

**POCKET COMPANION  
TO ACCOMPANY**

**DAVIS'S  
DRUG  
GUIDE  
FOR NURSES  
SEVENTH EDITION**

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{ } = Available in Canada only.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

# SECTION I

## Classifications

### AGENTS USED DURING PREGNANCY/ LACTATION\*

#### PHARMACOLOGIC PROFILE

##### General Use:

Drugs used during labor and delivery include tocolytic and oxytocic agents. Tocolytics suppress uterine muscle activity to prevent preterm labor. Oxytocics are used to stimulate uterine muscles to induce labor, control postpartum hemorrhage, terminate pregnancy, or to promote milk ejection in lactation.

##### General Action and Information:

Tocolytics include beta-sympathomimetics (ritodrine) and magnesium sulfate. Beta-sympathomimetics relax uterine smooth muscles by binding to beta<sub>2</sub>-receptors. Oxytocics (prostaglandins, synthetic oxytocin, and methylergonovine) stimulate uterine smooth muscle contractions.

##### Contraindications:

Beta-sympathomimetics are contraindicated in women with a history of cardiac, renal, or hepatic disease and in migraines, hyperthyroidism, asthma, or hypertension. Oxytocin is contraindicated in hypersensitivity and in anticipated nonvaginal delivery. Ergot alkaloids are contraindicated in hypersensitivity, hepatic and renal impairment, hypertension, and cardiovascular disease. Ergots should not be used to induce labor.

##### Precautions:

Use cautiously in first and second stages of labor, cardiovascular disease, hypertension, and renal disease (oxytocin). Use cautiously in patients with diabetes (beta-sympathomimetics).

##### Interactions:

**Oxytocin**—Severe hypertension if given after vasopressors. Excessive hypotension if used concurrently with cyclopropane anesthesia. **Methylergonovine**—Excessive vasoconstriction may result when used with other vasopressors. **Beta-sympathomimetics (ritodrine)**—Additive adrenergic side effects with other sympathomimetics. Use with MAO inhibitors may result in hypertensive crisis.

#### NURSING IMPLICATIONS

##### Assessment

- Monitor frequency, duration, and force of contractions and uterine resting tone. Opioid analgesics may be administered for uterine pain.
- Monitor temperature, pulse, and blood pressure periodically throughout therapy for cervical ripening or termination of pregnancy.

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### Potential Nursing Diagnoses

- Knowledge deficit, related to medication regimen (Patient/Family teaching).

### Implementation

- Administer RhoGAM into the deltoid muscle within 3 hr and up to 72 hr after delivery, miscarriage, abortion, or transfusion.
- Warm suppositories to room temperature just prior to use. Patient should remain supine for 10 min after vaginal suppository.
- Vaginal inserts are placed transversely in the posterior vaginal fornix immediately after removing from foil package. See monograph for dinoprostone for specific directions pertaining to administration.
- Endocervical gel is applied after determining degree of effacement. Do not administer above the level of the cervical os. Follow manufacturer's guidelines for administration.
- Wear gloves when handling unwrapped suppository and the gel to prevent absorption through the skin. Should skin contact, occur wash hands immediately.
- Administer intranasal oxytocin nasal spray by squeezing the bottle while the patient is in a sitting position.

### Patient/Family Teaching

- Advise patient to administer oxytocin nasal spray 2–3 min prior to planned breast feeding. Patient should notify health care professional if milk drips form non-nursed breast or if uterine cramping occurs.
- Explain the purpose of cervical ripening and abortifacient medications with the need for vaginal exams. Advise patient to inform health care professional if contractions become prolonged.
- Provide emotional support.
- Instruct patient receiving abortifacients to notify health care professional immediately if fever and chills, foul-smelling discharge, lower abdominal pain, or increased bleeding occurs.

### Evaluation

**Effectiveness of therapy is demonstrated by:** ■ Complete abortion ■ Cervical ripening and induction of labor ■ Effective letdown reflex ■ Prevention of preterm labor.

### Agents Used during Pregnancy/Lactation Included in *Davis's Drug Guide for Nurses*

#### **abortifacients**

carboprost 1172  
dinoprostone 297

#### **miscellaneous**

Rho D immune globulin 879

#### **oxytocics**

methylergonovine 631  
oxytocin 740

#### **tocolytics**

ritodrine, 1181

### AGENTS USED IN THE MANAGEMENT OF IMPOTENCE\*

#### PHARMACOLOGIC PROFILE

#### General Use:

Treatment of erectile dysfunction.

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### General Action and Information:

Sildenafil inhibits enzyme that inactivates cyclic guanosine monophosphate (cGMP). cGMP produces smooth muscle relaxation of the corpus cavernosum, which enhances blood flow and subsequent erection. Alprostadil is a prostaglandin that acts locally to relax trabecular smooth muscle and dilate cavernosal arteries.

### Contraindications:

Hypersensitivity. Sildenafil should not be used concurrently with nitrates (nitroglycerin, isosorbide). Alprostadil should not be used concurrently with penile implants or in cases of structural or pathologic abnormalities of the penis.

### Precautions:

Sildenafil should be used cautiously in patients with serious underlying cardiovascular disease, those already using antihypertensives or glipizide, and those with anatomic penile deformity. Use with caution in conditions associated with priapism and bleeding disorders or active peptic ulcer disease. Alprostadil should be used cautiously in patients with coagulation abnormalities.

### Interactions:

Sildenafil blood levels may be increased by cimetidine, erythromycin, ketoconazole, and itraconazole. Increased risk of serious hypotension when sildenafil is used with nitrates. (Concurrent use is contraindicated.)

## NURSING IMPLICATIONS

### Assessment

- Determine erectile dysfunction prior to administration. Sildenafil has no effect in the absence of sexual stimulation.
- Exclude disorders of the vascular system and cavernous body damage prior to use of alprostadil, because the drug is ineffective with these disorders.

### Potential Nursing Diagnoses

- Sexual dysfunction (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Sildenafil is administered PO. Dose is usually administered 1 hr prior to sexual activity. It may be administered 30 min to 4 hr before sexual activity.
- Alprostadil is injected into the dorsolateral aspect of the proximal third of the penis avoiding visible veins. Rotate injection sites from side to side. Dosage is determined in the prescriber's office.

### Patient/Family Teaching

- Instruct patient taking sildenafil to take the medication 1 hr prior to sexual activity and not more than once a day.
- Advise patient that sildenafil has not been approved for use in women.

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- Caution patient not to take sildenafil concurrently with nitrates.
- Instruct patient using alprostadil that it is not to be used more than 3 times per week.
- Teach patient that priapism (prolonged erection of >60 min) is dangerous, and immediate medical assistance should be sought. Failure to treat priapism may result in permanent irreversible damage.
- Drugs to treat erectile dysfunction do not protect against transmission of sexually transmitted diseases. Counsel patient that protection against sexually transmitted disease and HIV infection should be considered.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Male erection sufficient to allow intercourse without evidence of adverse effects.

### Agents Used in the Management of Impotence Included in *Davis's Drug Guide for Nurses*

alprostadil, 1168

sildenafil, 921

### ANDROGENS/ANABOLIC STEROIDS\*

#### PHARMACOLOGIC PROFILE

##### General Use:

Androgens (testosterone) are used to replace androgen deficiencies in hypogonadism. They are also used in endometriosis and for palliative treatment in metastatic breast cancer. Danazol, also an androgen, is used in the management of endometriosis, fibrocystic breast disease, and hereditary angioedema. Nandrolone (an anabolic steroid) is used to manage anemia associated with chronic renal failure.

##### General Action and Information:

Testosterone is necessary for the formation of the male sexual organs and for the development of primary and secondary male sex characteristics.

##### Contraindications:

Contraindicated in pregnancy and lactation; carcinoma of the prostate or male breast and hepatic disease; hypercalcemia; and coronary artery disease.

##### Precautions:

Use cautiously in elderly men who have an increased risk of prostatic hypertrophy and carcinoma and in patients with a history of liver or cardiac disease.

##### Interactions:

Increased sensitivity to oral anticoagulants, insulin, NSAIDs, and oral hypoglycemic agents. Use with adrenal corticosteroids may increase occurrence of edema. Danazol may increase cyclosporine levels. Nandrolone increases the risk of hepatotoxic reactions to drugs.

## NURSING IMPLICATIONS

### Assessment

- Monitor intake and output ratios, weigh patient twice weekly, and assess patient for edema. Report significant changes indicative of fluid retention.
- **Men:** Monitor for precocious puberty in boys (acne, darkening of skin, development of male secondary sex characteristics—increase in penis size, frequent erections, growth of body hair). Bone age determination should be measured every 6 mo to determine rate of bone maturation and effects on epiphyseal closure).
- Monitor for breast enlargement, persistent erections, and increased urge to urinate in men. Monitor for difficulty urinating in elderly men, because prostate enlargement may occur.
- **Women:** Assess for virilism (deepening of voice, unusual hair growth or loss, clitoral enlargement, acne, menstrual irregularity).
- In women with metastatic breast cancer, monitor for symptoms of hypercalcemia (nausea, vomiting, constipation, lethargy, loss of muscle tone, thirst, polyuria).
- **Danazol:** Assess for endometrial pain prior to and periodically throughout therapy.
- **Nandrolone:** Monitor responses for symptoms of anemia.

### Potential Nursing Diagnoses

- Sexual dysfunction (Indications, Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- **General Info:** Range of motion exercises should be done with bedridden patients to prevent mobilization of calcium from the bone.
- Treatment of endometriosis or fibrocystic breast disease with danazol should be started during menstruation or preceded by a pregnancy test.
- **IM:** Administer deep IM into the gluteal muscle.
- **Transdermal:** Apply patch to clean, dry, hairless skin.

### Patient/Family Teaching

- **General Info:** Advise the patient to report the following signs and symptoms promptly; in male patients, priapism (sustained and often painful erection) or gynecomastia; in female patients, virilism (which may be reversible if medication is stopped as soon as changes are noticed), hypercalcemia (nausea, vomiting, constipation, and weakness), edema (unexpected weight gain, swelling of the feet), hepatitis (yellowing of the skin or eyes and abdominal pain), or unusual bleeding or bruising.
- Explain rationale for prohibition of use for increasing athletic performance. Testosterone is neither safe nor effective, but this use has the potential risk of serious side effects.
- Advise diabetics to monitor blood for alterations in blood sugar concentrations.
- Emphasize the importance of regular follow-up physical exams, lab tests, and x-rays to monitor progress.
- Advise patient to use a nonhormonal form of contraception during therapy.
- Radiologic bone age determinations should be examined every 6 mo in prepubertal children to determine rate of bone maturation and effects on epiphyseal centers.
- **Transdermal:** Advise patient to notify health care professional if female sexual partner develops mild virilization.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of the signs of androgen deficiency without side effects. Therapy is usually limited to 3–6 mo, followed by bone growth or maturation determinations. ■ Increase in activity tolerance. ■ Decrease in size and spread of breast malignancy in postmenopausal women. In antineoplastic therapy, response may require 3 mo of therapy; if signs of disease progression appear, therapy should be discontinued.

n Decrease in symptoms of endometriosis. ■ Increased hemoglobin and red cell volume with decrease in symptoms of anemia.

## Androgens/Anabolic Steroids Included in *Davis's Drug Guide for Nurses*

danazol 261  
nandrolone 687

testosterone 966

## ANESTHETICS/ANESTHETIC ADJUNCTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Anesthetics (general, local, regional) are used to induce anesthesia during surgery, childbirth, dental or diagnostic procedures, and other treatments. General anesthesia is administered parenterally or by inhalation to produce progressive and reversible stages of CNS depression. Local anesthetics (topical, injectable) produce anesthesia in small, localized areas. Regional anesthetics are used for larger areas (spinal, epidural). Anesthetic adjuncts are given preoperatively, intraoperatively, or postoperatively to aid in the anesthetic process. Anesthetic adjuncts (anti-anxiety and sedative/hypnotic agents, anticholinergic agents, narcotic analgesics, neuromuscular blocking agents) are used to enhance anesthetic agents.

#### General Action and Information:

Reversibly block transport of ions in neuronal membrane channels and thereby prevent initiation and conduction of normal nerve impulses.

#### Contraindications:

Hypersensitivity and cross-sensitivity may occur.

#### Precautions:

Use cautiously in patients with liver disease, cardiac disease, hyperthyroidism, respiratory depression, shock, or heart block. Use with caution in pregnancy or lactation (safety not established).

#### Interactions:

Additive CNS depression when administered with other CNS depressants. Additive cardiac depression and toxicity when administered with phenytoin, quinidine, procainamide, or propranolol.

## NURSING IMPLICATIONS

### Assessment

- Assess degree of numbness of affected part.
- Topical applications should have site assessed for open wounds prior to application. Apply only to intact skin.
- When using lidocaine/prilocaine, assess application site for anesthesia following removal of system and prior to procedure.
- In local epidural drugs, assess for systemic toxicity, orthostatic hypotension, and unwanted motor and sensory deficits.
- When using a systemic agent (propofol), assess respiratory status, pulse, blood pressure, and level of consciousness continuously throughout therapy and following administration.

### Potential Nursing Diagnoses

- Pain, acute (Indications).
- Physical mobility, impaired (Adverse Reactions).
- Breathing patterns, ineffective (Adverse Reactions).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- **Local Infiltration:** Epinephrine may be added to lidocaine to minimize systemic absorption and prolong local anesthesia.
- **Lidocaine/Prilocaine:** Apply dose in a thick layer at the site of the impending procedure and cover with an occlusive dressing at least 1 hr before the start of the procedure.
- **Epidural Medications:** Dose is titrated to patient response until anesthetic response is achieved
- **Propofol:** Dose is titrated to patient response. Does not affect pain threshold, and adequate analgesia should always be used as an adjunct to surgical procedures. Shake well before IV administration, and use strict aseptic technique when administering.

### Patient/Family Teaching

- **Local Block or Infiltrate:** Instruct patient to notify health care professional if any sensation of pain is felt.
- **Lidocaine/Prilocaine:** Explain the purpose of the cream and occlusive dressing to patient and parents.
- **Epidural Medications:** Instruct patient to notify nurse if signs of systemic toxicity occur.
- **Propofol Use:** Inform patient that this medication will decrease recall of the procedure. Avoid use of alcohol or other CNS depressant agents for 24 hr following administration. Avoid driving or other activities requiring mental alertness for 24 hr after administration.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ **Local Infiltration and Epidural Medication:** Complete blocking of pain sensation ■ **Lidocaine/Prilocaine:** Anesthesia in the area of application ■ **Propofol:** Induction maintenance of anesthesia; amnesia.

**Anesthetics/Anesthetic Adjuncts Included in *Davis's Drug Guide for Nurses***

***Anesthetics (epidural)***

bupivacaine 342  
levobupivacaine 342  
ropivacaine 342

***Anesthetics (general)***

ketamine 1177  
propofol 844

***Anesthetics (topical, mucosal)***

lidocaine 577  
lidocaine/prilocaine 579

**ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS**

See Antihypertensive Agents, page C23.

**ACE Inhibitors Included in *Davis's Drug Guide for Nurses***

benazepril 63  
captopril 63  
enalapril, enalaprilat 63  
fosinopril 64  
lisinopril 64

moexipril 64  
perindopril 64  
quinapril 64  
ramipril 64  
trandolapril 64

**ANOREXIANTS\***

**PHARMACOLOGIC PROFILE**

**General Use:**

Short-term management of exogenous obesity in conjunction with behavior modification, diet, and exercise.

**General Action and Information:**

Appetite suppression probably due to depression of CNS appetite control center (phentermine, phenylpropanolamine). Act as inhibitors of the reuptake of serotonin, norepinephrine, and dopamine and increase the satiety-producing effects of serotonin (sibutramine).

**Contraindications:**

Safety not established in pregnancy and lactation and in children under age 12.

**Precautions:**

Use cautiously in patients with cardiovascular disease (including hypertension), glaucoma, hyperthyroidism, diabetes mellitus, and prostatic hypertrophy.

**Interactions:**

Additive sympathomimetic effects with other adrenergic agents. Should not be used with MAO inhibitors. May increase the risk of hypertension with reserpine, tricyclic antidepressants, or ganglionic blocking agents.

## NURSING IMPLICATIONS

### Assessment

- Exclude hypertension and diabetes prior to instituting phentermine.
- Assess patient for weight loss, and adjust concurrent medications (antihypertensive agents, antidiabetic agents, lipid-lowering agents) as needed.
- Monitor nutritional intake periodically throughout therapy.
- **Sibutramine:** Monitor blood pressure and heart rate regularly during therapy. Increases in blood pressure or heart rate, especially during early therapy, may require decrease in dose or discontinuation of the drug.

### Potential Nursing Diagnoses

- Body image disturbance (Indications).
- Nutrition, altered: more than body requirements (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Take once daily without regard to meals.
- **Phentermine:** Take once daily 30 min prior to breakfast or 10–14 hr before bedtime.

### Patient/Family Teaching

- Instruct patient to take medication as directed and not to exceed recommended dose. Some medications may need to be discontinued gradually.
- **Sibutramine:** Caution patient to avoid using other CNS depressant or excessive amounts of alcohol.
- Advise patient to follow a reduced-calorie diet in conjunction with exercise, as recommended by their health care professional.
- **Phentermine and Phenylpropranolamine:** Warn patient to avoid large amounts of coffee, tea, or colas containing caffeine.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Slow, consistent weight loss when combined with reduced-calorie diet.

### Anorexiants Included in *Davis's Drug Guide for Nurses*

phentermine 1179

sibutramine 919

phenylpropranolamine 788

## ANTIANGINAL AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Nitrates are used to treat and prevent attacks of angina. Only nitrates (sublingual, lingual spray, or intravenous) may be used in the acute treatment of attacks of angina pectoris. Calcium chan-

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

nel blockers and beta-adrenergic blockers are used prophylactically in long-term management of angina.

### **General Action and Information:**

Several different groups of medications are used in the treatment of angina pectoris. The nitrates (isosorbide dinitrate, isosorbide mononitrate, and nitroglycerin) are available as a lingual spray, sublingual tablets, parenterals, transdermal systems, and sustained-release oral dosage forms. Nitrates dilate coronary arteries and cause systemic vasodilation (decreased preload). Calcium channel blockers dilate coronary arteries (some also slow heart rate). Beta-adrenergic blocking agents decrease myocardial oxygen consumption via a decrease in heart rate. Therapy may be combined if selection is designed to minimize side effects or adverse reactions.

### **Contraindications:**

Hypersensitivity. Avoid use of beta blockers or calcium channel blockers in advanced heart block, cardiogenic shock, or untreated congestive heart failure.

### **Precautions:**

Beta-adrenergic blockers should be used cautiously in patients with diabetes mellitus, pulmonary disease, or hypothyroidism.

### **Interactions:**

Nitrates, calcium channel blockers, and beta-adrenergic blockers may cause hypotension with other antihypertensive agents or acute ingestion of alcohol. Verapamil, diltiazem, and beta-adrenergic blockers may have additive myocardial depressant effects when used with other agents that affect cardiac function. Verapamil has a number of other significant drug-drug interactions.

## **NURSING IMPLICATIONS**

### **Assessment**

- Assess location, duration, intensity, and precipitating factors of patient's anginal pain.
- Monitor blood pressure and pulse periodically throughout therapy.

### **Potential Nursing Diagnoses**

- Pain (Indications).
- Tissue perfusion, altered (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### **Implementation**

- Available in various dose forms. See specific drugs for information on administration.

### **Patient/Family Teaching**

- Instruct patient on concurrent nitrate therapy and prophylactic antianginal agents to continue taking both medications as ordered and to use SL nitroglycerin as needed for anginal attacks.

- Advise patient to contact health care professional immediately if chest pain does not improve; worsens after therapy; is accompanied by diaphoresis or shortness of breath; or if severe, persistent headache occurs.
- Caution patient to make position changes slowly to minimize orthostatic hypotension.
- Advise patient to avoid concurrent use of alcohol with these medications.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in frequency and severity of anginal attacks ■ Increase in activity tolerance.

### Antianginal Agents Included in *Davis's Drug Guide for Nurses*

#### ***beta-adrenergic blocking agents***

atenolol 79  
metoprolol 638  
nadolol 678  
propranolol 849

diltiazem 293  
nicardipine 699  
nifedipine 705  
verapamil 1037

#### ***calcium channel blockers***

amlodipine 41  
bepridil 98

#### ***nitrates and nitrites***

isosorbide dinitrate 539  
isosorbide mononitrate 539  
nitroglycerin 714

## ANTI-ANXIETY AND SEDATIVE/HYPNOTIC AGENTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Antianxiety agents and sedatives are used to treat anxiety disorders and to provide sedation before procedures. Hypnotics are used to treat insomnia. Selected agents are useful as anticonvulsants (clorazepate, diazepam, phenobarbital), as skeletal muscle relaxants (diazepam), as adjuncts in the treatment of alcohol withdrawal syndrome (chlordiazepoxide, clorazepate, diazepam, oxazepam), and as general anesthetic adjuncts (droperidol) or amnestics (midazolam, dizepam).

#### General Action and Information:

Cause general CNS depression. May produce tolerance with chronic use and have potential for psychological or physical dependence. These agents have no analgesic properties.

#### Contraindications:

Hypersensitivity. Should not be used in comatose patients or in those with pre-existing CNS depression. Should not be used in patients with uncontrolled severe pain. Avoid use during pregnancy or lactation.

#### Precautions:

Use cautiously in patients with hepatic dysfunction, severe renal impairment, or severe underlying pulmonary disease. Use with caution in patients who may be suicidal or who may have had previous drug addictions. Hypnotic use should be short term. Geriatric patients may be more sensitive to CNS depressant effects (initial dosage reduction may be required).

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

### Interactions:

Additive CNS depression with alcohol, antihistamines, antidepressants, opioid analgesics, or phenothiazines. Barbiturates induce release of hepatic drug-metabolizing enzymes and can decrease the effectiveness of drugs metabolized by the liver. Should not be used with MAO inhibitors.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Monitor blood pressure, pulse, and respiratory status frequently throughout IV administration.
- Prolonged high-dose therapy may lead to psychological or physical dependence. Restrict the amount of drug available to patient, especially if patient is depressed, suicidal, or has a history of addiction.
- **Insomnia:** Assess sleep patterns before and periodically throughout therapy.
- **Anxiety:** Assess degree of anxiety and level of sedation (ataxia, dizziness, slurred speech) before and periodically throughout therapy.
- **Seizures:** Observe and record intensity, duration, and characteristics of seizure activity. Institute seizure precautions.
- **Muscle Spasms:** Assess muscle spasms, associated pain, and limitation of movement before and throughout therapy.
- **Alcohol Withdrawal:** Assess patient experiencing alcohol withdrawal for tremors, agitation, delirium, and hallucinations. Protect patient from injury.

### Potential Nursing Diagnoses

- Sleep pattern disturbance (Indications).
- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Supervise ambulation and transfer of patients following administration of hypnotic doses. Remove cigarettes. Side rails should be raised and call bell within reach at all times. Keep bed in low position.

### Patient/Family Teaching

- Discuss the importance of preparing environment for sleep (dark room, quiet, avoidance of nicotine and caffeine). If less effective after a few weeks, consult health care professional; do not increase dose. Gradual withdrawal may be required to prevent reactions following prolonged therapy.
- May cause daytime drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to medication is known.
- Advise patient to avoid the use of alcohol and other CNS depressants concurrently with these medications.
- Advise patient to inform health care professional if pregnancy is planned or suspected.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Improvement in sleep patterns  
 ■ Decrease in anxiety level ■ Control of seizures ■ Decrease in muscle spasm ■ Decrease in tremulousness ■ More rational ideation when used for alcohol withdrawal.

## Anti-anxiety and Sedative/Hypnotic Agents Included in *Davis's Drug Guide for Nurses*

### **antihistamines**

diphenhydramine 300  
 hydroxyzine 493  
 promethazine 893

### **barbiturates**

pentobarbital 776  
 phenobarbital 784

### **benzodiazepines**

alprazolam 23  
 chlordiazepoxide 188  
 diazepam 279

flurazepam  
 lorazepam 588  
 midazolam 645  
 oxazepam 735  
 temazepam, 735  
 triazolam 1016

### **miscellaneous**

bupirone 131  
 doxepin 330  
 zaleplon 1064  
 zolpidem 1072

## ANTIARRHYTHMIC AGENTS

## PHARMACOLOGIC PROFILE

### General Use:

Suppression of cardiac arrhythmias.

### General Action and Information:

Correct cardiac arrhythmias by a variety of mechanisms, depending on the group used. The therapeutic goal is decreased symptomatology and increased hemodynamic performance. Choice of agent depends on etiology of arrhythmia and individual patient characteristics. Treatable causes of arrhythmias should be corrected before therapy is initiated (e.g., electrolyte disturbances). Major antiarrhythmics are generally classified by their effects on cardiac conduction tissue (see the following table). Adenosine, atropine, and digitalis glycosides (digoxin, digoxin) are also used as antiarrhythmics.

## MECHANISM OF ACTION OF MAJOR ANTIARRHYTHMIC DRUGS

GROUP	DRUGS	MECHANISM
I	morizine	Shares properties of IA, IB, and IC agents
IA	disopyramide, procainamide, quinidine	Depress Na conductance, increase APD and ERP, decrease membrane responsiveness
IB	lidocaine, mexiletine, phenytoin, tocainide,	Increase K conductance, decrease APD and ERP
IC	flecainide, propafenone	Profound slowing of conduction, markedly depress phase 0
II	acebutolol, esmolol, propranolol	Interfere with Na conductance, depress cell membrane, decrease automaticity, and increase ERP of the AV node, block excess sympathetic activity
III	amiodarone, bretylium, ibutilide, sotalol	Interfere with norepinephrine, increase APD and ERP
IV	diltiazem, verapamil	Increase AV nodal ERP, Ca channel blocker

APD = action-potential duration; Ca = calcium; ERP = effective refractory period; K = potassium; Na = sodium.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

**Contraindications:**

Differ greatly among various agents. See individual drugs.

**Precautions:**

Differ greatly among agents used. Appropriate dosage adjustments should be made in elderly patients and those with renal or hepatic impairment, depending on agent chosen. Correctable causes (electrolyte abnormalities, drug toxicity) should be evaluated. See individual drugs.

**Interactions:**

Differ greatly among agents used. See individual drugs.

**NURSING IMPLICATIONS**

**Assessment**

- Monitor ECG, pulse, and blood pressure continuously throughout IV administration and periodically throughout oral administration.

**Potential Nursing Diagnoses**

- Cardiac output, decreased (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Take apical pulse before administration of oral doses. Withhold dose and notify physician or other health care professional if heart rate is <50 bpm.
- Administer oral doses with a full glass of water. Most sustained-release preparations should be swallowed whole. Do not crush, break, or chew tablets or open capsules, unless specifically instructed.

**Patient/Family Teaching**

- Instruct patient to take oral doses around the clock, as directed, even if feeling better.
- Instruct patient or family member on how to take pulse. Advise patient to report changes in pulse rate or rhythm to health care professional.
- Caution patient to avoid taking OTC medications without consulting health care professional.
- Advise patient to carry identification describing disease process and medication regimen at all times.
- Emphasize the importance of follow-up exams to monitor progress.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of cardiac arrhythmias without detrimental side effects.

**Antiarrhythmic Agents Included in *Davis's Drug Guide for Nurses***

**group I**  
moricizine 665

**group IA**  
disopyramide 306

procainamide 828  
quinidine 868

**group IB**

lidocaine 577  
mexiletine 644  
phenytoin 790  
tocainide 1002

**group IC**

flecainide 400  
propafenone 841

**group II**

acebutolol 1  
esmolol 363  
metoprolol 638

propranolol 849

**group III**

amiodarone 35  
bretylum 117  
ibutilide 501  
sotalol 935

**group IV**

diltiazem 293  
verapamil 1037

**miscellaneous**

adenosine 11  
atropine 81  
digoxin 287

## ANTICHOLINERGIC AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

**Atropine**—Bradycardias. **Scopolamine**—Nausea and vomiting related to motion sickness and vertigo. **Propantheline and glycopyrrolate**—Decreasing gastric secretory activity and increasing esophageal sphincter tone. Atropine and scopolamine are also used as ophthalmic mydriatics.

#### General Action and Information:

Competitively inhibit the action of acetylcholine. In addition, atropine, glycopyrrolate, propantheline, and scopolamine are antimuscarinic in that they inhibit the action of acetylcholine at sites innervated by postganglionic cholinergic nerves.

