Bates' Guide To Physical Examination and History Taking 13th Edition Bickley Test Bank

CHAPTER 1 Foundations for Clinical Proficiency
MULTIPLE CHOICE
1. After completing an initial assessment of a patient, the nurse has charted that his respirations are eupneic and his pulse is 58 beats per minute. These types of data would be:

a.	Objective.
b.	Reflective.
c.	Subjective.
d.	Introspective.

ANS: A
Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. Subjective data is what the person *says* about him or herself during history taking. The terms *reflective* and *introspective* are not used to describe data.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
2. A patient tells the nurse that he is very nervous, is nauseated, and feels hot. These types of data would be:

a.	Objective.
b.	Reflective.
c.	Subjective.
d.	Introspective.

ANS: C
Subjective data are what the person says about him or herself during history taking. Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms *reflective* and *introspective* are not used

to describe data.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. The patients record, laboratory studies, objective data, and subjective data combine to form the:

a.	Data base.
b.	Admitting data.
c.	Financial statement.
d.	Discharge summary.

ANS: A
Together with the patients record and laboratory studies, the objective and subjective data form the data base. The other items are not part of the patients record, laboratory studies, or data.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. When listening to a patients breath sounds, the nurse is unsure of a sound that is heard. The nurses next action should be to:

a.	Immediately notify the patients physician.
b.	Document the sound exactly as it was heard.
c.	Validate the data by asking a coworker to listen to the breath sounds.
d.	Assess again in 20 minutes to note whether the sound is still present.

ANS: C
When unsure of a sound heard while listening to a patients breath sounds, the nurse validates the data to ensure accuracy. If the nurse has less experience in an area, then he or she asks an expert to listen.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is conducting a class for new graduate nurses. During the teaching session, the nurse should keep in mind that novice nurses, without a background of skills and experience from which to draw, are more likely to make their decisions using:

a.	Intuition.
b.	A set of rules.
c.	Articles in journals.
d.	Advice from supervisors.

ANS: B
Novice nurses operate from a set of defined, structured rules. The expert practitioner uses intuitive links.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 3
MSC: Client Needs: General
6. Expert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. These responses are referred to as:

a.	Intuition.
b.	The nursing process.
c.	Clinical knowledge.
d.	Diagnostic reasoning.

ANS: A
Intuition is characterized by pattern recognitionexpert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
MSC: Client Needs: General
7. The nurse is reviewing information about evidence-based practice (EBP). Which statement best reflects EBP?

a.	EBP relies on tradition for support of best practices.
b.	EBP is simply the use of best practice techniques for the treatment of patients.
c.	EBP emphasizes the use of best evidence with the clinicians experience.
d.	The patients own preferences are not important with EBP.

ANS: C
EBP is a systematic approach to practice that emphasizes the use of best evidence in combination with the clinicians experience, as well as patient preferences and values, when making decisions about care and treatment. EBP is more than simply using the best practice techniques to treat patients, and questioning tradition is important when no compelling and supportive research evidence exists.

DIF: Cognitive Level: Applying (Application) REF: p. 5
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
8. The nurse is conducting a class on priority setting for a group of new graduate nurses. Which is an example of a first-level priority problem?

a.	Patient with postoperative pain
b.	Newly diagnosed patient with diabetes who needs diabetic teaching
c.	Individual with a small laceration on the sole of the foot
d.	Individual with shortness of breath and respiratory distress

ANS: D
First-level priority problems are those that are emergent, life threatening, and immediate (e.g., establishing an airway, supporting breathing, maintaining circulation, monitoring abnormal vital signs) (see Table 1-1).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. When considering priority setting of problems, the nurse keeps in mind that second-level priority problems include which of these aspects?

a.	Low self-esteem
b.	Lack of knowledge
c.	Abnormal laboratory values
d.	Severely abnormal vital signs

ANS: C
Second-level priority problems are those that require prompt intervention to forestall further deterioration (e.g., mental status change, acute pain, abnormal laboratory values, risks to safety or security) (see Table 1-1).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
10. Which critical thinking skill helps the nurse see relationships among the data?

a.	Validation
b.	Clustering related cues
c.	Identifying gaps in data
d.	Distinguishing relevant from irrelevant

ANS: B
Clustering related cues helps the nurse see relationships among the data.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the_____diagnosis.

a.	Nursing
b.	Medical

c.	Admission
d.	Collaborative

ANS: A
An accurate nursing diagnosis provides the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable. The other items do not contribute to the development of appropriate nursing interventions.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 6
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. The nursing process is a sequential method of problem solving that nurses use and includes which steps?

a.	Assessment, treatment, planning, evaluation, discharge, and follow-up
b.	Admission, assessment, diagnosis, treatment, and discharge planning
c.	Admission, diagnosis, treatment, evaluation, and discharge planning
d.	Assessment, diagnosis, outcome identification, planning, implementation, and evaluation

ANS: D
The nursing process is a method of problem solving that includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 3
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. A newly admitted patient is in acute pain, has not been sleeping well lately, and is having difficulty breathing. How should the nurse prioritize these problems?

a.	Breathing, pain, and sleep
b.	Breathing, sleep, and pain
c.	Sleep, breathing, and pain

d.	Sleep, pain, and breathing

ANS: A
First-level priority problems are immediate priorities, remembering the ABCs (airway, breathing, and circulation), followed by second-level problems, and then third-level problems.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. Which of these would be formulated by a nurse using diagnostic reasoning?

a.	Nursing diagnosis
b.	Medical diagnosis
c.	Diagnostic hypothesis
d.	Diagnostic assessment

ANS: C
Diagnostic reasoning calls for the nurse to formulate a diagnostic hypothesis; the nursing process calls for a nursing diagnosis.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: General
15. Barriers to incorporating EBP include:

a.	Nurses lack of research skills in evaluating the quality of research studies.
b.	Lack of significant research studies.
c.	Insufficient clinical skills of nurses.
d.	Inadequate physical assessment skills.

ANS: A
As individuals, nurses lack research skills in evaluating the quality of research studies, are isolated from other colleagues who are knowledgeable in research, and often lack the time to visit the library to read research. The other responses are not considered barriers.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 6
MSC: Client Needs: General
16. What step of the nursing process includes data collection by health history, physical examination, and interview?

a.	Planning
b.	Diagnosis
c.	Evaluation
d.	Assessment

ANS: D
Data collection, including performing the health history, physical examination, and interview, is the assessment step of the nursing process (see Figure 1-2).

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 2
MSC: Client Needs: General
17. During a staff meeting, nurses discuss the problems with accessing research studies to incorporate evidence-based clinical decision making into their practice. Which suggestion by the nurse manager would best help these problems?

a.	Form a committee to conduct research studies.
b.	Post published research studies on the units bulletin boards.
c.	Encourage the nurses to visit the library to review studies.
d.	Teach the nurses how to conduct electronic searches for research studies.

ANS: D
Facilitating support for EBP would include teaching the nurses how to conduct electronic searches; time to visit the library may not be available for many nurses. Actually conducting research studies may be helpful in the long-run but not an immediate solution to reviewing existing research.

DIF: Cognitive Level: Applying (Application) REF: p. 6

MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. When reviewing the concepts of health, the nurse recalls that the components of holistic health include which of these?

a.	Disease originates from the external environment.
b.	The individual human is a closed system.
c.	Nurses are responsible for a patients health state.
d.	Holistic health views the mind, body, and spirit as interdependent.

ANS: D
Consideration of the whole person is the essence of holistic health, which views the mind, body, and spirit as interdependent. The basis of disease originates from both the external environment and from within the person. Both the individual human and the external environment are open systems, continually changing and adapting, and each person is responsible for his or her own personal health state.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. The nurse recognizes that the concept of prevention in describing health is essential because:

a.	Disease can be prevented by treating the external environment.
b.	The majority of deaths among Americans under age 65 years are not preventable.
c.	Prevention places the emphasis on the link between health and personal behavior.
d.	The means to prevention is through treatment provided by primary health care practitioners.

ANS: C
A natural progression to prevention rounds out the present concept of health. Guidelines to prevention place the emphasis on the link between health and personal behavior.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 7
MSC: Client Needs: General
20. The nurse is performing a physical assessment on a newly admitted patient. An example of objective information obtained during the physical assessment includes the:

a.	Patients history of allergies.
b.	Patients use of medications at home.
c.	Last menstrual period 1 month ago.
d.	2 5 cm scar on the right lower forearm.

ANS: D
Objective data are the patients record, laboratory studies, and condition that the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The other responses reflect subjective data.

DIF: Cognitive Level: Applying (Application) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. A visiting nurse is making an initial home visit for a patient who has many chronic medical problems. Which type of data base is most appropriate to collect in this setting?

a.	A follow-up data base to evaluate changes at appropriate intervals
b.	An episodic data base because of the continuing, complex medical problems of this patient
c.	A complete health data base because of the nurses primary responsibility for monitoring the patients health
d.	An emergency data base because of the need to collect information and make accurate diagnoses rapidly

ANS: C
The complete data base is collected in a primary care setting, such as a pediatric or family practice clinic, independent or group private practice, college health service, womens health care agency, visiting nurse agency, or community health agency. In these settings, the nurse is the first health professional to see the patient and has the primary responsibility for monitoring the persons health care.

DIF: Cognitive Level: Applying (Application) REF: p. 6
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
22. Which situation is most appropriate during which the nurse performs a focused or problem-centered history?

a.	Patient is admitted to a long-term care facility.
b.	Patient has a sudden and severe shortness of breath.
c.	Patient is admitted to the hospital for surgery the following day.
d.	Patient in an outpatient clinic has cold and influenza-like symptoms.

ANS: D
In a focused or problem-centered data base, the nurse collects a mini data base, which is smaller in scope than the completed data base. This mini data base primarily concerns one problem, one cue complex, or one body system.

DIF: Cognitive Level: Applying (Application) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
23. A patient is at the clinic to have her blood pressure checked. She has been coming to the clinic weekly since she changed medications 2 months ago. The nurse should:

a.	Collect a follow-up data base and then check her blood pressure.
b.	Ask her to read her health record and indicate any changes since her last visit.
c.	Check only her blood pressure because her complete health history was documented 2 months ago.
d.	Obtain a complete health history before checking her blood pressure because much of her history information may have changed.

ANS: A
A follow-up data base is used in all settings to follow up short-term or chronic health problems. The other responses are not appropriate for the situation.

DIF: Cognitive Level: Applying (Application) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
24. A patient is brought by ambulance to the emergency department with multiple traumas received in an automobile accident. He is alert and cooperative, but his injuries are quite severe. How would the nurse proceed with data collection?

a.	Collect history information first, then perform the physical examination and institute life-saving measures.

b.	Simultaneously ask history questions while performing the examination and initiating life-saving measures.
c.	Collect all information on the history form, including social support patterns, strengths, and coping patterns.
d.	Perform life-saving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

ANS: B
The emergency data base calls for a rapid collection of the data base, often concurrently compiled with life-saving measures. The other responses are not appropriate for the situation.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
25. A 42-year-old patient of Asian descent is being seen at the clinic for an initial examination. The nurse knows that including cultural information in his health assessment is important to:

a.	Identify the cause of his illness.
b.	Make accurate disease diagnoses.
c.	Provide cultural health rights for the individual.
d.	Provide culturally sensitive and appropriate care.

ANS: D
The inclusion of cultural considerations in the health assessment is of paramount importance to gathering data that are accurate and meaningful and to intervening with culturally sensitive and appropriate care.

CHAPTER 2 Evaluating Clinical Evidence
MULTIPLE CHOICE
1. When performing a physical assessment, the first technique the nurse will always use is:

a.	Palpation.
b.	Inspection.
c.	Percussion.

d.	Auscultation.

ANS: B
The skills requisite for the physical examination are inspection, palpation, percussion, and auscultation. The skills are performed one at a time and in this order (with the exception of the abdominal assessment, during which auscultation takes place before palpation and percussion). The assessment of each body system begins with inspection. A focused inspection takes time and yields a surprising amount of information.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
2. The nurse is preparing to perform a physical assessment. Which statement is *true* about the physical assessment? The inspection phase:

a.	Usually yields little information.
b.	Takes time and reveals a surprising amount of information.
c.	May be somewhat uncomfortable for the expert practitioner.
d.	Requires a quick glance at the patients body systems before proceeding with palpation.

ANS: B
A focused inspection takes time and yields a surprising amount of information. Initially, the examiner may feel uncomfortable, *staring* at the person without also *doing something*. A focused assessment is significantly more than a quick glance.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. The nurse is assessing a patients skin during an office visit. What part of the hand and technique should be used to best assess the patients skin temperature?

a.	Fingertips; they are more sensitive to small changes in temperature.
b.	Dorsal surface of the hand; the skin is thinner on this surface than on the palms.
c.	Ulnar portion of the hand; increased blood supply in this area enhances temperature sensitivity.

d.	Palmar surface of the hand; this surface is the most sensitive to temperature variations because of its increased nerve supply in this area.

ANS: B
The dorsa (backs) of the hands and fingers are best for determining temperature because the skin is thinner on the dorsal surfaces than on the palms. Fingertips are best for fine, tactile discrimination. The other responses are not useful for palpation.

DIF: Cognitive Level: Applying (Application) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. Which of these techniques uses the sense of touch to assess texture, temperature, moisture, and swelling when the nurse is assessing a patient?

a.	Palpation
b.	Inspection
c.	Percussion
d.	Auscultation

ANS: A
Palpation uses the sense of touch to assess the patient for these factors. Inspection involves vision; percussion assesses through the use of palpable vibrations and audible sounds; and auscultation uses the sense of hearing.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
5. The nurse is preparing to assess a patients abdomen by palpation. How should the nurse proceed?

a.	Palpation of reportedly tender areas are avoided because palpation in these areas may cause pain.
b.	Palpating a tender area is quickly performed to avoid any discomfort that the patient may experience.
c.	The assessment begins with deep palpation, while encouraging the patient to relax and to take deep breaths.
d.	The assessment begins with light palpation to detect surface characteristics and to accustom the patient to being touched.

