CLINICALJUDGE™ · MASTER REVIEW SERIES

ENDOCRINOLOGY — ALL MUST-KNOW CONTENT

Comprehensive NGN NCLEX 2026 review covering pituitary, thyroid, parathyroid, adrenal, and pancreatic disorders. Aligned to the NCSBN Clinical Judgment Measurement Model and the 2026 NGN test plan.

#NGN_NCLEX_2026 #ENDOCRINE #PHYSIOLOGIC_ADAPTATION #PHARMACOLOGY #REDUCTION_OF_RISK #CJMM

COLOR KEY Critical / Crisis · Pathophysiology · Safe / Expected · Complications · NCLEX Traps · Medications · Patient Education

01 PITUITARY DISORDERS

SIADH vs. Diabetes Insipidus — the “too much vs. too little ADH” dyad. High-yield because they are mirror images.

ADH PHYSIOLOGY — THE CORE CONCEPT

Posterior pituitary releases ADH → ADH acts on renal collecting ducts →
Water reabsorbed back into blood → Concentrated urine + diluted serum Na

Rule: ADH = Anti-Diuretic Hormone = "hold onto water." Too much ADH (SIADH) → water overload, dilutional hyponatremia. Too little ADH (DI) → massive water loss, hypernatremia.

SIADH — TOO MUCH ADH

- ↓ **Serum Na:** < 135 mEq/L (dilutional hyponatremia)
- ↓ **Serum osmolality:** < 275 mOsm/kg (dilute

DI — TOO LITTLE ADH

- ↑ **Serum Na:** > 145 mEq/L (hypernatremia)
- ↑ **Serum osmolality:** > 295 mOsm/kg (concentrated blood)

blood)

- ↓ **Urine:** concentrated, low output, high specific gravity (>1.030)
- ↓ **Weight:** gain without edema (water held intracellularly)
- ↓ **Neuro:** headache, confusion, seizures (cerebral edema)
- ↓ **Causes:** small-cell lung CA, head trauma, SSRIs, carbamazepine, post-op
- ↓ **Treatment:** fluid restriction (800–1000 mL/day), hypertonic 3% saline if severe, demeclocycline, tolvaptan/conivaptan (vaptans block ADH)

- ↑ **Urine:** dilute, output 4–20 L/day, specific gravity < 1.005
- ↑ **Weight:** loss; signs of dehydration, hypotension, tachycardia
- ↑ **Neuro:** intense thirst, dry mucous membranes, lethargy
- ↑ **Causes:** head injury, pituitary surgery, lithium (nephrogenic), idiopathic
- ↑ **Treatment:** desmopressin (DDAVP) IV/intranasal/PO, replace fluids, monitor I&O hourly

LAB / FINDING	SIADH	DI	NCLEX SIGNIFICANCE
Serum Na (135–145 mEq/L)	↓ < 135	↑ > 145	Na < 120 = seizure risk; Na > 160 = brain shrinkage risk
Serum Osmolality (275–295)	↓ Dilute	↑ Concentrated	Mirror of urine osmolality
Urine Specific Gravity (1.005–1.030)	↑ > 1.030	↓ < 1.005	Direct reflection of ADH activity
Urine Output	↓ Low	↑ 4-20 L/day	Hourly I&O is a priority assessment
Daily Weight	↑ Gain	↓ Loss	1 kg = 1 L fluid; same time, same scale

02 THYROID DISORDERS

Hypo- vs. hyperthyroidism — and the two life-threatening crises: myxedema coma & thyroid storm.

⚡ HPT AXIS & CONCEPT

Hypothalamus → TRH → Anterior pituitary → TSH → Thyroid → T3/T4 →

Sets metabolic rate of every cell

Inverse rule: Primary hypothyroidism = ↑ TSH, ↓ T4. Primary hyperthyroidism = ↓ TSH, ↑ T4. Body "shouts" for the missing hormone.

