National Indian Nurse Practitioners Association of America

(NINPAA)

SOUVENIR

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National Indian Nurse Practitioners Association of America (NINPAA)

Vision

Vision of the National Indian Nurse Practitioners Association of America (NINPAA) is to promote professional excellence, career advancement, quality healthcare through leadership, education and advocacy by Nurse Practitioners (NP).

Mission

Mission of NINPAA is to facilitate and enable Indian American Nurse Practitioners of all specialties to ensure the best quality primary and specialty health care to all. NINPAA encourages networking at state and national level and strives to provide educational and professional development of its members.

Values

- Identify best practices and promote high quality outcomes
- Professional Accountability and Reliability
- Foster evidence-based practice through research and continuous quality improvement
- Provide high quality education and resources for members
- Advocate for health care policies and collaborate with strategic partners in the policy arena

Nurse Practitioners' Timeline

1965 : Dr. Loretta Ford and Dr. Henry Silver developed the Nurse Practitioner program at the University of Colorado.

1967 : Boston College initiates one of the earliest masters programs for NPs.

1968 : Directed by a nurse and physician team, the Boston-based Bunker Hill/ Massachusetts General Nurse Practitioner Program begins.

1985 : A small group of visionaries convened under an apple tree in Pennsylvania to address the growing need for NPs of all specialties to have a unified voice. Thanks to their foresight, AANP has flourished and now represents the interests of over 222,000 NPs.


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Chief Editor's MESSAGE

Greetings from the Editorial Board!

As members of the editorial board, it gives us immense pleasure and a great sense of pride to present this first edition of National Indian Nurse Practitioners Association souvenir. For almost two years our members have been in pursuit of establishing an organization of our own to meet the needs and goals of Indian nurse practitioners in America.

As we all know, nurse practitioners have quickly become the health partner of choice for millions of Americans. NPs are more than just health care providers; they are mentors, educators, researchers, and administrators. Patients report an extremely high level of satisfaction with the care they receive from NPs.

This souvenir is the outcome of the consistent hard work of a dedicated team who was willing to walk the extra mile after their hectic daily work schedules. I feel honored and privileged to be working with this dynamic team for such a great cause.

Our sincere thanks go to Dr. Aney Paul, NINPAA President, for taking an active and extraordinary role in fulfilling this dream. Our thanks go to Tesmol James for the cover design and layout, Reena Zachariah and Grace Mani for editing the articles, and all the other members for contributing their time and talent for publishing this souvenir.

The references for the articles published in this souvenir will be available upon request. With lots of confidence and enthusiasm let us move forward for a great cause.

Sincerely,

Bridget Parappurath, CRNP, CCRN
Chief Editor

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Governor's MESSAGE

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

ANDREW M. CUOMO
GOVERNOR

March 27, 2017

Dear Friends:

It is a pleasure to send greetings to everyone gathered for this special event representing the official inauguration of the National Indian Nurse Practitioners Association of America.

The Empire State places a high priority on quality health care and values organizations that represent the interests and concerns of various sectors of the medical community, including professional nurse practitioners. Tonight's celebration marks the launch of your Association and I applaud such strongly exemplified pride in your profession and in your common ancestry.

The National Indian Nurse Practitioners Association of America is certain to provide a cohesive voice for the nationwide Indian community of nurse practitioners who share a connection through their heritage and professional affiliation. All New Yorkers appreciate those dedicated individuals who contribute to our state's system of health care, including the many nurse practitioners who remain an integral component of our health care system, as they work in a variety of settings to offer prevention as well as treatment of health problems.

On behalf of all New Yorkers, I welcome you to the Empire State and extend gratitude for your compassionate work, tireless efforts, and commitment to quality health care.

With warmest regards and best wishes for every future success.

Sincerely,

ANDREW M. CUOMO

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Senator's MESSAGE

Independent Democratic Conference Whip
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Committees:
Alcoholism and Drug Abuse
Energy and Telecommunications
Ethics
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Investigations and Government Operations
Local Government
Mental Health and Developmental Disabilities
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Veterans, Homeland Security and Military Affairs

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STATE OF NEW YORK

DAVID CARLUCCI
SENATOR, 38TH DISTRICT

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Albany, NY 12247
(518) 455-2991
Fax (518) 426-6737

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New City, NY 10956
(845) 623-3627
Fax (845) 708-7701

Westchester Office:
2 Church Street, Ste. 210
Ossining, NY 10562
(914) 941-2041
Fax (914) 941-2054

E-Mail Address:
Carlucci@nysenate.gov

March 27, 2017

Dear National Indian Nurse Practitioners Association of America (NINPAA),

Congratulations on your inauguration! As a state legislator, I have worked closely with non-profits throughout my tenure and greatly appreciate the commitment to helping others. Your mission statement is admirable and our state right now needs nothing more than the best possible quality care when it comes nursing.

I look forward to working with your organization and feel free to contact me if you ever have questions or concerns. You can contact me at the following telephone number: 845-623-3627.

Sincerely,

Senator David Carlucci
38th Senate District

DCS:PJS

President's MESSAGE

National Indian Nurse Practitioners Association of America (NINPAA)

C/o 37 Etna Place, Nanuet, NY 10954, 845-304-1580, aneypaul@yahoo.com

Welcome to the newly-formed National Indian Nurse Practitioners Association of America (NINPAA). NINPAA currently has more than 50 members from 9 states. I am humbled and honored to be the first President of NINPAA. I want to personally acknowledge each and every one of you and extend my sincere appreciation to our great team, an excellent group of dedicated, hardworking, loyal office-bearers who helped to bring this organization to fruition. I am sure that together we can take NINPAA to new heights. Today is just the beginning.

NINPAA has Indian-American Nurse Practitioners of various specialties, and our mission is to facilitate and enable Indian Nurse Practitioners to ensure the best quality primary and specialty healthcare to all. We aim to promote professional excellence, career advancement and quality healthcare through leadership, education and advocacy by Nurse Practitioners. We are in our infancy stage; it is important to increase awareness of NINPAA as a professional organization and to network with healthcare organizations locally, nationally and globally.

Since 2015 we had monthly conference calls and case presentations, discussing and sharing experiences to help improve our knowledge and we will continue that. We will help Nurse Practitioner students by mentoring, helping with clinical placements and encouraging advanced degrees. We will promote a healthy community, and encourage members to actively participate in local and national Nurse Practitioner associations. We will work with local and national Indian Nurses Associations, as well as with the Association of Kerala Medical Graduates (AKMG) and the American Association of Physicians of Indian Origin (AAPI).

I want to thank all of the sponsors, and all those who submitted articles. I want to thank all the executive board members, committees, the directors-at-large, and the editorial board for their valuable contribution. It is a privilege to have a great team with great passion and dedication. Your support will help us move forward with our current and future initiatives. Like any other professional group, leadership and member participation are vital forces that create a vibrant organization. There is power in numbers and certainly in unity. Let us work together, and together we can make a difference.

Thank you for the opportunity to serve. God bless you, and God bless America.

Aney Paul, DNP, MPH, MSN, PNP
NINPAA President

"Coming together is the beginning. Keeping together is progress. Working together is success."
- Henry Ford

Secretary's MESSAGE

Greetings!

It is my greatest honor to be working with such talented and outstanding nurse practitioners (NPs) of Indian origin. The National Indian Nurse Practitioner Association (NINPAA) was started in the year 2015 to fulfill the growing need for professional support for NPs of Indian origin. Since then, NINPAA has grown and now represents the interest of NPs from nine states with over 50 members with numbers increasing every day.

I take this opportunity to acknowledge those who worked tirelessly to register NINPAA as a national organization in August 2016. My sincere thanks to those who arranged and participated in the monthly conference calls and networking, which has now become the main form of communication among the members. I salute those who offered several educational presentations that were embraced with open arms. Hats off to those who organized the first NINPAA committee meeting in New York in December 2016. Since I am a great supporter for volunteer work, my heartfelt gratitude to those who volunteered via health fairs within United States and internationally. I commend all who are involved in the NINPAA inauguration and Souvenir presentation scheduled for April 29th in NY.

NINPAA has an exceptionally talented group of NPs with brilliant dreams. Our members write articles, present educational materials, write poems, draft logos and outline Souvenirs. I look forward to work together to continue to build this organization to ensure shared success for future generations of NPs.

Anu Varghese, DNP, FNP
Secretary, NINPAA

APRN Regulatory Model

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE). • Licensure is the granting of authority to practice. • Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs. • Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession. • Education is the formal preparation of APRNs in graduate degree-granting or postgraduate certificate programs.

Treasurer's MESSAGE

Dear Friends,

I am so humbled, honored and privileged to assume the role of treasurer of the National Indian Nurse Practitionbers Association (NINPAA). I am deeply grateful to our President Dr. Aney Paul, for her leadership and outstanding contributions to NINPPA during her Presidency, also to Secretary Dr. Anu Varghese and all other members of the Executive Committee and Board. I am inspired by their commitment to NINPPA. Indeed, the growth of NINPAA has been propelled collectively by the members. I wanted to thank all the members of the NINPAA for their membership and time contributions. I look forward to continue working towards fulfilling the mission of the association by reaching out to the community to increase membership and help the members advance in their career through educational programs.
Best wishes to all.

Prasanna Babu, MSN, FNP-C
Treasurer, NINPAA

Who is a Nurse Practitioner?

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. Nurse practitioners assess, diagnose, treat, and manage acute episodic and chronic illnesses. NPs are experts in health promotion and disease prevention. They order, conduct, supervise, and interpret diagnostic and laboratory tests, prescribe pharmacological agents and non-pharmacologic therapies, as well as teach and counsel patients, among other services. Licensed, independent clinicians, NPs practice autonomously and in coordination with health care professionals and other individuals. They may serve as health care researchers, interdisciplinary consultants, and patient advocates. NPs provide a wide-range of health care services to individuals, families, groups, and communities.

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Congratulations and Best Wishes to NINPAA

Tesmol James, FNP & Family (TX)

Congratulations and Best Wishes to NINPAA

Deepa Maria Jose, ANP & Family (NY)

MESSAGE

ASSOCIATION OF KERALA MEDICAL GRADUATES (AKMG)

GREATER NEW YORK CHAPTER

We at the Association of Kerala Medical Graduates (AKMG) Greater New York Chapter are proud of the great initiative of the National Indian Nurse Practitioners Association of America (NINPAA) to launch the national organization with a mission to facilitate and enable Quality Health Care and Network with Professionals in healthcare. Nurse Practitioners are now the backbone of healthcare rendering in our country and as we have seen over the years the role of Nurse Practitioners have evolved into broader and more specialties.

Our community of healthcare providers can network in so many avenues and help enrich our knowledge and be a constructive venue for outreach in the communities we live in. Medical education has advanced so much since our educational years and so much information is coming out which through these venues can be disseminated easily and effectively.