#### Contraindications:

Hypersensitivity, narrow-angle glaucoma, severe hemorrhage, tachycardia (due to thyrotoxicosis or cardiac insufficiency), or myasthenia gravis.

#### Precautions:

Geriatric and pediatric patients are more susceptible to adverse effects. Use cautiously in patients with urinary tract pathology; those at risk for GI obstruction; and those with chronic renal, hepatic, pulmonary, or cardiac disease.

#### Interactions:

Additive anticholinergic effects (dry mouth, dry eyes, blurred vision, constipation) with other agents possessing anticholinergic activity, including antihistamines, antidepressants, quinidine, and disopyramide. May alter GI absorption of other drugs by inhibiting GI motility and increasing transit time. Antacids may decrease absorption of anticholinergics.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## NURSING IMPLICATIONS

### Assessment

- Assess vital signs and ECG frequently during IV drug therapy. Report any significant changes in heart rate or blood pressure or increase in ventricular ectopy or angina promptly.
- Monitor intake and output ratios in elderly or surgical patients; may cause urinary retention.
- Assess patient regularly for abdominal distention and auscultate for bowel sounds. Constipation may become a problem. Increasing fluids and adding bulk to the diet may help alleviate constipation.

### Potential Nursing Diagnoses

- Cardiac output, decreased (Indications).
- Oral mucous membrane, altered (Side Effects).
- Constipation (Side Effects).

### Implementation

- **PO:** Administer oral doses of atropine, glycopyrrolate, propantheline, or scopolamine 30 min before meals.
- Scopolamine transdermal patch should be applied at least 4 hr before travel.

### Patient/Family Teaching

- **General Info:** Instruct patient that frequent rinses, sugarless gum or candy, and good oral hygiene may help relieve dry mouth.
- May cause drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to medication is known.
- **Ophth:** Advise patients that ophthalmic preparations may temporarily blur vision and impair ability to judge distances. Dark glasses may be needed to protect eyes from bright light.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Increase in heart rate ■ Decrease in nausea and vomiting related to motion sickness or vertigo ■ Dryness of mouth ■ Dilation of pupils ■ Decrease in GI motility ■ Resolution of signs and symptoms of Parkinson's disease.

### Anticholinergic Agents Included in *Davis's Drug Guide for Nurses*

atropine 81  
glycopyrrolate 444

propantheline 843  
scopolamine 913

## ANTICOAGULANTS

### PHARMACOLOGIC PROFILE

#### General Use:

Prevention and treatment of thromboembolic disorders including deep vein thrombosis, pulmonary embolism, and atrial fibrillation with embolization.

### General Action and Information:

Anticoagulants are used to prevent clot extension and formation. They do not dissolve clots. The two types of anticoagulants in common use are parenteral heparins and oral warfarin. Therapy is usually initiated with heparin because of its rapid onset of action, while maintenance therapy consists of warfarin. Warfarin takes several days to produce therapeutic anticoagulation. In serious or severe thromboembolic events, heparin therapy may be preceded by thrombolytic therapy (alteplase, anistreplase, streptokinase, or urokinase). Low doses of heparin, low-molecular-weight heparins, and heparin-like compounds (ardeparin, danaparoid, dalteparin, enoxaparin) are mostly used to prevent deep vein thrombosis after certain surgical procedures and in similar situations in which prolonged bedrest increases the risk of thromboembolism.

### Contraindications:

Underlying coagulation disorders, ulcer disease, malignancy, recent surgery, or active bleeding.

### Precautions:

Anticoagulation should be undertaken cautiously in any patient with a potential site for bleeding. Pregnant or lactating patients should not receive warfarin. Heparin does not cross the placenta. Heparin and heparin-like agents should be used cautiously in patients receiving epidural analgesia.

### Interactions:

Warfarin is highly protein bound and may displace or be displaced by other highly protein-bound drugs. The resultant interactions depend on which drug is displaced. Bleeding may be potentiated by aspirin or large doses of penicillins or penicillin-like drugs, cefamandole, cefotetan, cefoperazone, plicamycin, valproic acid, or NSAIDs.

## NURSING IMPLICATIONS

### Assessment

- Assess patient taking anticoagulants for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; tarry, black stools; hematuria; fall in hematocrit or blood pressure; guaiac-positive stools; urine; or nasogastric aspirate).
- Assess patient for evidence of additional or increased thrombosis. Symptoms will depend on area of involvement.
- **Lab Test Considerations:** Monitor activated partial thromboplastin time (aPTT) or international normalized ratio (INR) with full-dose heparin therapy, prothrombin time (PT) with warfarin therapy, and hematocrit and other clotting factors frequently during therapy.
- Monitor bleeding time throughout antiplatelet therapy. Prolonged bleeding time, which is time- and dose-dependent, is expected.
- **Toxicity and Overdose:** If overdose occurs or anticoagulation needs to be immediately reversed, the antidote for heparins is protamine sulfate; for warfarin, the antidote is vitamin K (phytonadione [AquaMEPHYTON]). Administration of whole blood or plasma may also be required in severe bleeding due to warfarin because of the delayed onset of vitamin K.

### Potential Nursing Diagnoses

- Tissue perfusion, altered (Indications).

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Inform all personnel caring for patient of anticoagulant therapy. Venipunctures and injection sites require application of pressure to prevent bleeding or hematoma formation.
- Use an infusion pump with continuous infusions to ensure accurate dosage.

### Patient/Family Teaching

- Caution patient to avoid activities leading to injury, to use a soft toothbrush and electric razor, and to report any symptoms of unusual bleeding or bruising to health care professional immediately.
- Instruct patient not to take OTC medications, especially those containing aspirin, NSAIDs, or alcohol, without advice of health care professional.
- Review foods high in vitamin K (see Appendix L) with patients on warfarin. Patient should have consistent limited intake of these foods, as vitamin K is the antidote for warfarin and greatly alternating intake of these foods will cause PT levels to fluctuate.
- Emphasize the importance of frequent lab tests to monitor coagulation factors.
- Instruct patient to carry identification describing medication regimen at all times and to inform all health care personnel caring for patient of anticoagulant therapy before lab tests, treatment, or surgery.

### Evaluation

**Clinical response can be evaluated by:** ■ Prevention of undesired clotting and its sequelae without signs of hemorrhage ■ Prevention of stroke, myocardial infarction, and vascular death in patients at risk.

### Anticoagulants Included in *Davis's Drug Guide for Nurses*

ardeparin 469	enoxaparin 469
dalteparin 469	heparin 465
danaparoid 469	warfarin 1057

## ANTICONSULSANTS

### PHARMACOLOGIC PROFILE

#### General Use:

See the following table.

#### General Action and Information:

Anticonvulsants include a variety of agents, all capable of depressing abnormal neuronal discharges in the CNS that may result in seizures. They may work by preventing the spread of seizure activity, depressing the motor cortex, raising seizure threshold, or altering levels of neurotransmitters, depending on the group. See individual drugs.

## MAJOR ANTICONVULSANT CLASSES, DRUGS, AND MOST COMMON USES

CLASS	DRUGS	TYPE OF SEIZURE CONTROLLED
Barbiturates	phenobarbital	Tonic-clonic and partial seizures, prophylaxis of febrile seizures
Benzodiazepines	clonazepam	Absence seizures, akinetic seizures, myoclonic seizures
	clorazepate	Partial seizures
	diazepam (IV)	Status epilepticus, tonic-clonic seizures
	lorazepam (IV)	Status epilepticus
Hydantoins	fosphenytoin	Short-term parenteral management of seizures, treatment/prevention of seizures during neurosurgery
	phenytoin	Tonic-clonic and partial seizures with complex symptomatology
Succinimides	ethosuximide	Absence seizures
Miscellaneous	acetazolamide	Refractory seizures
	carbamazepine	Tonic-clonic seizures, complex partial seizures, mixed seizures
	gabapentin	Adjunctive treatment of partial seizures
	lamotrigine	Adjunctive treatment of partial seizures
	magnesium sulfate	Eclamptic seizures
	oxcarbazepine	Adjunctive therapy of partial seizures
	tiagabine	Adjunct treatment of partial seizures
	topiramate	Adjunctive therapy of partial-onset seizures
	valproates	Simple and complex partial seizures

**Contraindications:**

Previous hypersensitivity.

**Precautions:**

Use cautiously in patients with severe hepatic or renal disease; dosage adjustment may be required. Choose agents carefully in pregnant and lactating women. Fetal hydantoin syndrome may occur in offspring of patients who receive phenytoin during pregnancy.

**Interactions:**

Barbiturates stimulate the metabolism of other drugs that are metabolized by the liver, decreasing their effectiveness. Hydantoins are highly protein-bound and may displace or be displaced by other highly protein-bound drugs. Lamotrigine, tiagabine, and topiramate are capable of interacting with several other anticonvulsants. For more specific interactions, see individual drugs. Many drugs are capable of lowering seizure threshold and may decrease the effectiveness of anticonvulsants, including tricyclic antidepressants and phenothiazines.

**NURSING IMPLICATIONS****Assessment**

- Assess location, duration, and characteristics of seizure activity.
- **Toxicity and Overdose:** Monitor serum drug levels routinely throughout anticonvulsant therapy, especially when adding or discontinuing other agents.

**Potential Nursing Diagnoses**

- Injury, risk for (Indications, Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## Implementation

- Administer anticonvulsants around the clock. Abrupt discontinuation may precipitate status epilepticus.
- Implement seizure precautions.

## Patient/Family Teaching

- Instruct patient to take medication every day, exactly as directed.
- May cause drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to medication is known. Do not resume driving until physician gives clearance based on control of seizures.
- Advise patient to avoid taking alcohol or other CNS depressants concurrently with these medications.
- Advise patient to carry identification describing disease process and medication regimen at all times.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease or cessation of seizures without excessive sedation.

## Anticonvulsants Included in *Davis's Drug Guide for Nurses*

### **barbiturates**

phenobarbital 784

### **benzodiazepines**

clonazepam 211

clorazepate 216

diazepam 279

lorazepam 588

### **hydantoins**

phenytoin/fosphenytoin 790

### **succinamide**

ethosuximide 1175

### **valproates**

divalproex sodium 1030

valproate sodium 1030

valproic acid 1030

### **miscellaneous**

carbamazepine 149

gabapentin 433

lamotrigine 561

magnesium sulfate 595

oxcarbazepine 736

tiagabine 989

topiramate 1006

## ANTIDEPRESSANTS

## PHARMACOLOGIC PROFILE

### General Use:

Used in the treatment of various forms of endogenous depression, often in conjunction with psychotherapy. Other uses include: ■ Treatment of anxiety (doxepin) ■ Enuresis (imipramine) ■ Chronic pain syndromes (amitriptyline, doxepin, imipramine, and nortriptyline) ■ Smoking cessation (bupropion) ■ Bulimia (fluoxetine) ■ Obsessive-compulsive disorder (fluoxetine, sertraline).

### General Action and Information:

Antidepressant activity most likely due to preventing the reuptake of dopamine, norepinephrine, and serotonin by presynaptic neurons, resulting in accumulation of these neurotransmitters.

The two major classes of antidepressants are the tricyclic antidepressants and the SSRI(s). Most tricyclic agents possess significant anticholinergic and sedative properties, which explains many of their side effects (amitriptyline, doxepin, imipramine, nortriptyline). The SSRIs are more likely to cause insomnia (fluoxetine, fluvoxamine, paroxetine, sertraline).

### Contraindications:

Hypersensitivity. Should not be used in narrow-angle glaucoma. Should not be used in pregnancy or lactation or immediately after myocardial infarction.

### Precautions:

Use cautiously in older patients and those with pre-existing cardiovascular disease. Elderly men with prostatic enlargement may be more susceptible to urinary retention. Anticholinergic side effects (dry eyes, dry mouth, blurred vision, and constipation) may require dosage modification or drug discontinuation. Dosage requires slow titration; onset of therapeutic response may be 2–4 wk. May decrease seizure threshold, especially bupropion.

### Interactions:

**Tricyclic antidepressants**—May cause hypertension, tachycardia, and convulsions when used with MAO inhibitors. May prevent therapeutic response to some antihypertensives. Additive CNS depression with other CNS depressants. Sympathomimetic activity may be enhanced when used with other sympathomimetics. Additive anticholinergic effects with other drugs possessing anticholinergic properties. **MAO inhibitors**—Hypertensive crisis may occur with concurrent use of MAO inhibitors and amphetamines, methyl dopa, levodopa, dopamine, epinephrine, norepinephrine, desipramine, imipramine, guanethidine, reserpine, vasoconstrictors, or ingestion of tyramine-containing foods. Hypertension or hypotension, coma, convulsions, and death may occur with meperidine or other opioid analgesics and MAO inhibitors. Additive hypotension with antihypertensives or spinal anesthesia and MAO inhibitors. Additive hypoglycemia with insulin or oral hypoglycemic agents and MAO inhibitors. **Fluoxetine, fluvoxamine, bupropion, citalopram, paroxetine, sertraline, or venlafaxine** should not be used in combination with or within weeks of MAO inhibitors (see individual monographs). Risk of adverse reactions may be increased by **rizatriptan, naratriptan, sumatriptan, or zolmitriptan**.

## NURSING IMPLICATIONS

### Assessment

- Monitor mental status and affect. Assess for suicidal tendencies, especially during early therapy. Restrict amount of drug available to patient.
- **Toxicity and Overdose:** Concurrent ingestion of monamine oxidase inhibitors and tyramine-containing foods may lead to hypertensive crisis. Symptoms include chest pain, severe headache, nuchal rigidity, nausea and vomiting, photosensitivity, and enlarged pupils. Treatment includes IV phentolamine.

### Potential Nursing Diagnoses

- Coping, ineffective individual (Indications).
- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## Implementation

- Administer drugs that are sedating at bedtime to avoid excessive drowsiness during waking hours, and administer drugs that cause insomnia (fluoxetine, fluvoxamine, paroxetine, sertraline, MAO inhibitors) in the morning. Bupropion must be given in divided doses.

## Patient/Family Teaching

- Caution patient to avoid alcohol and other CNS depressants. Patients receiving MAO inhibitors should also avoid OTC drugs and foods or beverages containing tyramine (see Appendix L for foods) during and for at least 2 wk after therapy has been discontinued, as they may precipitate a hypertensive crisis. Health care professional should be contacted immediately if symptoms of hypertensive crisis develop.
- Inform patient that dizziness or drowsiness may occur. Caution patient to avoid driving and other activities requiring alertness until response to the drug is known.
- Caution patient to make position changes slowly to minimize orthostatic hypotension.
- Advise patient to notify health care professional if dry mouth, urinary retention, or constipation occurs. Frequent rinses, good oral hygiene, and sugarless candy or gum may diminish dry mouth. An increase in fluid intake, fiber, and exercise may prevent constipation.
- Advise patient to notify health care professional of medication regimen before treatment or surgery. MAO inhibitor therapy usually needs to be withdrawn at least 2 wk before use of anesthetic agents.
- Emphasize the importance of participation in psychotherapy and follow-up exams to evaluate progress.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of depression ■ Decrease in anxiety ■ Control of bedwetting in children over 6 yr of age ■ Management of chronic neurogenic pain.

## Antidepressants Included in *Davis's Drug Guide for Nurses*

### **tricyclic antidepressants**

amitriptyline 39  
doxepin 330  
imipramine 509  
nortriptyline 719

### **selective serotonin reuptake**

**inhibitors**  
citalopram 202  
fluoxetine 417  
fluvoxamine 426  
paroxetine 752  
sertraline 916

### **monoamine oxidase (MAO)**

**inhibitors**  
phenelzine 661  
tranylcypromine 661

### **miscellaneous**

bupropion 129  
mirtazapine 654  
nefazodone 690  
trazodone 1015  
venlafaxine 1035

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## ANTIDIABETIC AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Insulin is used in the management of insulin-dependent diabetes mellitus (IDDM, type 1). It may also be used in non-insulin-dependent diabetes mellitus (NIDDM, type 2) when diet and/or oral hypoglycemic therapy fails to adequately control blood sugar. The choice of insulin preparation (rapid-acting, intermediate-acting, long-acting) and source (beef, beef/pork, pork, semisynthetic, human recombinant DNA) depend on the degree of control desired, daily blood sugar fluctuations, and history of previous reactions. Oral hypoglycemics can be used only in NIDDM, type 2. Oral agents are used when diet therapy alone fails to control blood sugar or symptoms or when patients are not amenable to using insulin. Some oral agents may be used with insulin.

#### General Action and Information:

Insulin, a hormone produced by the pancreas, lowers blood glucose by increasing transport of glucose into cells and promotes the conversion of glucose to glycogen. It also promotes the conversion of amino acids to proteins in muscle, stimulates triglyceride formation, and inhibits the release of free fatty acids. Sulfonylureas, repaglinide, and metformin lower blood sugar by stimulating endogenous insulin secretion by beta cells of the pancreas and by increasing sensitivity to insulin at intracellular receptor sites. Intact pancreatic function is required. Miglitol delays digestion of ingested carbohydrates, thus lowering blood sugar, especially after meals. It may be combined with sulfonylureas.

#### Contraindications:

**Insulin**—Hypoglycemia. **Oral hypoglycemic agents**—Hypersensitivity (cross-sensitivity with other sulfonylureas and sulfonamides may exist). Hypoglycemia. IDDM, type 1. Avoid use in patients with severe kidney, liver, thyroid, and other endocrine dysfunction. Should not be used in pregnancy or lactation.

#### Precautions:

**Insulin**—Infection, stress, or changes in diet may alter requirements. **Oral hypoglycemic agents**—Use cautiously in geriatric patients. Dosage reduction may be necessary. Infection, stress, or changes in diet may alter requirements. Use with sulfonylureas with caution in patients with a history of cardiovascular disease. Metformin may cause lactic acidosis.

#### Interactions:

**Insulin**—Additive hypoglycemic effects with oral hypoglycemic agents. **Oral hypoglycemic agents**—Ingestion of alcohol may result in disulfiram-like reaction with some agents. Alcohol, corticosteroids, rifampin, glucagon, and thiazide diuretics may decrease effectiveness. Anabolic steroids, chloramphenicol, clofibrate, MAO inhibitors, most NSAIDs, salicylates, sulfonamides, and warfarin may increase hypoglycemic effect. Beta-adrenergic blocking agents may produce hypoglycemia and mask signs and symptoms.

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## NURSING IMPLICATIONS

### Assessment

- Observe patient for signs and symptoms of hypoglycemic reactions.
- Miglitol and pioglitazone do not cause hypoglycemia when taken alone but may increase the hypoglycemic effect of other hypoglycemic agents.
- Patients who have been well controlled on metformin but develop illness or laboratory abnormalities should be assessed for ketoacidosis or lactic acidosis. Assess serum electrolytes, ketones, glucose, and, if indicated, blood pH, lactate, pyruvate, and metformin levels. If either form of acidosis is present, discontinue metformin immediately and treat acidosis.
- **Lab Test Considerations:** Serum glucose and glycosylated hemoglobin should be monitored periodically throughout therapy to evaluate effectiveness of treatment.

### Potential Nursing Diagnoses

- Nutrition, altered: more than body requirements (Indications).
- Knowledge deficit: related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

### Implementation

- **General Info:** Patients stabilized on a diabetic regimen who are exposed to stress, fever, trauma, infection, or surgery may require sliding scale insulin. Withhold metformin and reinstitute after resolution of acute episode.
- Patients switching from daily insulin dose may require gradual conversion to oral hypoglycemics.
- **Insulin:** Available in different types and strengths and from different species. Check type, species' source, dose, and expiration date with another licensed nurse. Do not interchange insulins without physician's order. Use only insulin syringes to draw up dose. Use only U100 syringes to draw up insulin lispro dose.

### Patient/Family Teaching

- **General Info:** Explain to patient that medication controls hyperglycemia but does not cure diabetes. Therapy is long-term.
- Review signs of hypoglycemia and hyperglycemia with patient. If hypoglycemia occurs, advise patient to take a glass of orange juice or 2–3 tsp of sugar, honey, or corn syrup dissolved in water (glucose, not table sugar, if taking miglitol), and notify health care professional.
- Encourage patient to follow prescribed diet, medication, and exercise regimen to prevent hypoglycemic or hyperglycemic episodes.
- Instruct patient in proper testing of serum glucose and ketones.
- Advise patient to notify health care professional if nausea, vomiting, or fever develops; if unable to eat usual diet; or if blood sugar levels are not controlled.
- Advise patient to carry sugar or a form of glucose and identification describing medication regimen at all times.
- Insulin is the recommended method of controlling blood sugar during pregnancy. Counsel female patients to use a form of contraception other than oral contraceptives and to notify health care professional promptly if pregnancy is planned or suspected.
- **Insulin:** Instruct patient on proper technique for administration; include type of insulin, equipment (syringe and cartridge pens), storage, and syringe disposal. Discuss the importance of not changing brands of insulin or syringes, selection and rotation of injection sites, and compliance with therapeutic regimen.

- **Sulfonylureas:** Advise patient that concurrent use of alcohol may cause a disulfiram-like reaction (abdominal cramps, nausea, flushing, headache, and hypoglycemia).
- **Metformin:** Explain to patient the risk of lactic acidosis and the potential need for discontinuation of metformin therapy if a severe infection, dehydration, or severe or continuing diarrhea occurs or if medical tests or surgery is required.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Control of blood glucose levels without the appearance of hypoglycemic or hyperglycemic episodes.

### Antidiabetic Agents Included in *Davis's Drug Guide for Nurses*

#### **alpha-glucosidase inhibitor**

miglitol 649

#### **biguanide**

metformin 619

#### **insulin mixture**

NPH/regular insulin mixture 520

#### **intermediate-acting insulin**

insulin, NPH (isophane insulin suspension) 520

insulin zinc suspension (lente insulin) 520

#### **long-acting insulin**

insulin zinc suspension, extended (ultralente insulin) 520

#### **rapid-acting insulin**

insulin, lispro, rDNA origin 520

regular insulin (insulin injection, crystalline zinc insulin) 520

#### **sulfonylureas**

glimepiride 495

glipizide 495

glyburide 495

#### **miscellaneous**

pioglitazone 801

repaglinide 877

rosiglitazone P-105

## ANTIDIARRHEAL AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

For the control and symptomatic relief of acute and chronic nonspecific diarrhea.

#### General Action and Information:

Diphenoxylate/atropine, difenoxin/atropine, and loperamide slow intestinal motility and propulsion. Kaolin/pectin and bismuth subsalicylate affect fluid content of the stool. Polycarbophil acts as an antidiarrheal by taking on water within the bowel lumen to create a formed stool. Octreotide is used specifically for diarrhea associated with GI endocrine tumors.

#### Contraindications:

Previous hypersensitivity. Severe abdominal pain of unknown cause, especially when associated with fever.

**Precautions:**

Use cautiously in patients with severe liver disease or inflammatory bowel disease. Safety in pregnancy and lactation not established (diphenoxylate/atropine and loperamide). Octreotide may aggravate gallbladder disease.

**Interactions:**

Kaolin/pectin may decrease absorption of digoxin. Polycarbophil decreases the absorption of tetracycline. Octreotide may alter the response to insulin or oral hypoglycemic agents.

**NURSING IMPLICATIONS****Assessment**

- Assess the frequency and consistency of stools and bowel sounds before and throughout therapy.
- Assess patient's fluid and electrolyte status and skin turgor for dehydration.

**Potential Nursing Diagnoses**

- Diarrhea (Indications).
- Constipation (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Shake liquid preparations before administration.

**Patient/Family Teaching**

- Instruct patient to notify health care professional if diarrhea persists; or if fever, abdominal pain, or palpitations occur.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in diarrhea.

**Antidiarrheal Agents Included in *Davis's Drug Guide for Nurses***

attapulgite 1171	kaolin/pectin 547
bismuth subsalicylate 110	loperamide 585
difenoxin/atropine 303	octreotide 723
diphenoxylate/atropine 303	polycarbophil 811

**ANTIDOTES****PHARMACOLOGIC PROFILE****General Use:**

See the following table.

**General Action and Information:**

Antidotes are used in accidental and intentional overdoses of medications or toxic substances. The goal of antidotal therapy is to decrease systemic complications of the overdose while supporting vital functions. Obtaining a precise history will determine aggressiveness of therapy, choice, and dose of agent. Some antidotes are designed to aid removal of the offending agent before systemic absorption occurs or to speed elimination (activated charcoal). Other agents are more specific and require more detailed history as to type and amount of agent ingested.

**POISONS AND SPECIFIC ANTIDOTES**

<b>POISON</b>	<b>ANTIDOTE</b>
acetaminophen	acetylcysteine
anticholinesterases	atropine, pralidoxime
benzodiazepines	flumazenil
cyclophosphamide	mesna
digoxin, digitoxin	digoxin immune Fab
doxorubicin	dexrazoxane
fluorouracil	leucovorin calcium
heparin	protamine sulfate
iron	deferoxamine
lead	succimer
methotrexate	leucovorin calcium
opiod analgesics, heroin	naloxone
warfarin	phytonadione (vitamin K)

**Contraindications:**

See individual drugs.

**Precautions:**

See individual drugs.

**Interactions:**

See individual drugs.

**NURSING IMPLICATIONS****Assessment**

- Inquire as to the type of drug or poison and time of ingestion.
- Consult reference, poison control center, or physician for symptoms of toxicity of ingested agent(s) and antidote. Monitor vital signs, affected systems, and serum levels closely.
- Monitor for suicidal ideation; institute suicide precautions as necessary.

**Potential Nursing Diagnoses**

- Coping, ineffective individual (Indications).
- Injury, risk for: poisoning (Patient/Family Teaching).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

### Implementation

- May be used in conjunction with induction of emesis or gastric aspiration and lavage, cathartics, agents to modify urine pH, and supportive measures for respiratory and cardiac effects of overdose or poisoning.

### Patient/Family Teaching

- When counseling about poisoning in the home, discuss methods of prevention and the need to confer with poison control center, physician, or emergency department prior to administering syrup of ipecac and the need to bring ingested substance to the hospital for identification. Reinforce need to keep all medications and hazardous substances out of the reach of children.

### Evaluation

**Effectiveness of therapy is demonstrated by:** ■ Prevention or resolution of toxic side effects of ingested agent.

### Antidotes Included in *Davis's Drug Guide for Nurses*

acetylcysteine 5	leucovorin calcium 567
amyl nitrate 1170	mesna 616
deferoxamine 268	naloxone 685
dextrazoxane 274	pralidoxime 1180
digoxin immune Fab 291	protamine sulfate 854
dimercaprol 1174	sodium nitrate 1181
edetate calcium disodium 1175	sodium thiosulfate 1181
flumazenil 406	succimer 939

## ANTIEMETIC AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Phenothiazines, dolasetron, granisetron, metoclopramide, trimethobenzamide, and ondansetron are used to manage nausea and vomiting of many causes, including surgery, anesthesia, and antineoplastic and radiation therapy. Dimenhydrinate, scopolamine, and meclizine are used almost exclusively to prevent motion sickness.

#### General Action and Information:

Phenothiazines act on the chemoreceptor trigger zone to inhibit nausea and vomiting. Dimenhydrinate, scopolamine, and meclizine act as antiemetics mainly by diminishing motion sickness. Metoclopramide decreases nausea and vomiting by its effects on gastric emptying. Dolasetron, granisetron, and ondansetron block the effects of serotonin.

#### Contraindications:

Previous hypersensitivity.

**Precautions:**

Use phenothiazines cautiously in children who may have viral illnesses. Choose agents carefully in pregnant patients (no agents are approved for safe use).

**Interactions:**

Additive CNS depression with other CNS depressants including antidepressants, antihistamines, opioid analgesics, and sedative/hypnotics. Phenothiazines may produce hypotension when used with antihypertensives, nitrates, or acute ingestion of alcohol.

**NURSING IMPLICATIONS****Assessment**

- Assess nausea, vomiting, bowel sounds, and abdominal pain before and following administration.
- Monitor hydration status and intake and output. Patients with severe nausea and vomiting may require IV fluids in addition to antiemetics.

**Potential Nursing Diagnoses**

- Fluid volume deficit (Indications).
- Nutrition, altered: less than body requirements (Indications).
- Injury, risk for (Side Effects).

**Implementation**

- For prophylactic administration, follow directions for specific drugs so that peak effect corresponds to time of anticipated nausea.
- Phenothiazines should be discontinued 48 hr before and not resumed for 24 hr following myelography, as they lower seizure threshold.

