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Review Article

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Review Article

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Schizophrenic Disorder

Amisha[1], Sonia[2], Subhashini[3]

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Abstract

In 1908 Eugen Bleuler coined the term "Schizophrenia". Schizomeans split and phren means mind. It means disorganised personality. Schizophrenia is a debilitating mental illness that affects 1% of the population in all cultures. It effects equal number of men and women but the onset is often later in women than in men. Schizophrenia is characterized by positive and negative symptoms. Positive symptoms include hallucinations, voices that Converse with or about the patient and delusions that are often paranoid. Negative symptoms include flattened effect, loss of sense of pleasure, loss of will or drive and social withdrawal. Both type of symptoms effects patient's families therefore, it is important for physician to provide guidance to all persons affected by the disease. Psychosocial and family interventions can improve outcomes. Medications can control symptoms but virtually all antipsychotics have neurologic or physical side effects (example weight gain, hypercholesterolemia, diabetes). There is 10% lifetime risk of suicide in patients with schizophrenia.

Keywords: Schizophrenia; Hallucinations; Religiosity; Waxy flexibility.

Introduction

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, violations, and faculties in the presence of clear consciousness which usually leads to social withdrawal. About 3-4/1000 in every community suffer from schizophrenia.

Causes of schizophrenia are both genetic factors and environmental factors. This is common in both men and women. Peak age of onset in men is 15-25 and the peak age of onset in women is 25-35. Onset is often later in women than in men. There are 6 different types of schizophrenia (i.e. catatonic, residual, paranoid, disorganised, undifferentiated, schizoaffective.) There are both positive and negative symptoms of schizophrenia.

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Causes

- Genetically
- Biochemical influences the dopamine hypothesis.
- Physiological influences anatomical abnormalities, physical conditions.
- Family theories- dysfunctional family system, over protectiveness.

Signs and Symptoms

Positive symptoms

- Hallucinations
- Delusions
- Paranoia
- Religiosity

Negative symptoms

- Flat affect

- Apathy
- Waxy flexibility
- Deteriorated appearance

Magnitude and Impact

Schizophrenia affects approximately 24 million people or 1 in 300 people worldwide. This rate is 1 in 222 people among adults. It is not as common as many other mental disorders. Onset is most often during late adolescence and the twenties, and onset tends to happen earlier among men than among women. Schizophrenia is frequently associated with significant distress and impairment in personal, family, social, educational, occupational, and other important areas of life. People with schizophrenia often experience human rights violations both inside mental health institution and in community settings. Stigma against people with this condition is intense and widespread, causing social exclusion, and impacting their relationships with others, including family and friends. This contributes to discrimination, which in turn can limit access to general health care, education, housing and employment.

Management

There is no objective diagnostic test, the diagnosis is used to describe observed behaviour that may stem from numerous different causes. Besides observed behaviour, doctors will also take.

History that includes the person's reported experiences, and reports of others familiar with the person. Treatment modalities is we can give atypical of typical antipsychotics. Typical antipsychotics are clorpromazine, fluphenazine, haloperidol, loxapine. Atypical antipsychotics are clozapine, risperidone, paliperidone, olanzapine, aripiprazole. But typical antipsychotics have more side effects than atypical antipsychotics. Precautions while taking antipsychotics are avoid alcohol, avoid driving, don't use heavy machinery because this makes you feel more dizzy and drowsy.

About half of those diagnosed with schizophrenia will have a significant improvement over the long term with no further relapses, and a small portion of these will recover completely. The other half will have a lifelong impairment. In some cases, people may be repeatedly admitted to hospitals.

Conclusion

Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in presence of clear consciousness, which usually leads to social withdrawal. As we know prevention is better than cure. If we have seen any of these symptoms in any person we have to immediately visit to the hospital and contact to doctors without any delay. We have to take proper care and proper medications for this condition so that we will manage this illness.

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Comparative Study to Assess the Problems among the Preschooler of Working and Non working Mothers in Selected Playgroups

Reshma Bodhak

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Abstract

Preschool children are of paramount importance in determining the future behaviors of children. Preschool behavior problems are now being recognized as clear some disorders are more common than others, and conditions range from mild to severe. The common behavioral problems identified in children includes Habit problems, Problems of eating, Sleep Problems, Speech problems, Scholastic problems, psychosexual problems, Personalityproblems and Psycho social problems. Often, a child will be having more than one disorder.[1]

Working women will have less time at her disposal for child care. The working mother has both positive and negative impact over the child's development. Hence the researcher intended to identify behavioral problems of preschool children of working mothers and to compare with that of non-working mothers. An awareness of the prevalence of these problems is important to plan mental health services for children in order to improve the quality of life of the affected children. Screening is necessary to detect developmental problems in preschool children. Therefore various problems always require special attention. Comparative study was carried out to assess the problems among the preschooler of working and non-working mothers in selected playgroups. A Quantitative Descriptive Research Approach was used. Exploratory Descriptive Comparative Research Design was applied The setting of the study was preschool of selected areas of the city, Non probability purposive sampling technique was used with a sample size of 100 (50 working and 50 non working mothers) The tool consisted of Two sections of demographic variables and likerts scale to assess the behavior problems . The analysis of the study was done using descriptive and inferential statistics where chi square test was applied to associate the study findings with selected demographic variable . The findings of the study concluded that Health problems are seen more in working mothers child as compare to non-working mothers child.