Healthcare in our country is going through much transition since last few years and what we see is, it is going to continue transformation for many more years to come. More than ever health education and awareness has become more important than ever before as many of those who cannot afford might be swaying away from going for routine screenings and as Community Healthcare Providers we should be the source of guiding them to better healthcare and decisions.

AKMG has been a pioneer in Ethnic Physicians Association in USA and has been in the forefront of education, cultural and charitable work for the last 37 years and our commitment stands stronger and better every year as we move forward. We are committed to work with NINPAA in all avenues we can to enrich our Educational and Networking Mission to better serve the communities we live in.

I applaud the leadership of Ms. Aney Paul, President NINPAA, and all the organizing leaders for this great venture and wish you all the very best in coming years to effectively be able to make your vision a great success.

Thomas P. Mathew, MD, FACP
President, AKMG Greater New York Chapter

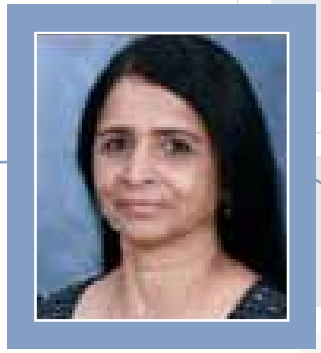
Congratulations and Best Wishes to NINPAA

Smitha Prasad, ANP & Family (NJ)

Congratulations and Best Wishes to NINPAA

Beena Rajagopal, ANP & Family (MA)

MESSAGE



INDIAN NURSES ASSOCIATION OF NEW YORK

It is an honor and privilege as the President of the Indian Nurses Association of New York (INA-NY) to congratulate the Executive Board of the National Indian Nurse Practitioners Association of America (NINPAA) on their inauguration on the 29th of April, 2017.

This is a celebration of Indian Nurses and their commitment to the advancement of the nursing profession. As the vision of NINPAA is to promote professional excellence, advancement and quality healthcare through leadership, education and advocacy by Nurse Practitioners. I have no doubt that the organization will succeed under the leadership and guidance of its founding members.

INA-NY encourages and invites NINPAA to collaborative and participate in our future events. We hope to achieve great visions and goals together and look forward to your support. Together we can encourage and motivate all nurses. Together we can foster evidence-based practice and help to contribute to research and improvement of nursing care. As a team we can bring positive change and representation to the nursing profession.

The Indian Nurses Association of New York would like to once again congratulate NINPAA and wish all its members an exciting journey ahead. We look forward to collaborating and supporting your organization as INANY was established to bring Indian Nurses together and enrich personal and professional growth to help better service to our community.

Sincerely,

Mary Philip RN, MSA, CNOR
President
Indian Nurses Association of New York

National Indian Nurse Practitioners Association of America (NINPAA)
c/o 37 Etna Place, Nanuet, NY 10954
845-623-8549

MEMBERSHIP FORM

Full Name	
Current Address	
Home Phone Number	
Cell Phone Number	
E-mail address	
Nursing College/ University attended in USA	
Nursing College/ University attended abroad	

PROFESSIONAL DETAILS

Education (please check all that apply)	☐ FNP ☐ ANP ☐ PNP ☐ CNM ☐ DNP ☐ PhD ☐ Other: _____
Work Setting (please check)	☐ **Clinic** ☐ Hospital ☐ School/College Health ☐ Academia ☐ Nursing Home ☐ Private Practice ☐ Other: _____

TYPE OF MEMBERSHIP

☐ *NP Membership (2-Year): $50.00* ☐ Associate *NP Membership (2-Year): $50.00*

☐ *Retired NP Membership (2-Year): $25.00* ☐ *Student NP Membership (2-Year): $25.00*

☐ *New Membership* ☐ *Renewal*

_____ _____

Signature of Member *Date*

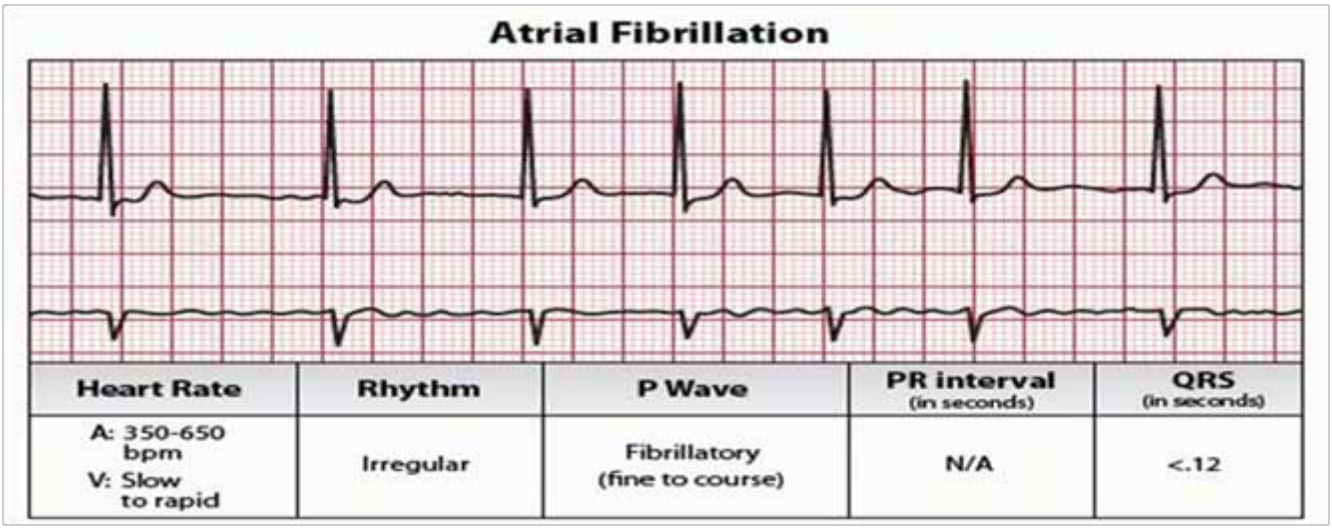
FOR OFFICIAL USE ONLY

Application/Fee Received on:_____ Check #: _____ Date: _____

Approved: ☐ Yes ☐ No Name of the Official: _____ Signature: _____:

Atrial Fibrillation or Irregular Heart Beat

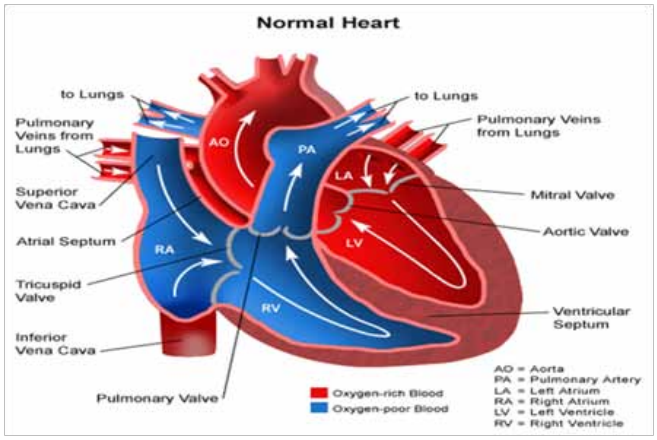
Gracy Sebastian
FNP

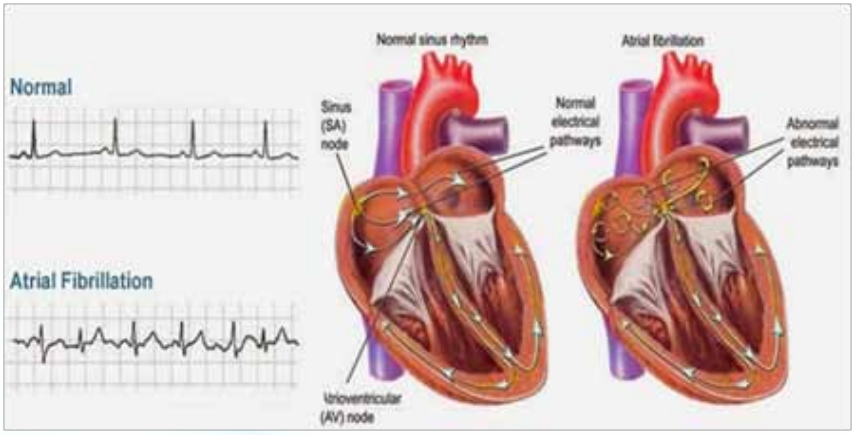


Heart Rate	Rhythm	P Wave	PR interval (in seconds)	QRS (in seconds)
A: 350-650 bpm V: Slow to rapid	Irregular	Fibrillatory (fine to course)	N/A	<.12

IRREGULAR HEARTBEAT

Irregular heart beat is a condition that causes the top chambers of the heart to shake instead if squeeze. Normally, the heart squeezes once every heart beat. Irregular heart beat causes it to squeeze more than that.





SIGNS AND SYMPTOMS

- Skipping or racing heart beat
- Feeling tired or weak
- Feeling dizzy
- Hard time breathing
- Chest tightness
- Nausea/vomiting

Congratulations and Best Wishes to NINPAA

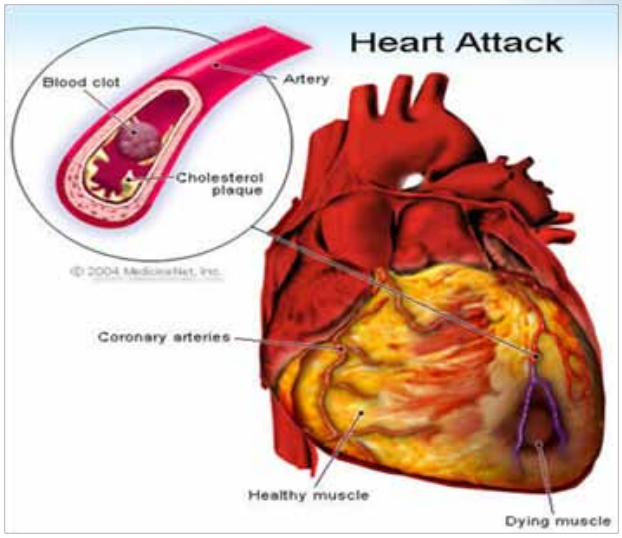
Prasanna Babu, FNP & Family (NY)