**Patient/Family Teaching**

- Advise patient and family to use general measures to decrease nausea (begin with sips of liquids and small, nongreasy meals; provide oral hygiene; and remove noxious stimuli from environment).
- May cause drowsiness. Advise patient to call for assistance when ambulating and to avoid driving or other activities requiring alertness until response to medication is known.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Prevention of, or decrease in, nausea and vomiting.

**Antiemetic Agents Included in *Davis's Drug Guide for Nurses*****anticholinergic**

scopolamine 913

**antihistamines**

dimenhydrinate 296

meclizine 604

***phenothiazines***

chlorpromazine 191  
prochlorperazine 833  
promethazine 839  
thiethylperazine 976  
trifluoperazine 1018

***serotonin (5-HT<sub>3</sub>) antagonists***

dolasetron 323  
granisetron 448  
ondansetron 728

***miscellaneous***

benzquinamide 1171  
cyclizine 1173  
metoclopramide 634  
trimethobenzamide 1022

**ANTIFUNGAL AGENTS**

**PHARMACOLOGIC PROFILE**

**General Use:**

Treatment of fungal infections. Infections of skin or mucous membranes may be treated with topical or vaginal preparations. Deep-seated or systemic infections require oral or parenteral therapy. New parenteral formulations of amphotericin employ lipid encapsulation technology designed to decrease toxicity.

**General Action and Information:**

Kill (fungicidal) or stop growth of (fungistatic) susceptible fungi by affecting the permeability of the fungal cell membrane or protein synthesis within the fungal cell itself.

**Contraindications:**

Previous hypersensitivity.

**Precautions:**

Because most systemic antifungals may have adverse effects on bone marrow function, use cautiously in patients with depressed bone marrow reserve. Amphotericin B commonly causes renal impairment. Fluconazole requires dosage adjustment in the presence of renal impairment. Adverse reactions to fluconazole may be more severe in HIV-positive patients.

**Interactions:**

Differ greatly among various agents. See individual drugs.

**NURSING IMPLICATIONS**

**Assessment**

- Assess patient for signs of infection and assess involved areas of skin and mucous membranes before and throughout therapy. Increased skin irritation may indicate need to discontinue medication.

**Potential Nursing Diagnoses**

- Infection, risk for (Indications).
- Skin integrity, impaired (Indications).

- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- **General Info:** Available in various dosage forms. Refer to specific drugs for directions for administration.
- **Topical:** Consult physician or other health care professional for cleansing technique before applying medication. Wear gloves during application. Do not use occlusive dressings unless specified by physician or other health care professional.

### Patient/Family Teaching

- Instruct patient on proper use of medication form.
- Instruct patient to continue medication as directed for full course of therapy, even if feeling better.
- Advise patient to report increased skin irritation or lack of therapeutic response to health care professional.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of signs and symptoms of infection. Length of time for complete resolution depends on organism and site of infection. Deep-seated fungal infections may require prolonged therapy (weeks–months). Recurrent fungal infections may be a sign of serious systemic illness.

### Antifungal Agents Included in *Davis's Drug Guide for Nurses*

#### ***ophthalmic antifungal***

natamycin 1158

#### ***systemic antifungals***

amphotericin B cholesteryl sulfate 48

amphotericin B deoxycholate 48

amphotericin B lipid complex 48

amphotericin B liposome 48

dapsone 1173

fluconazole 402

griseofulvin 450

itraconazole 543

ketoconazole 548

#### ***topical antifungals***

amphotericin B deoxycholate 48

butenafine 70

ciclopirox 70

clotrimazole 70

econazole 70

haloprogin 70

ketoconazole 548

miconazole 70

naftifine 70

nystatin 721

oxiconazole 70

sulconazole 70

terbinafine 70

tolnaftate 70

#### ***vaginal antifungals***

butoconazole 73

clotrimazole 73

miconazole 73

nystatin 721

terconazole 73

tioconazole 73

## ANTIHISTAMINES

### PHARMACOLOGIC PROFILE

#### General Use:

Relief of symptoms associated with allergies, including rhinitis, urticaria, and angioedema, and as adjunctive therapy in anaphylactic reactions. Some antihistamines are used to treat motion sickness (dimenhydrinate and meclizine), insomnia (diphenhydramine), Parkinson-like reactions (diphenhydramine), and other nonallergic conditions.

#### General Action and Information:

Antihistamines block the effects of histamine at the H<sub>1</sub> receptor. They do not block histamine release, antibody production, or antigen-antibody reactions. Most antihistamines have anticholinergic properties and may cause constipation, dry eyes, dry mouth, and blurred vision. In addition, many antihistamines cause sedation. Some phenothiazines have strong antihistaminic properties (hydroxyzine and promethazine).

#### Contraindications:

Hypersensitivity and narrow-angle glaucoma. Should not be used in premature or newborn infants.

#### Precautions:

Elderly patients may be more susceptible to adverse anticholinergic effects of antihistamines. Use cautiously in patients with pyloric obstruction, prostatic hypertrophy, hyperthyroidism, cardiovascular disease, or severe liver disease. Use cautiously in pregnancy and lactation.

#### Interactions:

Additive sedation when used with other CNS depressants, including alcohol, antidepressants, opioid analgesics, and sedative/hypnotics. MAO inhibitors prolong and intensify the anticholinergic properties of antihistamines.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Assess allergy symptoms (rhinitis, conjunctivitis, hives) before and periodically throughout therapy.
- Monitor pulse and blood pressure before initiating and throughout IV therapy.
- Assess lung sounds and character of bronchial secretions. Maintain fluid intake of 1500–2000 ml/day to decrease viscosity of secretions.
- **Nausea and Vomiting:** Assess degree of nausea and frequency and amount of emesis when administering for nausea and vomiting.
- **Anxiety:** Assess mental status, mood, and behavior when administering for anxiety.
- **Pruritus:** Observe the character, location, and size of affected area when administering for pruritic skin conditions.

### Potential Nursing Diagnoses

- Airway clearance, ineffective (Indications).

- Injury, risk for (Adverse Reactions).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- When used for prophylaxis of motion sickness, administer at least 30 min and preferably 1–2 hr before exposure to conditions that may precipitate motion sickness.
- When administering concurrently with opioid analgesics (hydroxyzine, promethazine), supervise ambulation closely to prevent injury secondary to increased sedation.

### Patient/Family Teaching

- Inform patient that drowsiness may occur. Avoid driving or other activities requiring alertness until response to drug is known.
- Caution patient to avoid using concurrent alcohol or CNS depressants.
- Advise patient that good oral hygiene, frequent rinsing of mouth with water, and sugarless gum or candy may help relieve dryness of mouth.
- Instruct patient to contact health care professional if symptoms persist.

### Evaluation

- Effectiveness of therapy can be demonstrated by:** ■ Decrease in allergic symptoms  
 ■ Prevention or decreased severity of nausea and vomiting ■ Decrease in anxiety ■ Relief of pruritus ■ Sedation when used as a sedative/hypnotic.

### Antihistamines Included in *Davis's Drug Guide for Nurses*

azatadine 84	diphenhydramine 300
brompheniramine 118	fexofenadine P-95
cetirizine 183	hydroxyzine 493
chlorpheniramine 190	loratadine 587
cyproheptadine 254	meclizine 604
dimenhydrinate 296	promethazine 839

## ANTIHYPERTENSIVE AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Treatment of hypertension of many causes, most commonly essential hypertension. Parenteral products are used in the treatment of hypertensive emergencies. Oral treatment should be initiated as soon as possible and individualized to ensure compliance for long-term therapy. Therapy is initiated with agents having minimal side effects. When such therapy fails, more potent drugs with different side effects are added in an effort to control blood pressure while causing minimal patient discomfort.

#### General Action and Information:

As a group, the antihypertensives are used to lower blood pressure to a normal level (<90 mm Hg diastolic) or to the lowest level tolerated. The goal of antihypertensive therapy is prevention of end-organ damage. Antihypertensives are classified into groups according to their site of

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

action. These include peripherally acting antiadrenergics; centrally acting alpha adrenergics; beta-adrenergic blockers; vasodilators; ACE inhibitors; angiotensin II antagonists; calcium channel blockers; diuretics; and indapamide, a diuretic with vasodilatory properties. Hypertensive emergencies may be managed with parenteral vasodilators such as nitroprusside or enalaprilat.

**Contraindications:**

Hypersensitivity to individual agents.

**Precautions:**

Choose agents carefully in pregnancy, during lactation, or in patients receiving cardiac glycosides. ACE inhibitors and angiotensin II antagonists should be avoided during pregnancy. Alpha-adrenergic agonists and beta-adrenergic blockers should be used only in patients who will comply, because abrupt discontinuation of these agents may result in rapid and excessive rise in blood pressure (rebound phenomenon). Thiazide diuretics may increase the requirement for insulin, diet therapy, or oral hypoglycemic agents in diabetics. Vasodilators may cause tachycardia if used alone and are commonly used in combination with beta-adrenergic blocking agents. Most antihypertensives (except for beta-adrenergic blockers, ACE inhibitors, angiotensin II receptor antagonists, and calcium channel blockers) cause sodium and water retention and are usually combined with a diuretic.

**Interactions:**

Many drugs can negate the therapeutic effectiveness of antihypertensives, including antihistamines, NSAIDs, sympathomimetic bronchodilators, decongestants, appetite suppressants, antidepressants, and MAO inhibitors. Hypokalemia from diuretics may increase the risk of cardiac glycoside toxicity. Potassium supplements and potassium-sparing diuretics may cause hyperkalemia when used with ACE inhibitors.

**NURSING IMPLICATIONS****Assessment**

- Monitor blood pressure and pulse frequently during dosage adjustment and periodically throughout therapy.
- Monitor intake and output ratios and daily weight.
- Monitor frequency of prescription refills to determine compliance.

**Potential Nursing Diagnoses**

- Tissue perfusion, altered (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

**Implementation**

- Many antihypertensive agents are available as combination products to enhance compliance (see Appendix B).

## Patient/Family Teaching

- Instruct patient to continue taking medication, even if feeling well. Abrupt withdrawal may cause rebound hypertension. Medication controls but does not cure hypertension.
- Encourage patient to comply with additional interventions for hypertension (weight reduction, low-sodium diet, regular exercise, discontinuation of smoking, moderation of alcohol consumption, and stress management).
- Instruct patient and family on proper technique for monitoring blood pressure. Advise them to check blood pressure weekly and report significant changes.
- Caution patient to make position changes slowly to minimize orthostatic hypotension. Advise patient that exercise or hot weather may enhance hypotensive effects.
- Advise patient to consult health care professional before taking any OTC medications, especially cold remedies.
- Advise patient to inform health care professional of medication regimen before treatment or surgery.
- Patients taking ACE inhibitors or angiotensin II antagonists should notify health care professional if pregnancy is planned or suspected.
- Emphasize the importance of follow-up exams to monitor progress.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in blood pressure.

## Antihypertensive Agents Included in *Davis's Drug Guide for Nurses*

### ***alpha-adrenergic blocking agent***

phenoxybenzamine 1179

### ***angiotensin-converting enzyme (ACE) inhibitors***

benazepril 63

captopril 63

enalapril, enalaprilat 63

fosinopril 64

lisinopril 64

moexipril 64

perindopril 64

quinapril 64

ramipril 64

trandolapril 64

### ***angiotensin II antagonists***

candesartan 61

irbesartan 61

losartan 61

valsartan 61

### ***beta-adrenergic blocking agents***

acebutolol 1

atenolol 79

betaxolol 100

carteolol 160

carvedilol 162

labetalol 555

metoprolol 638

nadolol 678

penbutolol 758

pindolol 799

propranolol 849

timolol 996

### ***calcium channel blockers***

amlodipine 41

diltiazem 293

felodipine 384

isradipine 541

nicardipine 699

nifedipine 705

nisoldipine 711

verapamil 1037

### ***centrally acting adrenergics***

clonidine 212

guanabenz 455

guanfacine 459

methylodopa P-96

### ***diuretics***

chlorothiazide 315

chlorthalidone 315

furosemide 308

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

hydrochlorothiazide 308

indapamide 512

metolazone 636

torsemide 308

***peripherally acting antiadrenergics***

doxazosin 328

guanadrel 457

prazosin 825

terazosin 960

***vasodilators***

hydralazine 481

minoxidil 652

nitroprusside 717

**ANTI-INFECTIVE AGENTS****PHARMACOLOGIC PROFILE****General Use:**

Treatment and prophylaxis of various bacterial infections. See specific drugs for spectrum and indications. Some infections may require additional surgical intervention and supportive therapy.

**General Action and Information:**

Kill (bactericidal) or inhibit the growth of (bacteriostatic) susceptible pathogenic bacteria. Not active against viruses or fungi. Anti-infective agents are subdivided into categories depending on chemical similarities and antimicrobial spectrum.

**Contraindications:**

Known hypersensitivity to individual agents. Cross-sensitivity among related agents may occur.

**Precautions:**

Culture and susceptibility testing are desirable to optimize therapy. Dosage modification may be required in patients with hepatic or renal insufficiency. Use cautiously in pregnant and lactating women. Prolonged inappropriate use of broad spectrum anti-infective agents may lead to superinfection with fungi or resistant bacteria.

**Interactions:**

Penicillins and aminoglycosides chemically inactivate each other and should not be physically admixed. Erythromycins may decrease hepatic metabolism of other drugs. Probenecid increases serum levels of penicillins and related compounds. Highly protein-bound anti-infectives such as sulfonamides may displace or be displaced by other highly bound drugs. See individual drugs. Extended-spectrum penicillins (ticarcillin, piperacillin) and some cephalosporins (cefamandole, cefoperazone, cefotetan) may increase the risk of bleeding with anticoagulants, antiplatelet agents, or NSAIDs. Fluoroquinolone absorption is decreased by antacids, bismuth subsalicylate, iron salts, sucralate, and zinc salts.

**NURSING IMPLICATIONS****Assessment**

- Assess patient for signs and symptoms of infection prior to and throughout therapy.
- Determine previous hypersensitivities in patients receiving penicillins or cephalosporins.
- Obtain specimens for culture and sensitivity prior to initiating therapy. First dose may be given before receiving results.

## Potential Nursing Diagnoses

- Infection, risk for (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

## Implementation

- Most anti-infectives should be administered around the clock to maintain therapeutic serum drug levels.

## Patient/Family Teaching

- Instruct patient to continue taking medication around the clock until finished completely, even if feeling better.
- Advise patient to report the signs of superinfection (black, furry overgrowth on the tongue; vaginal itching or discharge; loose or foul-smelling stools) and allergy to health care professional.
- Instruct patient to notify health care professional if fever and diarrhea develop, especially if stool contains pus, blood, or mucus. Advise patient not to treat diarrhea without consulting health care professional.
- Instruct patient to notify health care professional if symptoms do not improve.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of the signs and symptoms of infection. Length of time for complete resolution depends on organism and site of infection.

## Anti-infective Agents Included in *Davis's Drug Guide for Nurses*

### ***aminoglycosides***

amikacin 30  
gentamicin 30  
kanamycin 30  
neomycin 30  
netilmicin 30  
streptomycin 30  
tobramycin 30

### ***antimalarial***

quinine P-103

### ***antiprotozoal***

pentamide 171

### ***carbapenem***

imipenem/cilastatin 507

### ***cephalosporins—first generation***

cefadroxil 167  
cefazolin 167  
cephalexin 167  
cephapirin 167

cephradine 167

### ***cephalosporins—second generation***

cefaclor 171  
cefamandole 171  
cefmetazole 171  
cefonicid 171  
cefotetan 171  
cefoxitin 171  
cefprozil 171  
cefuroxime 171  
loracarbef 171

### ***cephalosporins—third generation***

cefdinir 176  
cefepime 176  
cefixime 176  
cefoperazone 176  
cefotaxime 177  
cefopodixime 177  
ceftazidime 177  
ceftibuten 177

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

ceftizoxime 177

ceftriaxone 177

***extended-spectrum penicillins***

piperacillin 802

piperacillin/tazobactam 802

ticarcillin 990

ticarcillin/clavulanate 990

***fluoroquinolones***

alatrovaflaxacin 408

ciprofloxacin 408

enoxacin 408

gatifloxacin 408

levofloxacin 408

lomefloxacin 408

moxifloxacin 408

norfloxacin 408

ofloxacin 408

sparfloxacin 408

trovaflaxacin 408

***macrolides***

azithromycin 87

clarithromycin 204

erythromycin 360

***penicillins***

amoxicillin 43

amoxicillin/clavulanate 45

ampicillin 51

ampicillin/sulbactam 54

benzathine penicillin G 764

penicillin G potassium 764

procaine penicillin G 764

penicillin G sodium 764

penicillin V 764

***penicillinase-resistant penicillins***

cloxacillin 767

dicloxacillin 767

methicillin 767

nafcillin 767

oxacillin 767

***sulfonamides***

sulfacetamide 1158

sulfamethoxazole 942

trimethoprim/sulfamethoxazole 1025

***tetracyclines***

demeclocycline 1173

doxycycline 969

minocycline 969

tetracycline 969

***miscellaneous***

bacitracin 1171

chloramphenicol 1157

clindamycin 206

dapsone 1173

immune globulin 879

metronidazole 641

nitrofurantoin 712

silver sulfadiazine 1181

trimethoprim 1024

vancomycin 1033

**ANTINEOPLASTIC AGENTS****PHARMACOLOGIC AGENTS****General Use:**

Used in the treatment of various solid tumors, lymphomas, and leukemias. Also used in some autoimmune disorders such as rheumatoid arthritis (cyclophosphamide, methotrexate). Often used in combinations to minimize individual toxicities and increase response. Chemotherapy may be combined with other treatment modalities such as surgery and radiation therapy. Doses vary greatly, depending on extent of disease, other agents used, and patient's condition. Some new formulations (daunorubicin, doxorubicin) encapsulated in a lipid membrane have less toxicity with greater efficacy.

**General Action and Information:**

Act by many different mechanisms (see the following table). Most commonly affect DNA synthesis or function. Action may not be limited to neoplastic cells.

## MECHANISM OF ACTION OF VARIOUS ANTINEOPLASTIC AGENTS

MECHANISM OF ACTION	AGENT	EFFECTS ON CELL CYCLE
ALKYLATING AGENTS Cause cross-linking of DNA	busulfan carboplatin chlorambucil cisplatin cyclophosphamide dacarbazine ifosfamide mechlorethamine melphalan procarbazine temozolamide thiotepa	Cell cycle–nonspecific
ANTHRACYCLINES Interfere with DNA and RNA synthesis	daunorubicin doxorubicin idarubicin	Cell cycle–nonspecific
ANTIMETABOLITES Take the place of normal proteins	capecitabine  cytarabine fluorouracil fludarabine hydroxyurea mercaptopurine methotrexate	Cell cycle–specific, work mostly in S phase (DNA synthesis)
ANTITUMOR ANTIBIOTICS Interfere with DNA and RNA synthesis	bleomycin dactinomycin mitomycin mitoxantrone plicamycin streptozocin	Cell cycle–nonspecific (except bleomycin)
ENZYMES Depletes asparagine	asparaginase	Cell-cycle phase–specific
ENZYME INHIBITORS Inhibit topoisomerase	pegaspargase irinotecan topotecan	Cell-cycle phase–specific
HORMONAL AGENTS Alter hormonal status in tumors that are sensitive	bicalutamide estramustine flutamide leuprolide megestrol nilutamide tamoxifen testosterone (androgens)	Unknown
HORMONAL AGENTS—AROMATASE INHIBITORS Inhibit enzyme responsible for activating estrogen	anastrozole letrozole	Unknown
IMMUNE MODULATORS	aldesleukin BCG trastuzumab	Unknown
PODOPHYLLOTOXIN DERIVATIVES Damages DNA before mitosis	etoposide tenoposide	Cell-cycle phase–specific
TAXOIDS Interrupt interphase and mitosis	docetaxel paclitaxel	Cell-cycle phase–specific
VINCA ALKALOIDS Interfere with mitosis	vinblastine vincristine vinorelbine	Cell cycle–specific, work during M phase (mitosis)
MISCELLANEOUS	aldesleukin altretamine	Unknown Unknown

**Contraindications:**

Previous bone marrow depression or hypersensitivity. Contraindicated in pregnancy and lactation.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

**Precautions:**

Use cautiously in patients with active infections, decreased bone marrow reserve, radiation therapy, or other debilitating illnesses. Use cautiously in patients with childbearing potential.

**Interactions:**

Allopurinol decreases metabolism of mercaptopurine. Toxicity from methotrexate may be increased by other nephrotoxic drugs or larger doses of aspirin or NSAIDs. Bone marrow depression is additive. See individual drugs.

**NURSING IMPLICATIONS****Assessment**

- Monitor for bone marrow depression. Assess for bleeding (bleeding gums, bruising, petechiae, guaiac stools, urine, and emesis) and avoid IM injections and rectal temperatures if platelet count is low. Apply pressure to venipuncture sites for 10 min. Assess for signs of infection during neutropenia. Anemia may occur. Monitor for increased fatigue, dyspnea, and orthostatic hypotension.
- Monitor intake and output ratios, appetite, and nutritional intake. Prophylactic antiemetics may be used. Adjusting diet as tolerated may help maintain fluid and electrolyte balance and nutritional status.
- Monitor IV site carefully and ensure patency. Discontinue infusion immediately if discomfort, erythema along vein, or infiltration occurs. Tissue ulceration and necrosis may result from infiltration.
- Monitor for symptoms of gout (increased uric acid, joint pain, and edema). Encourage patient to drink at least 2 liters of fluid each day. Allopurinol may be given to decrease uric acid levels. Alkalinization of urine may be ordered to increase excretion of uric acid.

**Potential Nursing Diagnoses**

- Infection, risk for (Side Effects).
- Nutrition, altered: less than body requirements (Adverse Reactions).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Solutions for injection should be prepared in a biologic cabinet. Wear gloves, gown, and mask while handling medication. Discard equipment in designated containers (see Appendix J for guidelines for safe handling).
- Check dose carefully. Fatalities have resulted from dosing errors.

**Patient/Family Teaching**

- Caution patient to avoid crowds and persons with known infections. Health care professional should be informed immediately if symptoms of infection occur.
- Instruct patient to report unusual bleeding. Advise patient of thrombocytopenia precautions.
- These drugs may cause gonadal suppression; however, patient should still use birth control, as most antineoplastics are teratogenic. Advise patient to inform health care professional immediately if pregnancy is suspected.
- Discuss with patient the possibility of hair loss. Explore methods of coping.
- Instruct patient to inspect oral mucosa for erythema and ulceration. If ulceration occurs, advise patient to use sponge brush and to rinse mouth with water after eating and drinking.

Topical agents may be used if mouth pain interferes with eating. Stomatitis pain may require treatment with opioid analgesics.

- Instruct patient not to receive any vaccinations without advice of health care professional. Antineoplastics may decrease antibody response and increase risk of adverse reactions.
- Advise patient of need for medical follow-up and frequent lab tests.

## Evaluation

- Effectiveness of therapy can be demonstrated by:**
- Decrease in size and spread of tumor
  - Improvement in hematologic status in patients with leukemia.

## Antineoplastic Agents Included in *Davis's Drug Guide for Nurses*

### **alkylating agents**

busulfan 132  
 carboplatin 154  
 chlorambucil 186  
 cisplatin 199  
 cyclophosphamide 249  
 estramustine 1175  
 ifosfamide 505  
 mechlorethamine 602  
 melphalan 609  
 procarbazine 830  
 temozolamide 959  
 thiotepea 1182

### **anthracyclines**

daunorubicin citrate liposome 265  
 daunorubicin hydrochloride 265  
 doxorubicin 332  
 doxorubicin hydrochloride liposome 333  
 idarubicin 502

### **antimetabolites**

cytarabine 256  
 floxuridine 1176  
 fludarabine 1176  
 fluorouracil 414  
 hydroxyurea 491  
 metacaptopurine 1178  
 methotrexate 627  
 thioguanine 1182

### **antitumor antibiotics**

bleomycin 114  
 mitomycin 656  
 mitoxantrone 659  
 plicamycin 809  
 streptozocin 1182

### **enzymes**

asparaginase 77

pegaspargase 754

### **enzyme inhibitors**

irinotecan 530  
 pentostatin 1179  
 topotecan 1008

### **estrogen blockers**

tamoxifen 954  
 toremifene 1010

### **hormones**

bicalutamide 103  
 estramustine 1175  
 flutamide 425  
 leuprolide 570  
 megestrol 608  
 nilutamide 708  
 tamoxifen 954

### **hormones–aromatase inhibitors**

anastrozole 60  
 letrozole 566

### **immune modifiers**

aldesleukin 15  
 BCG-Connaught Strain 1171  
 BCG-Tice Strain 1171  
 trastuzumab 1013

### **podophyllotoxin derivatives**

etoposide 380  
 teniposide 1152

### **taxoids**

docetaxel 319  
 paclitaxel 743

### **vinca alkaloids**

vinblastine 1040  
 vincristine 1042  
 vinorelbine 1045

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

***miscellaneous***

aldesleukin 15  
altretamine 24  
masoprocol 1177

mitotane 1178  
porfimer 1180  
tretinoin (oral) 1183

**ANTIPARKINSON AGENTS****PHARMACOLOGIC PROFILE****General Use:**

Used in the treatment of parkinsonism of various causes: degenerative, toxic, infective, neoplastic, or drug-induced.

**General Action and Information:**

Drugs used in the treatment of the parkinsonian syndrome and other dyskinesias are aimed at restoring the natural balance of two major neurotransmitters in the CNS: acetylcholine and dopamine. The imbalance is a deficiency in dopamine that results in excessive cholinergic activity. Drugs used are either anticholinergics (benztropine, biperiden, and trihexyphenidyl) or dopaminergic agonists (bromocriptine, levodopa, and pergolide). Pramipexole and ropinerole are two new nonergot dopamine agonists. Entacapone inhibits the enzyme that breaks down levodopa, thereby enhancing its effects.

**Contraindications:**

Anticholinergics should be avoided in patients with narrow-angle glaucoma.

**Precautions:**

Use cautiously in patients with severe cardiac disease, pyloric obstruction, or prostatic enlargement.

**Interactions:**

Pyridoxine, MAO inhibitors, benzodiazepines, phenytoin, phenothiazines, and haloperidol may antagonize the effects of levodopa. Agents that antagonize dopamine (phenothiazines, metoclopramide) may decrease effectiveness of dopamine agonists.

**NURSING IMPLICATIONS****Assessment**

- Assess parkinsonian and extrapyramidal symptoms (akinesia, rigidity, tremors, pill rolling, mask facies, shuffling gait, muscle spasms, twisting motions, and drooling) before and throughout course of therapy. On-off phenomenon may cause symptoms to appear or improve suddenly.
- Monitor blood pressure frequently during therapy. Instruct patient to remain supine during and for several hours after 1st dose of bromocriptine, as severe hypotension may occur.

**Potential Nursing Diagnoses**

- Physical mobility, impaired (Indications).
- Injury, risk for (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

## Implementation

- In the carbidopa/levodopa combination, the number following the drug name represents the milligram of each drug.

## Patient/Family Teaching

- May cause drowsiness or dizziness. Advise patient to avoid driving or other activities that require alertness until response to medication is known.
- Caution patient to make position changes slowly to minimize orthostatic hypotension.
- Instruct patient that frequent rinsing of mouth, good oral hygiene, and sugarless gum or candy may decrease dry mouth. Patient should notify health care professional if dryness persists (saliva substitutes may be used). Also notify the dentist if dryness interferes with use of dentures.
- Advise patient to confer with health care professional before taking OTC medications, especially cold remedies, or drinking alcoholic beverages. Patients receiving levodopa should avoid multivitamins. Vitamin B<sub>6</sub> (pyridoxine) may interfere with levodopa's action.
- Caution patient that decreased perspiration may occur. Overheating may occur during hot weather. Patients should remain indoors in an air-conditioned environment during hot weather.
- Advise patient to increase activity, bulk, and fluid in diet to minimize constipating effects of medication.
- Advise patient to notify health care professional if confusion, rash, urinary retention, severe constipation, visual changes, or worsening of parkinsonian symptoms occur.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of parkinsonian signs and symptoms ■ Resolution of drug-induced extrapyramidal symptoms.

