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ORIGINAL

Nursing care in postoperative patient of adnexal cyst in the obstetrics and gynecology service, in a national hospital of Calla

Cuidados de enfermería en paciente posoperada de quiste anexial en el servicio de gineco obstetricia, en un hospital nacional del Callao

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ABSTRACT

This research study was applied to a postoperative patient diagnosed with a right adnexal cyst who was hospitalized in the gynecologic-obstetric hospitalization service. The adnexal or ovarian cyst is one of the most common and ordinary gynecological pathologies in women during their reproductive stage, which can evolve and grow, producing acute symptoms that lead to surgical interventions, which has been the reason for the patient's admission to the service. The objective was to manage the nursing care process as an instrument for specialized nursing care, to a post-operative patient for a right adnexal cyst. The study had a qualitative approach, single case type with the Nursing Care Process methodology applied to a 30-year-old patient, applying the 5 stages: assessment stage that was carried out through the assessment guide of the 11 functional patterns of Marjorie Gordon, 9 altered functional patterns were found and the patterns were prioritized: perception-control of health, perceptive-cognitive, adaptation-tolerance to stress, self-perception-self-concept. Diagnostic stage. was developed based on NANDA's taxonomy II, ten nursing diagnoses were identified, prioritizing three of them: acute pain, anxiety and ineffective self-management of health, according to the SSPFR format (signs and symptoms, problem, related factor / risk factor). risk/ associated with). Execution stage, specific nursing care was provided for prioritized problems. Finally, the evaluation stage was expressed by the difference in the final and baseline scores of the respective indicators, obtaining as a result the change score of +2, +2, +1. In conclusion, the nursing care process for the patient was managed, providing nursing care in a holistic and comprehensive manner, with quality and warmth, favoring her recovery and promoting self-management of her health.

Keywords: Nursing Care; Patient; Postoperative; Adnexal Cyst.

RESUMEN

El quiste anexial u ovárico es una de las patologías ginecológicas más comunes y ordinarias en las mujeres durante su etapa reproductiva, que puede evolucionar y crecer produciendo sintomatología aguda que deriva en intervenciones quirúrgicas, lo cual ha sido el motivo de ingreso de la paciente al servicio. El objetivo fue gestionar el proceso de atención de enfermería como instrumento para el cuidado enfermero especializado, a una paciente posoperada de quiste anexial derecho. El estudio tuvo un enfoque cualitativo, tipo caso único con la metodología del Proceso de Atención de Enfermería aplicada a una paciente de 30 años de edad, aplicando las 5 etapas: etapa de valoración se realizó aplicando la guía de valoración de los 11 patrones funcionales de Marjorie Gordon. Etapa diagnóstica. se desarrolló en base a la taxonomía II de NANDA, se identificaron diez diagnósticos de enfermería, priorizándose tres de ellos: dolor agudo, ansiedad y autogestión ineficaz de la salud, según el formato SSPFR (signos y síntomas, problema, factor relacionado/ factor de riesgo/asociado a). Etapa de ejecución se brindaron los cuidados de enfermería específicos para los problemas priorizados. Por último, la etapa de evaluación estuvo expresada por la diferencia de

puntuaciones final y basal de los indicadores respectivos, obteniendo como resultado la puntuación de cambio de +2, +2, +1. En conclusión, se gestionó el proceso de atención de enfermería en la paciente, brindando cuidados de enfermería de manera holística e integral, con calidad y calidez, favoreciendo su recuperación y promoviendo la autogestión de su salud.

Palabras clave: Cuidados de Enfermería; Paciente Posoperada; Quiste Anexial.

INTRODUCTION

The adnexal or ovarian cyst, also known as benign mass, is one of the health problems at the gynecological level, most of them are functional and disappear with treatment, it is increasingly frequent in women of reproductive age.

According to the World Health Organization, women's health is influenced biologically, by sex, gender and the social aspects that characterize them.[1,2] It also states that morbidity is higher in women of reproductive age, and that the main cause of death in women continues to be non-communicable diseases.[3,4] Thus, current data to date show that 18,9 million women died in 2015, and this situation has been aggravated in recent years by the covid-19 pandemic, reaching 42,4 % of the total number of deaths in 2022.[5]

In Peru, in 2020, the prevalence of hospitalized women between 25 and 49 years of age with diseases of the genitourinary system was 43,97 % (8587). Even when the diseases are not specified, the total rate of hospitalized women in 2020 has decreased by more than 50% in relation to 10 previous years.[6,7]

In the hospital of Ventanilla Callao/Lima, of the 100% (123) of gynecological patients who were hospitalized during the year 2022; 18,70 % (23) have been patients who underwent surgery for ovarian adnexal cyst. Likewise, it is the second cause of hospitalization in the gynecology area, after patients with incomplete abortion.

Ovarian cysts are formed in the ovary and have fluid inside; they also occur on the surface of the ovary and can occur in both ovaries, they are more common in the reproductive age from puberty to menopause, i.e. in periods known as the fertile years of a woman, they are less common after menopause; sometimes you can develop a bag full of fluid that is any accumulation of fluid inside the ovary and in most cases the cysts are not painful and cause no symptoms.[8,9]

Among the causes and/or risk factors that contribute to the appearance of ovarian cysts are hormonal factors, characterized by an imbalance of hormones in the body and medications used for ovulation; in pregnancy they are produced at the beginning of gestation and disappear with the formation of the placenta; pelvic infection that includes the ovaries creating cysts; a history of having had an ovarian cyst increases the probability of presenting them again.[10,11,12]

Functional ovarian cysts are formed in the menstrual cycle and do not remit or disappear, there is a failure in the retraction of the follicle or corpus luteum, causing a physiological increase in the size of the ovary (diameter 3-8 cm) and consequently symptomatology occurs.

