Delawareans' reports of difficulty obtaining effective treatment for Lyme disease prompted lawmakers to address the issue in the spring of 2015. House Speaker Pete Schwartzkopf and Senator Ernie Lopez co-chaired the Lyme Disease Prevention Task Force, attended by representatives of various agencies, professional groups, and interested citizens. Multiple citizens testified to lack of treatment within Delaware and denial of insurance coverage, necessitating treatment out of state and payment out of pocket.

One outcome of the Task Force included drafted legislation to establish an oversight board to standardize education for medical professionals. Disagreement among medical professionals regarding diagnosis and treatment of Lyme disease may complicate consensus regarding the content of the education. Conflicting guidelines and evidence are at the heart of the treatment deficit problem, creating an ethical dilemma for providers who want to assist suffering patients, but are fearful of jeopardizing their licenses. To protect healthcare providers who do not adhere to Centers for Disease Control and Prevention (CDC) guidelines, several states have passed legislation shielding providers from medical board harassment (Suffolk Times, 2015). Some states have passed legislation mandating insurance coverage for treatment of Lyme, and in 2013, Virginia enacted a law requiring physicians ordering Lyme testing to disclose to patients that testing may not be reliable (Lymedisease.org, 2013).

Lyme disease is costly. Researchers at Johns Hopkins conducted a study of 52,795 individuals with a history of Lyme diagnosis and treatment between 2006-2010. Compared with a control group with a history of Lyme diagnosis and treatment, individuals with Lyme disease were more likely to have used emergency departments, physicians’ offices, and hospitalization, and suffered greater functional limitations and disability days. Compared with the control group, the mean medical charges were $18,527.37 for the study group, and $9,519.11 for the control group (Lyme Disease: Little Tick, Big Controversy, 2015).

Lyme disease is endemic within the northeastern region of the United States and in Delaware. Most often carried by deer ticks, it can be accompanied by various tick borne co-infections (TBIs) and lead to grave debilitation. Rebecca Jackson, Miss Delaware 2013, was misdiagnosed and bedridden for over a year prior to accurate diagnosis and treatment. Multiple citizens testified to lack of treatment within Delaware and denial of insurance coverage, necessitating treatment out of state and payment out of pocket.

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CORRECTION
Correction to 20+ Years of Membership: Cathie Wrede was mistakenly not included in the recognition of long time membership. DNA would like to recognize and thank her for her membership and support over the years.

Executive Director’s Report continued from page 1
At press time, the survey was still being implemented. The results of the survey will be available on the DNA website at www.denurses.org and welcome all to review.

In addition to these survey results, the Nursing Workforce in the State of Delaware: A Current Look 2014 report and information on workplace violence in Delaware are also available on the DNA website. According to the IOM Future of Nursing report, reliable data on the current nursing workforce and the needs of nurses must be collected in order to make necessary changes to improve the overall health care system. DNA will continue to forge ahead in data collection on the state of professional nursing in Delaware to support the improvement of care, the value of nursing and removing barriers. Your input would greatly help this effort.

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Lyme disease is a multisystem, multisymptom infectious disease that can present with early, disseminated, or late manifestations. Untreated or undertreated, Lyme can result in disability, crippling, and death. (Cerami, 2013; Fallon, 2006; Horowitz, 2013; Lawrence, Lipton, Lowry, & Coyle, 1995). It is most often caused by an ancient and complex spirochete bacterium strain called Borrelia burgdorferi. The pathogen bores into tissues and cartilage, potentially affecting all body systems and organs. Symptoms reflect this process, and, like syphilis (also caused by a spirochete), is described as the Great Limiter and is commonly misdiagnosed. Lyme typically exhibits periods of remission and recurrence, reflecting the ability of the spirochete, Borrelia burgdorferi, to persist and flourish in the human body. This is possible due to the presence of latent organisms, which increases with time. Subsequent to the initial inflammatory process, neuropsychiatric and inflammatory neuromuscular manifestations are typical manifestations, the prevalence of which increases with time. Subsequent to the inflammatory process, neuropsychiatric and musculoskeletal manifestations are the most commonly reported by patients (Fallon, 2009; Kindlerlehrer, 2014). Spirochetes have been identified in the brain as early as twelve hours following inoculation, and a tick can be attached for minutes to hours to infect (Spreen, 2013). Brain fog frequently continues, often accompanied by memory impairment, headache, sensory loss, distal paresthesia, spinal or radicular pain, sleep disturbance and, nightmares, which can lead to depression, and difficulty finding words (Mahoney, 2009). Sensory hypersensitivity, symptoms associated with anxiety and depression, muscle weakness, tics, and cognitive losses may occur, as well as sudden onset of obsessive compulsive tendencies, panic episodes, and occurrences of rage (Fallon, 2009; Mahoney, 2009; Spreen, 2007).

