



N321 Care Plan

Lakeview College of Nursing

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N321 Adult Health I

Professor Krystal Henry

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Demographics (3 points)

Date of Admission 9/24/23	Client Initials K.S.	Age 30	Gender Male
Race/Ethnicity African American/Black	Occupation Unemployed	Marital Status Single	Allergies None per patient
Code Status Full Code	Height 165.1 cm	Weight 64 kg	

Medical History (5 Points)

Past Medical History: Anxiety, HIV

Past Surgical History: Hernia repair 2014, has had wisdom teeth removed but doesn't know the dates.

Family History: Father deceased, unknown. Mother has history of epilepsy in her family. No brothers. 3 sisters with unknown medical problems. Patient has no children.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

Patient denies ever smoking, alcohol or drugs.

Assistive Devices: no assistive devices.

Living Situation: Prior to being incarcerated the patient states that he lived alone in an apartment.

Education Level: The highest level of education is 11th grade.

Admission Assessment

Chief Complaint (2 points): Lower abdominal pain.

History of Present Illness – OLD CARTS (10 points): Client states that he had lower abdominal pain for 1 week prior to hospitalization. He states that it was consistent pain that was not relieved by rest or activity. He states he was given medication for constipation at the jail a

few days before he was hospitalized. He states his pain was a 5 out of 10 on a 1-10 pain scale. He has not had a bowel movement for approximately 5 days.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Appendicitis

Secondary Diagnosis (if applicable): with abscess

Pathophysiology of the Disease, APA format (20 points): see attached.

Pathophysiology References (2) (APA):

Britannica, T. Editors of Encyclopedia (2023, August 14). *appendix*. *Encyclopedia Britannica*.

<https://www.britannica.com/science/appendix>

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Pruthi, S. (2023, August 18). *Appendicitis*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/appendicitis/symptoms-causes/syc-20369543>

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40-5.80 (10) ⁶ /mcl	4.97 (10) ⁶ /mcl	4.32 (10) ⁶ /mcl	Decreasing red blood cell count may be due to rupture of abscess (Pagana et. al., 2020)
Hgb	13.0-16.5 g/dL	15.0 g/dL	13.3 g/dL	
Hct	38.0-50.0 %	44.7%	39.2%	
Platelets	140-440 10(3)/mcL	253 10(3)/mcL	235 10(3)/mcL	
WBC	4.00-12.00 10(3)/mcL	12.60 10(3)/mcL	10.20 10(3)/mcL	Increased white blood cells may be due to increasing infection related to appendicitis (Pagana et. al., 2020)

Neutrophils	40.0-68.0%	82.3%	79.3%	High neutrophil count coincides with infection (Pagana et. al., 2020)
Lymphocytes	19.0-49.0%	7.8%	8.1%	Decreased lymphocytes may be due to late stages of HIV infection (Pagana et. al., 2020)
Monocytes	3.0-13.0%	9.2%	11.2%	
Eosinophils	0.0-8.0%	0.4%	1.0%	
Bands	0-5%	n/a	n/a	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145 mmol/L	134 mmol/L	132 mmol/L	Decrease in sodium may be due to intraluminal bowel obstruction related to appendicitis (Pagana et. al., 2020)
K+	3.5-5.1 mmol/L	4.7 mmol/L	4.3 mmol/L	
Cl-	98-107 mmol/L	98 mmol/L	103 mmol/L	
CO2	22-30 mmol/L	24 mmol/L	23 mmol/L	
Glucose	70-99 mg/dL	80 mg/dL	87 mg/dL	
BUN	9-21 mg/dL	10 mg/dL	8 mg/dL	Decreasing BUN levels are in conjunction with protein in the urine, related to appendicitis. (Jones et. al., 2023)
Creatinine	0.70-1.30 mg/dL	1.29 mg/dL	1.12 mg/dL	
Albumin	3.5-5.0 g/dL	4.4 g/dL	3.8 g/dL	
Calcium	8.7-10.5 mg/dL	9.9 mg/dL	8.9 mg/dL	
Mag	1.6-2.6 mg/dL	n/a	2.0	
Phosphate	2.5-4.5 mg/dL	n/a	n/a	
Bilirubin	0.2-1.2	1.8 mg/dL	1.2	Elevated level on admission