Generally, ovarian cysts are asymptomatic, but they can cause pain and can be aggravated if they increase in size (6-10 cm), when they bleed, when torsion occurs, decreasing the blood flow to the ovary, or rupture of the cyst.[13,14,15]

The clinical picture of sustentation cysts with symptoms such as: acute unilateral lower abdominal pain (sharp, intense stabbing type pain located in the pelvic area on the side of the abdomen where the cyst is located that increases with sexual intercourse and with movement); inflammation in the lower abdomen (with a feeling of fullness, heaviness, bloating and abdominal distention); pelvic pain around the menstrual cycle; constipation (abdominal swelling can cause problems with bowel transit and also pain during bowel movements); pelvic pain accompanied by nausea and vomiting (which would suggest ovarian torsion, or rupture of the cyst). [16,17,18]

Treatment can be hormonal with hormone-based oral contraceptives, which are administered to reduce the risk of new cysts, but do not reduce the size of existing cysts; the surgical treatment of choice is exploratory laparotomy, as a procedure to remove the cyst, the ovary and to perform a biopsy to rule out ovarian cancer. [19,20,21,22] Also, when ovarian cysts are complex and have not disappeared with contraceptive treatment, when rupture or torsion is confirmed, increase in size, risk of cancer in menopausal and postmenopausal women, and when the clinical picture becomes an obstacle to the patient's quality of life.[23,24]

Among the complications presented by women with ovarian cysts are: polycystic ovary syndrome (formation of multiple cysts in the ovary with an increase in male hormones and absence of ovulation), teratomas (solid tumors that form hair, teeth, bone or cartilage in their interior and produce infertility in women), amenorrhea and hemorrhages due to hormonal alteration;[25,26,27,28] ovarian torsion (the cysts grow in size more than 3,5 cm in size, causing the ovary to twist along with the ovary, reducing blood flow and generating intense pelvic pain, nausea and vomiting) and internal hemorrhage due to cyst rupture or hemorrhagic cyst (which causes severe

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pain and internal bleeding that is life-threatening).[29,30,31,32]

Care is the raison d'être of nursing and the philosophy of care is the foundation of nursing, is essential for the care of the person and denotes permanent action under the term caring, and to provide care is used as a tool the nursing care process (PAE), which is the scientific, orderly and systematic method, which directs the fundamental principles of the profession.[33,34,35] It is the central instrument for nursing care by which the professional provides comprehensive, holistic and scientific care to the person in the various stages of his or her life. It is the method that frames the theoretical foundations in professional practice, a problem-solving path that requires cognitive capacity, interpersonal skills, oriented to meet the needs of the patient, family and community. Therefore, nursing professionals specialized in obstetrics and gynecology are an important part of the multidisciplinary team and essential to ensure the right to health of the maternal and child population.

METHODOLOGY

The present study has a qualitative, single-case approach, and the research method used was the nursing process.

The subject of the study was a female patient, 30 years old, hospitalized in the gynecological-obstetrics area of a hospital in Callao, and the period of care was 12 hours on October 6, 2022, during the patient's postoperative period.

The techniques used for the investigation were interview, observation, documented review and physical examination of the patient. The assessment instrument used was Marjory Gordon's functional pattern assessment guide.[36]

Nine altered functional patterns were identified, from which 10 nursing diagnoses were determined, of which three were prioritized, based on the NANDA manual.[37]

The planning was based on the NOC NIC taxonomy. Most of the planned activities were carried out and compliance with the objectives was evaluated according to the indicators, taking into account the difference between the baseline and final scores.

NURSING CARE PROCESS

Assessment

General data.

Nombre: H.S.L.

Sex: female

Age: 30 years old

Days of nursing care: 12 hours

Date of assessment: 06/10/2022

Reason for admission: Patient was admitted to the obstetrics and gynecology hospitalization service after undergoing surgery. She was found in immediate postoperative period of 12 hours, lucid, awake, with oral tolerance, in bed, with a diagnosis of right adnexal cystectomy, complaining of pain in the surgical area and on mobilization, peripheral permeable airway for treatment.

Assessment according to Functional Patterns of Health

Functional Pattern I: Perception - Control of Health

Young adult patient in regular general condition with no family history of disease. She had a cesarean section for acute fetal distress (2012), and curettage on 2 occasions for 2 miscarriages (2014 and 2020). Also, she presented ovarian cysts 6 years ago (2016) being treated with oral medication. She is allergic to citrus fruits. She became ill with covid in 2020. She had a high cholesterol result 8 months ago (she does not remember the index). She has no risk factors for substance abuse. She keeps an untimed diet. She says "I need to know what operation I have undergone, I am confused, because I have been told that they have removed my ovary".

Functional Pattern II: Metabolic Nutrition.

Her current weight is 65 kg, height 1,49 m, BMI is 29,28 classified in the pre-obese level (25,00-29,99). Patient reports "I have a tendency to gain weight". Abdomen soft, depressible, painful to palpation. She has been prescribed a soft diet, but she reports lack of appetite, with presence of nausea. She has a clean and dry operative wound dressing. No drains. Normal hydroaerial sounds. She has a peripheral line in left upper limb dated October 5. Skin and mucous membranes slightly pale, although hydrated.

Laboratory results show: control Hb. 11,7 gr/dl, leukocytes 6,350 GB/ml, tumor markers: CEA: 3,02 U/ml, CA 125: 11,20 U/ml within normal values.