## Antiparkinson Agents Included in *Davis's Drug Guide for Nurses*

### **anticholinergics**

benztropine 96  
biperiden 107  
trihexyphenidyl 1021

### **catechol-O-methyltransferase inhibitor**

entacapone 341

### **dopamine agonists**

amantadine 1169  
bromocriptine 116  
carbidopa/levodopa 574  
levodopa 574  
pergolide 780  
pramipexole 823  
ropinirole 899

## ANTIPLATELET AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Antiplatelet agents are used to treat and prevent thromboembolic events such as stroke and myocardial infarction. Dipyridamole is commonly used after cardiac surgery.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

### General Action and Information:

Inhibit platelet aggregation, prolongs bleeding time, and are used to prevent myocardial infarction or stroke (aspirin, clopidogrel, dipyridamole, ticlopidine). Abciximab, eptifibatide, and tirofiban are used in the management of various acute coronary syndromes. These agents have been used concurrently/sequentially with anticoagulants and thrombolytic agents.

### Contraindications:

Hypersensitivity, ulcer disease, active bleeding, and recent surgery.

### Precautions:

Use cautiously in patients at risk for bleeding (trauma, surgery). History of GI bleeding or ulcer disease. Safety not established in pregnancy, lactation, or children.

### Interactions:

Concurrent use with NSAIDs, heparin, thrombolytic agents, or warfarin may increase the risk of bleeding.

## NURSING IMPLICATIONS

### Assessment

- Assess patient taking anticoagulants for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; tarry, black stools; hematuria; fall in hematocrit or blood pressure; guaiac-positive stools; urine; or nasogastric aspirate).
- Assess patient for evidence of additional or increased thrombosis. Symptoms will depend on area of involvement.
- Assess patient taking antiplatelet agents for symptoms of stroke, peripheral vascular disease, or myocardial infarction periodically throughout therapy.
- **Lab Test Considerations:** Monitor activated partial thromboplastin time (aPTT) or international normalized ratio (INR) with full-dose heparin therapy, prothrombin time (PT) with warfarin therapy, and hematocrit and other clotting factors frequently during therapy.
- Monitor bleeding time throughout antiplatelet therapy. Prolonged bleeding time, which is time- and dose-dependent, is expected.
- **Toxicity and Overdose:** If overdose occurs or anticoagulation needs to be immediately reversed, the antidote for heparins is protamine sulfate; for warfarin, the antidote is vitamin K (phytonadione [AquaMEPHYTON]). Administration of whole blood or plasma may also be required in severe bleeding due to warfarin because of the delayed onset of vitamin K.

### Potential Nursing Diagnoses

- Tissue perfusion, altered (Indications).
- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Inform all personnel caring for patient of anticoagulant therapy. Venipunctures and injection sites require application of pressure to prevent bleeding or hematoma formation.
- Use an infusion pump with continuous infusions to ensure accurate dosage.

### Patient/Family Teaching

- Caution patient to avoid activities leading to injury, to use a soft toothbrush and electric razor, and to report any symptoms of unusual bleeding or bruising to health care professional immediately.
- Instruct patient not to take OTC medications, especially those containing aspirin, NSAIDs, or alcohol, without advice of health care professional.
- Review foods high in vitamin K (see Appendix L) with patients on warfarin. Patient should have consistent limited intake of these foods, as vitamin K is the antidote for warfarin and greatly alternating intake of these foods will cause PT levels to fluctuate.
- Emphasize the importance of frequent lab tests to monitor coagulation factors.
- Instruct patient to carry identification describing medication regimen at all times and to inform all health care personnel caring for patient of anticoagulant therapy before laboratory tests, treatment, or surgery.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Prevention of undesired clotting and its sequelae without signs of hemorrhage ■ Prevention of stroke, myocardial infarction, and vascular death in patients at risk.

### Antiplatelet Agents Included in *Davis's Drug Guide for Nurses*

abciximab 1168	eptifibatide 354
aspirin 903	ticlopidine 993
clopidogrel 215	tirofiban 998
dipyridamole 304	

## ANTIPSYCHOTIC AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Treatment of acute and chronic psychoses, particularly when accompanied by increased psychomotor activity. Use of clozapine is limited to schizophrenia unresponsive to conventional therapy. Selected agents are also used as antihistamines or antiemetics. Chlorpromazine is also used in the treatment of intractable hiccups.

#### General Action and Information:

Block dopamine receptors in the brain; also alter dopamine release and turnover. Peripheral effects include anticholinergic properties and alpha-adrenergic blockade. Most antipsychotics are phenothiazines except for haloperidol, which is a butyrophenone, and clozapine, which is a miscellaneous compound. Newer agents such as olanzapine, quetiapine, and risperidone may have fewer adverse reactions. Phenothiazines differ in their ability to produce sedation (greatest with chlorpromazine and thioridazine), extrapyramidal reactions (greatest with prochlorperazine and trifluoperazine), and anticholinergic effects (greatest with chlorpromazine).

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### Contraindications:

Hypersensitivity. Cross-sensitivity may exist among phenothiazines. Should not be used in narrow-angle glaucoma. Should not be used in patients who have CNS depression.

### Precautions:

Safety in pregnancy and lactation not established. Use cautiously in patients with symptomatic cardiac disease. Avoid exposure to extremes in temperature. Use cautiously in severely ill or debilitated patients, diabetics, and patients with respiratory insufficiency, prostatic hypertrophy, or intestinal obstruction. May lower seizure threshold. Clozapine may cause agranulocytosis. Most agents are capable of causing neuroleptic malignant syndrome.

### Interactions:

Additive hypotension with acute ingestion of alcohol, antihypertensives, or nitrates. Antacids may decrease absorption. Phenobarbital may increase metabolism and decrease effectiveness. Additive CNS depression with other CNS depressants, including alcohol, antihistamines, antidepressants, opioid analgesics, or sedative/hypnotics. Lithium may decrease blood levels and effectiveness of phenothiazines. May decrease the therapeutic response to levodopa. May increase the risk of agranulocytosis with antithyroid agents.

## NURSING IMPLICATIONS

### Assessment

- Assess patient's mental status (orientation, mood, behavior) before and periodically throughout therapy.
- Monitor blood pressure (sitting, standing, lying), pulse, and respiratory rate before and frequently during the period of dosage adjustment.
- Observe patient carefully when administering medication to ensure medication is actually taken and not hoarded.
- Monitor patient for onset of *akathisia* (restlessness or desire to keep moving) and extrapyramidal side effects (*parkinsonian*—difficulty speaking or swallowing, loss of balance control, pill rolling, mask-like face, shuffling gait, rigidity, tremors; and *dystonia*—muscle spasms, twisting motions, twitching, inability to move eyes, weakness of arms or legs) every 2 mo during therapy and 8–12 wk after therapy has been discontinued. Parkinsonian effects are more common in geriatric patients and dystonias are more common in younger patients. Notify health care professional if these symptoms occur, as reduction in dosage or discontinuation of medication may be necessary. Trihexyphenidyl or diphenhydramine may be used to control these symptoms.
- Monitor for *tardive dyskinesia* (uncontrolled rhythmic movement of mouth, face, and extremities; lip smacking or puckering; puffing of cheeks; uncontrolled chewing; rapid or worm-like movements of tongue). Notify health care professional immediately if these symptoms occur; these side effects may be irreversible.
- Monitor for development of *neuroleptic malignant syndrome* (fever, respiratory distress, tachycardia, convulsions, diaphoresis, hypertension or hypotension, pallor, tiredness, severe muscle stiffness, loss of bladder control.) Notify health care professional immediately if these symptoms occur.

### Potential Nursing Diagnoses

- Thought processes, altered (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

- Noncompliance (Patient/Family Teaching).

### Implementation

- **General Info:** Keep patient recumbent for at least 30 min following parenteral administration to minimize hypotensive effects.
- To prevent contact dermatitis, avoid getting solution on hands.
- Phenothiazines should be discontinued 48 hr before and not resumed for 24 hr following myelography, as they lower the seizure threshold.
- **PO:** Administer with food, milk, or a full glass of water to minimize gastric irritation.
- Dilute most concentrates in 120 ml of distilled or acidified tap water or fruit juice just before administration.

### Patient/Family Teaching

- Advise patient to take medication exactly as directed and not to skip doses or double up on missed doses. Abrupt withdrawal may lead to gastritis, nausea, vomiting, dizziness, headache, tachycardia, and insomnia.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.
- Medication may cause drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to the medication is known.
- Caution patient to avoid taking alcohol or other CNS depressants concurrently with this medication.
- Advise patient to use sunscreen and protective clothing when exposed to the sun to prevent photosensitivity reactions. Extremes of temperature should also be avoided, as these drugs impair body temperature regulation.
- Advise patient that increasing activity, bulk, and fluids in the diet helps minimize the constipating effects of this medication.
- Instruct patient to use frequent mouth rinses, good oral hygiene, and sugarless gum or candy to minimize dry mouth.
- Advise patient to notify health care professional of medication regimen before treatment or surgery.
- Emphasize the importance of routine follow-up exams and continued participation in psychotherapy as indicated.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in excitable, paranoid, or withdrawn behavior ■ Relief of nausea and vomiting ■ Relief of intractable hiccups.

### Antipsychotic Agents Included in *Davis's Drug Guide for Nurses*

#### **butyrophenone**

haloperidol 463

#### **phenothiazines**

chlorpromazine 191

fluphenazine 419

prochlorperazine 833

thioridazine 978

trifluoperazine 1018

***miscellaneous***

clozapine 218  
olanzapine 725

quetiapine 867  
risperidone 891

**ANTIPYRETIC AGENTS**

**PHARMACOLOGIC PROFILE**

**General Use:**

Used to lower fever of many causes (infection, inflammation, and neoplasms).

**General Action and Information:**

Antipyretics lower fever by affecting thermoregulation in the CNS and by inhibiting the action of prostaglandins peripherally. Aspirin has the most profound effect on platelet function as compared with other salicylates, ibuprofen, or ketoprofen.

**Contraindications:**

Avoid aspirin, ibuprofen, or ketoprofen in patients with bleeding disorders (risk of bleeding is less with other salicylates). Aspirin and other salicylates should be avoided in children and adolescents.

**Precautions:**

Use aspirin, ibuprofen, or ketoprofen cautiously in patients with ulcer disease. Avoid chronic use of large doses of acetaminophen.

**Interactions:**

Large doses of aspirin may displace other highly protein-bound drugs. Additive GI irritation with aspirin, ibuprofen, ketoprofen, and other NSAIDs or corticosteroids. Aspirin, ibuprofen, ketoprofen, or naproxen may increase the risk of bleeding with other agents affecting hemostasis (anticoagulants, thrombolytics, antineoplastics, and certain anti-infectives).

**NURSING IMPLICATIONS**

**Assessment**

- Assess fever; note presence of associated symptoms (diaphoresis, tachycardia, and malaise).

**Potential Nursing Diagnoses**

- Body temperature, altered, risk for (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Administration with food or antacids may minimize GI irritation (aspirin, ibuprofen, ketoprofen, naproxen).
- Available in oral and rectal dosage forms and in combination with other drugs.

### Patient/Family Teaching

- Advise patient to consult health care professional if fever is not relieved by routine doses or if greater than 39.5°C (103°F) or lasts longer than 3 days.
- Centers for Disease Control and Prevention warns against giving aspirin to children or adolescents with varicella (chickenpox) or influenza-like or viral illnesses because of a possible association with Reye's syndrome.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Reduction of fever.

### Antipyretic Agents Included in *Davis's Drug Guide for Nurses*

acetaminophen 3	ibuprofen 499
aspirin 903	ketoprofen 550
choline and magnesium salicylates 903	salsalate 903
choline salicylate 903	

## ANTIRETROVIRAL AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

The goal of antiretroviral therapy in the management of HIV infection is to improve CD4 cell counts and decrease viral load. If accomplished, this generally results in slowed progression of the disease, improved quality of life, and decreased opportunistic infections. Perinatal use of agents also prevents transmission of the virus to the fetus. Postexposure prophylaxis with antiretrovirals is also recommended.

#### General Action and Information:

Because of the rapid emergence of resistance and toxicities of individual agents, HIV infection is almost always managed by a combination of agents. Selections and doses are based on individual toxicities, underlying organ system disease, concurrent drug therapy, and severity of illness. Various combinations are used; up to 4 agents may be used simultaneously. More than 100 agents are currently being tested in addition to those already approved by the Food and Drug Administration (FDA).

#### Contraindications:

Hypersensitivity. Because of highly varying toxicities among agents, see individual monographs for more specific information.

#### Precautions

Many agents require modification for renal impairment. Protease inhibitors may cause hyperglycemia and should be used cautiously in patients with diabetes. Hemophiliacs may also be at risk of bleeding when taking protease inhibitors. See individual monographs for specific information.

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

### Interactions:

There are many significant interactions among the antiretrovirals. They are affected by drugs that alter metabolism; some agents themselves affect metabolism. See individual agents.

## NURSING IMPLICATIONS

### Assessment

- Assess patient for change in severity of symptoms of HIV and for symptoms of opportunistic infections throughout therapy.
- **Lab Test Considerations:** Monitor viral load and CD4 counts prior to and periodically during therapy.

### Potential Nursing Diagnoses

- Infection, risk for (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

### Implementation

- Administer doses around the clock.

### Patient/Family Teaching

- Instruct patient to take medication exactly as directed, around the clock, even if sleep is interrupted. Emphasize the importance of complying with therapy, not taking more than prescribed amount, and not discontinuing without consulting health care professional. Missed doses should be taken as soon as remembered unless almost time for next dose; patient should not double doses. Inform patient that long-term effects are unknown at this time.
- Instruct patient that antiretrovirals should not be shared with others.
- Inform patient that antiretroviral therapy does not cure HIV and does not reduce the risk of transmission of HIV to others through sexual contact or blood contamination. Caution patient to use a condom during sexual contact and to avoid sharing needles or donating blood to prevent spreading the AIDS virus to others.
- Advise patient to avoid taking any Rx or OTC medications without consulting health care professional.
- Emphasize the importance of regular follow-up exams and blood counts to determine progress and monitor for side effects.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in viral load and increase in CD4 counts in patients with HIV.

### Antiretroviral Agents Included in *Davis's Drug Guide for Nurses*

#### ***non-nucleoside reverse transcriptase inhibitors***

delavirdine 270  
efavirenz 339  
nevirapine 695

#### ***nucleoside reverse transcriptase inhibitors***

didanosine 284  
lamivudine 559  
stavudine 937  
zalcitabine 1062

zidovudine 1066

nelfinavir 691

**protease inhibitors**

ritonavir 894

indinavir 514

saquinavir 909

## ANTITHYROID AGENTS

## PHARMACOLOGIC PROFILE

**General Use:**

Used in the treatment of hyperthyroidism of various causes (Graves' disease, multinodular goiter, thyroiditis, and thyrotoxic crisis) in children, pregnant women, and other patients in whom hyperthyroidism is not expected to be permanent. These agents are also used to prepare patients for thyroidectomy or for patients in whom thyroidectomy is contraindicated. Beta-adrenergic blockers (propranolol) are sometimes used in conjunction with antithyroid agents to control symptoms (tachycardia and tremor) but have no effect on thyroid status. Iodine and iodides are also used as radiation protectants.

**General Action and Information:**

Inhibit thyroid hormone formation (iodine) or inhibit oxidation of iodine (methimazole and propylthiouracil).

**Contraindications:**

Hypersensitivity. Previous bone marrow depression.

**Precautions:**

Use methimazole cautiously in patients with decreased bone marrow reserve.

**Interactions:**

Lithium may cause thyroid abnormalities and interfere with the response to antithyroid therapy. Phenothiazines may increase the risk of agranulocytosis.

## NURSING IMPLICATIONS

**Assessment**

- **General Info:** Monitor response of symptoms of hyperthyroidism or thyrotoxicosis (tachycardia, palpitations, nervousness, insomnia, fever, diaphoresis, heat intolerance, tremors, weight loss, diarrhea).
- Assess patient for development of hypothyroidism (intolerance to cold, constipation, dry skin, headache, listlessness, tiredness, or weakness). Dosage adjustment may be required.
- Assess patient for skin rash or swelling of cervical lymph nodes. Treatment may be discontinued if this occurs.
- Monitor thyroid function studies before and periodically throughout therapy.
- **Iodides:** Assess for signs and symptoms of iodism (metallic taste, stomatitis, skin lesions, cold symptoms, severe GI upset) or anaphylaxis. Report these symptoms promptly to physician or other health care provider.

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### Potential Nursing Diagnoses

- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Mix iodide solutions in a full glass of fruit juice, water, or milk. Administer after meals to minimize GI irritation.

### Patient/Family Teaching

- Instruct patient to take medication exactly as directed. Missing doses may precipitate hyperthyroidism.
- Advise patient to consult health care professional regarding dietary sources of iodine (iodized salt, shellfish, cabbage, kale, turnips).
- Advise patient to carry identification describing medication regimen at all times and to notify health care professional of medical regimen before treatment or surgery.
- Emphasize the importance of routine exams to monitor progress and check for side effects.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in severity of symptoms of hyperthyroidism ■ Decrease in vascularity and friability of the thyroid gland before preparation for surgery ■ Protection of the thyroid gland during radiation emergencies.

### Antithyroid Agents Included in *Davis's Drug Guide for Nurses*

methimazole 624

propylthiouracil 853

potassium iodide, saturated solution 525

strong iodine solution 525

## ANTITUBERCULAR AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Used in the treatment and prevention of tuberculosis and diseases caused by other mycobacteria, including *Mycobacterium avium* complex (MAC), seen mostly in HIV patients. Combinations are used in the treatment of active disease tuberculosis to rapidly decrease the infectious state and delay or prevent the emergence of resistant strains. In selected situations, intermittent (twice weekly) regimens may be employed. Streptomycin is also used as an antitubercular agent. The anti-infective agents, azithromycin and clarithromycin, are useful in the prevention and management of MAC disease. Rifampin is used in the prevention of meningococcal meningitis and *Haemophilus influenzae* type b disease.

#### General Action and Information:

Kill (tuberculocidal) or inhibit the growth of (tuberculostatic) mycobacteria responsible for causing tuberculosis. Combination therapy with two or more agents is required, unless used as prophylaxis (isoniazid alone).

#### Contraindications:

Hypersensitivity. Severe liver disease.

**Precautions:**

Use cautiously in patients with a history of liver disease or in elderly or debilitated patients. Ethambutol requires ophthalmologic follow-up. Safety in pregnancy and lactation not established, although selected agents have been used without adverse effects on the fetus. Compliance is required for optimal response.

**Interactions:**

Isoniazid inhibits the metabolism of phenytoin. Rifampin significantly decreases saquinavir levels (combination should be avoided).

**NURSING IMPLICATIONS****Assessment**

- Mycobacterial studies and susceptibility tests should be performed prior to and periodically throughout therapy to detect possible resistance.
- Assess lung sounds and character and amount of sputum periodically throughout therapy.

**Potential Nursing Diagnoses**

- Infection, risk for (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

**Implementation**

- Most medications can be administered with food or antacids if GI irritation occurs.

**Patient/Family Teaching**

- Advise patient of the importance of continuing therapy even after symptoms have subsided.
- Emphasize the importance of regular follow-up examinations to monitor progress and check for side effects.
- Inform patients taking *rifampin* that saliva, sputum, sweat, tears, urine, and feces may become red-orange to red-brown and that soft contact lenses may become permanently discolored.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Resolution of the signs and symptoms of tuberculosis ■ Negative sputum cultures.

**Antitubercular Agents Included in *Davis's Drug Guide for Nurses***

ethambutol 374  
isoniazid 537  
pyrazinamide 859

rifampin 886  
rifapentine 888

## ANTITUSSIVE AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Used for the symptomatic relief of cough due to various causes, including viral upper respiratory infections. Not intended for chronic use.

#### General Action and Information:

Antitussives (codeine, dextromethorphan, diphenhydramine, hydrocodone, and hydromorphone) suppress cough by central mechanisms. Benzonatate decreases cough by a local anesthetic action. Productive cough should not be suppressed unless it interferes with sleeping or other activities of daily living. Increasing fluid intake probably serves as the best expectorant, decreasing the viscosity of secretions so that they may be more easily mobilized.

#### Contraindications:

Hypersensitivity.

#### Precautions:

Use cautiously in children. Should not be used for prolonged periods unless under the advice of a physician or other health care professional.

#### Interactions:

Centrally acting antitussives may have additive CNS depression with other CNS depressants.

## NURSING IMPLICATIONS

### Assessment

- Assess frequency and nature of cough, lung sounds, and amount and type of sputum produced.

### Potential Nursing Diagnoses

- Airway clearance, ineffective (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Unless contraindicated, maintain fluid intake of 1500–2000 ml to decrease viscosity of bronchial secretions.

### Patient/Family Teaching

- Instruct patient to cough effectively, sit upright, and take several deep breaths before attempting to cough.
- Advise patient to minimize cough by avoiding irritants (cigarette smoke, fumes, dust). Humidification of environmental air, frequent sips of water, and sugarless hard candy may also decrease the frequency of dry, irritating cough.

- Caution patient to avoid taking concurrent alcohol or CNS depressants.
- May cause dizziness or drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to medication is known.
- Advise patient that any cough lasting over 1 wk or accompanied by fever, chest pain, persistent headache, or skin rash warrants medical attention.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in frequency and intensity of cough without eliminating patient's cough reflex.

### Antitussive Agents Included in *Davis's Drug Guide for Nurses*

benzonatate 95	diphenhydramine 300
codeine 221	hydrocodone 483
dextromethorphan 277	hydromorphone 486

### ANTI-ULCER AGENTS

#### PHARMACOLOGIC PROFILE

##### General Use:

Treatment and prophylaxis of peptic ulcer and gastric hypersecretory conditions such as Zollinger-Ellison syndrome. Histamine H<sub>2</sub>-receptor antagonists and gastric and pump inhibitors are also used in the management of GERD.

##### General Action and Information:

Because a great majority of peptic ulcer disease may be traced to GI infection with the organism *Helicobacter pylori*, eradication of the organism decreases symptomatology and recurrence. Anti-infectives with significant activity against the organism include amoxicillin, clarithromycin, metronidazole, and tetracycline. Bismuth also has anti-infective activity against *H. pylori*. Regimens may include 2 anti-infectives plus a gastric acid-pump inhibitor (lansoprazole, omeprazole) or 3 anti-infectives or 3 anti-infectives plus a gastric acid-pump inhibitor.

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

REGIMENS FOR ERADICATING *H. PYLORI*

REGIMEN	DOSING
omeprazole clarithromycin	40 mg once daily on 1st day, then 20 mg once daily for 2 wk
ranitidine bismuth citrate	500 mg 3 times daily for 2 wk
clarithromycin	400 mg twice daily for 4 wk
metronidazole	500 mg 3 times daily for 2 wk
metronidazole	250 mg 4 times daily (at meals and bedtime)
tetracycline	for 2 wk
bismuth subsalicylate	500 mg 4 times daily (at meals and bedtime)
	for 2 wk
	525 mg 4 times daily (at meals and bedtime)
	for 2 wk
lansoprazole	30 mg daily for 2 wk
clarithromycin	500 mg twice daily for 2 wk
amoxicillin	1 g twice daily for for 2 wk
lansoprazole	30 mg daily for 2 wk
amoxicillin	1 g 3 times daily for for 2 wk

Other medications used in the management of gastric/duodenal ulcer disease are aimed at neutralizing gastric acid (antacids), decreasing acid secretion (histamine H<sub>2</sub> antagonists, lansoprazole, misoprostol, omeprazole), or protecting the ulcer surface from further damage (misoprostol, sucralfate). Histamine H<sub>2</sub>-receptor antagonists (blockers) competitively inhibit the action of histamine at the H<sub>2</sub> receptor, located primarily in gastric parietal cells, resulting in inhibition of gastric acid secretion. Misoprostol decreases gastric acid secretion and increases production of protective mucus. Omeprazole and lansoprazole prevent the transport of hydrogen ions into the gastric lumen.

**Contraindications:**

Hypersensitivity.

**Precautions:**

Most histamine H<sub>2</sub> antagonists require dosage reduction in renal impairment and in elderly patients. Magnesium-containing antacids should be used cautiously in patients with renal impairment. Misoprostol should be used cautiously in women with childbearing potential.

**Interactions:**

Calcium and magnesium-containing antacids decrease the absorption of tetracycline and fluoroquinolones. Cimetidine inhibits the ability of the liver to metabolize several drugs, increasing the risk of toxicity from warfarin, tricyclic antidepressants, theophylline, metoprolol, phenytoin, propranolol, and lidocaine. Omeprazole decreases metabolism of phenytoin, diazepam, and warfarin. All agents that increase gastric pH will decrease the absorption of ketoconazole.

**NURSING IMPLICATIONS****Assessment**

- **General Info:** Assess patient routinely for epigastric or abdominal pain and frank or occult blood in the stool, emesis, or gastric aspirate.

- **Antacids:** Assess for heartburn and indigestion as well as the location, duration, character, and precipitating factors of gastric pain.
- **Histamine H<sub>2</sub> Antagonists:** Assess elderly and severely ill patients for confusion routinely. Notify physician or other health care professional promptly should this occur.
- **Misoprostol:** Assess women of childbearing age for pregnancy. Medication is usually begun on 2nd or 3rd day of menstrual period following a negative serum pregnancy test within 2 wk of beginning therapy.
- **Lab Test Considerations:** *Histamine H<sub>2</sub> antagonists* antagonize the effects of pentagastrin and histamine during gastric acid secretion test. Avoid administration during the 24 hr preceding the test.
- May cause false-negative results in skin tests using allergen extracts. These drugs should be discontinued 24 hr prior to the test.

### Potential Nursing Diagnoses

- Pain (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- **Antacids:** Antacids cause premature dissolution and absorption of enteric-coated tablets and may interfere with absorption of other oral medications. Separate administration of antacids and other oral medications by at least 1 hr.
- Shake liquid preparations well before pouring. Follow administration with water to ensure passage to stomach. Liquid and powder dosage forms are considered to be more effective than chewable tablets.
- Chewable tablets must be chewed thoroughly before swallowing. Follow with half a glass of water.
- Administer 1 and 3 hr after meals and at bedtime for maximum antacid effect.
- **Misoprostol:** Administer with meals and at bedtime to reduce the severity of diarrhea.
- **Pantoprazole, Rabeprazole, Omeprazole, and Lansoprazole:** Administer before meals, preferably in the morning. Capsules should be swallowed whole; do not open, crush, or chew.
- May be administered concurrently with antacids.
- **Sucralfate:** Administer on an empty stomach 1 hr before meals and at bedtime. Do not crush or chew tablets. Shake suspension well prior to administration. If nasogastric administration is required, consult pharmacist, as protein-binding properties of sucralfate have resulted in formation of a bezoar when administered with enteral feedings and other medications.

### Patient/Family Teaching

- **General Info:** Instruct patient to take medication as directed for the full course of therapy, even if feeling better. If a dose is missed, it should be taken as soon as remembered but not if almost time for next dose. Do not double doses.
- Advise patient to avoid alcohol, products containing aspirin, NSAIDs, and foods that may cause an increase in GI irritation.
- Advise patient to report onset of black, tarry stools to the physician or other health care professional promptly.
- Inform patient that cessation of smoking may help prevent the recurrence of duodenal ulcers.

- **Antacids:** Caution patient to consult health care professional before taking antacids for more than 2 wk or if problem is recurring. Advise patient to consult health care professional if relief is not obtained or if symptoms of gastric bleeding (black, tarry stools; coffee-ground emesis) occur.
- **Misoprostol:** Emphasize that sharing of this medication may be dangerous.
- Inform patient that misoprostol may cause spontaneous abortion. Women of childbearing age must be informed of this effect through verbal and written information and must use contraception throughout therapy. If pregnancy is suspected, the woman should stop taking misoprostol and immediately notify her health care professional.
- **Sucralfate:** Advise patient to continue with course of therapy for 4–8 wk, even if feeling better, to ensure ulcer healing.
- Advise patient that an increase in fluid intake, dietary bulk, and exercise may prevent drug-induced constipation.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in GI pain and irritation ■ Prevention of gastric irritation and bleeding. Healing of duodenal ulcers can be seen by x-rays or endoscopy. Therapy with histamine H<sub>2</sub> antagonists is continued for at least 6 wk after initial episode ■ Decreased symptoms of GERD ■ Increase in the pH of gastric secretions (antacids) ■ Prevention of gastric ulcers in patients receiving chronic NSAID therapy (misoprostol only).