Keywords: Preschooler ; Scholastic problems, Psychosexual problems; Mental health.

Introduction

Children are the inheritance from God. They are like clay in the potter's hand. Handled with love and care, they become something beautiful or else they will break Children of today are the citizens of tomorrow. The prosperity of the nation depends upon the health of its future citizens. Children with sound mind in sound body are essential for the future development of the country.[2]

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Every child should have tender loving care and sense of security from parents. The mother is more responsible for the integrated development of a child. The investment on our children in terms of developing environment both physical and emotional is going to reap rich individuals in future. As said by Karl Augustus Menninger "What s done to the children, they will do to the society".[3]

It stresses that the mother's reaction plays an important role in molding the behavior of the child. Different mothering styles may influence a child's behavior and inadequate attention may result in abnormal behavior in children. Sometimes such children show a wide variety of behavior which may even create problems to parents, family members and society. It may be minor but produce anxiety to the parents, which may be due to failure in adjustment to external environment.[3]

Need for the Study

Preschool period is one of rapid change in developmental, social, emotional, cognitive and linguistic abilities. The child is progressively developing more autonomy.4 Preschool children with early emergent behavior problems are likely to evince serious behavior problems, social skill deficits and academic difficulties later in life.[4]

A study was conducted on behavior problems among preschool children. Out of 200 Preschool children (aged 3-6 years), 44 (22%) had behavior problems. The prevalence was higher among boys and more common in children from nuclear families and a lower socio-economic status.[5]

The recent studies estimated that only about 50% of the psychosocial problems of the children are identified by their primary physician or parents, 12-25% of all American school age children and 13% preschoolers have emotional/behavioral disorders. The psychosocial problems increased from 6.8% to 18.7%. Intentional problems showed the greatest absolute increase (1.4%-9.2%) and emotional problems showed the increase (0.2-3.6%). The percentage of children with attention deficit/ hyperactivity problems receiving medications increased from 32% to 78%. These increase in psychosocial problems were associated with increase in the proportions of single-parent families, parents get divorced, mothers employment and parent child relationship.[6]

The preschool child (3-6 years of age) is more self reliant. During this age children are socialized into the culture. In some cultures they become quite independent and are required to take on considerable responsibility, even to the extent of being responsible for the care younger siblings. In other cultures children are not encouraged to develop independence until much later. They remain totally dependent on adults for their care and feeding. Again, the culture the child is raised in determines in the timing and the kinds of skills acquired in relation to self-care, independence and the development of responsibility. While in many cultures in the Majority World (the developing countries) children may be given the role of caretaker for younger siblings, children ages 3-6 also have needs of their own. They need: opportunities to develop fine motor skills: encouragement of language through talking reading, singing: activities that will develop a positive sense of mastery: opportunities to learn cooperation, helping, sharing: and experimentation with pre-writing and pre reading skills.[7]

The Statement of the Study

'Comparative study to assess the problems among the preschooler of working and non-working mothers in selected playgroups.

Objectives of Study

- To assess the problems among the preschoolers of working mothers in selected playgroups.
- To assess the problems among the preschoolers of non working mothers in selected playgroups.
- To compare the problems among the preschooler of working and non-working mothers in selected playgroups.
- To find out the association between problems among children of working andnon-working mothers in selected playgroups with selected demographic variables.

Assumption

This study is based on following assumptions

- The children of working mothers will have more health problems.
- Working mothers will spend less time towards the care of their children. There will be some difference in the occurrence problems among children of working and non-working mothers.
- Problems very from child to child.

Delimatation

The study is delimited to

- Mother's expressed views to the rating scale on problems of their child.
- Mother's working in Pune.
- Working and non working mothers whose children are attending preschool.
- The data collection period of four week.

Conceptual Framework

Health Promotion Model. The author of the theory was **Nola .J.Pender (Revised 1996)**

Review of Literature

Review of literature related to Behavioral problems among children

A study was conducted on problems among preschool children in Salem, India. The findings of the study reveals that, the level of behavioral problems among 50 preschool children of employed mothers, 33 (66%) of them had moderate behavioral problems and 17 (34%) of them had mild behavioral problems. Whereas among 50 preschool children of unemployed mothers, 11 (22%) of them had moderate behavioral problems and 39 (78%) of them had mild behavioral problems. The study findings shows that behavioral problems are found high among preschool children of employed mothers than the preschool children of unemployed mothers.[8]