ANS: D
Light palpation is initially performed to detect any surface characteristics and to accustom the person to being touched. Tender areas should be palpated last, not first.

DIF: Cognitive Level: Applying (Application) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
6. The nurse would use bimanual palpation technique in which situation?

a.	Palpating the thorax of an infant
b.	Palpating the kidneys and uterus
c.	Assessing pulsations and vibrations
d.	Assessing the presence of tenderness and pain

ANS: B
Bimanual palpation requires the use of both hands to envelop or capture certain body parts or organs such as the kidneys, uterus, or adnexa. The other situations are not appropriate for bimanual palpation.

DIF: Cognitive Level: Applying (Application) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
7. The nurse is preparing to percuss the abdomen of a patient. The purpose of the percussion is to assess the_____of the underlying tissue.

a.	Turgor
b.	Texture
c.	Density
d.	Consistency

ANS: C
Percussion yields a sound that depicts the location, size, and density of the underlying organ. Turgor and texture are assessed with palpation.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 115

MSC: Client Needs: Safe and Effective Care Environment: Management of Care
8. The nurse is reviewing percussion techniques with a newly graduated nurse. Which technique, if used by the new nurse, indicates that more review is needed?

a.	Percussing once over each area
b.	Quickly lifting the striking finger after each stroke
c.	Striking with the fingertip, not the finger pad
d.	Using the wrist to make the strikes, not the arm

ANS: A
For percussion, the nurse should percuss two times over each location. The striking finger should be quickly lifted because a resting finger damps off vibrations. The tip of the striking finger should make contact, not the pad of the finger. The wrist must be relaxed and is used to make the strikes, not the arm.

DIF: Cognitive Level: Applying (Application) REF: p. 116
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. When percussing over the liver of a patient, the nurse notices a dull sound. The nurse should:

a.	Consider this a normal finding.
b.	Palpate this area for an underlying mass.
c.	Reposition the hands, and attempt to percuss in this area again.
d.	Consider this finding as abnormal, and refer the patient for additional treatment.

ANS: A
Percussion over relatively dense organs, such as the liver or spleen, will produce a dull sound. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 117
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
10. The nurse is unable to identify any changes in sound when percussing over the abdomen of an obese patient. What should the nurse do next?

a.	Ask the patient to take deep breaths to relax the abdominal musculature.
b.	Consider this finding as normal, and proceed with the abdominal assessment.
c.	Increase the amount of strength used when attempting to percuss over the abdomen.
d.	Decrease the amount of strength used when attempting to percuss over the abdomen.

ANS: C
The thickness of the persons body wall will be a factor. The nurse needs a stronger percussion stroke for persons with obese or very muscular body walls. The force of the blow determines the loudness of the note. The other actions are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 116
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. The nurse hears bilateral loud, long, and low tones when percussing over the lungs of a 4-year-old child. The nurse should:

a.	Palpate over the area for increased pain and tenderness.
b.	Ask the child to take shallow breaths, and percuss over the area again.
c.	Immediately refer the child because of an increased amount of air in the lungs.
d.	Consider this finding as normal for a child this age, and proceed with the examination.

ANS: D
Percussion notes that are loud in amplitude, low in pitch, of a booming quality, and long in duration are normal over a childs lung.

DIF: Cognitive Level: Applying (Application) REF: p. 117
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. A patient has suddenly developed shortness of breath and appears to be in significant respiratory distress. After calling the physician and placing the patient on oxygen, which of these actions is the best for the nurse to take when further assessing the patient?

a.	Count the patients respirations.

b.	Bilaterally percuss the thorax, noting any differences in percussion tones.
c.	Call for a chest x-ray study, and wait for the results before beginning an assessment.
d.	Inspect the thorax for any new masses and bleeding associated with respirations.

ANS: B
Percussion is always available, portable, and offers instant feedback regarding changes in underlying tissue density, which may yield clues of the patients physical status.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. The nurse is teaching a class on basic assessment skills. Which of these statements is *true* regarding the stethoscope and its use?

a.	Slope of the earpieces should point posteriorly (toward the occiput).
b.	Although the stethoscope does not magnify sound, it does block out extraneous room noise.
c.	Fit and quality of the stethoscope are not as important as its ability to magnify sound.
d.	Ideal tubing length should be 22 inches to dampen the distortion of sound.

ANS: B
The stethoscope does not magnify sound, but it does block out extraneous room sounds. The slope of the earpieces should point forward toward the examiners nose. Long tubing will distort sound. The fit and quality of the stethoscope are both important.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 116
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. The nurse is preparing to use a stethoscope for auscultation. Which statement is *true* regarding the diaphragm of the stethoscope? The diaphragm:

a.	Is used to listen for high-pitched sounds.
b.	Is used to listen for low-pitched sounds.

c.	Should be lightly held against the persons skin to block out low-pitched sounds.
d.	Should be lightly held against the persons skin to listen for extra heart sounds and murmurs.

ANS: A
The diaphragm of the stethoscope is best for listening to high-pitched sounds such as breath, bowel, and normal heart sounds. It should be firmly held against the persons skin, firmly enough to leave a ring. The bell of the stethoscope is best for soft, low-pitched sounds such as extra heart sounds or murmurs.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 117
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
15. Before auscultating the abdomen for the presence of bowel sounds on a patient, the nurse should:

a.	Warm the endpiece of the stethoscope by placing it in warm water.
b.	Leave the gown on the patient to ensure that he or she does not get chilled during the examination.
c.	Ensure that the bell side of the stethoscope is turned to the on position.
d.	Check the temperature of the room, and offer blankets to the patient if he or she feels cold.

ANS: D
The examination room should be warm. If the patient shivers, then the involuntary muscle contractions can make it difficult to hear the underlying sounds. The end of the stethoscope should be warmed between the examiners hands, not with water. The nurse should never listen through a gown. The diaphragm of the stethoscope should be used to auscultate for bowel sounds.

DIF: Cognitive Level: Applying (Application) REF: p. 117
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
16. The nurse will use which technique of assessment to determine the presence of crepitus, swelling, and pulsations?

a.	Palpation
b.	Inspection

c.	Percussion
d.	Auscultation

ANS: A
Palpation applies the sense of touch to assess texture, temperature, moisture, organ location and size, as well as any swelling, vibration or pulsation, rigidity or spasticity, crepitation, presence of lumps or masses, and the presence of tenderness or pain.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 115
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. The nurse is preparing to use an otoscope for an examination. Which statement is *true* regarding the otoscope? The otoscope:

a.	Is often used to direct light onto the sinuses.
b.	Uses a short, broad speculum to help visualize the ear.
c.	Is used to examine the structures of the internal ear.
d.	Directs light into the ear canal and onto the tympanic membrane.

ANS: D
The otoscope directs light into the ear canal and onto the tympanic membrane that divides the external and middle ear. A short, broad speculum is used to visualize the nares.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 119
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. An examiner is using an ophthalmoscope to examine a patients eyes. The patient has astigmatism and is nearsighted. The use of which of these techniques would indicate that the examination is being correctly performed?

a.	Using the large full circle of light when assessing pupils that are not dilated
b.	Rotating the lens selector dial to the black numbers to compensate for astigmatism
c.	Using the grid on the lens aperture dial to visualize the external structures of the eye

d.	Rotating the lens selector dial to bring the object into focus

ANS: D
The ophthalmoscope is used to examine the internal eye structures. It can compensate for nearsightedness or farsightedness, but it will not correct for astigmatism. The grid is used to assess size and location of lesions on the fundus. The large full spot of light is used to assess dilated pupils. Rotating the lens selector dial brings the object into focus.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 119
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. The nurse is unable to palpate the right radial pulse on a patient. The best action would be to:

a.	Auscultate over the area with a fetoscope.
b.	Use a goniometer to measure the pulsations.
c.	Use a Doppler device to check for pulsations over the area.
d.	Check for the presence of pulsations with a stethoscope.

ANS: C
Doppler devices are used to augment pulse or blood pressure measurements. Goniometers measure joint range of motion. A fetoscope is used to auscultate fetal heart tones. Stethoscopes are used to auscultate breath, bowel, and heart sounds.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 120
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. The nurse is preparing to perform a physical assessment. The correct action by the nurse is reflected by which statement? The nurse:

a.	Performs the examination from the left side of the bed.
b.	Examines tender or painful areas first to help relieve the patients anxiety.
c.	Follows the same examination sequence, regardless of the patients age or condition.
d.	Organizes the assessment to ensure that the patient does not change positions too often.

ANS: D
The steps of the assessment should be organized to ensure that the patient does not change positions too often. The sequence of the steps of the assessment may differ, depending on the age of the person and the examiners preference. Tender or painful areas should be assessed last.

DIF: Cognitive Level: Applying (Application) REF: p. 121
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. A man is at the clinic for a physical examination. He states that he is very anxious about the physical examination. What steps can the nurse take to make him more comfortable?

a.	Appear unhurried and confident when examining him.
b.	Stay in the room when he undresses in case he needs assistance.
c.	Ask him to change into an examining gown and to take off his undergarments.
d.	Defer measuring vital signs until the end of the examination, which allows him time to become comfortable.

ANS: A
Anxiety can be reduced by an examiner who is confident, self-assured, considerate, and unhurried. Familiar and relatively nonthreatening actions, such as measuring the persons vital signs, will gradually accustom the person to the examination.

DIF: Cognitive Level: Applying (Application) REF: p. 121
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
22. When performing a physical examination, safety must be considered to protect the examiner and the patient against the spread of infection. Which of these statements describes the most appropriate action the nurse should take when performing a physical examination?

a.	Washing ones hands after removing gloves is not necessary, as long as the gloves are still intact.
b.	Hands are washed before and after every physical patient encounter.
c.	Hands are washed before the examination of each body system to prevent the spread of bacteria from one part of the body to another.
d.	Gloves are worn throughout the entire examination to demonstrate to the patient concern regarding the spread of infectious diseases.

ANS: B
The nurse should wash his or her hands before and after every physical patient encounter; after

contact with blood, body fluids, secretions, and excretions; after contact with any equipment contaminated with body fluids; and after removing gloves. Hands should be washed after gloves have been removed, even if the gloves appear to be intact. Gloves should be worn when potential contact with any body fluids is present.

DIF: Cognitive Level: Applying (Application) REF: p. 120
MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control
23. The nurse is examining a patients lower leg and notices a draining ulceration. Which of these actions is most appropriate in this situation?

a.	Washing hands, and contacting the physician
b.	Continuing to examine the ulceration, and then washing hands
c.	Washing hands, putting on gloves, and continuing with the examination of the ulceration
d.	Washing hands, proceeding with rest of the physical examination, and then continuing with the examination of the leg ulceration

ANS: C
The examiner should wear gloves when the potential contact with any body fluids is present. In this situation, the nurse should wash his or her hands, put on gloves, and continue examining the ulceration.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 120
MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control
24. During the examination, offering some brief teaching about the patients body or the examiners findings is often appropriate. Which one of these statements by the nurse is most appropriate?

a.	Your atrial dysrhythmias are under control.
b.	You have pitting edema and mild varicosities.
c.	Your pulse is 80 beats per minute, which is within the normal range.
d.	Im using my stethoscope to listen for any crackles, wheezes, or rubs.

ANS: C
The sharing of some information builds rapport, as long as the patient is able to understand the

terminology.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 122
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
25. The nurse keeps in mind that the most important reason to share information and to offer brief teaching while performing the physical examination is to help the:

a.	Examiner feel more comfortable and to gain control of the situation.
b.	Examiner to build rapport and to increase the patients confidence in him or her.
c.	Patient understand his or her disease process and treatment modalities.
d.	Patient identify questions about his or her disease and the potential areas of patient education.

ANS: B
Sharing information builds rapport and increases the patients confidence in the examiner. It also gives the patient a little more control in a situation during which feeling completely helpless is often present.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 122
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
26. The nurse is examining an infant and prepares to elicit the Moro reflex at which time during the examination?

a.	When the infant is sleeping
b.	At the end of the examination
c.	Before auscultation of the thorax
d.	Halfway through the examination

ANS: B
The Moro or startle reflex is elicited at the end of the examination because it may cause the infant to cry.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 123
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. When preparing to perform a physical examination on an infant, the nurse should:

a.	Have the parent remove all clothing except the diaper on a boy.
b.	Instruct the parent to feed the infant immediately before the examination.
c.	Encourage the infant to suck on a pacifier during the abdominal examination.
d.	Ask the parent to leave the room briefly when assessing the infants vital signs.

ANS: A
The parent should always be present to increase the childs feeling of security and to understand normal growth and development. The timing of the examination should be 1 to 2 hours after feeding when the baby is neither too drowsy nor too hungry. Infants do not object to being nude; clothing should be removed, but a diaper should be left on a boy.

DIF: Cognitive Level: Applying (Application) REF: p. 122
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
28. A 6-month-old infant has been brought to the well-child clinic for a check-up. She is currently sleeping. What should the nurse do first when beginning the examination?

a.	Auscultate the lungs and heart while the infant is still sleeping.
b.	Examine the infants hips, because this procedure is uncomfortable.
c.	Begin with the assessment of the eye, and continue with the remainder of the examination in a head-to-toe approach.
d.	Wake the infant before beginning any portion of the examination to obtain the most accurate assessment of body systems.

ANS: A
When the infant is quiet or sleeping is an ideal time to assess the cardiac, respiratory, and abdominal systems. Assessment of the eye, ear, nose, and throat are invasive procedures that should be performed at the end of the examination.

DIF: Cognitive Level: Applying (Application) REF: p. 123
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
29. A 2-year-old child has been brought to the clinic for a well-child checkup. The best way for the nurse to begin the assessment is to:

a.	Ask the parent to place the child on the examining table.
b.	Have the parent remove all of the childs clothing before the examination.
c.	Allow the child to keep a security object such as a toy or blanket during the examination.
d.	Initially focus the interactions on the child, essentially ignoring the parent until the childs trust has been obtained.

