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Fast Facts About the GYNECOLOGIC EXAM: A Professional Guide for NPs, PAs, and Midwives, 2e (Secor, Fantasia)
Jennifer R. Buettner, RN, CEN, currently serves as the nurse educator for the emergency department (ED) at DeKalb Medical Center at Hillandale, Lithonia, Georgia. In this role, Mrs. Buettner works to advance the careers of emergency nurses through education and evidence-based practice. She finds great joy in helping others grow professionally and cultivate their inner gifts and talents. She has developed ED orientation processes and education courses for several local hospitals in the Atlanta, Georgia, area. In her 17 years of ED nursing experience, she has spent several years precepting new emergency nurses and has served as a legal nurse consultant. Mrs. Buettner holds certifications in basic disaster life support (BDLS), advanced disaster life support (ADLS), and as a certified emergency nurse (CEN), and serves as an advanced cardiac life support (ACLS), pediatric advanced life support (PALS), and cardiopulmonary resuscitation (CPR) instructor. She is a course coordinator for the trauma nursing core course (TNCC) and emergency nursing pediatric course (ENPC). She is a current member of the Emergency Nurses Association and an advocate for the Board Certified Emergency Nursing exam. She received the Faculty Award from the Virginia Beach School of Practical Nursing, for the graduate who “has achieved excellence in both the academic and clinical settings and who best exemplifies the total integration of program philosophy to professional performance” (March 1999). In 2010, Mrs. Buettner was nominated as nurse of the year by the Atlanta Journal-Constitution. She was a finalist for the 2016 Atlanta March of Dime’s Nurse of the Year Award. Her passion to teach and mentor new ED nurses led her to create an original ED orientation manual made specifically for new emergency nurses and their preceptors.
This book is dedicated to ED nurses everywhere. May you always thirst for knowledge, but let your cup be full of strength, grace, compassion, mercy, and love. May God bless your hearts and hands as you touch so many patients in need every day.
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Preface

This is a book designed for real emergency department (ED) nurses by a real ED nurse. It is a quick reference book intended to aid your day-to-day ED orientation process with your preceptor and to guide you through the most common illnesses seen in the ED. This book does not cover basic anatomy and physiology, advanced cardiovascular life support, pediatric advanced life support, or the trauma nurse core course. The information in this book is compiled from basic ED knowledge and the sources used are considered reliable.

There are several points to take into consideration in referencing this book. First, all listed interventions that go beyond the scope of nursing practice should be followed as ordered by the ED provider. Second, the term “provider” in this book could be a physician (MD or DO), a nurse practitioner (NP), or a physician assistant (PA), who is qualified to provide such ED patient care. In most cases, interventions that go beyond the usual scope of nursing practice have been introduced using “Anticipate an order to” followed by a list of possible provider orders. As always, it is the nurse’s responsibility to check any noted medication dosages or treatments to ensure that all are current, recommended, and accepted practices.

After reading this book, you will become the “Jack of all illnesses.” So, put on your running shoes, keep a stash of dark chocolates, and when all else fails, practice unreasonable happiness. One thing is for sure: Just when you think you have seen it all, your next patient will come in!

Each chapter includes a brief introduction; an outline of materials, equipment, and drugs with which you should become familiar; a list of diagnoses that includes definitions, causes, signs and symptoms,
and interventions; a feature titled “Fast Facts in a Nutshell” that provides quick summaries of important points; and question-and-answer boxes for your review. The appendices at the end of the book include abbreviations, common lab values, EKG rhythms, and frequently used ED medications—information that should become second nature to all ED personnel.

There are two ways to use this book. You can review the book cover to cover, or you can use the skills check-off sheets in Appendix F and review the appropriate chapters.

Jennifer R. Buettner
Acknowledgments

I could not do what I do without the support of my loving husband, Nick, and our friends and family. Nevertheless, the base of my emergency nursing foundation was built by my first preceptor, Linda Whitt, BSN, RN. I thank her for her patience, sharing her wealth of knowledge, and setting a prime example of a truly humble, wise, and compassionate nurse. I cannot forget my second preceptor, Walter McCracken, RN, whose pearls of wisdom can be found in no book. Special thanks go to my editor, Elizabeth Nieginski, and the Springer Publishing team for bringing my thoughts and ideas for this book to life. I am truly honored to be a part of a dedicated, knowledgeable, and compassionate ED leadership team, including; Shunda Harper, MSN, RN, Tamiko Smith, MSN, FNP-C, Sealena White, BSN, RN, and Natasha Allen, RN, CEN—I thank you for mentoring, supporting, and inspiring me even on my weakest days! To all my friends and colleagues who have inspired me and molded me into the ED nurse I am today, I am forever grateful.