Dr. Rebecca Benson, DNP, PMHCNS-BC, for her willingness to extend to each nurse related to diagnosis and infectious disease as well as current conflicting views to nurses who continue to experience symptoms following treatment when testing criteria are met. Benchmark for diagnosing Lyme disease, according to the CDC, is a positive test (ELISA or IFA followed by Western blot, or “PCR”) with at least one positive benchmark and one negative benchmark. Reliability data regarding prevalence of co-infections is deficient. There are conflicting views on diagnosis, treatment, and even the existence of long term or chronic Lyme disease (Bransfield, n.d.; Cameron, 2010; Coyle, 2007; Kennedy, 2013; Lantos, 2015.) The Centers for Disease Control and Prevention (CDC) acknowledges that the currently CDC recommended two-tier testing procedure (ELISA or IFA followed by Western blot, or “PCR”) is not sensitive enough for surveillance and not as clinical diagnostic criteria (CDC, n.d.). Still, the procedure remains a rigid benchmark for diagnosing Lyme disease, according to the CDC. Infectious Diseases Society of America (IDSA) and some insurance companies. The CDC and IDSA recommend two to four weeks of antibiotic treatment when testing criteria are met. There is general agreement among all providers that the majority of patients who are treated early in the disease process recover with minimal residual symptoms. According to the CDC and IDSA, patients who continue to experience symptoms following treatment when testing criteria are met. The Delaware Nurses Association held its annual Spring Conference on March 18, 2016 at St. Francis Hospital in Wilmington, Delaware. The conference was well attended, and overall participant evaluations were very positive. Thank you to all the members of the planning committee for their hard work in making this conference a great success.

Welcome to the May-June-July issue of the DNA Reporter. This edition of the DNA Reporter is focused on Lyme disease. A special thank you to Rebecca Benson, DNP, PMHCNS-BC, for her willingness to extend to each nurse related to diagnosis and infectious disease as well as current conflicting views to nurses who continue to experience symptoms following treatment when testing criteria are met.
treatment are experiencing residual damage to tissues and the immune system resulting from the infection, or autoimmune responses that can occur following some infections. The position is that Lyme is easily diagnosed and treated, that continued infection does not occur, and that chronic infectious Lyme disease does not exist (CDC, n.d.; IDSA, n.d.). According to CDC and IDSA guidelines, patients who experience symptoms following treatment are identified as experiencing Post Treatment Lyme Disease Syndrome (PTLDS), and additional antibiotic treatment is not recommended. For patients with PTLDS, the CDC recommends a search for a different illness that may be causing symptoms. Treatment modalities for fibromyalgia and counseling are recommended (CDC, n.d.).

The opposing view, held by the International Lyme and Associated Diseases Society (ILADS), points to evidence that the CDC-supported two-tier testing criterion fails to detect up to 50% of cases and does not distinguish between acute, chronic or resolved infection (Holl-Weiden, Suerbaum, & Girschick, 2007; Spreen, 2013). Since the recommended ELISA and Western blot test results are inconsistent, ILADS recommends that the diagnosis should be based on patients' symptoms and practitioners' clinical assessment and judgment. Comprehensive assessment of individuals who have a history of possible exposure is advised, with testing playing a supportive, not a definitive, role. Bransfield (2015) has compiled a collection of more than 700 articles and studies supporting the existence of chronic infectious Lyme disease (ILADS, n.d.). ILADS published new guidelines in 2014 for diagnosis and treatment of Lyme disease, available on the National Guideline Clearinghouse website. The guidelines are patient centered, balancing risks and benefits for treatment when Lyme is diagnosed by the practitioner, and comply with Institute of Medicine (IOM) recommendations (Johnson, 2015). Continued treatment of patients who relapse or experience disease progression is recommended until symptoms resolve, with ongoing assessment for comorbidities (ILADS, 2014). Laboratories that specialize in tick-borne illnesses are recommended for testing. Another potential barrier to accurate diagnosis is the proposal that the FDA regulate laboratory tests, an action that would restrict the availability of alternative Lyme testing to health care providers and patients (FDA, 2014). Patients suffering with Lyme and other TBIs deserve a unified approach to diagnosis and treatment. Opposing guidelines create an ethical dilemma for practitioners and added hardship for patients. Informed critical thinking, informed attention to public policy, informed challenging of guidelines, and well-informed and unbiased examination of all available research is needed from health care providers. If a patient has been potentially exposed to persistent infection in Lyme disease, Lyme disease and co-infections should be diligently considered as differential diagnoses.

