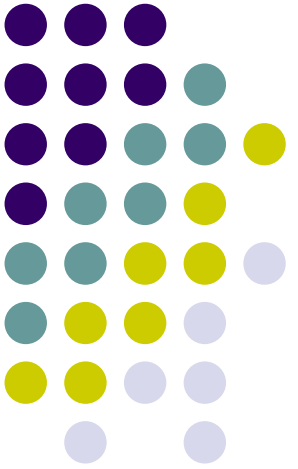
MILANO LODI IPASVI

Nursing Reference Center

Guida di utilizzo



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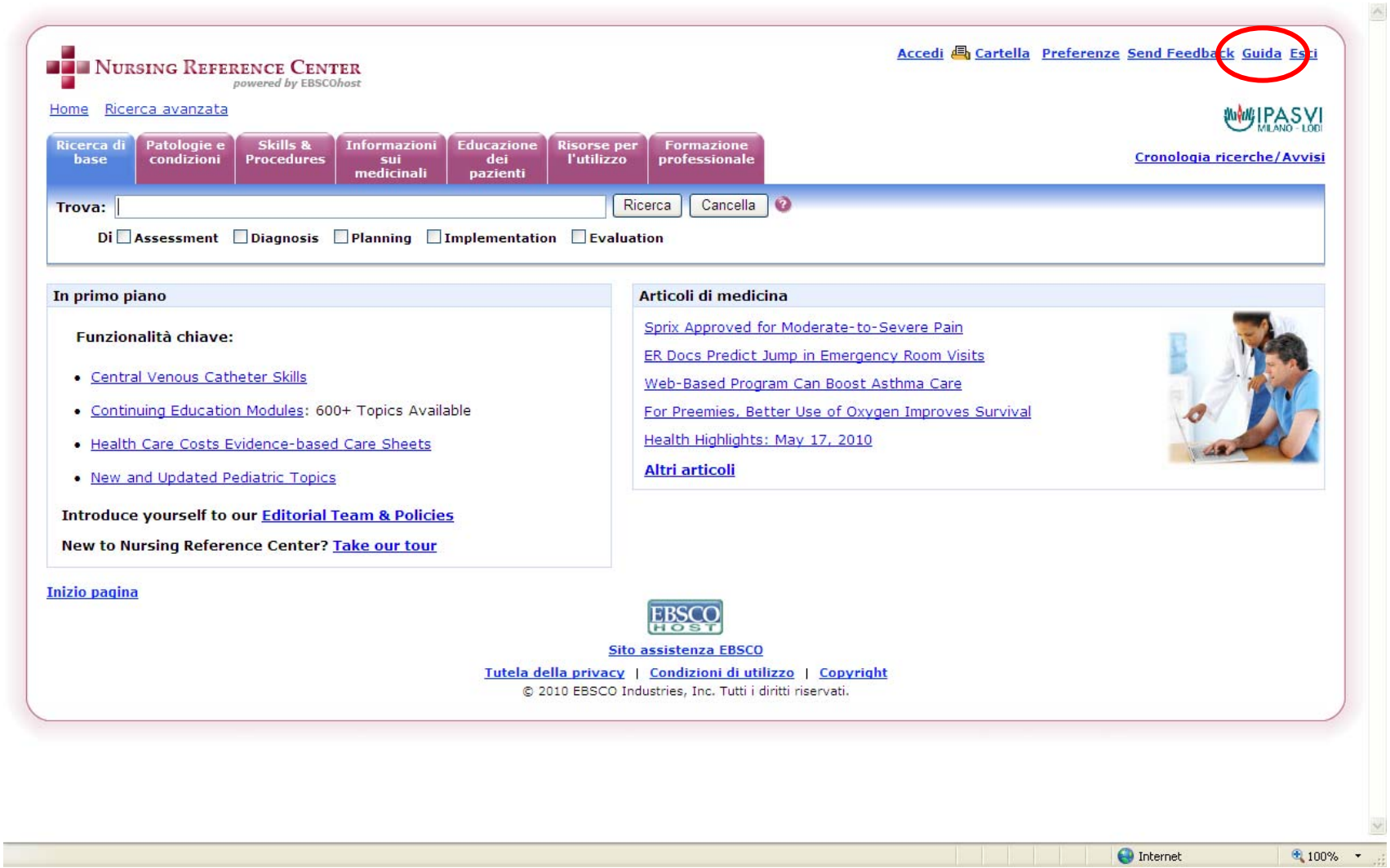
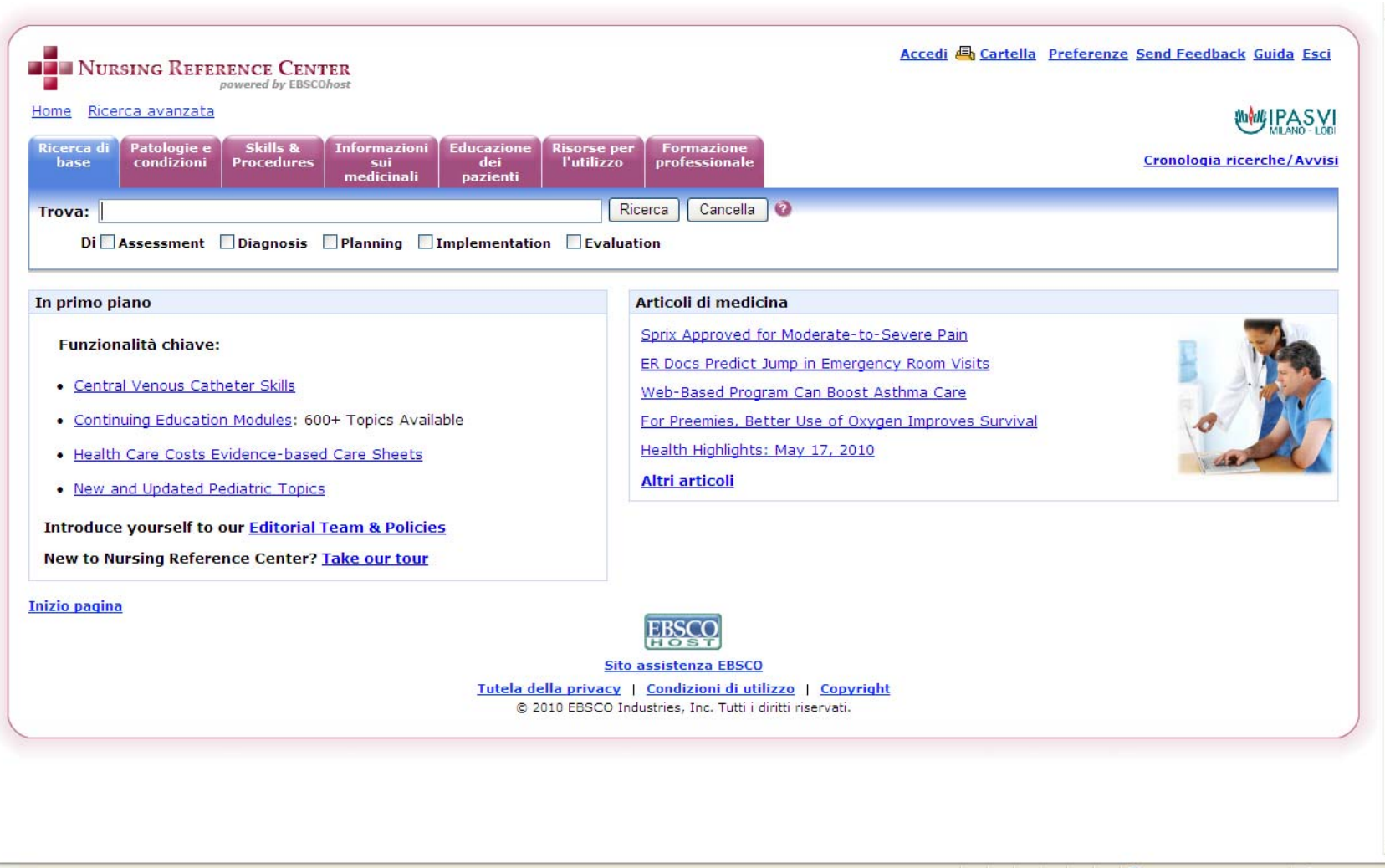
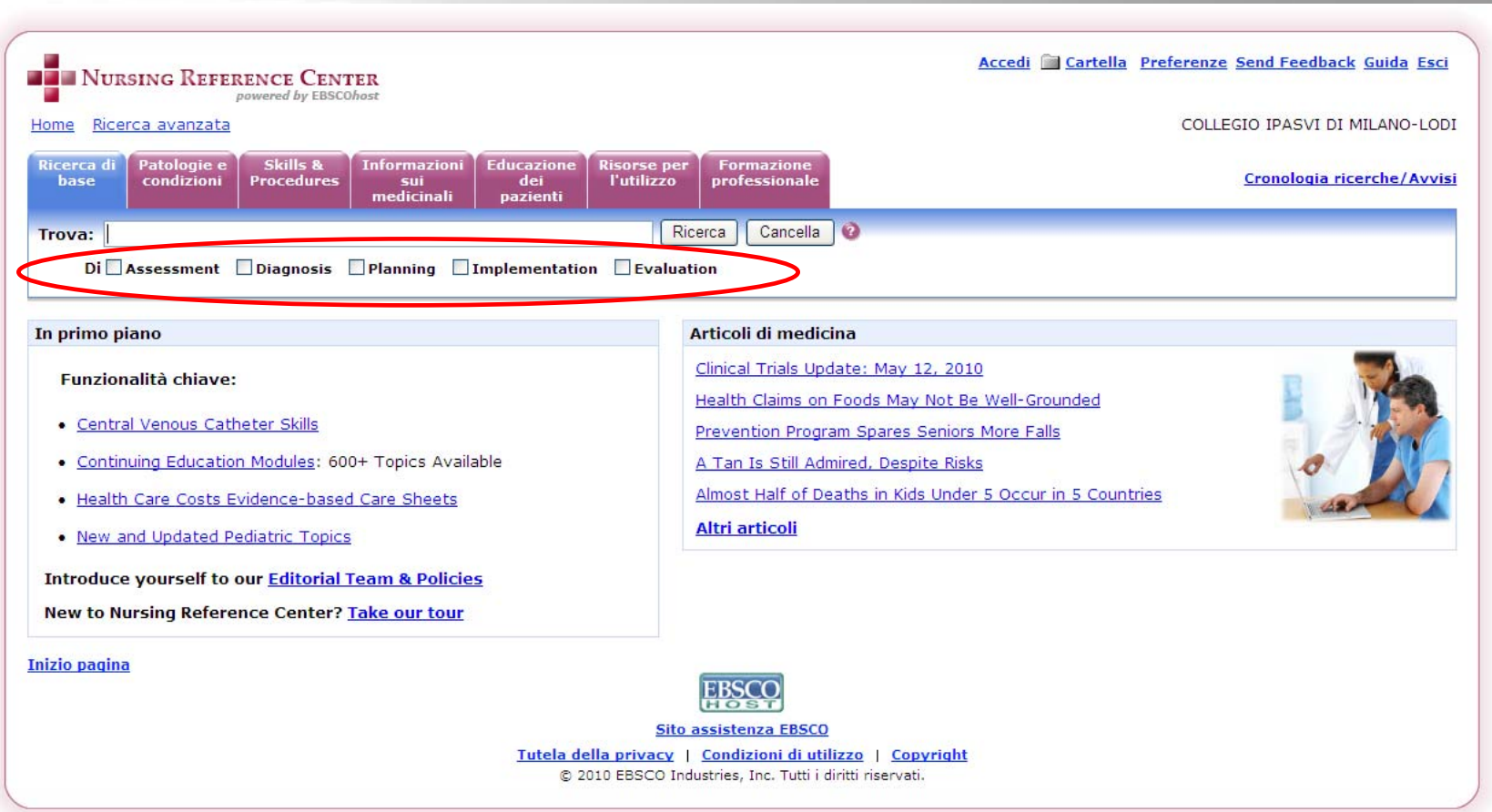