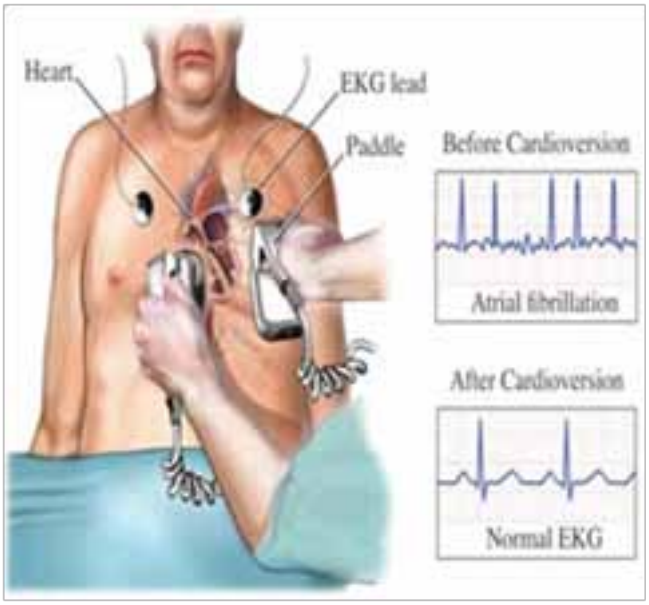
Congratulations and Best Wishes to NINPAA

Bridget Parappurath, FNP & Family (PA)

CAUSES OF IRREGULAR HEART BEAT

- High blood pressure
- High blood Sugar
- Stop breathing while you sleep
- Heart is not strong enough to pump blood
- Heart attack Increased alcohol intake



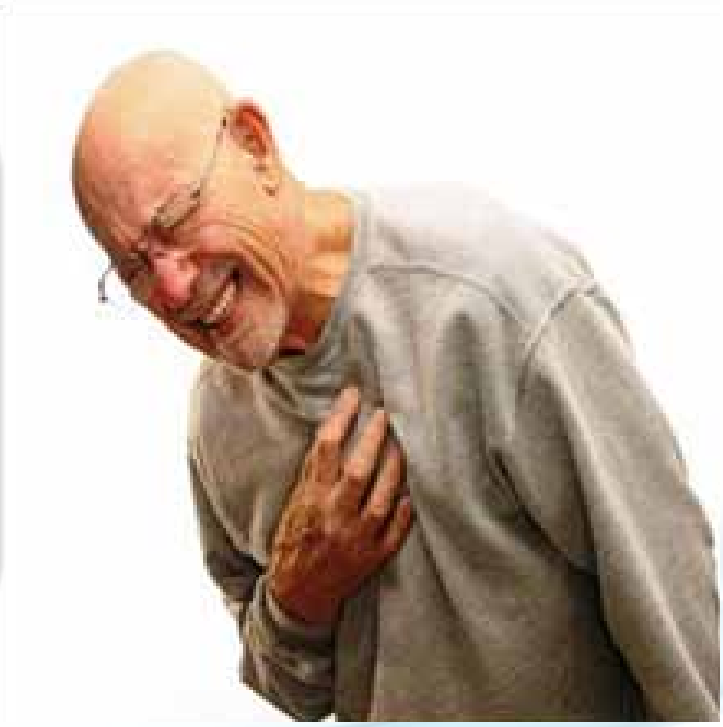


TREATMENTS

- Medicine to make blood thin (Aspirin)
- Medicine to slow your heart rate
- Medicine to normalize the rhythm
- Electric shock

CALL 911 RIGHT AWAY IF YOU HAVE ANY OF THESE FEELINGS:

- Chest pain
- Upset stomach
- Cold sweat
- If you can't breath
- Weakness of numbness in your arms, legs or face
- Sudden confusion
- Trouble talking
- Trouble understanding speech.



Congratulations and Best Wishes to NINPAA

Dr. Anu Varghese, DNP, FNP & Family (MA)

Congratulations and Best Wishes to NINPAA

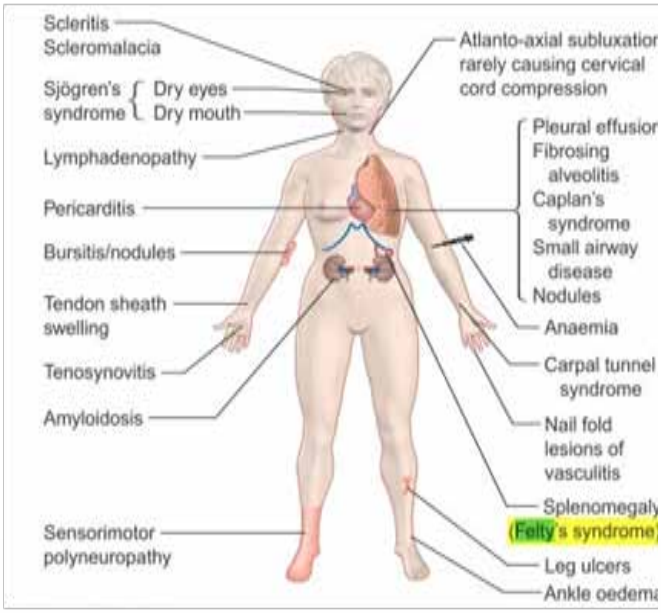
Dr. Kochurani Joseph, DNP, ANP & Family (NY)

Rheumatoid Arthritis in Primary Care Practice

Tesmol James
MSN, FNP-BC

Rheumatoid Arthritis (RA) a chronic, symmetric, debilitating, inflammatory condition that is destructive to multiple joints. Genetics contribute up to 50% and environmental factors such as smoking increases the risk. Presentation: includes symmetric joint stiffness and loss of function of the affected joint from swelling and tenderness. If not treated early, patients will encounter destruction of joints, which includes, but not limited to, ulnar and fibular deviation of small joints of hand and foot respectively. Swan neck deformity of the hand is typical for RA patients. Constitutional symptoms include fever, chills, malaise, and weight loss. Patients may also present with extra articular symptoms such as rheumatoid nodules in the skin, heart, sclera, and lungs; vasculitis, pericarditis, pulmonary hypertension, mono or polyneuritis, scleritis, anemia of chronic disease, and Felty's syndrome (RA, splenomegaly, granulocytopenia).

Diagnosis: laboratory findings include a positive rheumatoid factor and antibody to cyclic citrullinated peptide (anti-CCP), 20% of patients present with seronegative RA factors. In addition to a positive ANA, erythrocyte sedimentation and C-reactive proteins are elevated with 15% of the population. Radiographic evaluation may be used for disease progression and may indicate worsening if inadequate disease control with medication therapy. Patients have bone erosion with joint subluxation, and osteopenia. The American College of Rheumatology (ACR) and European League against Rheumatism (EULAR) have provided clinical assessment tools including clinical disease activity index (CDAI) scores to assess 68 joint counts to evaluate treatment efficacy and assess disease progression.



Congratulations and Best Wishes to NINPAA

Varghese Olahannan & Family (NY)

Management: primary care team identifying patients with RA should refer to a rheumatologist for Disease Modifying Anti Rheumatic Drugs (DMARDS) to reduce joint damage and arrest disease progression. Patients need frequent follow up and possible steroid treatment, if exacerbation of symptoms occurs. The goal of therapy is to achieve remission and increase length of stay of remission. Patients may need escalated doses or even change of medication classes including biologics to reach remission. Traditional DMARDs include methotrexate (not used as first line on patients with kidney disease, hepatitis, EtOH or lung disease), leflunomide, and sulfasalazine. Occasionally, hydroxychloroquine and azathioprine are used as well. Biological agents often used in the rheumatology settings for patient with RA, if negative for tuberculosis, include etanercept, infliximab, adalimumab, certolizumab, golimumab, abatacept, tocilizumab, rituximab, and tofacitinib. Patients taking any of the DMARDs or biologics are urged to follow up as recommended to avoid adverse events, reactions, and interactions.

Clinical Implications: primary care team plays a major role in assessing cardiovascular morbidity and mortality of RA patients with higher inflammatory processes. Reducing cardiovascular risk through lifestyle modification, strict lipid management, diabetes control and treating infections promptly are crucial. Special attention to vaccination should be provided along with patient education for positive patient outcomes. Surgical clearance should be done meticulously as high risk factors are involved in RA disease and treatment modalities (DMARDs along with biologics), and the way it impacts intra-op and post-op outcomes.

NINPAA Historical Timeline

In 2015, a small group of Nurse Practitioners (NP) under the leadership of Dr. Aney Paul recognized the growing need for starting a national organization in order to support NPs of Indian origin and to enhance the relevance and strength of their roles.

- Monthly Conference calls started in May 2015 and networking continues.
- NINPAA Vision and Mission finalized in February 2016.
- NNPAA was registered as a national organization in August 2016.
- Opened a bank account with Capital One Bank in October 2016.
- Board of directors, Committees and directors at large were appointed in October 2016
- NINPAA logo was designed and approved in November 2016.
- Membership form finalized November 2016
- Bylaws and NINPAA web site are in the process of being completed.
- First face to face committee meeting was held in NY on 12/3/2016.
- NINPAA president volunteered in Haiti in December 2016
- Dallas NINPAA members organized a health fair in February 2017
- New Jersey NINPAA members organized a health fair in March 2017
- Inauguration of NINPAA scheduled for April 29, 2017 in NY

NINPAA has blossomed and now represents the interest of NPs from nine states with over 50 members. Membership is open to all NPs of Indian origin regardless of their specialty and the focus of their practice. We continue to encourage more NPs to join the organization.

Dr. Anu Varghese, DNP, FNP, Secretary

NINPAA Activities

Dr. Aney Paul. PNP with Association of Kerala Medical Graduates Greater New York Chapter office-bearers

Dr. Anu Varghese, FNP, attending the Pri-Med Conference in Boston

President Dr. Aney Paul volunteering in Haiti with Haitian Nurse Association members

President Dr. Aney Paul Volunteering with Nurse Practitioners Association of New York school bag drive in Rockland

Bridget Parappurath, FNP, participating with PIANO in BLS Training in Philadelphia

Sunitha Menon, FNP attending the APNA Florida Chapter Conference in Tampa

NINPAA
Meeting, New York
12-03- 2016

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Dr. Aney Paul, DNP, PNP & Family (NY)

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Dr. Alphonsa Mathew, DNP, ANP & Family (NY)

Rose Parangimalil
MS, FNP

Current Management of Chronic Viral Hepatitis C: A Primary Care Perspective

Chronic Viral Hepatitis C, the inflammation of the liver with hepatitis C virus has serious consequences if left untreated. The objective of this article is to provide clinician with an overview of Hepatitis C, diagnosis, and management.

Incidence: Hepatitis C viral (HCV) infection is estimated to account for 15 percent of symptomatic cases of acute liver disease in the United States. About 193 million people are infected worldwide. According to the American Liver Foundation nearly 4 million people in the United States have hepatitis C.

Epidemiology: The disease-causing agent was identified in 1989 when the genome of the virus was cloned and the agent was designated the hepatitis C virus (HCV). The blood test became available in 1992. Until 1992 this infection was known as "non-A, non-B" hepatitis. Infection is spread through blood-to-blood contact. HCV has tremendous viral diversity which prevents the development of conventional vaccines. There are 6 genotypes: 1 (1a and 1b), 2, 3, 4, 6. The prevalent ones in USA are 1-3.