References
Neuropsychiatric Manifestations of Lyme & Associated Diseases

Anita Bains

Anita Bains learned her Lyme diagnosis from The Reading Hospital School of Nursing in 2004 and is a registered nurse with MSN from University of Victoria, Victoria, BC, Canada, and is an MSN in psychiatric mental health nursing from the University of Maryland. She is board certified as a psychiatric mental health clinical nurse specialist by the ANCC and has engaged in private practice for more than 30 years. Anita was chairperson of psychiatric nursing at University Memorial Hospital School of Nursing and Howard Community College, and currently serves in advocacy roles for psychiatric mental health nurses. In addition to expertise in traditional and cognitive psychosocial therapies, she has extensive training in mind-body and energy therapies, including Eye Movement Desensitization and Reprocessing (EMDR). Anita is an expert practitioner and teacher of Emotional Freedom Techniques (EFT) methods and makes use of EFT for alleviation of PTSD and other negative emotional processes and physical symptoms. She has written and spoken internationally on these topics, including The Chengdu University of Traditional Chinese Medicine in China. In addition to providing workshops and her private practice, Anita has given workshops to veterans and prison inmates. She has co-authored The Lyme Disease Workbook: Tapping into a Wellness State with Tracey Middleton, LCSW-C. The first of its kind book is expected to be published later this year. Diagnosed with late stage Lyme disease and Rocky Mountain spotted fever, the physical and emotional relief EFT provided to individuals suffering from Lyme and co-infections. Anita’s public policy advocacy activities are for trauma survivors. She can be reached by email at anitabains@verizon.net or by phone at 410-302-5446. Her website is www.anitabains.com.

Among diseases that present with psychological as well as physical symptoms are Lyme and Related Tick-Borne Infections (TBI) (p. 5). The primary challenges for the clinician as well as the patient. Horowitz (2013) stated that, “Lyme disease has been known to cause a host of neuropsychiatric abberations...” (p. 57). Guidelines developed in 2015 by the American Psychiatric Association (APA) included screening for infectious diseases, including Lyme disease, in the assessment of patients presenting with psychiatric symptoms (APA, n.d.). Lyme disease is a frequently missed diagnosis. Dr. Robert Bransfield, a New Jersey based psychiatrist and psychotherapist, who has studied the association of infectious causes of neuropsychiatric illness for decades, noted that, “Thousands of peer-reviewed articles demonstrate the causal association between Lyme/Tick-Borne diseases and neuropsychiatric symptoms” (Bransfield, 2012, p. 83). Bransfield has found that the activation of cytokines, pro-inflammatory protein molecules, is a major factor in development of neuropsychiatric symptoms. Cytokine activation contribute to encephalopathy and subsequent psychiatric symptoms. This process sets the stage for chronic encephalopathy, which can lead to unstable moods, severe emotional states, and impaired thinking and memory. When the stress response is not turned off, which occurs when the bacteria is not eradicated, inflammation increases and symptoms worsen. When the brain is affected in this way by Lyme disease, it is referred to as Lyme encephalopathy.

**Manifestations of Lyme Encephalopathy**

Lyme encephalopathy can result in profound fatigue, headaches, and sleep to strange dreams, paranoia, immobility, abnormal postures, hypersexomnia, artifactual vision, Petrie’s sign, Babesia or M. fermentans may experience more profound neuropsychiatric symptoms (Spreen, 2013). Cognitive impairments can include slow visual and auditory processing, memory difficulties, and word finding and communication deficits. Decline in executive functioning, such as ability to plan, organize, prioritize and create confusion, a decline in overall intellectual performance, and getting lost in familiar surroundings are also cognitive difficulties (Kindelberger, 2014). An affected patient’s presenting complaint may include the perception of losing one’s mind. Difficulty staying focused, trouble comprehending and retaining information, and confusion during attempts at decision making are frequently described by patients (Horowitz, 2013). Bransfield (2012) noted that late stage TBI neurological symptoms can occur in patients for whom TBI has never been considered, in patients who have been misdiagnosed, in patients who have been inadequately treated for a previously diagnosed TBI, and in patients in whom the disease has recurred without treatment (Bransfield, 2012). Horowitz (2013) explained, “Cognitive symptoms begin as executive dysfunction, such as weakness, lack of concentration, depressed mood, lethargy, hypoglossia, and word finding and communication deficits. The prolonged symptoms of cognitive dysfunction can easily be misinterpreted as psychiatric illness when there seems to be no evidence of a physical illness. This, along with the fact that Lyme/TBI mimics a variety of physical and psychiatric disorders, can make accurate diagnosis difficult for Lyme experts.” Delays to the behavioral and lack of sensitivity of the most available tests, blood testing is notoriously unreliable at most laboratories in the United States, making the comprehensive clinical diagnosis crucial. Dr. Robert Bransfield has developed a structured clinical interview, available at www.bransfieldmedicine.com, to provide assessment of patients with neuropsychiatric symptoms.

