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ORIGINAL ARTICLE

HOSPITALIZATION OF RECURRING URINARY TRACT INFECTION: PERCEPTION OF PREGNANT WOMEN

HOSPITALIZAÇÃO POR INFECÇÃO DO TRATO URINÁRIO RECORRENTE: PERCEPÇÃO DAS GESTANTES

HOSPITALIZACIÓN POR INFECCIÓN RECURRENTE DEL TRACTO URINARIO: PERCEPCIÓN DE LAS MUJERES EMBARAZADAS

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ABSTRACT

Objective: to identify the perception of pregnant women with recurrent urinary tract infection (RUTI) on the disease and hospitalization. ***Method:*** a descriptive study with a qualitative approach, developed with six pregnant women admitted to public hospital. Data was collected through semi-structured interviews, organized and analyzed according to the content analysis technique. ***Results:*** three categories emerged: << **Knowledge and unknowns of RUTI** >>; <<**Perception of the RUTI consequence**s; << **Perception of feelings aroused by RUTI** >>. ***Conclusion:*** it proposed to carry out educational practices in a dialogic manner with the help of order in the monitoring and prevention of complications. ***Descriptors*:** Nursing; Pregnancy; Urinary Tract; Infection; Hospitalization.

RESUMO

***Objetivo*:** identificar a percepção das gestantes com infecção do trato urinário recorrente (ITUR) diante da doença e hospitalização. ***Método*:** estudo descritivo, com abordagem qualitativa, desenvolvido com seis gestantes internadas em hospital da rede pública. Os dados foram coletados por meio de entrevistas semiestruturadas, organizados e analisados de acordo com a técnica de Análise de Conteúdo. ***Resultados*:** emergiram três categorias: **<< Conhecimentos e desconhecimentos da ITUR >>; << Percepção das consequências da ITUR >>; << Percepção dos sentimentos despertados pela ITUR >>**. ***Conclusão*:** propõe-se a realização de práticas educativas de forma dialógica, com o intuito de auxiliar no acompanhamento, bem como a prevenção de complicações. ***Descritores*:** Enfermagem; Gestação; Trato Urinário; Infecção; Hospitalização.

RESUMEN

Objetivo: identificar la percepción de las mujeres embarazadas con infección del tracto urinario recurrente (ITUR) frente a la enfermedad y hospitalización. ***Método:*** estudio descriptivo con enfoque cualitativo, desarrollado con seis mujeres embarazadas ingresadas al hospital de la red pública. Los datos fueron recogidos mediante entrevistas semiestructuradas, organizados y analizados según la técnica de análisis de contenido. ***Resultados:*** surgieron tres categorías: << **Conocimientos y desconocimientos de ITUR** >>; << **Percepción de las consecuencias de la ITUR**; << **Percepción de los sentimientos por la ITUR**>>. ***Conclusión:*** se propone llevar a cabo las prácticas educativas de forma dialógica, con el fin de ayudar en la supervisión, así como la prevención de complicaciones. ***Descriptores***: Enfermería; Embarazo; Las vías Urinarias; La infección; Hospitalización.

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INTRODUCTION

Pregnancy is a physiological process and it should be seen by women, society and health teams. Although it is a period marked by a series of physical, physiological and emotional changes that make women more vulnerable to the onset of diseases, evolution occurs, it is largely uneventful. However, this is a borderline situation, because some factors related to preconditions, previous reproductive history and current pregnancy, such as the mother is a carrier of a disease, suffers or develops some grievance, predisposes this to be classified as "high-risk pregnant women ", implying the need to be forwarded to secondary attention.[1,2]

The word risk is derived from the phrase "riscare" which means dare/go beyond. Thus, risk would be an alternative and not a destination. So, high-risk pregnancy is something which conceptualizes-life/health of the mother/fetus/baby that has a greater chance of being hit by the smallest grievance that is, the average population considered.[3]

