

## Nephrotic Syndrome (MNS)

- \* Clinical state with massive proteinuria, hypoalbuminemia, hyperlipidemia, & edema
- \* Increased glomerular permeability to plasma proteins with massive urinary protein loss
- \* Decreased albumin level, decreased pressure in capillaries
- \* Change in pressure causes interstitial fluid accumulation (edema, ascites)
- \* Hypovolemia occurs which stimulates ADH & aldosterone with increased absorption of water.
- \* The glomerular membrane is normally impermeable to protein/albumin.
- \* Unknown how hyperlipidemia occurs.
- \* "Self-limiting disease... meaning it will come to an end by itself"

### PATHOPHYSIOLOGY

- \* Peak incidence in children 2-8 years
- \* Males 2x greater females

### Cause not fully understood

- \* Includes metabolic, biochemical, physicochemical, or immune mediated errors.

### CLINICAL MANIFESTATIONS

- \* "P, U, E, W"
- Perioral effusion
- Urine alterations
- Facial edema, ascites
- Labial or scrotal swelling
- Easily fatigued
- Weight gain



### DIAGNOSIS

- Based on clinical manifestations
- Proteinuria, hypoalbuminemia, and hypercholesterolemia
- U/A: no gross hematuria
- **Hallmark is massive proteinuria**

### LABS

- Total serum protein is low
- serum albumin low
- plasma lipids elevated (don't know why)
- hem and crit usually normal
- platelet count up
- serum Na low

### MANAGEMENT

- \* "CPR in the ED"
- Control edema
- Corticosteroids (2mg/kg/day for ~2 weeks)
- Prevent/Treat infection
- Reduce proteinuria (keep child from losing protein)
- Establish balanced nutritional state
- Diuretics
- 25% albumin infusion (to reduce proteinuria, **Remember: this is a blood product- so do frequent vital signs**)

## Acute Glomerulonephritis

- \* Inflammation of the glomeruli can lead to, -----
- \* Destruction & sclerosis of glomeruli
- \* Which causes kidney damage...
- \* **Pathophysiology is not clear**, but we do know it is **related to Group A Strep**.
- \* Although, we don't find any bacteria in their urine, we just ask about their history.
- \* Typically, will be about a month after they've had strep- they either didn't go to doctor or didn't finish their antibiotics.
- \* Uncommon in kids less than 2- happens to older kids, happens more in boys than girls.

### CLINICAL MANIFESTATIONS

- \* "FACED"
- Ill appearing
- Irritability to **lethargy**
- Anorexia
- Cloudy, smoky brown urine (tea)
- Hypertension
- Edema → pulmonary edema
- Decreased urine output

### DIAGNOSIS

- \* "A CHIRP"
- **Anti-streptolysin (ASO) titer** (will be positive if having strep throat at some point)
- Chest x-ray
- **Hematuria** with red blood cell casts, **no bacteria**
- Increased BUN and Creatinine
- Reduced serum complements (C3) levels
- Proteinuria

### MANAGEMENT

- \* "G DASH"
- Generally supportive care
- Dietary restrictions
- Diuretics
- Daily Weights
- Antihypertensive meds
- Strict I & O
- Home Tx OK if good UOP/normal BP
- **Hospitalized**: oliguria, gross hematuria, HTN
- Skin integrity—edema
- Need early recognition and Rx of complications.
- Can sometimes be treated at home, if they're still producing urine and their blood pressure is okay.
- Teach hand hygiene
- Seizure precautions if Na low: bed in

## Acute Renal Failure

- \* Inability of kidneys to excrete waste materials, concentrate urine, & conserve bytes
- \* Abrupt reduction of renal function
- \* Most types are reversible
- \* **Caused by different clinical conditions**
- \* **DEHYDRATION IS MOST COMMON CAUSE**,

[which means it's easily fixed]