Teasing out whether problems with mood, thinking, and performing activities of daily life are related to Lyme/TBIs or something else is not a small task. Arriving at a TBI diagnosis involves ruling out other conditions and considering comorbidity.

**Addressing Neuropsychiatric Symptoms**

With these issues present, conditions are interpreted solely as mental illness, they cannot be properly treated. According to Horowitz (2013), “Prioritizing modes of treatment for the Lyme patient who presents with neuropsychiatric symptoms includes an application of combination antimicrobial therapies, psychotropic medications, herbal and vitamin therapies, and various forms of psychomotor and stress reduction techniques” (p. 52). Bransfield (2012) and Singleton (2008) concur with this recommended treatment.

Emotional Freedom Techniques (EFT), along with other traditional and cognitive therapies, can provide an effective means of disrupting and calming elevated states of stress, fear, anxiety, and hopelessness, the stress response, known as the fight or flight response. They belong to a family of modalities that combine Eastern and Western traditions that promote the healing of mind and body by balancing and restoring the energy reserves necessary for survival and well-being (Ruden, 2005). While there is no one right way to resolve an illness, a multidisciplinary approach can promote recovery.

**References**


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The Science

Lyme disease (LD) is caused by the bacterium Borrelia burgdorferi. In the northeastern and upper Midwest, B. burgdorferi is transmitted by the black-legged tick, Ixodes scapularis. This tick also transmits Anaplasma phagocytophilum (Anaplasmosis) and Babesia microti (Babesiosis) infections which are both associated with more severe and prolonged symptoms than those of LD.

It is believed that most humans are infected from the bite of immature ticks associated with more severe and prolonged symptoms than those of LD. Generally, the tick must be attached for 36 – 48 hours to transmit the bacterium (Centers for Disease Control and Prevention [CDC] 2015; Heymann, 2015; Kimberlin, 2015, National Institutes of Health [NIH], 2016).

Signs and Symptoms

Early symptoms of LD may be mild and can mimic many other disease conditions. The table below represents the usual presentations. Fever and general symptoms can occur in the absence of the classical erythema migrans (EM) rash, more commonly known as the “Bull’s Eye” rash. The CDC suggests that the rash occurs in approximately 70-80% of infected persons. LD case data available from Delaware Division of Public Health (DPH) points to a smaller percentage for infected cases that develop EM—approximately 50%. For those who develop the rash and seek medical care, the diagnosis is typically apparent. For others, the healthcare provider must use both the clinical symptoms combined with laboratory tests for LD to make the diagnosis (CDC, 2015; Heymann, 2015; Kimberlin, 2015, NIH, 2016).

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<thead>
<tr>
<th>Stage</th>
<th>Timing After Bite</th>
<th>Symptoms</th>
</tr>
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<tbody>
<tr>
<td>Early</td>
<td>3 - 30 days</td>
<td>fever, chills, headache, fatigue, arthralgias, myalgias, lymphadenopathy, single erythema migrans (EM)</td>
</tr>
<tr>
<td>Later</td>
<td>Weeks to months</td>
<td>meningitis, arthritis, facial palsy, cardiitis, neuropathy, radiculoneuritis, cranial neuritis, problems with short term memory, multiple EM</td>
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Diagnosis

Diagnosing LD in the absence of the classic EM rash can be difficult. Laboratory blood tests are helpful if used correctly and performed with validated methods. In LD endemic regions such as Delaware, a clinical diagnosis can be made in patients presenting with an EM rash, with or without the knowledge of a tick exposure. Providers should also have a high index of suspicion even if the rash does not present as the classic Bull’s Eye but the patient has concerning tick exposure. Serological tests in the early stages of illness should be interpreted with caution as antibodies against B. burgdorferi may not yet be detectable, and some individuals treated in the early stages of illness may never develop antibodies. Diagnosis of early disease without EM or late LD should be made on the basis of clinical findings and serologic test results. Virtually all patients with late disease have antibodies against B. burgdorferi which can persist for many years. Laboratory testing sensitivity increases in patients who have progressed to late disease have antibodies against B. burgdorferi.