Because of numerous injuries that may compromise the fetus and the mother, the high-risk pregnancy has become a topic discussed worldwide. These pregnant women, in addition to physical care, require greater psycho-emotional attention because they become more fragile emotionally, for various reasons, among them, stand out unexpected diagnosis, possible hospitalization and subsequent removal of the family. [3.4]

In such cases, frequent assessments are required, strict monitoring and use of technologies. Because it is specific care, requiring trained staff to meet the mother in her bio-psychosocial and spiritual needs, such a situation that has an impact not only on pregnant women and in the family, but in the economy, the needs of high cost treatments. [5, 3]

The identification of a risk does not always imply reference to pregnant women for high risk prenatal care. However, there are situations involving real risk to the mother and fetus, and necessarily, require frequent and technological assistance, however, when considering the situation resolved and / or intervention ever undertaken, these return to monitoring the primary level.[5]

Among the high-risk pregnancies, are those who develop urinary tract infections (UTI), or contamination by infectious agents of urinary tissues, whose most frequent complications are cystitis and pyelonephritis, which can affect the health of both the fetus, and the mother.[6,7] According to the Ministry of Health of Brazil, even UTI are considered a risk condition in pregnancy, monitoring can be done in basic care.[5]

However, with Recurrent Urinary Tract Infection (RUTI), this requires specialized care, ie, the pregnant woman should be referred for high risk prenatal care.[5-7] It is important to consider that women are conducive both to primary and recurrent infections, with about 25% chance to develop a new infection within six months of an episode, potentiated risk with the anatomical and physiological changes that occur in the urinary system during pregnancy.[8]

It is a condition considered relatively common among pregnant women, occurring after having acquired a asymptomatic bacteriuria frame. Etiologically, the RUTI is by bacteria causing the initial UTI (relapse) or by bacterial species other than the first infection (re-infection) .[8,10]

The main consequences associated with RUTI are spontaneous abortion, premature rupture of membranes, preterm labor, chorioamnionitis, postpartum fever, maternal and neonatal sepsis infection. Because it is a condition that sometimes presents systemic symptoms and rigorous follow-up, if the hospitalization is necessary for the pregnant woman.[11,7]

Although the hospital is a common conduct, it brings to the pregnant woman a detachment from family, loss of privacy, idleness, loneliness, absence from work, in addition to constant monitoring, which means frequent fasts, supervision and continuous monitoring of the multidisciplinary team, resulting in a period of anxiety, anguish and fears.[11,4]

Health education on pregnancy and childbirth should be centered on the user, as the form of expression of the mothers in the educational process can provide directions on the most appropriate guidelines to minimize feelings of apprehension. Therefore, it is necessary to consider the health education as a right, breaking the paternalistic, mechanist view of the body, pointing to the dialogue, socialization of knowledge and practices among professionals and users.[12,13]

In a study of pregnant women in the interior of Pernambuco, it was identified that the orientation deficit raises the prevalence of UTI and consequently its complications. Apart from that information that addresses genital hygiene, especially after intercourse, increased fluid intake and healthy urination practices are identified as possible factors reducing the incidence of RUTI.[2]

Therefore, it is important that during the prenatal care, health professionals guide pregnant women about the conditions

presented or that will be presented, in order to prevent diseases and amenable disorders prevention.[5]

Knowing that the RUTI is a common problem in pregnancy and considering that their evolution without proper treatment is responsible for triggering serious complications for the mother-fetus, we proposed to develop this study.

OBJECTIVE

- Identify the perception of pregnant women with RUTI on the disease and hospitalization.

MÉTHOD

A descriptive study with a qualitative approach, carried out in maternal and child referral hospital in the state of Maranhão, which serves a population of approximately 40 municipalities, as well as patients from other states, because of their geographical location. In this place, high-risk pregnancies are followed, as well as in emergency situations. It has 77 hospital beds, and the main diseases responsible for hospitalizations are amniorrhexis and RUTI.

The participants were six pregnant women addressed in any period of pregnancy, diagnosed with ruti and more than18 years old, regardless of color, race, religion or education level, admitted between October and November 2014. Those who did not present physical and/or emotional capacity to participate in the study were excluded, but there was no pregnant woman in this condition.