Review of Literature Related to Psychological Problem among Children

Mcintosh (2006) has made an attempt to find out how working mothers affect their children emotionally and academically, verses mothers who do not work outside the home. A purposive sampling technique was used. Data was collected qualitative open-ended questionnaire developed by the researcher was distributed directly to the participants. After each questionnaire was returned, the data was examined to define possible themes. The results of the study indicate that having a working or stay at home mother does not determine a child's academic ability. Both working and stay at home mothers, also fell that their child's emotional state was stable.[9]

Review of Literature Related to Physical Problem among Children

Schachter (1981) conducted a study to compare the toddlers of employed mothers with unemployed mothers matching family size, social class, intact status and group care experience. No differences were found on language development but intelligence of children of non-employed mothers was found to be significantly higher. Difference was found in emotional adjustment but children of employed mothers were found to be more peers oriented and self-sufficient.[10]

Methodology

Research Approach: Quantitative Descriptive Research Approach.

Research Design: Exploratory Descriptive Comparative Research Design.

Variable of Study

Variables

The variable in this study is problems of preschool children, working and non working mothers.

Setting of the Study: The study was conducted in selected play group in Pune.

Population

Target Population: Working and non-working mothers of preschooler children in selected playgroup in overall Pune city.

Sample: The sample comprised of working and non working mother of preschooler children in selected playgroup.

Sampling Technique: Non probability Purposive sampling techniques.

Sample Size: Sample size was 100. A sample of 50 working and 50 non working mothers of pre-school children will be selected for study. Total 100 sample.

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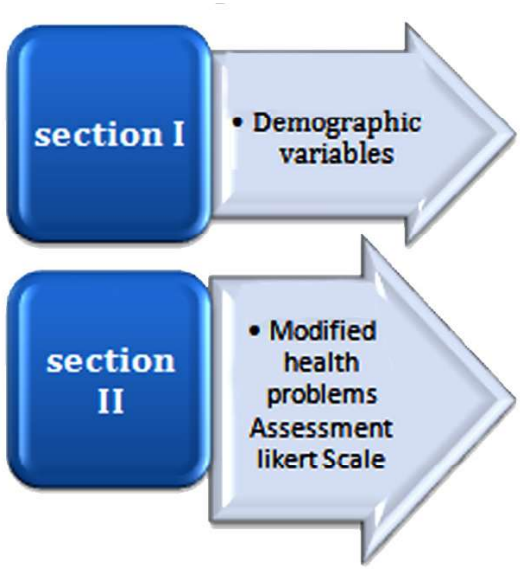

Major Studyfindings

Findings Related to Demographic Variables

- ***Age in years (Child):*** Majority 44% of samples in age group 3-4 years, 30% were in age group

of 5-6 years and minimum 26% were in age group of 4-5 years for the working mother's preschooler child. In non-working mothers preschooler child majority 44% of samples in age group 4-5 years, 32% were in age group of 3-4 years and minimum 24% were in age group 5-6 years.

- ***Gender (Child):*** Majority 60% of sample in gender of female and minimum 40% of sample in gender of male in working mother's preschooler child. In non-working mothers preschooler child majority 52% of sample in male and minimum 48% of sample in female result like a vice versa.
- ***Marital Status of Mother:*** Maximum 94% samples were married in non working mother and 88% samples were married in working mothers of preschooler 8% were widow in working mothers and 4% sample were widow in non-working mothers of preschooler 4% sample were divorced in working mother and 2% sample were divorced in non-working mothers of preschooler.0% sample were unmarried in both working and non-working mothers of preschooler child.
- ***Occupation:*** In working mother's majority 82% sample were private employee, 14% sample were government employee and 4% sample were business. In non working mothers majority 100% sample were house wife.
- ***Monthly Family Income:*** Majority 44% sample in working mothers and 38% sample in non-working mothers were having 20,000/- and above monthly income, minimum 8% in working mothers were having up to 10,000/- and 18% in non-working mothers were having up to 10,000/- & 10,001-15,001/- monthly income 14% were having 10,001-15,001/- , 34% having 15,001-20,000/- monthly income of working mothers.26% having 10,001-15,000/- monthly income of non-working mothers of preschooler.
- ***Type of Family:*** Majority 62% working mother's child and 54% non working mother's child leaves in nuclear family. Minimum 0% leaves in extended family both working and non-working mothers preschoolers child. 36% working mother's child and 46% non-working mothers child leaves in joint family 1% working mothers child leaves in single parent family.