HYPOTHYROIDISM (HASHIMOTO'S)

- ↓ **Metabolism:** slow, slow, slow
- ↓ **Vitals:** bradycardia, hypotension, hypothermia
- ↓ **Skin/hair:** dry, coarse hair, brittle nails, cold intolerance
- ↓ **GI:** constipation, weight gain despite anorexia
- ↓ **Neuro:** fatigue, lethargy, depression, slow speech
- ↓ **Female:** menorrhagia, infertility
- ↓ **Crisis:** myxedema coma — hypothermia, hypoventilation, hypotension, ↓ LOC
- ↓ **Labs:** ↑ TSH, ↓ T3/T4, ↑ cholesterol

HYPERTHYROIDISM (GRAVES')

- ↑ **Metabolism:** fast, fast, fast
- ↑ **Vitals:** tachycardia, hypertension (wide pulse pressure), low-grade fever, atrial fibrillation
- ↑ **Skin:** warm, sweaty, heat intolerance, fine hair
- ↑ **GI:** diarrhea, weight loss despite increased appetite
- ↑ **Neuro:** anxiety, tremor, insomnia, exophthalmos (Graves')
- ↑ **Female:** amenorrhea, infertility
- ↑ **Crisis:** thyroid storm — fever > 104°F, HR > 130, severe HTN, delirium, vomiting
- ↑ **Labs:** ↓ TSH, ↑ T3/T4, ↓ cholesterol

💜 KEY THYROID MEDICATIONS PHARMACOLOGY

LEVOTHYROXINE (Synthroid) — for hypothyroidism

Take on empty stomach, same time daily (early AM), with full glass of water. Wait 30–60 min before food, calcium, iron, antacids. Lifelong therapy. Monitor TSH q6–8 wk during titration. Watch for chest pain, palpitations (signs of overdose → hyperthyroid symptoms).

METHIMAZOLE / PROPYLTHIOURACIL (PTU) — for hyperthyroidism

Block thyroid hormone synthesis. **PTU** is preferred in 1st-trimester pregnancy and thyroid storm. Watch for agranulocytosis (sore throat, fever — STOP and call provider) and hepatotoxicity. Takes weeks to work.

PROPRANOLOL — adjunct in hyperthyroidism / thyroid storm

Beta blocker — controls HR, tremor, anxiety. Does NOT treat the thyroid itself but controls cardiac symptoms while antithyroid drugs take effect.

SSKI / LUGOL'S SOLUTION (potassium iodide)

Given in thyroid storm AFTER PTU/methimazole (otherwise iodine fuels the thyroid). Mix with juice, sip through straw to prevent tooth staining.

RADIOACTIVE IODINE (I-131)

Permanent ablation of thyroid. Pregnancy = absolute contraindication. Radiation precautions: flush toilet 2–3×, avoid pregnant women and small children for several days, no shared utensils, drink fluids to flush isotope.

🔥 THYROID STORM — PRIORITY NURSING LADDER

1. **Cool the patient** — cooling blanket, tepid sponge, acetaminophen. *NEVER aspirin* (displaces thyroid hormone from binding proteins → worsens storm).
2. **Cardiac monitoring** — continuous ECG; treat tachydysrhythmias with propranolol or esmolol.
3. **Block hormone production** — PTU or methimazole FIRST.
4. **Block hormone release** — iodine (SSKI) given 1+ hour AFTER antithyroid drug.
5. **Hydrocortisone IV** — prevents adrenal insufficiency from hypermetabolic stress.
6. **Hydrate** — IV fluids; replace insensible losses; monitor cardiac response (risk of HF in older adults).

🥶 MYXEDEMA COMA — PRIORITY NURSING LADDER

1. **AIRWAY first** — high risk of hypoventilation; intubation often required.
2. **IV levothyroxine** — given STAT, large loading dose.
3. **IV hydrocortisone** — coverage for likely concurrent adrenal insufficiency.
4. **Passive rewarming** — blankets only. *NO heating pads/electric blankets* — vasodilation drops BP further.

5 **Treat underlying trigger** — infection, cold exposure, sedatives, missed levothyroxine.

03 PARATHYROID DISORDERS

PTH controls calcium. Mirror disorders. Always ask: "Where is the calcium?"

