Lecture 2 • Mark Klimek • 101:54

Alcoholism

- The #1 psychological problem is **DENIAL**
- How do you **respond/treat** to pts in denial?
  - **Confront** them by pointing out the difference b/w what they say and what they do
  - For instance, say something like: "Ok, you say you're not an alcoholic but it is 10 a.m. and you've already had a 6 pack" … It is not the same as aggression. Don't attack the person
  - Good answer has "I" … Bad answer has "YOU"
  - One place where **denial** is ok—loss and grief Stages of grief are **"DABDA"—Denial, anger, bargaining, depression, acceptance**
  - So when the question is about pt in denial, pay attention to whether you are dealing with **loss** or **abusive** situation
    Support = Loss
    Confront = Abuse

The title of this section is alcoholism. However, this rule can be used for any abuse situation

1. So, what it the number 1 psychological problem in child abuse? … In gambling? … In cocaine abuse? … In spousal abuse? … In elder abuse?
   a. The answer is **denial**

Dependency vs. Co-dependency

- The #2 psychological problem is **Dependency or Co-Dependency**
- **Dependency:** when the get the significant other to do things or make decisions for them
  - The abuser is dependent
- **Co-dependency:** when the significant other derive self-esteem for doing things or making decisions for the abuser
  - The significant other is the co-dependent
- **Dependency and co-dependency has a symbiotic, yet a pathological relationship**
  - The dependent pt get a free ride on the co-dependent
  - The co-defendant pt feels good from "doing stuff" for the abuser
- How do you treat dependency/codependency?
  - Dependent pts are "abusers" … Confront them
  - Co-dependent pts have self-esteem issues … Teach pts how to set limits and enforce them
  - Agree in advance on what requests are allowed then enforce
  - Teach significant other to say **no**
  - Work on self-esteem on the co-dependent person

Manipulation

- Manipulation is when the **abuser gets the significant other to do** things or make decisions that are **not in the best interests of the significant other**
  - The nature of the act is dangerous and harmful to the significant other

- How is manipulation like dependency?
  - In both situations the dependent person gets the co-dependent person to do things or make decisions
  - If what the significant other is being asked to do is **not inherently dangerous and harmful**, then this is **dependency/co-dependency**
  - However, if the significant other is being asked to do something **inherently dangerous and harmful**, then this is **manipulation**
- Manipulation? Set LIMITS and Enforce them

Examples
Determine if either one of these situations is dependent/co-dependent problem or a manipulation problem

- A 49-year-old alcoholic gets her 17-year-old son to go to the store and buy alcohol for her.
  - The mother is manipulating the son
  - This is an illegal act = Harmful
  - Dependency … There are 2 patients
  - The dependent has a denial issue
  - The co-dependent has a self-esteem issue
- A 49-year-old alcoholic asks her 50-year-old husband to go to the store and buy alcohol for her.
  - This is not illegal for the husband to buy alcohol
  - This a dependency/co-dependency situation
  - Manipulation … There is 1 patient—no self-esteem issues
  - Easier to treat because no one like to be manipulated

Wernicke (Korsakoff) Syndrome

Typically, Wernicke and Korsafoff are 2 separate disorders. The NCLEX however bundles the 2 as 1 condition

- Wernicke is an encephalopathy
- Korsakoff is a psychosis
- Wernicke and Korsafoff tend to go together

Wernicke and Korsafoff

- Psychosis induced by Vitamin B1, thiamine deficiency
- This is a situation the pt loses touch with reality due to vit B1 deficiency
- The primary S/Sx are amnesia (memory loss) and confabulation (making up stories)
  - Confabulation—The lies for this pts are just as real as reality

How do deal with a pt with Wernicke and Korsafoff who is confabulating about going to a meeting with Barack Obama this morning?

- **Redirect** the pt to something he can do
  - For instance, tell pt something along that line: “Why can we go watch TV to see what is on the news today”

Characteristics of Wernicke and Korsafoff syndrome

1. Preventable … Take B1
2. Arrestable (stop it from getting worse) … Take B1
3. Irreversible (70%) … Will kill brain cells

Antabuse and Revia (Disulfiram)