ANS: C
The best place to examine the toddler is on the parents lap. Toddlers understand symbols; therefore, a security object is helpful. Initially, the focus is more on the parent, which allows the child to adjust gradually and to become familiar with you. A 2-year-old child does not like to take off his or her clothes. Therefore, ask the parent to undress one body part at a time.

DIF: Cognitive Level: Applying (Application) REF: p. 123
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
30. The nurse is examining a 2-year-old child and asks, May I listen to your heart now? Which critique of the nurses technique is *most* accurate?

a.	Asking questions enhances the childs autonomy
b.	Asking the child for permission helps develop a sense of trust
c.	This question is an appropriate statement because children at this age like to have choices
d.	Children at this age like to say, No. The examiner should not offer a choice when no choice is available

ANS: D
Children at this age like to say, No. Choices should not be offered when no choice is really available. If the child says, No and the nurse does it anyway, then the nurse loses trust. Autonomy is enhanced by offering a limited option, Shall I listen to your heart next or your tummy?

CHAPTER 3 Interviewing and the Health History
MULTIPLE CHOICE
1. The nurse is conducting an interview with a woman who has recently learned that she is pregnant and who has come to the clinic today to begin prenatal care. The woman states that she and her husband are excited about the pregnancy but have a few questions. She looks nervously at her hands during the interview and sighs loudly. Considering the concept of communication,

which statement does the nurse know to be *most* accurate? The woman is:

a.	Excited about her pregnancy but nervous about the labor.
b.	Exhibiting verbal and nonverbal behaviors that do not match.
c.	Excited about her pregnancy, but her husband is not and this is upsetting to her.
d.	Not excited about her pregnancy but believes the nurse will negatively respond to her if she states this.

ANS: B
Communication is all behaviors, conscious and unconscious, verbal and nonverbal. All behaviors have meaning. Her behavior does not imply that she is nervous about labor, upset by her husband, or worried about the nurses response.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 28
MSC: Client Needs: Psychosocial Integrity
2. Receiving is a part of the communication process. Which receiver is most likely to misinterpret a message sent by a health care professional?

a.	Well-adjusted adolescent who came in for a sports physical
b.	Recovering alcoholic who came in for a basic physical examination
c.	Man whose wife has just been diagnosed with lung cancer
d.	Man with a hearing impairment who uses sign language to communicate and who has an interpreter with him

ANS: C
The receiver attaches meaning determined by his or her experiences, culture, self-concept, and current physical and emotional states. The man whose wife has just been diagnosed with lung cancer may be experiencing emotions that affect his receiving.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 28
MSC: Client Needs: Psychosocial Integrity
3. The nurse makes which adjustment in the physical environment to promote the success of an interview?

a.	Reduces noise by turning off televisions and radios
b.	Reduces the distance between the interviewer and the patient to 2 feet or less
c.	Provides a dim light that makes the room cozy and helps the patient relax
d.	Arranges seating across a desk or table to allow the patient some personal space

ANS: A
The nurse should reduce noise by turning off the television, radio, and other unnecessary equipment, because multiple stimuli are confusing. The interviewer and patient should be approximately 4 to 5 feet apart; the room should be well-lit, enabling the interviewer and patient to see each other clearly. Having a table or desk in between the two people creates the idea of a barrier; equal-status seating, at eye level, is better.

DIF: Cognitive Level: Applying (Application) REF: p. 29
MSC: Client Needs: Psychosocial Integrity
4. In an interview, the nurse may find it necessary to take notes to aid his or her memory later. Which statement is *true* regarding note-taking?

a.	Note-taking may impede the nurses observation of the patients nonverbal behaviors.
b.	Note-taking allows the patient to continue at his or her own pace as the nurse records what is said.
c.	Note-taking allows the nurse to shift attention away from the patient, resulting in an increased comfort level.
d.	Note-taking allows the nurse to break eye contact with the patient, which may increase his or her level of comfort.

ANS: A
The use of history forms and note-taking may be unavoidable. However, the nurse must be aware that note-taking during the interview has disadvantages. It breaks eye contact too often and shifts the attention away from the patient, which diminishes his or her sense of importance. Note-taking may also interrupt the patients narrative flow, and it impedes the observation of the patients nonverbal behavior.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 30
MSC: Client Needs: Psychosocial Integrity
5. The nurse asks, I would like to ask you some questions about your health and your usual daily activities so that we can better plan your stay here. This question is found at the _____

phase of the interview process.

a.	Summary
b.	Closing
c.	Body
d.	Opening or introduction

ANS: D
When gathering a complete history, the nurse should give the reason for the interview during the opening or introduction phase of the interview, not during or at the end of the interview.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 31
MSC: Client Needs: Psychosocial Integrity
6. A woman has just entered the emergency department after being battered by her husband. The nurse needs to get some information from her to begin treatment. What is the best choice for an opening phase of the interview with this patient?

a.	Hello, Nancy, my name is Mrs. C.
b.	Hello, Mrs. H., my name is Mrs. C. It sure is cold today!
c.	Mrs. H., my name is Mrs. C. How are you?
d.	Mrs. H., my name is Mrs. C. Ill need to ask you a few questions about what happened.

ANS: D
Address the person by using his or her surname. The nurse should introduce him or herself and give the reason for the interview. Friendly small talk is not needed to build rapport.

DIF: Cognitive Level: Applying (Application) REF: p. 31
MSC: Client Needs: Psychosocial Integrity
7. During an interview, the nurse states, You mentioned having shortness of breath. Tell me more about that. Which verbal skill is used with this statement?

a.	Reflection
b.	Facilitation
c.	Direct question
d.	Open-ended question

ANS: D
The open-ended question asks for narrative information. It states the topic to be discussed but only in general terms. The nurse should use it to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 31
MSC: Client Needs: Psychosocial Integrity
8. A patient has finished giving the nurse information about the reason he is seeking care. When reviewing the data, the nurse finds that some information about past hospitalizations is missing. At this point, which statement by the nurse would be most appropriate to gather these data?

a.	Mr. Y., at your age, surely you have been hospitalized before!
b.	Mr. Y., I just need permission to get your medical records from County Medical.
c.	Mr. Y., you mentioned that you have been hospitalized on several occasions. Would you tell me more about that?
d.	Mr. Y., I just need to get some additional information about your past hospitalizations. When was the last time you were admitted for chest pain?

ANS: D
The nurse should use direct questions after the persons opening narrative to fill in any details he or she left out. The nurse also should use direct questions when specific facts are needed, such as when asking about past health problems or during the review of systems.

DIF: Cognitive Level: Applying (Application) REF: p. 31
MSC: Client Needs: Psychosocial Integrity
9. In using verbal responses to assist the patients narrative, some responses focus on the patients frame of reference and some focus on the health care providers perspective. An example of a verbal response that focuses on the health care providers perspective would be:

a.	Empathy.
b.	Reflection.
c.	Facilitation.
d.	Confrontation.

ANS: D
When the health care provider uses the response of confrontation, the frame of reference shifts from the patients perspective to the perspective of the health care provider, and the health care provider starts to express his or her own thoughts and feelings. Empathy, reflection, and facilitation responses focus on the patients frame of reference.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 32
MSC: Client Needs: Psychosocial Integrity
10. When taking a history from a newly admitted patient, the nurse notices that he often pauses and expectantly looks at the nurse. What would be the nurses best response to this behavior?

a.	Be silent, and allow him to continue when he is ready.
b.	Smile at him and say, Dont worry about all of this. Im sure we can find out why youre having these pains.
c.	Lean back in the chair and ask, You are looking at me kind of funny; there isnt anything wrong, is there?
d.	Stand up and say, I can see that this interview is uncomfortable for you. We can continue it another time.

ANS: A
Silent attentiveness communicates that the person has time to think and to organize what he or she wishes to say without an interruption from the nurse. Health professionals most often interrupt this *thinking silence*. The other responses are not conducive to ideal communication.
11. Which of these statements represents subjective data the nurse obtained from the patient regarding the patients skin?

a.	Skin appears dry.
b.	No lesions are obvious.

c.	Patient denies any color change.
d.	Lesion is noted on the lateral aspect of the right arm.

ANS: C
The history should be limited to patient statements or subjective datafactors that the person says were or were not present.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 54
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. The nurse is obtaining a history from a 30-year-old male patient and is concerned about health promotion activities. Which of these questions would be appropriate to use to assess health promotion activities for this patient?

a.	Do you perform testicular self-examinations?
b.	Have you ever noticed any pain in your testicles?
c.	Have you had any problems with passing urine?
d.	Do you have any history of sexually transmitted diseases?

ANS: A
Health promotion for a man would include the performance of testicular self-examinations. The other questions are asking about possible disease or illness issues.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 56
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. Which of these responses might the nurse expect during a functional assessment of a patient whose leg is in a cast?

a.	I broke my right leg in a car accident 2 weeks ago.
b.	The pain is decreasing, but I still need to take acetaminophen.
c.	I check the color of my toes every evening just like I was taught.

d.	Im able to transfer myself from the wheelchair to the bed without help.

ANS: D
Functional assessment measures a persons self-care ability in the areas of general physical health or absence of illness. The other statements concern health or illness issues.

DIF: Cognitive Level: Applying (Application) REF: p. 56
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. In response to a question about stress, a 39-year-old woman tells the nurse that her husband and mother both died in the past year. Which response by the nurse is most appropriate?

a.	This has been a difficult year for you.
b.	I dont know how anyone could handle that much stress in 1 year!
c.	What did you do to cope with the loss of both your husband and mother?
d.	That is a lot of stress; now lets go on to the next section of your history.

ANS: C
Questions about coping and stress management include questions regarding the kinds of stresses in ones life, especially in the last year, any changes in lifestyle or any current stress, methods tried to relieve stress, and whether these methods have been helpful.

DIF: Cognitive Level: Applying (Application) REF: p. 57
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
15. In response to a question regarding the use of alcohol, a patient asks the nurse why the nurse needs to know. What is the reason for needing this information?

a.	This information is necessary to determine the patients reliability.
b.	Alcohol can interact with all medications and can make some diseases worse.
c.	The nurse needs to be able to teach the patient about the dangers of alcohol use.
d.	This information is not necessary unless a drinking problem is obvious.

ANS: B

Alcohol adversely interacts with all medications and is a factor in many social problems such as child or sexual abuse, automobile accidents, and assaults; alcohol also contributes to many illnesses and disease processes. Therefore, assessing for signs of hazardous alcohol use is important. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 58
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
16. The mother of a 16-month-old toddler tells the nurse that her daughter has an earache. What would be an appropriate response?

a.	Maybe she is just teething.
b.	I will check her ear for an ear infection.
c.	Are you sure she is really having pain?
d.	Describe what she is doing to indicate she is having pain.

ANS: D
With a very young child, the parent is asked, How do you know the child is in pain? A young child pulling at his or her ears should alert parents to the childs ear pain. Statements about teething and questioning whether the child is really having pain do not explore the symptoms, which should be done before a physical examination.

DIF: Cognitive Level: Applying (Application) REF: p. 59
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. During an assessment of a patients family history, the nurse constructs a genogram. Which statement best describes a genogram?

a.	List of diseases present in a persons near relatives
b.	Graphic family tree that uses symbols to depict the gender, relationship, and age of immediate family members
c.	Drawing that depicts the patients family members up to five generations back
d.	Description of the health of a persons children and grandchildren

ANS: B
A genogram (or pedigree) is a graphic family tree that uses symbols to depict the gender,

relationship, and age of immediate blood relatives in at least three generations (parents, grandparents, siblings). The other options do not describe a genogram.

DIF: Cognitive Level: Applying (Application) REF: pp. 52-53
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. A 5-year-old boy is being admitted to the hospital to have his tonsils removed. Which information should the nurse collect before this procedure?

a.	Childs birth weight
b.	Age at which he crawled
c.	Whether the child has had the measles
d.	Childs reactions to previous hospitalizations

ANS: D
How the child reacted to previous hospitalizations and any complications should be assessed. If the child reacted poorly, then he or she may be afraid now and will need special preparation for the examination that is to follow. The other items are not significant for the procedure.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 64
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. As part of the health history of a 6-year-old boy at a clinic for a sports physical examination, the nurse reviews his immunization record and notes that his last measles-mumps-rubella (MMR) vaccination was at 15 months of age. What recommendation should the nurse make?

a.	No further MMR immunizations are needed.
b.	MMR vaccination needs to be repeated at 4 to 6 years of age.
c.	MMR immunization needs to be repeated every 4 years until age 21 years.
d.	A recommendation cannot be made until the physician is consulted.

ANS: B
Because of recent outbreaks of measles across the United States, the American Academy of Pediatrics (2006) recommends two doses of the MMR vaccine, one at 12 to 15 months of age and one at age 4 to 6 years.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 60
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. In obtaining a review of systems on a healthy 7-year-old girl, the health care provider knows that it would be important to include the:

a.	Last glaucoma examination.
b.	Frequency of breast self-examinations.
c.	Date of her last electrocardiogram.
d.	Limitations related to her involvement in sports activities.

ANS: D
When reviewing the cardiovascular system, the health care provider should ask whether any activity is limited or whether the child can keep up with her peers. The other items are not appropriate for a child this age.

CHAPTER 4 Beginning the Physical Examination: General Survey, Vital Signs, and Pain
MULTIPLE CHOICE
1. The nurse is performing a general survey. Which action is a component of the general survey?

a.	Observing the patients body stature and nutritional status
b.	Interpreting the subjective information the patient has reported
c.	Measuring the patients temperature, pulse, respirations, and blood pressure
d.	Observing specific body systems while performing the physical assessment

ANS: A
The general survey is a study of the whole person that includes observing the patients physical appearance, body structure, mobility, and behavior.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 127
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
2. When measuring a patients weight, the nurse is aware of which of these guidelines?

a.	The patient is always weighed wearing only his or her undergarments.
b.	The type of scale does not matter, as long as the weights are similar from day to day.
c.	The patient may leave on his or her jacket and shoes as long as these are documented next to the weight.
d.	Attempts should be made to weigh the patient at approximately the same time of day, if a sequence of weights is necessary.

