

# Nursing assignment: Practice paper

## ASSIGNMENT

Write a client history, a nursing diagnosis, recommendations for care, your rationales, and expected and actual outcomes. Use interview notes, the client's health records, and relevant research findings.

- 1 Key terms
- 2 Purpose: to provide client history, diagnosis, recommendations, and outcomes
- 3 Evidence: interviews, health records, and research findings

ALL AND HTN IN ONE CLIENT

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Acute Lymphoblastic Leukemia and Hypertension in One Client:  
A Nursing Practice Paper

### Physical History

E.B. is a 16-year-old white male 5'10" tall weighing 190 lb. He was admitted to the hospital on April 14, 2006, due to decreased platelets and a need for a PRBC transfusion. He was diagnosed in October 2005 with T-cell acute lymphoblastic leukemia (ALL), after a 2-week period of decreased energy, decreased oral intake, easy bruising, and petechia. The client had experienced a 20-lb weight loss in the previous 6 months. At the time of diagnosis, his CBC showed a WBC count of 32, an H & H of 13/38, and a platelet count of 34,000. His initial chest X-ray showed an anterior mediastinal mass. Echocardiogram showed a structurally normal heart. He began induction chemotherapy on October 12, 2005, receiving vincristine, 6-mercaptopurine, doxorubicin, intrathecal methotrexate, and then high-dose methotrexate per protocol. During his hospital stay he required packed red cells and platelets on two different occasions. He was diagnosed with hypertension (HTN) due to systolic blood pressure readings consistently ranging between 130s and 150s and was started on nifedipine. E.B. has a history of mild ADHD, migraines, and deep vein thrombosis (DVT). He has tolerated the induction and consolidation phases of chemotherapy well and is now in the maintenance phase, in which he receives a daily dose of mercaptopurine, weekly doses of methotrexate, and intermittent doses of steroids.

Evidence from client's medical chart for overall assessment.

Specialized nursing language (*echocardiogram, chemotherapy, and so on*).

Instead of a thesis, or main claim, the writer gives a diagnosis, recommendations for care, and expected outcomes, all supported by evidence from observations and client records.