### Anti-ulcer Agents Included in *Davis's Drug Guide for Nurses*

#### *antacids*

aluminum hydroxide 26  
 magaldrate 591  
 magnesium hydroxide/aluminum hydroxide 591  
 sodium bicarbonate 926

#### *anti-infectives*

amoxicillin 43  
 bismuth subsalicylate 110  
 clarithromycin 204  
 metronidazole 641  
 tetracycline 969

#### *gastric acid-pump inhibitors*

lansoprazole 563  
 omeprazole 727  
 pantoprazole 751  
 rabeprazole 875

#### *histamine H<sub>2</sub>-receptor antagonists*

cimetidine 472  
 famotidine 472  
 nizatidine 472  
 ranitidine 472

#### *miscellaneous*

misoprostol 655  
 sucralfate 941

## ANTIVIRAL AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Acyclovir, famciclovir, and valacyclovir are used in the management of herpesvirus infections. Acyclovir also is used in the management of chickenpox. Zanamivir is used primarily in the prevention of influenza A viral infections. Cidofovir, ganciclovir, and foscarnet are used in the treatment of cytomegalovirus (CMV) retinitis.

#### General Action and Information:

Most agents inhibit viral replication.

**Contraindications:**

Previous hypersensitivity.

**Precautions:**

All except zanamivir require dosage adjustment in renal impairment. Acyclovir may cause renal impairment. Acyclovir may cause CNS toxicity. Foscarnet increases risk of seizures.

**Interactions:**

Acyclovir may have additive CNS and nephrotoxicity with drugs causing similar adverse reactions.

**NURSING IMPLICATIONS****Assessment**

- **General Info:** Assess patient for signs and symptoms of infection before and throughout therapy.
- **Ophth:** Assess eye lesions before and daily during therapy.
- **Topical:** Assess lesions before and daily during therapy.

**Potential Nursing Diagnoses**

- Infection, risk for (Indications).
- Skin integrity, impaired (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Most systemic antiviral agents should be administered around the clock to maintain therapeutic serum drug levels.

**Patient/Family Teaching**

- Instruct patient to continue taking medication around the clock for full course of therapy, even if feeling better.
- Advise patient that antivirals and antiretrovirals do not prevent transmission to others. Precautions should be taken to prevent spread of virus.
- Instruct patient in correct technique for topical or ophthalmic preparations.
- Instruct patient to notify health care professional if symptoms do not improve.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Prevention or resolution of the signs and symptoms of viral infection. Length of time for complete resolution depends on organism and site of infection.

**Antiviral Agents Included in *Davis's Drug Guide for Nurses***

acyclovir 8	ganciclovir 436
amantadine 1169	rimantadine 1181
cidofovir 196	trifuradine 1158
famciclovir 383	valacyclovir 1029
foscarnet 430	zanamivir 1065

**BRONCHODILATORS****PHARMACOLOGIC PROFILE****General Use:**

Used in the treatment of reversible airway obstruction due to asthma or COPD. Recently revised recommendations for management of asthma recommend that rapid-acting inhaled beta-agonist bronchodilators (not salmeterol) be reserved as acute relievers of bronchospasm; repeated or chronic use indicates the need for additional long-term control agents including inhaled corticosteroids, mast cell stabilizers, and long-acting bronchodilators (oral theophylline or beta-agonists) and leukotriene modifiers (montelukast, zafirlukast). The place of the new agent zafirlukast has not yet been established.<sup>†</sup>

**General Action and Information:**

Beta-adrenergic agonists (albuterol, epinephrine, isoproterenol, metaproterenol, pirbuterol, and terbutaline) produce bronchodilation by stimulating the production of cyclic adenosine monophosphate (cAMP). Newer agents (albuterol, metaproterenol, pirbuterol, and terbutaline) are relatively selective for pulmonary (beta<sub>2</sub>) receptors, whereas older agents produce cardiac stimulation (beta<sub>2</sub>-adrenergic effects) in addition to bronchodilation. Onset of action allows use in management of acute attacks except for salmeterol, which has delayed onset. Phosphodiesterase inhibitors (aminophylline, dyphylline, oxtriphylline, and theophylline) inhibit the breakdown of cAMP. Ipratropium is an anticholinergic compound that produces bronchodilation by blocking the action of acetylcholine in the respiratory tract. Montelukast and zafirlukast are leukotriene modifiers. Leukotrienes are components of slow-reacting substance of anaphylaxis A (SRS-A), which may be a cause of bronchospasm.

**Contraindications:**

Hypersensitivity to agents, preservatives (bisulfites), or propellants used in their formulation. Avoid use in uncontrolled cardiac arrhythmias.

**Precautions:**

Use cautiously in patients with diabetes, cardiovascular disease, or hyperthyroidism.

**Interactions:**

Therapeutic effectiveness may be antagonized by concurrent use of beta-adrenergic blocking agents. Additive sympathomimetic effects with other adrenergic (sympathetic) drugs, including vasopressors and decongestants. Cardiovascular effects may be potentiated by antidepressants and MAO inhibitors.

<sup>†</sup>Highlights of the Expert Panel Report 2: Guidelines for the diagnosis and management of asthma. NIH Publication No. 97-4051A. May 1997.

## NURSING IMPLICATIONS

### Assessment

- Assess blood pressure, pulse, respiration, lung sounds, and character of secretions before and throughout therapy.
- Patients with a history of cardiovascular problems should be monitored for ECG changes and chest pain.

### Potential Nursing Diagnoses

- Airway clearance, ineffective (Indications).
- Activity intolerance (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Administer around the clock to maintain therapeutic plasma levels.

### Patient/Family Teaching

- Emphasize the importance of taking only the prescribed dose at the prescribed time intervals.
- Encourage the patient to drink adequate liquids (2000 ml/day minimum) to decrease the viscosity of the airway secretions.
- Advise patient to avoid OTC cough, cold, or breathing preparations without consulting health care professional and to minimize intake of xanthine-containing foods or beverages (colas, coffee, and chocolate), as these may increase side effects and cause arrhythmias.
- Caution patient to avoid smoking and other respiratory irritants.
- Instruct patient on proper use of metered-dose inhaler (see Appendix I).
- Advise patient to contact health care professional promptly if the usual dose of medication fails to produce the desired results, symptoms worsen after treatment, or toxic effects occur.
- Patients using other inhalation medications and bronchodilators should be advised to use bronchodilator first and allow 5 min to elapse before administering the other medication, unless otherwise directed by health care professional.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decreased bronchospasm

- Increased ease of breathing.

### Bronchodilators Included in *Davis's Drug Guide for Nurses*

#### **beta-adrenergic agonists**

albuterol 13  
 epinephrine 345  
 isoproterenol 1177  
 metaproterenol 617  
 pirbuterol 805  
 salmeterol 907  
 terbutaline 964

#### **leukotriene antagonists**

montelukast 664  
 zafirlukast 1061

#### **phosphodiesterase inhibitors**

**(xanthines)**  
 aminophylline 120  
 dyphylline 120  
 oxtriphylline 120  
 theophylline 120

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## CARDIOTONIC AND INOTROPIC AGENTS\*

## PHARMACOLOGIC PROFILE

**General Use:**

Management of congestive heart failure or cardiac decompensation unresponsive to conventional therapy with cardiac glycosides, diuretics, or vasodilators. Also used during cardiac surgery.

**General Action and Information:**

Increase cardiac output mainly by direct myocardial effects and some peripheral vascular effects. Myocardial contractility is increased by inhibiting cyclic adenosine monophosphate (cAMP) phosphodiesterase, which increases intracellular cAMP.

**Contraindications:**

Hypersensitivity. Avoid use in patients with hypertrophic cardiomyopathy.

**Precautions:**

Safety in pregnancy, lactation, and children not established.

**Interactions:**

Amrinone may produce excessive hypotension when given with disopyramide. Agents that cause hypokalemia, hypomagnesemia, or hypercalcemia increase the risk of cardiac glycoside toxicity. Bradycardia from beta blockers may be additive with digitalis glycosides. Quinidine increases serum digoxin levels.

## NURSING IMPLICATIONS

**Assessment**

- Monitor blood pressure, pulse, and respiration before and periodically throughout therapy.
- Monitor intake and output ratios and daily weights. Assess patient for signs and symptoms of congestive heart failure (peripheral edema, rales/crackles, dyspnea, weight gain, jugular vein distentions) throughout therapy.
- Before administering initial loading dose, determine if patient has taken any cardiac glycoside preparations in the preceding 2–3 wk.
- **Lab Test Considerations:** Serum electrolyte levels, especially potassium, magnesium, and calcium, and renal and hepatic function should be evaluated periodically during therapy.
- **Toxicity and Overdose:** Patients taking digitalis glycosides should have serum levels measured regularly.

**Potential Nursing Diagnoses**

- Cardiac output, decreased (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

## Implementation

- Hypokalemia should be corrected before administration of amrinone, milrinone, digoxin, or digitoxin.
- Hypovolemia should be corrected with volume expanders before administrations.

## Patient/Family Teaching

- Advise patient to notify health care professional if symptoms are not relieved or worsen.
- Instruct patient to notify nurse immediately if pain or discomfort at the insertion site occurs during IV administration.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Increased cardiac output ■ Decrease in severity of congestive heart failure. ■ Increased urine output.

## Cardiotonic and Inotropic Agents Included in *Davis's Drug Guide for Nurses*

amrinone 58	dopamine 326
digoxin 2287	milrinone 650
dobutamine 317	

## CENTRAL NERVOUS SYSTEM STIMULANTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

CNS stimulants are used as an adjunct in the treatment of ADHD and in the treatment of narcolepsy.

#### General Action and Information:

CNS stimulation results in increased attention span in ADHD, increased motor activity, mental alertness, and decreased fatigue in narcoleptic patients.

#### Contraindications:

Hypersensitivity. Pregnancy or lactation. Should not be used in patients with psychiatric illness or chemical dependence.

#### Precautions:

Use cautiously in patients with cardiovascular disease, hypertension, diabetes, and seizure disorders.

#### Interactions:

Additive sympathomimetic effects with other adrenergic agents. Use with MAO inhibitors results in hypertensive crisis.

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## NURSING IMPLICATIONS

### Assessment

- Monitor blood pressure, pulse, and respiration before and periodically throughout therapy.
- In treatment of ADHD, monitor weight biweekly and inform prescriber of significant loss. Monitor height periodically in children; report growth inhibition.
- In narcolepsy, observe and document frequency of narcoleptic episodes.
- Assess attention span, motor, or vocal tics; impulse control; and interactions with others for children with ADHD.
- May produce a false sense of euphoria and well-being. Monitor and provide rest periods.
- These agents have a high dependence abuse potential. Tolerance to medication occurs rapidly; do not increase dose.

### Potential Nursing Diagnoses

- Thought processes, altered (Side Effects).
- Sleep pattern disturbance (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Therapy should use the lowest possible dose.
- Sustained-release capsules should be swallowed whole; do not break, crush, or chew.
- Chewable tablets should be chewed thoroughly before swallowing.
- **ADHD:** When symptoms are under control, dose reduction or interruption of therapy may be possible during the summer, or may be given on each of the 5 school days, with medication-free days on weekends and holidays.

### Patient/Family Teaching

- Instruct patient to take medication at least 6 hr before bedtime to avoid sleep disturbances
- Inform patient that the side effect of dry mouth can be minimized with frequent mouth rinses with water or by chewing sugarless gum or candies.
- Advise patient to avoid caffeine.
- Medication may impair judgment, cause dizziness or blurred vision. Advise patient to use caution when driving or during other activities requiring mental alertness.
- Instruct patient to inform health care professional if nervousness, restlessness, insomnia, anorexia, or dry mouth becomes severe.
- Inform patient that periodic holiday from the drug may be ordered to assess progress and decrease dependence.
- Advise the patient to take weight measurements twice weekly and report weight loss to health care professional.
- In children receiving the medication for ADHD, inform school nurse of regimen.
- In patients taking pemoline, instruct about signs of hepatitis and to report promptly to the health care professional if they occur.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Calming effect with decreased hyperactivity and prolonged attention span in children with ADHD ■ Decrease in the frequency of narcolepsy symptoms.

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## Central Nervous System Stimulants Included in *Davis's Drug Guide for Nurses*

amphetamine 1170  
methyphenidate 632

pemoline 756

### CHOLINERGIC AGENTS

### PHARMACOLOGIC PROFILE

#### General Use:

Used in the treatment of nonobstructive urinary retention (bethanechol) and in the diagnosis and treatment (neostigmine and pyridostigmine) of myasthenia gravis. Cholinesterase inhibitors may be used to reverse nondepolarizing neuromuscular blocking agents.

#### General Action and Information:

Cholinergic agents intensify and prolong the action of acetylcholine by either mimicking its effects at cholinergic receptor sites (bethanechol) or preventing the breakdown of acetylcholine by inhibiting cholinesterases (neostigmine). Effects include increased tone in GU and skeletal muscle, decreased intraocular pressure, increased secretions, and decreased bladder capacity.

#### Contraindications:

Hypersensitivity. Avoid use in patients with possible obstruction of the GI or GU tract.

#### Precautions:

Use with extreme caution in patients with a history of asthma, peptic ulcer disease, cardiovascular disease, epilepsy, or hyperthyroidism. Safety in pregnancy and lactation not established. Atropine should be available to treat excessive dosage.

#### Interactions:

Additive cholinergic effects. Do not use with depolarizing neuromuscular blocking agents. Use with ganglionic blocking agents may result in severe hypotension.

### NURSING IMPLICATIONS

#### Assessment

- **General Info:** Monitor pulse, respiratory rate, and blood pressure frequently throughout parenteral administration.
- **Myasthenia Gravis:** Assess neuromuscular status (ptosis, diplopia, vital capacity, ability to swallow, and extremity strength) before and at time of peak effect.
- Assess patient for overdosage and underdosage or resistance. Both have similar symptoms (muscle weakness, dyspnea, and dysphagia), but symptoms of overdosage usually occur within 1 hr of administration, while underdosage symptoms occur 3 hr or more after administration. A Tensilon test (edrophonium chloride) may be used to distinguish between overdosage and underdosage.

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- **Antidote to Nondepolarizing Neuromuscular Blocking Agents:** Monitor reversal of effects of neuromuscular blocking agents with a peripheral nerve stimulator.
- **Urinary Retention:** Monitor intake and output ratios. Palpate abdomen for bladder distention. Catheterization may be done to assess postvoid residual.
- **Glaucoma:** Monitor patient for changes in vision, eye irritation, and persistent headache.
- **Toxicity and Overdose:** Atropine is the specific antidote.

### Potential Nursing Diagnoses

- Urinary elimination, altered (Indications).
- Breathing pattern, ineffective (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- **Myasthenia Gravis:** For patients who have difficulty chewing, medication may be administered 30 min before meals.

### Patient/Family Teaching

- **General Info:** Instruct patients with myasthenia gravis to take medication exactly as ordered. Taking the dose late may result in myasthenic crisis. Taking the dose early may result in a cholinergic crisis. This regimen must be continued as a lifelong therapy.
- **Ophth:** Instruct patient on correct method of application of drops or ointment (see Appendix I).
- Explain to patient that pupil constriction and temporary stinging and blurring of vision are expected. Notify health care professional if blurred vision and brow ache persist.
- Caution patient that night vision may be impaired.
- Advise patient of the need for regular eye exams to monitor intraocular pressure and visual fields.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Reversal of CNS symptoms secondary to anticholinergic excess resulting from drug overdosage or ingestion of poisonous plants  
 ■ Control of elevated intraocular pressure ■ Increase in bladder function and tone ■ Decrease in abdominal distention ■ Relief of myasthenic symptoms ■ Differentiation of myasthenic from cholinergic crisis ■ Reversal of paralysis after anesthesia ■ Resolution of supraventricular tachycardia.

### Cholinergic Agents Included in *Davis's Drug Guide for Nurses*

#### *cholinomimetic*

bethanechol 102

#### *cholinesterase inhibitors*

demerarium 1161

echothiophate 1161

isofluorophate 1161

neostigmine 693

physostigmine 1161, 1179

pyridostigmine 860

tacrine 951

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## CORTICOSTEROIDS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Used in replacement doses (20 mg of hydrocortisone or equivalent) to treat adrenocortical insufficiency. Larger doses are usually used for their anti-inflammatory, immunosuppressive, or antineoplastic activity. Used adjunctively in many other situations, including hypercalcemia and autoimmune diseases. Topical corticosteroids are used in a variety of inflammatory and allergic conditions. Inhalant corticosteroids are used in the chronic management of reversible airway disease (asthma); intranasal and ophthalmic corticosteroids are used in the management of chronic allergic and inflammatory conditions.

#### General Action and Information:

Produce profound and varied metabolic effects, in addition to modifying the normal immune response and suppressing inflammation. Available in a variety of dosage forms, including oral, injectable, topical, and inhalation. Prolonged use of large amounts of topical or inhaled agent may result in systemic absorption and/or adrenal suppression.

#### Contraindications:

Serious infections (except for certain forms of meningitis). Do not administer live vaccines to patients on larger doses.

#### Precautions:

Prolonged treatment will result in adrenal suppression. Do not discontinue abruptly. Additional doses may be needed during stress (surgery and infection). Safety in pregnancy and lactation not established. Long-term use in children will result in decreased growth. May mask signs of infection. Use lowest dose possible for shortest time possible. Alternate-day therapy is preferable during long-term treatment.

#### Interactions:

Additive hypokalemia with amphotericin B, potassium-losing diuretics, mezlocillin, piperacillin, and ticarcillin. Hypokalemia may increase the risk of cardiac glycoside toxicity. May increase requirements for insulin or oral hypoglycemic agents. Phenytoin, phenobarbital, and rifampin stimulate metabolism and may decrease effectiveness. Oral contraceptives may block metabolism. Cholestyramine and colestipol may decrease absorption.

## NURSING IMPLICATIONS

### Assessment

- These drugs are indicated for many conditions. Assess involved systems prior to and periodically throughout course of therapy.
- Assess patient for signs of adrenal insufficiency (hypotension, weight loss, weakness, nausea, vomiting, anorexia, lethargy, confusion, restlessness) prior to and periodically throughout course of therapy.
- Children should have periodic evaluations of growth.

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### Potential Nursing Diagnoses

- Infection, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Body image disturbance (Side Effects).

### Implementation

- **General Info:** If dose is ordered daily or every other day, administer in the morning to coincide with the body's normal secretion of cortisol.
- **PO:** Administer with meals to minimize gastric irritation.

### Patient/Family Teaching

- Emphasize need to take medication exactly as directed. Review symptoms of adrenal insufficiency that may occur when stopping the medication and that may be life-threatening.
- Encourage patients on long-term therapy to eat a diet high in protein, calcium, and potassium and low in sodium and carbohydrates.
- These drugs cause immunosuppression and may mask symptoms of infection. Instruct patient to avoid people with known contagious illnesses and to report possible infections. Advise patient to consult health care professional before receiving any vaccinations.
- Discuss possible effects on body image. Explore coping mechanisms.
- Advise patient to carry identification in the event of an emergency in which patient cannot relate medical history.

### Evaluation

- Effectiveness of therapy can be demonstrated by:**
- Suppression of the inflammatory and immune responses in autoimmune disorders, allergic reactions, and organ transplants
  - Replacement therapy in adrenal insufficiency
  - Resolution of skin inflammation, pruritus, or other dermatologic conditions.

### Corticosteroids Included in *Davis's Drug Guide for Nurses*

#### ***corticosteroids, inhalation***

beclomethasone 229  
 budesonide 229  
 flunisolide 229  
 fluticasone 229  
 triamcinolone 229

#### ***corticosteroids, nasal***

beclomethasone 233  
 budesonide 233  
 dexamethasone 233  
 flunisolide 233

fluticasone 233  
 mometasone 233  
 triamcinolone 233

#### ***corticosteroids, ophthalmic***

dexamethasone 1161  
 fluomethalone 1161  
 loteprednol 1161  
 medrysone 1161  
 prednisone 236  
 rimexolone 1161

**corticosteroids, systemic  
(short-acting)**

cortisone 236  
hydrocortisone 236

**corticosteroids, systemic  
(intermediate-acting)**

methylprednisolone 236  
prednisolone 236  
prednisone 236  
triamcinolone 236

**cocorticosteroids, systemic  
(long-acting)**

betamethasone 236  
dexamethasone 236

**corticosteroids, topical/local**

alclometasone 244  
amcinonide 244

betamethasone 244  
clobetasol 244  
clocortolone 244  
desonide 244  
desoximetasone 244  
dexamethasone 244  
diflorasone 244  
flucinolone 244  
fluocinonide 244  
flurandrenolide 244  
fluticasone 244  
halcinonide 244  
halobetasol 244  
hydrocortisone 245  
methylprednisolone 245  
mometasone 245  
prednicarbate 245  
triamcinolone 245

**DIURETICS****PHARMACOLOGIC PROFILE****General Use:**

Thiazide and loop diuretics are used alone or in combination in the treatment of hypertension or edema due to congestive heart failure or other causes. Potassium-sparing diuretics have weak diuretic and antihypertensive properties and are used mainly to conserve potassium in patients receiving thiazide or loop diuretics. Osmotic diuretics are often used in the management of cerebral edema.

**General Action and Information:**

Enhance the selective excretion of various electrolytes and water by affecting renal mechanisms for tubular secretion and reabsorption. Groups commonly used are thiazide diuretics and thiazide-like diuretics (chlorothiazide, chlorthalidone, hydrochlorothiazide, indapamide, and metolazone), loop diuretics (bumetanide, furosemide, and tosemeide), potassium-sparing diuretics (amiloride, spironolactone, and triamterene), and osmotic diuretics (mannitol). Mechanisms vary, depending on agent.

**Contraindications:**

Hypersensitivity. Thiazide diuretics may exhibit cross-sensitivity with other sulfonamides.

**Precautions:**

Use with caution in patients with renal or hepatic disease. Safety in pregnancy and lactation not established.

### Interactions:

Additive hypokalemia with corticosteroids, amphotericin B, mezlocillin, piperacillin, or ticarcillin. Hypokalemia enhances digitalis glycoside toxicity. Potassium-losing diuretics decrease lithium excretion and may cause toxicity. Additive hypotension with other antihypertensives or nitrates. Potassium-sparing diuretics may cause hyperkalemia when used with potassium supplements or ACE inhibitors.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Assess fluid status throughout therapy. Monitor daily weight, intake and output ratios, amount and location of edema, lung sounds, skin turgor, and mucous membranes.
- Assess patient for anorexia, muscle weakness, numbness, tingling, paresthesia, confusion, and excessive thirst. Notify physician or other health care professional promptly if these signs of electrolyte imbalance occur.
- **Hypertension:** Monitor blood pressure and pulse before and during administration. Monitor frequency of prescription refills to determine compliance in patients treated for hypertension.
- **Increased Intracranial Pressure:** Monitor neurologic status and intracranial pressure readings in patients receiving osmotic diuretics to decrease cerebral edema.
- **Increased Intraocular Pressure:** Monitor for persistent or increased eye pain or decreased visual acuity.
- **Lab Test Considerations:** Monitor electrolytes (especially potassium), blood glucose, BUN, and serum uric acid levels before and periodically throughout course of therapy.
- Thiazide diuretics may cause increased serum cholesterol, LDL, and triglyceride concentrations.

### Potential Nursing Diagnoses

- Fluid volume excess (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Administer oral diuretics in the morning to prevent disruption of sleep cycle.
- Many diuretics are available in combination with antihypertensives or potassium-sparing diuretics.

### Patient/Family Teaching

- **General Info:** Instruct patient to take medication exactly as directed. Advise patients on antihypertensive regimen to continue taking medication, even if feeling better. Medication controls but does not cure hypertension.
- Caution patient to make position changes slowly to minimize orthostatic hypotension. Caution patient that the use of alcohol, exercise during hot weather, or standing for long periods during therapy may enhance orthostatic hypotension.
- Instruct patient to consult health care professional regarding dietary potassium guidelines.
- Instruct patient to monitor weight weekly and report significant changes.
- Caution patient to use sunscreen and protective clothing to prevent photosensitivity reactions.
- Advise patient to consult health care professional before taking OTC medication concurrently with this therapy.

- Instruct patient to notify health care professional of medication regimen before treatment or surgery.
- Advise patient to contact health care professional immediately if muscle weakness, cramps, nausea, dizziness, or numbness or tingling of extremities occurs.
- Emphasize the importance of routine follow-up.
- **Hypertension:** Reinforce the need to continue additional therapies for hypertension (weight loss, regular exercise, restricted sodium intake, stress reduction, moderation of alcohol consumption, and cessation of smoking).
- Instruct patients with hypertension in the correct technique for monitoring weekly blood pressure.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decreased blood pressure  
 ■ Increased urine output ■ Decreased edema ■ Reduced intracranial pressure ■ Prevention of hypokalemia in patients taking diuretics ■ Treatment of hyperaldosteronism.

### Diuretics Included in *Davis's Drug Guide for Nurses*

#### **loop diuretic**

bumetanide 124

furosemide 315

toremide 315

#### **osmotic diuretic**

mannitol 597

#### **potassium-sparing diuretics**

amiloride 312

spironolactone 312

triamterene 312

#### **thiazide and thiazide-like diuretics**

chlorothiazide 315

chlorthalidone 315

hydrochlorothiazide 315

indapamide 512

methyclothiazide 809

metolazone 636

trichlormethiazide 1176

### ESTROGENS/PROGESTINS/HORMONAL CONTRACEPTIVES\*

#### PHARMACOLOGIC PROFILE

##### General Use:

Used to treat hormonal deficiency states in menopausal women to minimize vasomotor symptoms and to prevent and treat osteoporosis. Estrogens and/or progestins are effective as oral contraceptives for women during the reproductive years.

##### General Action and Information:

Hormonal contraceptives block the ovulatory cycle through a negative feedback mechanism on the hypothalamus, by suppressing the production of follicle-stimulating hormone and luteinizing hormone. In addition to suppressing ovulation, these agents affect the movement of the ovum and sperm and creates an environment that is unfavorable for the implantation of a fertilized ovum. Estrogens promote the growth and development of female sex organs and the maintenance of secondary sex characteristics. Estrogens inhibit bone resorption in the prevention and treatment of osteoporosis.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

**Contraindications:**

Should not be used in thromboembolic disease, cerebrovascular accident or patients with a history of coronary artery or ischemic heart disease, pregnancy, breast cancer or patients with a history of breast cancer, and severe liver disease.

**Precautions:**

Use cautiously in women over age 35 who smoke heavily and in patients with hypertension, diabetes, renal disease, lactation, and family history of hyperlipidemia.

**Interactions:**

May alter requirement for warfarin, oral hypoglycemic agents, or insulin. Antibiotics and anti-convulsants (except valproic acid) may decrease effectiveness. Cigarette smoking increases the risk of adverse cardiovascular effects.

**NURSING IMPLICATIONS****Assessment**

- Assess blood pressure prior to the start of and periodically during therapy.
- Exclude thrombophlebitis and breast cancer by history or physical exam prior to initiating therapy.
- Exclude pregnancy prior to starting therapy.
- Assess smoking habits and encourage individuals to stop smoking while on hormonal therapy.
- Assess for history of gallbladder disease, hypertension, impaired liver function, obesity, and conditions that may be aggravated by fluid retention. Monitor these individuals at more frequent intervals.

**Potential Nursing Diagnoses**

- Noncompliance (Family/Patient Teaching).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Oral doses may be administered with or immediately after food to reduce nausea.
- Implant is inserted subdermally in midportion of upper arm about 8–10 cm above the elbow crease.
- Administer IM doses deep into the gluteal or deltoid muscle.

**Patient/Family Teaching**

- Instruct patient to take oral medication as directed at the same time each day. Pills should be taken in proper sequence and kept in the original container.
- Advise patient of need to use another form of contraception for the first 3 wk when beginning to use oral contraceptives
- Warn patient that many other medications (e.g., certain antibiotics) may interfere with the action of oral contraceptives and to remind their health care professional that he or she is taking birth control pills whenever any other medications are prescribed for them.
- If nausea is a problem, advise patient that eating solid food often provides relief.

- Advise patient to report signs of fluid retention, thromboembolic disorders, mental depression, hepatic dysfunction, or abnormal vaginal bleeding.
- Inform patient to stop taking medication and to contact their health care professional if pregnancy is suspected.
- Caution patient that cigarette smoking during estrogen therapy may increase the risk of serious side effects, especially for women over age 35.
- Warn patient to wear sunscreen and protective clothing to prevent increased pigmentation.
- Caution patient that oral contraceptives do not protect against HIV and other sexually transmitted diseases.
- Advise patient to notify health care professional of medication regimen prior to treatment or surgery.
- Emphasize the importance of routine follow-up exams, including blood pressure, breast, abdomen, pelvic, and PAP smears, every 6–12 mo.

### Evaluation

- Effectiveness of therapy can be demonstrated by:** ■ Prevention of pregnancy  
 ■ Regulation of menstrual cycle ■ Decrease in acne ■ Control of menopausal symptoms.