Guida all'utilizzo di **Nursing Reference Center (NRC)**

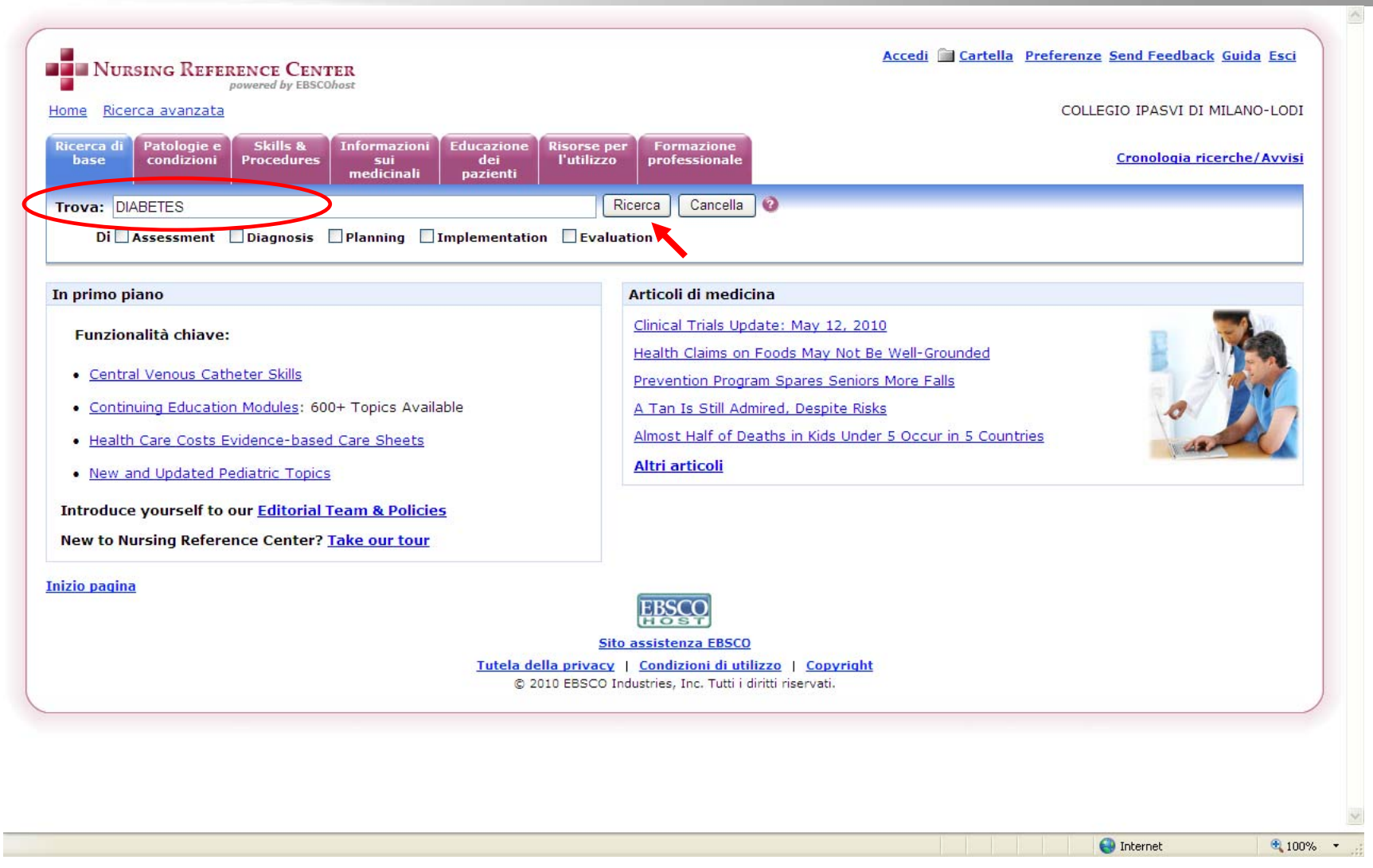
Questa guida mostra le opzioni di ricerca e di consultazione della banca dati. Se vi servissero informazioni più dettagliate su specifiche funzioni, potete utilizzare il link **Guida** visualizzato in ogni pagina in alto a destra.



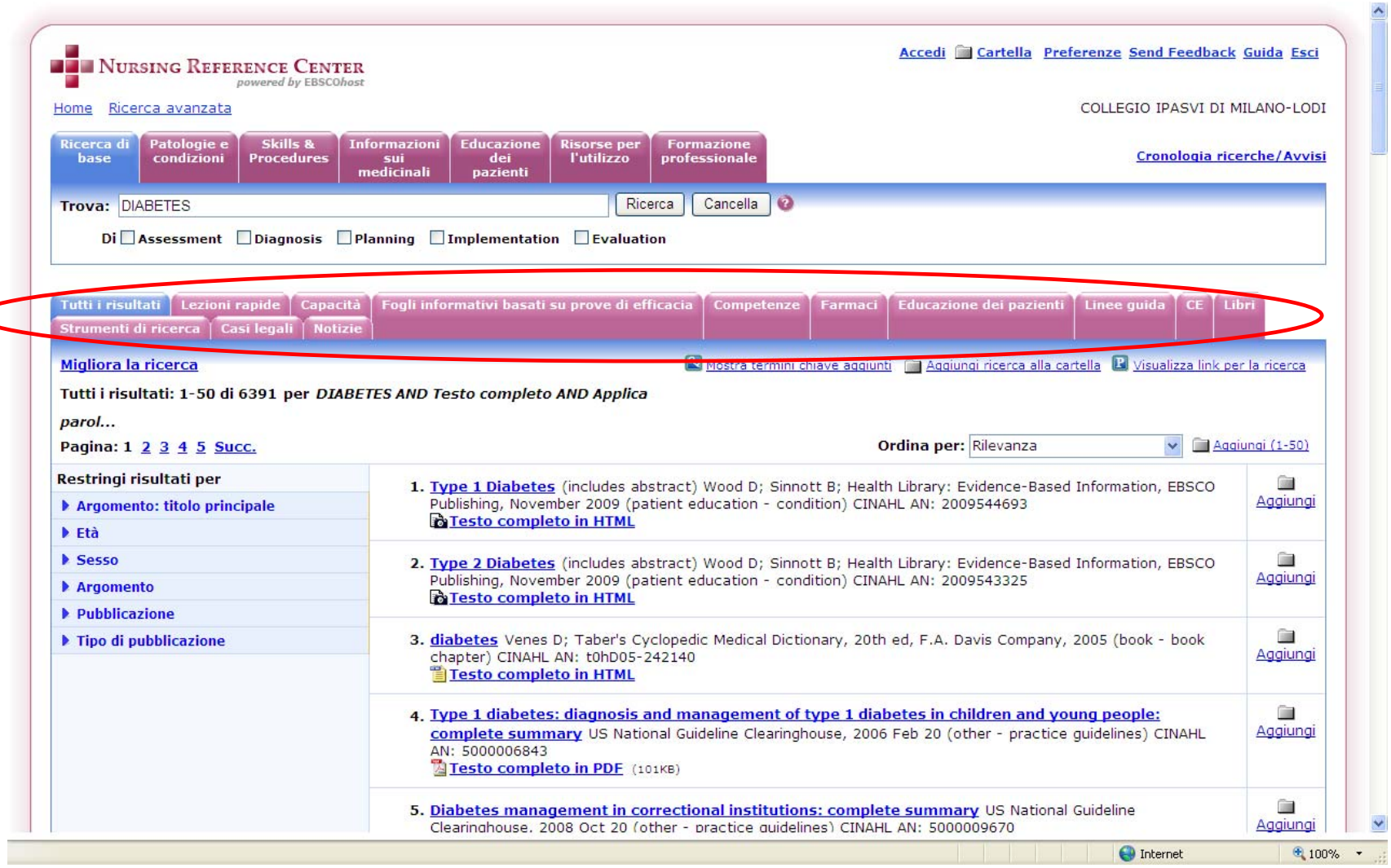
NRC offre ad infermieri, studenti, docenti e biblioteche in ambito sanitario le migliori e più recenti evidenze cliniche. Contiene inoltre informazioni di *reference*, ricercabili e consultabili attraverso un'interfaccia grafica dedicata appositamente al personale infermieristico.



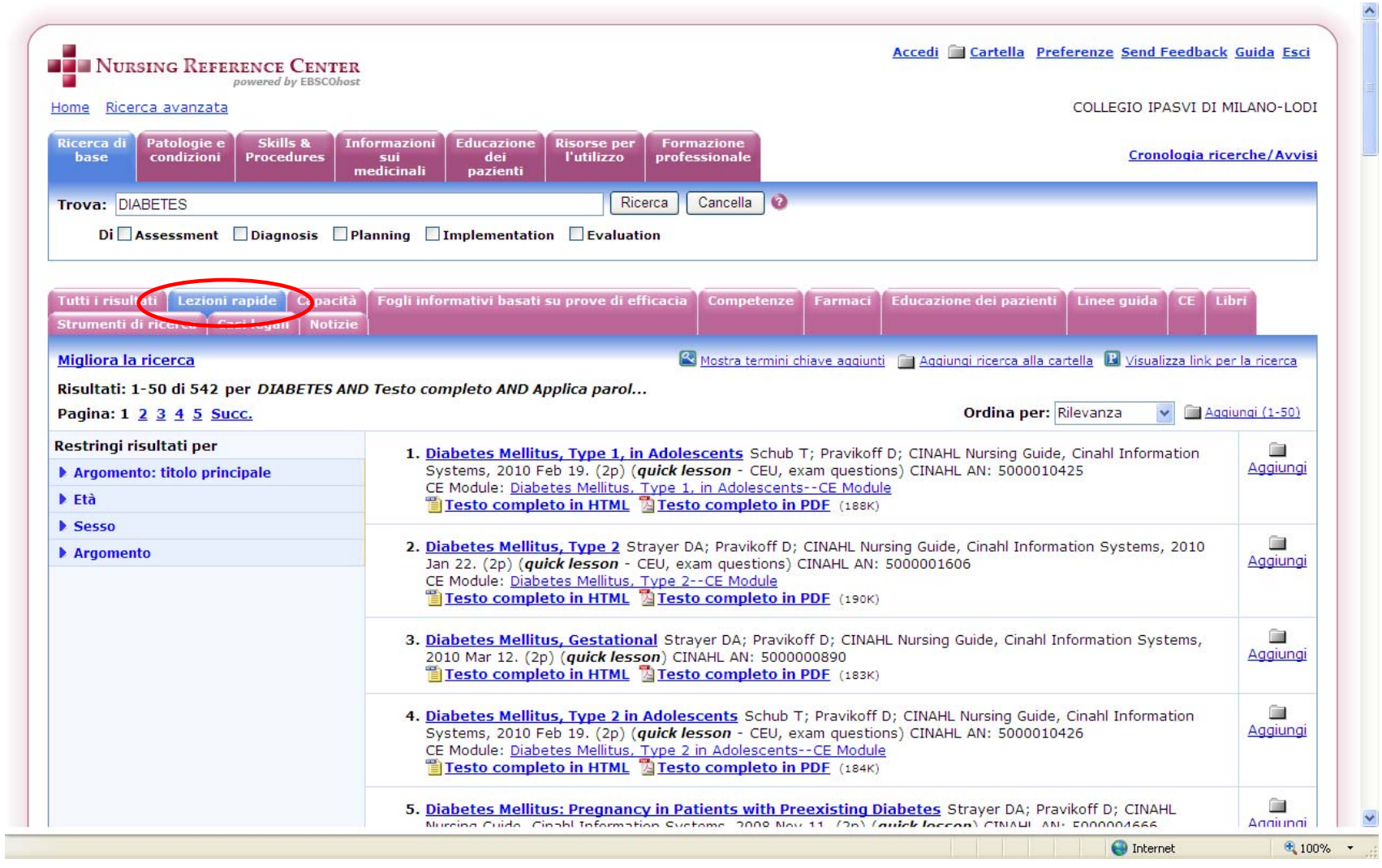
Usando NRC potrete compiere una ricerca per parola chiave oppure selezionare uno specifico argomento. Quando viene effettuata una ricerca per parola chiave, NRC fornisce utili **Limitatori**, che rispecchiano i normali processi seguiti dalla maggior parte degli infermieri professionali che operano a contatto con il paziente. Questo permette all'infermiere di reperire precise informazioni, relative ad un momento preciso del processo di cura.