Functional Pattern III: Clearance.

No bowel movement since preoperative, two days ago. Urine examination: cloudy appearance, density 1030,

germs (++), leukocytes 2-4 x field. He is supported to go to the bathroom to perform physiological eliminations. No presence of foley catheter. No dysuria.

Functional Pattern IV: Activity - Exercise

Respiratory activity: respiratory rate of 20x' and SO2 of 97%. No cough or respiratory distress. He ventilated spontaneously.

Circulatory activity: blood pressure of 100/60 mm/Hg and heart rate of 75x'.

He has a peripheral line in the left upper limb for analgesic and antispasmodic treatment. No lower limb edema.

Functional Pattern V: Rest - Sleep.

Patient reports being very sleepy during her stay in the hospital, but is observed to be stressed with difficulty sleeping at night.

Functional Pattern VI: Perceptual - Cognitive.

Patient is oriented in time, space and person. Currently in postoperative period she is very anxious and worried. She does not present headaches.

She verbally refers acute pain caused by the surgical wound she presents, and pain fascia is observed. She also refers pain when moving in bed and also when moving out of bed. VAS scale: 7-8

Functional Pattern VII: Self-perception - Self-concept.

Patient with low self-esteem, refers "I am impatient, I get angry quickly and I get angry that I cannot control". She states "I am worried about my health".

Functional Pattern VIII: Relationships - Role.

The patient works in a bar on weekends in the evenings.

She has a partner, with whom she reports having a non-stable relationship. She has a 10-year-old daughter from a previous engagement. She states that she receives support from her current partner and her family. She says, "Despite having completed my technical studies in hotel management, tourism and English, I have not yet been able to fulfill myself.

Functional Pattern IX: Sexuality / Reproduction.

The patient had her menarche at 13 years of age and started sexual life at 18 years of age. She has had one pregnancy that ended in cesarean section. Her LMP is due on September 5, 2022. She has a regular menstrual cycle and uses condoms as a method of family planning. Oral contraceptive methods have not helped her to realize that she was pregnant. She has no vaginal discharge. Non-gravid uterus. Breasts in normal condition. She presented candidiasis (she does not remember the date) and was treated with pills (she does not remember the name).

Functional Pattern X: Adaptation - Tolerance to the situation and stress.

The patient's family situation influences her and her relationship with her partner. She refers that she argues with her current partner and as a consequence she often responds with impatience and anger. Patient reports "I get stressed easily". She is not familiar with relaxation therapies. She is worried and sad about her mother who separated from her father and has not yet been able to overcome her grandmother's grief. Patient states that when she heals from the operation she wants to have therapy with her partner to overcome stress and improve her emotions.

Functional Pattern XI: Values and Beliefs

The patient belongs to the Catholic religion. The patient is a tenacious and responsible person, she believes in the human values of truth, honesty, love, etc.

PRIORITIZED NURSING DIAGNOSES

First Diagnosis.

Diagnostic label: Acute pain (00132).

Definition: "Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset,

of any intensity from mild to severe with an anticipated or predictable end, and lasting less than 3 months."

Defining characteristics: VAS 7/10 pain rating scale, facial expression of pain and pain on mobilization.

Related factors: physical injurious agents

Diagnostic statement: acute pain related to physical injury agent, manifested by pain assessment scale (PSA) 7/10, facial expression of pain, pain on mobilization.

Second diagnosis.

Diagnostic label: Anxiety (00146).

Definition: "Emotional response to a diffuse threat in which the individual anticipates non-specific imminent danger, catastrophe or misfortune."

Defining characteristics: expression of pain upon mobilization, expresses anxiety about changes in life events, unfulfilled life longings, inappetence and expression "I get stressed easily" "I am worried about my health".

Related factors: pain, stressful situations, unmet needs.

Diagnostic statement: anxiety related to pain, stressful situations, unmet needs, manifested by expression of pain upon mobilization, anxiety expressed by changes in life events, unfulfilled life longings, inappetence and expression "I get stressed easily" "I am worried about my health".

Third Diagnosis.

Diagnostic label: Ineffective self-management of health (00276).

Definition: "Unsatisfactory symptom management, treatment regimen, physical, psychosocial and spiritual consequences and lifestyle changes inherent in living with a chronic illness."

Related factor: decreased perception of quality of life.

Defining characteristics: inattention to signs and symptoms of illness, ineffective decisions in daily life (eating on the spur of the moment, pre-obesity).

Diagnostic statement: ineffective self-management of health manifested by decreased perception of quality of life, evidenced by inattention to signs and symptoms of illness and ineffective decisions in daily life (untimely eating, pre-obesity).

PLANNING

First diagnosis.

Acute pain (00132)

Nursing outcomes

NOC (2102) Pain level

Indicators:

- Referred pain
- Duration of pain episodes
- Facial expressions of pain

Nursing interventions.

NIC (1410) Acute Pain Management

Activities:

- Perform a comprehensive assessment of pain including location, onset, duration, frequency and intensity, as well as relieving and aggravating factors.
- Monitor pain using the VAS scale.
- Ask the patient about the level of pain that allows comfort and treat appropriately.
- Administer immediate analgesia before the pain increases, observing the patient's breathing pattern.
- Administer combined analgesics if the pain level is severe and does not subside.
- Prevent or control side effects of medications.
- Keep the patient in an antalgic position.
- Provide accurate information to the family about the patient's pain.

Second diagnosis.

Anxiety (00146)

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Nursing outcomes.

NOC (1302) Coping with problems.