Finding Related to Health Problems among the Preschooler of Working and non Working mothers

Behavioral Problems

- In working mothers some sample responses for disrespect 60% samples are never, 26% are rarely and 14% are sometime, 2% are always. In non-working mothers some sample responses for 50% samples are never, 32% are rarely, 18% are sometimes and 0% are always.
- In working mothers some sample responses for aggressive behavior 44% samples are rarely, 38% are sometime and 18% are never, 0% are always. In non-working mothers some sample responses for 40% samples are rarely, 34% are never, 24% are sometimes and 2% are always.
- In working mothers some sample responses for habit of nail bites 50% samples are rarely, 24% are never and 16% are sometime, 10% are always. In non-working mothers some sample responses for 46% samples are never, 40% are rarely, 12% are sometimes and 2% are always.
- In working mothers some sample responses for Anger 48% samples are rarely, 30% are sometime and 14% are never, 8% are always. In non-working mothers some sample responses for 36% samples are never, 32% are sometime, 30% are rarely and 2% are always.
- In working mothers some sample responses for Bed wetting 40% samples are never, 40% are rarely and 20% are sometime, 0% are always. In non-working mothers some sample responses for 48% samples are never, 40% are rarely, 12% are sometimes and 0% are always.
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- In working mothers some sample responses for Excessive crying 46% samples are rarely, 34% are never and 14% are sometime, 6% are always. In non working mothers some sample responses for 46% samples are never, 28% are rarely, 22% are sometimes and 4% are always.

- In working mothers some sample responses for School phobia 34% samples are never, 28% are rarely and 28% are sometime, 6% are always. In non-working mothers some sample responses for 46% samples are never, 32% are rarely, 12% are sometimes and 0% are always.

Psychological problems

- In working mothers some sample responses for Anxious 40% samples are rarely, 36% are never and 18% are sometime, 6% are always. In non-working mothers some sample responses for 54% samples are never, 26% are rarely, 18% are sometimes and 2% are always.
- In working mothers some sample responses for Hyperactivity 36% samples are rarely, 30% are never and 24% are sometime, 10% are always. In non-working mothers some sample responses for 44% samples are never, 40% are rarely, 14% are sometimes and 2% are always.
- In working mothers some sample responses for Lack of concentration 38% samples are rarely, 38% are never and 24% are sometime, 0% are always. In non-working mothers some sample responses for 52% samples are never, 36% are rarely, 10% are sometimes and 2% are always.
- In working mothers some sample responses for Lack of motivation 46% samples are never, 38% are rarely and 14% are sometime, 2% are always. In non-working mothers some sample responses for 66% samples are never, 28% are rarely, 4% are sometime and 2% are always.
- In working mothers some sample responses for impaired memory 46% samples are never, 34% are rarely and 16% are sometime, 4% are always. In non working mothers some sample responses for 70% samples are never, 18% are rarely, 12% are sometimes and 0% are always.
- In working mothers some sample responses for Difficulty in learning 38% samples are sometime, 38% are never and 22% are never, 1% are always. In non-working mothers some sample responses for 60% samples are never, 22% are rarely, 18% are sometimes and 0% are always.
- In working mothers some sample responses for staying alone 30% samples are rarely, 27% are never and 12% are sometime, 4% are always. In non-working mothers some sample responses for 72% samples are never, 20% are rarely, 8% are sometimes and 0% are always.
- In working mothers some sample responses for fear about separation from parents50% samples are never, 28% are some time and 12% are always, 10% are rarely. In non-working mothers some sample responses for 42% samples are never, 26% are rarely, 22% are sometimes and 10% are always.

Physical Problems

- In working mothers some sample responses for Weakness 46% samples are rarely, 34% are never and 14% are sometime, 6% are always. In non working mothers some sample responses for 46% samples are never, 28% are rarely, 14% are sometimes and 2% are always.
- In working mothers some sample responses for pain 40% samples are rarely, 40% are never and 18% are sometime, 2% are always. In non working mothers some sample responses for 70% samples are never, 24% are rarely, 21% are sometimes and 4% are always.
- In working mothers some sample responses for fatigue 52% samples are rarely, 28% are never and 18% are sometime, 2% are always. In non working mothers some sample responses for 52% samples are never, 36% are rarely, 10% are sometimes and 2% are always.
- In working mothers some sample responses for Drowsiness 50% samples are rarely, 38% are never and 10% are sometime, 2% are always. In non working mothers some sample responses for 60% samples are never, 32% are rarely, 8% are sometime and 0% are always.
- In working mothers some sample responses for Fever 40% are sometime, 26% samples are rarely, 22% are never and, 12% are always. In non-working mothers some sample responses for 42% samples arerarely, 34% are never, 22% are sometimes and 2% are always.
- In working mothers some sample responses for Allergy 52% samples are never, 30% are rarely and 14% are sometime, 4% are always. In non-working mothers some sample

responses for 64% samples are never, 26% are rarely, 6% are sometimes and 0% are always.

- In working mothers some sample responses for cold and cough 34% samples are sometime, 30% are rarely and 20% are never, 16% are always. In non working mothers some sample responses for 46% samples are rarely, 20% are never, 20% are sometimes and 4% are always.
- In working mothers some sample responses for skin rashes 50% samples are never, 44% are rarely and 6% are sometime, 0% are always. In non-working mothers some sample responses for 72% samples are never, 26% are rarely, 1% are sometimes and 0% are always.

Overall Health Problems Findings

Health Problem wise Overall Frequency and Mean

Behavioral Problems: In working mothers child 160 (40%) samples are rarely, 125 (31.2%) are never, 97(24.2%) are sometime and 18 (4.5%) are always. In non-working mothers child 180 (45%) samples are never, 137 (34.2%) are rarely, 74 (18.5%) are sometime and 9 (2.2%) are always.