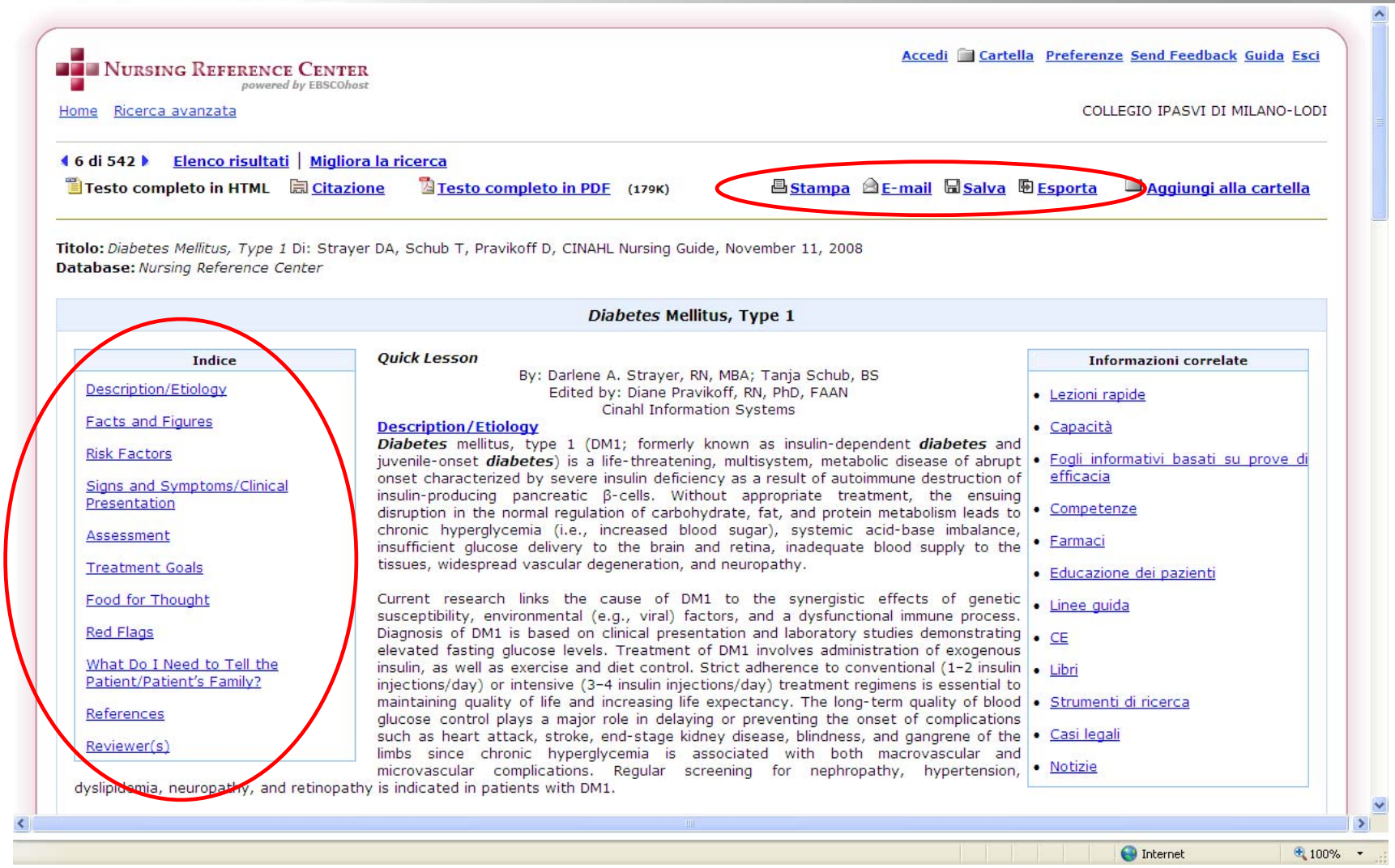
Per compiere una ricerca tramite parola chiave, digitare il termine nel campo **Trova** e selezionare **Ricerca**



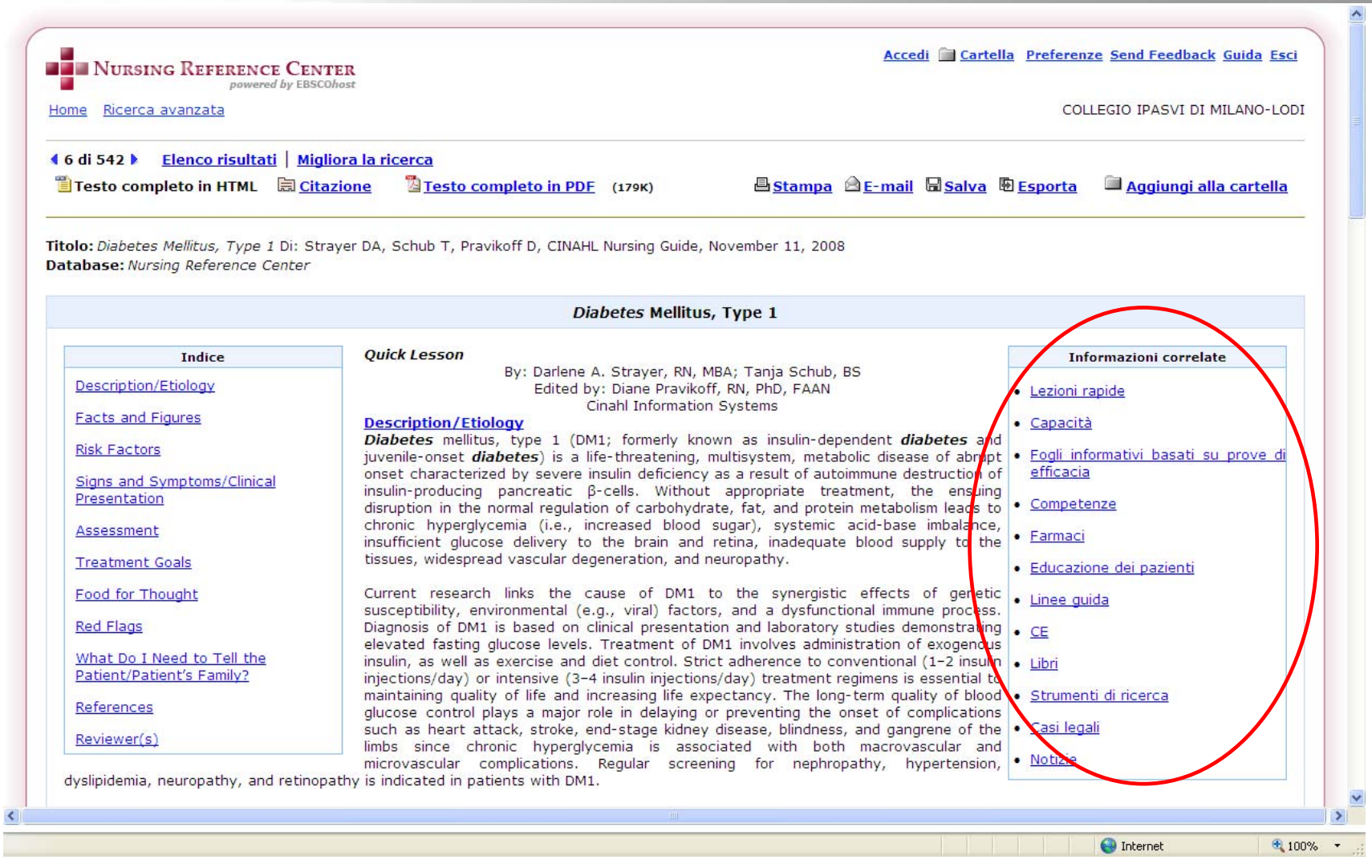
NRC mostra una lista completa di tutti i documenti che includono il termine di ricerca indicato. I risultati sono suddivisi in una serie di sezioni, a seconda del tipo di documento.



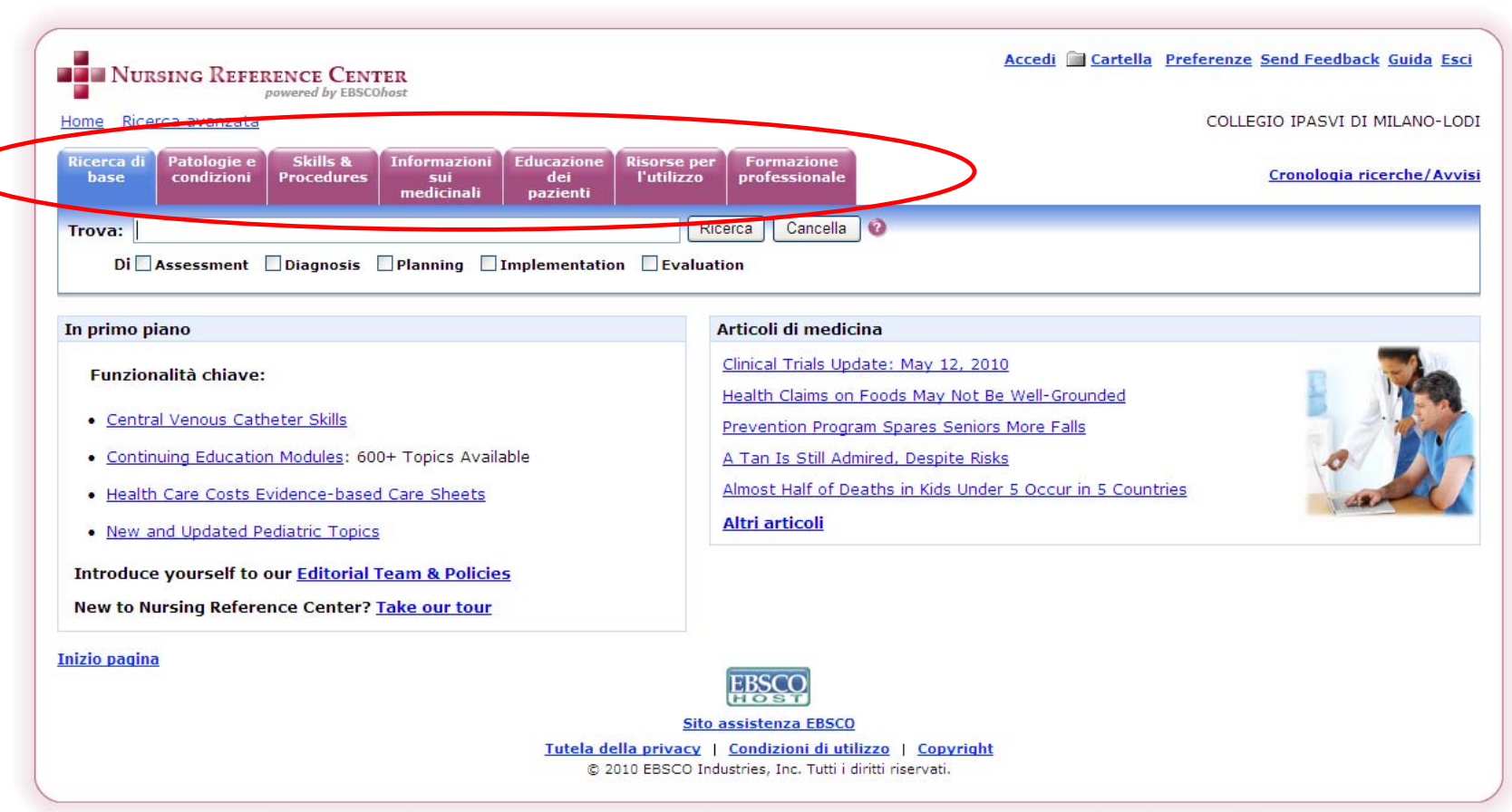
Selezionando ad esempio la sezione **Lezioni Rapide**, si visualizzano una serie di documenti in testo completo che descrivono tutti gli aspetti della patologia correlata al termine ricercato