PTH CONCEPT

PTH released when serum Ca is low → Pulls Ca from bone → Reabsorbs Ca in kidneys → Activates vitamin D for gut absorption

Inverse rule: Calcium and phosphorus are inverse. ↑ Ca → ↓ Phos. PTH always pushes calcium UP.

HYPOPARATHYROIDISM

- **Pathophys:** ↓ PTH → ↓ Ca, ↑ Phos
- **Cause:** often post-thyroidectomy (accidentally removed parathyroids)
- **S&S:** tetany, perioral numbness, paresthesias, muscle cramps
- **+ Chvostek's** (cheek tap = facial twitch)
- **+ Trousseau's** (BP cuff = carpal spasm)
- **Severe:** laryngospasm, seizures, prolonged QT
- **Treatment:** IV calcium gluconate (slow push), oral calcium + vitamin D for life
- **Diet:** high calcium, low phosphorus (avoid dairy excess, dark colas)

HYPERPARATHYROIDISM

- **Pathophys:** ↑ PTH → ↑ Ca, ↓ Phos
- **Classic mnemonic:** "Stones, bones, abdominal groans, psychic moans"
- **Stones:** kidney stones, polyuria
- **Bones:** osteoporosis, pathologic fractures, bone pain
- **Groans:** constipation, anorexia, peptic ulcers, pancreatitis
- **Moans:** fatigue, depression, confusion
- **Treatment:** parathyroidectomy, IV NS + furosemide, calcitonin, bisphosphonates
- **Diet:** low calcium, high fluid intake (3–4 L/day), avoid thiazides

04 ADRENAL DISORDERS

Cortisol, aldosterone, and catecholamines — three hormones, three classic disease patterns.

⚡ ADRENAL CONCEPT — "THE 3 S'S OF THE CORTEX"

SALT — aldosterone (Na + water retention, K excretion) →

SUGAR — cortisol (gluconeogenesis, anti-inflammatory, stress) → SEX — androgens

Medulla: epinephrine + norepinephrine (catecholamines) — pheochromocytoma source.

FEATURE	ADDISON'S (HYPOSECRETION)	CUSHING'S (HYPERSECRETION)
Cortisol / Aldosterone	↓ Both	↑ Both (or just cortisol)
Blood Pressure	↓ Hypotension	↑ Hypertension
Sodium	↓ Hyponatremia	↑ Hypernatremia
Potassium	↑ Hyperkalemia	↓ Hypokalemia
Glucose	↓ Hypoglycemia	↑ Hyperglycemia
Weight	↓ Loss, anorexia	↑ Truncal obesity, moon face, buffalo hump
Skin	Bronze hyperpigmentation (↑ ACTH)	Thin, easy bruising, purple striae
Immunity	Adequate (no cortisol suppression)	Suppressed → infection risk
Mood	Depression, fatigue	Mood swings, psychosis
Crisis	Addisonian crisis — shock, ↓ BP, ↓ glucose, ↑ K	Heart failure, infection, GI bleed, fracture
Treatment	Lifelong hydrocortisone + fludrocortisone	Treat cause: surgery, taper steroids, ketoconazole
Diet	High Na, high protein, high carb	Low Na, low cal, high K, high protein, high Ca

⚠ ADDISONIAN CRISIS — PRIORITY NURSING LADDER

1. **IV hydrocortisone** 100 mg STAT — life-saving cortisol replacement.
2. **IV fluids** — 0.9% NS, often with D5 (treats hypovolemia + hypoglycemia together).

3 **Treat hyperkalemia** — insulin + dextrose, kayexalate, or calcium gluconate if EKG changes.

4 **Identify trigger** — infection, surgery, abrupt steroid withdrawal, trauma, stress.

5 **Patient teaching** — never abruptly stop steroids; carry medical alert ID; "sick day rules" → double dose during illness.

⚡ PHEOCHROMOCYTOMA HIGH BP CRISIS

Catecholamine-secreting tumor of the adrenal medulla. Episodic bursts of epinephrine + norepinephrine cause severe paroxysmal HTN.

Classic triad (5 H's): Hypertension (severe, episodic), Headache (pounding), Hyperhidrosis (sweating), Heart palpitations, Hyperglycemia.