- **Antabuse—**Alcohol deterrent
- **Revia—**Antidote
- Aversion (strong hatred) Therapy—a type of behavior therapy designed to make a patient give up an undesirable habit by causing them to associate it with an unpleasant effect
  - Works in theory better than in reality
- **Onset** (how long it takes to start working) and **duration** (how long it lasts) of effectiveness of Antabuse/Revia is 2 weeks
  - For instance, if pt will be at a function and would like to drink, the pt must be on Antabuse/Revia at least 2 weeks prior to the event
- Patient teaching
  - Teach pt to avoid all forms of EtOH (alcohol). Not doing so may lead to symptoms of n/v, even death (n/v is nausea and vomiting)
  - Teach them to avoid the followings items as they contain alcohol … Mouth wash, cologne, perfume, aftershave, elixir, most OTC liquid medicine, insect repellant, hand sanitizer, vanilla extract **(can't have cupcake with unbaked icing)**
  - **On the exam, do not pick the Red Wine vinaigrettes … It does not have alcohol in it**

Overdose and Withdrawal

First thing you ask in an overdose question is: Is it an **Upper** or a **Downer?**

- This is because every abuse drug is either an **Upper** or a **Downer**
- However, laxative abuse in the elderly is neither an Upper nor a Downer

Upper	**Downer**
• Caffeine • Cocaine • PCP/LSD (psychedelics/hallucinogens) • Methamphetamines • Adderall • Memorize these five for the NCLEX	• There are over 135 drugs that are downers • If it is not an upper, it is a downer
Signs and Symptoms	**Signs and Symptoms**
• Things go UP! • Euphoria, seizures, restlessness, irritability, hyperreflexia (3+, 4+), tachycardia, increased bowels (borborygmi), diarrhea	• Things go DOWN! • Lethargic, respiratory depression/arrest, constipated, etc.

What are the highest nursing priority to anticipate in an Upper or Downer?

- **Upper:** The highest priority to anticipate in an **Upper** is **suctioning** due to **seizures**
- **Downer:** The highest priority to anticipate in a **Downer** is **intubation/ventilation** due to **respiratory arrest**

Example

One of your pt is "high on cocaine." What is critically important to assess?

- Having a RR of 12 is not a critical measurement to assess for that pt
- However, assessing for reflexes (3+ or 4+), irritability, borborygmi (increased bowel sounds), or increased temperature would be more appropriate
  - The "ABC rule" does not apply here … In fact, the pt's ABC in cocaine toxicity is unremarkable

After you know that the drug in question is an **Upper** or a **Downer**, the second question you should ask yourself is whether it is an **Overdose** or a **Withdrawal**

- Overdose and withdrawal have the opposite effects

Overdose

Overdose on an Upper	**Overdose on a Downer**
• Too much	• Too little

Withdrawal

Withdrawal on an Upper	**Withdrawal on a Downer**
• Too little	• Too much

Question

The driver of a squad car calls the ER and says he is bringing a pt who in ODed on cocaine. What do you expect to see? … Select all that apply

- Pt ODed on Upper OD … Expect to see Too much
  - First question: Upper or a Downer?
  - Second question: Overdose or Withdrawal?
  - S/Sx would be: Irritability, 4+ reflexes, borborygmi, increased temperature, etc.

Question

The same pt is withdrawing from cocaine … Same question

- This pt is an Upper in Withdrawal = Too little
- Therefore, respiratory is under 12, pt is difficult to arouse, give them Narcan

Drug Abuse in the Newborn

Always assume intoxication, not withdrawal at birth, in a newborn less than 24 hours after birth. 24 hours or more after birth, you can assume the newborn is in withdrawal.

Question
You are caring for an infant born to Quaalude addicted mother 24 hours after birth. Select all that apply

- Overdose/withdrawal condition … Ask the following 2 questions
  - Is it an Upper or a Downer? … We don't what it is because it is a "Quaalude" (it is likely a Downer)
  - Is it Overdose or Withdrawal? … 24 hours after birth (Withdrawal)
  - A Downer in Withdrawal = Too much
  - S/Sx = Difficult to console, seizure risk, shrill, high-pitched cry, exaggerated startle reflex

Alcohol Withdrawal Syndrome vs. Delirium Tremens (alcohol withdrawal delirium)

Alcohol Withdrawal Syndrome and Delirium Tremens are not the same

- Every alcoholic goes through alcohol withdrawal approximately 24 hours after the person stops drinking
- However, less than 20% of alcoholics in alcohol withdrawal syndrome progress to delirium tremens … Delirium tremens occurs about 72 hours after the person stop drinking
- Alcohol withdrawal syndrome always precedes delirium tremens; however, delirium tremens does not always follow alcohol withdrawal syndrome