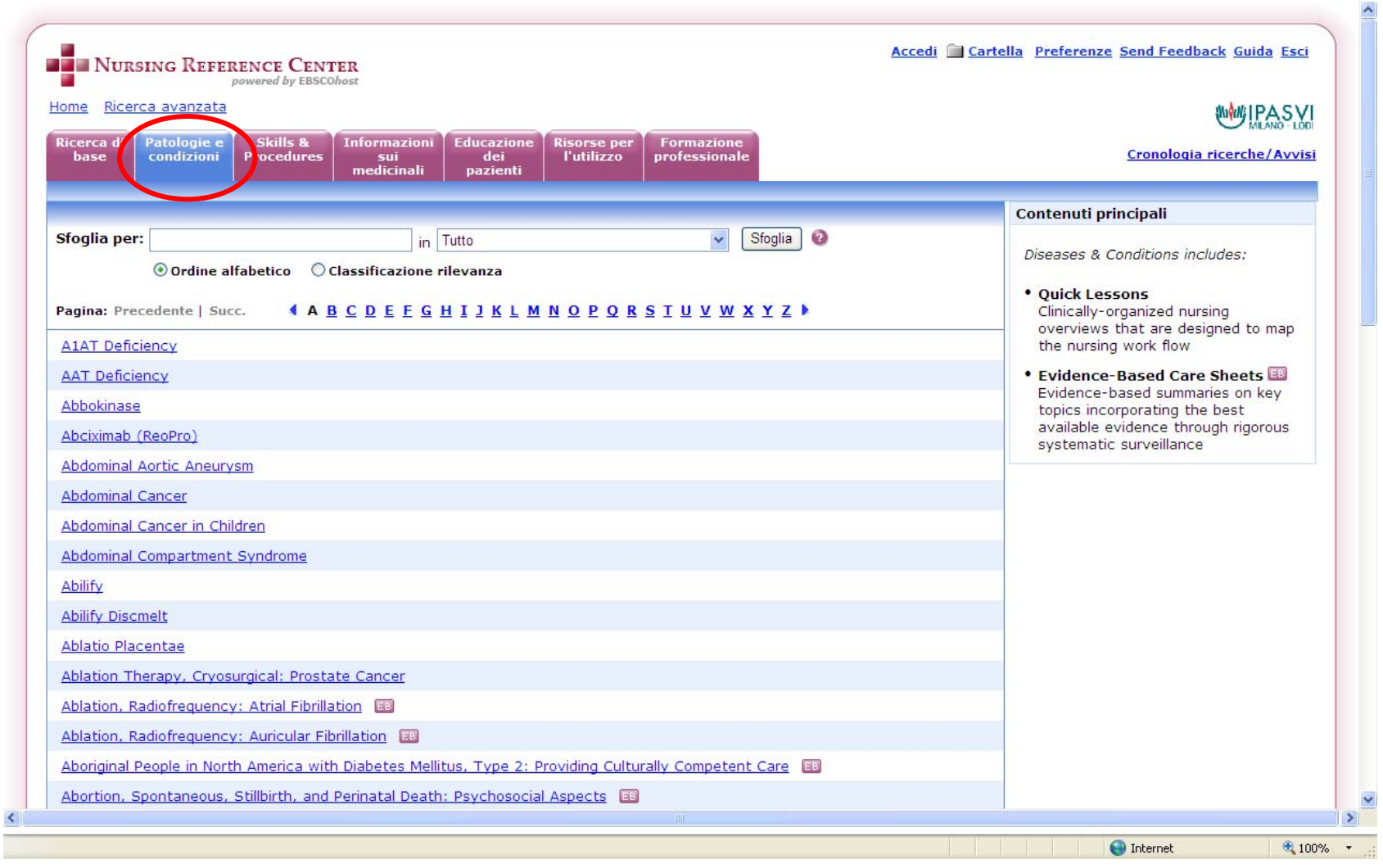
Sia le **Lezioni Rapide**, i **Fogli Informativi basati su Prove di Efficacia** (*Evidence-Based Care Sheets*), le **monografie sui farmaci**, che i **Casi Legali** possono essere visualizzati in formato HTML, in moda da poter usufruire dell'indice che permette una facile navigazione tra i contenuti di ogni singolo documento. Da questa videtata, avete anche la possibilità di stampare, salvare o inviare il record tramite e-mail.



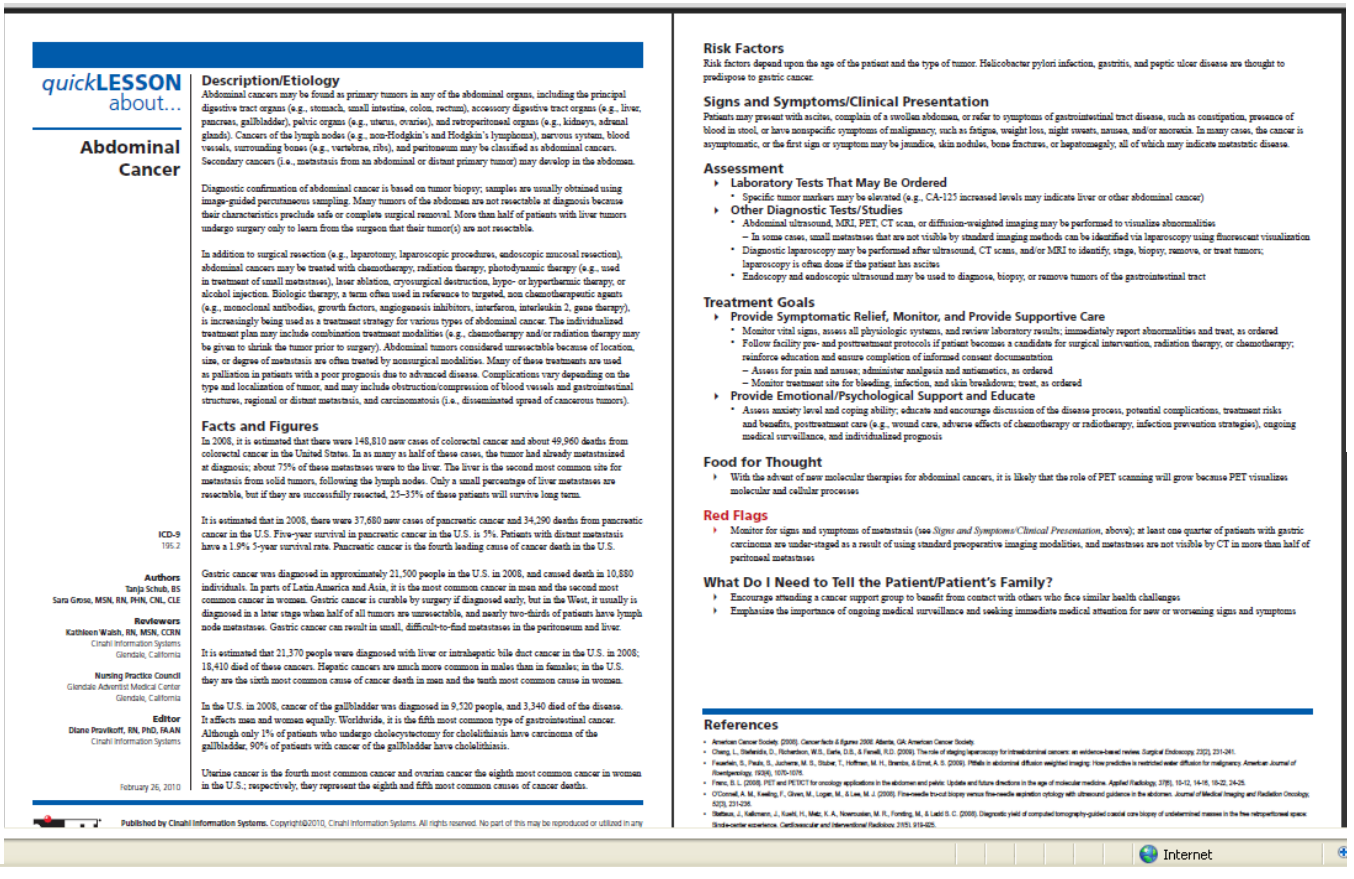
Se disponibili, sono riportati sulla destra i link ad altri documenti relativi all'argomento cercato. Basta selezionare una voce per raggiungere il record di riferimento.



NRC è suddivisa in diverse sezioni, ognuna delle quali include specifici documenti e informazioni.



La sezione **Patologie e Condizioni** offre la possibilità di cercare e accedere alle Lezioni Rapide e alle Schede Evidence-Based relative a specifiche patologie e condizioni.



quickLESSON about...

Abdominal Cancer

Description/Etiology

Abdominal cancers may be found as primary tumors in any of the abdominal organs, including the principal digestive tract organs (e.g., stomach, small intestine, colon, rectum), accessory digestive tract organs (e.g., liver, pancreas, gallbladder), pelvic organs (e.g., uterus, ovaries), and retroperitoneal organs (e.g., kidneys, adrenal glands). Cancers of the lymph nodes (e.g., non-Hodgkin's and Hodgkin's lymphoma), nervous system, blood vessels, surrounding bones (e.g., vertebrae, ribs), and peritoneum may be classified as abdominal cancers. Secondary cancers (i.e., metastasis from an abdominal or distant primary tumor) may develop in the abdomen.

Diagnostic confirmation of abdominal cancer is based on tumor biopsy; samples are usually obtained using image-guided percutaneous sampling. Many tumors of the abdomen are not resectable at diagnosis because their characteristics preclude safe or complete surgical removal. More than half of patients with liver tumors undergo surgery only to learn from the surgeon that their tumor(s) are not resectable.

In addition to surgical resection (e.g., laparotomy, laparoscopic procedures, endoscopic mucosal resection), abdominal cancers may be treated with chemotherapy, radiation therapy, photodynamic therapy (e.g., used in treatment of small metastases), laser ablation, cryosurgical destruction, hypo- or hyperthermic therapy, or alcohol injection. Biologic therapy, a term often used in reference to targeted, non chemotherapeutic agents (e.g., monoclonal antibodies, growth factors, angiogenesis inhibitors, interferon, interleukin 2, gene therapy), is increasingly being used as a treatment strategy for various types of abdominal cancer. The individualized treatment plan may include combination treatment modalities (e.g., chemotherapy and/or radiation therapy may be given to shrink the tumor prior to surgery). Abdominal tumors considered unresectable because of location, size, or degree of metastasis are often treated by nonsurgical modalities. Many of these treatments are used as palliation in patients with a poor prognosis due to advanced disease. Complications vary depending on the type and localization of tumor, and may include obstruction/compression of blood vessels and gastrointestinal structures, regional or distant metastasis, and carcinomatosis (i.e., disseminated spread of cancerous tumors).

Facts and Figures

In 2008, it is estimated that there were 148,810 new cases of colorectal cancer and about 49,960 deaths from colorectal cancer in the United States. In as many as half of these cases, the tumor had already metastasized at diagnosis; about 75% of these metastases were to the liver. The liver is the second most common site for metastasis from solid tumors, following the lymph nodes. Only a small percentage of liver metastases are resectable, but if they are successfully resected, 25–35% of these patients will survive long term.

It is estimated that in 2008, there were 37,680 new cases of pancreatic cancer and 34,290 deaths from pancreatic cancer in the U.S. Five-year survival in pancreatic cancer in the U.S. is 5%. Patients with distant metastasis have a 1.9% 5-year survival rate. Pancreatic cancer is the fourth leading cause of cancer death in the U.S.

Gastric cancer was diagnosed in approximately 21,500 people in the U.S. in 2008, and caused death in 10,880 individuals. In parts of Latin America and Asia, it is the most common cancer in men and the second most common cancer in women. Gastric cancer is curable by surgery if diagnosed early, but in the West, it usually is diagnosed in a later stage when half of all tumors are unresectable, and nearly two-thirds of patients have lymph node metastases. Gastric cancer can result in small, difficult-to-find metastases in the peritoneum and liver.

It is estimated that 21,370 people were diagnosed with liver or intrahepatic bile duct cancer in the U.S. in 2008; 18,410 died of these cancers. Hepatic cancers are much more common in males than in females; in the U.S. they are the sixth most common cause of cancer death in men and the tenth most common cause in women.