Psychological Problems: In working mothers child 169 (42.2%) samples are never, 124 (31%) are rarely, 87(21.7%) are sometime and 20 (5%) are always. In non-working mothers child 230 (57.5%) samples are never, 108 (27%) are rarely, 53 (13.2%) are sometime and 9 (2.2%) are always.

Physical Problems: In working mothers child 159 (39.7%) samples are rarely, 142 (35.5%) are never, 77 (19.2%) are sometime and 22 (5.5%) are always. In non working mothers child 221 (55.2%) samples are never, 133 (33.2%) are rarely, 40 (10%) are sometime and 7 (1.7%) are always.

Finding Related to the Association between Demographic Variables

This section deals with association between selected demographic variables assessed by using chi-square test. The result summaries of chi-square test are tabulated below:

Selected Variables	Calculated Value (X^2)	T Value (P 0.05)	DF	Association
Age in years (child)	3.989	5.99	2	Not significant
Gender (Child)	0.724	3.84	1	Not significant
Marital status of Mother	0.548	7.82	3	Not significant
Occupation of mother	50	7.82	3	Significant
Monthly Family Income:	3.2	7.82	3	Not significant
Type of Family:	0.941	7.82	3	Not significant

Result

Health problems are more in working mothers childas compare to non-working mothers child.

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Review Article

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Clinical Manifestations and Treatment of Ashtma

Anjali Chauhan[1], Anshipriya[2], Simrat Kaur[3], S P Subashini[4]

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Abstract

The most frequent chronic respiratory condition is asthma. Despite substantial advancements in asthma diagnosis and care the majority of Indians with asthma continue to have poor control. Control can be achieved in the majority bof individuals, however with the use of avoidance strategies and suitable medications therapies. For the vast majority of patients, imhaled corticosteroids (ICS) constitute the standard of therapy. Most individuals who fails to establish control with ICS medication prefer combination ICS/ long acting beta2 - agonists inhalers. Biologic medicines that target immunoglobulin E or interleukin 5 have just recently been added to the asthma therapy arsenal, although they may be useful in certain cases of difficult to control asthma. Allergen specific immunotherapy has the potential to be a disease modifying therapy for many asthma patients, but it should only be recommended by allergy specialists. Regular monitoring of asthma control using objective testing methods such as Spirometry, if possible are key components of asthma care, in addition to avoidance tactics and medicines. Whenever possible; writing asthma action plans; monitoring treatment obstacles and therapy adherence ; and reviewing inhaler device technique. This article contains an overview of current evidence as well as guidelines for diagnosing and treating asthma in adults and children.

Keywords: Clinical Manifestations; Immunoglobulin; Bronchodilator medications; Pharmacological.

Introduction

Asthma is a chronic, non communicable disease, that affect both children and adults. Asthma symptoms are caused by inflammation and narrowing of the tiny airways in the lungs, which can include any combination of cough, wheeze shortness of breath and chest tightness.

In india, asthma affected an estimated 262 million individuals and resulted in 461000 deaths. Asthma symptoms can be controlled with inhaled medication, allowing patients with asthma to live a normal, active life. The majority of ashtma related deaths occur in low lower middle income nation, where diagnosis and treatment are difficulty to come by. Asthma is caused by complex gene-environment interactions, resulting in heterogeneity in clinical presentation as well as the kind and severity of airway inflammation and remodeling. The goal of asthma treatment is to achieve control, or to reduce the severity of symptoms and the risk of exacerbations. The mainstay of asthma treatment is anti inflammatory and bronchodilator medications, which are taken in a stepwise manner. Pharmacological treatment is centred on a cycle of assessment and re-evaluation by mens of shared judgements of symptoms control, risk factors, co-morbidities, side effects and patients satisfaction. Asthma is classified as severe when it requires high intensity treatment to keep it under control or when it does not respond to treatment. New biological therapeutics for the treatment of severe asthma, together with advances in biomarkers, open the door to phenotype specific interventions and more personalised treatment. We present a

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clinically oriented overview of asthma in adults and children older than 5 years, encompassing epidemiology, Pathophysiology, clinical diagnosis, asthma phenotypes, severe asthama, acute exacerbations, and therapeutic management bof disease. Im addition, new therapies, controversies, and unknown in asthma care are reviewed.

Etiology

Asthma is a term that refers to a group of disorders with a wide range of characteristics. A genetic susceptibility to asthma, specifically a personal or family history of atopy, is one of the identified reasons (propensity to allergy, usually seen as eczema, hay fever, and the ashthma).

Exposure to cigarette smoke and other inflammatory chemicals and particulates has also been linked to ashthma.

The overall etiology is complex and still unknown particularly when it comes to predicting which children with paediatric asthma will develop asthma as adults (upto 40% of children have a wheeze, but only 1% of adults have asthma), but it is agreed that asthma is a multifactorial pathology influenced by both genetics and environmental exposure.