Etiology: The exposure to infected blood through recreational IV drug use, or sexual and nosocomial (health care workers-needle sticks, perinatal) remain to be the main source of transmission in recent decades. Risk of transmission through blood transfusion is rare although that was a reason before 1992 in spread of infection. Other minor risk factors include sharing razors, tooth brushes, getting tattoos, snorting cocaine, body piercing and acupuncture with unsterilized needle. The risk is low in monogamous relationships.

Incubation period: Acute hepatitis typically develops 2 to 26 weeks after exposure to hepatitis C virus (HCV), with a mean onset of 7 to 8 weeks. In patients who experience symptoms, the acute illness usually lasts for 2 to 12 weeks.

Clinical manifestations: Most patients who are acutely infected with HCV are asymptomatic. Some patients develop symptoms of acute hepatitis such as fatigue, low-grade fever and chills, jaundice, nausea, dark urine, and right upper quadrant pain. Loss of appetite, pruritus, muscle aches, mood disturbances, joint pain, dyspepsia, and confusion may be seen in advanced liver diseases. Within one to two days following an exposure, a patient without prior infection should have a negative plasma HCV RNA Quantitative reading (negative antibodies), and normal transaminases. It may sometimes take 4-8 weeks to form detectable levels of antibodies in blood.

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Diagnosis is based on careful history taking, physical exam, and diagnostic studies. Hepatitis C antibody testing (HCV Ab) is the baseline test used to determine exposure. A positive test should be followed by HCV RNA Quantitative Analysis. If a detected presence of ongoing HCV infection is confirmed, liver function tests may show mild to moderate elevation in transaminases. Patients are to be screened for co-infections such as HIV, Hepatitis A, and B. A baseline abdominal sonogram with Doppler flow is recommended. If liver lesions are identified it must be followed up with CT scan or MRI, with and without contrast.

Treatment: It is recommended that positive cases be referred to Gastroenterology/Hepatology for expert care. Current Antiviral regimens with direct-acting antivirals are highly effective. The goal of treatment is to eradicate HCV and thereby decrease liver-related death, need for liver transplantation, hepatocellular carcinomas, and other liver-related complications. Widely used medications include Harvoni, Epclusa, Zepatier with or without Ribavirin with a duration of 3-6 months of treatment. Cure of HCV is determined by attainment of a sustained virologic response (SVR). An undetectable level at 12 weeks post-treatment is generally accepted as test of cure.

Nursing Implications: The ability to achieve SVR depends in part upon the degree of adherence with therapy. The health care provider must be non-judgmental and respectful, developing rapport and mutual trust. Clients should be empowered with sufficient information to make informed decisions. Non-steroidal anti-inflammatory drugs can be hepatotoxic and should be avoided. Patients do not need to avoid acetaminophen, but the recommendation is to not exceed 2 g in 24 hours from all sources.

Rose Parangimalil is a Nurse Practitioner since 1996 currently serving Veterans in Dallas, Texas.

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Shaimole Kumpiluvely, PNP & Family (NY)

NINPAA
Registration, Dallas

President Dr. Aney Paul Volunteering in Haiti with
Haitian Nurses Association and Rockland Haiti relief.

NINPAA
Health Fair, Dallas

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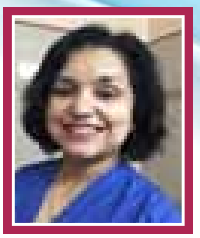
Leena Alapatt, PNP & Family (NY)

Zika Virus Infection and Newborns



Leena Alapatt
CPNP

Zika virus is named after the Ugandan forest where it was first isolated from a rhesus monkey in 1947. The first human cases were detected in 1952 in Uganda and Tanzania. The virus subsequently spread across equatorial Africa and Asia, where it was associated with sporadic infections. Zika virus infections were first detected in the Western hemisphere in February 2014 on Chile's Easter Island. Subsequently it was detected in Brazil in May 2015. In the United States, mosquito-borne transmission has occurred in Florida and Texas, and many imported Zika infection has been reported in travelers in NY, Hawaii and many other areas.

Zika virus infection during pregnancy is very serious that it can cause microcephaly and other severe brain defects in newborns. Not every pregnant woman infected with Zika will have a baby with a related health condition at birth. Zika on developing embryo, pathogenesis and prevention are still being explored, and many questions remain unanswered. Children affected by Zika requires continuing needs that require ongoing care planning to provide positive outcomes.

Congenital Zika syndrome is a recently recognized pattern of congenital anomalies associated with Zika virus infection during pregnancy that includes microcephaly, intracranial calcifications or other brain anomalies, or eye anomalies, among others.

Zika virus RNA has been detected in blood, urine, semen, saliva, female genital tract secretions, cerebrospinal fluid, amniotic fluid, and breast milk of infected persons. Specimens submitted for testing must be accompanied by CDC Form 50.34. Laboratory specimens may be sent to the CDC Arboviral Diagnostic Laboratory; instructions are available online. Communication should be initiated with the laboratory via telephone (1-970-221-6400) prior to shipment of specimens. FDA has authorized many commercial labs to do Zika testing now as well.

Diagnostic tests includes both molecular (real-time reverse transcription–polymerase chain reaction [rRT-PCR]) and serologic (immunoglobulin M [IgM]) testing. Initial samples should be collected directly from the infant in the first 2 days of life, if possible; testing of cord blood is not recommended. A positive infant serum or urine rRT-PCR test result confirms congenital Zika virus infection. Positive Zika virus IgM testing, with a negative rRT-PCR result, indicates probable congenital Zika virus infection.

In addition to infant Zika virus testing, initial evaluation of all infants born to mothers with laboratory evidence of Zika virus infection during

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pregnancy should include a comprehensive physical examination, including a neurologic examination, postnatal head ultrasound, and standard newborn hearing screen. Infants with laboratory evidence of congenital Zika virus infection should have a comprehensive ophthalmologic exam and hearing assessment by auditory brainstem response (ABR) testing before 1 month of age.

Recommendations for follow-up of infants with laboratory evidence of congenital Zika virus infection depend on whether abnormalities consistent with congenital Zika syndrome are present. Infants with abnormalities consistent with congenital Zika syndrome should have a coordinated evaluation by multiple specialists within the first month of life; additional evaluations will be needed within the first year of life, including assessments of vision, hearing, feeding, growth, and neurodevelopmental and endocrine function. Families and caregivers will also need ongoing psychosocial support and assistance with coordination of care. Infants with laboratory evidence of congenital Zika virus infection without apparent abnormalities should have ongoing developmental monitoring and screening by the primary care provider; along with hearing testing periodically.

Parental support and early intervention is the key in management of infants with Zika infection. Perinatal Zika virus disease should also be suspected in an infant in the first 2 weeks of life if the mother traveled to or resided in an affected area within 2 weeks of delivery or the infant has one or more of the following manifestations: fever, rash, conjunctivitis, or arthralgia. Aspirin should never be used for the risk of Reyes syndrome. Avoid all types of NSAIDs for 6 months of age.

Research is ongoing for a vaccine, but any product is years away from the market. There's no drug treatment and experts all say the best way to control Zika is to control mosquitoes and protect people from their bites — as well as from sexual transmission of the virus.

Smile, Keep Smiling

Dr. Aney Paul
DNP, MPH, MSN, PNP

When I smile you smile
When we smile they smile
Let us all smile
Smile keep smiling

Smile is loving
Smile is caring
Smile is sharing
Smile is welcoming

Smile at home
Smile at children
Smile at work
Smile brightens the day

Smile at patients
Smile reduce the pain
Smile helps to heal
Smile gives hope

Care with a smile
Serve with a smile
Smile relieves stress
Smile brings happiness

Smile has one culture
Smile has one language
Smile has no religion
Smile has no boundaries

Smile is a gift
Smile is love
Smile is positive
Smile is powerful

Smile makes life beautiful
Smile makes difference
Let us make a difference
Smile keep smiling

NINPAA
Health Fair, New Jersey

Pre-Diabetes and Diabetes Prevention Program

Aliyamma Samuel
MSN, ANP, CDE

"Prevention is better than cure." So, it is time to prevent diabetes now. The number of people with diabetes has risen from 108 million in 1980, to 422 million in 2014. One out of three American adults has prediabetes, though most do not know it. The CDC states that eighty-six million people are not aware they have prediabetes. Having prediabetes means your blood glucose level is higher than normal, but not high enough to be diagnosed as diabetes. You are at risk for developing Type 2 diabetes at a future date. If your fasting blood sugar is between 100-125 mg/dL, it is considered prediabetes and can become diabetes within 3 years. You may have prediabetes and be at increased risk for Type 2 diabetes if you:

- Are 45 years of age or older
- Are overweight
- Have a family history of Type 2 diabetes
- Are physically active fewer than 3 times per week.
- Have gestational diabetes or gave birth to baby weighing more than 9 lbs. The goals of a diabetes prevention program are delaying the onset of diabetes, preserving beta cell function, and preventing microvascular complications. So, it is the time to initiate the "Diabetes Prevention Program" or "DPP" which includes:

1. Lifestyle modifications: increase physical activity gradually to 30 minutes daily. When you hear the term exercise, it doesn't just refer to sports or going to a gym. It also includes activities such as cleaning your own home, gardening, taking a walk, raking leaves, sweeping the floor, or anything the keeps you moving for an extended period of time. Physical activity lowers blood glucose levels. The body uses glucose to fuel your activities. Regular physical activity can also help you use your insulin better daily. Try to maintain your body weight according to your height.

2. Healthy eating: nutrition is a key factor in controlling blood sugar. The person with diabetes has to identify which foods raise blood sugar. This can be achieved by visiting a dietitian. He/she will plan a diet according to an individual's weight and height, as well as his/her cultural or ethnic background. The person should have the desire and motivation to change by making correct food choices. For example, use the plate method which designates half the plate for non-starchy vegetables, one quarter with starchy vegetables, and one quarter with protein. Make most of your fat sources from fish, nuts, and vegetable oil. Meal planning should be individualized.
3. Habits: If you are a smoker, quit smoking.

Finally, if you are at risk for getting type 2 diabetes, take the risk assessment tool "Could you have prediabetes?", an online quiz at www.cdc.gov/diabetes/prevention.

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Usha George & Family (NY)

Grace Mani
FNP-BC

Chikungunya

Chikungunya is a mosquito-borne viral disease mainly characterized by acute onset of fever and polyarthralgia. It often occurs as large outbreaks and is more commonly seen in Africa, Asia, and Europe. Chikungunya virus is spread by Aedes aegypti and Aedes albopictus mosquitoes. Transmission of illness to humans (the primary host during an epidemic) occurs through bites of infected mosquitoes and symptoms develop in 3-7 days. Transmission via needle stick, laboratory exposure, or intrapartum is very rare.