The total number of subjects were defined from the data saturation criterion, which is reached when the answers become similar and there are no new or different situations to subsidize theorization.[14]

A semi-structured interview was used to collect the information, divided into two parts: the first containing the data identification and obstetrical data; and the second having as a guide with three guiding questions. They are namely: "What do you know about urinary infection,"; "Do you know what the consequences of this disease are?; Tell me about it. "" How do you feel about being here hospitalized with this problem? ". A tape recorder was used to assist in data collection.

For the processing of the data, we opted for the analysis of technical content, which aims to infer implied messages in apparent text and consists of three stages: pre-analysis, material exploration and processing of results. In the pre-analysis, the material was organized following the completeness criteria, representativeness, consistency, relevance and exclusivity. Moreover, at this stage the interviews were transcribed in full and, after initial reading, themes that recurred with frequency were marked.[15]

In the second phase, called exploration of material, the raw data found in the pre-analysis was coded and organized into categories, classified from the construction of isotopes frame, allowing the description of the relevant characteristics of the content. The third and final phase of content analysis is constituted in the inference, from the analyzed material interpretations, in which they tried to understand what lay beneath the apparent reality, which meant truly enunciated speech, and what he meant in depth, certain apparently superficial statements.[15]

The research project was approved by the Research Ethics Committee of the University Hospital of Federal University of Maranhão / UFMA, under opinion No. 545,512.

RESULTS AND DISCUSSION

The six pregnant women interviewed were in the age group of 20 to 27 years, setting a young population. All were literate, but five did not complete primary school and one finished high school.

None had employment, claiming to be housewives. All were multiparous and four of these have reported having problems in the current pregnancy, in addition to the RUTI, and two women with bleeding in the first trimester of pregnancy, reported to have shown changes in blood pressure associated with headache and other exposed to having risk of premature birth.

About the perception of RUTI three themes were revealed, namely: Knowledge and unknowns of RUTI; Perception of the consequences of RUTI; and perception of feelings aroused by RUTI.

♦ Knowledge and unknowns of RUTI

Most of the women did not know what it means to have the disease which they were going through, as shown by the speaches:

> *I do not know what it is, I never knew you had it here (Pregnant 1)*
>
> *I do not know many things. I know it is dangerous, infection is dangerous business [...] (Pregnant 2)*
>
> *I do not know what it is (Pregnant 3)*
>
> *I don't know what it is woman(4 Maternity)*

This shows the gap in communication between the health professional and the mother during the service. It is important to note that in all care provided to pregnant women, this should be seen in a

biopsychosocial and spiritual perspective, therefore, in addition to technical competence, the professional must demonstrate concern for pregnant women and their way of life, listening to their complaints and considering their difficulties, fears and anxieties.

Therefore, it is necessary to have active listening, in order to provide the creation of bonds. So the professional contributes to changes in attitudes and life habits.[5] In this context, the authors claim that it is important to have a dialogue between professionals and pregnant women, as the purpose of this is to allow individuals to express their thoughts, needs and doubts.[3]

Dialogue is an important means to guide pregnant women about pregnancy and/or about your health condition process because it gives them the necessary autonomy to prevent or control complications during pregnancy, childbirth and postpartum.[13]

Another reason why women are unaware of their condition is by the way the information is being passed on by professionals, connecting to the probable misunderstanding of the contents. Thus, it is important to note that the guidelines should contain a clear and understandable language, respecting the culture and popular knowledge, to facilitate the participation and understanding of the process. The information is not compatible with the level of understanding and can generate more questions and have a negative impact, causing the woman to neglect self-care, developing or aggravating health problems.[13]

Other pregnant women answered about RUTI conceptualizing it from presenting symptoms, as shown by the following statements:

I know it hurts a lot (Pregnant 5)

Just know that it gets inflamed but I do not know the cause of the disease (Pregnant 6)

