**How is nursing assessment done on someone who has syphilis?**

**Introduction**

We first need to understand the meaning of the two term ***syphilis*** and ***nurse assessment.*** Nurse assessment is the procedural evaluation of the patient health information by gathering, sorting, and analyzing of the information so as to keep the record of the health status of the patient in regards to a particular disease.

Syphilis is a bacterial infection which is usually transmitted through sexual contact. Its causative agent is *Treponema pallidum,* a bacterium*.* It is one of the most common types of Sexually Transmitted Diseases (STD) that one can easily contract in case they have unprotected sexual intercourse with an infected person.

In their article***; Syphilis (nursing)***, Maria E. Tudor et.al gives a brief history on the origin of this disease and how it spread to the rest of the world. They claim that, through the Columbian theory which is the most accepted theory, syphilis came from Europe in the 1490s. This is the time when Columbus arrived in the America which was referred to as the New World. Syphilis is therefore claimed to spread when Christopher Columbus arrived in Naples (Italy). This new disease spread across Europe after Naples lost the battle to the French troops.

**Risk factors**

Syphilis is a contagious disease that can be contracted by both male and female. Those prone to this disease are; gay (men who are sexually involved with other men), women, commercial sex workers and those who have multiple sexual partners.

This disease can also be passed to the newborn from the mother during birth. According to the report by ***WHO Guidelines for the treatment of Treponema Pallidum(2016)***, the World Health Organisation reported that in 2012, an estimation of 350 000 adverse pregnancy outcomes worldwide were accredited to syphilis, including 143 000 early fetal deaths or stillbirths, 62 000 neonatal deaths, 44 000 preterm or low-birth-weight babies and 102 000 infants are born infected. The report also mentions that there is also an increase in mother-to-child transmission of HIV among pregnant.

**Stages and symptoms**

For easy assessment of these diseases, it is important to understand the different stages and the symptoms that are exhibited during each stage. Syphilis occurs in different stages and therefore, the symptom that may be diagnosed at different stages depends on the level at which the infection is: the stages are as discussed below:

1. **Primary syphilis**

This is where a small sore which is referred to as Chancre develops on the skin as a small spot where the bacteria enters the body. The sore is usually painless and hidden and hence it takes a while after exposure before the victim notices that they are infected. Some people may develop only one sore while others may develop many sores. The painless spot may heal on its own after two or three weeks.

1. **Secondary syphilis**

This second stage of syphilis infection occurs just few weeks after healing from the original chancre. One experiences/develops painless rushes that may cover the whole body and eventually cover the palm of the hands and the feet.

Common symptoms of this level are: hair loss, muscle aches, fever, sore throat and swelling of the lymph nodes. However, these symptoms are expected to disappear within a few weeks or occur repeatedly within a year.

1. **Latent syphilis**

This is the third stage and it can last for years. Signs and symptoms may not be seen, and the disease may progress to the tertiary stage.

1. **Tertiary syphilis**

In this late stage, the disease may damage the vital organs of the body such as the brain, nerves, eyes, heart, etc. These symptoms may occur many years after the first chancre fails to be treated

1. **Neurological and Ocular syphilis**

Through his report on **Neurological and Ocular involvement(2020)** to ***Illinois Department of Public Health (IDPH***) Singh indicates that Neurologic involvement also known as Neuro syphilis may occur at any stage of syphilis. This is experienced at a stage where syphilis infection invaded the nervous system and with this, there may be a wide range of symptoms. These symptoms may include; headaches, altered behavior, one may have difficulty in coordinating muscle movements, sensory deficits etc.

The report by IDPH also indicates that; Ocular involvement or ocular syphilis on the other hand may also occur at any stage of syphilis, but eye involvement seems to occur most in the secondary and late syphilis stages.

**Nursing Assessment**

Nursing assessment or nursing care of syphilis involves 4 main steps. In this steps the nurse aims at obtaining; subjective data and objective data, giving nursing diagnosis to achieve the desired outcome. The nurse is also expected to give nursing intervention which is aimed at giving a positive result after evaluation. The nurse may also outline the rationale for the assessment.