The majority (72-97%) of infected people show clinical symptoms within 3-7 days (range 1-12 days), including acute onset of fever (>102°F) and severe polyarthralgia (usually bilateral, symmetric, severe and debilitating). Additional symptoms are headaches, myalgia, conjunctivitis, nausea/vomiting, and rash. Persons at risk for severe disease include neonates exposed intrapartum, older adults (>65 years), and people with underlying medical conditions like diabetes, cancer and cardiovascular diseases. Though rare, possible complications include uveitis, retinitis, myocarditis, hepatitis, nephritis, hemorrhage, meningoencephalitis, myelitis and cranial nerve palsies and possible death.

Diagnosis is based mainly on the clinical presentation, travel history, and any contact with people who recently traveled to infected areas. Laboratory findings may be lymphopenia, thrombocytopenia, and elevated hepatic enzymes. A viral culture should be done in less than 3 days. Virus-specific IgM and IgG should be done within 4 days of the onset of illness.

Intervention is mainly management of the symptoms. Increasing fluids and rest is very important. Acetaminophen may be used to reduce fever and pain until dengue fever is ruled out, as use of NSAIDS can increase the risk of bleeding. Illness should be managed as dengue until it is ruled out (warning signs of dengue include bleeding, pleural effusion or ascites, lethargy, enlarged liver and hemoconcentration with thrombocytopenia). Patients should be evaluated for medical conditions like malaria and other bacterial infections. Once dengue is ruled out, persistent joint pain may be treated with NSAIDS, corticosteroids or physiotherapy.

Since there is no vaccine or medication available to prevent or treat infection, the importance of prevention should be advised to all travelers. The primary preventive measure is to avoid mosquito exposure. People with compromised immune system should avoid travel to areas with ongoing outbreaks. Infected individuals should avoid further mosquito bites during the first week of illness to limit the spread of disease. People should be encouraged to use air conditioning, window and door screens, mosquito repellents, as well as long sleeves and pants to avoid mosquito bites. All diagnosed cases should be reported to state.

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Betty Bobby Thomas, FNP & Family (TX)

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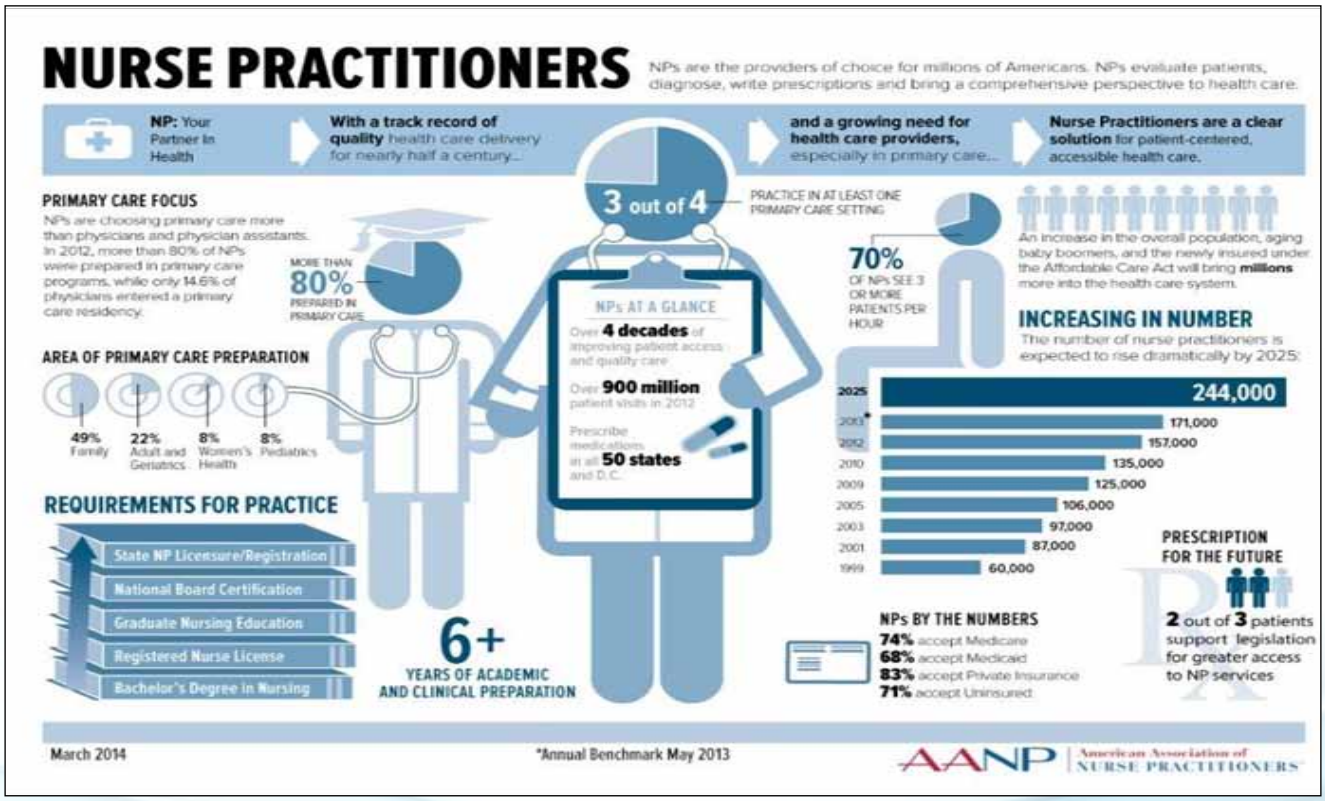
Rachel Zachariah, PhD & Reena Zachariah, ANP (MA)

Dr. Alphonsa Mathew
DNP, ANP-C

Spirituality in Medicine

Spirituality has been defined as believing in a Higher Power that guides one's life and is a source of unconditional love, peace and strength; therefore, one is able to cope with life's situations and maintain a positive attitude and assurance that all is well (Conway, 2014). Recent scientific research suggests connections between religion, spirituality, and both mental and physical health. These findings are consistent with severe or chronic illnesses or terminal illness and who are having stressful psychological and social changes. Recent studies indicate that religious beliefs influence medical decisions, such as the use of chemotherapy and other life-saving treatments, and at times may even have conflicting views to medical care.

Spirituality is a field that makes many providers uncomfortable, or they may think it is not important. Additionally, they worry about spending additional time with patients and overstepping ethical boundaries. While these fears are valid, each can be addressed in a sensible way. Taking a spiritual history, supporting and respecting the patient's beliefs, and facilitating the fulfillment of their spiritual needs are time consuming, however, it can help patients understand and cope with their medical illness (Koenig, 2004). It is recommended that a brief spiritual history be taken from all patients with a serious or chronic illness. If spiritual issues are present, referral to chaplains or other spiritual care experts is suggested.



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Raji Mathew, FNP & Family (DE)

Anticoagulant Therapy - Warfarin (Coumadin®)

Dr. Kochurani Joseph
DNP, FNP

Warfarin, or Coumadin®, is the most commonly used oral anticoagulant. In the 1920s, cattle in the Northern United States and Canada were dying due to an outbreak of an unusual disease characterized by fatal bleeding. Veterinarians Schofield and Roderick concluded that consumption of bad sweet clover hay was the cause of the deaths. Roderick, in 1931, identified prothrombin deficiency as the cause of the delayed clotting of the blood. In 1939, Dr. Link and his student discovered that the anticoagulant in sweet clover was 3,3'-methylenebis (4-hydroxy coumarin). Warfarin was initially promoted as a rodenticide in the United States in 1948 and then for human use from the early 1950s.

Warfarin is recommended for the prophylaxis and treatment of venous thrombosis, pulmonary embolism (PE), and thromboembolic complications associated with atrial fibrillation (AF) and/or cardiac valve replacement. Warfarin is also indicated to prevent thromboembolic events in patients with hypercoagulable state and after myocardial infarction. Some contraindications for warfarin include bleeding dyscrasias, active gastrointestinal bleeding, hemorrhagic retinopathy, hemorrhagic stroke or uncontrolled hypertension (risk of stroke), and pregnancy.

Mechanism of Action: Warfarin belongs to a class of drugs called the coumarins, or vitamin K antagonists, which inhibit the activation of vitamin K and interfere with the coagulant activity of factors II, VII, IX, X and the anticoagulant proteins C and S. Vitamin K is an important cofactor for the synthesis of the vitamin K-dependent clotting factors. Warfarin is quickly absorbed in the intestine, metabolized by the liver, and excreted through the kidneys. It has high bioavailability (>90%), attaining peak serum concentrations at 90 min, with a half-life of 36-42 hours.

Warfarin Management: The main adverse effect associated with warfarin is bleeding. The effect of warfarin therapy is measured as prothrombin time expressed in a standardized way as the international normalization ratio (INR). The dose of warfarin is frequently adjusted to maintain the INR level, usually between 2 and 3.5, based on the indication of treatment. Managing patients on warfarin can be difficult because of its narrow therapeutic window and wide variations in anticoagulant effects among patients.

A patient's coagulation profile, complete blood count, liver function tests, and renal profile should be checked before initiating warfarin therapy. Initiation of warfarin at a dose of 5 mg daily is recommended, with smaller doses indicated for the elderly or patients with liver disease, poor nutritional status, or heart failure. A patient's bleed risk potential sensitivity to warfarin, indication, goal INR range, and possibility of potential drug interactions must also be considered when determining the initial warfarin dose.

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Dr. Jeeny Job, MD & Family (NY)

Providers may use warfarindosing.org for calculating the initial and maintenance dose. Often warfarin is bridged with low-molecular weight heparin (LMWH) or unfractionated heparin (UFH) and overlapped for 5-7 days or INR is above the goal for 24 to 48 hours to prevent rebound thrombosis from fall in protein C levels. Patients need frequent INR checks during the initial period of warfarin therapy. Warfarin dose adjustments should be based on current INR results and trends, and assessment of possible interactions with warfarin that may result by addition of new medications or discontinuation of prior medications. When managing a moderate out-of-range INR value in previously stable warfarin patients, providers may change the maintenance warfarin dose, give a one-time dose adjustment, followed by continuation of the previous warfarin dose, or continue the same warfarin dose with no adjustment. The decision to bridge while the patient has a subtherapeutic INR should be considered when the thromboembolic event occurred within the past three months, the event was life-threatening or associated with severe morbidity and with prolonged duration of low INR.

