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- Nursing care plans are made easy by the 5-step nursing process organizational format

And…

- Essential concepts are highlighted (boldface and italics)
- Acronyms and mnemonics (memory aids) help retention
- Study time is with concise outline format and chapter summaries of points

You will find this NurseNotes Series a different way to learn and review

About the Authors:
Christine Hooper, RN, EdD
Dr. Christine Hooper is an Associate Professor in the School of Nursing at San Jose State University, and the faculty Director of Nurses at the Hooper Center for Nursing. Dr. Hooper has practiced in a variety of settings, including neurosurgery, cardiovascular surgery, orthopedics, and adult medical-surgical care.

Robyn M. Nelson, DNSc, RN, is currently the Dean of the College of Health and Human Sciences, Touro University—Nevada. Dr. Nelson has over 30 years experience teaching nursing and over 15 years as a faculty member for ATI for Nurses, Inc.

About the Editor:
Sally Lambert Lagerquist, RN, MS
Sally Lambert Lagerquist, RN, MS is the founder and president of ATI for Nurses, Inc. and ATI Nurse Notes. She is a nursing professor at San Francisco State University. She was the author of the ATI NurseNotes Medical-Surgical Series, the ATI NurseNotes Psychiatric-Mental Health, and the ATI NurseNotes Medical-Surgical, Psychiatric-Mental Health, and Pediatric-Medical/Surgical Review Questions.

ATI NurseNotes Series will serve as a supplement to course texts, and as an independent study tool in:

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ATI NurseNotes
Medical–Surgical
Core Content At-A-Glance

Edited by:
Sally Lambert Lagerquist, RN, MS
Former Instructor in Undergraduate and Graduate Programs and Continuing Education in Nursing
University of California, San Francisco, School of Nursing
President, Review for Nurses, Inc., and RN Tapes Company
San Francisco, California

Contributing Authors:
Christine Hooper, RN, EdD
Associate Professor
San Jose State University
San Jose, California

Robyn M. Nelson, RN, DNSc
Dean, College of Health and Human Services
Touro University, Nevada
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A. Common Acronyms and Abbreviations  
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2. Palpitations.
3. Nausea.
4. Discomfort during or after eating.

B. Objective data:
1. Diaphoresis.
2. Diarrhea.
3. Fainting.
4. Symptoms of hypoglycemia.

II. Analysis/nursing diagnosis
A. Altered nutrition, more than body requirements, related to body's inability to properly digest high carbohydrate, high sodium foods.
B. Diarrhea related to food passing into jejunum too quickly.
C. Risk for injury related to hypoglycemia.
D. Knowledge deficit related to dietary restrictions.

III. Nursing care plan/implementation
A. Goal: slow gastric emptying.
   1. Increase fat, protein in diet to delay emptying; fiber.
   2. Rest after meals.
   3. Eat small, frequent meals.
   4. Drink fluids between meals.
B. Goal: health teaching.
   1. Avoid foods high in refined carbohydrate.
   2. Practice portion control.
   3. Stress management, particularly at mealtime.
   4. Symptom management.

IV. Evaluation/outcome criteria
A. No complications.
B. Client heals.
C. Incorporates health teaching into life-style and prevents syndrome.

---Diagnostic Studies/Procedures---

### Common Fluoroscopic Examinations

#### Upper GI—ingestion of barium sulfate or meglumine diatrizoate (Gastrografin, a white, chalky, radiopaque substance), followed by fluoroscopic and x-ray examination; used to determine:
1. Patency and caliber of esophagus; may also detect esophageal varices.
2. Mobility and thickness of gastric walls, presence of ulcer craters, filling defects due to tumors, pressures from outside the stomach, and patency of pyloric valve.
3. Rate of passage in small bowel and presence of structural abnormalities.

#### Lower GI—rectal instillation of barium sulfate followed by fluoroscopic and x-ray examination; used to determine contour and mobility of colon and presence of any space-occupying tumors; perform before upper GI. Client preparation: explain purpose; no food after evening meal the evening before test; stool softeners, laxatives, enemas, and suppositories to cleanse the bowel before the test; NPO after midnight prior to test; oral medications not permitted day of test.

After completion of exam: food, increased liquid intake, and rest; laxatives for at least 2 d or until stools are normal in color and consistency.

**Examination of Gastric Contents**

Gastric analysis—aspiration of the contents of the fasting stomach for analysis of free and total acid.
1. Gastric acidity is generally increased in presence of duodenal ulcer.
2. Gastric acidity is usually decreased in pernicious anemia, cancer of the stomach.

**Stool specimens**—examined for: amount, consistency, color, character, and melena; used to determine presence of: urobilinogen, fat, nitrogen, parasites, and other substances.

**Esophagoscopy and gastroscopy**—visualization of the esophagus, the stomach, and sometimes the duodenum by means of a lighted tube inserted through the mouth.