Diagnosis: 24-hour urine for VMA + metanephrines + catecholamines. Avoid caffeine, bananas, vanilla, citrus before collection.

Treatment: adrenalectomy. *Pre-op: alpha blockade FIRST (phenoxybenzamine), THEN beta blocker.* Beta first = unopposed alpha = hypertensive crisis.

Avoid: palpation of abdomen (can trigger catecholamine release).

05 DIABETES MELLITUS & PANCREATIC DISORDERS

The single highest-yield endocrine topic on the NGN — Type 1 vs. Type 2, DKA vs. HHS, hypoglycemia, and insulin pharmacology.

FEATURE	TYPE 1 DM	TYPE 2 DM
Pathophysiology	Autoimmune β-cell destruction → no insulin	Insulin resistance + relative deficiency
Onset	Sudden, usually < 30 yrs	Gradual, usually > 40 yrs
Body Habitus	Thin / weight loss	Often overweight
Insulin Need	Required for life	Diet/exercise/oral first; insulin later
Ketones	Yes — DKA risk	Rare — HHS risk instead
Classic Triad	Polyuria, polydipsia, polyphagia (with weight loss in T1)	

DIAGNOSTIC TEST	NORMAL	PRE-DM	DIABETES
Fasting BG	< 100	100–125	≥ 126 (×2)
Random BG + symptoms	—	—	≥ 200
2-hr OGTT	< 140	140–199	≥ 200
HbA1c	< 5.7%	5.7–6.4%	≥ 6.5% (target < 7% for most adults)

💜 INSULIN — TYPES, ONSET, PEAK, DURATION PHARMACOLOGY

TYPE	EXAMPLES	ONSET	PEAK	DURATION
Rapid	Lispro, Aspart, Glulisine	15 min	1 hr	3–5 hr
Short (Regular)	Humulin R, Novolin R	30–60 min	2–3 hr	5–8 hr
Intermediate	NPH	1–2 hr	4–12 hr	12–18 hr
Long	Glargine, Detemir, Degludec	1–2 hr	No peak	≥ 24 hr

Mixing rule: CLEAR before CLOUDY (Regular before NPH). Roll NPH; don't shake. **NEVER mix glargine** with anything. Regular insulin is the only insulin given IV. Rotate sites within one anatomic area; abdomen is fastest absorption.

💜 ORAL ANTIDIABETICS — HIGH-YIELD PHARMACOLOGY

METFORMIN (biguanide)

First-line for T2DM. ↓ hepatic glucose, ↑ insulin sensitivity. **Hold 24–48 hr before contrast dye** (lactic acidosis risk). Avoid with renal impairment, alcohol.

SULFONYLUREAS (glipizide, glyburide)

Stimulate β-cell insulin release. **Risk: hypoglycemia.** Avoid alcohol (disulfiram-like reaction).

GLP-1 AGONISTS (semaglutide, liraglutide, tirzepatide)

SubQ injection (semaglutide also PO). Slow gastric emptying, ↑ satiety. Watch for pancreatitis, thyroid C-cell tumors. Hold for surgery per anesthesia protocol.

SGLT2 INHIBITORS (-gliflozins)

Excrete glucose in urine. Risk: euglycemic DKA, GU infection, hypovolemia. Cardio/renal-protective.

DPP-4 INHIBITORS (-gliptins)

Prolong endogenous incretins. Generally well tolerated. Watch pancreatitis.

HYPOGLYCEMIA (BG < 70)

- **Sympathetic:** shaky, sweaty, tachycardia, anxiety
- **Neuroglycopenic:** confusion, slurred speech, headache, seizure, coma
- **Cause:** too much insulin, missed meal, exercise without snack, alcohol
- **Rule of 15 (conscious):** 15 g fast carb → wait 15 min → recheck
- **Examples:** 4 oz juice, 3–4 glucose tabs, 1 tbsp honey
- **Unconscious:** IV D50 (hospital), **glucagon IM/SC/IN** (home/EMS)
- **Always** follow with complex carb + protein once stable

HYPERGLYCEMIA (BG > 250)