### Estrogens/Progestins/Hormonal Contraceptives Included in *Davis's Drug Guide for Nurses*

#### **estrogens**

estrogens, conjugated 368  
 estropipate 371

#### **progestins**

medroxyprogesterone 605  
 progesterone 837

#### **contraceptives, hormonal (monophasic)**

ethinyl estradiol/desogestrel 225  
 ethinyl estradiol/ethynodiol 225  
 ethinyl estradiol/norethindrone 225  
 ethinyl estradiol/norgestrel 225

#### **contraceptives, hormonal (biphasic)**

ethinyl estradiol/northindrone 225

#### **contraceptives, hormonal (triphasic)**

ethinyl estradiol/norethindrone 225  
 ethinyl estradiol/norgestrel 225  
 ethinyl estradiol/norgestimate 225

#### **progestin only**

norethindrone 226  
 norgestrel 225

#### **contraceptive implant**

levonorgestrel 226

#### **contraceptives, hormonal (emergency contraceptives)**

ethinyl estradiol/levonorgestrel 225

### IMMUNOSUPPRESSANT AGENTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Azathioprine, basiliximab, cyclosporine, daclizumab, mycophenolate, sirolimus, and tacrolimus are used with glucocorticoids in the prevention of transplantation rejection reactions. Muromonab-CD3 is used to manage rejection reactions not controlled by other agents. Azathioprine, cyclophosphamide, and methotrexate are used in the management of selected autoimmune diseases (nephrotic syndrome of childhood and severe rheumatoid arthritis).

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### General Action and Information:

Inhibit cell-mediated immune responses by different mechanisms. In addition to azathioprine and cyclosporine, which are used primarily for their immunomodulating properties, cyclophosphamide and methotrexate are used to suppress the immune responses in certain disease states (nephrotic syndrome of childhood and severe rheumatoid arthritis). Muromonab-CD3 is a recombinant immunoglobulin antibody that alters T-cell function. Basiliximab and daclizumab are monoclonal antibodies.

### Contraindications:

Hypersensitivity to drug or vehicle.

### Precautions:

Use cautiously in patients with infections. Safety in pregnancy and lactation not established.

### Interactions:

Allopurinol inhibits the metabolism of azathioprine. Drugs that alter liver-metabolizing processes may change the effect of cyclosporine. The risk to toxicity of methotrexate may be increased by other nephrotoxic drugs, large doses of aspirin, or NSAIDs. Muromonab-CD3 has additive immunosuppressive properties; concurrent immunosuppressive doses should be decreased or eliminated.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Monitor for infection (vital signs, sputum, urine, stool, WBC). Notify physician or other health care professional immediately if symptoms occur.
- **Organ Transplant:** Assess for symptoms of organ rejection throughout therapy.
- **Lab Test Considerations:** Monitor CBC and differential throughout therapy.

### Potential Nursing Diagnoses

- Infection, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Protect transplant patients from staff and visitors who may carry infection.
- Maintain protective isolation as indicated.

### Patient/Family Teaching

- Reinforce the need for lifelong therapy to prevent transplant rejection. Review symptoms of rejection for transplanted organ and stress need to notify health care professional immediately if they occur.
- Advise patient to avoid contact with contagious persons and those who have recently taken oral poliovirus vaccine. Patients should not receive vaccinations without first consulting with health care professional.
- Emphasize the importance of follow-up exams and lab tests.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Prevention or reversal of rejection of organ transplants or decrease in symptoms of autoimmune disorders.

## Immunosuppressant Agents Included in *Davis's Drug Guide for Nurses*

azathioprine 85	methotrexate 627
basiliximab 92	muromonab-CD3 672
cyclophosphamide 249	sirolimus 924
cyclosporine 252	

## LAXATIVES

### PHARMACOLOGIC PROFILE

#### General Use:

Used to treat or prevent constipation or to prepare the bowel for radiologic or endoscopic procedures.

#### General Action and Information:

Induce one or more bowel movements per day. Groups include stimulants (bisacodyl, senna), saline laxatives (magnesium salts and phosphates), stool softeners (docusate), bulk-forming agents (polycarbophil and psyllium), and osmotic cathartics (lactulose, polyethylene glycol/electrolyte). Increasing fluid intake, exercising, and adding more dietary fiber are also useful in the management of chronic constipation.

#### Contraindications:

Hypersensitivity. Contraindicated in persistent abdominal pain, nausea, or vomiting of unknown cause, especially if accompanied by fever or other signs of an acute abdomen.

#### Precautions:

Excessive or prolonged use may lead to dependence. Should not be used in children unless advised by a physician or other health care professional.

#### Interactions:

Theoretically may decrease the absorption of other orally administered drugs by decreasing transit time.

## NURSING IMPLICATIONS

### Assessment

- Assess patient for abdominal distention, presence of bowel sounds, and usual pattern of bowel function.
- Assess color, consistency, and amount of stool produced.

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## Potential Nursing Diagnoses

- Constipation (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

## Implementation

- Many laxatives may be administered at bedtime for morning results.
- Taking oral doses on an empty stomach will usually produce more rapid results.
- Do not crush or chew enteric-coated tablets. Take with a full glass of water or juice.
- Stool softeners and bulk laxatives may take several days for results.

## Patient/Family Teaching

- Advise patients, other than those with spinal cord injuries, that laxatives should be used only for short-term therapy. Long-term therapy may cause electrolyte imbalance and dependence.
- Advise patient to increase fluid intake to a minimum of 1500–2000 ml/day during therapy to prevent dehydration.
- Encourage patients to use other forms of bowel regulation: increasing bulk in the diet, increasing fluid intake, and increasing mobility. Normal bowel habits are individualized and may vary from 3 times/day to 3 times/wk.
- Instruct patients with cardiac disease to avoid straining during bowel movements (Valsalva maneuver).
- Advise patient that laxatives should not be used when constipation is accompanied by abdominal pain, fever, nausea, or vomiting.

## Evaluation

- Effectiveness of therapy can be demonstrated by:**
- A soft, formed bowel movement
  - Evacuation of colon.

## Laxatives Included in *Davis's Drug Guide for Nurses*

### **bulk-forming agents**

polycarbophil 811  
psyllium 858

### **osmotic agents**

lactulose 557  
polyethylene glycol/electrolyte 813

### **saline laxatives**

magnesium citrate 593

magnesium hydroxide 593  
phosphate/biphosphate 794

### **stimulants**

bisacodyl 108  
senna, sennosides 915

### **stool softener**

docusate 322

## LIPID-LOWERING AGENTS

## PHARMACOLOGIC PROFILE

### General Use:

Used as a part of a total plan including diet and exercise to reduce blood lipids in an effort to reduce the morbidity and mortality of atherosclerotic cardiovascular disease and its sequelae.

### General Action and Information:

HMG-CoA reductase inhibitors (fluvastatin, lovastatin, pravastatin, simvastatin) inhibit an enzyme involved in cholesterol synthesis. Bile acid sequestrants (cholestyramine, colestipol) bind cholesterol in the GI tract. Niacin and gemfibrozil act by other mechanisms (see individual monographs).

### Contraindications:

Hypersensitivity.

### Precautions:

Safety in pregnancy, lactation, and children not established. See individual drugs. Dietary therapy should be given a 2–3 mo trial before drug therapy is initiated.

### Interactions:

Bile acid sequestrants (cholestyramine and colestipol) may bind lipid-soluble vitamins (A, D, E, and K) and other concurrently administered drugs in the GI tract. The risk of myopathy from HMG-CoA reductase inhibitors is increased by niacin, erythromycin, gemfibrozil, and cyclosporine.

## NURSING IMPLICATIONS

### Assessment

- Obtain a diet history, especially in regard to fat and alcohol consumption.
- **Lab Test Considerations:** Serum cholesterol and triglyceride levels should be evaluated before initiating and periodically throughout therapy. Medication should be discontinued if paradoxical increase in cholesterol level occurs.
- Liver function tests should be assessed before and periodically throughout therapy. May cause an increase in levels.

### Potential Nursing Diagnoses

- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

### Implementation

- See specific medications to determine timing of doses in relation to meals.

### Patient/Family Teaching

- Advise patient that these medications should be used in conjunction with diet restrictions (fat, cholesterol, carbohydrates, and alcohol), exercise, and cessation of smoking.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decreased serum triglyceride and LDL cholesterol levels and improved high-density lipoprotein HDL cholesterol ratios. Therapy is usually discontinued if the clinical response is not evident after 3 mo of therapy.

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

**Lipid-Lowering Agents Included in *Davis's Drug Guide for Nurses******bile acid sequestrants***cholestyramine 105  
colestipol 105lovastatin 478  
pravastatin 478  
simvastatin 478***HMG-CoA reductase inhibitors***atorvastatin 478  
cerivastatin 478  
fluvastatin 478***miscellaneous***gemfibrozil 440  
niacin, niacinamide 697**MINERALS/ELECTROLYTES\*****PHARMACOLOGIC PROFILE****General Use:**

Electrolytes are used to prevent or treat fluid and electrolyte imbalances and to maintain acid-base balance and osmotic pressure. Minerals are used to prevent or treat deficiencies in trace minerals.

**General Action and Information:**

Electrolytes are essential for homeostasis in the body. Maintenance of electrolyte levels within normal limits is necessary for many physiologic processes, such as cardiac, nerve, and muscle function, bone growth and stability; and others. Minerals are needed for normal growth and function; as cofactors in enzymatic reactions; and as stabilizing factors in hemoglobin synthesis, protein synthesis, and many other physiologic processes.

**Contraindications:**

Contraindicated in situations in which replacement would cause excess or when risk factors for fluid retention are present.

**Precautions:**

Use cautiously in disease states in which electrolyte imbalances are common, such as hepatic or renal disease, adrenal disorders, pituitary disorders, and diabetes mellitus.

**Interactions:**

See individual agents.

**NURSING IMPLICATIONS****Assessment**

- Observe patient carefully for evidence of electrolyte excess or insufficiency. Monitor lab values before and periodically throughout therapy.
- Nutrition, altered: less than body requirements (Indications).
- Knowledge deficit, related to medication and dietary regimens (Patient/Family Teaching).

**Implementation**

- **Potassium Chloride:** Do not administer parenteral potassium chloride undiluted.

**Patient/Family Teaching**

- Review diet modifications with patients with chronic electrolyte disturbances.

**Evaluation**

**Effectiveness of therapy can be demonstrated by:** ■ Return to normal serum electrolyte concentrations and resolution of clinical symptoms of electrolyte imbalance ■ Changes in pH or composition of urine, which prevent formation of renal calculi.

**Minerals/Electrolytes Included in *Davis's Drug Guide for Nurses*****calcium supplements**

calcium acetate 142  
 calcium carbonate 142  
 calcium chloride 142  
 calcium citrate 142  
 calcium gluconate 142  
 calcium gluceptate 142  
 calcium gluconate 142  
 calcium lactate 142  
 tricalcium phosphate 142

**iron supplements**

carbonyl iron 532  
 ferrous fumarate 533  
 ferrous gluconate 533  
 ferrous sulfate 533  
 iron dextran 533  
 iron polysaccharide 533  
 sodium ferric gluconate complex 533

**magnesium salts**

magnesium salts (oral) 593

**phosphate supplements**

potassium phosphate 817  
 potassium and sodium phosphates 815  
 sodium phosphate 932

**potassium supplements**

potassium acetate 819  
 potassium bicarbonate 819  
 potassium chloride, 819  
 potassium citrate 819  
 potassium gluconate 820  
 trikaltes 820

**miscellaneous**

sodium bicarbonate 926  
 sodium chloride 928

**NON-OPIOID ANALGESICS\*****PHARMACOLOGIC PROFILE****General Use:**

Used to control mild to moderate pain and/or fever. Phenazopyridine is used only to treat urinary tract pain, and capsaicin is used topically for a variety of painful syndromes.

**General Action and Information:**

Most non-opioid analgesics inhibit prostaglandin synthesis peripherally for analgesic effect and centrally for antipyretic effect.

**Contraindications:**

Hypersensitivity and cross-sensitivity among NSAIDs may occur.

**Precautions:**

Use cautiously in patients with severe hepatic or renal disease, chronic alcohol use/abuse, or malnutrition. Tramadol has CNS depressant properties.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

### Interactions:

Chronic use of acetaminophen with NSAIDs may increase the risk of adverse renal effects. Chronic high-dose acetaminophen may increase the risk of bleeding with warfarin. Hepatotoxicity may be additive with other hepatotoxic agents, including alcohol. NSAIDs increase the risk of bleeding with warfarin, thrombolytic agents, antiplatelet agents, some cephalosporins, and valproates (effect is greatest with aspirin). NSAIDs may also decrease the effectiveness of diuretics and antihypertensives. The risk of CNS depression with tramadol is increased by concurrent use of other CNS depressants, including alcohol, antihistamines, sedative/hypnotics, and some antidepressants.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Patients who have asthma, allergies, and nasal polyps or who are allergic to tartrazine are at an increased risk for developing hypersensitivity reactions.
- **Pain:** Assess pain and limitation of movement; note type, location, and intensity prior to and at the peak (see Time/Action Profile) following administration.
- **Fever:** Assess fever and note associated signs (diaphoresis, tachycardia, malaise, chills).
- **Lab Test Considerations:** Hepatic, hematologic, and renal function should be evaluated periodically throughout prolonged, high-dose therapy. Aspirin and most NSAIDs prolong bleeding time due to suppressed platelet aggregation and, in large doses, may cause prolonged prothrombin time. Monitor hematocrit periodically in prolonged high-dose therapy to assess for GI blood loss.

### Potential Nursing Diagnoses

- Pain (Indications).
- Body temperature, altered (Indications).
- Knowledge deficit related to medication regimen (Patient/Family Teaching).

### Implementation

- **PO:** Administer salicylates and NSAIDs after meals or with food or an antacid to minimize gastric irritation.

### Patient/Family Teaching

- Instruct patient to take salicylates and NSAIDs with a full glass of water and to remain in an upright position for 15–30 min after administration.
- Adults should not take acetaminophen longer than 10 days and children not longer than 5 days unless directed by health care professional. Short-term doses of acetaminophen with salicylates or NSAIDs should not exceed the recommended daily dose of either drug alone.
- Caution patient to avoid concurrent use of alcohol with this medication to minimize possible gastric irritation; 3 or more glasses of alcohol per day may increase the risk of GI bleeding with salicylates or NSAIDs. Caution patient to avoid taking acetaminophen, salicylates, or NSAIDs concurrently for more than a few days, unless directed by health care professional to prevent analgesic nephropathy.
- Advise patients on long-term therapy to inform health care professional of medication regimen prior to surgery. Aspirin, salicylates, and NSAIDs may need to be withheld prior to surgery.

## Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Relief of mild to moderate discomfort ■ Reduction of fever.

### Non-opioid Analgesics Included in *Davis's Drug Guide for Nurses*

#### **nonsteroidal anti-inflammatory**

##### **drugs**

etodolac 379  
 ibuprofen 499  
 ketorolac 552  
 naproxen P-98

##### **salicylates**

aspirin 903

choline and magnesium salicylates 903

choline salicylate 903

salsalate 903

##### **miscellaneous**

acetaminophen 3  
 phenazopyridine 783  
 tramadol 1011

## NONSTEROIDAL ANTI-INFLAMMATORY AGENTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

NSAIDs are used to control mild to moderate pain, fever, and various inflammatory conditions, such as rheumatoid arthritis and osteoarthritis. Ophthalmic NSAIDs are used to decrease post-operative ocular inflammation, to inhibit perioperative miosis, and to decrease inflammation due to allergies.

#### General Action and Information:

NSAIDs have analgesic, antipyretic, and anti-inflammatory properties. Analgesic and anti-inflammatory effects are due to inhibition of prostaglandin synthesis. Antipyretic action is due to vasodilation and inhibition of prostaglandin synthesis in the CNS.

#### Contraindications:

Hypersensitivity to aspirin is a contraindication for the whole group of NSAIDs. Cross-sensitivity may occur.

#### Precautions:

Use cautiously in patients with a history of bleeding disorders, GI bleeding, and severe hepatic, renal, or cardiovascular disease. Safe use in pregnancy is not established and, in general, should be avoided during the second half of pregnancy.

#### Interactions:

NSAIDs prolong bleeding time and potentiate the effect of warfarin, thrombolytic agents, plicamycin, some cephalosporins, antiplatelet agents, and valproates. Chronic use with aspirin may result in increased GI side effects and decreased effectiveness. NSAIDs may also decrease response to diuretics or antihypertensive therapy.

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## NURSING IMPLICATIONS

### Assessment

- **General Info:** Patients who have asthma, allergies, and nasal polyps or who are allergic to tartrazine are at an increased risk for developing hypersensitivity reactions.
- **Pain:** Assess pain and limitation of movement; note type, location, and intensity prior to and at the peak (see Time/Action Profile) following administration.
- **Fever:** Assess fever and note associated signs (diaphoresis, tachycardia, malaise, chills).
- **Lab Test Considerations:** Most NSAIDs prolong bleeding time due to suppressed platelet aggregation and, in large doses, may cause prolonged prothrombin time. Monitor periodically in prolonged high-dose therapy to assess for GI blood loss.

### Potential Nursing Diagnoses

- Pain (Indications).
- Body temperature, altered (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- PO: Administer NSAIDs after meals or with food or an antacid to minimize gastric irritation.

### Patient/Family Teaching

- Instruct patient to take NSAIDs with a full glass of water and to remain in an upright position for 15–30 min after administration.
- Caution patient to avoid concurrent use of alcohol with this medication to minimize possible gastric irritation; 3 or more glasses of alcohol per day may increase the risk of GI bleeding with salicylates or NSAIDs. Caution patient to avoid taking acetaminophen, salicylates, or NSAIDs concurrently for more than a few days, unless directed by health care professional to prevent analgesic nephropathy.
- Advise patient on long-term therapy to inform health care professional of medication regimen prior to surgery. NSAIDs may need to be withheld prior to surgery.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Relief of mild to moderate discomfort. ■ Reduction of fever.

## Nonsteroidal Anti-inflammatory Agents Included in *Davis's Drug Guide for Nurses*

### **nonsteroidal anti-inflammatory drugs**

aspirin 903  
 celecoxib 166  
 choline and magnesium salicylates 903  
 choline salicylate 903  
 diclofenac 282  
 etodolac 378  
 flurbiprofen 423  
 ibuprofen 499  
 ketoprofen 550

ketorolac 522  
 nabumetone 677  
 naproxen P-98  
 oxaprozin 733  
 piroxicam 807  
 rofecoxib 898  
 salsalate 903  
 sulindac 946  
 tolmetin 1003

### ***ophthalmic NSAIDs***

diclofenac 1164  
flurbiprofen 1164

ketorolac 1164  
suprofen 1164

## OPIOID ANALGESICS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Management of moderate to severe pain. Fentanyl is used as a general anesthetic adjunct.

#### General Action and Information:

Opioids bind to opiate receptors in the CNS, where they act as agonists of endogenously occurring opioid peptides (eukephalins and endorphins). The result is alteration to the perception of and response to pain.

#### Contraindications:

Hypersensitivity to individual agents.

#### Precautions:

Use cautiously in patients with undiagnosed abdominal pain, head trauma or pathology, liver disease, or history of addiction to opioids. Use smaller doses initially in the elderly and those with respiratory diseases. Chronic use may result in tolerance and the need for larger doses to relieve pain. Psychological or physical dependence may occur.

#### Interactions:

Increases the CNS depressant properties of other drugs, including alcohol, antihistamines, anti-depressants, sedative/hypnotics, phenothiazines, and MAO inhibitors. Use of partial-antagonist opioid analgesics (buprenorphine, butorphanol, dezocine, nalbuphine, and pentazocine) may precipitate opioid withdrawal in physically dependent patients. Use with MAO inhibitors or procarbazine may result in severe paradoxical reactions (especially with meperidine). Nalbuphine or pentazocine may decrease the analgesic effects of other concurrently administered opioid analgesics.

### NURSING IMPLICATIONS

#### Assessment

- Assess type, location, and intensity of pain prior to and at peak following administration. When titrating opioid doses, increases of 25–50% should be administered until there is either a 50% reduction in the patient's pain rating on a numerical or visual analogue scale or the patient reports satisfactory pain relief. A repeat dose can be safely administered at the time of the peak if previous dose is ineffective and side effects are minimal. Patients requiring higher doses of opioid agonist-antagonists should be converted to an opioid agonist. Opioid agonist-antagonists are not recommended for prolonged use or as first-line therapy for acute or cancer pain.
- An equianalgesic chart (see Appendix C) should be used when changing routes or when changing from one opioid to another.

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- Assess blood pressure, pulse, and respirations before and periodically during administration. If respiratory rate is  $<10/\text{min}$ , assess level of sedation. Physical stimulation may be sufficient to prevent significant hypoventilation. Dose may need to be decreased by 25–50%. Initial drowsiness will diminish with continued use.
- Assess prior analgesic history. Antagonistic properties of agonist-antagonists may induce withdrawal symptoms (vomiting, restlessness, abdominal cramps, and increased blood pressure and temperature) in patients physically dependent on opioids.
- Prolonged use may lead to physical and psychological dependence and tolerance. This should not prevent patient from receiving adequate analgesia. Most patients who receive opioid analgesics for pain do not develop psychological dependence. Progressively higher doses may be required to relieve pain with long-term therapy.
- Assess bowel function routinely. Prevention of constipation should be instituted with increased intake of fluids and bulk, stool softeners, and laxatives to minimize constipating effects. Stimulant laxatives should be administered routinely if opioid use exceeds 2–3 days, unless contraindicated.
- Monitor intake and output ratios. If significant discrepancies occur, assess for urinary retention and inform physician or other health care professional.
- **Toxicity and Overdose:** If an opioid antagonist is required to reverse respiratory depression or coma, naloxone (Narcan) is the antidote. Dilute the 0.4-mg ampule of naloxone in 10 ml of 0.9% NaCl and administer 0.5 ml (0.02 mg) by direct IV push every 2 min. For children and patients weighing  $<40$  kg, dilute 0.1 mg of naloxone in 10 ml of 0.9% NaCl for a concentration of 10 mcg/ml and administer 0.5 mcg/kg every 1–2 min. Titrate dose to avoid withdrawal, seizures, and severe pain.

### Potential Nursing Diagnoses

- Pain (Indications).
- Sensory-perceptual alteration: visual, auditory (Side Effects).
- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Do not confuse morphine with hydromorphone or meperidine; errors have resulted in fatalities.
- Explain therapeutic value of medication before administration to enhance the analgesic effect.
- Regularly administered doses may be more effective than prn administration. Analgesic is more effective if given before pain becomes severe.
- Coadministration with nonopioid analgesics may have additive analgesic effects and may permit lower doses.
- Medication should be discontinued gradually after long-term use to prevent withdrawal symptoms.

### Patient/Family Teaching

- Instruct patient on how and when to ask for pain medication.
- Medication may cause drowsiness or dizziness. Caution patient to call for assistance when ambulating or smoking and to avoid driving or other activities requiring alertness until response to medication is known.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.
- Caution patient to avoid concurrent use of alcohol or other CNS depressants with this medication.

- Encourage patient to turn, cough, and breathe deeply every 2 hr to prevent atelectasis.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decreased severity of pain without a significant alteration in level of consciousness or respiratory status.

### Opioid Analgesics Included in *Davis's Drug Guide for Nurses*

#### **opioid agonists**

codeine 221  
 fentanyl (parenteral) 391  
 fentanyl (transdermal) 394  
 fentanyl (transmucosal) 1176  
 hydrocodone 482  
 hydromorphone 486  
 meperidine 611  
 methadone 621  
 morphine 666

oxycodone, P-101  
 oxymorphone 1119  
 propoxyphene 847

#### **opioid agonists/antagonists**

buprenorphine 127  
 butorphanol 137  
 dezocine 1120  
 pentazocine 724

## SKELETAL MUSCLE RELAXANTS

### PHARMACOLOGIC PROFILE

#### General Use:

Two major uses are spasticity associated with spinal cord diseases or lesions (baclofen and dantrolene) or adjunctive therapy in the symptomatic relief of acute painful musculoskeletal conditions (cyclobenzaprine, diazepam, and methocarbamol). IV dantrolene is also used to treat and prevent malignant hyperthermia.

#### General Action and Information:

Act either centrally (baclofen, carisoprodol, cyclobenzaprine, diazepam, and methocarbamol) or directly (dantrolene).

#### Contraindications:

Baclofen and oral dantrolene should not be used in patients in whom spasticity is used to maintain posture and balance.

#### Precautions:

Safety in pregnancy and lactation not established. Use cautiously in patients with a previous history of liver disease.

#### Interactions:

Additive CNS depression with other CNS depressants, including alcohol, antihistamines, antidepressants, opioid analgesics, and sedative/hypnotics.

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\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

## NURSING IMPLICATIONS

### Assessment

- Assess patient for pain, muscle stiffness, and range of motion before and periodically throughout therapy.

### Potential Nursing Diagnoses

- Pain (Indications).
- Physical mobility, impaired (Indications).
- Injury, risk for (Side Effects).

### Implementation

- Provide safety measures as indicated. Supervise ambulation and transfer of patients.

### Patient/Family Teaching

- Encourage patient to comply with additional therapies prescribed for muscle spasm (rest, physical therapy, heat).
- Medication may cause drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to drug is known.
- Advise patient to avoid concurrent use of alcohol or other CNS depressants with these medications.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Decreased musculoskeletal pain ■ Decreased muscle spasticity ■ Increased range of motion ■ Prevention or decrease in temperature and skeletal rigidity in malignant hyperthermia.

### Skeletal Muscle Relaxants Included in *Davis's Drug Guide for Nurses*

#### **centrally acting**

baclofen 91  
carisoprodol 157  
chlorzoxazone 195  
cyclobenzaprine 247  
diazepam 279

methocarbamol 626  
orphenadrine 1178

#### **direct-acting**

dantrolene 262

## THROMBOLYTIC AGENTS\*

### PHARMACOLOGIC PROFILE

#### General Use:

Acute management of coronary thrombosis (myocardial infarction). Streptokinase and urokinase are used in the management of massive pulmonary emboli, deep vein thrombosis, and arterial thromboembolism. Alteplase is used in the management of acute ischemic stroke.

### General Action and Information:

Converts plasminogen to plasmin, which then degrades fibrin in clots. Alteplase, reteplase, and urokinase directly activate plasminogen. Anistreplase and streptokinase bind with plasminogen to form activator complexes, which then convert plasminogen to plasmin. Results in lysis of thrombi in coronary arteries, pulmonary emboli, or deep vein thrombosis, or clearing of clots in cannulae/catheters.

### Contraindications:

Hypersensitivity. Cross-sensitivity with anistreplase and streptokinase may occur. Contraindicated in active internal bleeding, history of cerebrovascular accident, recent CNS trauma or surgery, neoplasm, or arteriovenous malformation. Severe uncontrolled hypertension and known bleeding tendencies.

### Precautions:

Recent (within 10 days) major surgery, trauma, GI or GU bleeding. Severe hepatic or renal disease. Subacute bacterial endocarditis or acute pericarditis. Use cautiously in geriatric patients. Safety not established in pregnancy, lactation, or children.

### Interactions:

Concurrent use with aspirin, NSAIDs, warfarin, heparins, abciximab, ticlopidine, or dipyridamole may increase the risk of bleeding, although these agents are frequently used together or in sequence. Risk of bleeding may also be increased by concurrent use with cefamandole, cefotetan, cefoperazone, plicamycin, and valproic acid.

## NURSING IMPLICATIONS

### Assessment

- Begin therapy as soon as possible after the onset of symptoms.
- Monitor vital signs, including temperature, continuously for coronary thrombosis and at least every 4 hr during therapy for other indications. Do not use lower extremities to monitor blood pressure.
- Assess patient carefully for bleeding every 15 min during the 1st hr of therapy, every 15–30 min during the next 8 hr, and at least every 4 hr for the duration of therapy. Frank bleeding may occur from sites of invasive procedures or from body orifices. Internal bleeding may also occur (decreased neurologic status; abdominal pain with coffee-ground emesis or black, tarry stools; hematuria; joint pain). If uncontrolled bleeding occurs, stop medication and notify physician immediately.
- Inquire about previous reaction to anistreplase or streptokinase therapy. Assess patient for hypersensitivity reaction (rash, dyspnea, fever, changes in facial color, swelling around the eyes, wheezing). If these occur, inform physician promptly. Keep epinephrine, an antihistamine, and resuscitation equipment close by in the event of an anaphylactic reaction.
- Inquire about recent streptococcal infection. Anistreplase and streptokinase may be less effective if administered between 5 days and 6 mo of a streptococcal infection.
- Assess neurologic status throughout therapy.
- Altered sensorium or neurologic changes may be indicative of intracranial bleeding.
- **Coronary Thrombosis:** Monitor ECG continuously. Notify physician if significant arrhythmias occur. IV lidocaine or procainamide (Pronestyl) may be ordered prophylactically. Cardiac

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enzymes should be monitored. Radionuclide myocardial scanning and/or coronary angiography may be ordered 7–10 days following therapy to monitor effectiveness of therapy.