Stage Timing After Bite Symptoms
Early 3 - 30 days fever, chills, headache, fatigue, arthralgias, myalgias, lymphadenopathy, single erythema migrans (EM)
Later Weeks to months meningitis, arthritis, facial palsy, cardiitis, neuropathy, radiculoneuritis, cranial neuritis, problems with short term memory, multiple EM
"Post-treatment Lyme disease Syndrome" (PTLDS). It is now recognized that chronic Lyme disease, though not characterized by the persistence of symptoms attributable to the Lyme spirochete, is a very controversial illness. Lyme disease is also a very controversial illness.

References


Lyme Carditis, a Rare and Serious Complication

Margaret O. McElligott, MSN, RN

Margaret McElligott earned a Bachelor of Science in Nursing from The Catholic University of America in Washington, DC & a Master of Science in Nursing from Wesley College in Dover, DE. She has been certified in Critical Care Nursing and is currently preparing to earn certification in Health Care Simulation Education. Margaret completed a certificate in simulation program from Drexel University. Margaret has extensive nursing experience in all areas of critical care. Starting her career in hematology/oncology, she moved into bone marrow transplant, coronary care, cardiovascular interventional lab, Level II trauma/ED and finally medical ICU. Employers included Christiana Medical Center, George Washington University Medical Center in Washington DC, United Hospital in St. Paul, MN, St. Mary Medical Center in suburban Philadelphia and finally Bayhealth Medical Center in Dover, DE. In 2009, Margaret began teaching critical care clinical for Wesley College, while still practicing ICU nursing. She became faculty at Wesley in 2011, specializing in simulation.

Margaret is currently an Instructor of Nursing and a Simulation Coordinator for Wesley College in Dover, DE. She has been teaching in critical care and palliative care nursing courses. In spring 2015 she co-taught a field study in Guatemala, with undergraduate nursing students. Spring 2016 she will return to Guatemala with students and a fellow nursing professor. Margaret can be reached by email at Maggie.mcelligott@wesley.edu or at her office at (302) 736-2157.

Lyme disease is a challenging infectious disease to diagnose and treat effectively. Unfortunately, this has led to significant morbidity and multi-system complications among Lyme sufferers (Spreen, 2013). The following case study illustrates the potentially devastating consequence for Wesley College’s Director of Developmental Therapeutics at the Duke Cancer Institute was a victim of Lyme carditis. In an interview with Dana Parish of the Huffington Post (2016), Dr. Neil Spector described his initial experience of cardiac arrhythmias and brain fog in 1993. In 1996, he developed arthritis in his wrist to the point that he could not hold objects. As a result of another condition, he started taking doxycycline and the arthritis resolved within twenty-four hours. He subsequently developed profound fatigue, burning heels, and night terrors, and then suspected Lyme. Three negative lab tests resulted in no treatment, irreversible heart failure and then a heart transplant. After seeing multiple physicians, he eventually connected with a New Jersey based physician who had him tested for Lyme at a specialty lab, IGeneX, which produced a positive finding for Lyme. Dr. Spector subsequently wrote the book, Gone in a Heartbeat: A Physician’s Search for True Healing. He continues his work at Duke University as an Associate Professor of Medicine and of Pharmacology and Cancer Biology. He qualified that there are biological reasons why some strains of Tick borne infections (TBI) end up in the heart verses the brain and other locations, just like in cancer. Studies indicate that the Borrelia organism has an affinity for collagen-rich tissue, located in the cardiac and nervous systems as well the skin, joints and eyes (Pearson, 2015).

Lyme disease has been found to generally present in three distinct stages. Stage 1, which is the early localized stage, typically occurs from several days up to one month of an infected tick bite. Most infected patients experience flu-like symptoms and some develop the erythema migrans rash. Stage 2 is the early dissemination stage, occurring weeks to months from infection. The hallmark of this stage is musculoskeletal, neurological, and sometimes cardiac abnormalities may present. The principal manifestation of Lyme carditis is conduction system disturbances, including second and third degree atrioventricular block. Cardiac rhythms may vary from 1st degree AV block to complete heart block. Stage 3 occurs several months to years after infection by Borrelia burgdorferi, is characterized by mononarthritis or arthritis, and is known as the late disseminated stage. Patients with more severe conduction system disturbances may present with a myriad of indicators. The goal of treatment in the early stage of Lyme disease is to eradicate the infection and prevent the associated sequelae with antibiotic therapy. When Lyme carditis patients present with mild cardiac symptoms, antibiotic treatment is recommended based on clinical presentation, disease stage, and a PR interval less than 0.30 seconds. With severe symptoms and a PR interval of less than 0.30 seconds, they can be effectively treated with the oral amoxicillin or doxycycline. Patients with more severe conduction system disturbances, including second and third degree atrioventricular block or a PR interval greater than 0.30 seconds, require more aggressive support. Typically these cardiac abnormalities may present with a myriad of indicators. The prevalence of Lyme carditis is higher in North America than Europe. Estimates of case numbers are 4% to 10% in the United States and 0.5% to 0.9% in Europe respectively. Of note, while there is only a slight predominance, male to female, in occurrence of Lyme disease cases, Lyme carditis occurs with a 3:1 male to female predominance (Fish et al., 2008).