ANS: D
A standardized balance scale is used to measure weight. The patient should remove his or her shoes and heavy outer clothing. If a sequence of repeated weights is necessary, then the nurse should attempt to weigh the patient at approximately the same time of day and with the same types of clothing worn each time.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 129
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. A patients weekly blood pressure readings for 2 months have ranged between 124/84 mm Hg and 136/88 mm Hg, with an average reading of 126/86 mm Hg. The nurse knows that this blood pressure falls within which blood pressure category?

a.	Normal blood pressure
b.	Prehypertension
c.	Stage 1 hypertension
d.	Stage 2 hypertension

ANS: B
According to the Seventh Report of the Joint National Committee (JNC 7) guidelines, prehypertension blood pressure readings are systolic readings of 120 to 139 mm Hg or diastolic readings of 50 to 89 mm Hg.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 159
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. During an examination of a child, the nurse considers that physical growth is the best index of a childs:

a.	General health.
b.	Genetic makeup.
c.	Nutritional status.
d.	Activity and exercise patterns.

ANS: A
Physical growth is the best index of a childs general health; recording the childs height and weight helps determine normal growth patterns.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 146
MSC: Client Needs: Health Promotion and Maintenance
5. A 1-month-old infant has a head measurement of 34 cm and has a chest circumference of 32 cm. Based on the interpretation of these findings, the nurse would:

a.	Refer the infant to a physician for further evaluation.
b.	Consider these findings normal for a 1-month-old infant.
c.	Expect the chest circumference to be greater than the head circumference.
d.	Ask the parent to return in 2 weeks to re-evaluate the head and chest circumferences.

ANS: B
The newborns head measures approximately 32 to 38 cm and is approximately 2 cm larger than the chest circumference. Between 6 months and 2 years, both measurements are approximately the same, and after age 2 years, the chest circumference is greater than the head circumference.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 147
MSC: Client Needs: Health Promotion and Maintenance
6. The nurse is assessing an 80-year-old male patient. Which assessment findings would be considered normal?

a.	Increase in body weight from his younger years

b.	Additional deposits of fat on the thighs and lower legs
c.	Presence of kyphosis and flexion in the knees and hips
d.	Change in overall body proportion, including a longer trunk and shorter extremities

ANS: C
Changes that occur in the aging person include more prominent bony landmarks, decreased body weight (especially in men), a decrease in subcutaneous fat from the face and periphery, and additional fat deposited on the abdomen and hips. Postural changes of kyphosis and slight flexion in the knees and hips also occur.

DIF: Cognitive Level: Applying (Application) REF: p. 150
MSC: Client Needs: Health Promotion and Maintenance
7. The nurse should measure rectal temperatures in which of these patients?

a.	School-age child
b.	Older adult
c.	Comatose adult
d.	Patient receiving oxygen by nasal cannula

ANS: C
Rectal temperatures should be taken when the other routes are impractical, such as for comatose or confused persons, for those in shock, or for those who cannot close the mouth because of breathing or oxygen tubes, a wired mandible, or other facial dysfunctions.

DIF: Cognitive Level: Applying (Application) REF: p. 133
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
8. The nurse is preparing to measure the length, weight, chest, and head circumference of a 6-month-old infant. Which measurement technique is correct?

a.	Measuring the infants length by using a tape measure
b.	Weighing the infant by placing him or her on an electronic standing scale

c.	Measuring the chest circumference at the nipple line with a tape measure
d.	Measuring the head circumference by wrapping the tape measure over the nose and cheekbones

ANS: C
To measure the chest circumference, the tape is encircled around the chest at the nipple line. The length should be measured on a horizontal measuring board. Weight should be measured on a platform-type balance scale. Head circumference is measured with the tape around the head, aligned at the eyebrows, and at the prominent frontal and occipital bonesthe widest span is correct.

DIF: Cognitive Level: Applying (Application) REF: p. 147
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. The nurse knows that one advantage of the tympanic membrane thermometer (TMT) is that:

a.	Rapid measurement is useful for uncooperative younger children.
b.	Using the TMT is the most accurate method for measuring body temperature in newborn infants.
c.	Measuring temperature using the TMT is inexpensive.
d.	Studies strongly support the use of the TMT in children under the age 6 years.

ANS: A
The TMT is useful for young children who may not cooperate for oral temperatures and fear rectal temperatures. However, the use a TMT with newborn infants and young children is conflicting.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 147
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
10. When assessing an older adult, which vital sign changes occur with aging?

a.	Increase in pulse rate
b.	Widened pulse pressure
c.	Increase in body temperature

d.	Decrease in diastolic blood pressure

ANS: B
With aging, the nurse keeps in mind that the systolic blood pressure increases, leading to widened pulse pressure. With many older people, both the systolic and diastolic pressures increase. The pulse rate and temperature do not increase.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 151
MSC: Client Needs: Health Promotion and Maintenance
11. The nurse is examining a patient who is complaining of feeling cold. Which is a mechanism of heat loss in the body?

a.	Exercise
b.	Radiation
c.	Metabolism
d.	Food digestion

ANS: B
The body maintains a steady temperature through a thermostat or feedback mechanism, which is regulated in the hypothalamus of the brain. The hypothalamus regulates heat production from metabolism, exercise, food digestion, and external factors with heat loss through radiation, evaporation of sweat, convection, and conduction.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 132
MSC: Client Needs: General
12. When measuring a patients body temperature, the nurse keeps in mind that body temperature is influenced by:

a.	Constipation.
b.	Patients emotional state.
c.	Diurnal cycle.
d.	Nocturnal cycle.

ANS: C
Normal temperature is influenced by the diurnal cycle, exercise, and age. The other responses do not influence body temperature.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 133
MSC: Client Needs: General
13. When evaluating the temperature of older adults, the nurse should remember which aspect about an older adults body temperature?

a.	The body temperature of the older adult is lower than that of a younger adult.
b.	An older adults body temperature is approximately the same as that of a young child.
c.	Body temperature depends on the type of thermometer used.
d.	In the older adult, the body temperature varies widely because of less effective heat control mechanisms.

ANS: A
In older adults, the body temperature is usually lower than in other age groups, with a mean temperature of 36.2 C.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 133
MSC: Client Needs: Health Promotion and Maintenance
14. A 60-year-old male patient has been treated for pneumonia for the past 6 weeks. He is seen today in the clinic for an unexplained weight loss of 10 pounds over the last 6 weeks. The nurse knows that:

a.	Weight loss is probably the result of unhealthy eating habits.
b.	Chronic diseases such as hypertension cause weight loss.
c.	Unexplained weight loss often accompanies short-term illnesses.
d.	Weight loss is probably the result of a mental health dysfunction.

ANS: C
An unexplained weight loss may be a sign of a short-term illness or a chronic illness such as endocrine disease, malignancy, depression, anorexia nervosa, or bulimia.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 129
MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort
15. When assessing a 75-year-old patient who has asthma, the nurse notes that he assumes a tripod position, leaning forward with arms braced on the chair. On the basis of this observation, the nurse should:

a.	Assume that the patient is eager and interested in participating in the interview.
b.	Evaluate the patient for abdominal pain, which may be exacerbated in the sitting position.
c.	Assume that the patient is having difficulty breathing and assist him to a supine position.
d.	Recognize that a tripod position is often used when a patient is having respiratory difficulties.

ANS: D
Assuming a tripod positionleaning forward with arms braced on chair armsoccurs with chronic pulmonary disease. The other actions or assumptions are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 128
MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort
16. Which of these actions illustrates the correct technique the nurse should use when assessing oral temperature with a mercury thermometer?

a.	Wait 30 minutes if the patient has ingested hot or iced liquids.
b.	Leave the thermometer in place 3 to 4 minutes if the patient is afebrile.
c.	Place the thermometer in front of the tongue, and ask the patient to close his or her lips.
d.	Shake the mercury-in-glass thermometer down to below 36.6 C before taking the temperature.

ANS: B
The thermometer should be left in place 3 to 4 minutes if the person is afebrile and up to 8 minutes if the person is febrile. The nurse should wait 15 minutes if the person has just ingested hot or iced liquids and 2 minutes if he or she has just smoked.

DIF: Cognitive Level: Applying (Application) REF: p. 133
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. The nurse is taking temperatures in a clinic with a TMT. Which statement is *true* regarding use of the TMT?

a.	A tympanic temperature is more time consuming than a rectal temperature.
b.	The tympanic method is more invasive and uncomfortable than the oral method.
c.	The risk of cross-contamination is reduced, compared with the rectal route.
d.	The tympanic membrane most accurately reflects the temperature in the ophthalmic artery.

ANS: C
The TMT is a noninvasive, nontraumatic device that is extremely quick and efficient. The chance of cross-contamination with the TMT is minimal because the ear canal is lined with skin, not mucous membranes.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 134
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. To assess a rectal temperature accurately in an adult, the nurse would:

a.	Use a lubricated blunt tip thermometer.
b.	Insert the thermometer 2 to 3 inches into the rectum.
c.	Leave the thermometer in place up to 8 minutes if the patient is febrile.
d.	Wait 2 to 3 minutes if the patient has recently smoked a cigarette.

ANS: A
A lubricated rectal thermometer (with a short, blunt tip) is inserted only 2 to 3 cm (1 inch) into the adult rectum and left in place for 2 minutes. Cigarette smoking does not alter rectal temperatures.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 133
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. Which technique is correct when the nurse is assessing the radial pulse of a patient? The pulse is counted for:

a.	1 minute, if the rhythm is irregular.
b.	15 seconds and then multiplied by 4, if the rhythm is regular.
c.	2 full minutes to detect any variation in amplitude.
d.	10 seconds and then multiplied by 6, if the patient has no history of cardiac abnormalities.

ANS: A
Recent research suggests that the 30-second interval multiplied by 2 is the most accurate and efficient technique when heart rates are normal or rapid and when rhythms are regular. If the rhythm is irregular, then the pulse is counted for 1 full minute.

DIF: Cognitive Level: Applying (Application) REF: p. 134
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. When assessing a patients pulse, the nurse should also notice which of these characteristics?

a.	Force
b.	Pallor
c.	Capillary refill time
d.	Timing in the cardiac cycle

ANS: A
The pulse is assessed for rate, rhythm, and force.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 134
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. When assessing the pulse of a 6-year-old boy, the nurse notices that his heart rate varies with his respiratory cycle, speeding up at the peak of inspiration and slowing to normal with expiration. The nurses next action would be to:

a.	Immediately notify the physician.
b.	Consider this finding normal in children and young adults.

c.	Check the childs blood pressure, and note any variation with respiration.
d.	Document that this child has bradycardia, and continue with the assessment.

ANS: B
Sinus arrhythmia is commonly found in children and young adults. During the respiratory cycle, the heart rate varies, speeding up at the peak of inspiration and slowing to normal with expiration.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 135
MSC: Client Needs: Health Promotion and Maintenance
22. When assessing the force, or strength, of a pulse, the nurse recalls that the pulse:

a.	Is usually recorded on a 0- to 2-point scale.
b.	Demonstrates elasticity of the vessel wall.
c.	Is a reflection of the hearts stroke volume.
d.	Reflects the blood volume in the arteries during diastole.

ANS: C
The heart pumps an amount of blood (the stroke volume) into the aorta. The force flares the arterial walls and generates a pressure wave, which is felt in the periphery as the pulse.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 134
MSC: Client Needs: General
23. The nurse is assessing the vital signs of a 20-year-old male marathon runner and documents the following vital signs: temperature36 C; pulse48 beats per minute; respirations14 breaths per minute; blood pressure104/68 mm Hg. Which statement is *true* concerning these results?

a.	The patient is experiencing tachycardia.
b.	These are normal vital signs for a healthy, athletic adult.
c.	The patients pulse rate is not normalhis physician should be notified.

d.	On the basis of these readings, the patient should return to the clinic in 1 week.

ANS: B
In the adult, a heart rate less than 50 beats per minute is called *bradycardia*, which normally occurs in the well-trained athlete whose heart muscle develops along with the skeletal muscles.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 135
MSC: Client Needs: Health Promotion and Maintenance
24. The nurse is assessing the vital signs of a 3-year-old patient who appears to have an irregular respiratory pattern. How should the nurse assess this childs respirations?

a.	Respirations should be counted for 1 full minute, noticing rate and rhythm.
b.	Childs pulse and respirations should be simultaneously checked for 30 seconds.
c.	Childs respirations should be checked for a minimum of 5 minutes to identify any variations in his or her respiratory pattern.
d.	Patients respirations should be counted for 15 seconds and then multiplied by 4 to obtain the number of respirations per minute.

ANS: A
Respirations are counted for 1 full minute if an abnormality is suspected. The other responses are not correct actions.

DIF: Cognitive Level: Applying (Application) REF: p. 136
MSC: Client Needs: Health Promotion and Maintenance
25. A patients blood pressure is 118/82 mm Hg. He asks the nurse, What do the numbers mean? The nurses best reply is:

a.	The numbers are within the normal range and are nothing to worry about.
b.	The bottom number is the diastolic pressure and reflects the stroke volume of the heart.
c.	The top number is the systolic blood pressure and reflects the pressure of the blood against the arteries when the heart contracts.
d.	The concept of blood pressure is difficult to understand. The primary thing to be concerned about is the top number, or the systolic blood pressure.

ANS: C
The systolic pressure is the maximum pressure felt on the artery during left ventricular

contraction, or systole. The diastolic pressure is the elastic recoil, or resting, pressure that the blood constantly exerts in between each contraction. The nurse should answer the patients question and use terms he can understand.