- **3 P's:** polyuria, polydipsia, polyphagia
- **Skin:** warm, flushed, dry mucous membranes
- **Breath:** fruity (DKA only)
- **Resp:** Kussmaul (deep, rapid — DKA compensating for acidosis)
- **Mental:** confusion, lethargy, coma
- **Cause:** illness/infection, missed insulin, dietary indiscretion, stress, steroids
- **Treatment:** IV regular insulin, fluids, electrolytes — see DKA/HHS ladder

FEATURE	DKA (TYPE 1)	HHS (TYPE 2)
Onset	Hours to 1 day	Days — slower, more insidious
Blood Glucose	> 250 mg/dL	> 600 mg/dL (often 1000+)
pH	< 7.30 (acidotic)	> 7.30 (normal)
Bicarb	< 18 mEq/L	> 18 mEq/L
Ketones	Positive (urine + blood)	Negative / trace
Anion Gap	↑ (> 12)	Normal
Serum Osmolality	< 320	> 320
Breath	Fruity (acetone)	Not fruity

FEATURE	DKA (TYPE 1)	HHS (TYPE 2)
Respirations	Kussmaul	Normal/shallow
Mental Status	Alert → drowsy	More profound LOC change, often coma
Mortality	~ 1–5%	10–20% (much higher)

🚨 DKA / HHS — PRIORITY NURSING LADDER

1. **FLUIDS first** — 0.9% NS 1 L/hr initially; switch to 0.45% NS once stable. HHS may need 6–10 L total.
2. **IV regular insulin drip** (0.1 unit/kg/hr) — only insulin given IV. Goal: ↓ BG ~50–75 mg/dL/hr (faster = cerebral edema risk).
3. **POTASSIUM** — most lethal lab. Insulin drives K into cells. Hold insulin if K < 3.3. Replace K aggressively even if initial level looks normal.
4. **Add D5** to IVF when BG reaches ~200–250 (DKA) or ~300 (HHS) — prevents hypoglycemia while continuing insulin to clear ketones.
5. **Bicarb only if pH < 6.9** — routine bicarb worsens cerebral edema, esp. in pediatrics.
6. **Identify trigger** — infection (#1 cause), MI, missed insulin, new-onset T1DM, pregnancy, steroids.
7. **Transition to SubQ insulin** only after gap closes, pH > 7.30, bicarb > 18 — overlap drip 1–2 hours with first SubQ dose.

06 IF → THEN CLINICAL JUDGMENT RULES

Bedside decisions the NCLEX expects you to make automatically.

IF

Post-thyroidectomy patient develops perioral numbness + Trousseau's sign

THEN

Suspect hypocalcemia → notify provider, prepare IV calcium gluconate, keep tracheostomy tray at bedside.

IF

DI patient becomes hypotensive with urine output > 500 mL/hr

THEN

Give IV fluids per protocol, administer DDAVP, monitor I&O hourly, daily weights, watch for dysrhythmias from hypernatremia.

IF

SIADH patient on fluid restriction reports headache and confusion; Na = 118

THEN

Implement seizure precautions, notify provider for hypertonic 3% saline (slow infusion to avoid central pontine myelinolysis).

IF

Patient on long-term prednisone says they want to stop because of weight gain

THEN

Stop and educate — never stop abruptly (risk of addisonian crisis). Always taper. Notify provider.

IF

Diabetic patient is NPO for surgery in the morning

THEN

Hold short-acting/oral agents per protocol; usually ½ dose of long-acting insulin or per provider; monitor BG q1–2h; never withhold all insulin from a T1DM (DKA risk).

IF

Patient receiving insulin drip for DKA: BG drops from 320 to 240 in last hour

THEN

Add D5 to IVF and continue insulin drip — do NOT stop insulin until anion gap closes.

IF

Patient with thyroid storm has T 104.5°F

THEN

Cooling blanket + acetaminophen — never aspirin (worsens storm).

IF

Patient with pheochromocytoma has SBP 220

THEN

IV alpha blocker (phentolamine) FIRST. Avoid abdominal palpation.

IF

Patient on metformin scheduled for CT with contrast tomorrow

THEN

Hold metformin morning of procedure and 48 hr after; resume only when renal function confirmed.