It is essential to consider the socio-cultural influence on Interpretation and experience of threats to pregnancy. This is what will influence the decision to search for a qualified health care or turn to the knowledge of the closest individuals as a psychosocial alternative, spiritual or alternative therapies.[16]

♦ Perception of the consequences of RUTI

The following data shows that even empirically, women have struggled to answer about the consequences that could befall them if they do not seek care:

I know it's bad for the baby [...] (Pregnant 5)

You can pass it on to baby (Pregnant 2)

I know it can kill the child (Maternity 4)

The nurse [...] said the baby may be born blind and deaf (Pregnant 3)

There are numerous complications that can affect the pregnant woman and binomial fetus. The main related to pregnant women are anemia, gestational hypertension, acute pyelonephritis, postpartum UTI; in addition to the most serious, represented by septicemia hydronephrosis, in varying degrees and which together are responsible for sharp mortality, particularly when diagnosis is delayed, and when treatment is delayed. The fetus may suffer complications such as delayed intrauterine growth retardation, preterm delivery, intrauterine death, infection and/or neonatal death.[17]

It is important to note in the speeches that despite pregnant women being susceptible to diseases and complications, show concern only with the consequences that can aggravate the life and health of the fetus. Once affected by conditions that favor a harm to the health of the fetus and premature birth, women do not appreciate the risks to their own health, disregarding them at the expense of efforts to encourage the survival of children.[18]

Noteworthy is the lack of complications for them and the unborn child if they do not treat the RUTI, as shown in the statements:

I do not know what may happen if I have this (Pregnant 6)

I do not know what can happen (Pregnant 1)

Since we do not know the pathology and risks that can occur, neglect of care and self-care and non-adherence to treatment becomes frequent. As pregnant women receive information on health and illness, their care practices are magnified because when you realize the risks that involve value treatment and self-care in order to avoid agravations.[13]

It is noteworthy that consultations represent the ideal time to develop health education, regardless of the profession, as individual guidance seeks to educate the customer about self-care, facilitating their adherence to therapeutic and preventive schemes in order to achieve better health levels and hence possible improved quality of life.[13]

Professionals should be alert to all forms of prevention that pregnant women need to know. The nurse should be directly involved in the role of educator and advisor, using methods that facilitate dialogue, filling in the gaps of knowledge, seeking to raise public awareness of the target.[17]

♦ Perception of feelings aroused by RUTI

Several negative feelings were expressed, such as loneliness, longing, anxiety, worry,

sadness, fear and idleness. These were given by the fact that women are not prepared for hospitalization, considering that pregnancy is not characterized as a disease.

The environment and the hospital routine are perceived as negative, since it changes their routine and deprive them of the social environment, as claimed in the reports:

> *Being hospitalized is a nightmare, I just wanted to go home. Because there is this hospital smell of medicine. it is very bad. (Pregnant 7)*
>
> *I could be at home relaxing, and here I am taking medicine [...] (Pregnant 5)*

Hospitalization is a necessary procedure in the risk of pregnancy and is an additional stressor. During this period, women should be supported and monitored properly, because the hospital requires biological and emotional conditions of positive pregnant women to adapt to the hospital environment and new habits.[19]

Antibiotic therapy requires a period of hospitalization of at least five days, considered prolonged by pregnant women because it is marked by feelings of worry, longing, loneliness and anxiety, since the woman was taken from the family environment in which, since the beginning, is performed the function of caregiving.

The following statements demonstrate these feelings by expressing a desire to return to their homes:

> *Oh, it's too bad to be hospitalized, I feel like running away already, wanting to go home [...] because I'm with no one. (Pregnant 6)*
>
> *It's bad because what we want is at home with the children, taking care of things and is not very good (Pregnant 2)*
>
> *[...] I wanted to just solve this problem [...] (Pregnant 1)*

Hospitalization causes changes in the familiar rhythm, especially the woman with her household removal. Distancing causes of dissatisfaction and denial of hospitalization reactions, especially when you have small children, which is revealed as the main difficulty to reconcile the treatment. Despite the possible family support network, mothers cannot reassure the separation of a child, even when awaiting the arrival of a new member.[4]

Another feeling noticed during the interviews was idleness, especially in prolonged hospitalization, as shown by the pregnant woman who said: "It's bad. I cannot do anything, just stay here in this hospital "(Pregnant 3).