Indicators:

- Verbalizes need for assistance.
- Refers decrease in physical symptoms of stress.
- Verbalizes acceptance of the situation
- Verbalizes feeling of control
- Reports increased psychological well-being

Nursing interventions.

NIC (4920) Active listening

Activities:

- Show interest in the patient.
- Ask questions or make statements that encourage the expression of thoughts, feelings, concerns.
- Determine the meaning of messages, reflecting on attitudes, past experiences and current situation.
- Provide the response at the appropriate time to reflect understanding of the message received.
- Listen attentively to the words that are avoided, as well as to the nonverbal messages that accompany the words expressed.
- Avoid barriers to active listening (minimizing feelings, offering simple solutions, interrupting, talking about oneself, and ending prematurely).
- Identify with the patient the possible actions to be taken in the medium, short and long term.
- Make sure to share relaxation therapies.
- Encourage hope in the patient.

NIC (5270) Emotional support

Activities:

- Provide positive and effective support.
- Make empathic and supportive statements with the patient.
- Explore with the patient what triggered the emotions.
- Help the patient recognize feelings such as anxiety, anger, or sadness.
- Encourage conversation or crying as a means of decreasing the emotional response.
- Discuss with the patient the consequences of not addressing feelings of guilt or shame.
- Facilitate identification of the usual pattern of coping with fears.

Third diagnosis.

Ineffective health self-management (00276)

Nursing Outcomes.

NOC (1606) Participation in health decisions.

Indicators:

- Claims responsibility for decision making.
- Demonstrates self-control in making decisions
- Uses problem-solving techniques to achieve desired results
- States intention to act on decision

Nursing interventions

NIC (4480) Facilitating self-responsibility.

Activities:

- Hold the patient responsible for his or her own behavior.
- Point out the patient's appropriate knowledge of his or her health care.
- Provide the patient with opportunities for self-evaluation and self-reflection.
- Discuss with the patient the consequences of not assuming one's own responsibilities.
- Assist the patient in setting goals, especially in the eating schedule and how to achieve a healthy lifestyle.
- Encourage the patient to take responsibility for his or her own self-care as much as possible.

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IMPLEMENTATION

At this stage, the nursing care plan developed for this specific case was developed based on the collection of detailed and accurate information on the patient's health status. The activities carried out to meet the objectives were: the annotation of nursing care, providing verbal nursing information and above all the updating of the care plan. The following tables are presented:

Table 1. Implementation of the acute pain management intervention for the nursing diagnosis Acute Pain

Intervention: Acute pain management		
Date	**Time**	**Activities**
October 6, 2022	8.00 am	Vital functions were controlled and pain was assessed according to location, onset, duration, frequency and intensity and the factors that alleviate and aggravate it.
	9.30 am	The level of pain was monitored, asking the patient and using the VAS scale, in order to carry out the appropriate treatment.
	9.30 am	Ketoprofen 100mg was administered intravenously, to prevent the pain from increasing.
	10.00 am	The patient was kept in an antalgic position.
	2.00 pm	Tramal 100 mg was administered intravenously for severe pain.
	2.20 pm	The side effects of the medication were observed and monitored.
	4.00 pm	Accurate information was provided to the family about the patient's pain.

Note: Based on the Classification of Nursing Interventions NIC.

Table 2. Implementation of the active listening intervention for the nursing diagnosis Anxiety

Intervention: Active listening		
Date	**Time**	**Activities**
October 6, 2022	8.00 am	Interest was shown in the patient
	2.30 pm	She was asked questions or affirmations that encourage her to express thoughts, feelings, concerns, observing the patient's nonverbal messages, and words that are avoided during their expression.
	3.00 pm	The meaning of the messages was determined with the patient, reflecting on her attitudes, past experiences and current situation; and a response was given at the appropriate time reflecting the understanding of the message received.
		Active listening was carried out avoiding minimizing feelings, giving simple solutions, interrupting, talking about oneself and ending prematurely.
	6.00 pm	Possible actions to be taken in the medium, short and long term were identified with the patient.
		She was assured to share with the patient about relaxation therapy.
	6.30 pm	Encouraged the patient to be hopeful.

Note: Based on the Classification of Nursing Interventions NIC

Table 3. Implementation of the emotional support intervention for the nursing diagnosis Anxiety

Intervention: Emotional support		
Date	**Time**	**Activities**
October 6, 2022	8.00am	Positive and affective support was provided
	2.30 pm	Empathic and supportive affirmations were made with the patient; and she was helped to recognize feelings such as anxiety, anger or sadness.
	2.45 pm	Conversation or crying was encouraged as a means of de-escalating the emotional response and explored with the patient what triggered the emotions.
	4.30 pm	Discussed with the patient the consequences of not addressing feelings of guilt or shame.
	5.00 pm	The patient was helped to identify the usual pattern of coping with her fears.

Note: Based on the Classification of Nursing Interventions NIC

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Table 4. Implementation of the intervention facilitating self-responsibility for the nursing diagnosis of ineffective self-management of health

Intervention: Facilitating self-responsibility		
Date	**Time**	**Activities**
October 6, 2022	8.00 am	The patient was held responsible for her own behavior.
	10.00am	The patient's adequate knowledge about her health care was pointed out.
	3.00 pm	The patient was provided with opportunities for self-evaluation and self-reflection.
	5.30 am	Discussed with the patient the consequences of not assuming one's own responsibilities.
	6.00 pm	The patient was assisted in setting goals, especially the eating schedule and how to achieve a healthy lifestyle.
	6.45 pm	The patient was encouraged to take responsibility for her own self-care as much as possible.

Nota: Elaboración a partir de la Clasificación de Intervenciones de Enfermería NIC.