CHAPTER 5 Behavior and Mental Status
MULTIPLE CHOICE
1. During an examination, the nurse can assess mental status by which activity?

a.	Examining the patients electroencephalogram
b.	Observing the patient as he or she performs an intelligence quotient (IQ) test
c.	Observing the patient and inferring health or dysfunction
d.	Examining the patients response to a specific set of questions

ANS: C
Mental status cannot be directly scrutinized like the characteristics of skin or heart sounds. Its functioning is inferred through an assessment of an individuals behaviors, such as consciousness, language, mood and affect, and other aspects.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)
REF: p. 67 MSC: Client Needs: Psychosocial Integrity
2. The nurse is assessing the mental status of a child. Which statement about children and mental status is *true*?

a.	All aspects of mental status in children are interdependent.
b.	Children are highly labile and unstable until the age of 2 years.
c.	Childrens mental status is largely a function of their parents level of functioning until the age of 7 years.
d.	A childs mental status is impossible to assess until the child develops the ability to concentrate.

ANS: A
Separating and tracing the development of only one aspect of mental status is difficult. All aspects are interdependent. For example, consciousness is rudimentary at birth because the cerebral cortex is not yet developed. The infant cannot distinguish the self from the mothers body. The other statements are not true.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)
REF: p. 68 MSC: Client Needs: Psychosocial Integrity
3. The nurse is assessing a 75-year-old man. As the nurse begins the mental status portion of the assessment, the nurse expects that this patient:

a.	Will have no decrease in any of his abilities, including response time.
b.	Will have difficulty on tests of remote memory because this ability typically decreases with age.
c.	May take a little longer to respond, but his general knowledge and abilities should not have declined.
d.	Will exhibit had a decrease in his response time because of the loss of language and a decrease in general knowledge.

ANS: C
The aging process leaves the parameters of mental status mostly intact. General knowledge does not decrease, and little or no loss in vocabulary occurs. Response time is slower than in a youth. It takes a little longer for the brain to process information and to react to it. Recent memory, which requires some processing, is somewhat decreased with aging, but remote memory is not affected.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 68 MSC: Client Needs: Psychosocial Integrity
4. When assessing aging adults, the nurse knows that one of the first things that should be assessed before making judgments about their mental status is:

a.	Presence of phobias
b.	General intelligence
c.	Presence of irrational thinking patterns
d.	Sensory-perceptive abilities

ANS: D
Age-related changes in sensory perception can affect mental status. For example, vision loss (as detailed in Chapter 14) may result in apathy, social isolation, and depression. Hearing changes are common in older adults, which produces frustration, suspicion, and social isolation and makes the person appear confused.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 68 MSC: Client Needs: Psychosocial Integrity
5. The nurse is preparing to conduct a mental status examination. Which statement is *true* regarding the mental status examination?

a.	A patients family is the best resource for information about the patients coping skills.
b.	Gathering mental status information during the health history interview is usually sufficient.
c.	Integrating the mental status examination into the health history interview takes an enormous amount of extra time.
d.	To get a good idea of the patients level of functioning, performing a complete mental status examination is usually necessary.

ANS: B
The full mental status examination is a systematic check of emotional and cognitive functioning. The steps described, however, rarely need to be taken in their entirety. Usually, one can assess mental status through the context of the health history interview.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 68 MSC: Client Needs: Psychosocial Integrity
6. A woman brings her husband to the clinic for an examination. She is particularly worried because after a recent fall, he seems to have lost a great deal of his memory of recent events. Which statement reflects the nurses best course of action?

a.	Perform a complete mental status examination.
b.	Refer him to a psychometrician.
c.	Plan to integrate the mental status examination into the history and physical examination.
d.	Reassure his wife that memory loss after a physical shock is normal and will soon subside.

ANS: A
Performing a complete mental status examination is necessary when any abnormality in affect or behavior is discovered or when family members are concerned about a persons behavioral changes (e.g., memory loss, inappropriate social interaction) or after trauma, such as a head injury.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 69 MSC: Client Needs: Psychosocial Integrity
7. The nurse is conducting a patient interview. Which statement made by the patient should the nurse more fully explore during the interview?

a.	I sleep like a baby.
b.	I have no health problems.
c.	I never did too good in school.
d.	I am not currently taking any medications.

ANS: C
In every mental status examination, the following factors from the health history that could affect the findings should be noted: any known illnesses or health problems, such as alcoholism or chronic renal disease; current medications, the side effects of which may cause confusion or depression; the usual educational and behavioral level, noting this level as the patients normal baseline and not expecting a level of performance on the mental status examination to exceed it; and responses to personal history questions, indicating current stress, social interaction patterns, and sleep habits.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 69 MSC: Client Needs: Psychosocial Integrity
8. A patient is admitted to the unit after an automobile accident. The nurse begins the mental status examination and finds that the patient has dysarthric speech and is lethargic. The nurses best approach regarding this examination is to:

a.	Plan to defer the rest of the mental status examination.
b.	Skip the language portion of the examination, and proceed onto assessing mood and affect.
c.	Conduct an in-depth speech evaluation, and defer the mental status examination to another time.
d.	Proceed with the examination, and assess the patient for suicidal thoughts because dysarthria is often accompanied by severe depression.

ANS: A
In the mental status examination, the sequence of steps forms a hierarchy in which the most basic functions (consciousness, language) are assessed first. The first steps must be accurately assessed

to ensure validity of the steps that follow. For example, if consciousness is clouded, then the person cannot be expected to have full attention and to cooperate with new learning. If language is impaired, then a subsequent assessment of new learning or abstract reasoning (anything that requires language functioning) can give erroneous conclusions.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 69 MSC: Client Needs: Psychosocial Integrity
9. A 19-year-old woman comes to the clinic at the insistence of her brother. She is wearing black combat boots and a black lace nightgown over the top of her other clothes. Her hair is dyed pink with black streaks throughout. She has several pierced holes in her nares and ears and is wearing an earring through her eyebrow and heavy black makeup. The nurse concludes that:

a.	She probably does not have any problems.
b.	She is only trying to shock people and that her dress should be ignored.
c.	She has a manic syndrome because of her abnormal dress and grooming.
d.	More information should be gathered to decide whether her dress is appropriate.

ANS: D
Grooming and hygiene should be notedthe person is clean and well groomed, hair is neat and clean, women have moderate or no makeup, and men are shaved or their beards or moustaches are well groomed. Care should be taken when interpreting clothing that is disheveled, bizarre, or in poor repair because these sometimes reflect the persons economic status or a deliberate fashion trend.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 70 MSC: Client Needs: Psychosocial Integrity
10. A patient has been in the intensive care unit for 10 days. He has just been moved to the medical-surgical unit, and the admitting nurse is planning to perform a mental status examination. During the tests of cognitive function, the nurse would expect that he:

a.	May display some disruption in thought content.
b.	Will state, I am so relieved to be out of intensive care.
c.	Will be oriented to place and person, but the patient may not be certain of the date.

d.	May show evidence of some clouding of his level of consciousness.

ANS: C
The nurse can discern the orientation of cognitive function through the course of the interview or can directly and tactfully ask, Some people have trouble keeping up with the dates while in the hospital. Do you know todays date? Many hospitalized people have trouble with the exact date but are fully oriented on the remaining items.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: pp. 70-71 MSC: Client Needs: Psychosocial Integrity
11. During a mental status examination, the nurse wants to assess a patients affect. The nurse should ask the patient which question?

a.	How do you feel today?
b.	Would you please repeat the following words?
c.	Have these medications had any effect on your pain?
d.	Has this pain affected your ability to get dressed by yourself?

ANS: A
Judge mood and affect by body language and facial expression and by directly asking, How do you feel today? or How do you usually feel? The mood should be appropriate to the persons place and condition and should appropriately change with the topics.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 70 MSC: Client Needs: Psychosocial Integrity
12. The nurse is planning to assess new memory with a patient. The best way for the nurse to do this would be to:

a.	Administer the FACT test.
b.	Ask him to describe his first job.
c.	Give him the Four Unrelated Words Test.
d.	Ask him to describe what television show he was watching before coming to the clinic.

ANS: C
Ask questions that can be corroborated, which screens for the occasional person who confabulates or makes up answers to fill in the gaps of memory loss. The Four Unrelated Words Test tests the persons ability to lay down new memories and is a highly sensitive and valid memory test.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 71 MSC: Client Needs: Psychosocial Integrity
13. A 45-year-old woman is at the clinic for a mental status assessment. In giving her the Four Unrelated Words Test, the nurse would be concerned if she could not____four unrelated words ____.

a.	Invent; within 5 minutes
b.	Invent; within 30 seconds
c.	Recall; after a 30-minute delay
d.	Recall; after a 60-minute delay

ANS: C
The Four Unrelated Words Test tests the persons ability to lay down new memories. It is a highly sensitive and valid memory test. It requires more effort than the recall of personal or historic events. To the person say, I am going to say four words. I want you to remember them. In a few minutes I will ask you to recall them. After 5 minutes, ask for the four words. The normal response for persons under 60 years is an accurate three- or four-word recall after a 5-, 10-, and 30-minute delay.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 71 MSC: Client Needs: Psychosocial Integrity
14. During a mental status assessment, which question by the nurse would best assess a persons judgment?

a.	Do you feel that you are being watched, followed, or controlled?
b.	Tell me what you plan to do once you are discharged from the hospital.
c.	What does the statement, People in glass houses shouldnt throw stones, mean to you?

d.	What would you do if you found a stamped, addressed envelope lying on the sidewalk?

ANS: B
A person exercises judgment when he or she can compare and evaluate the alternatives in a situation and reach an appropriate course of action. Rather than testing the persons response to a hypothetical situation (as illustrated in the option with the envelope), the nurse should be more interested in the persons judgment about daily or long-term goals, the likelihood of acting in response to delusions or hallucinations, and the capacity for violent or suicidal behavior.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 74 MSC: Client Needs: Psychosocial Integrity
15. Which of these individuals would the nurse consider at highest risk for a suicide attempt?

a.	Man who jokes about death
b.	Woman who, during a past episode of major depression, attempted suicide
c.	Adolescent who just broke up with her boyfriend and states that she would like to kill herself
d.	Older adult man who tells the nurse that he is going to join his wife in heaven tomorrow and plans to use a gun

ANS: D
When the person expresses feelings of sadness, hopelessness, despair, or grief, assessing any possible risk of physical harm to him or herself is important. The interview should begin with more general questions. If the nurse hears affirmative answers, then he or she should continue with more specific questions. A precise suicide plan to take place in the next 24 to 48 hours with use of a lethal method constitutes high risk.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 74 MSC: Client Needs: Psychosocial Integrity
16. The nurse is performing a mental status assessment on a 5-year-old girl. Her parents are undergoing a bitter divorce and are worried about the effect it is having on their daughter. Which action or statement might lead the nurse to be concerned about the girls mental status?

a.	She clings to her mother whenever the nurse is in the room.
b.	She appears angry and will not make eye contact with the nurse.

c.	Her mother states that she has begun to ride a tricycle around their yard.
d.	Her mother states that her daughter prefers to play with toddlers instead of kids her own age while in daycare.

ANS: D
The mental status assessment of infants and children covers behavioral, cognitive, and psychosocial development and examines how the child is coping with his or her environment. Essentially, the nurse should follow the same Association for Behavioral and Cognitive Therapies (ABCT) guidelines as those for the adult, with special consideration for developmental milestones. The best examination technique arises from a thorough knowledge of the developmental milestones (described in Chapter 2). Abnormalities are often problems of omission (e.g., the child does not achieve a milestone as expected).

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 75 MSC: Client Needs: Psychosocial Integrity
17. The nurse is assessing orientation in a 79-year-old patient. Which of these responses would lead the nurse to conclude that this patient is oriented?

a.	I know my name is John. I couldnt tell you where I am. I think it is 2010, though.
b.	I know my name is John, but to tell you the truth, I get kind of confused about the date.
c.	I know my name is John; I guess Im at the hospital in Spokane. No, I dont know the date.
d.	I know my name is John. I am at the hospital in Spokane. I couldnt tell you what date it is, but I know that it is February of a new year2010.

ANS: D
Many aging persons experience social isolation, loss of structure without a job, a change in residence, or some short-term memory loss. These factors affect orientation, and the person may not provide the precise date or complete name of the agency. You may consider aging persons oriented if they generally know where they are and the present period. They should be considered oriented to time if the year and month are correctly stated. Orientation to place is accepted with the correct identification of the type of setting (e.g., hospital) and the name of the town.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 76 MSC: Client Needs: Psychosocial Integrity
18. The nurse is performing the Denver II screening test on a 12-month-old infant during a routine well-child visit. The nurse should tell the infants parents that the Denver II:

a.	Tests three areas of development: cognitive, physical, and psychological
b.	Will indicate whether the child has a speech disorder so that treatment can begin.
c.	Is a screening instrument designed to detect children who are slow in development.
d.	Is a test to determine intellectual ability and may indicate whether problems will develop later in school.

ANS: C
The Denver II is a screening instrument designed to detect developmental delays in infants and preschoolers. It tests four functions: gross motor, language, fine motor-adaptive, and personal-social. The Denver II is not an intelligence test; it does not predict current or future intellectual ability. It is not diagnostic; it does not suggest treatment regimens.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 75 MSC: Client Needs: Psychosocial Integrity
19. A patient drifts off to sleep when she is not being stimulated. The nurse can easily arouse her by calling her name, but the patient remains drowsy during the conversation. The best description of this patients level of consciousness would be:

a.	Lethargic
b.	Obtunded
c.	Stuporous
d.	Semialert

ANS: A
Lethargic (or somnolent) is when the person is not fully alert, drifts off to sleep when not stimulated, and can be aroused when called by name in a normal voice but looks drowsy. He or she appropriately responds to questions or commands, but thinking seems slow and fuzzy. He or she is inattentive and loses the train of thought. Spontaneous movements are decreased. (See Table 5-3 for the definitions of the other terms.)