Patients with cardiac manifestations of Lyme disease may present with a myriad of indicators. Dizziness, palpitations, syncope, angina pectoris, dyspnea, and congestive heart failure are some of the presenting symptoms. The cause of many of these symptoms is conduction system irregularities or inflammation related to pericarditis or myocarditis. The most common cardiac conduction system abnormalities are fluctuating degrees of atrioventricular block. Cardiac rhythms may vary from 1st degree AV block to complete heart block. Therapeutic interventions range from observance to permanent pacemaker. Typically these cardiac rhythms disturbances are temporary and responsive to treatment. In undiagnosed cases of Lyme disease where Lyme carditis is suspected, serum testing must be performed. Because of the low sensitivity in the early phase of the infection, a negative test should be repeated within six weeks. Treatment is bactericidal based on clinical presentation, disease stage, and a PR interval less than 0.30 seconds, they can be effectively treated with the oral amoxicillin or doxycycline. Patients with more severe conduction system disturbances, including second and third degree atrioventricular block or a PR interval greater than 0.30 seconds, require more aggressive support. Typically these cardiac abnormalities may present with a myriad of indicators. The prevalence of Lyme carditis is higher in North America than Europe. Estimates of case numbers are 4% to 10% in the United States and 0.5% to 0.9% in Europe respectively. Of note, while there is only a slight predominance, male to female, in occurrence of Lyme disease cases, Lyme carditis occurs with a 3:1 male to female predominance (Fish et al., 2008).

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References

Time for Lyme Awareness continued from page 1
of 263,975 individuals. Lyme patients made 87 per cent more doctor office visits and 71 percent more emergency room visits in the year following diagnosis and treatment. It was also found that 63 percent of patients had at least one Lyme related diagnosis and spent about $3800.00 more annually in health care costs than individuals without Lyme (Mervine, 2013). Citing CDC guidelines, insurance companies often refuse to cover such costs. Findings estimated the financial cost of Lyme disease and post-treatment complications to be between $712 million and $1.3 billion annually. The cost in human suffering is incalculable.

Thousands of individuals who believe they are suffering from persistent symptoms of TBI have created dozens of support groups across the U.S. and internationally. Members interact through websites, blogs, and community meetings to share information and to advocate for CDC policy changes and legal interventions. The Lyme Disease Network (lymedisease.org) includes all 50 states. In Delaware, three organizations operate, including Lyme Disease Association of Delmarva, Inc., Southern Delaware Lyme Disease Support Group, and Delaware Lyme Support.

Regardless of barriers to treatment, allegations of commercial conflicts of interest, restricted research funding, patented test protection, and collusion among government agencies and pharmaceutical companies abound, along with calls for investigations of the CDC and FDA (Johnson, 2015). Meanwhile, Lyme patients and providers carry burdens resulting from the conflicts. There is an opportunity for Nursing to follow a path different than competition and reticulation. Nursing can engage in critical thinking, consider all evidence, question all guidelines, and engage in collaboration. Believing what we want to believe and not knowing what we don’t know is unacceptable as Lyme disease expands. Patients have the “moral and legal right” to complete information regarding available options for treatment (Guido, 2014, p.189). In order to provide patients with information to support informed consent, healthcare providers must become informed. The following articles contain some conflicting evidence, reflecting the conflicted state of Lyme disease diagnosis and treatment. The first article is an overview of Lyme disease and related issues. Neuropsychiatric manifestations are covered by Anita Bains, MSN, PMHCNS-BN, followed by Margie McElliott, MSN, RN. Paula Eggers, RN, BS covers epidemiology, CDC guidelines, and prevention. Shari Tenner, MSN, RN wrote an article on co-infections. Diligent examination of findings is essential, along with support for ongoing objective research.