Evaluation

In this stage, compliance with the planned activities was evaluated in relation to the patient's health conditions in order to determine the achievement of the expected results.

Result 1: Pain level.

Table 5. Baseline and final score of the pain level outcome indicators

Indicators	**Baseline score**	**Final score**
Referred pain	2	4
Duration of pain episodes	2	4
Facial expressions of pain	2	5

Note: Based on the Nursing Outcome Classification NOC

Table 5 shows that the mode of the pain level outcome indicators selected for the diagnosis of acute pain before the nursing interventions was 2 (substantial); after the application of the interventions, the mode was 4 (mild), corroborated by the patient's reference to having decreased her pain, decrease in pain episodes and facial expressions of pain. The average baseline score was 2, achieving a final score of 4 and obtaining a change score of +2.

Result 2: Coping with problems.

Table 6. Baseline and final score of the indicators of the coping with problems outcome

Indicators	**Baseline score**	**Final score**
Verbalized need for assistance	3	5
Refers decrease in physical symptoms of stress	2	4
Verbalized acceptance of the situation	2	4
Verbalized sense of control	2	3
Reports increased psychological well-being	2	4

Note: Based on the Nursing Outcome Classification NOC

Table 6 shows the mode of the selected coping outcome indicators for the anxiety diagnosis; before the nursing interventions, the baseline score was 2 (rarely demonstrated); after the administration of the interventions, the mode was 4 (frequently demonstrated), corroborated by the expression of the need to be listened to, by the moments of attention in which the patient expresses her thoughts and recognizes feelings of anger or sadness, as well as the desire to improve her life, face her fears and make decisions for her future. The average baseline score is 2, and the average final score is 4, achieving a change score of +2.

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Result 3: Participation in health decisions

Table 7. Baseline and final score of the indicators of the outcome participation in health decisions

Indicators	Baseline score	Final score
Claims responsibility for decision making	2	4
Exhibits self-control in decision making	3	4
Uses problem-solving techniques to achieve desired results	3	4
Declares intention to act on the decision	3	4

Note: Based on the Nursing Outcomes Classification NOC

Table 7 shows that the mode of the outcome indicators participation in health decisions selected for the diagnosis of ineffective self-management of health before the nursing interventions the baseline score was 3 (sometimes demonstrated); after the application of the same, the mode was 4 (frequently demonstrated), corroborated by the desire to improve their life, to take alternatives to improve their character and their environment. The average baseline score was 3, and the average final score was 4, reaching a change score of +1.

RESULTS

Regarding the evaluation of the assessment phase, data collection was obtained from the patient as the primary source of information collection; data were obtained from the clinical history and physical examination, an indispensable means of data collection. Then, the information was organized using the assessment guide based on Marjory Gordon's functional health patterns. In this phase, information was obtained from the patient herself, so conducting the interview and physical examination was easy.

In the diagnostic phase, the analysis of significant data according to NANDA-I was performed, obtaining ten nursing diagnoses, of which three were prioritized: acute pain, anxiety, and ineffective self-management of health. At this stage we had no difficulty in prioritizing the diagnoses.

The planning phase was carried out, taking into account the NOC and NIC taxonomies. The analysis was executed to determine the nursing outcomes that relate to the three nursing diagnoses and the interventions in such a way that they have concordance and coherence with the outcomes. The difficulty in this phase was in the assessment of the score of the outcome indicators in the final evaluation due to the patient's evolution.

In the execution phase, the planning was carried out with no significant difficulties due to the expertise in carrying out the activities of each intervention and due to the patient's acceptance of the execution of the interventions administered.

Finally, the evaluation phase allowed for feedback at each stage during the care provided to the patient in this study.

DISCUSSION

Pain

According to the authors, *pain* is defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (redefined by the IASP in 2020); sudden or slow onset, of any intensity from mild to severe with an anticipated or predictable end, and lasting less than 3 months.[38,39]

It is personal and influenced by biological, psychological, and social factors.

The American Society of Anesthesiologists (ASA) defines *postoperative pain* as a prevalent sensation in the operated patient caused by the disease, the surgical procedure, and its complications. It is a pain that is predictable as it is the result of an intended and deliberate assault on the patient's body that occurs at the onset of surgery and ends with the healing of the disease that caused it. Postoperative pain can increase morbidity and mortality and thus can extend the hospital stay of patients.[40,41,42]

Acute pain is given by a biological component of alert emitted by the protective systems of the organism as an immediate sensory consequence of the activation of the nociceptive system.

The patient under study presented acute pain produced by gynecological surgery for a right adnexal cyst during the immediate postoperative period.

The factor related to acute pain is a physical injurious agent.[43,44,45] Acute postoperative pain is secondary to an intentional direct physical aggression that occurs during the surgical act. It should also include pain produced by the surgical technique and also that originated by the anesthetic technique, inadequate posture during the operation, muscle contractures, bladder distension or lack of bowel emptying, and others. In hospitals and gynecological-obstetric areas, gynecological surgery has a high incidence. Adequate control of

acute postoperative pain is essential to achieve a rapid postoperative recovery, which, in clinical terms, implies a decrease in morbidity.[46]

In the defining characteristics, the acute pain presented by the patient H.S.L. has caused the patient to express pain facies and report pain 7/10 on the VAS scale; in postoperative pain, the nociceptive or sensory element given by the painful sensation prevails and is due to the transmission of the injurious impulses through the nerve pathways to the cerebral cortex.[47,48]