Triggers for Asthma Include

- Viral respiratory tract infections
- Exercise
- Gastroesophageal reflux disease
- Chronic sinusitis
- Environmental allergens
- Use of aspirin, beta blockers
- Tobacco smoke
- Insects, plants, chemical fumes
- Obesity l
- Emotional factors or stress

Epidemiology

Asthma is a prevalent disease that affect approximately 15 person to 20% of persons in affluent countries and 2% of 4% of people in less developed countries. It is far more prevalent in children. Regardless of lung function testing, upto 40% children will develop a wheeze at some point, which if reversible with beta-2 agonists, is diagnosed as asthma. Asthma is linked to cigarette smoke to these substances.

Asthma is common in boys in childhood, with a male to female ratio of 2:1 until puberty, when the ratio drops to 1:1. Females bare more likely to develop asthma after puberty, and adult onset cases after, the age of 40 are primarily females. Due to airway reactivity and lesser levels of lung function, asthma prevalence is higher at extreme ages.

Approximately 66% of ashthma cases are detected before the ages of 18. During early adulthood, over half of children with asthma have a reduction in severity or complete cessation of symptoms.

Pathophysiology

Asthma is a disorder characterized by acute, entirely reversible airway inflammation, which often occurs as a result bof exposure bto a trigger. The pathogenic process starts with the inhalation of an irritant (such as cold air) or allergen (such as pollen), which causes airway inflammation and increased mucus production due to bronchial hypersensitivity. This causes a large increase in airway resistance, which is most noticeable when you exhale.

The following Factors can Cause Airway Obstruction

- Infiltration of inflammatory cells.
- Hypersecretion of mucus with the development of mucus plugs.
- Contraction of smooth muscle

Due to Time, these Irreversible Alterations may become Irrevocable

- basement membrane thickening, collagen deposition, and epithelial desquamation are all symptoms of basement membrane thickening.
- smooth muscle hypertrophy and hyperplasia cause airway remodeling nin chronic illness.

Asthma may become more difficult to treat if not treated quickly, because mucus production inhibits inhaled medication from reaching the mucosa. Edema develop when the inflammation worsens. Beta-2 agonists (e.g., salbutamol, salmetrol, albuterol) and muscrainic and relax the bronchial muscle, as well as mucus production.

Signs and Symptoms

Signs and Symptoms of Asthma may Include

- Chest tightness

- Coughing, especially at night or early morning
- Shortness of breath
- Wheezing, which causes a whistling sound when you exhale

While other conditions can cause the same symptoms as asthma, the pattern of symptoms in people who have asthma usually has some of the following characteristics.

- They come and go over time or within the same day.
- They start or get worse with viral infections, such as a cold.
- They are triggered by exercise, allergies, cold air, or hyperventilation from laughing or crying.
- They are worse at night or in the morning.

Treatment / Management

Conservative Measures

Calming the patient to get them to relax, moving outside or away from the likely source of allergen, and cooling the person are all things to consider. It is sometimes done to remove allergies by removing clothing and the washing the face, but this is not supported by evidence.

If one wants to avoid recurrent episodes, environmental control is essential. Avoiding allergens can greatly improve one's quality of life. Tobacco, dust mites, animals and pollen should all be avoided.

Obese asthmatica can improve their control by losing weight. Immunotherapy for allergens is still contentious. Large scale trials have found no substantial benefits, and the procedure is excessively expensive.

Patients with moderate to severe asthma who have a positive skin test should monoclonal antibody therapy. The procedure can help you lose weight.

Allergen immunotherapy remains controversial. Large studies have not shown any significant benefit, and the technique is prohibitively expensive. The therapy can lower igE levels, lowering histamine production as a result. However, the injection are expensive. Bronchial thermoplasty is a relatively recent treatment for reducing airway constriction by delivering heat energy to the airway wall. Several studies have shown that it can minimize emergency room visits and school days missed.

Medical

Bronchodilators such as beta-2 agonist and muscarinic antagonists (salbutamol and ipratropium bromide, respectively) as well as anti-inflammatories such as inhaled steriods are used im medical treatment.

High flow oxygen inhalation, systemic steriods, back to back nebulizations with short acting beta 2 agonists band short acting muscarinic antagonists, and intravenous magnesium sulphate are used to treat patients with life threatening asthma. The consultation of the critical care team early in the process helps to reduce mortality. Early incubation and mechanical ventilation are required in the case of near fatal asthma.

Surgical

Surgical intervention is not used in the treatment of normal asthma.

Long-Term/Other

Weight loss, quitting smoking, changing jobs and self monitoring are all beneficial in preventing disease progression and reducing the number of acute attacks.