The process nursing assessment maybe explained as follows;

1. **Nursing care Plan one**

The ***subjective data*** obtained by the nurse is that the patient complains about pain.

The ***objective data*** is that the nurse assesses the level of pain where the patient may show some protective behavior during assessment due to the pain felt.

***Nursing diagnosis*** done by the nurse shows that the patient has chronic pain related to lesion in the body tissues

The ***desired outcome*** of this first plan is to help free the patient from pain which they are currently experiencing.

***Nursing intervention*** given at this first plan may include:

* Assessment of the history of pain and response of the patient to pain during doctors examination/diagnosis.
* The nurse may also help in the intervention process.
* The nurse can also give an assessment on the different ways of reducing pain and explain the techniques that the patient can practice to help reduce the pain.
* Creating a comfortable environment and reducing unpleasant stimuli in terms of medication is also one of the interventions the nurse can recommend or use.
* The patient is expected to collaborate with the nurse in providing analgesics.

1. **Nursing care Plan two**

The ***subjective data*** is that the patient complains of the increase in temperature where one might complain of too much heat or the body feeling hot.

The ***objective data*** is that the nurse assesses the vital symptoms of the patient, which includes the body temperature

***Nursing diagnosis*** follows where the nurse carries out hyperthermia in relation to the relation to infection process.

The ***desired outcome*** is to reduce the body temperature of the patient to help reduce fever.

***Nursing intervention*** includes:

* Observation of the general condition of the patient especially on the vital signs. This is usually carried out after every two hours.
* Administering of antipyretics to reduce fever (as prescribed).
* The nurse can also administer some cold compress on the forehead and arm of the patient to help reduce fever.
* The nurse can recommend that the patient use thin and loose clothing.
* The nurse can advise patient to take plenty of fluids so as to maintain fluid balance.
* When evaluation is done, the patient is expected to have normal body temperature

1. **Nursing care Plan three**

The patient complains of lack of sleep or having difficulty in sleeping and this becomes the ***subjective data.***

The nurse does assessment on the patient and concludes that restless and anxiety is the cause of the difficulty in sleeping. This is the ***objective data.***

***Nursing diagnosis*** is done to find out if the anxiety is due to the disease treatment process.

The ***goal*** of this plan is to reduce the anxiety.

***Nursing intervention*** at this stage includes:

* Assessment of the level of fear and anxiety of the patient.
* Providing care and a safe environment.
* The family of the client and the client are also involved in the implementation process.
* Teaching the patient the use of relaxation techniques. Tell patient about the disease and the simple actions to be carried out simply.

The ***evaluatio***n results expected after this plan is that the patient will show no or reduced level of anxiety.

1. **Nursing care Plan four**

The ***subjective data*** is that the patient asks the doctor about syphilis.

The nurse obtains ***objective data*** by assessing the patient’s level of knowledge about syphilis

The patient shows deficient knowledge related to lack of adequate information about syphilis.

***Expected outcome*** of the fourth care plan is to improve the level of knowledge of the patient.

***Nursing intervention*** in this care plan level will include the following:

* Assessment of the level of knowledge of the patient.
* The nurse educates the patient about syphilis, it’s causative agent, transmission methods and treatment.
* The nurse also advices the patient to avoid practicing unprotected sexual relations.
* The nurse teaches the patient about the treatment schedule.

**Evaluation** of this level is expected to exhibit knowledge about syphilis.

**Conclusion**

After successful assessment, the patient is expected to start treatment that if well maintained, the patient can be declared free from the congenital disease and hence lead a normal life and practice the precautions which include avoiding unprotected sexual intercourse which is the primary cause of this disease.

# REFERENCE

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# Maria E. Tudor; et. al *Syphilis (Nursing)(2023).*[Author Information and Affiliations](https://www.ncbi.nlm.nih.gov/books/NBK568808/#__NBK568808_ai__)

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