	mg/dL		mg/dL	coincides with ruptured abscess (Pagana et. al., 2020)
Alk Phos	40-150 U/L	67 U/L	64 U/L	
AST	5-34 U/L	11 U/L	16 U/L	
ALT	0-55 U/L	8 U/L	8 U/L	
Amylase	40-140 U/L	n/a	n/a	
Lipase	10-140 U/L	n/a	n/a	
Lactic Acid	2-4 mmol/L	n/a	n/a	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	2.0-3.0	n/a	n/a	
PT	10-13 seconds	n/a	n/a	
PTT	25-35 seconds	n/a	n/a	
D-Dimer	<0.50 ng/mL	n/a	n/a	
BNP	<100 pg/mL	n/a	n/a	
HDL	>40 mg/dL	n/a	n/a	
LDL	<100 mg/dL	n/a	n/a	
Cholesterol	<200 mg/dL	n/a	n/a	
Triglycerides	<150 mg/dL	n/a	n/a	
Hgb A1c	<5.7%	n/a	n/a	
TSH	0.4-4.0 mIU/L	n/a	n/a	

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Clear, yellow	Yellow	Yellow	
pH	5.0-9.0	6.0	6.0	
Specific Gravity	1.003-1.030	>1.030	>1.030	Related to protein in the urine associated with appendicitis (Jones et. al., 2023)
Glucose	Negative	Negative	Negative	
Protein	Negative	1+	1+	This is an expected finding in appendicitis (Jones et. al., 2023)
Ketones	Negative	3+	3+	This is an expected finding in appendicitis (Jones et. al., 2023)
WBC	Neg 0-5/hpf	0-5/hpf	0-5/hpf	
RBC	Neg 0-2/hpf	0-2/hpf	0-2/hpf	
Leukoesterase	Negative	Negative	Negative	

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	n/a	n/a	
Blood Culture	Negative	n/a	n/a	
Sputum Culture	Negative	n/a	n/a	
Stool Culture	Negative	n/a	n/a	

Lab Correlations Reference (1) (APA):

Jones, M. W., Lopez, R. A., & Deppen, J. G. (2023). *Appendicitis - statpearls - NCBI bookshelf*.

National Library of Medicine. <https://www.ncbi.nlm.nih.gov/books/NBK493193/>

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT abdomen/pelvis with contrast-results showed a ruptured abscess; EKG-NSR

Diagnostic Test Correlation (5 points): CT scan is usually performed with a diagnosis of appendicitis to visualize the tissue and any rupture or perforation (Pagana et. al., 2020)

An EKG is performed to rule out chest problems, maybe the patient was anxious in the emergency room, but did not specify in the interview.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Current Medications (10 points, 1 point per completed med) *10 different medications must be completed*

Home Medications (5 required)

Brand/ Generic	Tylenol/ Acetaminophen	TUMS/ Calcium Carbonate	Dilaudid/ Hydromorphone	Toradol/ Ketorolac	Milk of Magnesia/Ma gnesium Hydroxide
Dose	650 mg	1000mg	0.5 mg	15 mg	400mg/5 ml
Frequency	Every 4 hours/PRN	Every 8 hours/PR N	Every 4 hours, PRN	Every 6 hours/PRN	Daily/PRN
Route	oral	Oral	IV	IV	Oral suspension
Classificati on	Nonsalicylate/ nonopioid analgesic	Calcium salts/antac id	Opioid; opioid analgesic	NSAID; analgesic	Mineral; electrolyte replacement
Mechanism of Action	Stops cyclooxygenase	Increases calcium	Binds with spinal cord	Reduces inflammatio	As an antacid this drug