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References
Tick Borne Illness and Co-infections of Lyme Disease

Shari Tenner, MSN, RN

Shari Tenner, MSN, RN earned a diploma in nursing in 1979 from the Ann May School of Nursing, a BSN from Drexel University and a MSN in Education and Faculty role from Drexel University. Her area of practice has focused primarily on care of the perioperative patient. Currently she is the Director of Campus Learning Resources for the Department of Nursing at Wesley College.

Lyme disease is a zoonotic, vector borne sequelae of a tick bite (lymedisease.org). Today the prevalence of co-infections following a tick bite are ubiquitous and warrant further diagnosis and treatment to avoid permanent illness, complications, and long term disability (Spreen, 2013). Traditionally, Babesiosis has been associated with Ehrlichiosis, and Bartonellosis (Adelson, 2004). Associated with Lyme disease include Babesiosis, and like malaria, it infects red blood cells (Spreen, 2013). Ehrlichiosis is a parasitic Rickettsia or bacterial infection attacking white blood cells (monocytes or granulocytes, depending on the variety of tick). Bartonellosis is a bacterial infection, found within the cell structure, especially within the endothelial cell (Buhner, 2013). Symptoms are usually flu like, but can occasionally be severe, requiring hospitalization. Central nervous system and neurological symptoms including seizures, thrombocytopenia, elevated liver function tests, and low platelets can be typical but variable. Babesiosis can precipitate opportunistic infections and complications resulting in life threatening and fatal results (Ismail, Bloch & McBride, 2010). This TBI was previously believed to infect only animals and is often misdiagnosed (Lyme Awareness of Cape Cod, n.d.). Multiplying within the host these organisms manifesting as those of nondescript inflammation. Patients with already weakened immune systems will be vastly compromised by TBI with a greater likelihood for negative outcomes and debilitating side effects. Concurrent infectious processes tax the body and further weaken the immune system. Treatment, therefore, should strive to strengthen the immune system while eradicating the TBI. Initial treatment success may be related to eradication of the TBI or merely a brief respite due to a dormancy of the organism while it retreats to recharge and resume later in a new location with different symptoms (Northage-Orr, 2013). Retreatment is necessary and an enormous range of options and alternative treatment options may be presented to Lyme sufferers seeking cure.

Babesiosis is sometimes called American malaria, since its acute presentation can resemble malaria, and like malaria, it infects human red blood cells (Spreen, 2013). Traditionally, Babesia has been associated with illness in cattle and horses, however several species of the Babesia genus are carried by ticks and cause disease in humans. Babesiosis is diagnosed via visualization on blood smears during the early weeks of infection. Polymerase chain reaction (PCR) looks for DNA sequence specific to Babesia, which is currently only good for Babesia microti. False negative findings are frequent and should not be used as a treatment guide (lymedisease.org). Symptoms can range from mild to severe, and may re-emerge until after the Lyme symptoms subside and can include cycles of muscle aches, rapid onset severe headache, high fever, chills, rashes, and rigors in the acute stage, as the parasite is released from broken red blood cells. Acute presentation with delirium and rages occur but are rare. Symptoms can progress to alterations in blood pressure, liver and kidney function and anemia. Profound fatigue and air hunger can be debilitating, and symptoms depend on the Babesia strain. Bursting red blood cells can lead to icterus and jaundice. Hypo coagulability, low cortisol levels, and ongoing muscle pain can alert the health care provider to the possibility of Babesiosis, especially in a patient who continues to be acutely ill despite adequate treatment for Lyme. Treatment includes Atovaquone (Nepron) plus Azithromycin (Zithromax). For continued success may be related to eradication of the TBI while eradicating the Babesia. Initial treatment therefore, should strive to strengthen the immune system while eradicating the TBI. Initial treatment success may be related to eradication of the TBI or merely a brief respite due to a dormancy of the organism while it retreats to recharge and resume later in a new location with different symptoms (Northage-Orr, 2013). Retreatment is necessary and an enormous range of options and alternative treatment options may be presented to Lyme sufferers seeking cure.

References

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Questions to Ask in Making the Decision to Accept a Staffing Assignment for Nurses

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1. What is the assignment? Clarify the assignment. Do not assume. Be certain that what you believe is the assignment is indeed correct.

2. What are the characteristics of the patients being assigned? Do not just respond to the number of patients, make a critical assessment of the needs of each patient, his or her age, condition, other factors that contribute to special needs, and the resources available to meet those needs. Who else is on the unit or within the facility that might be a resource for the assignment? Do nurses on the unit have access to those resources? How stable are the patients, and for what period of time have they been stable? Do any patients have communication and/or physical limitations that will require accommodation and extra supervision during the shift? Will there be discharges to offset the load? If there are discharges, will there be admissions, which require extra time and energy?