Drug-Drug, Drug-Food Interactions: Many drugs and some foods are known to affect the anticoagulation effect of warfarin. Interactions occur through a variety of mechanisms, including: interfering with warfarin metabolism, displacement from protein binding sites and disturbances of vitamin K absorption or metabolism. Some of the drugs that cause high INR are fluconazole, sulfamethoxazole and trimethoprim, metronidazole, amiodarone, levofloxacin, ciprofloxacin, vancomycin, high doses of acetaminophen, statins and clarithromycin. Common drugs that causes low INR are griseofulvin and rifampin. Many herbal medications and over -the- counter medications interact with warfarin, e.g. alfalfa, black cohosh, capsicum, chamomile, coenzyme q10, fish oil, gingko, licorice, onion, St John's wart. Foods such as mango, tamarind, papaya, guava, cranberries pomegranate, grapefruit etc. may affect the anticoagulation effect of warfarin.

The numerous limitations of warfarin, especially the slow onset and offset of action, genetic variation in metabolism, multiple food and drug interactions, the need for frequent INR tests, and a narrow therapeutic window, led to the development of other oral anticoagulants, including apixaban (Eliquis®) dabigatran (Pradaxa®), rivaroxaban(Xarelto®). However, many problems are also associated with the use of these drugs, including concerns about medication adherence without laboratory monitoring, uncertainty about dosing in patients with renal dysfunction and marked extremes of body weight, and higher drug costs compared to warfarin (Bauer, 2013). Another issue is lack of long-term use data in the general population, in pregnant and lactating women, children, and African Americans. Due to these limitations of the new anticoagulants, warfarin is still the most commonly prescribed oral anticoagulant.

Prerequisites to Becoming a Nurse Practitioner

- Earn a nursing undergraduate degree.
- Become a registered nurse by passing the NCLEX-RN.
- Complete a graduate degree in the field of nursing.
- Obtain a license to be an Advanced Practice Nursing licensee.
- Specialize by obtaining certifications in specific fields.

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Bindu Gigi, FNP & Family (NY)

Prasanna Babu
MSN, FNP-C

Acute Coronary Syndrome

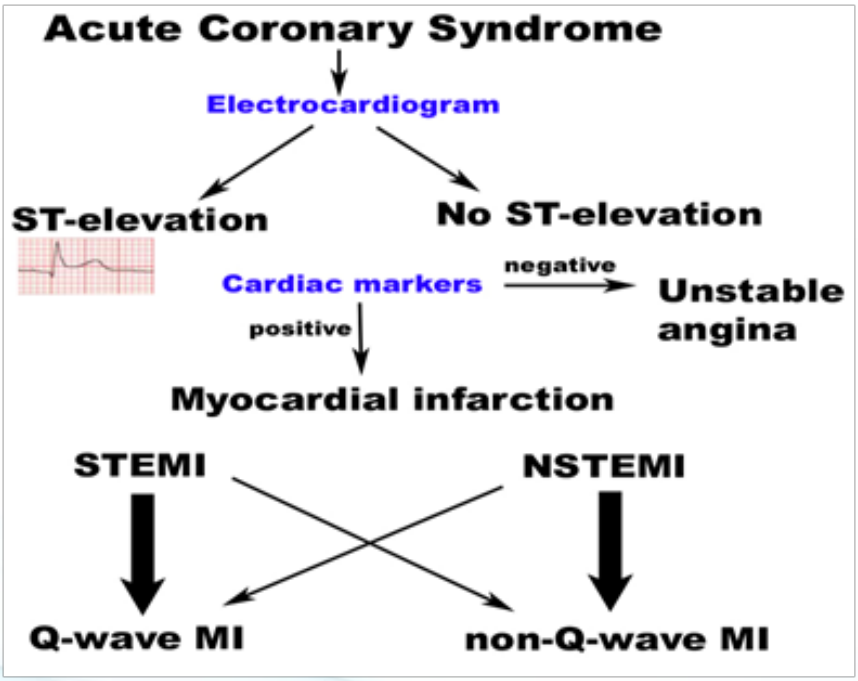
Acute Coronary Syndrome (ACS) includes unstable angina, non-ST-segment elevation MI (NSTEMI) and ST-segment elevation MI (STEMI).

Typical angina presents with substernal chest discomfort, onset with exertion or emotional stress and relief with rest or nitroglycerin. Atypical angina meets only two of the above criteria, while non-cardiac chest pain meets only one. Other symptoms include shortness of breath, lightheadedness, dizziness or fainting, profuse sweating nausea or vomiting.

Patients with typical angina are considered to have unstable angina when the episode of angina increases in severity or duration, has onset at rest or at low level of exertion, or when it is unrelieved by the amount of nitroglycerin or rest that had previously relieved the pain. Patients not known to have typical angina are considered to have unstable angina when they present with their first episode with usual activity or at rest within the previous two weeks or have prolonged pain at rest.

The diagnosis of acute MI (STEMI/NSTEMI) is made by at least three of the following: ischemic symptoms, diagnostic ECG changes, and serum cardiac marker elevations.

If the chest pain is suggestive of ischemia, an immediate assessment should occur within ten minutes. Initial labs and tests include a 12 lead ECG, initial cardiac enzymes, electrolytes, cbc lipids, bun/cr, glucose, coags, and a CXR.



On ECG, STEMIs will present with ST elevation or new LBBB. NSTEMIs will present with ST Depression or dynamic T-wave inversion. Unstable angina will have a non-specific ECG finding.

Cardiac markers include troponin, CK-MB, SGOT and LDH. Troponin, which is both specific and sensitive, rises 4-8 hours after injury, remains elevated for up to two weeks, and can provide prognostic information.

The Cardiac Care goals are to decrease amount of myocardial necrosis, preserve LV function, prevent major adverse cardiac events, and treat life threatening complications.

Treatment of STEMI

After assessing the STEMI patient, the reperfusion strategy must be determine. Fibrinolysis is preferred if <3 hours from onset, PCI not available/ delayed (door to balloon > 90min), door to needle goal <30min, and there are no contraindications. PCI is preferred if available, door to balloon < 90min, there are contraindications to fibrinolysis, late presentation > 3 hr, high risk STEMI, or if STEMI diagnosis is in doubt.

Medical therapy can be determined by the mnemonic: MONA + BAH. Morphine (analgesic) helps reduce pain and anxiety by decreasing sympathetic tone, systemic vascular resistance and oxygen demand. Be careful in patients with hypotension, hypovolemia and respiratory depression. Oxygen may limit ischemic myocardial damage by increasing oxygen delivery (reducing ST elevation). Nitrogylcerin (analgesic) dilates coronary vessels therefore increasing blood flow, reduces systemic vascular resistance and preload. Be careful in patients with recent erectile dysfunction medications, hypotension, bradycardia, tachycardia, and RV infarction. Aspirin (reduces mortality) irreversibly inhibits platelet aggregation, stabilizes plaque and arrests the thrombus. Be careful in patients with active PUD, hypersensitivity, and bleeding disorders. Beta-blockers reduce mortality. Contraindications include CHF, heart block, and hypotension. ACE-Inhibitors/ ARB are started in patients with anterior MI, pulmonary congestion, LVEF <40% in absence of contraindication/hypotension. Heparin, either low molecular weight heparin or unfractionated heparin, is started because it indirectly inhibits thrombin. Heparin is used in combination with aspirin and/or other platelet inhibitors: Clopidogrel/ Ticagrelor, Glycoprotein IIb/IIIa inhibitors. Aldosterone blockers may also be given to post-STEMI patients.

Treatment of UA/NSTEMI

For patients presenting with high risk ACS, the invasive therapy option includes: coronary angiography and revascularization within 12 to 48 hours after presentation to ED; MONA + BAH; Clopidogrel; Glycoprotein IIb/IIIa inhibitors.

Conservative therapy consists of: MONA + BAH, Clopidogrel, Glycoprotein IIB/ IIIa inhibitors, and surveillance in the hospital through serial ECGs and markers.

Secondary Prevention

Disease Management: Blood pressure goal < 140/90; LDL < 100 (<70), Triglycerides < 200; A1C < 7% if diabetic. Smoking cessation is of major importance. Patients should also be counseled on exercising for 30-60 minutes daily and a healthy diet.

Smitha Prasad
MSN, APN

Seasonal Influenza

The flu is a contagious respiratory illness caused by influenza virus. There are different types of flu including flu like avian, swine, and canine flu. This presentation focuses on seasonal influenza in the USA, occurring between October- March (winter season). Seasonal flu in winter is caused by Influenza A and B viruses. The A virus is subdivided based on the proteins on the virus hemagglutinins (H) and neuraminidase (N) like HINI, whereas B has no subtypes.

Mode of spread: Transmission of flu is by respiratory droplets and direct contact. The typical incubation period is 1-4 days, with an average of 2 days.

Signs and symptoms: Influenza causes severe illness in children, the elderly, and patients who are immunocompromised or have comorbidities, usually with an abrupt onset. Common clinical features include fever/feeling feverish, chills, headache, runny or stuffy nose, muscle or body aches. Fatigue and nausea or vomiting is more commonly seen in children than adults. It is important to remember that not everyone with flu may have a fever.

Complications: The most severe complication is pneumonia either by flu virus or superimposed by bacterial infection. Other complications include sinusitis, myocarditis, rhabdomyolysis, and multi organ failure.

People at high risk for flu complications: Children under 5 years (more among under 2 years), the elderly above 65 years, immunocompromised patients, patients with neurological disorders such as epilepsy, mental retardation, developmental delay, stroke, muscular dystrophy, and spinal cord injury, pregnant women, patients with diabetes, kidney and liver disorders, those who are under 19 years receiving long term aspirin therapy, and people with morbid obesity BMI above 40%.

Diagnostic testing: The most widely used test is rapid flu antigen testing which is a point of care testing that gives the result within 15 minutes. Other tests include Rapid molecular assay (›20minutes), immunofluorescence (1-4 hours), PCR-RT (1-8 hours), rapid cell culture (1-3 days) and viral tissue cell culture(1-10days).

Treatment: Influenza is mostly a self-limiting condition in which symptoms subside in 1-2 weeks. Antiviral medications are most effective if initiated within 48-72 hours, but if the symptoms are severe and persist, it is recommended to have treatment to minimize the symptoms and to prevent the complications especially in high risk patients. There are three FDA-approved influenza antiviral drugs recommended by CDC this season to treat influenza: oseltamivir (Tamiflu) in pill or liquid form, zanamivir (Relenza) is an inhaled powder which is not recommended for patients with asthma, and peramivir (Rapivab) is an injectable (IV) form anti-viral medicine for flu. Tamiflu is safe for pregnant women.

Prevention: Influenza is a seasonal epidemic that can be controlled with the annual flu vaccine which is effective against specific strains of flu virus determined to be in the environment in that particular season. Annual vaccination is essential because of the yearly strain variations of the influenza virus. There are 2 types of flu vaccines available – quadrivalent and trivalent, both are inactivated, only 1 dose per season needed for ages above 6 months and up. Live attenuated influenza vaccine (LAIV) is not recommended in this season as per CDC.