	enzyme which blocks prostaglandins from producing pain impulse.	levels in the blood to affect homeostasis, may also buffer stomach acid and decrease pain	opioid receptors to block pain stimulus.	n and pain associated with prostaglandin production	reacts with gastric fluid and increases the pH.
Reason Client Taking	Reduce abdominal pain from appendicitis	Attempt to reduce abdominal pain	abdominal pain from appendicitis.	Reduce abdominal pain from appendicitis	Attempt to reduce abdominal pain
Contraindications (2)	Patients with liver disease; liver impairment	Renal calculi/kidney stones, symptoms of ventricular fibrillation	Acute asthma; GI obstruction	Active peptic ulcer disease; renal impairment	Diverticulitis; acute abdominal problem; fecal impaction
Side Effects/Adverse Reactions (2)	Liver toxicity; Stevens-Johnson syndrome	Hypotension, hypercalcemia	Respiratory depression, laryngeal edema, or spasms	High risk for bleeding; may cause anemia	Arrhythmia; respiratory depression
Nursing Considerations (2)	Monitor liver and renal function for long-term use; calculate total levels from all drugs so patient doesn't go over daily dose.	Monitor serum calcium levels, assess for Chvostek and Trousseau's signs	Assess for decreasing respirations, remember that this drug is highly addictive	Do not give to patient with a recent MI or heart failure; drug can cause fluid retention.	Assess for hypermagnesemia, low blood pressure, dyspnea, decrease DTR; not for long-term use

Hospital Medications (5 required)

Brand/ Generic	Bictgravir-emtricitabin	Lovenox/enoxaparin	Pepcid/famotidine	Zosyn/piperacillin-	0.9% NaCl Solution
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	e- tenofovir			tazobactam	
Dose	50-200-25 mg tablet	40 mg	20mg/2ml	3.375 g in 0.9% NS 100ml	Continuous 100ml/hr
Frequency	daily	Daily	2 times a day	Every 8 hours	continuous
Route	oral	Sub q injection	IV	IVPB	IV
Classification	Nucleoside analog; antiretroviral	Low-molecular weight Heparin; anticoagulant	Histamine-2 blocker; antiulcer agent	Beta lactamase inhibitor; antibiotic	Isotonic IV solution
Mechanism of Action	Stops activity of HIV-1 virus in the DNA	Stops clotting factor Xa and thrombin in clotting cascade	Helps prevent or heal peptic ulcers in the GI tract	Fight bacterial infection in the body	Has the same tonicity as blood and does not cause fluid shift
Reason Client Taking	History of HIV	To prevent DVT while admitted due to decreased mobility	Healing possible ulcers related to appendicitis	Appendicitis	Administering fluid and IV medication
Contraindications (2)	Liver problems, pregnancy	Active major bleeding; allergy to pork products	Phenylketonuria; difficulty swallowing or active vomiting	Penicillin allergy; kidney disease	Hypervolemia ; edema
Side Effects/Adverse Reactions (2)	Worsening renal impairment; neutropenia	Bleeding; anaphylaxis	May cause Seizures or hepatitis	Hives; seizure; low WBC count	n/a
Nursing Considerations (2)	Test patient for Hep B before administering; monitor liver enzymes	Monitor for signs of bleeding; Instruct patient to reduce risk for bleeding	Assess whether the patient is treating a malignancy; drug contains aspartame may cause phenylketonuria	Educate client to take full dose; discard unused med after 24 hours	Assess vitals, monitor labs for signs of excess fluid retention and electrolytes

Medications Reference (1) (APA):

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.). F.A. Davis Company.

Comerford, K. C., & Durkin, M. T. (Eds.). (2023). *Nursing2023 drug handbook*. Wolters Kluwer.

Multum, C. (2022). *Prescription drug information*. Drugs.com. <https://www.drugs.com/>

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and oriented to person, place, time, and situation x 4. No apparent distress Appears appropriately dressed and responds adequately to verbal stimuli, no painful stimuli administered.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color brown, no apparent abnormalities. Warm, dry, intact. No presence of bruising, rashes, or wounds. Skin turgor normal mobility. Braden score: 22, no risk for pressure ulcer development No drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck are symmetrical. Ears symmetrical, no visual signs of deformities, or wounds. Eyes bilateral sclera is white, clear corneas, pink conjunctiva, no drainage. PERRLA. Nose septum is midline, no signs of drainage or swelling. .</p>
<p>CARDIOVASCULAR: Heart sounds:</p>	<p>Clear S1 and S2 without murmurs, gallops or rubs.</p>