In the U.S. in 2008, cancer of the gallbladder was diagnosed in 9,520 people, and 3,340 died of the disease. It affects men and women equally. Worldwide, it is the fifth most common type of gastrointestinal cancer. Although only 1% of patients who undergo cholecystectomy for cholelithiasis have carcinoma of the gallbladder, 90% of patients with cancer of the gallbladder have cholelithiasis.

Uterine cancer is the fourth most common cancer and ovarian cancer the eighth most common cancer in women in the U.S.; respectively, they represent the eighth and fifth most common causes of cancer deaths.

ICD-9
195.2

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Risk Factors

Risk factors depend upon the age of the patient and the type of tumor. Helicobacter pylori infection, gastritis, and peptic ulcer disease are thought to predispose to gastric cancer.

Signs and Symptoms/Clinical Presentation

Patients may present with ascites, complain of a swollen abdomen, or refer to symptoms of gastrointestinal tract disease, such as constipation, presence of blood in stool, or have nonspecific symptoms of malignancy, such as fatigue, weight loss, night sweats, nausea, and/or anorexia. In many cases, the cancer is asymptomatic, or the first sign or symptom may be jaundice, skin nodules, bone fractures, or hepatomegaly, all of which may indicate metastatic disease.

Assessment

- **Laboratory Tests That May Be Ordered**
  - Specific tumor markers may be elevated (e.g., CA-125 increased levels may indicate liver or other abdominal cancer)
- **Other Diagnostic Tests/Studies**
  - Abdominal ultrasound, MRI, PET, CT scan, or diffusion-weighted imaging may be performed to visualize abnormalities
    - In some cases, small metastases that are not visible by standard imaging methods can be identified via laparoscopy using fluorescent visualization
  - Diagnostic laparoscopy may be performed after ultrasound, CT scans, and/or MRI to identify, stage, biopsy, remove, or treat tumors; laparoscopy is often done if the patient has ascites
  - Endoscopy and endoscopic ultrasound may be used to diagnose, biopsy, or remove tumors of the gastrointestinal tract

Treatment Goals

- **Provide Symptomatic Relief, Monitor, and Provide Supportive Care**
  - Monitor vital signs, assess all physiologic systems, and review laboratory results; immediately report abnormalities and treat, as ordered
  - Follow facility pre- and posttreatment protocols if patient becomes a candidate for surgical intervention, radiation therapy, or chemotherapy; reinforce education and ensure completion of informed consent documentation
    - Assess for pain and nausea; administer analgesia and antiemetics, as ordered
    - Monitor treatment site for bleeding, infection, and skin breakdown; treat, as ordered
- **Provide Emotional/Psychological Support and Educate**
  - Assess anxiety level and coping ability; educate and encourage discussion of the disease process, potential complications, treatment risks and benefits, posttreatment care (e.g., wound care, adverse effects of chemotherapy or radiotherapy, infection prevention strategies), ongoing medical surveillance, and individualized prognosis

Food for Thought

- With the advent of new molecular therapies for abdominal cancers, it is likely that the role of PET scanning will grow because PET visualizes molecular and cellular processes

Red Flags

- Monitor for signs and symptoms of metastasis (see *Signs and Symptoms/Clinical Presentation*, above); at least one quarter of patients with gastric carcinoma are under-staged as a result of using standard preoperative imaging modalities, and metastases are not visible by CT in more than half of peritoneal metastases

What Do I Need to Tell the Patient/Patient's Family?

- Encourage attending a cancer support group to benefit from contact with others who face similar health challenges
- Emphasize the importance of ongoing medical surveillance and seeking immediate medical attention for new or worsening signs and symptoms

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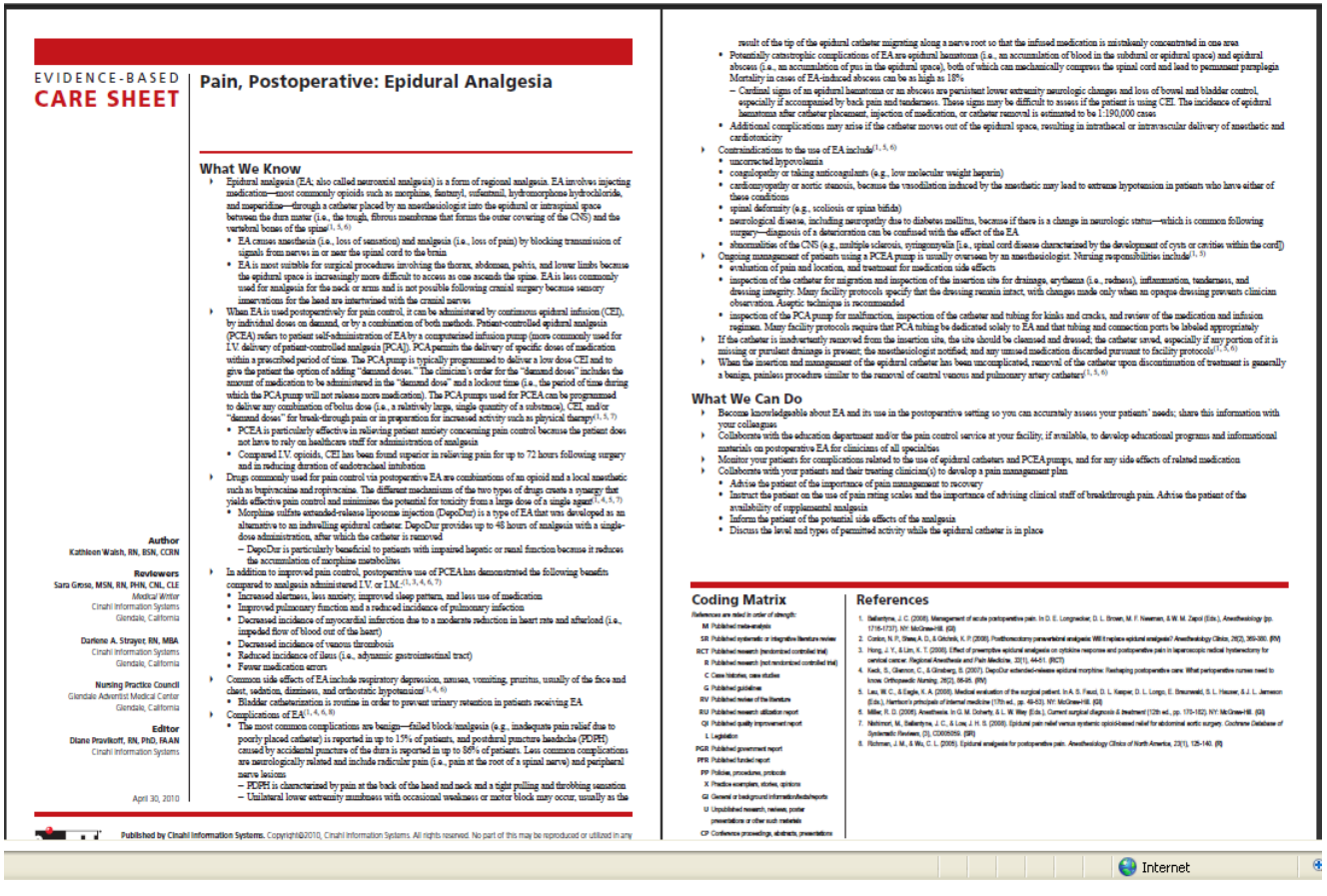
Le **Lezioni Rapide** forniscono la descrizione, i segnali e i sintomi, I test diagnostici e terapeutici normalmente prescritti e le attività nelle quali l'infermiere è coinvolto nel processo di cura del paziente.



EVIDENCE-BASED
CARE SHEET

Pain, Postoperative: Epidural Analgesia

What We Know

- Epidural analgesia (EA; also called neuroaxial analgesia) is a form of regional analgesia. EA involves injecting medication—most commonly opioids such as morphine, fentanyl, sufentanil, hydromorphone hydrochloride, and meperidine—through a catheter placed by an anesthesiologist into the epidural or intraspinal space between the dura mater (i.e., the tough, fibrous membrane that forms the outer covering of the CNS) and the vertebral bones of the spine[1, 5, 6]
  - EA causes anesthesia (i.e., loss of sensation) and analgesia (i.e., loss of pain) by blocking transmission of signals from nerves in or near the spinal cord to the brain
  - EA is most suitable for surgical procedures involving the thorax, abdomen, pelvis, and lower limbs because the epidural space is increasingly more difficult to access as one ascends the spine. EA is less commonly used for analgesia for the neck or arms and is not possible following cranial surgery because sensory innervations for the head are intertwined with the cranial nerves
- When EA is used postoperatively for pain control, it can be administered by continuous epidural infusion (CEI), by individual doses on demand, or by a combination of both methods. Patient-controlled epidural analgesia (PCEA) refers to patient self-administration of EA by a computerized infusion pump (more commonly used for I.V. delivery of patient-controlled analgesia [PCA]). PCA permits the delivery of specific doses of medication within a prescribed period of time. The PCA pump is typically programmed to deliver a low dose CEI and to give the patient the option of adding "demand doses." The clinician's order for the "demand doses" includes the amount of medication to be administered in the "demand dose" and a lockout time (i.e., the period of time during which the PCA pump will not release more medication). The PCA pumps used for PCEA can be programmed to deliver any combination of bolus dose (i.e., a relatively large, single quantity of a substance), CEI, and/or "demand doses" for breakthrough pain or in preparation for increased activity such as physical therapy[1, 3, 7]
  - PCEA is particularly effective in relieving patient anxiety concerning pain control because the patient does not have to rely on healthcare staff for administration of analgesia
  - Compared I.V. opioids, CEI has been found superior in relieving pain for up to 72 hours following surgery and in reducing duration of endotracheal intubation
- Drugs commonly used for pain control via postoperative EA are combinations of an opioid and a local anesthetic such as bupivacaine and ropivacaine. The different mechanisms of the two types of drugs create a synergy that yields effective pain control and minimizes the potential for toxicity from a large dose of a single agent[1–4, 6, 7]
  - Morphine sulfate extended-release liposome injection (DepoDur) is a type of EA that was developed as an alternative to an indwelling epidural catheter. DepoDur provides up to 48 hours of analgesia with a single-dose administration, after which the catheter is removed
    - DepoDur is particularly beneficial to patients with impaired hepatic or renal function because it reduces the accumulation of morphine metabolites
- In addition to improved pain control, postoperative use of PCEA has demonstrated the following benefits compared to analgesia administered I.V. or I.M.[1, 3, 4, 6, 7]
  - Increased alertness, less anxiety, improved sleep pattern, and less use of medication
  - Improved pulmonary function and a reduced incidence of pulmonary infection
  - Decreased incidence of myocardial infarction due to a moderate reduction in heart rate and afterload (i.e., impeded flow of blood out of the heart)
  - Decreased incidence of venous thrombosis
  - Reduced incidence of ileus (i.e., adynamic gastrointestinal tract)
  - Fewer medication errors
- Common side effects of EA include respiratory depression, nausea, vomiting, pruritus, usually of the face and chest, sedation, dizziness, and orthostatic hypotension[1, 4, 6]
  - Bladder catheterization is routine in order to prevent urinary retention in patients receiving EA
- Complications of EA[1, 4, 6, 8]
  - The most common complications are benign—failed block/analgesia (e.g., inadequate pain relief due to poorly placed catheter) is reported in up to 15% of patients, and postdural puncture headaches (PDPH) caused by accidental puncture of the dura is reported in up to 86% of patients. Less common complications are neurologically related and include radicular pain (i.e., pain at the root of a spinal nerve) and peripheral nerve lesions
    - PDPH is characterized by pain at the back of the head and neck and a tight pulling and throbbing sensation
    - Unilateral lower extremity numbness with occasional weakness or motor block may occur, usually as the result of the tip of the epidural catheter migrating along a nerve root so that the infused medication is mistakenly concentrated in one area
  - Potentially catastrophic complications of EA are epidural hematoma (i.e., an accumulation of blood in the subdural or epidural space) and epidural abscess (i.e., an accumulation of pus in the epidural space), both of which can mechanically compress the spinal cord and lead to permanent paraplegia. Mortality in cases of EA-induced abscess can be as high as 18%
    - Cardinal signs of an epidural hematoma or an abscess are persistent lower extremity neurologic changes and loss of bowel and bladder control, especially if accompanied by back pain and tenderness. These signs may be difficult to assess if the patient is using CEI. The incidence of epidural hematoma after catheter placement, injection of medication, or catheter removal is estimated to be 1:190,000 cases
  - Additional complications may arise if the catheter moves out of the epidural space, resulting in intrathecal or intravascular delivery of anesthetic and cardiotoxicity
- Contraindications to the use of EA include[1, 5, 6]
  - uncorrected hypovolemia
  - coagulopathy or taking anticoagulants (e.g., low molecular weight heparin)
  - cardiomyopathy or aortic stenosis, because the vasodilation induced by the anesthetic may lead to extreme hypotension in patients who have either of these conditions
  - spinal deformity (e.g., scoliosis or spina bifida)
  - neurological disease, including neuropathy due to diabetes mellitus, because if there is a change in neurologic status—which is common following surgery—diagnosis of a deterioration can be confused with the effect of the EA
  - abnormalities of the CNS (e.g., multiple sclerosis, syringomyelia [i.e., spinal cord disease characterized by the development of cysts or cavities within the cord])
- Ongoing management of patients using a PCEA pump is usually overseen by an anesthesiologist. Nursing responsibilities include[1, 5]
  - evaluation of pain and location, and treatment for medication side effects
  - inspection of the catheter for migration and inspection of the insertion site for drainage, erythema (i.e., redness), inflammation, tenderness, and dressing integrity. Many facility protocols specify that the dressing remain intact, with changes made only when an opaque dressing prevents clinician observation. Aseptic technique is recommended
  - inspection of the PCA pump for malfunction, inspection of the catheter and tubing for kinks and cracks, and review of the medication and infusion regimen. Many facility protocols require that PCA tubing be dedicated solely to EA and that tubing and connection ports be labeled appropriately
- If the catheter is inadvertently removed from the insertion site, the site should be cleansed and dressed; the catheter saved, especially if any portion of it is missing or purulent drainage is present; the anesthesiologist notified; and any unused medication discarded pursuant to facility protocols[1, 5, 6]
- When the insertion and management of the epidural catheter has been uncomplicated, removal of the catheter upon discontinuation of treatment is generally a benign, painless procedure similar to the removal of central venous and pulmonary artery catheters[1, 5, 6]

