if there need to be any adjustments made to ensure adequate control. Living with ulcerative colitis is a challenge, but it is not impossible. As Samantha said in the last paragraph, she is now able to be active in her life and her family's life without any worry thanks to her careful management and being proactive in avoiding activities or foods that would

cause flare-ups. Encouragement and support are needed to allow Samantha to be more comfortable with her diagnosis going forward.

Disorders of Absorption and Elimination

Match the term with the definition.

1. Colonoscopy **H** ~~A. An incarcerated hernia whose blood supply has been cut off leading to tissue death~~
2. Peritonitis **K** ~~B. Age 40 and up; IBD; genetics; high fat, high protein, low fiber diet; polyps~~
3. Irreducible hernia **A** ~~C. Increase fiber & fluids; stool softener; Sitz bath~~
4. Irritable bowel syndrome (IBS) **T** ~~D. Swollen, twisted, varicose veins in the rectal region~~
5. Bowel obstruction types **G** ~~E. Inflammation of the appendix~~
6. Ulcerative colitis s/s **I** ~~F. Inflammation of the diverticula~~
7. Non-mechanical bowel obstruction treatment **C** ~~G. Mechanical or paralytic~~
8. Diverticulitis **F** ~~H. Examination of the colon using a flexible scope~~
9. Diverticulitis Treatment **P** ~~I. Bloody diarrhea, pain, weight loss~~
10. Appendicitis (definition) **E** ~~J. RLQ pain, low grade fever, nausea, rebound tenderness~~
11. Appendicitis S/S **J** ~~K. Can be fatal if not treated promptly~~
12. Colon cancer risk factors **B** ~~L. GI rest; NPO; ambulate; IV fluids~~
13. Colon cancer screening **X** ~~M. Worms in GI tract~~
14. Large bowel obstruction s/s **Q** ~~N. Surgical adaption to waste removal~~
15. Dehydration S/S **V** ~~O. Cannot be returned to its organic region via manual manipulation~~
16. Hemorrhoids **D** ~~P. I.V. antibiotics, opioids for severe pain, stool softeners and bulk forming laxatives~~
17. Ostomy **N** ~~Q. wavelike abdominal pain & fecal vomiting~~
18. Hemorrhoidectomy considerations **L** ~~R. Surgical removal of all or part of the colon~~
19. Small bowel obstruction s/s **U** ~~S. Highly transmissible spore containing diarrhea~~
20. Strangulated hernia **O** ~~T. Periodic disturbances of bowel function, usually associated with abdominal pain~~
21. Causes of IBS **W** ~~U. Gradual onset; pain; vomiting; distention; bowel sounds present then become hypoactive~~
22. Hernia **Y** ~~V. Dry mucous membranes; Lower urine output and concentrated; Weakness; Hypotension~~
23. C-Diff **S** ~~W. Factors include heredity, stress, high-fat diet, irritating foods, alcohol, and smoking use~~

24. Colectomy **R** ~~X. Ages 50-75; fecal occult blood test annually ; Colonoscopy q10y~~

25. Parasitic infections **M** ~~Y. Protrusion of the intestine through a weakness in the abdominal wall~~