- Monitor heart sounds and breath sounds frequently. Inform physician if signs of congestive heart failure occur (rales/crackles, dyspnea, S<sub>3</sub> heart sound, jugular venous distention, relieved CVP).
- Monitor heart sounds and breath sounds frequently. Inform physician if signs of congestive heart failure occur (rales/crackles, dyspnea, S<sub>3</sub> heart sound, jugular venous distention, relieved CVP).
- **Pulmonary Embolism:** Monitor pulse, blood pressure, hemodynamics, and respiratory status (rate, degree of dyspnea, ABGs).
- **Deep Vein Thrombosis/Acture Arterial Occlusion:** Observe extremities and palpate pulses of affected extremities every hour. Notify physician immediately if circulatory impairment occurs. Computerized axial tomography, impedance plethysmography, quantitative Doppler effect determination, and/or angiography or venography may be used to determine restoration of blood flow and duration of therapy; however, repeated venograms are not recommended.
- **Cannula/Catheter Occlusion:** Monitor ability to aspirate blood as indicator of patency. Ensure that patient exhales and holds breath when connecting and disconnecting IV syringe to prevent air embolism.
- **Acute Ischemic Stroke:** Assess neurologic status. Determine time of onset of stroke symptoms. Alteplase must be administered within 3 hr of onset.
- **Lab Test Considerations:** Hematocrit, hemoglobin, platelet count, fibrin/fibrin degradation product (FDP/fdp) titer, fibrinogen concentration, prothrombin time, thrombin time, and activated partial thromboplastin time may be evaluated prior to and frequently throughout therapy. Bleeding time may be assessed prior to therapy if patient has received platelet aggregation inhibitors. Obtain type and crossmatch and have blood available at all times in case of hemorrhage. Stools should be tested for occult blood loss and urine for hematuria periodically during therapy
- **Toxicity and Overdose:** If local bleeding occurs, apply pressure to site. If severe or internal bleeding occurs, discontinue infusion. Clotting factors and/or blood volume may be restored through infusions of whole blood, packed RBCs, fresh frozen plasma, or cryoprecipitate. Do not administer dextran, as it has antiplatelet activity. Aminocaproic acid (Amicar) may be used as an antidote.

### Potential Nursing Diagnoses

- Tissue perfusion (Indications).
- Injury, risk for (Side effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- This medication should be used only in settings in which hematologic function and clinical response can be adequately monitored.
- Starting two IV lines prior to therapy is recommended: one for the thrombolytic agent, the other for any additional infusions.
- Avoid invasive procedures, such as IM injections or arterial punctures, with this therapy. If such procedures must be performed, apply pressure to all arterial and venous puncture sites for at least 30 min. Avoid venipunctures at noncompressible sites (jugular vein, subclavian site).
- Systemic anticoagulation with heparin is usually begun several hours after the completion of thrombolytic therapy.
- Acetaminophen may be ordered to control fever.

### Patient/Family Teaching

- Explain purpose of medication and the need for close monitoring to patient and family. Instruct patient to report hypersensitivity reactions (rash, dyspnea) and bleeding or bruising.
- Explain need for bedrest and minimal handling during therapy to avoid injury. Avoid all unnecessary procedures such as shaving and vigorous tooth brushing.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Lysis of thrombi and restoration of blood flow ■ Prevention of neurologic sequelae in acute ischemic stroke ■ Cannula or catheter patency.

### Thrombolytic Agents Included in *Davis's Drug Guide for Nurses*

alteplase 980	streptokinase 980
anistreplase 980	urokinase 980
reteplase 980	

## VASCULAR HEADACHE SUPPRESSANTS

### PHARMACOLOGIC PROFILE

#### General Use:

Used for acute treatment of vascular headaches (migraine, cluster headaches, migraine variants). Other agents such as some beta-adrenergic blockers and some calcium channel blockers are used for suppression of frequently occurring vascular headaches.

#### General action and information:

Ergot derivative agents (ergotamine, dihydroergotamine) directly stimulate alpha-adrenergic and serotonergic receptors, producing vascular smooth muscle vasoconstriction. Sumatriptan and zolmitriptan produce vasoconstriction by acting as serotonin agonists.

#### Contraindications:

Avoid using these agents in patients with ischemic cardiovascular disease.

#### Precautions:

Use cautiously in patients with a history of or risk for cardiovascular disease.

#### Interactions:

Avoid concurrent use of ergot derivative agents with serotonin agonist agents; see also individual agents.

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## NURSING IMPLICATIONS

### Assessment

- Assess pain location, intensity, duration, and associated symptoms (photophobia, phonophobia, nausea, vomiting) during migraine attack.

### Potential Nursing Diagnoses

- Pain (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### Implementation

- Medication should be administered at the first sign of a headache.

### Patient/Family Teaching

- Inform patient that medication should be used only during a migraine attack. It is meant to be used for relief of migraine attacks but not to prevent or reduce the number of attacks.
- Advise patient that lying down in a darkened room following medication administration may further help relieve headache.
- May cause dizziness or drowsiness. Caution patient to avoid driving or other activities requiring alertness until response to medication is known.
- Advise patient to avoid alcohol, which aggravates headaches.

### Evaluation

**Effectiveness of therapy can be demonstrated by:** ■ Relief of migraine attack.

### Vascular Headache Suppressants Included in *Davis's Drug Guide for Nurses*

#### **ergot derivatives**

dihydroergotamine 357  
ergotamine 357  
naratriptan 688  
rizatriptan 896

#### **serotonin agonists**

sumatriptan 947  
zolmitriptan 1070

## VITAMINS

### PHARMACOLOGIC PROFILE

#### General Use:

Used in the prevention and treatment of vitamin deficiencies and as supplements in various metabolic disorders.

#### General Action and Information:

Serve as components of enzyme systems that catalyze numerous varied metabolic reactions. Necessary for homeostasis. Water-soluble vitamins (B-vitamins and vitamin C ) rarely cause toxicity. Fat-soluble vitamins (vitamins D and E) may accumulate and cause toxicity.

**Contraindications:**

Hypersensitivity to additives, preservatives, or colorants.

**Precautions:**

Dosage should be adjusted to avoid toxicity, especially for fat-soluble vitamins.

**Interactions:**

Pyridoxine in large amounts may interfere with the effectiveness of levodopa. Cholestyramine, colestipol, and mineral oil decrease absorption of fat-soluble vitamins.

**NURSING IMPLICATIONS****Assessment**

- Assess patient for signs of vitamin deficiency before and periodically throughout therapy.
- Assess nutritional status through 24-hr diet recall. Determine frequency of consumption of vitamin-rich foods.

**Potential Nursing Diagnoses**

- Nutrition, altered: less than body requirements (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**Implementation**

- Because of infrequency of single vitamin deficiencies, combinations are commonly administered.

**Patient/Family Teaching**

- Encourage patients to comply with diet recommendations of physician or other health care professional. Explain that the best source of vitamins is a well-balanced diet with foods from the four basic food groups.
- Patients self-medicating with vitamin supplements should be cautioned not to exceed RDA (see Appendix M). The effectiveness of megadoses for treatment of various medical conditions is unproved and may cause side effects and toxicity.

**Evaluation**

**Effectiveness of therapy may be demonstrated by:** ■ Prevention of or decrease in the symptoms of vitamin deficiencies.

**Vitamins Included in *Davis's Drug Guide for Nurses******fat-soluble vitamins***

calcitriol 1050  
 dihydrotachysterol 1050  
 ergocalciferol 1050  
 paricalcitol 1050  
 phytonadione (vitamin K) 795

vitamin D compounds 1050  
 vitamin E 1053

***water-soluble vitamins***

ascorbic acid (vitamin C) 75  
 cyanocobalamin (vitamin B<sub>12</sub>) 1047  
 folic acid 428

\*Because of space limitations, additional classes or drugs not represented in *Davis's Drug Guide for Nurses*, 7th edition, are provided in this *Pocket Companion*.

hydroxocobalamin (vitamin B<sub>12</sub>) 1048  
niacin, niacinamide (vitamin B<sub>3</sub>) 697  
pyridoxine (vitamin B<sub>6</sub>) 863

riboflavin (vitamin B<sub>2</sub>) 883  
thiamine (vitamin B<sub>1</sub>) 974

## SECTION II

### Drugs Not Represented in

### *Davis's Drug Guide for Nurses, 7th Edition\**

#### **CALCITONIN (human)**

(kal-si-toe-nin)  
Cibacalcin

#### **CALCITONIN (salmon)**

Calcimar, Miacalcin, Osteocalcin,  
Salmonine

#### **CLASSIFICATION(S):**

Calcium/phosphorous regulating hormones (hypocalcemic)

#### **Pregnancy Category C**

#### **INDICATIONS**

- **IM, SC:** Treatment of Paget's disease of bone
- Adjunctive therapy for hypercalcemia
- **IM, SC, Intranasal:** Management of postmenopausal osteoporosis.

#### **ACTION**

- Decreases serum calcium by a direct effect on bone, kidney, and GI tract
- Promotes renal excretion of calcium. **Therapeutic Effects:**
- Decreased rate of bone turnover
- Lowering of serum calcium.

#### **PHARMACOKINETICS**

**Absorption:** Completely absorbed from IM and SC sites. Rapidly absorbed from nasal mucosa; absorption is 3% compared with parenteral administration.

**Distribution:** Unknown.

**Metabolism and Excretion:** Rapidly metabolized in kidneys, blood, and tissues.

**Half-life:** 70–90 min.

#### **CONTRAINDICATIONS AND PRECAUTIONS**

**Contraindicated in:** ■ Hypersensitivity to salmon protein or gelatin diluent ■ Pregnancy or lactation (use not recommended).

**Use Cautiously in:** ■ Children (safety not established).

#### **ADVERSE REACTIONS AND SIDE EFFECTS†**

**CNS:** headaches.

**EENT:** *nasal only*—epistaxis, nasal irritation, rhinitis.

**GI:** *IM, SC*—nausea, vomiting, altered taste, diarrhea.

**GU:** *IM, SC*—urinary frequency.

**Derm:** rashes.

**Local:** injection site reactions.

**MS:** *nasal*—arthralgia, back pain.

**Misc:** allergic reactions including **ANAPHYLAXIS**, facial flushing, swelling, tingling, and tenderness in the hands.

#### **INTERACTIONS**

**Drug-Drug:** ■ Previous bisphosphonate therapy, including **alendronate** **etidronate** and **pamidronate** may decrease response to calcitonin.

#### **ROUTE AND DOSAGE**

##### **Postmenopausal osteoporosis**

■ **IM, SC (Adults):** 100 IU/day.

■ **Intranasal (Adults):** 200 IU/day.

##### **Paget's disease**

■ **IM, SC (Adults):** 100 IU/day initially, after titration, maintenance dose is usually 50IU/day or every other day.

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{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

### □ Hypercalcemia

- **IM, SC (Adults):** 4 IU/kg q 12 hr; may be increased after 1–2 days to 8 IU/kg q 12 hr, and if necessary after 2 more days may be increased to 8 IU q 6 hr.

### AVAILABILITY

- **Injection:** 200 IU/ml in 2 ml vials<sup>Rx</sup> ■ **Cost:** \$34.00–53.40/vial
- **Nasal spray:** 200 IU/actuation in 2 ml bottles<sup>Rx</sup> ■ **Cost:** \$56.72/bottle.

### TIME/ACTION PROFILE

	ONSET	PEAK	DURATION
IM, SC*	Unknown	2 hr	6–8 hr
Intranasal†	rapid	31–39 min	Unknown

\*Effects on serum calcium.

†Serum levels of administered calcitonin.

### NURSING IMPLICATIONS

#### ASSESSMENT

- Observe patient for signs of hypersensitivity (skin rash, fever, hives, anaphylaxis, serum sickness). Keep epinephrine, antihistamines, and oxygen nearby in the event of a reaction.
- Assess patient for signs of hypocalcemic tetany (nervousness, irritability, paresthesia, muscle twitching, tetanic spasms, convulsions) during the first several doses of calcitonin. Parenteral calcium, such as calcium gluconate, should be available in case of this event.
- **Lab Test Considerations:** Serum calcium and alkaline phosphatase should be monitored periodically throughout therapy. These levels should normalize within a few months of initiation of therapy.
- Urine hydroxyproline (24 hr) may be monitored periodically in patients with Paget's disease.

#### POTENTIAL NURSING DIAGNOSES

- Pain (Indications).
- Injury, risk for (Indications, Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

#### IMPLEMENTATION

- **General Info:** Assess for sensitivity to calcitonin-salmon by administering an intradermal test dose on the inner aspect of the forearm prior to initiating therapy. Test dose is prepared

in a dilution of 10 IU/ml by withdrawing 0.05 ml in a tuberculin syringe and filling to 1 ml with 0.9% NaCl for injection. Mix well and discard 0.9 ml. Administer 0.1 ml and observe site for 15 min. More than mild erythema or wheal constitutes positive response.

- Store solution in refrigerator.
- **IM, SC:** Inspect injection site for the appearance of redness, swelling, or pain. Rotate injection sites. SC is the preferred route. Use IM route if dose exceeds 2 ml in volume. Use multiple sites to minimize inflammatory reaction.
- Do not administer solutions that are discolored or contain particulate matter.

#### PATIENT/FAMILY TEACHING

- **General Info:** Advise patient to take medication exactly as directed. If dose is missed and medication is scheduled for twice a day, take only if possible within 2 hr of correct time. If scheduled for daily dose, take only if remembered that day. If scheduled for every other day, take when remembered and restart alternate day schedule. If taking 1 dose 3 times weekly (Mon, Wed, Fri), take missed dose the next day and set each injection back 1 day; resume regular schedule the following week. Do not double doses.
- Instruct patient in the proper method of self-injection.
- Advise patient to report signs of hypercalcemic relapse (deep bone or flank pain, renal calculi, anorexia, nausea, vomiting, thirst, lethargy) or allergic response promptly.
- Reassure patient that flushing and warmth following injection are transient and usually last about 1 hr.
- Explain that nausea following injection tends to decrease even with continued therapy.
- Instruct patient to follow low-calcium diet if recommended by health care professional (see Appendix L). Women with postmenopausal osteoporosis should adhere to a diet high in calcium and vitamin D.
- **Osteoporosis:** Advise patients receiving calcitonin for the treatment of osteoporosis that exercise has been found to arrest and reverse bone loss. The patient should discuss any exercise limitations with health care professional before beginning program.

- **Intranasal:** Instruct patient on correct use of nasal spray. Before first use, activate pump by holding upright and depressing white side arms down toward bottle 6 times until a fine spray is emitted. Following activation, place nozzle firmly in nostril with head in an upright position and depress the pump toward the bottle.
- Advise patient to notify health care professional if significant nasal irritation occurs.

**EVALUATION**

**Effectiveness of therapy can be demonstrated by:** ■ Lowered serum calcium levels ■ Decreased bone pain ■ Slowed progression of postmenopausal osteoporosis. Significant increases in bone marrow density may be seen as early as a month after initiation of therapy.

**FEXOFENADINE**  
(fex-oh-fen-a-deen)  
Allegra

**CLASSIFICATION(S):**  
*Antihistamines*

**Pregnancy Category C**

**INDICATIONS**

- Relief of symptoms of seasonal allergic rhinitis.

**ACTION**

■ Antagonizes the effects of histamine at peripheral histamine-1 (H) receptors, including pruritus and urticaria ■ Also has a drying effect on the nasal mucosa. **Therapeutic Effects:** ■ Decreased sneezing, rhinorrhea, itchy eyes, nose, and throat associated with seasonal allergies.

**PHARMACOKINETICS**

**Absorption:** Rapidly absorbed after oral administration.  
**Distribution:** Unknown.  
**Metabolism and Excretion:** 80% excreted in urine, 11% excreted in feces.  
**Half-life:** 14.4 hr (increased in renal impairment).

**CONTRAINDICATIONS AND PRECAUTIONS**

**Contraindicated in:** ■ Hypersensitivity.  
**Use Cautiously in:** ■ Impaired renal function (increased dosing interval recommended)  
 ■ Pregnancy, lactation, or children <12 yr (safety not established).

**ADVERSE REACTIONS AND SIDE EFFECTS†**

**CNS:** drowsiness, fatigue.  
**GI:** dyspepsia.  
**Endo:** dysmenorrhea.

**INTERACTIONS**

**Drug-Drug:** ■ None significant.

**ROUTE AND DOSAGE**

- **PO (Adults and Children ≥12 yr):** 60 mg twice daily.
- **Renal Impairment**
- **PO (Adults):** 60 mg once daily.

**AVAILABILITY**

■ **Capsules:** 60 mg<sup>Rx</sup> ■ **Cost:** \$99.42/100 ■ **In combination with:** pseudoephedrine (Allegra-D<sup>Rx</sup>). See Appendix B.

**TIME/ACTION PROFILE (antihistaminic effect)**

	ONSET	PEAK	DURATION
PO	within 1 hr	2–3 hr	12 hr

**NURSING IMPLICATIONS**

**ASSESSMENT**

- Assess allergy symptoms (rhinitis, conjunctivitis, hives) before and periodically throughout therapy.
- Assess lung sounds and character of bronchial secretions. Maintain fluid intake of 1500–2000 ml/day to decrease viscosity of secretions.
- **Lab Test Considerations:** Will cause false-negative reactions on allergy skin tests; discontinue 3 days before testing.

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

**POTENTIAL NURSING DIAGNOSES**

- Ineffective airway clearance (Indications).
- Injury, risk for (Adverse Reactions).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

**IMPLEMENTATION**

- **PO:** Administer with food or milk to decrease GI irritation.

**PATIENT/FAMILY TEACHING**

- Instruct patient to take medication as directed. If a dose is missed, take as soon as remembered unless almost time for next dose.
- Inform patient that drug may cause drowsiness, although it is less likely to occur than with other antihistamines. Avoid driving or other activities requiring alertness until response to drug is known.
- Instruct patient to contact health care professional if symptoms persist.

**EVALUATION**

Effectiveness of therapy can be demonstrated by: ■ Decrease in allergic symptoms.

**METHYLDOPA**

(meth-ill-doe-pa)

Aldomet, {Apo-Methyldopa}, {Dopamet}, {Novamedopa}, {Nu-Medopa}

**CLASSIFICATION(S):**

*Antihypertensive agents (centrally acting alpha-adrenergic agonist)*

**Pregnancy Category B**

**INDICATIONS**

- Management of moderate to severe hypertension (with other agents).

**ACTION**

■ Stimulates CNS alpha-adrenergic receptors, producing a decrease in sympathetic outflow to heart, kidneys, and blood vessels. Result is decreased blood pressure and peripheral resistance, a slight decrease in heart rate, and no change in cardiac output. **Therapeutic Effects:** ■ Lowering of blood pressure.

**PHARMACOKINETICS**

**Absorption:** 50% absorbed from the GI tract. Parenteral form, methyldopate hydrochloride, is slowly converted to methyldopa.

**Distribution:** Crosses the blood-brain barrier. Crosses the placenta; small amounts enter breast milk.

**Metabolism and Excretion:** Partially metabolized by the liver, partially excreted unchanged by the kidneys.

**Half-life:** 1.7 hr.

**CONTRAINDICATIONS AND PRECAUTIONS**

**Contraindicated in:** ■ Hypersensitivity ■ Active liver disease ■ Some products contain alcohol or bisulfites and should be avoided in patients with known intolerance.

**Use Cautiously in:** ■ Previous history of liver disease ■ Geriatric patients (increased risk of adverse reactions) ■ Pregnancy (has been used safely) ■ Lactation.

**ADVERSE REACTIONS AND SIDE EFFECTS†**

**CNS:** sedation, decreased mental acuity, depression.

**EENT:** nasal stuffiness.

**CV:** MYOCARDITIS, bradycardia, edema, orthostatic hypotension.

**GI:** DRUG-INDUCED HEPATITIS, diarrhea, dry mouth.

**GU:** impotence.

**Hemat:** eosinophilia, hemolytic anemia.

**Misc:** fever.

**INTERACTIONS**

**Drug-Drug:** ■ Additive hypotension with other antihypertensive agents, acute ingestion of alcohol, anesthesia, and nitrates

■ Amphetamines, barbiturates, tricyclic antidepressants, NSAIDs, and phenothiazines may decrease antihypertensive effect of methyldopa ■ Increased effects and risk of psychoses with haloperidol ■ Excess sympathetic stimulation may occur with concurrent use of MAO inhibitors or sympathomimetics ■ May increase the effects of tolbutamide ■ May increase lithium toxicity ■ Additive hypotension and CNS toxicity with levodopa ■ Additive CNS depression may occur with alcohol, antihistamines, sedative/hypnotics, some antidepressants, and opioids ■ Concurrent use with

**nonselective beta-blockers** may rarely cause paradoxical hypertension.

## ROUTE AND DOSAGE

- **PO (Adults):** 250–500 mg 2–3 times daily (not to exceed 500 mg/day if used with other agents); may be increased q 2 days as needed; usual maintenance dose is 500 mg–2 g/day (not to exceed 3 g/day).
- **PO (Children):** 10 mg/kg/day (300 mg/m<sup>2</sup>/day); may be increased q 2 days up to 65 mg/kg/day in divided doses (not to exceed 3 g/day).
- **IV (Adults):** 250–500 mg q 6 hr (up to 1 g q 6 hr).
- **IV (Children):** 5–10 mg/kg q 6 hr; up to 65 mg/kg/day in divided doses (not to exceed 3 g/day).

## AVAILABILITY

- **Tablets:** 125 mg<sup>Rx</sup>, 250 mg<sup>Rx</sup>, 500 mg<sup>Rx</sup> ■ **Cost:** *Aldomet*—125 mg \$29.85/100, 250 mg \$38/100, 500 mg \$69.44/100; *generic*—125 mg \$9.75–\$26.72/100, 250 mg \$12.50–\$34.01/100, 500 mg \$22.50–\$62.25/100
- **Oral suspension (orange-pineapple flavor):** 250 mg/5 ml<sup>Rx</sup> ■ **Injection:** 250 mg/5 ml in 5- and 10-ml vials<sup>Rx</sup> ■ **In combination with:** hydrochlorothiazide (Aldoril)<sup>Rx</sup> or chlorothiazide (Aldoclor)<sup>Rx</sup>. See Appendix B.

## TIME/ACTION PROFILE (antihypertensive effect)

	ONSET	PEAK	DURATION
PO	12–24 hr	4–6 hr	24–48 hr
IV	4–6 hr	unknown	10–16 hr

## NURSING IMPLICATIONS

### ASSESSMENT

- Monitor blood pressure and pulse frequently during initial dosage adjustment and periodically throughout therapy. Report significant changes.
- Monitor frequency of prescription refills to determine compliance.
- Monitor intake and output ratios and weight and assess for edema daily, especially at beginning of therapy. Report weight gain or

edema; sodium and water retention may be treated with diuretics.

- Assess patient for depression or other alterations in mental status. Notify physician or other health care professional promptly if these symptoms develop.
- Monitor temperature during therapy. Drug fever may occur shortly after initiation of therapy and may be accompanied by eosinophilia and hepatic function changes. Monitor hepatic function test if unexplained fever occurs.
- **Lab Test Considerations:** Renal and hepatic function and CBC should be monitored before and periodically throughout therapy.
- Monitor direct Coombs' test before and after 6 and 12 mo of therapy. May cause a positive direct Coombs' test, rarely associated with hemolytic anemia.
- May cause increased BUN, serum creatinine, potassium, sodium, prolactin, uric acid, AST, ALT, alkaline phosphatase, and bilirubin concentrations.
- May cause prolonged prothrombin times.
- May interfere with serum creatinine and AST measurements.

### POTENTIAL NURSING DIAGNOSES

- Injury, risk for (Side Effects).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).
- Noncompliance (Patient/Family Teaching).

### IMPLEMENTATION

- **General Info:** Fluid retention and expanded volume may cause tolerance to develop within 2–3 mo after initiation of therapy. Diuretics may be added to regimen at this time to maintain control.
- Dosage increases should be made with the evening dose to minimize drowsiness.
- When changing from IV to oral forms, dosage should remain consistent.
- **PO:** Shake suspension before administration.
- **Intermittent Infusion:** Dilute in 100 ml of D5W, 0.9% NaCl, D5/0.9% NaCl, 5% sodium bicarbonate, or Ringer's solution.
- **Rate:** Infuse slowly over 30–60 min.

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

- **Y-Site Compatibility:** ♦ esmolol ♦ heparin ♦ meperidine ♦ morphine ♦ theophylline.

**PATIENT/FAMILY TEACHING**

- Emphasize the importance of continuing to take this medication, even if feeling well. Instruct patient to take medication at the same time each day; last dose of the day should be taken at bedtime. If a dose is missed, take as soon as remembered but not if almost time for next dose. Do not double doses.
- Encourage patient to comply with additional interventions for hypertension (weight reduction, low-sodium diet, smoking cessation, moderation of alcohol consumption, regular exercise, and stress management). Methyl-dopa controls but does not cure hypertension.
- Instruct patient and family on proper technique for monitoring blood pressure. Advise them to check blood pressure at least weekly and to report significant changes.
- Inform patient that urine may darken or turn red-black when left standing.
- May cause drowsiness. Advise patient to avoid driving or other activities requiring alertness until response to medication is known. Drowsiness usually subsides after 7–10 days of continuous use.
- Caution patient to avoid sudden changes in position to decrease orthostatic hypotension.
- Advise patient that frequent mouth rinses, good oral hygiene, and sugarless gum or candy may minimize dry mouth. Notify health care professional if dry mouth continues for >2 wk.
- Caution patient to avoid concurrent use of alcohol or other CNS depressants.
- Advise patient to consult health care professional before taking any cough, cold, or allergy remedies.
- Advise patient to notify health care professional of medication regimen before treatment or surgery.
- Instruct patient to notify health care professional if fever, muscle aches, or flu-like syndrome occurs.

**EVALUATION**

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in blood pressure without appearance of side effects.

**NAPROXEN**

(na-prox-en)  
 {Apo-Naproxen}, EC-Naprosyn, Naprelan, Napron X, Naprosyn, {Naprosyn-E}, {Naprosyn-SR}, {Naxen}, {Novo-Naprox}, {Novo-Naprox Sodium}, {Nu-Naprox}

**NAPROXEN SODIUM**

(na-prox-en soe-dee-um)  
 Aleve, Anaprox, Anaprox DS, {Apo-Napro-Na}, Apo-Napro-Na DS, Naprelan, {Novo-Naprox Sodium}, {Novo-Naprox Sodium DS}, {Synflex}, {Synflex DS}

**CLASSIFICATION(S):**  
*Non-opioid analgesics, Nonsteroidal anti-inflammatory agents*

**Pregnancy Category B (first trimester)**

**INDICATIONS**

- Mild to moderate pain
- Dysmenorrhea
- Fever
- Inflammatory disorders, including: □ Rheumatoid arthritis □ Osteoarthritis.

**ACTION**

- Inhibit prostaglandin synthesis. **Therapeutic Effects:** ■ Decreased pain ■ Reduction of fever ■ Suppression of inflammation.

**PHARMACOKINETICS**

**Absorption:** Completely absorbed from the GI tract. Sodium salt (Anaprox) is more rapidly absorbed.  
**Distribution:** Crosses the placenta; enters breast milk in low concentrations.  
**Protein Binding:** >99%  
**Metabolism and Excretion:** Mostly metabolized by the liver.  
**Half-life:** 10–20 hr.

**CONTRAINDICATIONS AND PRECAUTIONS**

- Contraindicated in:** ■ Hypersensitivity ■ Cross-sensitivity may occur with other NSAIDs, including aspirin ■ Active GI bleeding ■ Ulcer disease.

**Use Cautiously in:** ■ Severe cardiovascular, renal, or hepatic disease ■ History of ulcer disease ■ Chronic alcohol use/abuse ■ Pregnancy or lactation (safety not established; avoid using during 2nd half of pregnancy).