<p>S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Peripheral pulses 3 + bilaterally Capillary refill < 2 seconds bilaterally No neck vein distention No edema present</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respiration is regular, non-labored, normal rhythm and rate. Breath sounds clear No accessory muscle use No ET Tube present</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Bowel sounds active in all 4 quadrants upon auscultation. Current diet is regular, no special diet Height: 65 inches Weight: 140 lbs. Last BM: 4 days ago; 9/20/23; patient states that this is abnormal for him, usually has BM every other day. Patient states that he is constipated. Pain 2/10 upon palpation, just given Dilaudid for pain. No signs of distension, bloating, scars, drains, or wounds No presence of ostomy No nasogastric tube No feeding/PEG tubes</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Urine color yellow, diluted, clear. Patient had 1450 ml output of urine during PM shift.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM:</p>	<p>All extremities have active full range of motion. Unable to assess gait due to incarceration and</p>

<p>Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>pain 2/10. Patient was just given Dilaudid, he was previously experiencing 5/10 pain.</p> <p>Fall score: 4, no risk for falls.</p> <p>Patient is independent, no need for assistance to ambulate</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient moves all extremities well.</p> <p>PERRLA assessed.</p> <p>Strength is equal in all extremities bilaterally 5+</p> <p>Oriented x 4</p> <p>Mental status is appropriate. Speech is appropriate. No sensory disturbance verbalized by patient. No LOC.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>The patient states that he has a therapist he talks to about problems with coping. Developmental level is intimacy versus isolation. Does not follow a religion. Does not state that he is close with his family members for support.</p>

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1313	86	126/79	16	99.6 F temporal	95%
1500	85	124/81	16	99.1 F temporal	96%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

1313	number	Abdomen	5/10	Throbbing	Administer Dilaudid IV
1700	Number	Abdomen	5/10	Dull	Administer Dilaudid IV

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	20 Guage Right antecubital 9/24/2023 Patent No signs of erythema, drainage, swelling or coolness IV dressing transparent, clean, and dry

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
900 ml 0.9% NS + 275 ml water intake + 100 ml IV Zosyn= 1275 ml	375 ml urine+ 475 ml urine + 625 ml urine= 1450 ml

Nursing Care

Summary of Care (2 points)

Overview of care: Upon arrival to shift patient was complaining of chest pain, after assessment with nurse it was determinately due to the administration of Dilaudid. The doctor was initially called, but the patient cancelled the consultation. Patient cooperated during the physical exam and answered questions appropriately. He did not complain of pain during that time.

Procedures/testing done: no testing performed during shift.

Complaints/Issues: Patient complained of constipation and not having an appetite.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Not tolerating diet due to loss of appetite, unable to perform activities due to incarceration and bed rest for appendicitis.

Physician notifications: The physician was initially notified of complaint of chest pain, but the patient decided not to consult with the doctor.

Future for client: The client may undergo surgery to remove the abscessed appendix, or he may continue to be treated with IV antibiotics until his infection clears up. He will stay in the hospital until he is stable.

Discharge Planning (2 points)

Discharge location: The patient will discharge back to the jail where he is currently incarcerated.

Home health needs (if applicable): not applicable.

Equipment needs (if applicable): not applicable.

Follow up plan: Patient will follow up with the medical staff at the jail if he continues to feel pain or worsening conditions.

Education needs: Patient may need education on continuing antibiotic treatment for the fully prescribed treatment even if symptoms are not present.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
1. Risk for infection as evidenced by ruptured abscess on CT scan	Patient is at risk for infection due to a ruptured abscess and underlying HIV which would make him more immunocompromised.	1. Assess vital signs, abdominal pain, distention, nausea/vomiting	1. Patient will not show signs of increasing infection.	The patient did not show increasing signs of infection during physical assessment.

		2. Administer antibiotics IVPB as prescribed		IVPB antibiotics hung at 1700
2. Acute pain related to infectious process as evidenced by abdominal pain and increased WBC.	It is important to manage a patient’s pain to further assess signs of infection and keep him comfortable and cooperative.	1. Assess patient pain and quality, OLDCARTS 2. Administer pain medication as prescribed	1. Patient will verbalize a decrease in pain	Patient states that he does not have pain after administering Dilaudid at 1300 and 1700.
3. Constipation related to limited physical activity as evidenced by bowel movement > 4 days.	Constipation may be an underlying cause of appendicitis and subsequent rupture, may need education on how to manage his bowels.	1. Assess bowel sounds in all 4 quadrants for motility. 2. Educate patient about constipation related to frequency, diet, and activity.	1. Patient will verbalize understanding regarding constipation and increase hydration and activity when tolerated.	The patient verbalized understanding about what helps relieve constipation including drinking more water, eating more fiber, and increasing his activity when he can.

