nurse has the responsibility of observing for signs of transfusion reaction (see Table 24-3 later in this chapter). Because hypervolemia from too-rapid transfusion can increase the workload of the heart, the nurse also must be alert to signs of cardiac failure.

In splenic sequestration, gently measure the size of the spleen, because increasing splenomegaly is an ominous sign (see Abdomen, Chapter 4). A decrease in spleen size denotes response to therapy. The nurse also closely monitors vital signs and blood pressure to detect impending shock. Anemia is typically not a presenting complication in VOC but is a critical problem in other types of crises. The nurse monitors for evidence of increasing anemia and institutes appropriate nursing interventions (see earlier in chapter). Oxygen is not beneficial in vasoocclusive episodes unless hypoxemia is present (Heeney and Dover, 2009). It does not reverse sickled RBCs, and if used in a nonhypoxic patient, it will decrease erythropoiesis (Vichinsky and Styles, 1996). Because prolonged use of oxygen can aggravate the anemia, report any signs of lack of therapeutic benefit, such as restlessness, increased pallor, and continued pain.

Record intake, especially of IV fluids, and output. The child's weight should be taken on admission, because it serves as a baseline for evaluating hydration. Because diuresis can result in electrolyte loss, the nurse observes for signs of hypokalemia and should be familiar with normal serum electrolyte values to report changes.

### Recognize Other Complications

Nurses also need to be aware of the signs of ACS and CVA, which are both potentially fatal complications.

#### Nursing Alert

Report signs of the following immediately:

**Acute chest syndrome** (ACS):

- Severe chest, back, or abdominal pain
- Fever of 38.5° C (101.3° F) or higher