What We Can Do

- Become knowledgeable about EA and its use in the postoperative setting so you can accurately assess your patients' needs; share this information with your colleagues
- Collaborate with the education department and/or the pain control service at your facility, if available, to develop educational programs and informational materials on postoperative EA for clinicians of all specialties
- Monitor your patients for complications related to the use of epidural catheters and PCEA pumps, and for any side effects of related medication
- Collaborate with your patients and their treating clinician(s) to develop a pain management plan
  - Advise the patient of the importance of pain management to recovery
  - Instruct the patient on the use of pain rating scales and the importance of advising clinical staff of breakthrough pain. Advise the patient of the availability of supplemental analgesia
  - Inform the patient of the potential side effects of the analgesia
  - Discuss the level and types of permitted activity while the epidural catheter is in place

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Coding Matrix

References are listed in order of strength:
M Published meta-analysis
SR Published systematic or integrative literature review
RCT Published research (randomized controlled trial)
R Published research (not randomized controlled trial)
C Case histories, case studies
G Published guidelines
RV Published review of the literature
RU Published research utilization report
QI Published quality improvement report
L Legislation
PGR Published government report
PFR Published funded report
PP Policies, procedures, protocols
X Practice exemplars, stories, opinions
GI General or background information/texts/reports
U Unpublished research, reviews, poster presentations or other such materials
CP Conference proceedings, abstracts, presentations

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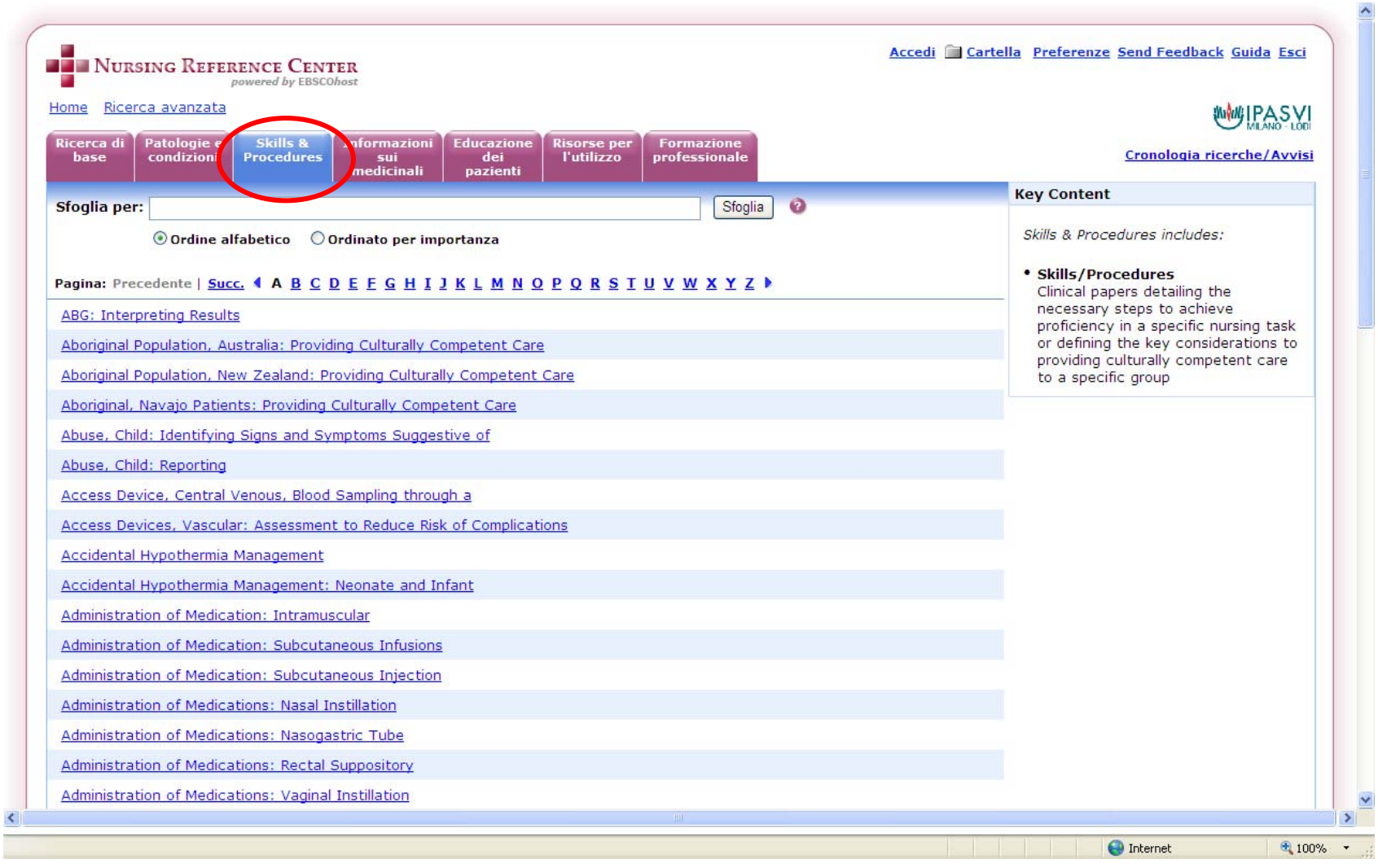
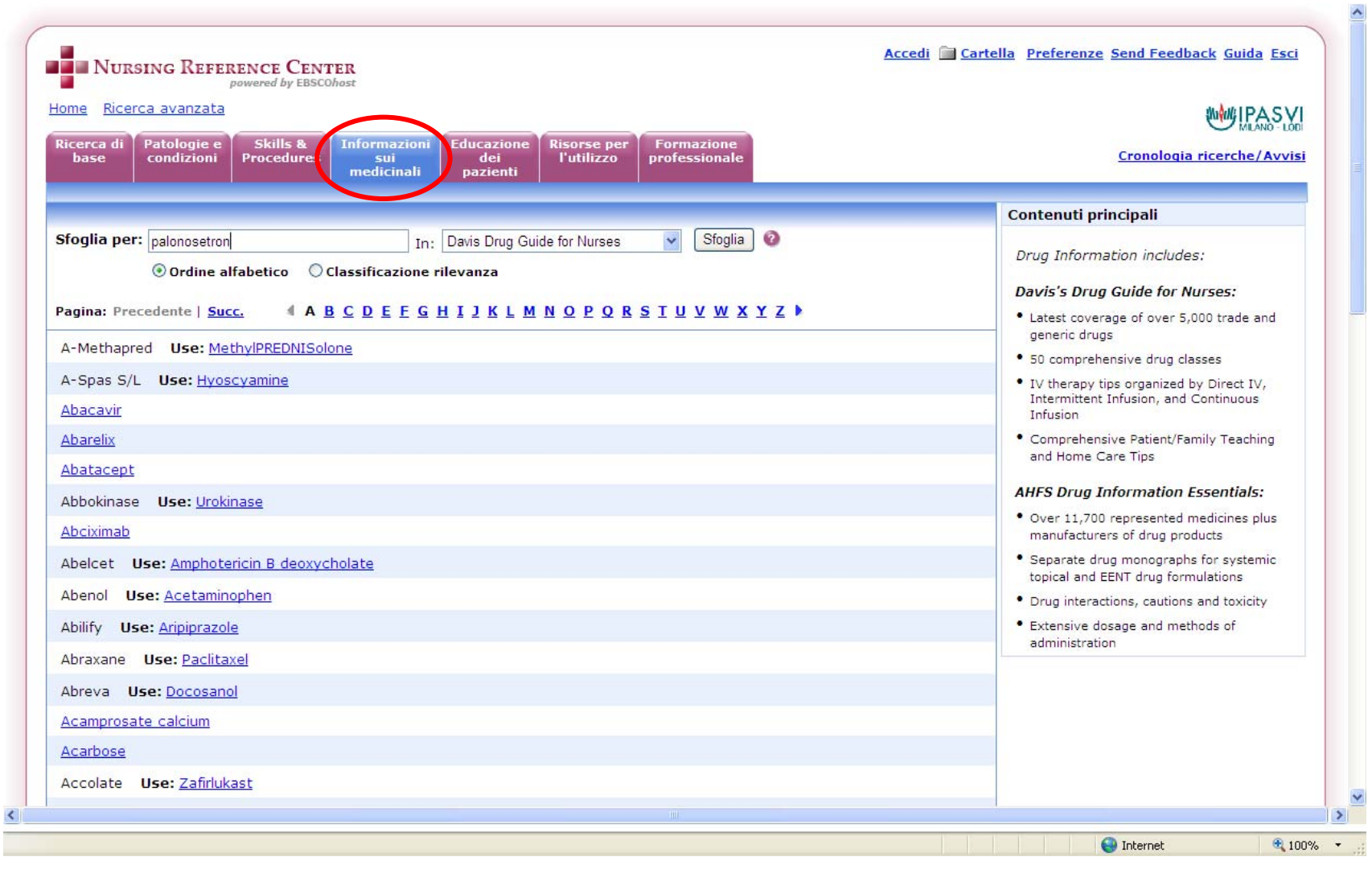
Internet