IF

Patient with Cushing's reports new low-grade fever and back pain

THEN

Suspect occult infection (cortisol masks symptoms) and possible vertebral compression fracture — assess and notify provider.

07 TOP NCLEX TRAPS

The "almost-right" answers test writers love — and how to spot them.

TRAP 01

Holding all insulin when patient is NPO. Type 1 patients still need basal insulin — withholding causes DKA. Hold short-acting; manage long-acting per protocol.

TRAP 02

Giving aspirin for fever in thyroid storm. Aspirin displaces thyroid hormone from binding proteins. Use acetaminophen.

TRAP 03

TRAP 04

Giving beta blocker before alpha blocker in pheochromocytoma. Causes unopposed alpha → hypertensive crisis. Alpha first.

Stopping insulin in DKA when BG normalizes. Stop only when anion gap closes; add D5 to fluids instead.

TRAP 05

Iodine before PTU in thyroid storm. Iodine first = fuels thyroid hormone synthesis. PTU/methimazole FIRST, then iodine ≥1 hour later.

TRAP 06

Active rewarming in myxedema coma. Heating pads cause vasodilation and shock. Passive rewarming with blankets only.

TRAP 07

Abruptly stopping prednisone. Always taper. Abrupt withdrawal → addisonian crisis.

TRAP 08

Forgetting potassium in DKA. Insulin drives K into cells. Even normal K at admission will plummet — replace early.

TRAP 09

Mixing glargine. Long-acting analogs (glargine, detemir, degludec) are NEVER mixed with another insulin in same syringe.

TRAP 10

Giving levothyroxine with calcium, iron, antacids, or PPIs. Drastically reduces absorption. Take alone, AM, empty stomach, full water glass, wait 30–60 min.

TRAP 11

Treating SIADH hyponatremia rapidly. Correcting Na > 8–12 mEq/L per 24 hr → central pontine myelinolysis.

TRAP 12

Palpating the abdomen on a pheochromocytoma patient. Can trigger massive catecholamine release. Avoid.

08 HIGH-YIELD NCLEX PATTERNS

Pattern-recognition shortcuts: hear this stem, think this dx.

BRONZE SKIN + ↓ BP + ↑ K Addison's disease	**MOON FACE + BUFFALO HUMP + STRIAE** Cushing's syndrome	**EPISODIC HTN + HEADACHE + SWEATING** Pheochromocytoma
COLD, SLOW, WEIGHT GAIN, ↑ TSH Hypothyroidism	**HOT, FAST, WEIGHT LOSS, EXOPHTHALMOS** Graves' / hyperthyroidism	**+ CHVOSTEK + TROUSSEAU POST-THYROIDECTOMY** Hypocalcemia / hypoparathyroidism
STONES, BONES, GROANS, MOANS Hyperparathyroidism	**3 P'S + FRUITY BREATH + KUSSMAUL** DKA	**BG > 600 + DRY + NO KETONES** HHS

SHAKY, SWEATY, CONFUSED, BG 50

Hypoglycemia

POLYURIA + DILUTE URINE + ↑ NA

Diabetes Insipidus

CONCENTRATED URINE + ↓ NA + WEIGHT GAIN

SIADH

09 NGN BOW-TIE CLINICAL JUDGMENT SUMMARIES

The exam's anchor item type. Take an action — connect the condition — monitor outcomes.

BOW-TIE 1 — DKA

ACTIONS TO TAKE	CONDITION	PARAMETERS TO MONITOR
Initiate IV 0.9% NS bolus	**Diabetic Ketoacidosis**	Blood glucose q1h
Start IV regular insulin drip	Insulin deficit → ketone production	Anion gap, bicarb, pH
Monitor potassium q1–2h	Anion gap metabolic acidosis	Potassium, magnesium, phosphate
Add D5 when BG ~200–250	Severe dehydration	LOC, urine output, lung sounds

