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个案与短篇

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复杂眼内异物摘出联合玻璃体切割手术治疗的护理

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复杂眼内异物摘除术是眼科疑难手术。玻璃体切除手术使复杂眼内异物摘除率明显提高[1,2],可减少其并发症,较好地保留或提高患者的视功能,但对患者的护理,特别是术前、术后护理及并发症的观察提出了更高的要求。我科于2003年8月至2007年6月共收治复杂眼内异物伤患者45例,治疗护理效果满意,现将护理体会报告如下。

1 临床资料

1.1 一般资料

2003年8月至2007年6月收治的复杂眼内异物患者45例(45眼),男性42例,女性3例,年龄14~70岁,平均33岁,异物在眼内存留3 d至2个月。后嵴球壁23例,巨大异物11例,非磁性异物38例。异物性质:铁锈7例,铜屑1例,石块32例,玻璃3例,木屑2例。术前视力:光感至数指25例,0.01~0.1者11例,0.15~0.25者9例。术前并发角膜裂伤及外伤性白内障20眼,玻璃体积血2例,视网膜脱离18例,眼内炎4例,其中7眼曾在外院行巩膜切开术失败。

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1.2 手术方法

采用平坦部闭合式三切口玻璃体切除术,先清除中轴部玻璃体,再切除基底部玻璃体,寻找到异物后将周围玻璃体及机化条索切断切除,异物有机化包裹时,先将异物包裹刺开,将其松动游离。据异物大小将平坦部切口扩大,入球内异物钳摘取异物,对视网膜上的异物巢及裂孔进行激光治疗。若有视网膜脱离先用重水或气液交换,使视网膜贴回脉络膜再作激光。根据眼内情况,进行不同的眼内充填,惰性气体(C_3F_8)及硅油注入。术后必要时进行激光补充治疗[1,2]。术后视力较术前提高者29眼(64%),不变者9眼(20%),下降者7眼(16%);45眼中42眼1次摘除成功,余3眼因术中大量出血,再次行玻璃体切除术摘除。

2 护理体会

2.1 术前护理

患者大部分为青壮年,突然受伤引起视力下降,担心视力不能提高;多数患者为外出打工者,经济条件差,担心医疗费用问题而情绪低落;患者急于通过手术提高视力,对手术产生畏惧心理,并担心预后视力。护理人员应做好心理护理,主动接近

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无明显关联。这一研究结果与国外报道一致[10,11]。

目前缺乏这2个多态性位点对功能的影响,若要验证基因多态性是否影响ESR2基因表达,要用不同基因型的ESR2基因构建质粒,再转染细胞,检测ESR2基因活性和蛋白产量。研究发现ESR2基因CA重复序列多态性位点与G1082A多态性位点非不平衡连锁,这仅能说明ESR2基因CA重复序列多态性较G1082A多态性与绝经后女性BMD的关系更为密切。

综上所述,绝经后女性中,ESR2基因第5内含子的CA重复序列多态性可能对BMD的遗传调节起作用,而位于ESR2基因第5外显子的G1082A多态性可能对BMD无明显影响。

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并关心体贴患者,及时给予安慰、鼓励和解释,讲解有关病情和治疗方法,并与经管医师联系尽量使用价格低廉且能达到治疗效果的药物,以使患者解除思想顾虑,稳定情绪,主动配合治疗和护理;协助医师做好检查工作,如及时做异物定位检查、眼B超检查,以明确诊断和选择手术时机;做好术前常规检查及准备,如做好血、尿、大便常规检查,完成胸透、心电图等检查,以排除手术禁忌证;抗生素眼液点眼每日4次,术前剪睫毛、冲洗泪道及结膜囊、消毒眼眶局部皮肤。

2.2 术后护理

术后加强病情观察,做好对症处理。注意局部疼痛的性质及程度,有无渗血,如伤口疼痛者适当给予镇静止痛剂。单纯异物取出或术中出现玻璃体出血患者术后行半卧位休息,以利于眼内血液吸收。行惰性气体(C_3F_8)及硅油填充术者,术后应俯卧位休息。为减少患者俯卧位时的不适,使用我科自制的U字形软枕来减少患者特殊体位的不适度,同时给予患者受压部位皮肤适当的按摩,促进局部血液循环,并反复向患者强调体位对手术成功的重要性,使患者积极配合[3]。当患者眼内充填入膨胀惰性气体(C_3F_8)膨胀时,若因眼压增高引起疼痛,应及时向医师反映,立即按医嘱给予降眼压处理。为了保护术眼,应告之患者不能用力揉眼及碰触术眼,动作轻柔、不能过度摇晃头部,避免再次视网膜脱离。另外,长时间被动体位导致患者活动受限,胃肠蠕动减弱,术后患者应进食清淡易消化且营养丰富的食物,多进食水果、蔬菜,保持大变通畅,避免咀嚼坚硬食物防止伤口裂开。嘱咐患者注意保护术眼,避免再次外伤,保持术眼清洁、干燥,勿用不洁手或纸巾等揉眼。必须向患者强调复查时间,了解视网膜情况,若有不适立即就诊。

关键词: 复杂眼内异物;联合玻璃体切割手术;护理
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