Several factors make remote development activities in the hospital environment, such as environmental structure associated with rest, intravenous medications and the characteristic physical discomfort of the condition, which does not prevent the carrying out of activities. In this context, educational activities involving women, contribute to the clarification of doubts, information about the disease, reducing the concerns, anxieties and fears, but also ensures the adoption of healthy habits.[13]

Pain is another contributing factor to the negative feelings during hospitalization, as shown in the statements:

> *Look, I feel bad right? [...] it is bad because of pain right ?! (Pregnant 5)*
>
> *I'm not putting up with this much pain (Pregnant 1)*

In the tables of RUTI, pain is a common sign in about 83% of pregnant women with high intensity in 40% of cases. Complaints usually begin from the second trimester of pregnancy, with a prevalence of 43%, and worsened in the third quarter 48% of pregnant women, a fact that actively contributes to the removal in performing activities of daily living. The perception of pain is different between different subjects. There are those who are more sensitive and others that support better this experience. Thus, the pain is used as a thermometer to measure the threshold of each subject.[2,19]

The physiognomic expression, crying and restlessness of some pregnant women during the interview shows that referred pain is not composed only physiologically, but is loaded with emotions, interpretation of time, standard of living, learning and experiences. When these elements are interrelated, they provide to pregnant women a better face on admission, as shown in the accounts:

> *I feel better right, because I was not able to even walk (...) here is good. (Pregnant 4) It is good to be in the hospital because I am improving [...] (Pregnant 1)*

The accessibility of the service and dedication of the health team, arouses positive feelings in these women, bringing them hope of healing and the birth of a healthy baby. Thus, after overcoming the impact of the diagnosis of a risky pregnancy, they are glad to have access to specialized service with human, physical and material resources, since the disruption of some services in the health network in Brazil contribute to generation of other sufferings, other than those brought by disease.[4]

Every woman is a unique being, with individual perceptions and idealizations about what being a woman and being a mother is, built from its cultural, social and family background, which exert strong influence on the adaptation to new contexts.[19]

It is believed that the sensitivity of professionals, especially nurses, as well as the provision of quality care, paying attention to the subjective perception of the patient, can minimize negative sentiments expressed during hospitalization, allowing the woman to better cope with the situation .

CONCLUSION

The classification of a pregnancy as a risk to pregnant women implies specific care is often necessary to use procedures with greater technological density, however, attention should not be restricted to technical and scientific procedures, turning to assistance in mechanical practices. Technological advances, undoubtedly, give greater security for the development of a healthy pregnancy and a smooth delivery, however, the emotional and psychological aspects of these women should be considered by health professionals.

In this sense, it is important that professionals value the perceptions of pregnant women and their different ways of thinking, acting and feeling, because, with this knowledge, it is possible to identify the main difficulties and help them find ways to recover, avoiding injuries, allowing them to live with quality, despite its limitations.

During hospitalization negative feelings emerged in this way, it becomes evident the need to meet the woman holistically support her and accompany her properly so that this period is faced with a positive outlook.

The study also showed that pregnant women hospitalized with diagnosis of RUTI present lack of knowledge about the disease and its consequences, which can interfere directly in care, self-care and adherence to treatment proposed by health professionals.

Given this, it is proposed to carry out educational dialogic activities during hospitalization, in order to support and guide pregnant women about care to prevent or treat diseases, covering knowledge gaps and reducing idleness.

It is important to note that here identified results cannot be generalized, but suggest the need for a critical look at the assistance with regard to listening, care and guidance. Tackling hospitalization every woman is unique, so an individualized approach is necessary, identifying needs and helping to promote health.

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