Last, but not least, I would like to thank the nurse and good friend who inspired me to write this book and never stopped believing in me, Nichole Lunsford Howell, BSN, RN.

Above all, my faith has sustained me through all my endeavors; I give thanks and glory to God for all of His gifts and blessings.

I would like to acknowledge the work of the following individuals in offering their professional opinions and reviewing the content in this book for accuracy.
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Fast Facts for the ER Nurse: Emergency Department Orientation in a Nutshell, Third Edition
The endocrine system is made up of several complex hormone-secreting glands. These include the pituitary, pineal gland, hypothalamus, parathyroid, thyroid, pancreas, adrenals, testes, and ovaries. When one thinks of the endocrine system, the word that might come to mind is “hormones.” While the endocrine system is responsible for hormone production, it also affects metabolism, growth and development, emotions, tissue function, and homeostasis. Although there are many endocrine-related illnesses, this chapter includes only the most common and emergent. After reviewing this chapter, you will be able to differentiate the different types of endocrine emergencies and their causes, manifestations, and treatments.

During this part of your orientation, locate and become familiar with:

- Blood glucose monitoring devices
- Diabetic ketoacidosis (DKA) policy and procedures
- Dietary supplies in your emergency department (ED)
- Medications to know: Insulin, insulin drips, antipyretics, beta-blockers, iodides, and propylthiouracil (PTU), oral and intravenous (IV) potassium, sodium bicarbonate, IV calcium, IV dextrose, glucagon, sodium polystyrene sulfonate (Kayexalate), and albuterol
PANCREATIC-RELATED EMERGENCIES

The pancreas is located in the mid-upper abdomen and is responsible for production and secretion of insulin and digestive enzymes such as amylase and lipase.

Diabetic Ketoacidosis (DKA)

DKA is a state of metabolic acidosis that is the result of elevated blood sugar (> 250 mg/dL). When the blood sugar is this high, the body does not have sufficient insulin to break down sugar for energy. To compensate, the body breaks down fat, thereby releasing toxic ketone acids.

- **Causes:** Uncontrolled blood sugar in diabetes mellitus, pancreatitis, and alcohol or drug abuse.
- **Signs and symptoms:** Dry, flushed skin; serum glucose level greater than 250 mg/dL; nausea and vomiting; abdominal pain; increased thirst; tachycardia; hypotension; urinary frequency; weakness; Kussmaul breathing; ketones in urine; change in level of consciousness; and coma.
- **Interventions:**
  - **Fluid replacement:** Administer IV normal saline bolus. Use caution if patient has a history of congestive heart failure or renal failure. Once you replace fluids, be prepared for urinary frequency. Provide urinals or bedpans. Collect urinalysis and monitor intake and output.
  - **Correct acidosis:** Check arterial blood gases; obtain beta-hydroxybutyrate (BHB) levels; monitor pulse oximetry or wave form capnography; administer IV sodium bicarbonate if ordered.
  - **Balance electrolytes:** Monitor anion gap, metabolic panel, cardiac rhythm; give nothing by mouth (NPO); medicate for nausea and vomiting. Anticipate IV potassium orders for hypokalemia. *Insulin administration drives potassium back into the cells, further reducing serum potassium levels.*
  - **Treat hyperglycemia:** Obtain and monitor hourly blood glucose, acetone level, and urinalysis; give insulin (first, 5–10 units of regular IV push, and then 0.1 units per kilogram per hour by IV fusion on a pump). Once the patient's blood sugar is less than 200 to 250 mg/dL, change from IV to subcutaneous insulin per the provider's order. IV 5% dextrose 0.45% normal saline (D5½NS) at a rate of 150 to 200 mL per hour.
Hyperosmolar Hyperglycemic Syndrome (HHS)

This is a severe state of dehydration as a result of a very high blood sugar count (>600 mg/dL, but usually in the 1,000s). It is commonly associated with type 2 diabetes, recent surgery, or illness.

- **Causes:** The high level of sugar results in very thick blood, as the body tries to void the sugar. The process of frequent voiding, however, results in excessive loss of body fluids.

- **Signs and symptoms:** Imagine a shriveled, dried-up raisin, as this is your patient with hyperosmolar hyperglycemic syndrome (HHS). Look for thirst; warm and dry skin; dry mucosa; urinary frequency; weakness; change in level of consciousness; seizures; tachycardia; hypotension; fever; and absence of ketones in urine.