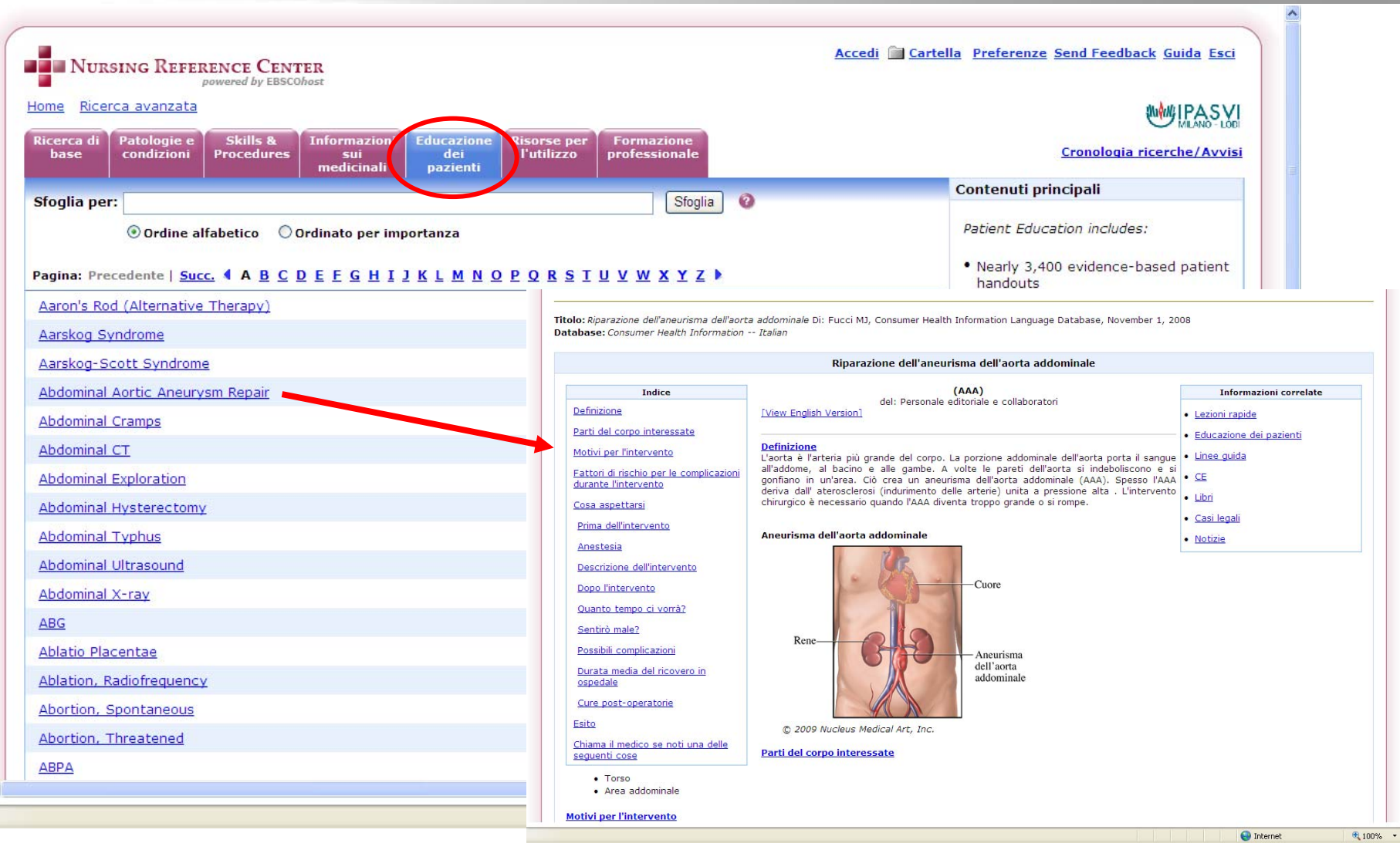
Le **Schede Evidence-Based** forniscono invece le migliori evidenze, ovvero cosa si sa di una specifica patologia e come questa può essere curata.



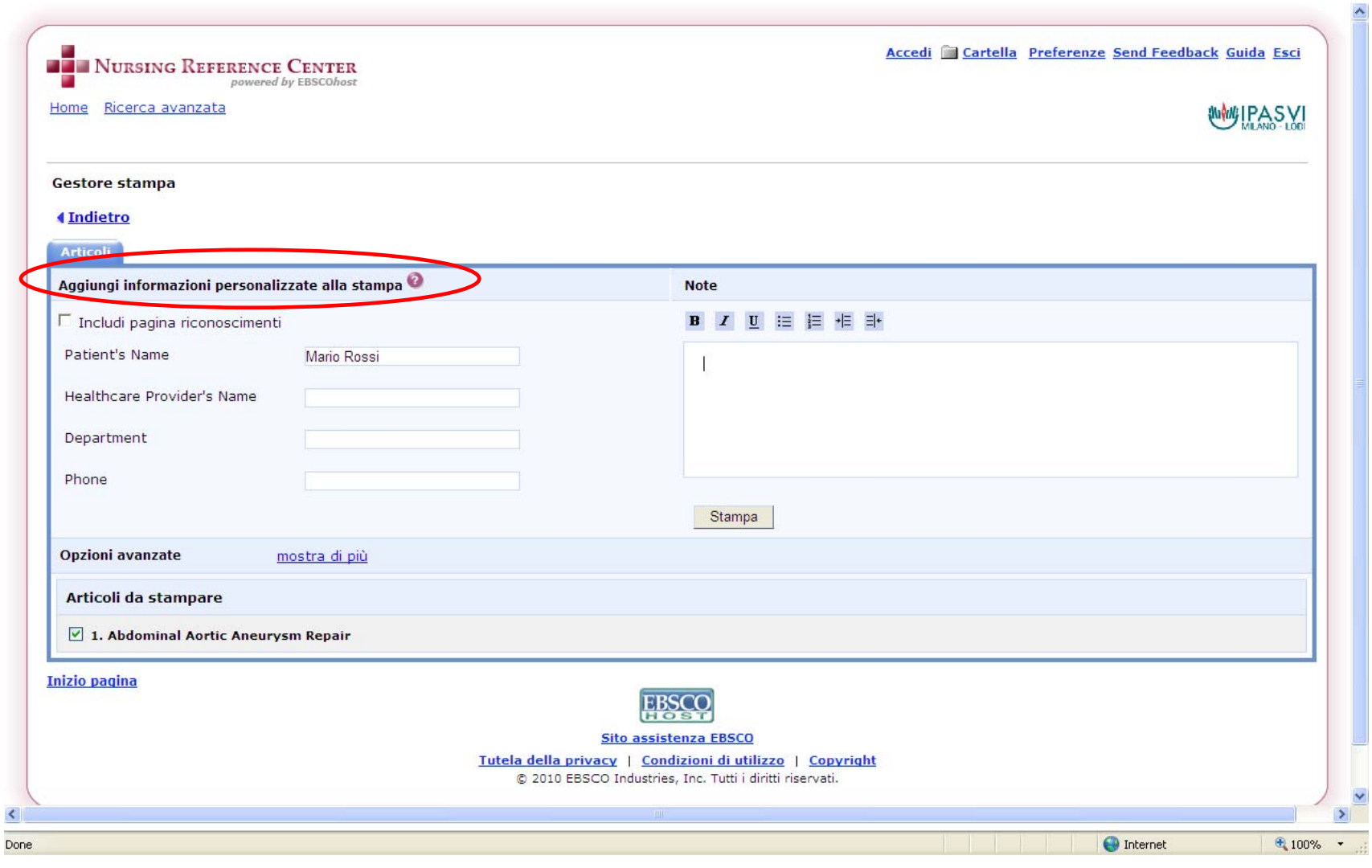
Nella sezione ***Skills & Procedures*** si trovano documenti clinici che descrivono i passaggi necessari a raggiungere una buona conoscenza su una specifica attività infermieristica o a definire la principali azioni da compiere per fornire un valido supporto culturale ad un gruppo specifico di persone.



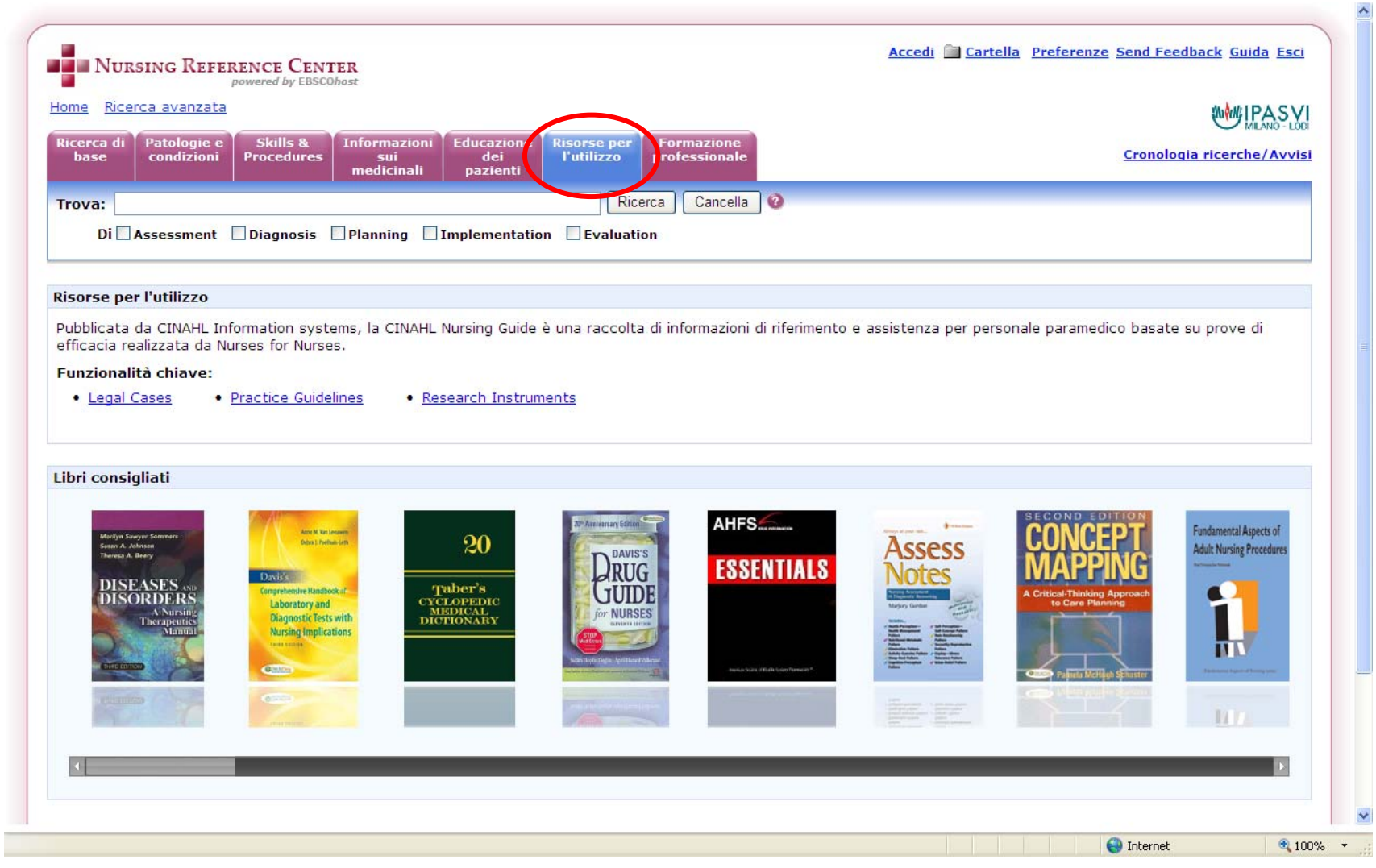
Le **Informazioni sui Medicinali** consentono di cercare dettagliate informazioni su specifici farmaci all'interno di monografie dedicare: *Davis's Drug Guide for Nurses* e *AHFS Drug Information Essentials*



