### NURSING PROCESS FOCUS  Clients Receiving Androgen Therapy

<table>
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<th>Assessment</th>
<th>Potential Nursing Diagnoses</th>
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| Prior to administration:  
- Obtain a complete health history including male breast or prostatic cancer; BPH; cardiac, kidney, or liver disease; diabetes; or hypercalcemia.  
- Obtain lab results including renal function tests, blood urea nitrogen (BUN), creatinine, and PSA.  
- Obtain a drug history to determine possible drug interactions and allergies. |  
- Body Image, Disturbed, related to effects of decreased or increased hormone function  
- Sexual Dysfunction, related to effects of drug therapy or decreased hormone function  
- Sleep Pattern, Disturbed, related to effects of drug therapy  
- Knowledge, Deficient, related to disease process and drug therapy |

**Planning: Client Goals and Expected Outcomes**

The client will:  
- Demonstrate improvement of the underlying condition for which testosterone was ordered.  
- Demonstrate an ability to correctly self-administer the prescribed drug.  
- Demonstrate an understanding of the drug’s action by accurately describing drug side effects and precautions.

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<th>Interventions and (Rationales)</th>
<th>Client Education/Discharge Planning</th>
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| Monitor serum cholesterol levels. (Elevated cholesterol levels secondary to testosterone administration may increase client’s risk of cardiovascular disease.) | Instruct client to:  
- Have cholesterol levels measured periodically during therapy.  
- Modify factors that may lower risk of hypercholesterolemia: decrease fat in diet, increase exercise, decrease consumption of red meat. |
| Monitor calcium levels. (Testosterone can cause hypercalcemia.) | Instruct client to:  
- Have calcium levels checked during therapy.  
- Recognize and report symptoms of increased serum calcium, including deep bone and flank pain, anorexia, nausea/vomiting, thirst, constipation, lethargy, and psychoses. |
| Monitor bone growth in children and adolescents. (Premature epiphyseal closing may occur, leading to growth retardation.) | Instruct the pediatric caregiver to have bone-age determinations performed on the child every 6 months. |
| Monitor input, output, and client weight. (Testosterone can cause retention of salt and water, leading to edema.) | Instruct client to check weight twice weekly and report increases, particularly if accompanied by dependent edema. |
| Monitor blood glucose, especially in clients with diabetes. (Testosterone therapy may affect glucose tolerance.) | Instruct client to:  
- Monitor blood glucose daily and report significant changes.  
- Recognize that adjustments may need to be made in hypoglycemic medications and diet. |
| Monitor proper self-administration. (Proper self-administration is key to safety and effectiveness.) | Instruct client to:  
- Mark calendar so medication can be taken/given at appropriate intervals.  
- Apply transdermal patch to dry, clean scrotal skin that has been dry shaved, and not to use chemical depilatories.  
- Notify female partner of transdermal patch use; there is a chance of absorbing testosterone, resulting in mild virilization.  
- Avoid showering or swimming for at least 1 hour after gel application. |

**Evaluation of Outcome Criteria**

Evaluate the effectiveness of drug therapy by confirming that client goals and expected outcomes have been met (see “Planning”).  
- The client demonstrates improvement in the condition for which the drug was ordered.  
- The client demonstrates safe self-administration of the drug.  
- The client demonstrates an understanding of the drug’s action by accurately describing drug side effects and precautions.

▶ See Table 46.1 for a list of drugs to which these nursing actions apply.