It is essential to evaluate the degree of postoperative pain, as well as the intensity, and to consider that pain has a multifactorial origin. There are several pain assessment scales applicable to adults. One of them is the visual analog scale (VAS), which allows pain to be graded from 1 to 10 according to its intensity. The WHO has created the pain ladder in order to generate pain management, taking into account the medications that should be used for each case, according to the intensity of the pain and the cause of the pain.[49]

Among the activities related to the NIC Pain management have been considered:

Perform a comprehensive assessment of pain, including location, onset, duration, frequency, and intensity, as well as the factors that relieve and aggravate it and keep the patient in an antalgic position; it is necessary to consider before a good assessment of pain such as onset, frequency, change of pain pattern during the day, location, irradiation, characteristics of pain, intensity, factors that increase or relieve pain, physical limitation, barriers, previous treatment and response, adverse events such as respiratory problems.[50]

Monitor pain using the VAS scale and ask the patient about the level of pain that allows for comfort; it is essential to assess and control pain. Pain assessment scales should be simple and accurate to quantify pain and determine the treatment to be followed. The main difficulty in assessing pain is the difference between what the professional staff assesses and what the patient reports. It is, therefore, essential to ask the patient since pain is a subjective sensation, and this helps the professional to make appropriate decisions.[51]

The objective assessment of pain is complicated due to the subjective and affective manifestations of the patient. Among the scales for measuring pain, unidimensional scales are the most commonly used in the case of acute postoperative pain because they measure intensity. We have the verbal descriptive scale (the patient indicates the degree of pain, and the scale is graded as follows: no pain, mild pain, moderate pain, and severe pain). The numerical scale (is simple and easy since it values from 0 as the absence of pain up to 10 as maximum pain). The visual analog scale (VAS or VAS, on a horizontal line on the left side, is considered no pain, and on the far right, the worst pain).

Administer immediate analgesia before the pain increases, observe the respiratory pattern, and administer combined analgesics if the pain level is intense and does not subside, as well as prevent or control the side effects of medications; good pain management is an indicator of quality care practice. There is a coincidence in studies where the highest percentage considers moderate to severe pain in the first 24 hours postoperatively.[52,53,54]

It is essential to administer analgesics according to the stage in which the patient is: immediate postoperative (24 hours), intermediate (24 to 72 hours), or late (more than 72 hours), and taking into account the intensity of pain in the patient, new drugs, analgesic techniques and protocols that have arisen in view of current surgical techniques.[55,56,57]

It is essential to consider a scale from less to more in the management of pain medications, taking into account the history (allergies) and the current situation of each patient that allows the administration of medications and their indication. Mild pain generally requires non-opioid analgesics, moderate pain requires the use of weak opioids, and severe pain requires potent opioids.

Pain control is critical to the patient's recovery, as getting up and moving around depends on it.[58]

The standard treatment for pain control after surgery is analgesics.

Analgesics have the function of reducing or relieving the pain of the operated patient. There is a wide range of analgesics for postoperative pain control, including opioids, which are one of the most potent analgesics for reducing pain perception, including Tramadol, among others. The most important thing is to achieve patient compliance with the treatment and a good impact on their quality of life, both at rest and during activity.[59,60]

Please provide accurate information to the family about the patient's pain; the family is the patient's primary companion, so the information they are given about the patient's situation is critical to his or her recovery. Beyond the rights it brings them, there are also the emotional needs it generates in them and the patient.[61]

Anxiety

According to the NANDA, *anxiety* is defined as an "emotional response to a diffuse threat in which the individual anticipates an unspecified imminent danger, catastrophe or misfortune". [62]

The Ministry of Health (MINSA), in its technical guide on mental health care for health workers in the context of COVID-19, defines anxiety as an emotion that appears as a response to a stimulus that is not always objective. It can also be explained as a response of the organism with the manifestation of psychic and somatic symptoms that occur in the face of a situation of physical or psychological danger that the person considers a threat, leading the organism to increase its energy to respond to the danger by annulling or counteracting it.[63]

Anxiety is described according to response systems: the first is a triple response at the physiological, cognitive, and motor levels, and the second is a cognitive response within a complex system of physiological, behavioral, and affective response (called threat mode), which is activated upon the anticipation of certain events or circumstances evaluated as aversive.[64]

Anxiety is a complex response of the individual to potentially risky situations and stimuli. In the postoperative period, the person may present a situation of constant discomfort, which leads to the generation of adverse psychological, physiological, and behavioral responses.[65,66,67]

In the patient, H.S.L., the anxiety she is going through is characterized by the emotion produced as a consequence of stressful situations before, during, and after the surgery she underwent. The patient's response system is mainly cognitive due to concern for her health and motor due to the presence of postoperative pain.[68]

The factors related to anxiety are pain, stressful situations, and unsatisfied needs.[69]

Anxiety is also a reaction to stress. Stress is a derived demand on the brain and physique triggered by events of frustration and nervousness. It can produce physical and psychological symptoms such as stomach pain, muscle tension, changes in appetite, sleep problems, and interfering with the person's daily life. Among the factors that provoke it are suffering an illness or injury, death of a family member, etc.

The following have been considered as defining characteristics: the expression of pain on mobilization, expression of anxiety due to changes in life events, unfulfilled life longings, lack of appetite, the expression "I get stressed easily" and "I am worried about my health".[70]

People with anxiety are characterized by presenting anxious thoughts or beliefs that are difficult to control and that make them tense and restless and can interfere with their daily lives. Anxiety is a reaction of the organism to stress, while in stress, there is an external response; in anxiety, there is an internal manifestation through persistent feelings that do not go away. Both can affect the mind and the organism and can interfere with one's life and work.