Alcohol Withdrawal Syndrome	**Delirium Tremens**
• Occurs **after 24 hours** after drinking • Non-life threatening to self and others	• Occurs **after 72 hours** after drinking • Life threatening to self and others
Nursing Care Plan • Regular diet • Semiprivate room, anywhere on the unit • Pt is up ad lib (Pt is free to move around as desired) • No restraints	**Nursing Care Plan** • NPO (seizures) or clear liquid diet • Private room, near nursing station • Restricted bed rest (Pt is not free to move around as desired—no bathroom) • Restraints (vest or 2-point lock letters)

Note

- "Up ad lib" or "up ad liberum" means pt may have activity or free to move around as desired any time
- 2-point lock letters restraints: Restraints in 1 upper and the contralateral lower extremities. Release and secure upper arm first, and then release and secure the foot. Switch extremities every 2 hours
- Give both anti-HTN medication, tranquilizer, multivitamin containing vit B1

Question
So what two situations would respiratory arrest be a priority?

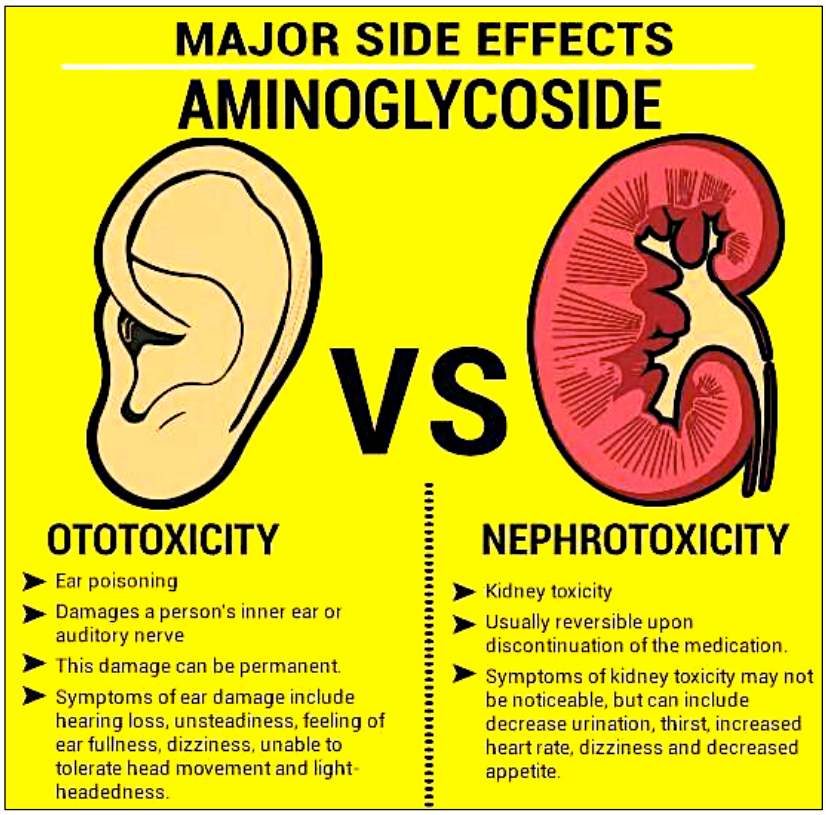
- Overdose of a Downer
- Withdrawal of an Upper

Question
Which pts would seizure be a risk for?

- Overdose of an Upper
- Withdrawal of a Downers

Aminoglycosides (Top 5 most tested drugs)

Aminoglycosides are the big guns of ABXs (antibiotics)—use them when nothing else works. Aminoglycosides are unsafe at toxic levels and safety then becomes an issue. They are the 5th most tested drugs on the NCLEX



The most tested drugs on the NCLEX are:

- Top 5
  - Psychiatric
  - Insulin
  - Anticoagulant
  - Digitalis
  - Aminoglycosides
- Others
  - Steroids
  - Beta-blockers
  - Calcium channel blockers
  - Pain medications
  - Obstetrics medications

"A Mean Old Mysin" = Aminoglycosides
Would be used to treat serious, resistant, life-threatening, Gram negatives infections

- So, **treat a mean old infection** with a **"Mean Old Mycin"**
  - Examples are: TB, septic peritonitis, fulminating pyelonephritis, septic shock, infection from third degree wound covering >80% of the body
  - However, sinusitis, otitis media, bladder infection, viral pharyngitis, and strep throat are not **old mean infections** and are not treated with a mean old mycin

All aminoglycosides end in Mycin

- Genta**mycin**, Vanco**mycin**, and Clinda**mycin**, Strepto**mycin**, Cleo**mycin**, Tobra**mycin**
- Not all drugs ending in **mycin** are aminoglycosides
  - Azi**thro**mycin, Clari**thro**mycin, Ery**thro**mycin … All have **THRO** in the middle … So, THRO them off the **"Mean Old Mycin"** list

What are toxic effects?