### CLINICAL MANIFESTATIONS

- \* "HONED"
- HTN
- Oliguria associated with... *Anorexia (which nitrogen is in the blood), metabolic acidosis, diverse electrolyte disturbances*
- Nausea/vomiting
- Edema
- Drowsiness

### DIAGNOSIS

- Diagnosis is made primarily in urinalysis, Urine Culture, CBC (H&H low), and Serum Chemistry: BUN, Serum creatinine, Na, K+ (monitor if high or low) (high: give Kayexalate PO or rectal to absorb the extra K) if this doesn't work: dialysis)
- Ca levels

### MANAGEMENT

- Diuretics (to get fluid shift going in the right direction)
- Management of complications
- Provide supportive therapy
- Rehydration (fluid boluses & PO fluid)
- Treat underlying cause

### COMPLICATIONS

- \* "CASH"
- \*\* Cardiac failure
- \*\* Anemia
- \*\* Seizures
- \*\* HTN
- \*\* Hyperkalemia (>7mEq/L)

## Chronic Renal Failure

- \* Progressive irreversible
- \* **Caused by congenital malformations, reflux, pyelonephritis, infections**
- \* Plasma creatinine levels gradually become elevated as renal function decreases—cannot get this back to normal.

### CLINICAL MANIFESTATIONS

- \* "WHUP DAMN FF"
- Weight loss
- Headache, HTN
- Uremic syndrome (dry, itchy skin with uremic froth, "the breath")
- Pallor
- Dry/itchy skin
- Anorexia
- Muscle cramps
- N/V
- Fatigue
- Facial edema

### MANAGEMENT

- Dialysis
- Diet regulation (if needed, may restrict sodium, potassium, & water)

### ENCOURAGE PROTEIN

- to make sure they have enough to promote healing]
- Fluids
- Medications: side effects, (if they're taking meds that are excreted by the kidney and the kidneys aren't working properly)
- Prevent/treat infections
- Transplant (will end up on this list, because you can't get your kidneys back once they're damaged)

- Prognosis: POOR, children will end up on dialysis

# Pediatric Nursing Study Guide

**Lippincott**



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*National Library of Medicine Current Catalog* National Library of Medicine (U.S.),

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## **Table of Contents Pediatric Nursing Study Guide**

1. Understanding the eBook Pediatric Nursing Study Guide
  - The Rise of Digital Reading Pediatric Nursing Study Guide
  - Advantages of eBooks Over Traditional Books
2. Identifying Pediatric Nursing Study Guide
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Pediatric Nursing Study Guide
  - User-Friendly Interface
4. Exploring eBook Recommendations from Pediatric Nursing Study Guide
  - Personalized Recommendations
  - Pediatric Nursing Study Guide User Reviews and Ratings
  - Pediatric Nursing Study Guide and Bestseller Lists
5. Accessing Pediatric Nursing Study Guide Free and Paid eBooks
  - Pediatric Nursing Study Guide Public Domain eBooks
  - Pediatric Nursing Study Guide eBook Subscription Services
  - Pediatric Nursing Study Guide Budget-Friendly Options
6. Navigating Pediatric Nursing Study Guide eBook Formats

- ePub, PDF, MOBI, and More
- Pediatric Nursing Study Guide Compatibility with Devices
- Pediatric Nursing Study Guide Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Pediatric Nursing Study Guide
  - Highlighting and Note-Taking Pediatric Nursing Study Guide
  - Interactive Elements Pediatric Nursing Study Guide
- 8. Staying Engaged with Pediatric Nursing Study Guide
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Pediatric Nursing Study Guide
- 9. Balancing eBooks and Physical Books Pediatric Nursing Study Guide
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Pediatric Nursing Study Guide
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Pediatric Nursing Study Guide
  - Setting Reading Goals Pediatric Nursing Study Guide
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Pediatric Nursing Study Guide
  - Fact-Checking eBook Content of Pediatric Nursing Study Guide
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks



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