---Summary of Key Points---

1. Gastric disorders may include problems with ingestion (getting the food to the stomach) digestion (the process of secreting gastric juices and breaking down protein), or absorption (transfer of food particles into circulation).

2. Regardless of the disorder, the client often complains of pain (erosion or stretching), loss of appetite (impaired gastric emptying), nausea (gastric tension), bleeding (erosion or trauma), diarrhea (increased peristalsis), belching or flatus, dyspepsia (heartburn), or a combination of these.

3. Enteral (NG or gastric tube) or parenteral (TPN) feedings may be supplemental or replacement. If they are replacing oral feedings, mouth care and satisfying oral needs are important.

4. Though similar in many ways, the differences between a duodenal and gastric ulcer are distinctive. A duodenal ulcer is more common, the characteristic gnawing pain occurs hours after a meal or at night, and food relieves the pain.

5. Treatment is medical (rest, drugs, diet, decreased stress), unless the ulcer: becomes chronic, recurs, perforates, causes obstruction, or bleeds—then surgery is indicated.

6. Drug therapy inhibits acid secretion and neutralizes or protects the gastric mucosa. Client teaching must include whether a drug is taken before, with, or how long after meals.

7. The dumping syndrome is controlled by regulating the volume and type of food—decrease carbohydrates and fluids, increase protein and fat to delay gastric emptying.
Chapter 15. Gastric Disorders

Questions

1. After esophagoscopy is done to diagnose gastroesophageal reflux, the most important nursing action would be to:
   1. Check the client’s vital signs frequently, as ordered.
   2. Assess for cervical crepitus in the neck.
   3. Place the client in a side-lying position to prevent aspiration.
   4. Give the client an anesthetic lozenge for sore throat.

2. Which instruction should be included in health care counseling for a client with a hiatal hernia?
   1. Restrict intake of high carbohydrate foods, which speed emptying.
   2. Increase fluid intake with meals to facilitate food passage.
   3. Increase fat intake to delay gastric emptying.
   4. Eat three regular meals daily at least 5 hours apart.

3. When giving morphine sulfate (5 mg) in an IV push to a 65-year-old client after a gastrectomy, the best technique would be to:
   1. Dilute it in 5 mL of normal saline and give it over 4 to 5 minutes.
   2. Dilute it in 10 mL of 5% dextrose in water and give it over 30 minutes.
   3. Give it undiluted at the injection site closest to the client.
   4. Give it undiluted at the injection site farthest from the client.

Diaphragmatic Hernia

Antacid therapy
- Magnesium and aluminum hydroxide (Mylanta): 500–1000 mg 3–6 times/day
- (Maalox suspension): 5–30 mL pc and hs
- (Gaviscon): 30–60 mL pc and hs

Histamine receptor antagonists
- Ranitidine (Zantac): 150 mg bid.
- Avoid anticholinergic drugs because they decrease lower esophageal sphincter function

Proton pump inhibitors
- Lansoprazole (Prevacid): 15 mg PO qd
- Omeprazole (Prilosec): 20 mg PO qd for 4–8 wk

Dumping Syndrome

Anticholinergic
- (e.g., propantheline): to decrease gastric activity

Vasopressor
- (e.g., ephedrine): to relieve vasomotor symptoms

Drug Review

Peptic Ulcer Disease

Anticholinergic
- Propantheline bromide (ProBanthine): 15 mg tid, 30 mg hs

Antiinfactives
- Amoxicillin: 250–500 mg q8h
- Clarithromycin: (Biaxin) 250–500 mg q 12h
- Metronidazole: (Flagyl) 250 mg tid
- Tetracycline: 500 mg qid

Antiulceratives
- Aluminum hydroxide gel (Amphojel): 5–10 mL q2–4h or 1h pc
- Calcium carbonate (Titralac): 1–2 g with water after meals and hs
- Magnesium and aluminum hydroxides (Maalox suspension): 5–30 mL pc and hs
- Omeprazole (Prilosec): 20 mg qd for 4–8 wk

Histamine antagonists
- Cimetidine (Tagamet): 300–600 mg q6h
- Ranitidine (Zantac): 150 mg bid

Proton pump inhibitors
- Lansoprazole (Prevacid): 15 mg PO qd.
- Omeprazole (Prilosec): 20 mg PO qd for 4–8 wk.

Protectant
- Sucralfate (Carafate): 1 g ac and hs

Study and Memory Aids

Diets

Diaphragmatic Hernia

<table>
<thead>
<tr>
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<th>Protein</th>
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<tbody>
<tr>
<td>Protein</td>
<td>Fat</td>
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<tr>
<td>Soft, bland</td>
<td>Size of portions</td>
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Dumping Syndrome

<table>
<thead>
<tr>
<th>Fat</th>
<th>Carbohydrate</th>
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<tr>
<td>Fiber</td>
<td>Fluids at mealtime</td>
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<tr>
<td>Frequency</td>
<td>Portion size</td>
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