Other References (APA):

Anny, M., Daswani, M., Rn, T. J., Cuthbertson, K., Janet, A. I., Balaswamy, C. V., Vera, M., Rizwan, M., Sheriff, S., Rashid, M., BNSC, H. Y. R., Omolara, B. O., jompol, P., idachaba, T., Muleta, B., Kanjanapiroj, J., Tambuwal, M. I., Nchagakie, C., opeyemi, O., Delorino, A. (2023, July 30). *Nursing diagnosis ultimate guide: Everything you need to know*. Nurseslabs. <https://nurseslabs.com/nursing-diagnosis/>

Concept Map (20 Point)

Patient states that he had abdominal for about 1 week prior to coming to the emergency room, he was given acetaminophen, TUMS, and milk of magnesia to manage his pain in the jail. He rated his pain as 5/10 that did not get better with rest or activity.

1. Risk for infection related to appendicitis as evidenced by ruptured abscess on CT scan.
 - Patient will not show signs of increasing infection.
2. Acute pain related to infectious process as evidenced by abdominal pain and increased WBC.
 - Patient will verbalize a decrease in pain.
3. Constipation related to limited physical activity as evidenced by bowel movement > 4 days.
 - Patient will verbalize understanding regarding constipation and increase hydration and activity when tolerated.

Vitals: BP- 124/81
 Pulse: 85
 Resp: 16
 Oxygen: 96%
 Temp: 99.1 F temporal
 Pain: 5/10
 CT Scan: ruptured abscess

30-year-old male with lower abdominal pain for 1 week admitted for appendicitis with ruptured abscess. He has a history of HIV and anxiety. He also complains of constipation.

1. Assess vital signs, abdominal pain, distention, nausea/vomiting
2. Administer antibiotics IVPB as prescribed
3. Assess patient pain and quality, OLDCARTS
4. Administer pain medication as prescribed.
5. Assess bowel sounds in all 4 quadrants for motility.
6. Educate patient about constipation related to frequency, diet, and activity.

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Appendicitis

The appendix is a small pouch that hangs off the cecum, which is the beginning of the large intestine, where the small intestine ends. Its purpose is still unknown (Britannica, 2023). Appendicitis is a common inflammatory condition of the large intestine that is caused by a blockage of indigestible contents that limits the blood supply to the tissue, causing pain, or which bacteria accumulate and cause an infection (Capriotti & Frizzell, 2020).

Signs and symptoms are sudden right lower abdominal pain, pain that becomes worse when moving or coughing, nausea, vomiting, fever, bloating, and loss of appetite (Pruthi, 2023). The patient may display signs of guarding the abdomen due to pain, or rebound pain after palpation (Pruthi, 2023). Psoas and obturator tests can be performed during assessment to rule out appendicitis (Capriotti & Frizzell, 2020). The patient complained of persistent abdominal pain that was not relieved by rest.

Diagnostic testing such as complete blood count (CBC) will show an elevated leukocyte count to 20,000 mcl due to infection (Britannica, 2023). A c-reactive protein (CRP) lab will show inflammation in the body. A computerized tomography (CT) scan, x-ray, or abdominal ultrasound may be performed to visualize any obstruction of the tissue (Pruthi, 2023). The CBC drawn for the patient showed slightly increased white blood cells on admission. A CT scan was performed on the patient, which finalized the diagnosis of appendicitis due to an image of a ruptured abscess in the lower right abdominal cavity.

Treatment for appendicitis includes antibiotics, IV fluid, monitoring the patient for peritonitis, and surgically removing the appendix (Capriotti & Frizzell, 2020). The patient was given antibiotics through IV piggyback as well as Dilaudid to manage his pain. He was not scheduled for surgery yet.