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Review Article

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A Quasi Experimental Study to Assess the Effectiveness of Structured Teaching Programmeon knowledge Regarding Prevention of Covid-19 Among Staff Nurse working in Selected Hospital

Diksha Bhimrao Patil[1], Harsha Gajanan Ghumde[2], Shivani Kishor Pudke[3], Ankit Gajanan Kalbande[4], Komal Manohar Maraskolhe[5] Sahil Chinmantwar[6], Navmi Badge[7]

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Abstract

The covid-19 is a pandemic make in India is a part of the worldwide pandemic of corona virus disease. Corona virus are a large family of virus that causes illness ranging from the common cold to more severe disease such as middle east respiratory syndrome and severe acute respiratory syndrome. Novel corona virus is a new strain that has not been previously identified in human. Corona virus are zoonotic meaning they are transmitted between animal and people.[1]

Epidemiological evidence shows that 2019 and covid-19 can be transmitted from one individual to another. In previous outbreak of other corona virus such as any covid and SARS, human-to-human transmission occurred most commonly through droplets, personal contact and contaminated object.[2]

Keywords: Effectiveness of Structure teaching programme on knowledge regarding prevention of covid-19; Staff Nurses at selected hospital.

Introduction

A novel coronavirus (Co-V) is a new strain of coronavirus. The disease caused by the novel coronavirus first identified in Wuhan, China, has been named coronavirus disease 2019 (COVID-19) 'CO' stands for corona, 'VI' for virus, and 'D' for disease. Formerly, this disease was referred to as '2019 novel coronavirus' or '2019-nCoV.' The COVID-19 virus is a new virus linked to the same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.

The virus is transmitted through direct contact with respiratory droplets of an infected person (generated through coughing and sneezing), and touching surfaces contaminated with the virus. The COVID-19 virus may survive on surfaces for several hours, but simple disinfectants can kill it. Symptoms can include fever, cough and shortness of breath. In more severe cases, infection can cause pneumonia or breathing difficulties. More rarely, the disease can be fatal. These symptoms are similar to the flu (influenza) or the common cold, which are a lot more common than COVID-19. This is why testing is required to confirm if someone has COVID-19. It's important to remember that key prevention measures are the same frequent hand washing, and respiratory hygiene (cover your cough or sneeze with a flexed elbow or tissue, then throw away the tissue into a closed bin).[3]

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Activities such as vaccination, COVID appropriate behaviour, testing and treatment of cases, IEC and surveillance are core activities which should be carried out on priority in all districts of India while other activities such as contact tracing, restrictions on gatherings, closure of business and travel restrictions should be undertaken based on prevalent scenario in an area.[4]

Masud Rana, et.al; (2020) A study was conducted on the Knowledge of prevention of COVID-19 among the general people in Bangladesh: A cross-sectional study in Rajashi district. The study was conducted from March 10 to April 25, 2020. The aim of the study was to assess the knowledge of the general people, Bangladesh regarding the COVID-19 preventive measures. Data were collected with a semi-structured questionnaire from 436 adult respondents selected by using a mixed sampling technique. The result of study is only 21.6% of the respondents had good knowledge of the COVID-19 preventive measures. The highest 67.2%. The conclusion is the knowledge level of the general people regarding prevention of COVID-19 was alarmingly low in Bangladesh.[5]

Jingjing Shang Ashley M. Chastain (19 January 2021) The Study was conducted on the state of infection prevention and control at home health agencies in the United States prior to COVID-19. The aim of the study was they conducted a national survey to assess infection prevention and control-related policies, infrastructure, and procedures prior to the SARS-CoV-2 pandemic. The method of study was Survey data were linked to publicly-available data on the quality of patient care, patient satisfaction, and other agency characteristics. The result of the study was 35.6% of agencies responded (n = 536). Rural agencies are more likely to not have anyone in charge of infection prevention and control compared to those in urban areas. Only 39.7% of agencies provide N95 respirators to their clinical staff; rural agencies are significantly more likely to provide those supplies than urban agencies (50.7% vs. 37.7%, p = 0.004).[6]

Problem definition: "A study to assess the effectiveness of structure teaching programme on knowledge regarding prevention of COVID-19 among staff Nurses in selected Hospital".

Methodology

Research Approach: Quantitative evaluative research approach was used for this study.

Research design: Quasi experimental one group pre-test and post test research design.

Variables under study

- ***Independent Variable:*** Structure teaching programme on prevention of COVID-19.
- ***Dependent Variable:*** Knowledge of Staff Nurses on prevention of COVID-19.The study was conducted in selected Hospital.

Population: In this study, the population includedstudent in selected hospital

Target population: Staff nurses at selected hospital.

Accessible population staff nurses in selected hospital. Who fulfill the inclusive and exclusive criteria.

Sample and sampling technique

Sample: In the study Staff Nurses in selected Hospital.

Sample size: The sample size for the present study is 30 Staff Nurses who fulfill the set inclusion criteria.

Sampling technique: Probability simple random sampling.

Inclusion criteria: Students who are

- Staff Nurses, who are able to read, write and speak English.
- Staff Nurses who are willing to participate in the study.

Exclusion criteria: Students who are

- Who are sick at time of dada collection

Preparation of the tool

Section A: Demographic data,

Section B: Assessment of level of knowledge

Section C: Effectiveness of structured teaching programme.

