EUROPEAN JOURNAL OF BIOMEDICAL AND PHARMACEUTICAL SCIENCES
http://www.ejbps.com

ISSN 2349-8870
Volume: 5
Issue: 8
179-180
Year: 2018

CROHN DISEASE OR REGIONAL ILEITIS

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Article Received on 27/05/2018 **Article Revised on 16/06/2018** **Article Accepted on 05/07/2018**

ABSTRACT
Crohn disease is a chronic debilitating inflammatory disease of the gastro intestinal tract. It can affect any part of the digestive tract from the mouth to the anus but usually involves the terminal part of the ileum and ileocecal region. Perianal region is commonly affected. The disease like ulcerative colitis is characterized by relapses and remissions. The inflammatory process often starts in the lining mucosa and progresses through the various layers of the intestine (trans mural inflammation) initially. There are small aphthoid ulcers at the sites of intense inflammation and spreads to become but are usually separated by areas of relatively healthy tissue with little or no inflammation (cobble stone appearances).

KEYWORD: connective tissue, Entro cutaneous fistula, multisystem, inflammation

INCIDENCE AND ETIOLOGY

Crohn disease though a disease of the west, has shown a steady increase in recent times in India, more in south India than north India. The disease affects all age groups but is commonly seen between 15-30 yrs. and rarely. Crohn disease is slightly more common among men than women. In general, the prevalence is higher in Urban areas than in Rural areas. It is also in upper socioeconomic states.

ETIOLOGICAL FACTORS

The Aetiogy is Unknown
- Smoking
-Genetic: -1 in 7 patients have a relative with the illness Chromosomes 3,7 and 12 disorders
-Infective:-
Mycobacterium Tuberculosis,E.coli, Viruses eg.Measles post infective bacteria, clostridium,Bacteroids (Gram –ve bacteria).

ENVIRONMENTAL FACTORS

Poor hygiene, parasites infestation, some antibiotics, Refrigerated diet, vaccines, tobacco, vit. D, deficiency, vaccines, tobacco.
Clinical Manifestations:- It is charecterised by.
-Diarrhea with abdominal cramp.
-Abdominal pain usually in right lower abdomen.
-Fever, malaise & easy fatigability.
-Growth failure.
-Amenorrhea pubertal delay.
-perianal disease(tags,fistula,Abcess).
-It gastric or duodeninal involvement may be associated with recurrent vomiting & epigastric pain.
-Partial small bowel obstruction caused by narrowing of the bowel lumen from inflammation or stricture.
-Inflammation cause penetrating the intestinal tract this may cause fistula formation (between bowel and urinary bladder, entro cutaneous fistula (between bowel and abdominal skin).

EXTRA INTESTINAL MANIFESTATIONS

-Stomatitis, peripheral arthritis, Erythma nodosum, digital glubbing, renal stones, gallstones, steatorihroea.

DIAGNOSTIC FINDING

Physical examination –Rt.lower quadrant pain,weight loss, often malnourished.

Complete blood count
- Demonstrates anemia
-ESR Elevated or normal, elevated platelet count
-WBC Count maybe used
-If albumin decreased – indicating small bowl inflammation

Radiologic & Endoscopic studies
Esophagogastroduodenoscopy & ileocolonoscopy – visualize the upper GIT, Terminal item & entire colon.
colonoscopy – Finding any patchy, specific inflammatory changes, vascular pattern, ulcers nodularity, strictures.

Biopsy - nonspecific chronic inflammatory changes & trans mural granulomas (small sound out growth made up of small blood vessel & connective tissue).

Plain films – finding small bowl obstructions.
-Upper GI contrast study – showing ulceration & blister on the mucus membrane & thickened modular folds as well as narrowing or structuring of the lumen (cobble stone appearance) CT scan & MRI – Finding the intestinal wall thickening of bowl wall & extra luminal findings such as abscess (or) fistulas.

MANAGEMENT
Mesalamine (50-100mg/kg/day)

5-Aminosalicylate
Corticosteroids (prednisone, 1-2 mg /kg /day max 40-60mg)

Immunomodulaters –Azathioprine,6-mercaptopurine (1.0-1.5mg/kg/day)may be effective in some children who have a pour response to prednisone.

Infliximab (5mg /kg IV) a chimeric monoclonal antibody TNF – ALPHA has been shown to be effective for the induction & maintenance of remission & mucosal healing in chronically active moderate to severe crohn disease.

Exclusive enteral nutritional therapy is an effective primary as well as adjunctive treatment.

SURGICAL MANAGEMENT
Surgery Include development of fistula (or) stricture.

Treatment of choice for bowel perforation, stricture and partial small bound obstruction, Perianal abscess.

NURSING CARE MANAGEMENT
1. Managing diet 2. Coping with factors that increase stress & emotional ability 3. Adjusting to a disease of remissions &.

1 MANAGING DIET
-Encouraging Small, frequent meals (or)snacks rather than three large meals a day, serving meals around medication schedules when diarrhea mouth pain & intestinal spasm are controlled, preparing high protein, high calorie food such as egg, milkshakes, cream, soups, puddings.

-Mouth care before eating & the selection of bland foods help relieve the discomfort of mouth sores.

2. Coping with factors that increase stress & emotional ability
The nurse should acknowledge the anxieties of the child & family members and give them adequate time to demonstrate the skills necessary to continue the therapy at home if needed.

The importance of continued drug therapy despite remission of symptoms must be stressed to the child and family members. failure to adhere to the pharmacologic regimen can result in exacerbation of the disease.

3. Adjusting
The nurse should attend to the emotional components of the disease & asses any sources of stress Frequently, the nurse can help children adjust to problems of growth restriction, delayed sexual maturation, dietary restriction, feeling of being different (or) sickly inability to compete with peers & necessary absence from school during exacerbations of the illness.

4. When Indicated
If a permanent colectomy –ileostomy is required, the nurse can teach the child & family how to care for the ileostomy. The nurse can also emphasize the positive aspects of surgery, particularly accelerated growth & sexual development, permanent recovery and eliminated risk of colonic cancer, as well as the normality of life despite bowel diversion.

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