Anxiety is always evident to a greater or lesser degree, both preoperatively and postoperatively.[71]

Depression and anxiety are frequently associated with pain, but painful manifestations also increase depressive and anxious symptoms.

Among the activities related to NIC active listening interventions, the following have been considered:

Showing interest in the patient, asking questions or statements that encourage expressing thoughts, feelings, and concerns, determining the meaning of messages, and reflecting on attitudes, past experiences, and the current situation. The main treatments for anxiety disorders are psychotherapy (talk therapy), medication, or both. Cognitive behavioral therapy is a type of psychotherapy that is often used to treat anxiety disorders. It teaches different ways of thinking and behaving. It can help you change how you react to things that cause fear and anxiety. It may include exposure therapy, which focuses on confronting your fears so you can do the things you have been avoiding.[49]

Active listening is that which is practiced to understand what the other person is saying, is empathic and is characterized by the attention paid to the person, without interrupting and without anticipating what is going to be answered, being attentive to nonverbal communication, and avoiding distractions; Thus, the person who feels listened to improves and reduces stress. [72]

Offer the answer at the right time so that it reflects the understanding of the message received and identify with the patient the possible actions to take in the medium, short, and long term; anxiety can interfere with daily life and with the present events in a person. Then, it is necessary to take into account how to approach the person, considering the type of relationship and method, depending on how receptive he/she is. The goal is that the approach is well received. Ask questions that go directly to what the person is feeling if he/she is uncommunicative, agitated, or sleeps a lot. Listen without interrupting, and try to encourage, validating the feelings that emerge from her. Accompanying the person at all times and being in contact with the person is important.[73]

Make sure to share relaxation therapies, relaxation techniques are techniques that help to control stressful situations, especially those related to health problems. The benefits they provide are: balance vital functions, improve homeostasis, improve mood and sleep, reduce anger and frustration, and help develop self-confidence. They should be practiced frequently and require the person to focus their attention on something that calms them and connects them with their own body. We have autogenous relaxation (which comes from within the person), mentally repeating words that help you relax and reduce muscle tension; progressive muscle relaxation, which is to contract and then relax the muscles of the body starting from the head to the feet; visualization, is to visualize images in the mind that can lead the person to a calm and relaxing experience. Deep breathing, massage, meditation, etc., can also be practiced.[74]

Encouraging hope in the patient; encouraging hope in the patient changes her worries to the comforting peace of God. Hope is the positive vision of life that a person is able to have beyond the situations that surround him/her. To build hope, the person must be convinced that there are good things for her; she must create the

spaces for things to happen, even if it is difficult, and she needs to believe that God is her God, her Father and that He only wants the best for her. God alone is in control of existence and life.[75]

According to NANDA, the disposition to improve hope considers a pattern of perspectives and longings to mobilize energy and acquire positive results or prevent a potentially threatening or harmful situation, which can be strengthened.[76]

In the patient, it is necessary to build more hope from a positive vision of life that includes the longings and expectations of wellbeing and health, that considers all dimensions of life, and above all, to grow in faith in the triune God.[77]

Within the activities related to emotional support, N.I.C. interventions have been considered:

Provide positive and practical support; one of the essential activities in emotional support is to provide a hug to the patient; this physical contact contributes to improving the welfare, safety, and security of the patient, reduces tension, and increases self-esteem, hugs not only have an emotional component but are also very beneficial to health, this gesture is one of the most important, rewarding that the patient can receive this makes her feel confident and comfortable, especially in situations of anxiety or nervousness. Hugs are a healthy practice at any stage of life, making us feel special and comforting us, causing a great sense of wellbeing, which leads us to significant support for our patients.[78]

Make empathic and supportive affirmations with the patient; this activity is a bidirectional relationship because nurses provide an emotional exchange; empathic affirmations, in addition to beautiful words, serve as encouragement and help the patient feel safe.

Explore with the patient what has triggered the emotions; it is essential that the patient feels the presence of the caregiver, i.e., the nurse, and feels her authentic support. In this way, the patient becomes confident and expresses her problems and thus favors the regulation of some of the emotions that led the patient to stressful and anxious situations.[79]

Help the patient to recognize feelings such as anxiety, anger, or sadness; anxiety is frequent and the most frequently observed in clinical practice. It is related to a subjective feeling of uneasiness or fear of something terrible. The clinician must differentiate whether the anxiety, anger, or sadness is due to another disease process or if it presents itself. Their causes can be as varied as the events that life has in store, and this means that in a situation of lack of control, they can be affected. This help is essential because it allows early identification and recognition, together with the patient, of signs that can put her life at risk. The more the patient recognizes and expresses her feelings, perceptions, and fears, the more it will help to reduce the level of anxiety.

Please discuss with the patient the consequences of not addressing feelings of guilt or shame and facilitate the identification of the usual pattern of coping with fears; fear, guilt, and shame are considered as negative emotions; they are understood as an almost instinctive reaction and inherent to the human condition. Therefore, it is essential to dialogue and discuss with the patient the consequences of not raising feelings of guilt or shame. In this activity, the importance of preventing the risks and the ways of problematization is valued. Emotions are read as a means to explain the forms of human organization.[46]

Ineffective self-management of health.

According to NANDA, ineffective self-management of health refers to "unsatisfactory management of symptoms, treatment regimen, physical, psychosocial, and spiritual consequences, and lifestyle changes inherent in living with a chronic illness.[80]

Self-management is the ability of the person to drive his or her own behavior, thoughts, and emotions in a way that benefits his or her own life. Thus, the person excels in fulfilling responsibilities on a personal and professional level that brings benefit to him or herself, to him or herself, and his or her environment.

