NR 546 Week 6 Case Study
……. – Aug 2023

HISTORY OF PRESENT ILLNESS:

A 57-year-old male was brought to ED by his aunt. The client has been experiencing hematemesis and chest pain, starting at 3:00 p.m. He is being triaged in the emergency department. A medical history is taken. The client has no history of myocardial infarction (MI) but has hypertension and a history of ulcers. The client appears anxious and hypervigilant. He repeatedly asks the nurse if "he can have something for pain" and becomes increasingly guarded as the nurse requests more details about his medical history, replying smirkingly, "you have all of that in my records." He denies feeling depressed and says he is "just stressed out about his housing situation." He is cooperative with ECG but is restless.

The clients' aunt asks if she can speak to the ED provider for a "quick moment" and then explains that the client often leaves home on weeknights but does not return home until the evening of Sunday. Furthermore, she states sometimes, he goes missing several nights a week. Throughout the week, he often reports that he is in pain 12-18 hrs. a day. She also noticed some emesis off and on these past few months. He often accuses others of stealing his phone and his money from his bank account despite being the only person with access. She acknowledges that he has been having problems coping since his discharge from the Marines and the injury to his jaw.

PAST PSYCHIATRIC HISTORY:
The client denies any past psychiatric history; he has never been hospitalized in a psychiatric hospital but is currently taking an antidepressant. He denies that he uses drugs recreationally, but recent UDS indicated cocaine. Patient states, "I am just here 'cause I'm throwing up blood."

PAST MEDICAL HISTORY:
The client reports he has TMJ d/t previous surgery and ulcers because he takes too much aspirin (1000 mg – 2500 mg a dose of aspirin or Tylenol). Patient has prescription of oxycodone 5 mg- 10 mg for severe TMJ pain.

MENTAL STATUS EXAM:
The client is alert and oriented and appears inappropriately dressed, with short pants and a winter jacket. His speech is rapid and mildly increased in volume but slightly garbled. He is restless and looks around the room frequently, though he does not exhibit psychomotor agitation. Client describes his mood as "good for now," "just having chest pain but I think the bleeding stopped," but his affect is extremely anxious, irritable, and guarded. Client thought process is linear and goal-directed, but thought content shows some paranoid ideation toward the ER staff. The client denies hallucinations and suicidal or homicidal ideation. His cognition is intact. Insight and judgment seem to be limited.

PHYSICAL EXAM:
VITAL SIGNS: HR= 94/min.; B/P 210/98; Temp= 98.5 F, resp.= 18/min.
The client is breathing comfortably and appears restless without obvious signs of distress. The client appears average weight for his height, and there are traces of dried blood noted on his chin. Cardiac exam reveals no signs or murmurs, rubs, or gallops. The remainder of the exam was likewise unremarkable.

NEUROLOGIC EXAM:
Cranial nerves 2-12 are intact. Pupils are pinpoint.
A mild tremor is noted in both hands. No other abnormal movements are noted. There are no sensory or motor deficits. Gait is normal.

LAB. TESTING:
CPK= 60 micrograms mcg/L (WNL); other cardiac enzymes show no indication of MI.

DIAGNOSTIC TESTING:
EKG: Normal sinus rhythm at 100 bpm; flipped T waves in several leads. Chest x-ray normal.

Diagnosis: Opioid Use Disorder (F11.20)

A. Select one drug to treat the diagnosis(es) or symptoms.

Having an understanding that when dealing with Opioid Use Disorder (OUD) treatment will require an effort by both the client and the healthcare team. The current approach can utilize any number of medications when using a medication assisted treatment (MAT). The benefits of MAT are: Facilitates safer withdrawal by relieving symptoms and controlling cravings, reduces the risk of death due to overdose, increases retention in treatment with safer, controlled medications, decreases illegal drug use and, with it, the potential dangers and legal consequences, and prevents relapse when integrated with counseling and behavioral therapies. According to Ghanem, N., Dromgoole, D., Hussein, A. & Jermyn, R. (2022), "three medications have been approved for the treatment of OUD: methadone, naltrexone, and buprenorphine." After discussing with the client, the method and the requirements for each medication, a joint decision was made for Buprenorphine.

B. List medication class and mechanism of action for the chosen medication.

Buprenorphine is classified as a mu opioid receptor partial agonist that works by binding to the mu opioid receptor, preventing exogenous opioids from binding there and thereby preventing the pleasurable effects of opioid consumption.