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Rose Zacharia, FNP & Family (NY)

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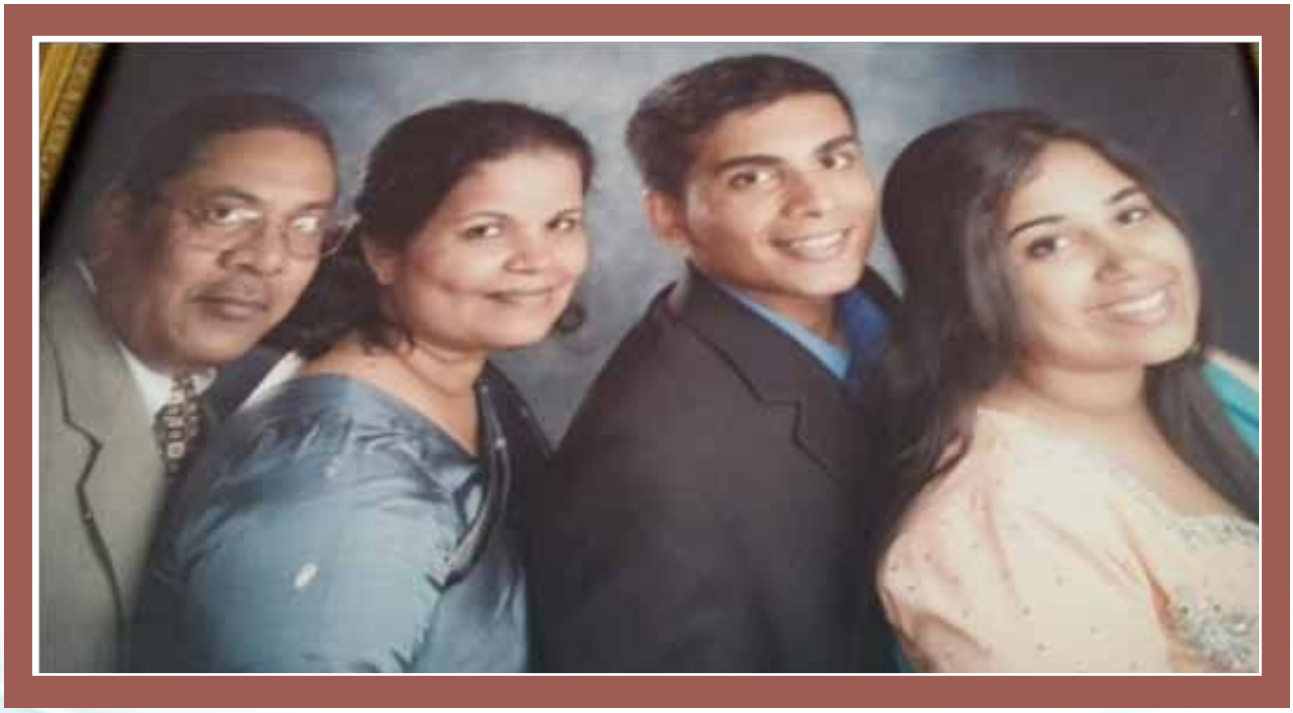

Mariamma Dubey, PhD, FNP & Family (NY)

Management of Ear, Nose, Throat Infections

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What are some common pathogens that cause ENT infections? Do you recommend a limited or an involved use of antibiotics in treatment of these diseases and other unconfirmed bacterial illnesses and why?

The three bacterial organisms most often associated with Acute Otitis Media include streptococcal pneumonia, Haemophilus influenzae, and Moraxella catarrhalis. Frequently, viral organisms coexist with one of the preceding bacterial causes. Otitis externa (OE) is inflammation of the canal. Frequent causes include pseudomonas and fungal organisms. Sore throat is a very frequent complaint in primary care settings. Most episodes of sore throat are associated with self-limited viral upper respiratory infections. Most cases of pharyngitis are viral in origin, and any number of the respiratory viruses can cause inflammation of the throat. The majority of viral pharyngitis cases are self-limited. Herpes infections can also affect the pharynx. Group A beta-hemolytic streptococcal (GABHS) pharyngitis is a bacterial infection of the pharynx, commonly called strep throat. Complications of GABHS pharyngitis, although rare, include rheumatic heart disease and glomerulonephritis, and the condition requires prompt diagnosis and definitive treatment. Other bacterial causes of pharyngitis include mycoplasmal pneumonia, gonorrhea, and diphtheria. Infectious Mononucleosis is another common child hood disorder caused by Epstein-Barr virus (EBV)(Burns, Dunn, Brady, Starr, & Blosser, 2013, p. 127).

Tonsillitis involves infection of the tonsils. Viral tonsillitis (often associated with EBV) is more common in very young children. A number of pharyngeal and upper respiratory infections can also involve the larynx, resulting in hoarseness. As per CDC Director Tom Frieden, in a related article in Medical News Today, when antibiotics are prescribed incorrectly, our children are needlessly put at risk for health problems including C. difficile infection and dangerous antibiotic resistant infections and recommend avoiding use of antibiotics without evidence of bacterial infection.

What are the standards regarding the use of antibiotics in pediatric population, and what assessment findings would warrant prescribing an antibiotic for ENT or respiratory symptoms?

Upper respiratory tract infections account for millions of visits to family physicians each year in the United States. Early antibiotic treatment may be indicated in patients with acute otitis media, group A beta-hemolytic streptococcal pharyngitis, epiglottitis, or bronchitis caused by pertussis. Persistent cases of rhinosinusitis may necessitate the use of antibiotics if symptoms persist beyond a period of observation. The common cold is a mild, self-limited URI with symptoms of runny nose, sore throat, cough, sneezing, and nasal congestion. It is a heterogeneous group of viral diseases, and therefore does not respond to antibiotics (Zoorob & Sidani, 2012). Influenza is an acute URI caused by influenza virus A or B. Vaccination is the mainstay of prevention. Supportive care is the foundation of treatment. Differentiating between viral and bacterial rhinosinusitis is important because treatment of all cases would result in the overprescribing of antibiotics. The diagnosis of acute bacterial rhinosinusitis should not be made until symptoms have persisted for at least 10 days or after initial improvement followed by worsening of symptoms.10 Four symptoms

are more predictive of bacterial rather than viral rhinosinusitis: purulent nasal discharge, maxillary tooth or facial pain, unilateral maxillary sinus tenderness, and worsening symptoms after initial improvement.

The American Academy of Pediatrics and the American Academy of Family Physicians developed guidelines for the treatment of AOM. These guidelines list observation as an option for children older than six months; observation involves deferring antibiotic treatment for 48 to 72 hours and initiating therapy only if symptoms persist or worsen. Immediate initiation of antibiotics is recommended in children younger than two years with bilateral AOM and in those with AOM and otorrhea. Amoxicillin (80 to 90 mg per kg per day, in two divided doses) is recommended as first-line treatment for AOM. Children with AOM should be reevaluated in three months to document clearance of middle ear effusion. Approximately 70 percent of children with pharyngitis have viral infections. The Infectious Diseases Society of America recommends diagnostic testing to confirm group A beta-hemolytic streptococcal infection before initiating antibiotics to avoid overuse. However, the American Academy of Family Physicians and the American College of Physicians recommend using the modified Centor criteria, which are based on age and the presence or absence of fever, tonsillar erythema or exudates, anterior cervical lymphadenopathy, and cough.

Laryngitis is a self-limited, viral disease that does not respond to antibiotic therapy. Acute bronchitis is a self-limited inflammation of the large airways (including the trachea) that presents with cough and possibly phlegm production. The predominant etiology of acute bronchitis is viral; therefore, antibiotics are not indicated in most patients. It is important to differentiate pneumonia and influenza from bronchitis because antibiotics are recommended for patients with pneumonia, and antivirals may be indicated for those with influenza (Zoorob & Sidani, 2012).

Do the etiology, diagnosis, and management of a child who is wheezing vary according to the child's age? Why or why not? Which objective of the clinical findings will guide your diagnosis? Why? When is a chest x-ray indicated in this case?

With nearly a third of all children having a wheezing episode before their third birthday

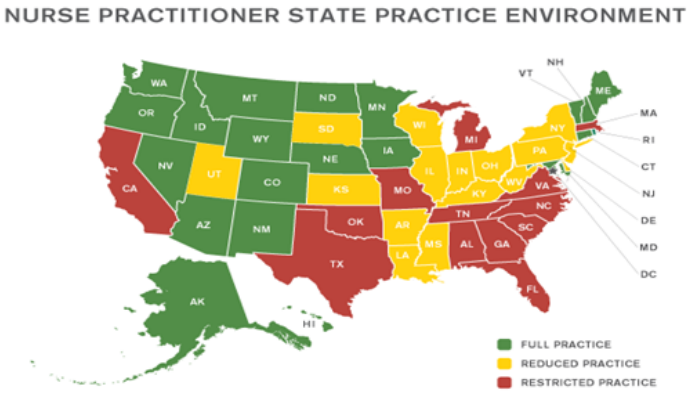
and half by age 6 years, wheezing is one of the most common problems for which preschool children are seen in the pediatrician's office. Not all that wheezes is asthma (Bassi, 2015). Wheezing is the principal sound patients make if the obstruction allows enough air to pass through the narrowed lumen. Etiology, diagnosis and management of wheezing vary according to the age. Because the causes of wheezing can be different, so does the management. Examples of causative factors include neuromuscular weakness, lobar pneumonia, pleural effusion or masses, severe pectus excavatum, or abdominal distention. Key findings of restrictive lung disease are rapid respiratory rate and decreased tidal volume/ capacity. Differential diagnosis for wheezing includes Foreign body in trachea or bronchus Vocal cord dysfunction (VCD) ,vascular rings or laryngeal webs, laryngotracheomalacia, tracheal stenosis, or bronchostenosis, enlarged lymph nodes or tumor, Viral bronchiolitis or obliterative bronchiolitis, Cystic fibrosis, Bronchopulmonary dysplasia, Heart disease(Burns et al., 2013, p. 710). Chest radiography is indicated in complicated cases in which treatment fails to elicit a response, in patients with respiratory distress, or in those who require hospitalization (Bennet, 2013).

Nurse Practitioners are the Health Care Provider of Choice

Dr. Anu Varghese
DNP, FNP

Nurse Practitioners (NPs) are licensed, independent clinicians who treat people's health conditions and prevent diseases (AANP 2016). Independently and in collaboration with health care professionals, NPs provide a full range of primary, acute, and specialty health care services. Additionally, NPs provide counseling, education on disease prevention, and positive health and lifestyle choices. Thus, NPs are set apart from other health care providers by their unique blend of medical and nursing care and emphasis on the health and well-being of the whole person.