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)
REF: p. 79 MSC: Client Needs: Psychosocial Integrity
20. A patient has had a cerebrovascular accident (stroke). He is trying very hard to communicate. He seems driven to speak and says, I buy obie get spirding and take my train. What is the best

description of this patients problem?

a.	Global aphasia
b.	Brocas aphasia
c.	Echolalia
d.	Wernickes aphasia

ANS: D
This type of communication illustrates Wernickes or receptive aphasia. The person can hear sounds and words but cannot relate them to previous experiences. Speech is fluent, effortless, and well articulated, but it has many paraphasias (word substitutions that are malformed or wrong) and neologisms (made-up words) and often lacks substantive words. Speech can be totally incomprehensible. Often, a great urge to speak is present. Repetition, reading, and writing also are impaired. Echolalia is an imitation or the repetition of another persons words or phrases. (See Table 5-4 for the definitions of the other disorders.)

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 80 MSC: Client Needs: Psychosocial Integrity
21. A patient repeatedly seems to have difficulty coming up with a word. He says, I was on my way to work, and when I got there, the thing that you step into that goes up in the air was so full that I decided to take the stairs. The nurse will note on his chart that he is using or experiencing:

a.	Blocking
b.	Neologism
c.	Circumlocution
d.	Circumstantiality

ANS: C
Circumlocution is a roundabout expression, substituting a phrase when one cannot think of the name of the object.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)
REF: p. 84 MSC: Client Needs: Psychosocial Integrity

22. During an examination, the nurse notes that a patient is exhibiting flight of ideas. Which statement by the patient is an example of flight of ideas?

a.	My stomach hurts. Hurts, spurts, burts.
b.	Kiss, wood, reading, ducks, onto, maybe.
c.	Take this pill? The pill is red. I see red. Red velvet is soft, soft as a babys bottom.
d.	I wash my hands, wash them, wash them. I usually go to the sink and wash my hands.

ANS: C
Flight of ideas is demonstrated by an abrupt change, rapid skipping from topic to topic, and practically continuous flow of accelerated speech. Topics usually have recognizable associations or are plays on words.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)
REF: p. 84 MSC: Client Needs: Psychosocial Integrity
23. A patient describes feeling an unreasonable, irrational fear of snakes. His fear is so persistent that he can no longer comfortably look at even pictures of snakes and has made an effort to identify all the places he might encounter a snake and avoids them. The nurse recognizes that he:

a.	Has a snake phobia.
b.	Is a hypochondriac; snakes are usually harmless.
c.	Has an obsession with snakes.
d.	Has a delusion that snakes are harmful, which must stem from an early traumatic incident involving snakes.

ANS: A
A phobia is a strong, persistent, irrational fear of an object or situation; the person feels driven to avoid it. (See Table 5-7 for the definitions of the other terms.)

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: p. 85 MSC: Client Needs: Psychosocial Integrity
24. A patient has been diagnosed with schizophrenia. During a recent interview, he shows the nurse a picture of a man holding a decapitated head. He describes this picture as horrifying but then laughs loudly at the content. This behavior is a display of:

a.	Confusion
b.	Ambivalence
c.	Depersonalization
d.	Inappropriate affect

ANS: D
An inappropriate affect is an affect clearly discordant with the content of the persons speech. (See Table 5-5 for the definitions of the other terms.)

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: p. 81 MSC: Client Needs: Psychosocial Integrity
25. During reporting, the nurse hears that a patient is experiencing hallucinations. Which is an example of a hallucination?

a.	Man believes that his dead wife is talking to him.
b.	Woman hears the doorbell ring and goes to answer it, but no one is there.
c.	Child sees a man standing in his closet. When the lights are turned on, it is only a dry cleaning bag.
d.	Man believes that the dog has curled up on the bed, but when he gets closer he sees that it is a blanket.

ANS: A
Hallucinations are sensory perceptions for which no external stimuli exist. They may strike any sense: visual, auditory, tactile, olfactory, or gustatory.

CHAPTER 6 The Skin, Hair, and Nails
MULTIPLE CHOICE
1. The nurse educator is preparing an education module for the nursing staff on the epidermal layer of skin. Which of these statements would be included in the module? The epidermis is:

a.	Highly vascular.

b.	Thick and tough.
c.	Thin and nonstratified.
d.	Replaced every 4 weeks.

ANS: D
The epidermis is thin yet tough, replaced every 4 weeks, avascular, and stratified into several zones.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 199
MSC: Client Needs: General
2. The nurse educator is preparing an education module for the nursing staff on the dermis layer of skin. Which of these statements would be included in the module? The dermis:

a.	Contains mostly fat cells.
b.	Consists mostly of keratin.
c.	Is replaced every 4 weeks.
d.	Contains sensory receptors.

ANS: D
The dermis consists mostly of collagen, has resilient elastic tissue that allows the skin to stretch, and contains nerves, sensory receptors, blood vessels, and lymphatic vessels. It is not replaced every 4 weeks.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 200
MSC: Client Needs: General
3. The nurse is examining a patient who tells the nurse, I sure sweat a lot, especially on my face and feet but it doesnt have an odor. The nurse knows that this condition could be related to:

a.	Eccrine glands.
b.	Apocrine glands.

c.	Disorder of the stratum corneum.
d.	Disorder of the stratum germinativum.

ANS: A
The eccrine glands are coiled tubules that directly open onto the skin surface and produce a dilute saline solution called *sweat*. Apocrine glands are primarily located in the axillae, anogenital area, nipples, and naval area and mix with bacterial flora to produce the characteristic musky body odor. The patients statement is not related to disorders of the stratum corneum or the stratum germinativum.

DIF: Cognitive Level: Applying (Application) REF: p. 200
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
4. A newborn infant is in the clinic for a well-baby checkup. The nurse observes the infant for the possibility of fluid loss because of which of these factors?

a.	Subcutaneous fat deposits are high in the newborn.
b.	Sebaceous glands are overproductive in the newborn.
c.	The newborns skin is more permeable than that of the adult.
d.	The amount of vernix caseosa dramatically rises in the newborn.

ANS: C
The newborns skin is thin, smooth, and elastic and is relatively more permeable than that of the adult; consequently, the infant is at greater risk for fluid loss. The subcutaneous layer in the infant is inefficient, not thick, and the sebaceous glands are present but decrease in size and production. Vernix caseosa is not produced after birth.

DIF: Cognitive Level: Applying (Application) REF: p. 201
MSC: Client Needs: Health Promotion and Maintenance
5. The nurse is bathing an 80-year-old man and notices that his skin is wrinkled, thin, lax, and dry. This finding would be related to which factor in the older adult?

a.	Increased vascularity of the skin
b.	Increased numbers of sweat and sebaceous glands

c.	An increase in elastin and a decrease in subcutaneous fat
d.	An increased loss of elastin and a decrease in subcutaneous fat

ANS: D
An accumulation of factors place the aging person at risk for skin disease and breakdown: the thinning of the skin, a decrease in vascularity and nutrients, the loss of protective cushioning of the subcutaneous layer, a lifetime of environmental trauma to skin, the social changes of aging, a increasingly sedentary lifestyle, and the chance of immobility.

DIF: Cognitive Level: Applying (Application) REF: p. 201
MSC: Client Needs: Health Promotion and Maintenance
6. During the aging process, the hair can look gray or white and begin to feel thin and fine. The nurse knows that this occurs because of a decrease in the number of functioning:

a.	Metrocytes.
b.	Fungacytes.
c.	Phagocytes.
d.	Melanocytes.

ANS: D
In the aging hair matrix, the number of functioning melanocytes decreases; as a result, the hair looks gray or white and feels thin and fine. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 201
MSC: Client Needs: Health Promotion and Maintenance
7. During an examination, the nurse finds that a patient has excessive dryness of the skin. The best term to describe this condition is:

a.	Xerosis.
b.	Pruritus.
c.	Alopecia.

d.	Seborrhea.

ANS: A
Xerosis is the term used to describe skin that is excessively dry. Pruritus refers to itching, alopecia refers to hair loss, and seborrhea refers to oily skin.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 203
MSC: Client Needs: Health Promotion and Maintenance
8. A 22-year-old woman comes to the clinic because of severe sunburn and states, I was out in the sun for just a couple of minutes. The nurse begins a medication review with her, paying special attention to which medication class?

a.	Nonsteroidal antiinflammatory drugs for pain
b.	Tetracyclines for acne
c.	Proton pump inhibitors for heartburn
d.	Thyroid replacement hormone for hypothyroidism

ANS: B
Drugs that may increase sunlight sensitivity and give a burn response include sulfonamides, thiazide diuretics, oral hypoglycemic agents, and tetracycline.

DIF: Cognitive Level: Applying (Application) REF: p. 204
MSC: Client Needs: Health Promotion and Maintenance
9. A woman is leaving on a trip to Hawaii and has come in for a checkup. During the examination the nurse learns that she has diabetes and takes oral hypoglycemic agents. The patient needs to be concerned about which possible effect of her medications?

a.	Increased possibility of bruising
b.	Skin sensitivity as a result of exposure to salt water
c.	Lack of availability of glucose-monitoring supplies
d.	Importance of sunscreen and avoiding direct sunlight

ANS: D
Drugs that may increase sunlight sensitivity and give a burn response include sulfonamides, thiazide diuretics, oral hypoglycemic agents, and tetracycline.

DIF: Cognitive Level: Applying (Application) REF: p. 204
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
10. A 13-year-old girl is interested in obtaining information about the cause of her acne. The nurse should share with her that acne:

a.	Is contagious.
b.	Has no known cause.
c.	Is caused by increased sebum production.
d.	Has been found to be related to poor hygiene.

ANS: C
Approximately 90% of males and 80% of females will develop acne; causes are increased sebum production and epithelial cells that do not desquamate normally.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 205
MSC: Client Needs: Health Promotion and Maintenance
11. A 75-year-old woman who has a history of diabetes and peripheral vascular disease has been trying to remove a corn on the bottom of her foot with a pair of scissors. The nurse will encourage her to stop trying to remove the corn with scissors because:

a.	The woman could be at increased risk for infection and lesions because of her chronic disease.
b.	With her diabetes, she has increased circulation to her foot, and it could cause severe bleeding.
c.	She is 75 years old and is unable to see; consequently, she places herself at greater risk for self-injury with the scissors.
d.	With her peripheral vascular disease, her range of motion is limited and she may not be able to reach the corn safely.

ANS: A
A personal history of diabetes and peripheral vascular disease increases a persons risk for skin lesions in the feet or ankles. The patient needs to seek a professional for assistance with corn removal.

DIF: Cognitive Level: Applying (Application) REF: p. 206
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
12. The nurse keeps in mind that a thorough skin assessment is extremely important because the skin holds information about a persons:

a.	Support systems.
b.	Circulatory status.
c.	Socioeconomic status.
d.	Psychological wellness.

ANS: B
The skin holds information about the bodys circulation, nutritional status, and signs of systemic diseases, as well as topical data on the integumentary system itself.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 210
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. A patient comes in for a physical examination and complains of freezing to death while waiting for her examination. The nurse notes that her skin is pale and cool and attributes this finding to:

a.	Venous pooling.
b.	Peripheral vasodilation.
c.	Peripheral vasoconstriction.
d.	Decreased arterial perfusion.

ANS: C
A chilly or air-conditioned environment causes vasoconstriction, which results in false pallor and coolness (see Table 12-1).

DIF: Cognitive Level: Applying (Application) REF: p. 207
MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort
14. A patient comes to the clinic and tells the nurse that he has been confined to his recliner chair

for approximately 3 days with his feet down and he asks the nurse to evaluate his feet. During the assessment, the nurse might expect to find:

a.	Pallor
b.	Coolness
c.	Distended veins
d.	Prolonged capillary filling time

ANS: C
Keeping the feet in a dependent position causes venous pooling, resulting in redness, warmth, and distended veins. Prolonged elevation would cause pallor and coolness. Immobilization or prolonged inactivity would cause prolonged capillary filling time (see Table 12-1).

DIF: Cognitive Level: Applying (Application) REF: p. 207
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. A patient is especially worried about an area of skin on her feet that has turned white. The health care provider has told her that her condition is vitiligo. The nurse explains to her that vitiligo is:

a.	Caused by an excess of melanin pigment
b.	Caused by an excess of apocrine glands in her feet
c.	Caused by the complete absence of melanin pigment
d.	Related to impetigo and can be treated with an ointment

ANS: C
Vitiligo is the complete absence of melanin pigment in patchy areas of white or light skin on the face, neck, hands, feet, body folds, and around orificesotherwise, the depigmented skin is normal.

DIF: Cognitive Level: Applying (Application) REF: p. 207
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. A patient tells the nurse that he has noticed that one of his moles has started to burn and bleed. When assessing his skin, the nurse pays special attention to the danger signs for

pigmented lesions and is concerned with which additional finding?

a.	Color variation
b.	Border regularity
c.	Symmetry of lesions
d.	Diameter of less than 6 mm

ANS: A
Abnormal characteristics of pigmented lesions are summarized in the mnemonic ABCD: asymmetry of pigmented lesion, border irregularity, color variation, and diameter greater than 6 mm.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 208
MSC: Client Needs: Health Promotion and Maintenance
17. A patient comes to the clinic and states that he has noticed that his skin is redder than normal. The nurse understands that this condition is due to hyperemia and knows that it can be caused by:

a.	Decreased amounts of bilirubin in the blood
b.	Excess blood in the underlying blood vessels
c.	Decreased perfusion to the surrounding tissues
d.	Excess blood in the dilated superficial capillaries

ANS: D
Erythema is an intense redness of the skin caused by excess blood (hyperemia) in the dilated superficial capillaries.