Section D: Association of level of post-test knowledge score regarding prevention of covid-19 among staff nurses in relation to demographic variable.

Results: Organization of the data

Section I: Demographic Variables

This section deals with percentage wise distribution of staff nurses with regards to their demographic characteristics. A convenient sample of 30 subjects was drawn from the study population, who were

from selected hospital in a city. The data obtained to describe the sample characteristics including age, gender, education, previous knowledge regarding prevention of COVID-19 and source of information respectively.

Percentage wise distribution of Staff Nurses according to their age in years: Each 16.70% of staff nurses were in the age group of less than 22 years and more than 24 years, 40% of them were in the age group of 22-23 years and 26.70% were in the age group of 23-24 years.

Percentage wise distribution of Staff Nurses according to their gender: 76.70% of staff nurses were females and 23.30% of them were males.

Percentage wise distribution of Staff Nurses according to their educational level: 50% of staff nurses were educated up to BSc nursing, 10% up to MSc nursing and 40% of them were educated up to P.B. BSc nursing.

Percentage wise distribution of Staff Nurses according to previous knowledge on prevention of COVID-19: All (100%) of staff nurses were having knowledge about prevention of COVID-19

Percentage wise distribution of Staff Nurses according to source of information about prevention of COVID-19: 56.70% of staff nurses were having knowledge about prevention of COVID-19 from mass media, each 3.30% had information through family and friends, books/journals and other sources and 33.30% had knowledge through workshop/conference and workshop.

Table 1: Percentage wise distribution of staff nurses according to their demographic characteristics.

Demographic Variables	No. of Staff Nurses	Percentage (%)
Age in years		
<22 yrs.	5	16.7
22-23 yrs.	12	40.0
23-24 yrs.	8	26.7
>24 yrs.	5	16.7
Gender		
Male	7	23.3
Female	23	76.7
Educational Status		
BSc Nursing	15	50.0
MSc Nursing	3	10.0
PBBSc Nursing	12	40.0
Previous knowledge regarding prevention of COVID-19		
Yes	30	100
No	0	0
Source of information		
Mass Media	17	56.7
Family and friends	1	3.3
Workshop/conference/ seminar	10	33.3
Books/Journal	1	3.3
Others	1	3.3

Section-B: This section deals with the assessment of level of knowledge regarding prevention of COVID-19 among staff nurses working in selected hospital. The level of knowledge score is divided under following heading of poor, average, good, very good and excellent.

Pre Test: 23.33% of the staff nurses had good level of knowledge score and 76.67% of staff nurses had very good level of knowledge score.

Minimum knowledge score in pretest was 16 and maximum knowledge score in pretest was 22.

Mean knowledge score in pretest was 19.26±1.70 and mean percentage of knowledge score in pre-test was 64.22±5.66.

Post Test: 83.33% of the staff nurses had very good level of knowledge score and 16.67% of staff nurses had excellent level of knowledge score.

Minimum knowledge score in posttest was 19 and maximum knowledge score in posttest was 25.

Mean knowledge score in posttest was 22.36±1.80 and mean percentage of knowledge score in post-test was 74.55±6.03

Section-C: This section deals with the effectiveness of structured teaching program on knowledge regarding prevention of COVID-19 among staff nurses working in selected hospital. The hypothesis is tested statistically with distribution of pretest and posttest mean and standard deviation and mean percentage knowledge score. The levels of knowledge during the pretest and post-test are compared to prove the effectiveness of Structured Teaching Program. Significance of difference at 5% level of significance is tested with student's paired 't' test and tabulated 't' value is compared with calculated 't' value. Also, the calculated 'p' values are compared with acceptable 'p' value i.e., 0.05.

the comparison of pretest and post-test knowledge scores of staff nurses regarding prevention of COVID-19. Mean, standard deviation and mean difference values are compared and student's paired't' test is applied at 5% level of significance. The tabulated value for n=30-1 i.e., 29 degrees of freedom was 2.05. The calculated 't' value i.e., 10.57 are much higher than the tabulated value at 5% level of significance for overall knowledge score of postnatal working mothers which is statistically acceptable level of significance. Hence it is statistically interpreted that Structured Teaching Program on knowledge regarding prevention of COVID-19 among staff nurses was effective. Thus, the H1 is accepted.

Section D: The association of knowledge score with age in years of staff nurses from selected hospital of the city. The tabulated 'F' values were 2.98 (df=3,26) which is less than the calculated 'F' i.e., 9.56 at 5% level of significance. Also, the calculated 'p'=0.0001 which was less than the acceptable level of significance i.e., 'p'=0.05. Hence it is interpreted that age in years of staff nurses is statistically associated with their post-test knowledge score.

Conclusion

The study findings concluded that the staff nurses had poor knowledge regarding prevention of covid-19. The structure teaching programme had great potential for accelerating the awareness regarding knowledge of prevention of covid-19.

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Standard journal article

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Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792–801.

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[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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