- **Interventions:**
  - **Fluid replacement:** These patients may need up to 9 to 12 L of IV fluids. Anticipate orders to start with normal saline IV bolus. Increased bolus rate may be ordered if hypotension is present. Frequently document vital signs. Use caution if patient has a history of congestive heart failure or renal failure. Once you may be ordered as serum sodium returns to normal and glucose levels reach 250 mg/dL or less. Prepare for possible intensive care unit admission.

**Question:** A 29-year-old diabetic female arrives who has dried skin, is flushed, is hot, and has Kussmaul respirations. What is the underlying illness?

**Answer:** DKA—check her blood sugar.

**Question:** When is DKA considered resolved?

**Answer:** When the serum pH is greater than 7.3, serum bicarbonate level is greater than or equal to 18 mEq/L, blood glucose is less than 200 mg/dL, and anion gap is less than or equal to 12; corrections should be gradual to avoid cerebral edema.

**Question:** How often should you check blood sugars on a patient receiving an insulin IV drip?

**Answer:** Every hour.
replace fluids, be prepared for urinary frequency. Provide urinals or bedpans. Collect urinalysis and monitor intake and output.

- **Balance electrolytes:** Monitor serum osmolality, metabolic panel, and cardiac rhythm; obtain electrocardiogram; keep NPO; medicate for nausea and vomiting. Anticipate IV potassium orders for hypokalemia. *Insulin administration drives potassium back into the cells, further reducing serum potassium levels.*

- **Treat hyperglycemia:** Obtain and monitor blood glucose hourly, acetone level, and urinalysis; give insulin (5–10 units of regular IV push, and then 0.05 units per kilogram per hour by IV fusion on a pump until blood sugar is less than 300 mg/dL). Goal is to reduce serum glucose by 50 to 70 mg/dL per hour. Once the patient’s blood sugar is less than 200 to 300 mg/dL, change from IV to subcutaneous insulin per the provider’s order. IV 5% dextrose 0.45% normal saline (D5½NS) at a rate of 150 to 200 mL per hour may be ordered as serum sodium returns to normal and glucose levels reach 250 mg/dL or less. Prepare for possible intensive care unit admission.

**Notes:** ____________________________________________________________

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**Fast Facts in a Nutshell**

Note the symptom and blood sugar differences between HHS and DKA.

- **Hyperosmolar hyperglycemic syndrome** means that blood sugar is very high (600–1,000s mg/dL). It is more common in type 2 diabetics. Patient is severely dehydrated, serum pH is normal, and there are no ketones in the urine.

- **DKA blood sugar** is moderately high (250–600 mg/dL). It is more common in type 1 diabetics or new onset. The patient may be mildly dehydrated, arterial blood gas (ABGs) reveal acidosis, and ketones are present in the urine.

**Hypoglycemia**

Hypoglycemia is defined as a low blood sugar (<60–70 mg/dL) and most commonly affects type 1 diabetics.
Causes: Taking too much insulin or diabetic medication; lack of food intake; pancreatic tumor; sepsis; stress; pregnancy; alcohol ingestion; adrenal insufficiency; liver disease; and certain medications such as beta-blockers, nonsteroidal anti-inflammatory drugs (NSAIDs), and thyroid hormones.

Signs and symptoms: Anxiety; hunger; sweating; dry mouth; pallor; altered mental status; confusion; lethargy; headache; hypothermia; loss of consciousness; and death.

Interventions: Obtain accurate history, complete neurological assessment, and assess for cause of hypoglycemia. Anticipate orders to obtain blood glucose, monitor cardiac rhythm and vital signs, provide warm blankets and warming measures if hypothermic, obtain IV access, obtain complete blood count and metabolic panel, and recheck the blood glucose in 1 hour of treatment and as needed.

If conscious: Anticipate orders to give simple carbohydrates orally in the form of orange juice, soda, or glucose gel to quickly raise the blood sugar. Then give the patient a sandwich meal or regular diet tray to provide complex carbohydrates that will sustain the blood sugar.

If unconscious: Anticipate orders to give IV dextrose or intramuscular glucagon if unable to obtain IV access. Once patient regains consciousness, give simple carbohydrates followed by complex carbohydrates. Vomiting may occur after glucagon administration; consider aspiration precautions.

Notes: _____________________________

Pancreatitis

This is the result of an increase in pancreatic enzymes. Whether it is caused by overproduction or obstruction, the enzymes erode or eat away the pancreatic tissues. Pancreatitis can spread to the liver, diaphragm, lungs, and other nearby organs. It is basically the pancreas in self-destruct or autodigestion mode.