BOW-TIE 2 — ADDISONIAN CRISIS

ACTIONS TO TAKE	CONDITION	PARAMETERS TO MONITOR
IV hydrocortisone 100 mg STAT	**Acute Adrenal Insufficiency**	BP, HR, MAP
IV 0.9% NS with D5	Cortisol + aldosterone deficit	Sodium & potassium
Continuous cardiac monitoring	Hypovolemic shock + ↑ K + ↓ glucose	Blood glucose
Identify and treat trigger		EKG for hyperkalemia

BOW-TIE 3 — THYROID STORM

ACTIONS TO TAKE	CONDITION	PARAMETERS TO MONITOR
Cooling blanket + acetaminophen	**Thyrotoxic Crisis**	Core temperature q1h
PTU/methimazole FIRST	Massive thyroid hormone release	Continuous ECG (afib/SVT)

Iodine ≥ 1 hour after PTU

IV propranolol or esmolol

IV hydrocortisone

Hyperthermia + tachydysrhythmia

Often triggered by infection/surgery

Mental status / agitation

I&O, signs of HF

10 PATIENT & FAMILY EDUCATION

Discharge teaching the NGN expects you to deliver and document.

DIABETES SELF-MANAGEMENT

DAILY CARE

- ☐ Check BG before meals + bedtime; log readings
- ☐ Rotate injection sites within one body region
- ☐ Never share lancets, pens, or meters
- ☐ Inspect feet daily; wear well-fitting shoes; never barefoot
- ☐ Carry fast-acting carb (glucose tabs) at all times

SICK DAY RULES

- ☐ Never stop insulin during illness — body needs more
- ☐ Check BG q2–4h; check urine ketones if BG > 240
- ☐ Drink 8 oz sugar-free fluid hourly
- ☐ Call provider for vomiting > 4 h, BG > 240 + ketones, fever
- ☐ Wear medical alert ID

STEROID THERAPY (ADDISON'S, POST-ADRENALECTOMY, CHRONIC PREDNISONE)

ADHERENCE

- ☐ Take EXACTLY as prescribed; never skip or stop abruptly
- ☐ Take with food to prevent GI upset
- ☐ Take morning dose to mimic cortisol rhythm
- ☐ Wear medical alert ID; carry emergency hydrocortisone

SICK DAY DOUBLING RULE

- ☐ Double oral dose during fever, infection, illness
- ☐ Triple/IM hydrocortisone for vomiting, trauma, surgery
- ☐ Notify provider before any procedure or dental work
- ☐ Watch for crisis: weakness, low BP, abdominal pain

LEVOTHYROXINE — LIFELONG TEACHING

ADMINISTRATION

- ☐ Same time every morning, empty stomach

MONITOR & REPORT

- ☐ Chest pain, palpitations, tremor → too much

- ☐ Wait 30–60 minutes before eating
- ☐ Separate from calcium, iron, antacids by 4 hours
- ☐ Do not switch brands without provider approval
- ☐ Fatigue, weight gain, cold intolerance → too little
- ☐ TSH labs every 6–8 weeks during titration
- ☐ Lifelong therapy; do not discontinue when feeling better

🩺 POST-THYROIDECTOMY / PARATHYROIDECTOMY

IMMEDIATE POST-OP

- ☐ Semi-Fowler's; support head/neck when moving
- ☐ Tracheostomy tray + IV calcium gluconate at bedside
- ☐ Assess voice hourly (laryngeal nerve injury)
- ☐ Check posterior dressing for hidden bleeding
- ☐ Monitor for tetany, Chvostek, Trousseau

DISCHARGE

- ☐ Lifelong levothyroxine if total thyroidectomy
- ☐ Calcium + vitamin D if parathyroids damaged
- ☐ Voice rest, gradual ROM exercises
- ☐ Report numbness, tingling, muscle spasms immediately

CLINICALJUDGE™ ENDOCRINE MASTER REVIEW · NGN NCLEX 2026
Aligned to the NCSBN Clinical Judgment Measurement Model (Recognize Cues → Analyze Cues → Prioritize Hypotheses → Generate Solutions → Take Actions → Evaluate Outcomes).
PDF EXPORT: Chrome / Edge → File → Print → Destination: `Save as PDF` → Layout: `Portrait` → Scale: `65-70%` → Margins: `None` → ✅ Background graphics → Save.