DIF: Cognitive Level: Applying (Application) REF: p. 209
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
18. During a skin assessment, the nurse notices that a Mexican-American patient has skin that is yellowish-brown; however, the skin on the hard and soft palate is pink and the patients scleras are not yellow. From this finding, the nurse could probably rule out:

a.	Pallor
b.	Jaundice
c.	Cyanosis
d.	Iron deficiency

ANS: B
Jaundice is exhibited by a yellow color, which indicates rising levels of bilirubin in the blood. Jaundice is first noticed in the junction of the hard and soft palate in the mouth and in the scleras.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 209
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
19. A black patient is in the intensive care unit because of impending shock after an accident. The nurse expects to find what characteristics in this patients skin?

a.	Ruddy blue.
b.	Generalized pallor.
c.	Ashen, gray, or dull.
d.	Patchy areas of pallor.

ANS: C
Pallor attributable to shock, with decreased perfusion and vasoconstriction, in black-skinned people will cause the skin to appear ashen, gray, or dull (see Table 12-2).

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 208-209
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
20. An older adult woman is brought to the emergency department after being found lying on the kitchen floor for 2 days; she is extremely dehydrated. What would the nurse expect to see during the examination?

a.	Smooth mucous membranes and lips

b.	Dry mucous membranes and cracked lips
c.	Pale mucous membranes
d.	White patches on the mucous membranes

ANS: B
With dehydration, mucous membranes appear dry and the lips look parched and cracked. The other responses are not found in dehydration.

DIF: Cognitive Level: Applying (Application) REF: p. 210
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
21. A 42-year-old woman complains that she has noticed several small, slightly raised, bright red dots on her chest. On examination, the nurse expects that the spots are probably:

a.	Anasarca.
b.	Scleroderma.
c.	Senile angiomas.
d.	Latent myeloma.

ANS: C
Cherry (senile) angiomas are small, smooth, slightly raised bright red dots that commonly appear on the trunk of adults over 30 years old.

DIF: Cognitive Level: Applying (Application) REF: p. 211
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
22. A 65-year-old man with emphysema and bronchitis has come to the clinic for a follow-up appointment. On assessment, the nurse might expect to see which finding?

a.	Anasarca
b.	Scleroderma
c.	Pedal erythema

d.	Clubbing of the nails

ANS: D
Clubbing of the nails occurs with congenital cyanotic heart disease and neoplastic and pulmonary diseases. The other responses are assessment findings not associated with pulmonary diseases.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 213
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
23. A newborn infant has Down syndrome. During the skin assessment, the nurse notices a transient mottling in the trunk and extremities in response to the cool temperature in the examination room. The infants mother also notices the mottling and asks what it is. The nurse knows that this mottling is called:

a.	Caf au lait.
b.	Carotenemia.
c.	Acrocyanosis.
d.	Cutis marmorata.

ANS: D
Persistent or pronounced cutis marmorata occurs with infants born with Down syndrome or those born prematurely and is a transient mottling in the trunk and extremities in response to cool room temperatures. A caf au lait spot is a large round or oval patch of light-brown pigmentation. Carotenemia produces a yellow-orange color in light-skinned persons. Acrocyanosis is a bluish color around the lips, hands and fingernails, and feet and toenails.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 217
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
24. A 35-year-old pregnant woman comes to the clinic for a monthly appointment. During the assessment, the nurse notices that she has a brown patch of hyperpigmentation on her face. The nurse continues the skin assessment aware that another finding may be:

a.	Keratoses.
b.	Xerosis.

c.	Chloasma.
d.	Acrochordons.

ANS: C
In pregnancy, skin changes can include striae, linea nigra (a brownish-black line down the midline), chloasma (brown patches of hyperpigmentation), and vascular spiders. Keratoses are raised, thickened areas of pigmentation that look crusted, scaly, and warty. Xerosis is dry skin. Acrochordons, or *skin tags*, occur more often in the aging adult.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 220
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
25. A man has come in to the clinic for a skin assessment because he is worried he might have skin cancer. During the skin assessment the nurse notices several areas of pigmentation that look greasy, dark, and stuck on his skin. Which is the best prediction?

a.	Senile lentigines, which do not become cancerous
b.	Actinic keratoses, which are precursors to basal cell carcinoma
c.	Acrochordons, which are precursors to squamous cell carcinoma
d.	Seborrheic keratoses, which do not become cancerous

ANS: D
Seborrheic keratoses appear like dark, greasy, stuck-on lesions that primarily develop on the trunk. These lesions do not become cancerous. Senile lentigines are commonly called *liver spots* and are not precancerous. Actinic (senile or solar) keratoses are lesions that are red-tan scaly plaques that increase over the years to become raised and roughened. They may have a silvery-white scale adherent to the plaque. They occur on sun-exposed surfaces and are directly related to sun exposure. They are premalignant and may develop into squamous cell carcinoma. Acrochordons are *skin tags* and are not precancerous.

CHAPTER 7 The Head and Neck
MULTIPLE CHOICE
1. A physician tells the nurse that a patients vertebra prominens is tender and asks the nurse to reevaluate the area in 1 hour. The area of the body the nurse will assess is:

a.	Just above the diaphragm.
b.	Just lateral to the knee cap.
c.	At the level of the C7 vertebra.
d.	At the level of the T11 vertebra.

ANS: C
The C7 vertebra has a long spinous process, called the *vertebra prominens*, which is palpable when the head is flexed.

DIF: Cognitive Level: Applying (Application) REF: p. 251
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
2. A mother brings her 2-month-old daughter in for an examination and says, My daughter rolled over against the wall, and now I have noticed that she has this spot that is soft on the top of her head. Is something terribly wrong? The nurses best response would be:

a.	Perhaps that could be a result of your dietary intake during pregnancy.
b.	Your baby may have craniosynostosis, a disease of the sutures of the brain.
c.	That soft spot may be an indication of cretinism or congenital hypothyroidism.
d.	That soft spot is normal, and actually allows for growth of the brain during the first year of your babys life.

ANS: D
Membrane-covered soft spots allow for growth of the brain during the first year of life. They gradually ossify; the triangular-shaped posterior fontanel is closed by 1 to 2 months, and the diamond-shaped anterior fontanel closes between 9 months and 2 years.

DIF: Cognitive Level: Applying (Application) REF: p. 255
MSC: Client Needs: Health Promotion and Maintenance
3. The nurse notices that a patients palpebral fissures are not symmetric. On examination, the nurse may find that damage has occurred to which cranial nerve (CN)?

a.	III

b.	V
c.	VII
d.	VIII

ANS: C
Facial muscles are mediated by CN VII; asymmetry of palpebral fissures may be attributable to damage to CN VII (Bell palsy).

DIF: Cognitive Level: Applying (Application) REF: p. 259
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
4. A patient is unable to differentiate between sharp and dull stimulation to both sides of her face. The nurse suspects:

a.	Bell palsy.
b.	Damage to the trigeminal nerve.
c.	Frostbite with resultant paresthesia to the cheeks.
d.	Scleroderma.

ANS: B
Facial sensations of pain or touch are mediated by CN V, which is the trigeminal nerve. Bell palsy is associated with CN VII damage. Frostbite and scleroderma are not associated with this problem.

DIF: Cognitive Level: Applying (Application) REF: pp. 252-253
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
5. When examining the face of a patient, the nurse is aware that the two pairs of salivary glands that are accessible to examination are the_____and_____glands.

a.	Occipital; submental
b.	Parotid; jugulodigastric

c.	Parotid; submandibular
d.	Submandibular; occipital

ANS: C
Two pairs of salivary glands accessible to examination on the face are the parotid glands, which are in the cheeks over the mandible, anterior to and below the ear; and the submandibular glands, which are beneath the mandible at the angle of the jaw. The parotid glands are normally nonpalpable.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 253
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
6. A patient comes to the clinic complaining of neck and shoulder pain and is unable to turn her head. The nurse suspects damage to CN_____and proceeds with the examination by _____.

a.	XI; palpating the anterior and posterior triangles
b.	XI; asking the patient to shrug her shoulders against resistance
c.	XII; percussing the sternomastoid and submandibular neck muscles
d.	XII; assessing for a positive Romberg sign

ANS: B
The major neck muscles are the sternomastoid and the trapezius. They are innervated by CN XI, the spinal accessory. The innervated muscles assist with head rotation and head flexion, movement of the shoulders, and extension and turning of the head.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 260
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
7. When examining a patients CN function, the nurse remembers that the muscles in the neck that are innervated by CN XI are the:

a.	Sternomastoid and trapezius.
b.	Spinal accessory and omohyoid.

c.	Trapezius and sternomandibular.
d.	Sternomandibular and spinal accessory.

ANS: A
The major neck muscles are the sternomastoid and the trapezius. They are innervated by CN XI, the spinal accessory.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 253
MSC: Client Needs: General
8. A patients laboratory data reveal an elevated thyroxine (T4) level. The nurse would proceed with an examination of the_____gland.

a.	Thyroid
b.	Parotid
c.	Adrenal
d.	Parathyroid

ANS: A
The thyroid gland is a highly vascular endocrine gland that secretes T4 and triiodothyronine (T3). The other glands do not secrete T4.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 253
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. A patient says that she has recently noticed a lump in the front of her neck below her Adams apple that seems to be getting bigger. During the assessment, the finding that leads the nurse to suspect that this may not be a cancerous thyroid nodule is that the lump (nodule):

a.	Is tender.
b.	Is mobile and not hard.
c.	Disappears when the patient smiles.

d.	Is hard and fixed to the surrounding structures.

ANS: B
Painless, rapidly growing nodules may be cancerous, especially the appearance of a single nodule in a young person. However, cancerous nodules tend to be hard and fixed to surrounding structures, not mobile.

DIF: Cognitive Level: Applying (Application) REF: p. 262
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
10. The nurse notices that a patients submental lymph nodes are enlarged. In an effort to identify the cause of the node enlargement, the nurse would assess the patients:

a.	Infraclavicular area.
b.	Supraclavicular area.
c.	Area distal to the enlarged node.
d.	Area proximal to the enlarged node.

ANS: D
When nodes are abnormal, the nurse should check the area into which they drain for the source of the problem. The area proximal (upstream) to the location of the abnormal node should be explored.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 255
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. The nurse is aware that the four areas in the body where lymph nodes are accessible are the:

a.	Head, breasts, groin, and abdomen.
b.	Arms, breasts, inguinal area, and legs.
c.	Head and neck, arms, breasts, and axillae.
d.	Head and neck, arms, inguinal area, and axillae.

ANS: D

Nodes are located throughout the body, but they are accessible to examination only in four areas: head and neck, arms, inguinal region, and axillae.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 255
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. A mother brings her newborn in for an assessment and asks, Is there something wrong with my baby? His head seems so big. Which statement is *true* regarding the relative proportions of the head and trunk of the newborn?

a.	At birth, the head is one fifth the total length.
b.	Head circumference should be greater than chest circumference at birth.
c.	The head size reaches 90% of its final size when the child is 3 years old.
d.	When the anterior fontanel closes at 2 months, the head will be more proportioned to the body.

ANS: B
The nurse recognizes that during the fetal period, head growth predominates. Head size is greater than chest circumference at birth, and the head size grows during childhood, reaching 90% of its final size when the child is age 6 years.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 264
MSC: Client Needs: Health Promotion and Maintenance
13. A patient, an 85-year-old woman, is complaining about the fact that the bones in her face have become more noticeable. What explanation should the nurse give her?

a.	Diets low in protein and high in carbohydrates may cause enhanced facial bones.
b.	Bones can become more noticeable if the person does not use a dermatologically approved moisturizer.
c.	More noticeable facial bones are probably due to a combination of factors related to aging, such as decreased elasticity, subcutaneous fat, and moisture in her skin.
d.	Facial skin becomes more elastic with age. This increased elasticity causes the skin to be more taught, drawing attention to the facial bones.

ANS: C
The facial bones and orbits appear more prominent in the aging adult, and the facial skin sags, which is attributable to decreased elasticity, decreased subcutaneous fat, and decreased moisture

in the skin.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 255
MSC: Client Needs: Health Promotion and Maintenance
14. A patient reports excruciating headache pain on one side of his head, especially around his eye, forehead, and cheek that has lasted approximately to 2 hours, occurring once or twice each day. The nurse should suspect:

a.	Hypertension.
b.	Cluster headaches.
c.	Tension headaches.
d.	Migraine headaches.

ANS: B
Cluster headaches produce pain around the eye, temple, forehead, and cheek and are unilateral and always on the same side of the head. They are excruciating and occur once or twice per day and last to 2 hours each.

DIF: Cognitive Level: Applying (Application) REF: p. 256
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. A patient complains that while studying for an examination he began to notice a severe headache in the frontotemporal area of his head that is throbbing and is somewhat relieved when he lies down. He tells the nurse that his mother also had these headaches. The nurse suspects that he may be suffering from:

a.	Hypertension.
b.	Cluster headaches.
c.	Tension headaches.
d.	Migraine headaches.

ANS: D
Migraine headaches tend to be supraorbital, retroorbital, or frontotemporal with a throbbing quality. They are severe in quality and are relieved by lying down. Migraines are associated with

a family history of migraine headaches.

DIF: Cognitive Level: Applying (Application) REF: p. 256
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. A 19-year-old college student is brought to the emergency department with a severe headache he describes as, Like nothing Ive ever had before. His temperature is 40 C, and he has a stiff neck. The nurse looks for other signs and symptoms of which problem?

a.	Head injury
b.	Cluster headache
c.	Migraine headache
d.	Meningeal inflammation

ANS: D
The acute onset of neck stiffness and pain along with headache and fever occurs with meningeal inflammation. A severe headache in an adult or child who has never had it before is a *red flag*. Head injury and cluster or migraine headaches are not associated with a fever or stiff neck.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 258
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
17. During a well-baby checkup, the nurse notices that a 1-week-old infants face looks small compared with his cranium, which seems enlarged. On further examination, the nurse also notices dilated scalp veins and downcast or setting sun eyes. The nurse suspects which condition?

a.	Craniotabes
b.	Microcephaly
c.	Hydrocephalus
d.	Caput succedaneum

ANS: C
Hydrocephalus occurs with the obstruction of drainage of cerebrospinal fluid that results in excessive accumulation, increasing intracranial pressure, and an enlargement of the head. The

face looks small, compared with the enlarged cranium, and dilated scalp veins and downcast or setting sun eyes are noted. Craniotabes is a softening of the skulls outer layer. Microcephaly is an abnormally small head. A caput succedaneum is edematous swelling and ecchymosis of the presenting part of the head caused by birth trauma.