The NP scope of practice is divided into independent (full), collaborative (reduced), and supervised (restricted) practice, and is determined by each state. Full practice allows the NP to evaluate and diagnose patients, order and interpret diagnostic tests, and initiate and manage treatment including medication prescriptions under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Board of Nursing. The reduced practice model allows the NP to diagnose and treat patients, but requires physician's oversight to prescribe medications. The restricted NP practice model requires physician oversight to diagnose and treat patients.



Regardless of the difference in NPs scope of practice, the patients in the study reported an extremely high level of satisfaction with the care they received from NPs (Stanickhut et al 2013). While this study report empowers the NP profession enormously, I like to peek into a typical day of my practice as NP and the job satisfaction I receive from the long term care of disabled children. Most of our 90 patients have cerebral palsy as their main diagnosis. They are physically and intellectually challenged, depend on wheel chair for ambulation, and depend on others for their activities of daily living.

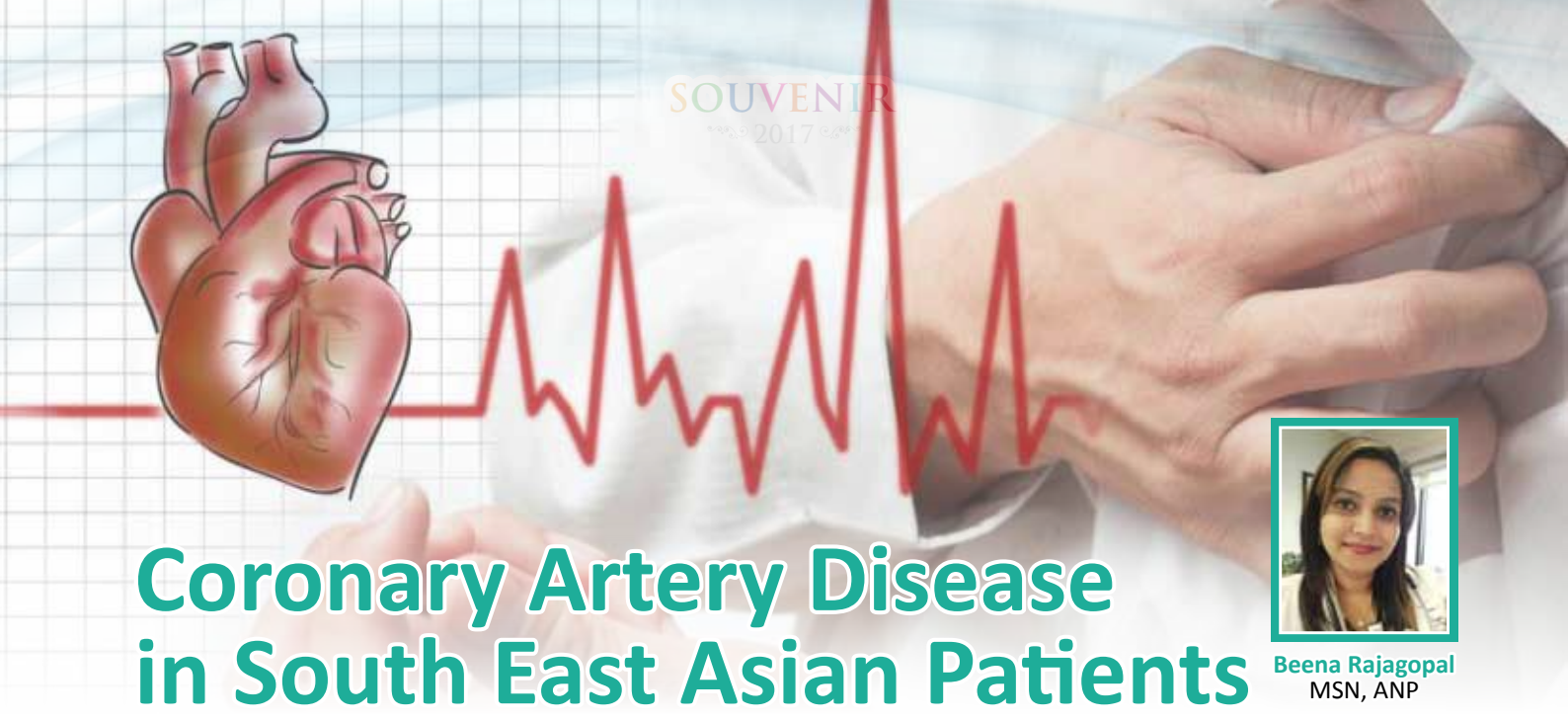
A typical day for me starts with making the rounds along with three NPs and four pediatricians. As providers, we share the job equally and address any urgent care. Afterward, I am usually at my desk catching up on charting and eating a quick breakfast by 10am. The rest of my morning usually involves coordinating specialty care for my patients and educating patients and/or parents. My afternoons go by quickly, attending interdisciplinary team meetings and checking lab reports until the end of the day. Today, I had a busy but productive day with a lot of satisfaction and positive feelings. I took care of a patient with fever and respiratory symptoms who required influenza testing, blood work, and a chest X-ray. Two patients with an asthma exacerbation required medication adjustments. A patient with vomiting required intravenous hydration, and an insulin-dependent diabetic

patient needed blood sugar issues corrected. In my practice, you won't see any one wearing a white coat which helps to avoid professional hierarchy. Here, RNs, NPs, pediatricians, and therapists work together as a great team to give those special children the best chance to reach their potential and bring smiles to their faces.

One Day

One day a life is borne
One day a little smile
A sparkle in eyes warmly welcomes you.
Tiny fingers reach for height
Tiny toes takes steps so light
One day a perfect walk
One day a perfect talk.
The life is just a start
One day is to run
One day is for lots of fun
Keep smiling, keep going.
One day you will win the world
One day you will know God's love
One day you will know his power
Trust in him and he will lead you
ONE DAY YOUR WISH WILL COME TRUE!

Tesmol James
MSN, FNP-BC



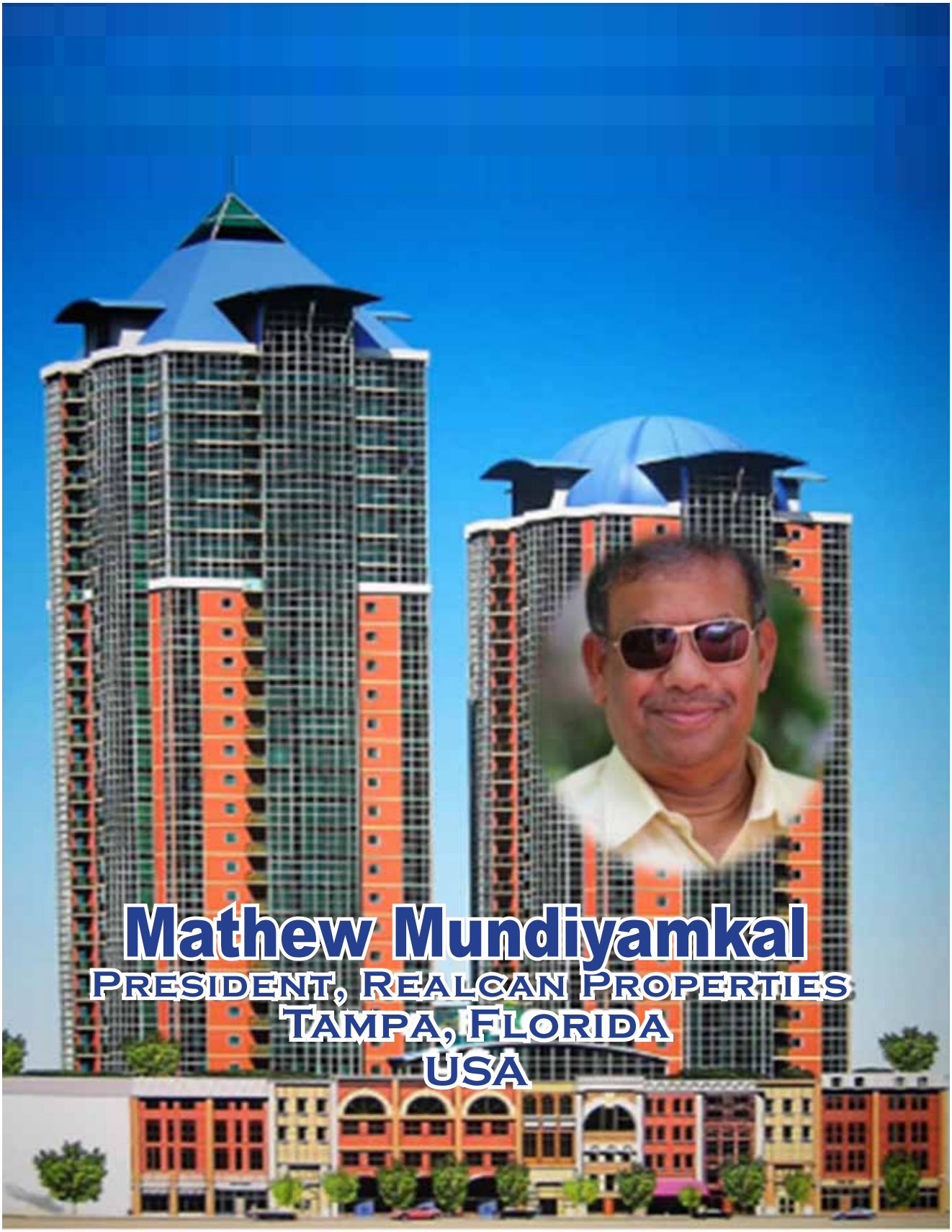
Coronary Artery Disease in South East Asian Patients

Beena Rajagopal
MSN, ANP

In the Southeast-Asian (SEA) population, Coronary Artery Disease (CAD) is more severe, malignant, and with more premature-onset (before the age of 40). However, the SEA population remains unaware of the alarming rates of premature onset of CAD. The lack of awareness of this problem among primary health care providers contributes to delays in early assessment, screening, and treatment resulting in poor patient outcomes with high morbidity and mortality.

NPs can significantly impact the community through education, screening and CAD prevention through proper identification of ethnicity in primary care, inpatient admission, discharge, research studies, rehab, and in death certificates as SEA. Secondly, NPs should screen the patients for emerging risk factors as per current evidence which is SEA-specific include high levels of Lipoprotein A, homo-cysteine, low HDL, fibrinogen, and/or insulin resistance. Finally, by patient empowerment through education and cardio-protective life style modifications before the mid 30's, and NPs can make a change in their practice to help the SEA population to improve patient outcomes and prevent CAD.

Clinical evidence is promising that heart disease is preventable and treatable among SEA. Prompt identification of high risk SEA, early screening, and patient empowerment through education and cardio-protective lifestyle changes, makes CAD preventable to a great extent.



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