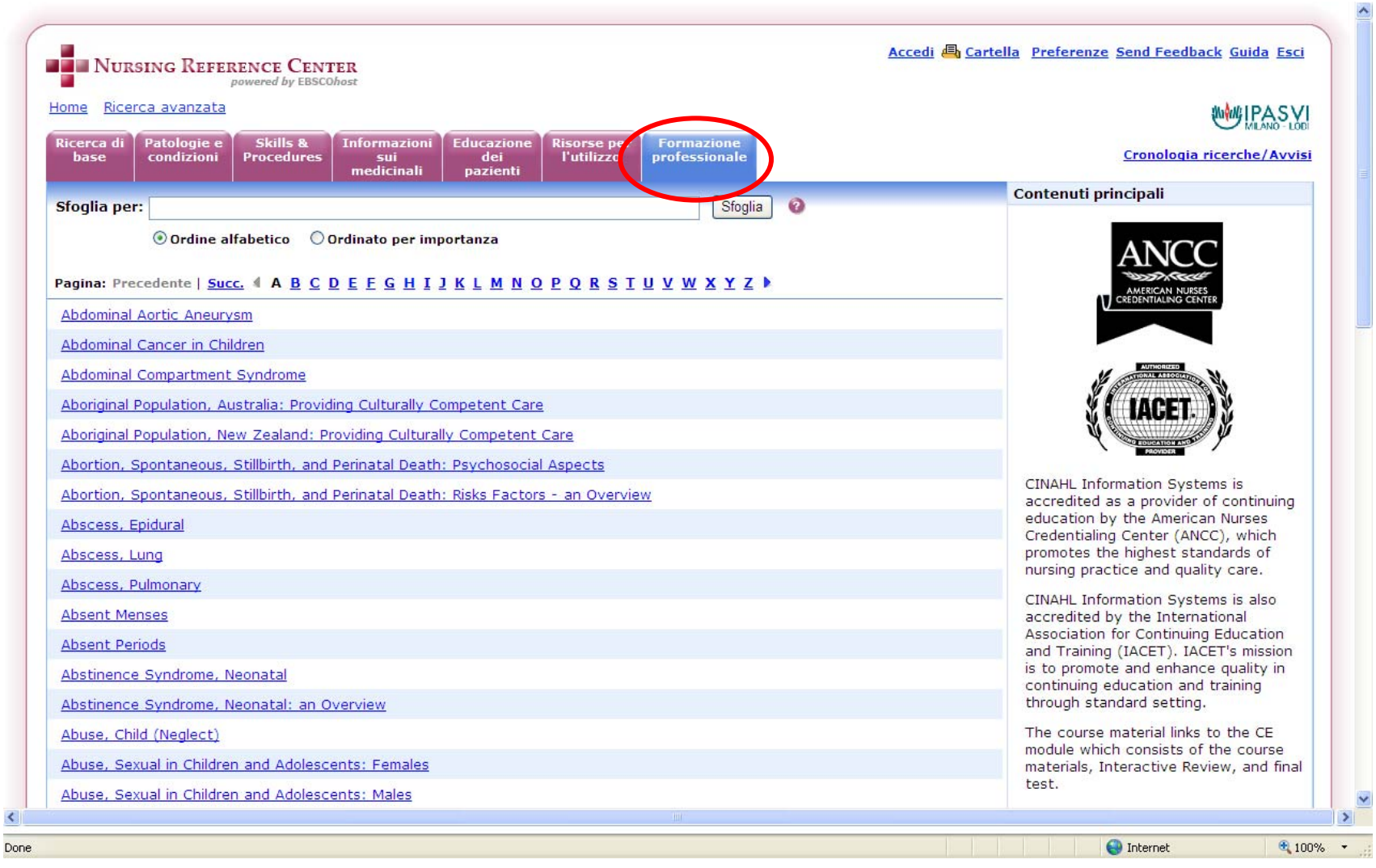
La sezione **Educazione dei Pazienti** contiene schede informative, basate sulla medicina dell'evidenza, dedicate ai pazienti. Ad oggi le schede sono principalmente in inglese, ma ne sono incluse anche circa 200 in lingua italiana.



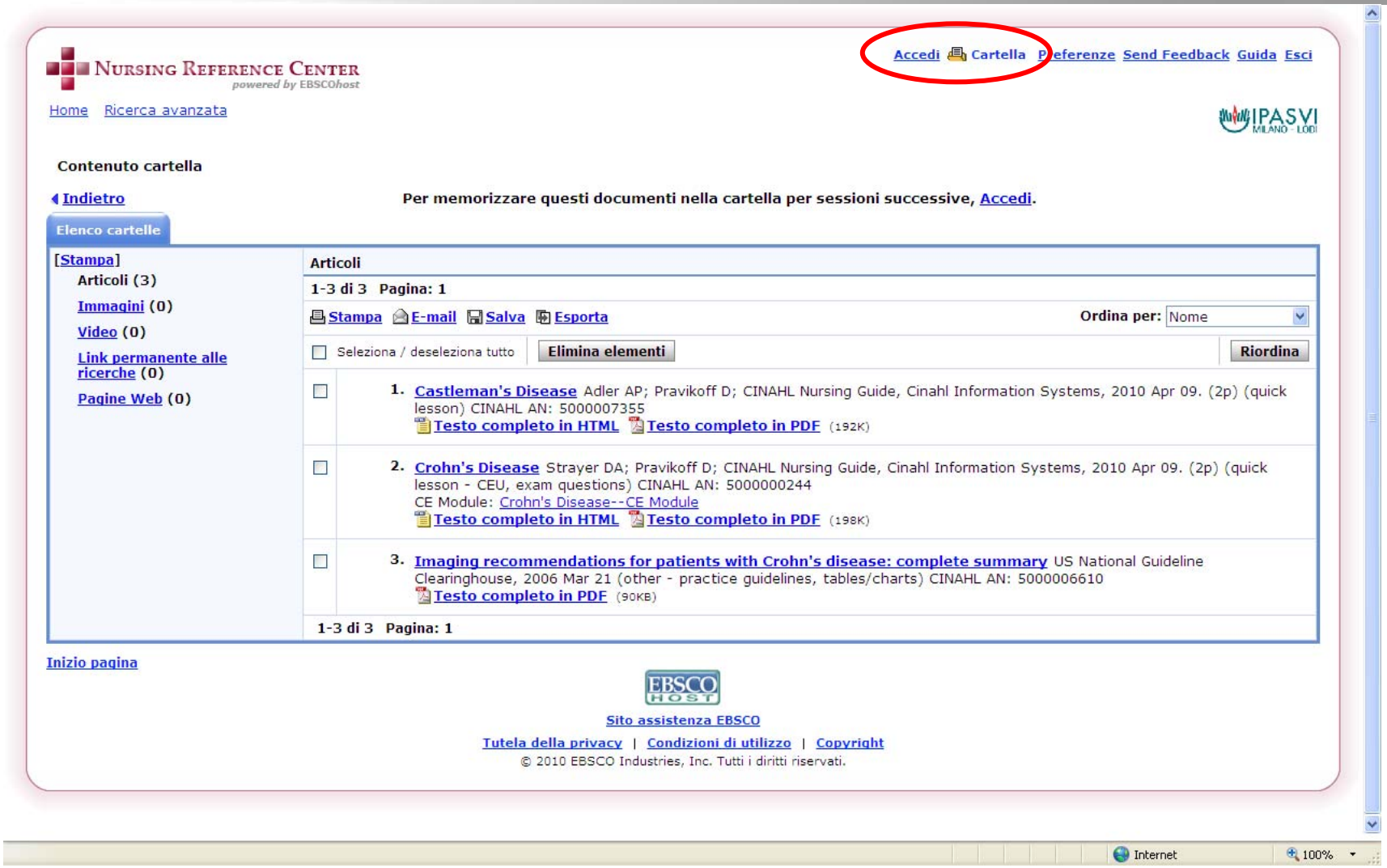
E’ possibile stampare la scheda per il paziente aggiungendo delle note specifiche, ovvero personalizzando l’informazione per l’utente finale.



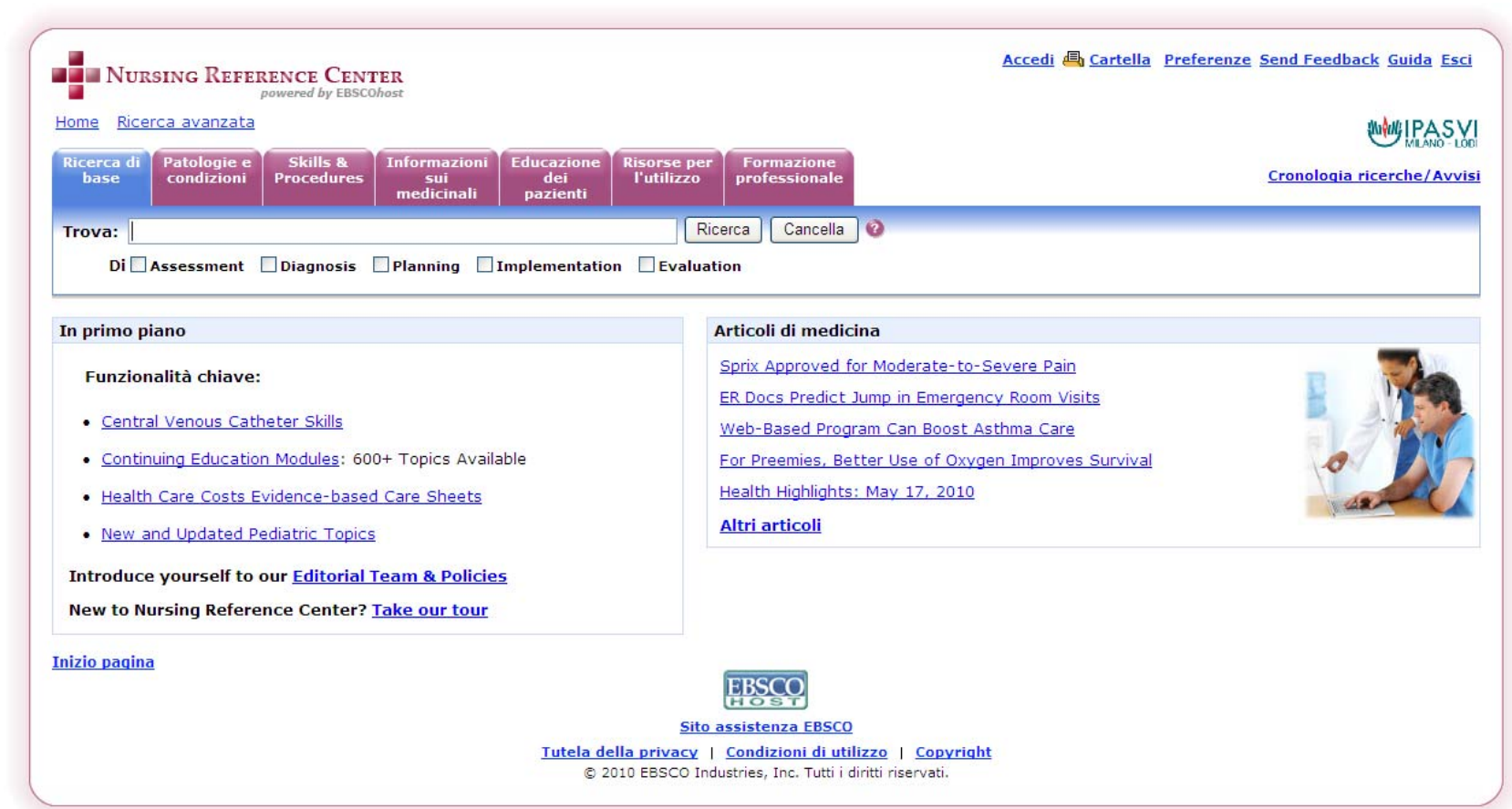
La **Risorse per l'Utilizzo** fornisce l'accesso a specifiche risorse, come manuali sui farmaci, linee guida, casi legali e strumenti di ricerca



Infine, nella sezione **Formazione Professionale**, si trovano moduli per valutare l'auto-apprendimento su specifici argomenti trattati dalla banca dati.



Attraverso NRC è possibile creare una propria cartella personale, all'interno della quale salvare i documenti di interesse, i risultati di una ricerca specifica, criteri di ricerca già impostati oppure impostare un servizio di avviso automatico sull'uscita di nuove informazioni che riguardano un argomento di interesse. E' sufficiente registrarsi una sola volta per crearsi una propria cartella personale e avere quindi



Ritornando all'**Home Page**, si trovano alcune interessanti informazioni, che variano nel tempo.

L'area definita **In Primo Piano** contiene collegamenti ad alcune funzioni chiave di NRC.

Lo spazio definito invece **Articoli di Medicina** contiene link ad articoli particolarmente utili.