3. Do I have the expertise to care for the patients? Am I familiar with caring for the types of patients assigned? If this is a “float assignment,” am I cross-trained to care for these patients? Is there a “buddy system” in place with staff who are familiar with the unit? If there is no cross-training or “buddy system,” has the patient load been modified accordingly?

4. Do I have the experience and knowledge to manage the patients for whom I am being assigned care? If the answer to the question is “no,” you have an obligation to articulate limitations. Limitations in experience and knowledge may not require refusal of the assignment but rather an agreement—regarding supervision or a modification of the assignment to ensure patient safety. If no accommodation for limitations is considered, the nurse has an obligation to refuse an assignment for which she or he lacks education or experience.

5. What is the geography of the assignment? Am I being asked to care for patients who are in close proximity for efficient management, or are the patients at opposite ends of the hall or on different units? If there are geographic difficulties, what resources are available to manage the situation? If my patients are on more than one unit and I must go to another unit to provide care, who will monitor patients out of my immediate attention?

6. Is this a temporary assignment? When other staff are located to assist, will I be relieved? If the assignment is temporary, it may be possible to accept a difficult assignment, knowing that there will soon be reinforcements. Is there a pattern of short staffing, or is this truly an emergency?

7. Is this a crisis or an ongoing staffing pattern? If the assignment is being made because of an immediate need on the unit, a crisis, the decision to accept the assignment may be based on that immediate need. However, if the staffing pattern is an ongoing problem, the nurse has the obligation to identify unmet standards of care that are occurring as a result of ongoing staffing inadequacies. This may result in a request for “safe harbor” and/or peer review.

8. Can I take the assignment in good faith? If not you will need to get the assignment modified or refuse the assignment. Consult your individual state’s nursing practice act regarding clarification of accepting an assignment in good faith. In understanding good faith, it is sometimes easier to identify what would constitute bad faith. For example, if you had not taken care of pediatric patients since nursing school and you were asked to take charge of a pediatric unit, unless this were an extreme emergency, such as a disaster (in which case you would need to let people know your limitations, but you might still be the best person, given all factors for the assignment), it would be bad faith to accept the assignment. It is always your responsibility to articulate your limitations and to get an adjustment to the assignment that acknowledges the limitations you have articulated. Good faith acceptance of the assignment means that you are concerned about the situation and believe that a different pattern of care or policy should be considered. However, you acknowledge the difference of opinion on the subject between you and your supervisor and are willing to take the assignment and await the judgment of other peers and supervisors.

In 2010, the Institute of Medicine released a landmark report, The Future of Nursing: Leading Change, Advancing Health, which recommended increasing the number of nurse leaders in pivotal decision-making roles on boards and commissions that work to improve the health of everyone in America. The Nurses on Boards Coalition (NOBC) was created in response to this, as a way to help recruit and engage nurses to step into leadership roles. The NOBC represents nursing and other organizations working to build healthier communities in America by increasing nurses’ presence on corporate, health-related, and other boards, panels, and commissions. The coalition’s goal is to help ensure that at least 10,000 nurses are on boards by 2020, as well as raise awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health in the United States.

We encourage each and every one of you, over 3 million strong, to visit www.nursesonboardscoalition.org, sign up to be counted if you are on a board and read more about the efforts being made to help build the future of our profession.

2016 Nurses Week Theme Announced

Join ANA in celebrating the important role nurses play in health care during National Nurses Week, May 6 - 12. This year’s official theme is “Culture of Safety: It starts with YOU!” Visit the National Nurses Week at www.nursingworld.org.

National Nurses Week begins each year on May 6 and ends on May 12, Florence Nightingale’s birthday. These permanent dates enhance planning, and position National Nurses Week as an established recognition event. As of 1998, May 8 was designated as National Student Nurses Day, to be celebrated annually. And as of 2003, National School Nurse Day is celebrated on the Wednesday within National Nurses Week each year.

The nursing profession has been supported and promoted by the American Nurses Association (ANA) since 1896. Each of ANA’s state and territorial nurses associations promotes the nursing profession at the state and regional levels. Each conducts celebrations on these dates to recognize the contributions that nurses and nursing make to the community. The ANA supports and encourages National Nurses Week recognition programs through the state and district nurses associations, other specialty nursing organizations, educational facilities, and independent health care companies and institutions.
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