- Mycin—Sounds like Mice (Think ears) … Monitor **hearing (#1)**, balance, tinnitus (ringing of the ear, CN8 toxicity)
- The human ears are shaped like a kidney so another toxic effect of aminoglycosides is nephrotoxicity (Toxic to the kidneys)
  - Therefore, monitor Creatinine

What would be your answer if in a question, you have to choose which is the best between **24-hour creatinine** and **serum creatinine**?

1. Creatinine = Best indicator of kidney function
2. 24-hour creatinine clearance is better than Serum creatinine

The figure 8 drawn inside the ear should remind you of of 2 things
They are toxic to CN8
Administer them q8 hour

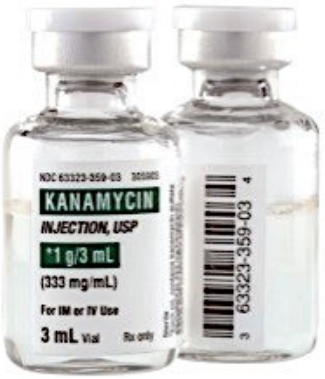
Do not give Mean Old Mycins PO because they are not absorbed, and therefore would not have any systemic effects

There are 2 cases where Mean Old Mycins are given PO

- Hepatic encephalopathy (or hepatic coma) where ammonia level gets too high
- Pre-op bowel surgery: to sterilize the bowel before surgery
- In both cases, the ABX stays in the gut (not absorbed), sterilizes the bowel, and would not be toxic
- **The #1 action of an "oral mycin" … Sterilize the bowel**
  - Who can sterilize my bowel?
    Neo Kan
  - Neomycin and Kanamycin

"A Mean Old Mycin" is given IM or IV because it is excreted in feces and not absorbed in the GI tract. It is used in hepatic encephalopathy to kill E. coli, and bowel surgery (to sterilize the bowel).

Note
E. coli in the gut is the #1 producer of ammonia, which at toxic levels, leads to encephalopathy



Troughs and Peaks

- **Troughs** is when drugs is at their **lowest concentration** in the pt's blood
- **Peaks** is when drugs is at their **highest concentration** in a pt's blood

"TAP" Levels

- A method to remember what is done before or after, when dealing with a medication with troughs and peaks
- **"TAP"**—**T**rough, **A**dminister, **P**eak
  - Trough before drug administration
  - Peak after drug administration
  - Trough and Peak levels are drawn because of a drug's narrow therapeutic window or index
  - Narrow therapeutic window or index means that there is a small difference in what works and what kills

Which one of the following medications would "trough and peak" important?

- Lasix (furosemide)
  - Smaller dose: 5 or 10
  - Larger dose: 80 or 120
- Digitalis (digoxin)
  - Smaller dose: 0.125
  - Larger dose: 0.25
  - Would draw "TAP" (**T**rough, **A**dminister, **P**eak) on digitalis

Note

1. Draw TAP on Mean Old Mycins because of their narrow therapeutic index

When to Draw a Trough and a Peak

- **Both Trough and Peak are not medication-dependent**
- The **trough**, it is **always drawn 30 minutes before** next dose
- For the **peak**, it depends on the route
  - Peak SubL 5 to 10 minutes after drug is dissolved
  - Peak IV 15 to 30 minutes after drug is finished (bag empty)
  - Peak IM 30 to 60 minutes
  - Peak SubQ Depends on insulin (See diabetes lecture)
  - Peak for PO Not necessary, not tested

Question

You give 100 mL of a drug at 200 mL per hour (the drug takes 30 minutes to run). If you hang the drug at 10 a.m., it will finish running at 10:30 a.m. When will the drug peak?

1. 10:15 a.m.
2. 10:30 a.m.
3. 10:45 a.m.
4. 11:00 a.m.

Answer: Two right answers—pick 11:00 a.m. In this case, play the "Price Is Right"—go with the highest time w/o going over

Note

- The same drug given by 2 different routes at the same time will have different peaks
  - Morphine
- However, 2 different drugs given at the same time and route (IV) will peak together
  - Morphine and amphetamine