## ADVERSE REACTIONS AND SIDE EFFECTS†

**CNS:** dizziness, drowsiness, headache.

**EENT:** tinnitus.

**Resp:** dyspnea.

**CV:** edema, palpitations, tachycardia.

**GI:** DRUG-INDUCED HEPATITIS, GI BLEEDING, constipation, dyspepsia, nausea, anorexia, diarrhea, discomfort, flatulence, vomiting.

**GU:** cystitis, hematuria, renal failure.

**Derm:** photosensitivity, rashes, sweating.

**Hemat:** blood dyscrasias, prolonged bleeding time.

**Misc:** allergic reactions including ANAPHYLAXIS.

## INTERACTIONS

**Drug-Drug:** ■ Concurrent use with **aspirin** decreases naproxen blood levels and may decrease effectiveness ■ Increased risk of bleeding with **anticoagulants**, **thrombolytic agent** **sepsitibiditirofiban**, **cefamandole**, **cefotetan**, **cefoperazone**, **valproic acid**, **clopidogrel**, **clopidinepicamycin** ■ Additive adverse GI side effects with **aspirin**, **corticosteroids**, and other **NSAIDs** ■ **Probenecid** increases blood levels and may increase toxicity ■ Increased risk of photosensitivity with other **photosensitizing agents** ■ May increase the risk of toxicity from **methotrexate**, **antineoplastic agents**, or **radiation therapy** ■ May increase serum levels and risk of toxicity from **lithium** ■ Increased risk of adverse renal effects with **cyclosporine** or chronic use of **acetaminophen** ■ May decrease response to **antihypertensives** or **diuretics** ■ May increase risk of hypoglycemia with **insulin** or **oral hypoglycemic agents**.

## ROUTE AND DOSAGE

275 mg naproxen sodium is equivalent to 250 mg naproxen.

## □ Anti-inflammatory/Analgesic/ Antidysmenorrheal

■ **PO (Adults):** *Naproxen*—250–500 mg naproxen bid (up to 1.5 g/day). *Delayed-release naproxen*—375–500 mg twice daily. *Naproxen sodium*—275–550 mg twice daily (up to 1.65 g/day).

■ **PO (Children):** 5 mg/kg/day twice daily as naproxen suspension.

## □ Antigout

■ **PO (Adults):** *Naproxen*—750 mg naproxen initially, then 250 mg q 8 hr. *Naproxen sodium*—825 mg initially, then 275 mg q 8 hr.

## □ OTC Use

■ **PO (Adults):** 200 mg q 8–12 hr or 400 mg followed by 200 mg q 12 hr (not to exceed 600 mg/24 hr).

■ **PO (Geriatric Patients >65 yr):** Not to exceed 200 mg q 12 hr.

## AVAILABILITY

### □ Naproxen (generic available)

■ **Tablets (*Naprosyn*, {*Apo-Naproxen*, *Naxen*, *Novo-Naprox*, *Nu-Naprox*}):** {125 mg<sup>Rx</sup>, 250 mg<sup>Rx</sup>, 375 mg<sup>Rx</sup>, 500 mg<sup>Rx</sup>}

■ **Controlled-release tablets (*Naprelan*):** 375 mg<sup>Rx</sup>, 500 mg<sup>Rx</sup> ■ **Delayed-release tablets (*EC-Naprosyn*, {*Naprosyn-E*}):** {250 mg<sup>Rx</sup>, 375 mg<sup>Rx</sup>, 500 mg<sup>Rx</sup>}

■ **Extended-release tablets (*Naprosyn-SR*):** {750 mg<sup>Rx</sup>}

■ **Oral suspension (*Naprosyn*):** 125 mg/5 ml<sup>Rx</sup> ■ **Suppositories (*Naprosyn*, {*Naxen*}):** {500 mg<sup>Rx</sup>}

### □ Naproxen Sodium

■ **Tablets (*Aleve*, *Anaprox*, *Anaprox DS*, {*Apo-Napro-Na*, *Novo-Naprox Sodium*, *Novo-Naprox Sodium DS*, *Synaflex*, *Synaflex DS*}):** 220 mg<sup>OTC</sup>, 275 mg<sup>Rx</sup>, 550 mg<sup>Rx</sup>.

## TIME/ACTION PROFILE

	ONSET	PEAK	DURATION
PO (analgesic)	1 hr	Unknown	up to 7 hr
PO (anti-inflammatory)	14 days	2–4 wk	Unknown

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

## NURSING IMPLICATIONS

### ASSESSMENT

- **General Info:** Patients who have asthma, aspirin-induced allergy, and nasal polyps are at increased risk for developing hypersensitivity reactions. Assess for rhinitis, asthma, and urticaria.
- **Pain:** Assess pain (note type, location, and intensity) prior to and 1–2 hr following administration.
- **Arthritis:** Assess pain and range of motion prior to and 1–2 hr following administration.
- **Fever:** Monitor temperature; note signs associated with fever (diaphoresis, tachycardia, malaise).
- **Lab Test Considerations:** BUN, serum creatinine, CBC, and liver function tests should be evaluated periodically in patients receiving prolonged courses of therapy.
- Serum potassium, BUN, serum creatinine, alkaline phosphatase, LDH, AST, and ALT tests may show increased levels. Blood glucose, hemoglobin, and hematocrit concentrations, leukocyte and platelet counts, and CCR may be decreased.
- Bleeding time may be prolonged up to 4 days following discontinuation of therapy.
- May alter test results for urine 5-HIAA and urine steroid determinations.

### POTENTIAL NURSING DIAGNOSES

- Pain (Indications).
- Impaired physical mobility (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### IMPLEMENTATION

- **General Info:** Administration in higher than recommended doses does not provide increased effectiveness but may cause increased side effects.
- Coadministration with opioid analgesics may have additive analgesic effects and may permit lower opioid doses.
- Analgesic is more effective if given before pain becomes severe.
- **PO:** For rapid initial effect, administer 30 min before or 2 hr after meals. May be administered with food, milk, or antacids to decrease GI irritation. Food slows but does not reduce the

extent of absorption. Do not mix suspension with antacid or other liquid prior to administration.

- **Dysmenorrhea:** Administer as soon as possible after the onset of menses. Prophylactic treatment has not been shown to be effective.

### PATIENT/FAMILY TEACHING

- Advise patient to take this medication with a full glass of water and to remain in an upright position for 15–30 min after administration.
- Instruct patient to take medication exactly as directed. If a dose is missed, it should be taken as soon as remembered but not if almost time for the next dose. Do not double doses.
- May cause drowsiness or dizziness. Advise patient to avoid driving or other activities requiring alertness until response to the medication is known.
- Caution patient to avoid the concurrent use of alcohol, aspirin, acetaminophen, or other OTC medications without consulting health care professional. Use of naproxen with 3 or more glasses of alcohol per day may increase risk of GI bleeding.
- Advise patient to inform health care professional of medication regimen prior to treatment or surgery.
- Caution patient to wear sunscreen and protective clothing to prevent photosensitivity reactions.
- Instruct patients not to take OTC naproxen preparations for more than 3 days for fever and to consult health care professional if symptoms persist or worsen.
- Advise patient to consult health care professional if rash, itching, visual disturbances, tinnitus, weight gain, edema, black stools, persistent headache, or influenza-like syndrome (chills, fever, muscle aches, pain) occurs.

### EVALUATION

- Effectiveness of therapy can be demonstrated by:**
- Relief of pain
  - Improved joint mobility. Partial arthritic relief is usually seen within 2 wk, but maximum effectiveness may require 2–4 wk of continuous therapy. Patients who do not respond to one NSAID may respond to another
  - Reduction of fever.

**OXYCODONE**

(ox-i-koe-done)

Endocodone, Oxycontin, OxyFAST, OxyIR, Percolone, Roxicodone, Roxicodone SR, {Supeudol}

**OXYCODONE/ACETAMINOPHEN**

(See also acetaminophen monograph on page 3.)

{Endocet}, {Oxycocet}, Percocet, {Percocet}, Roxicet, Roxilox, Tylox

**OXYCODONE/ASPIRIN**

(See also salicylates monograph on page 903.)

{Endodan}, {Oxycodan}, Percodan, Percodan-Demi, Roxiprin

**CLASSIFICATION(S):**

*Opioid analgesic (agonist)*

**Pregnancy Category C (oxycodone alone)**

**INDICATIONS**

- Management of moderate to severe pain.

**ACTION**

- Bind to opiate receptors in the CNS
- Alter the perception of and response to painful stimuli, while producing generalized CNS depression.

**Therapeutic Effects:** ■ Decreased pain.

**PHARMACOKINETICS**

**Absorption:** Well absorbed from the GI tract.

**Distribution:** Widely distributed. Cross the placenta; enter breast milk.

**Metabolism and Excretion:** Mostly metabolized by the liver.

**Half-life:** 2–3 hr.

**CONTRAINDICATIONS AND PRECAUTIONS**

- Contraindicated in:** ■ Hypersensitivity
- Pregnancy or lactation (avoid chronic use)
  - Some products contain alcohol or bisulfites and should be avoided in patients with known intolerance or hypersensitivity.

- Use Cautiously in:** ■ Head trauma
- Increased intracranial pressure
  - Severe renal, hepatic, or pulmonary disease
  - Hypothyroidism
  - Adrenal insufficiency
  - Alcoholism
  - Geriatric or debilitated patients (initial dosage reduction recommended)
  - Undiagnosed abdominal pain
  - Prostatic hypertrophy.

**ADVERSE REACTIONS AND SIDE EFFECTS**

**CNS:** confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, headache, unusual dreams.

**EENT:** blurred vision, diplopia, miosis.

**Resp:** RESPIRATORY DEPRESSION.

**CV:** orthostatic hypotension.

**GI:** constipation, dry mouth, nausea, vomiting.

**GU:** urinary retention.

**Derm:** flushing, sweating.

**Misc:** physical dependence, psychological dependence, tolerance.

**INTERACTIONS**

- Drug-Drug:** ■ Use with caution in patients receiving MAO inhibitors (may result in unpredictable reactions—decrease initial dose of oxycodone to 25% of usual dose)
- Additive CNS depression with alcohol, antihistamines, and sedative/hypnotics
  - Administration of partial-antagonist opioid analgesics may precipitate withdrawal in physically dependent patients
  - Nalbuphine, buprenorphine, dezocine, or pentazocine may decrease analgesia.

**ROUTE AND DOSAGE**

Larger doses may be required during chronic therapy. Consider cumulative effects of additional acetaminophen/aspirin; if toxic levels are exceeded, change to pure oxycodone product.

- **PO (Adults ≥ 50 kg):** 5–10 mg q 3–4 hr initially, as needed. Controlled-release tablets (Oxycontin) may be given q 12 hr.
- **PO (Adults < 50 kg or Children):** 0.2 mg/kg q 3–4 hr initially, as needed.
- **Rect (Adults):** 10–40 mg 3–4 times daily initially, as needed.

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

## AVAILABILITY

## □ Oxycodone

■ **Tablets:** 5 mg (Percolone, Roxicodone, Supedul)<sup>Rx</sup> ■ **Cost:** *Percolone*—68.75/100; *Roxicodone*—\$31.04/100; *generic*—\$27.00–41.99/100 ■ **Immediate-release capsules:** 5 mg (OxyIR)<sup>Rx</sup> ■ **Controlled-release tablets:** 10 mg<sup>Rx</sup>, 20<sup>Rx</sup>, 40 mg<sup>Rx</sup>, 80 mg (Oxycontin, Roxicodone SR)<sup>Rx</sup>, 160 mg (Oxycontin) ■ **Cost:** *Oxycontin*—10 mg \$117.10/100, 20 mg \$224.11/100, 40 mg \$397.66/100, 80 mg \$747.79/100; *Roxicodone SR*—■ **Oral solution (burgundy cherry):** 5 mg/5 ml in 500-ml bottle (Roxicodone)<sup>Rx</sup> ■ **Cost:** 41.65/500 ml

■ **Concentrated oral solution:** 20 mg/ml in 30-ml bottle with dropper (Roxicodone Intensol, OxyFAST)<sup>Rx</sup> ■ **Cost:** *Roxicodone Intensol* 40.56/30 ml; *OxyFAST*—\$33.75/30 ml

## □ Oxycodone/Acetaminophen

■ **Tablets:** 2.5 mg oxycodone with 325 mg acetaminophen (Percocet 2.5)<sup>Rx</sup>, 5 mg oxycodone with 325 mg acetaminophen (Endocet, Oxyset, Percocet, Roxicet)<sup>Rx</sup>, 7.5 mg oxycodone with 500 mg acetaminophen (Percocet 7.5)<sup>Rx</sup>, 10 mg oxycodone with 650 mg acetaminophen (Percocet 10)<sup>Rx</sup> ■ **Cost:** *Endocet*—\$25.73/100, *Percocet 5*—\$83.75/100, *Roxicet*—\$25.73/100,

■ **Capsules:** 5 mg oxycodone with 500 mg acetaminophen (Roxilox, Tylox)<sup>Rx</sup> ■ **Cost:** *Roxilox*—\$57.72/100; *Tylox*—\$87.35/100

■ **Caplets:** 5 mg oxycodone with 500 mg acetaminophen (Roxicet 5/500)<sup>Rx</sup> ■ **Cost:** \$57.60/100 ■ **Oral solution (mint):** 5 mg oxycodone with 325 mg acetaminophen/5 ml (Roxicet Solution) in 500-ml bottles<sup>Rx</sup> ■ **Cost:** \$37.37/500 ml.

## □ Oxycodone/Aspirin

■ **Tablets:** 2.44 mg oxycodone with 325 mg aspirin (Percodan-Demi)<sup>Rx</sup>, 4.88 mg oxycodone with 325 mg aspirin (Endodan, Oxycodan, Percodan, Roxiprin)<sup>Rx</sup>.

## TIME/ACTION PROFILE (analgesic effects)

	ONSET	PEAK	DURATION
PO	10–15 min	60–90 min	3–6 hr
PO-CR	10–15 min	3 hr	12 hr

## NURSING IMPLICATIONS

## ASSESSMENT

- Assess type, location, and intensity of pain prior to and 1 hr (peak) after administration. When titrating opioid doses, increases of 25–50% should be administered until there is either a 50% reduction in the patient's pain rating on a numerical or visual analogue scale or the patient reports satisfactory pain relief. A repeat dose can be safely administered at the time of the peak if previous dose is ineffective and side effects are minimal.
- Patients taking controlled-release tablets should also be given supplemental short-acting opioid doses for breakthrough pain.
- An equianalgesic chart (see Appendix C) should be used when changing routes or when changing from one opioid to another.
- Assess blood pressure, pulse, and respirations before and periodically during administration. If respiratory rate is <10/min, assess level of sedation. Physical stimulation may be sufficient to prevent significant hypoventilation. Dose may need to be decreased by 25–50%. Initial drowsiness will diminish with continued use.
- Prolonged use may lead to physical and psychological dependence and tolerance. This should not prevent patient from receiving adequate analgesia. Most patients who receive oxycodone for pain do not develop psychological dependence. Progressively higher doses may be required to relieve pain with long-term therapy.
- Assess bowel function routinely. Prevention of constipation should be instituted with increased intake of fluids and bulk, and laxatives to minimize constipating effects. Stimulant laxatives should be administered routinely if opioid use exceeds 2–3 days, unless contraindicated.
- **Lab Test Considerations:** May increase plasma amylase and lipase levels.
- **Toxicity and Overdose:** If an opioid antagonist is required to reverse respiratory depression or coma, naloxone (Narcan) is the antidote. Dilute the 0.4-mg ampule of naloxone in 10 ml of 0.9% NaCl and administer 0.5 ml (0.02 mg) by direct IV push every 2 min. For children and patients weighing <40 kg, dilute 0.1 mg of naloxone in 10 ml of 0.9%

NaCl for a concentration of 10 mcg/ml and administer 0.5 mcg/kg every 2 min. Titrate dose to avoid withdrawal, seizures, and severe pain.

## POTENTIAL NURSING DIAGNOSES

- Pain (Indications).
- Sensory-perceptual alterations visual, auditory (Side Effects).
- Injury, risk for (Side Effects).

## IMPLEMENTATION

- **General Info:** Explain therapeutic value of medication prior to administration to enhance the analgesic effect.
- Regularly administered doses may be more effective than prn administration. Analgesic is more effective if given before pain becomes severe.
- Coadministration with nonopioid analgesics may have additive analgesic effects and may permit lower doses.
- Medication should be discontinued gradually after long-term use to prevent withdrawal symptoms.
- **PO:** May be administered with food or milk to minimize GI irritation.
- Administer solution with properly calibrated measuring device.
- Controlled-release tablets should be swallowed whole; do not crush, break, or chew.
- **Controlled Release:** Dose should be based on 24-hr opioid requirement determined with short-acting opioids then converted to controlled-release form.

## PATIENT/FAMILY TEACHING

- Instruct patient on how and when to ask for pain medication.
- Medication may cause drowsiness or dizziness. Advise patient to call for assistance when ambulating or smoking. Caution patient to avoid driving and other activities requiring alertness until response to medication is known.
- Advise patients taking Oxycontin tablets that empty matrix tablets may appear in stool.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.

- Advise patient to avoid concurrent use of alcohol or other CNS depressants with this medication.
- Encourage patient to turn, cough, and breathe deeply every 2 hr to prevent atelectasis.

## EVALUATION

**Effectiveness of therapy can be demonstrated by:** ■ Decrease in severity of pain without a significant alteration in level of consciousness or respiratory status.

## QUININE (kwi-nine)

**CLASSIFICATION(S):**  
*Anti-infective agents (antimalarial)*

**Pregnancy Category X**

## INDICATIONS

■ Combination with other agents in the treatment of chloroquine-resistant malaria. **Unlabeled Uses:** ■ Prophylaxis and treatment of nocturnal recumbency leg cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

## ACTION

■ Disrupts metabolism of the erythrocytic phase of *Plasmodia falciparum* ■ Increases the refractory period of skeletal muscle, increases the distribution of calcium within muscle fibers, decreases the excitability of motor end-plate regions, resulting in decreased response to repetitive nerve stimulation and acetylcholine. **Therapeutic Effects:** ■ Death of *P. falciparum* ■ Decreased severity of leg cramps.

## PHARMACOKINETICS

**Absorption:** Rapidly and almost completely (80%) absorbed following oral administration.

**Distribution:** Varies with condition and patient; does not enter CSF well. Crosses the placenta and enters breast milk.

**Protein Binding:** >90% in patients with cerebral malaria, pregnant women and children, 85–

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

90% in patients with uncomplicated malaria, 70% in healthy adults.

**Metabolism and Excretion:** >80% metabolized by the liver; metabolites have less activity than quinine; metabolites excreted in urine. 20% excreted unchanged in urine. Excretion increased in acidic urine.

**Half-life:** 11 hr (increased in patients with malaria).

## CONTRAINDICATIONS AND PRECAUTIONS

**Contraindicated in:** ■ Hypersensitivity  
■ Pregnancy or lactation.

**Use Cautiously in:** ■ Recurrent or interrupted malaria therapy ■ History of arrhythmias, especially QT prolongation ■ G6PD deficiency ■ Hypoglycemia ■ Myasthenia gravis ■ History of thrombocytopenic purpura.

## ADVERSE REACTIONS AND SIDE EFFECTS†

**GI:** abdominal cramps/pain, diarrhea, nausea, vomiting, hepatotoxicity.

**Derm:** rash.

**Endo:** hypoglycemia.

**Hemat:** bleeding, blood dyscrasias.

**Misc:** cinchonism, hypersensitivity reactions including fever and HEMOLYTIC UREMIC SYNDROME.

## INTERACTIONS

**Drug-Drug:** ■ May increase serum **digoxin** levels ■ May increase the risk of hemolytic, ototoxic, or neurotoxic reactions when used concurrently with **agents sharing these toxicities** ■ Concurrent use with **quinidine** may increase the risk of adverse cardiovascular reactions ■ May increase the risk of bleeding with **warfarin** ■ Concurrent use with **mefloquine** increases the risk of seizures and adverse cardiovascular reactions.

## ROUTE AND DOSAGE

- **PO (Adults):** *Malaria*—600–650 mg q 8 hr for 3 days (7 days in southeast Asia) with tetracycline or doxycycline or sulfadoxine/pyramethamine or clindamycin; *leg cramps (unlabeled)*—200–300 mg at bedtime, if needed an additional 200–300 mg may be given with supper.
- **PO (Children):** 8.3 mg/kg q 8 hr for 3 days (7 days in southeast Asia) with tetracycline or

doxycycline (if child is over 8 yr) or sulfadoxine/pyramethamine or clindamycin.

## AVAILABILITY

- **Capsules:** 200 mg<sup>Rx</sup>, 300 mg<sup>Rx</sup>, 325 mg<sup>Rx</sup> ■ **Cost:** 325 mg \$5.15–\$8.28/30
- **Tablets:** 260 mg<sup>Rx</sup>, 325 mg<sup>Rx</sup> ■ **Cost:** 260 mg \$3.89–\$3.95/30.

TIME/ACTION PROFILE (antimalarial blood levels)

	ONSET	PEAK	DURATION
PO	unknown	3.2–5.9 hr	8 hr

## NURSING IMPLICATIONS

### ASSESSMENT

- **Malaria:** Assess patient for improvement in signs and symptoms of condition daily throughout therapy.
- **Nocturnal recumbency leg cramps:** Assess frequency and severity of nocturnal leg cramps. If cramps do not occur for several consecutive nights, may be discontinued to determine if continued use is required.
- **Lab Test Considerations:** May cause elevated urinary 17-ketogenic steroids when metyrapone or Zimmerman method is used.
- **Toxicity and Overdose:** Plasma quinine levels of >10 mcg/ml may cause tinnitus and impaired hearing.
- Signs of toxicity or cinchonism include tinnitus, headache, nausea, and slightly disturbed vision; usually disappear rapidly upon discontinuing quinine.

### POTENTIAL NURSING DIAGNOSES

- Infection, risk for (Indications).
- Pain, chronic (Indications).
- Knowledge deficit, related to medication regimen (Patient/Family Teaching).

### IMPLEMENTATION

- **PO:** Administer with or after meals to minimize GI distress. Aluminum-containing antacids will decrease and delay absorption; avoid concurrent use.

### PATIENT/FAMILY TEACHING

- Instruct patient to take medication exactly as directed and continue full course of therapy, even if feeling better. Missed doses should be

taken as soon as remembered, unless almost time for the next dose. Do not double doses or take more than recommended.

- Review methods of minimizing exposure to mosquitoes with patients receiving chloroquine prophylactically (use repellent, wear long-sleeved shirt and long trousers, use screen or netting).
- Quinine may cause visual changes. Caution patient to avoid driving or other activities requiring alertness until response to medication is known.
- May cause diarrhea, nausea, stomach cramps or pain, vomiting, or ringing in the ears. Advise patient to notify health care professional promptly if these become pronounced.
- Advise patient to stop quinine and notify health care professional of any evidence of allergy (flushing, itching, rash, fever, stomach pain, difficult breathing, ringing in the ears, visual problems).

## EVALUATION

**Effectiveness of therapy can be demonstrated by:** ■ Prevention of or improvement in signs and symptoms of malaria ■ Decrease in frequency and severity of nocturnal redundancy leg cramps.

## ROSIGLITAZONE

(roe-zi-**glit**-a-zone)  
Avandia

### CLASSIFICATION(S):

*Antidiabetic agents (thiazolidinedione)*

**Pregnancy Category C**

## INDICATIONS

■ Used as an adjunct to diet and exercise in the management of type 2 diabetes mellitus; may also be used with metformin when the combination of diet, exercise, and metformin does not achieve glycemic control.

## ACTION

■ Improves sensitivity to insulin by acting as an agonist at receptor sites involved in insulin re-

sponsiveness and subsequent glucose production and utilization ■ Requires insulin for activity.

**Therapeutic Effects:** ■ Decreased insulin resistance, resulting in glycemic control without hypoglycemia.

## PHARMACOKINETICS

**Absorption:** Well absorbed (99%) following oral administration.

**Distribution:** Unknown.

**Protein Binding:** 99.8% bound to plasma proteins.

**Metabolism and Excretion:** Entirely metabolized by the liver.

**Half-life:** 3.2–3.6 hr (increased in liver disease).

## CONTRAINDICATIONS AND PRECAUTIONS

**Contraindicated in:** ■ Hypersensitivity ■ Pregnancy or lactation (not recommended for use during pregnancy or lactation; insulin should be used) ■ Children <18 yr or type 1 diabetes (requires insulin for activity) ■ Diabetic ketoacidosis ■ Clinical evidence of active liver disease or increased ALT (>2.5 times upper limit of normal).

**Use Cautiously in:** ■ Edema ■ Congestive heart failure (avoid use in moderate to severe CHF unless benefits outweigh risks) ■ Hepatic impairment ■ Women with child-bearing potential (may restore ovulation and risk of pregnancy).

## ADVERSE REACTIONS AND SIDE EFFECTS†

**CV:** edema.

**Hemat:** anemia.

**Metab:** increased total cholesterol, LDL and HDL, weight gain.

## INTERACTIONS

**Drug-Drug:** ■ None known.

## ROUTE AND DOSAGE

■ **PO (Adults):** 4 mg as a single dose once daily or 2 mg twice daily; after 12 weeks, may be increased if necessary to 8 mg once daily or 4 mg twice daily.

{ } = Available in Canada only.

†CAPITALS indicate life-threatening; underlines indicate most frequent.

**AVAILABILITY**

■ **Tablets:** 2 mg<sup>Rx</sup>, 4 mg<sup>Rx</sup>, 8 mg<sup>Rx</sup>.

**TIME/ACTION PROFILE** (effects on blood glucose)

	ONSET	PEAK	DURATION
PO	unknown	unknown	12–24 hr

**NURSING IMPLICATIONS****ASSESSMENT**

□ Observe patient taking current insulin for signs and symptoms of hypoglycemic reactions (sweating, hunger, weakness, dizziness, tremor, tachycardia, anxiety).

■ **Lab Test Considerations:** Serum glucose and glycosylated hemoglobin should be monitored periodically throughout therapy to evaluate effectiveness of treatment.

□ Monitor CBC with differential periodically throughout therapy. May cause decrease in hemoglobin, hematocrit, and WBC, usually during the first 4–8 wk of therapy; then levels stabilize.

□ Monitor AST and ALT every 2 months during the first 12 months of therapy and periodically thereafter or if jaundice or symptoms of hepatic dysfunction occur. May cause irreversible elevations in AST and ALT or hepatic failure (rare). If ALT increases to >3 times the upper limit of normal, recheck ALT promptly. Discontinue rosiglitazone if ALT remains >3 times normal.

□ May cause increases in total cholesterol, LDL, and HDL and decreases in free fatty acids.

**POTENTIAL NURSING DIAGNOSES**

■ Nutrition: altered, more than body requirements (Indications).

■ Knowledge deficit (Patient/Family Teaching).

**IMPLEMENTATION**

■ **General Info:** Patients stabilized on a diabetic regimen who are exposed to stress, fever, trauma, infection, or surgery may require administration of insulin.

■ **PO:** May be administered with or without meals.

**PATIENT/FAMILY TEACHING**

□ Instruct patient to take medication exactly as directed. If dose for 1 day is missed, do not double dose the next day.

□ Explain to patient that this medication controls hyperglycemia but does not cure diabetes. Therapy is long-term.

□ Review signs of hypoglycemia and hyperglycemia with patient. If hypoglycemia occurs, advise patient to take a glass of orange juice or 2–3 tsp of sugar, honey, or corn syrup dissolved in water and notify health care professional.

□ Encourage patient to follow prescribed diet, medication, and exercise regimen to prevent hypoglycemic or hyperglycemic episodes.

□ Instruct patient in proper testing of serum glucose and ketones. These tests should be closely monitored during periods of stress or illness and health care professional notified if significant changes occur.

□ Advise patient to notify health care professional immediately if signs of hepatic dysfunction (nausea, vomiting, abdominal pain, fatigue, anorexia, dark urine, jaundice) occur.

□ Insulin is the preferred method of controlling blood sugar during pregnancy. Counsel female patients that higher doses of oral contraceptives or a form of contraception other than oral contraceptives may be required and to notify health care professional promptly if pregnancy is planned or suspected.

□ Advise patient to inform health care professional of medication regimen prior to treatment or surgery.

□ Advise patient to carry a form of sugar (sugar packets, candy) and identification describing disease process and medication regimen at all times.

□ Emphasize the importance of routine follow-up exams.

**EVALUATION**

**Effectiveness of therapy can be demonstrated by:** ■ Control of blood glucose levels.

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## NOTES

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