

# [Reading ekg strips–nur 105](https://assignbuster.com/reading-ekg-stripsnur-105/)

if there is a P-wave, the rhythm will be one of these sinus rhythmssinus rhythm: normal sinus rhythm, sinus bradycardia, or sinus tachycardiaif you do not have a P-wave, the rhythm isventricular ONREADING EKG STRIPS– NUR 105 SPECIFICALLY FOR YOUFOR ONLY$13. 90/PAGEOrder Nowdetermine the rate60-100 (NSR or AJR) <60 (SB or JR) > 100 (ST or JT)PR interval= 0. 12-0. 20 (3-5 little boxes)sinus rhythm, sinus brady, sinus tachPR interval= <0. 12 (less than 3 boxes)junctional rhythm, next look at ratePR interval=> 0. 201st degree heart block--type of rhythm with 1st degree heart blockno p-waveventricular tachycardia, ideoventricular, atrial flutter, fixed conductionregular QRS0. 06-0. 10super ventricular tachycardia <3 little boxeswhen do you cardiovertwhen you have a pulsewhen do you defibrulatewhen you have no pulsewhat drug(s) do you use for asystoleepinephrine, atropinethe drug used to chemically cardiovert SVT isadenosinenursing diagnosis related to CABGfear, deficient knowledge, ineffective cardiac tissue perfusion, decreased cardiac output, impaired gas exchange, risk for imbalanced fluid volume, disturbed sensory perception, acute pain, ineffective tissue perfusion, ineffective thermoregulationCVP normal value: wedge pressure: PAPCVP: 0-4 wedge pressure: 8-15 PAP 20-30/5-15pulmonary edemamassive left sided heart failure, full of fluid, pink frothy secretions   
treatment: diuretics (lasix first line); if pt has renal failure (nitroglycerin and morphine)irregular rhythmsa-flutter, sinus arrhythmia, 2 degree or 3 degree heart block, a-fibnarrowing pulse pressure would be seen in which patienttamponade, also massive JVDpacemaker information required on chartmodel of pacemaker, type of generator, date and time of insertion, location of pulse generator, stimulation threshold, pacer settings (eg, rate, energy output, sensitivity, duration of interval between atrial and ventricular impulses)endocarditis infective risk factorsrisk factors: heart valve prosthesis, hx of heart disease (mitral valve prolapse), chronic dibilitatin disease, IV drug abuse and immunosuppressionpericarditisfriction rub, notched T wave   
S/S: fever, positional chest discomfort, nonspecific ST segment elevation, elevated ESR erythrocyte sedimentation rate, retrosternal pain that worsens during supine positioning, pulsus paradoxushypokalemia wave from changesU waves after the Thyperkalemiatall QRS complexeshypomagensiumtorsades de pointesmedications to treat ventricular dysrhythmiaslidocaine, beta blockers, amiodarone (drug of choice for v-tac)right heart failure (chronic condition)JVD, dependent edema, right upper gastric pain (right heart handles systemic blood return)left heart failurebibasilar fine crackles, dyspnea, tachycardia, S3 and S4 heart sounds, fatigue, hemoptysis, non-productive cough, cool pale skin, PMI displaces toward the left anterior axillary lineinferior wall myocardial infarctiont-wave inversion: inadequate blood supply   
ST segment elevation: injury, prolonged ischemia   
pathological Q waves: are all signs of tissue hypoxiadigoxinhold if apical pulse is less than 60bpm   
digitalis toxicity= vision changes (halos), dysrhythmia, anorexia, nausea, vomiting, headache, and malaise   
increases force of myocardial contraction and decreases HRa-fibwarfarin to prevent clots and decrease risk of stroke, digoxin to control HR12 lead EKGST elevation indicates immediate myocardial injury   
ST depressions indicate myocardial ischemia   
Q wave forms several days after a myocardial infarction   
U wave is a sign of hypokalemialasix furosemideIV push: give at a rate of 20mg/min or less   
rapid injection can cause hearing loss as a result of ototoxicity   
normal daily dose: 40mg loop diureticnitroglycerinreduces oxygen consumption to reverse ischemia and relieve pain. vasodilator mainly in veins and reduces blood return to heart and preload is reduced. may cause a significant drop in cardiac output and BP if pt is hypovolemic at higher dosescalcium channel blockersslows heart rate and decreases strength of contraction which decreases workload of heart. relaxes blood vessels decreasing BP and increases coronary artery perfusionrheumatic fevercaused by streps/s of infective endocarditisosler's nodes (red, painful nodules on the fingers and toes), splinter hemorrhages, fever, diaphoresis, joint pain, weakness, abdominal pain, new murmur, Janeway's lesions (small, hemorrhagic areas on fingers, toes, ear, and nose)myocarditis s/sflu-like symptoms, fatigue, dyspnea, palpitations, and occasional discomfort in the chest and upper abdomen. may develop dysrhythmias, or ST-T wave changes. systolic murmur, gallop rhythmACE inhibitorspromote vasodilation and diuresis by decreasing afterload and preloaddobutamineleft ventricular dysfunction. increases cardiac contractility. at high doses, it also increases HR and incidence of ectopic beats and tachydysrhythmias. take care in pt with a-fibCK-MB earliest increase, peak and return to normal4-8hrs, peaks 12-24hrs, and retunrs to normal 1-3 weekstroponin earliest increase, peak and return to normal3-4hrs, peaks in 4-24hrs and returns to normal 1-3weekslabs for heart failureBUN, TSH, CBC, BNPmitral stenosis: rhythms, S/Sdyspnea, progressive fatigue, hemoptysis, paroxysmal nocturnal dyspnea, cough, wheeze, repeated respiratory infections   
dysrhythmias like a-fib   
tests doppler echocardiographyaortic regurgitation: causecaused by inflammatory lesions that deform the leaflets of the aortic valve. also infective or rheumatic endocarditis, congenital abnormalities, diseases such as syphilis, dissecting aneurysm, blunt chest trauma, or valve replacementaortic regurgitation: S/Sforceful heartbeats in head and neck, arterial pulsations that are visible or palpable at the carotid or temporal arteries. exertional dyspnea, fatigue, progressive s/s of left ventricular failure including breathing difficulties, orthopnea, PNDvalve replacement teaching: pre and posttake long term anticoagulant therapy, frequent follow up appointments and blood lab studies. may need to take aspirin, prescribed medication teachingcardiac tamponade: S/Slife threatening need stat interventions, fullness within the chest, substantial or ill defined pain, sob, massive JVD, falling systolic blood pressure, narrowing pulse pressure, rising venous pressure (increased JVD) and distant heart soundscardiac tamponade treatmentpericardiocentesis, pericardiotomy (pericardial window)CABG70% occlusion (60% if in the left main), artery must be patent beyond the occlusion. use greater saphenous vein, lesser saphenous, cephalic and basilic veins