Causes: Alcohol abuse; gallstones; infections; injury; autoimmune disorder; and drug toxicity. Contributing factors include smoking, stress, and crash dieting or binge eating.

Signs and symptoms: Midepigastric abdominal pain radiating to the back; diminished bowel sounds; nausea and vomiting;
abdominal distention; fever; jaundice if gallstones; weight loss; tachycardia; hypotension; frothy and foul-smelling stools; dark urine; Grey Turner’s sign (see Figure 6.1); Cullen’s sign (see Figure 6.2); and altered blood sugar.

**Interventions:** Anticipate orders to administer fluids intravenously; monitor serum amylase, serum lipase, and blood glucose level; use nasogastric tube for decompression; administer nothing by mouth; give medications (antacids, anticholinergics, histamine receptor agonists, insulin, and analgesics/narcotics); prevent and treat infections; prepare for ultrasound or CT; prepare for possible surgery; and instruct patient on diet (low-fat diet, no caffeine, and no alcohol).

**Notes:**

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**Question:** What is the normal serum amylase level in adults younger than 60 years?

**Answer:** 25 to 125 U/L.

The patient who is actively vomiting cannot drink water before seeing the ED provider *in case the patient ends up going to surgery.*

---

**Figure 6.1** Grey Turner’s sign. *Source: Photo by Herbert L. Fred and Hendrik A. van Dijk (Wikimedia Commons).*
THYROID-RELATED EMERGENCIES

The thyroid is located in the anterior aspect of the neck and affects calcium metabolism. Thyroid emergencies are rare, but can be life threatening.

Thyroid Storm

Thyroid storm is a life-threatening emergency that results from poorly managed hyperthyroidism.

- **Causes**: Uncontrolled hyperthyroidism. Risk factors include history of Graves’ disease, medication noncompliance, trauma, infection, child birth, recent surgery, illness, or stress.
- **Signs and symptoms**: Vary, but may include: high fever; tachycardia; hypertension; vomiting; diarrhea; jaundice; thinning hair; weight loss; sweating; restlessness; exophthalmos; goiter; and tremors.
- **Interventions**: Obtain accurate history and list of medications; promptly manage any airway, breathing, and circulation concerns first; and provide supportive care. Anticipate orders to administer antipyretics, beta-blockers (propranolol), iodides, and PTU; obtain IV access; obtain serum thyroid function, metabolic panel, complete blood count, and toxicology screen; apply
cooling blankets for targeted temperature management; give supplemental oxygen; and obtain CT of head.

Notes: _______________________________________

Fast Facts in a Nutshell

A patient in thyroid storm may appear almost toxic with extremely high fevers reaching as high as 103° to 105°F. Treatment should be aggressive, as this a life-threatening emergency!

Myxedema Coma

Myxedema coma is a rare but emergent complication of uncontrolled or undiagnosed hypothyroidism. It is more common in women than in men and occurs more often in the winter months.

- **Causes:** Iodine deficiency; pituitary dysfunction; medications such as lithium, beta-blockers, amiodarone, narcotics, interferon, anticonvulsants, and general anesthesia; stress; burns; infection; surgery; trauma; and hypothermia.
- **Signs and symptoms:** Fatigue; shortness of breath; weight gain; generalized edema; constipation; pale cool skin; multiple organ dysfunction; hypothermia; bradycardia; bradypnea; confusion; depression; decreased urinary output; possible hypoglycemia; altered mental status or psychosis; coma; respiratory failure; and death.
- **Interventions:** Support airway, breathing, and circulation. Anticipate orders to obtain IV access; complete blood count, thyroid levels, metabolic panel, and serum creatinine levels; have electrocardiogram (EKG); administer IV or oral thyroxine (T4); slowly and passively rewarmed patient; monitor intake and output; and administer analgesics and glucocorticoids.

Notes: _______________________________________

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SUMMARY

Those little hormones can affect so much more than just your mood. The endocrine system can affect multiple body systems. If you have ever been pregnant, you may have experienced just how much hormones can affect the rest of the body. Early recognition, thorough assessment, and rapid treatment are crucial to the survival of an endocrine-related emergency.

Fast Facts in a Nutshell

Be sure to closely monitor the cardiac rhythm of a myxedema coma patient. EKG findings associated with myxedema coma include bundle branch blocks, complete heart blocks, ST segment and T-wave changes, and bradycardia with prolonged QT intervals.

Question: Prolonged QT intervals can be a precursor for which type of arrhythmias?
Answer: Ventricular tachycardia and torsades de pointes.