From synergetics, self-management is indispensable for the life of a person, and that elevated to the plane of health is configured as the main point of the search to improve physical, emotional, and spiritual health, leading the person to a path of personal transformation from within. It creates in her an aligned, harmonized, and totally healthy person.[81]

Inpatient H.S.L., there is evidence of ineffective self-management of her health because her decisions, thoughts, and emotions do not currently benefit her life and environment. Although there is a quest to improve her health and manifest it, there needs to be a way to lead her to the goal of being an aligned, harmonized, and totally healthy person.[82]

The factor related to ineffective self-management of health is the decrease in the perception of quality of life. Health-related quality of life is a leading indicator that is currently considered very valuable in guiding clinical practice, research, and management at all levels, and above all, has been shown to be concordant with disease-specific clinical factors of patients, such as age, gender, educational level, physical, mental comorbidity, etc.

Likewise, health-related quality of life is understood as the subjective perception that the person has of his

or her current state of health, the functional and emotional outcome of the disease and treatment, and the ability to carry out the activities that are a priority in his or her life. Because of this, the behavior of health and disease is experienced and accepted differently by men and women. It will depend on the roles assumed in their environment and those that society demands of each one.[83]

The patient under study has a diminished perception of her quality of life due to all the worries and stress she faces every day and the opportunity given to her at the time of her hospitalization to realize her reality and take positive alternatives for her life.[84]

The following have been considered as defining characteristics: lack of attention to the signs and symptoms of the disease, ineffective decisions in daily life (eating at the wrong time, pre-obesity).

Self-care is defined as the ability of individuals, families, and communities to promote and maintain health and prevent and cope with disease, with or without the support of a health professional. All people are active agents in managing their health. WHO emphasizes worldwide self-care interventions to achieve global health coverage and to promote global health and security in such a way that it is an extension of the health system. These interventions favor self-determination, self-efficacy, autonomy, and participation in one's health.[85]

The patient accepts her current health conditions and the reasons that have led her to decisions unfavorable to her life. With help, she will be able to be an agent of self-management of her health, and to be vigilant in detecting early on her weaknesses in the face of disease.

Among the activities related to N.I.C. interventions to facilitate self-responsibility, the following have been considered:

Consider the patient responsible for their behavior, and dialogue with the patient about the consequences of not assuming their responsibilities; self-care, according to WHO, is an active, dynamic, adapted, self-care pathway in which people participate, are willing and able to empower themselves by making decisions for the good of their health. Such as good habits, activities of daily living, a healthy way of life, disease management, coping with social or emotional situations, etc.[86]

Self-management in health, as part of self-care, implies personal management in health, in which the person can participate responsibly in their decisions and attitudes about the management of their health and complete wellbeing.[87]

Self-management or health management involves loving and valuing oneself, taking into account one's reality, and considering the resources and tools that each person possesses (abilities, aptitudes, dreams, knowledge, limitations, fears, concerns). It is essential to strengthen the immune system, manage emotions, maintain a healthy diet, restful rest, and exercise according to age. On the other hand, it is necessary to "listen" and "see" what the body is telling us about the signs and symptoms it manifests in order to go to the source and deal with what is happening.[88]

Suppose the patient is aware of her responsibility in the self-management and self-care of her health. In that case, she will assume the consequences of her actions, which will favor her in all the dimensions of her personal life and that of her own family.

Encourage the patient to take responsibility for his self-care as much as possible and point out the adequate knowledge that the patient has about his health care; self-care should be centered on the care of people considering their environment and their personal and social needs. Likewise, the patient's participation in promoting his or her health, including in his or her reality as a patient, is favored. Within the recommendations on good practices, trained health professionals should, among others, promote in people the practice of emotional strength, health and wellbeing, as well as identify when and how a person becomes responsible for managing and monitoring their health care.[50]

Assisting the patient in setting goals, especially in the eating schedule and how to reach a healthy lifestyle, and providing the patient with spaces for self-assessment and self-reflection; self-care behaviors are not always related to physical health, but the care of the mind is also essential. Therefore, self-care includes those alternatives to improve the psychological and emotional state of patients. Dorothea Orem, in her theory of self-care, states that a person can maintain his/her physical and psychological wellbeing by considering 5 elements in his/her life: maintenance of consumption needs as natural resources necessary for life; care of the process of elimination of toxic and hazardous waste; balance in the habits of activity and rest, interaction and solitude; prevention of risks that derive in diseases; promotion of human functioning to help the person to reach his/her most significant potential and achieve a harmonious development in the world that surrounds him/her.

CONCLUSIONS

The Nursing Care Process (P.A.E.) was managed as a scientific, systematic, and humanistic method developing the 5 stages, which allowed us to apply the nursing practice and evaluate the progress and changes of improvement in the patient from our care. Finally, we ensured quality care, achieving the progressive recovery, maintenance and progress of the patient's health.

The P.A.E., as an excellent research tool in our professional training, allowed us to provide care in a rational,

logical, and systematic way to strengthen the health condition and improve the patient's quality of life, helping us to empower assistance in the specialty of obstetrics and gynecology.

It was possible to identify and direct the solution to the problems and needs of the patient case study, elaborating the nursing diagnoses according to the NANDA taxonomy; care was planned by identifying the results through the N.O.C. taxonomy and selecting the interventions of the N.I.C. taxonomy.

Due to the patient's current health conditions, care was basically oriented to the improvement of the patient's physical and psycho-emotional health, with follow-up monitoring and timely treatment to prevent complications, as well as psychological, emotional, and spiritual support. Therefore, a progressive recovery is expected in the medium and long term, allowing the patient to self-manage her health.

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