DIF: Cognitive Level: Applying (Application) REF: p. 272
MSC: Client Needs: Health Promotion and Maintenance
18. The nurse needs to palpate the temporomandibular joint for crepitation. This joint is located just below the temporal artery and anterior to the:

a.	Hyoid bone.
b.	Vagus nerve.
c.	Tragus.
d.	Mandible.

ANS: C
The temporomandibular joint is just below the temporal artery and anterior to the tragus.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 259
MSC: Client Needs: General
19. A patient has come in for an examination and states, I have this spot in front of my ear lobe on my cheek that seems to be getting bigger and is tender. What do you think it is? The nurse notes swelling below the angle of the jaw and suspects that it could be an inflammation of his:

a.	Thyroid gland.
b.	Parotid gland.
c.	Occipital lymph node.
d.	Submental lymph node.

ANS: B
Swelling of the parotid gland is evident below the angle of the jaw and is most visible when the head is extended. Painful inflammation occurs with mumps, and swelling also occurs with abscesses or tumors. Swelling occurs anterior to the lower ear lobe.

DIF: Cognitive Level: Applying (Application) REF: p. 253
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
20. A male patient with a history of acquired immunodeficiency syndrome (AIDS) has come in for an examination and he states, I think that I have the mumps. The nurse would begin by examining the:

a.	Thyroid gland.
b.	Parotid gland.
c.	Cervical lymph nodes.
d.	Mouth and skin for lesions.

ANS: B
The parotid gland may become swollen with the onset of mumps, and parotid enlargement has been found with human immunodeficiency virus (HIV).

DIF: Cognitive Level: Applying (Application) REF: p. 276
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
21. The nurse suspects that a patient has hyperthyroidism, and the laboratory data indicate that the patients T4 and T3 hormone levels are elevated. Which of these findings would the nurse most likely find on examination?

a.	Tachycardia
b.	Constipation
c.	Rapid dyspnea
d.	Atrophied nodular thyroid gland

ANS: A
T4 and T3 are thyroid hormones that stimulate the rate of cellular metabolism, resulting in tachycardia. With an enlarged thyroid gland as in hyperthyroidism, the nurse might expect to find diffuse enlargement (goiter) or a nodular lump but not an atrophied gland. Dyspnea and constipation are not findings associated with hyperthyroidism.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 277
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
22. A visitor from Poland who does not speak English seems to be somewhat apprehensive about the nurse examining his neck. He would probably be more comfortable with the nurse examining his thyroid gland from:

a.	Behind with the nurses hands placed firmly around his neck.
b.	The side with the nurses eyes averted toward the ceiling and thumbs on his neck.
c.	The front with the nurses thumbs placed on either side of his trachea and his head tilted forward.
d.	The front with the nurses thumbs placed on either side of his trachea and his head tilted backward.

ANS: C
Examining this patients thyroid gland from the back may be unsettling for him. It would be best to examine his thyroid gland using the anterior approach, asking him to tip his head forward and to the right and then to the left.

DIF: Cognitive Level: Applying (Application) REF: p. 263
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
23. A patients thyroid gland is enlarged, and the nurse is preparing to auscultate the thyroid gland for the presence of a bruit. A bruit is a_____sound that is heard best with the _____ of the stethoscope.

a.	Low gurgling; diaphragm
b.	Loud, whooshing, blowing; bell
c.	Soft, whooshing, pulsatile; bell
d.	High-pitched tinkling; diaphragm

ANS: C
If the thyroid gland is enlarged, then the nurse should auscultate it for the presence of a bruit, which is a soft, pulsatile, whooshing, blowing sound heard best with the bell of the stethoscope.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 264
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. The nurse notices that an infant has a large, soft lump on the side of his head and that his mother is very concerned. She tells the nurse that she noticed the lump approximately 8 hours after her babys birth and that it seems to be getting bigger. One possible explanation for this is:

a.	Hydrocephalus.
b.	Craniosynostosis.
c.	Cephalhematoma.
d.	Caput succedaneum.

ANS: C
A cephalhematoma is a subperiosteal hemorrhage that is the result of birth trauma. It is soft, fluctuant, and well defined over one cranial bone. It appears several hours after birth and gradually increases in size.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 265
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
25. A mother brings in her newborn infant for an assessment and tells the nurse that she has noticed that whenever her newborns head is turned to the right side, she straightens out the arm and leg on the same side and flexes the opposite arm and leg. After observing this on examination, the nurse tells her that this reflex is:

a.	Abnormal and is called the *atonic neck reflex*.
b.	Normal and should disappear by the first year of life.
c.	Normal and is called the *tonic neck reflex*, which should disappear between 3 and 4 months of age.
d.	Abnormal. The baby should be flexing the arm and leg on the right side of his body when the head is turned to the right.

ANS: C
By 2 weeks, the infant shows the tonic neck reflex when supine and the head is turned to one side (extension of same arm and leg, flexion of opposite arm and leg). The tonic neck reflex disappears between 3 and 4 months of age.

CHAPTER 8 The Thorax and Lungs
MULTIPLE CHOICE

1. Which of these statements is *true* regarding the vertebra prominens? The vertebra prominens is:

a.	The spinous process of C7.
b.	Usually nonpalpable in most individuals.
c.	Opposite the interior border of the scapula.
d.	Located next to the manubrium of the sternum.

ANS: A
The spinous process of C7 is the vertebra prominens and is the most prominent bony spur protruding at the base of the neck. Counting ribs and intercostal spaces on the posterior thorax is difficult because of the muscles and soft tissue. The vertebra prominens is easier to identify and is used as a starting point in counting thoracic processes and identifying landmarks on the posterior chest.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 414
MSC: Client Needs: General
2. When performing a respiratory assessment on a patient, the nurse notices a costal angle of approximately 90 degrees. This characteristic is:

a.	Observed in patients with kyphosis.
b.	Indicative of pectus excavatum.
c.	A normal finding in a healthy adult.
d.	An expected finding in a patient with a barrel chest.

ANS: C
The right and left costal margins form an angle where they meet at the xiphoid process. Usually, this angle is 90 degrees or less. The angle increases when the rib cage is chronically overinflated, as in emphysema.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 414
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. When assessing a patients lungs, the nurse recalls that the left lung:

a.	Consists of two lobes.
b.	Is divided by the horizontal fissure.
c.	Primarily consists of an upper lobe on the posterior chest.
d.	Is shorter than the right lung because of the underlying stomach.

ANS: A
The left lung has two lobes, and the right lung has three lobes. The right lung is shorter than the left lung because of the underlying liver. The left lung is narrower than the right lung because the heart bulges to the left. The posterior chest is almost all lower lobes.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 415
MSC: Client Needs: General
4. Which statement about the apices of the lungs is *true*? The apices of the lungs:

a.	Are at the level of the second rib anteriorly.
b.	Extend 3 to 4 cm above the inner third of the clavicles.
c.	Are located at the sixth rib anteriorly and the eighth rib laterally.
d.	Rest on the diaphragm at the fifth intercostal space in the midclavicular line (MCL).

ANS: B
The apex of the lung on the anterior chest is 3 to 4 cm above the inner third of the clavicles. On the posterior chest, the apices are at the level of C7.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 415
MSC: Client Needs: General
5. During an examination of the anterior thorax, the nurse is aware that the trachea bifurcates anteriorly at the:

a.	Costal angle.

b.	Sternal angle.
c.	Xiphoid process.
d.	Suprasternal notch.

ANS: B
The sternal angle marks the site of tracheal bifurcation into the right and left main bronchi; it corresponds with the upper borders of the atria of the heart, and it lies above the fourth thoracic vertebra on the back.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 416
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
6. During an assessment, the nurse knows that expected assessment findings in the normal adult lung include the presence of:

a.	Adventitious sounds and limited chest expansion.
b.	Increased tactile fremitus and dull percussion tones.
c.	Muffled voice sounds and symmetric tactile fremitus.
d.	Absent voice sounds and hyperresonant percussion tones.

ANS: C
Normal lung findings include symmetric chest expansion, resonant percussion tones, vesicular breath sounds over the peripheral lung fields, muffled voice sounds, and no adventitious sounds.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 426 |p. 431
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
7. The primary muscles of respiration include the:

a.	Diaphragm and intercostals.
b.	Sternomastoids and scaleni.
c.	Trapezii and rectus abdominis.

d.	External obliques and pectoralis major.

ANS: A
The major muscle of respiration is the diaphragm. The intercostal muscles lift the sternum and elevate the ribs during inspiration, increasing the anteroposterior diameter. Expiration is primarily passive. Forced inspiration involves the use of other muscles, such as the accessory neck musclessternomastoid, scaleni, and trapezii muscles. Forced expiration involves the abdominal muscles.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 418
MSC: Client Needs: General
8. A 65-year-old patient with a history of heart failure comes to the clinic with complaints of being awakened from sleep with shortness of breath. Which action by the nurse is most appropriate?

a.	Obtaining a detailed health history of the patients allergies and a history of asthma
b.	Telling the patient to sleep on his or her right side to facilitate ease of respirations
c.	Assessing for other signs and symptoms of paroxysmal nocturnal dyspnea
d.	Assuring the patient that paroxysmal nocturnal dyspnea is normal and will probably resolve within the next week

ANS: C
The patient is experiencing paroxysmal nocturnal dyspneabeing awakened from sleep with shortness of breath and the need to be upright to achieve comfort.

DIF: Cognitive Level: Applying (Application) REF: p. 421
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. When assessing tactile fremitus, the nurse recalls that it is normal to feel tactile fremitus most intensely over which location?

a.	Between the scapulae
b.	Third intercostal space, MCL
c.	Fifth intercostal space, midaxillary line (MAL)

d.	Over the lower lobes, posterior side

ANS: A
Normally, fremitus is most prominent between the scapulae and around the sternum. These sites are where the major bronchi are closest to the chest wall. Fremitus normally decreases as one progresses down the chest because more tissue impedes sound transmission.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 426
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
10. The nurse is reviewing the technique of palpating for tactile fremitus with a new graduate. Which statement by the graduate nurse reflects a *correct* understanding of tactile fremitus? Tactile fremitus:

a.	Is caused by moisture in the alveoli.
b.	Indicates that air is present in the subcutaneous tissues.
c.	Is caused by sounds generated from the larynx.
d.	Reflects the blood flow through the pulmonary arteries.

ANS: C
Fremitus is a palpable vibration. Sounds generated from the larynx are transmitted through patent bronchi and the lung parenchyma to the chest wall where they are felt as vibrations. *Crepitus* is the term for air in the subcutaneous tissues.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 426
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. During percussion, the nurse knows that a dull percussion note elicited over a lung lobe most likely results from:

a.	Shallow breathing.
b.	Normal lung tissue.
c.	Decreased adipose tissue.
d.	Increased density of lung tissue.

ANS: D
A dull percussion note indicates an abnormal density in the lungs, as with pneumonia, pleural effusion, atelectasis, or a tumor. Resonance is the expected finding in normal lung tissue.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 427
MSC: Client Needs: General
12. The nurse is observing the auscultation technique of another nurse. The correct method to use when progressing from one auscultatory site on the thorax to another is_____comparison.

a.	Side-to-side
b.	Top-to-bottom
c.	Posterior-to-anterior
d.	Interspace-by-interspace

ANS: A
Side-to-side comparison is most important when auscultating the chest. The nurse should listen to at least one full respiration in each location. The other techniques are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 435
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. When auscultating the lungs of an adult patient, the nurse notes that low-pitched, soft breath sounds are heard over the posterior lower lobes, with inspiration being longer than expiration. The nurse interprets that these sounds are:

a.	Normally auscultated over the trachea.
b.	Bronchial breath sounds and normal in that location.
c.	Vesicular breath sounds and normal in that location.
d.	Bronchovesicular breath sounds and normal in that location.

ANS: C
Vesicular breath sounds are low-pitched, soft sounds with inspiration being longer than expiration. These breath sounds are expected over the peripheral lung fields where air flows

through smaller bronchioles and alveoli.

DIF: Cognitive Level: Applying (Application) REF: p. 430
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. The nurse is auscultating the chest in an adult. Which technique is *correct*?

a.	Instructing the patient to take deep, rapid breaths
b.	Instructing the patient to breathe in and out through his or her nose
c.	Firmly holding the diaphragm of the stethoscope against the chest
d.	Lightly holding the bell of the stethoscope against the chest to avoid friction

ANS: C
Firmly holding the diaphragm of the stethoscope against the chest is the correct way to auscultate breath sounds. The patient should be instructed to breathe through his or her mouth, a little deeper than usual, but not to hyperventilate.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 429
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
15. The nurse is percussing over the lungs of a patient with pneumonia. The nurse knows that percussion over an area of atelectasis in the lungs will reveal:

a.	Dullness.
b.	Tympany.
c.	Resonance.
d.	Hyperresonance.

ANS: A
A dull percussion note signals an abnormal density in the lungs, as with pneumonia, pleural effusion, atelectasis, or a tumor.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 427
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. During auscultation of the lungs, the nurse expects decreased breath sounds to be heard in

which situation?

a.	When the bronchial tree is obstructed
b.	When adventitious sounds are present
c.	In conjunction with whispered pectoriloquy
d.	In conditions of consolidation, such as pneumonia

ANS: A
Decreased or absent breath sounds occur when the bronchial tree is obstructed, as in emphysema, and when sound transmission is obstructed, as in pleurisy, pneumothorax, or pleural effusion.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 430
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
17. The nurse knows that a normal finding when assessing the respiratory system of an older adult is:

a.	Increased thoracic expansion.
b.	Decreased mobility of the thorax.
c.	Decreased anteroposterior diameter.
d.	Bronchovesicular breath sounds throughout the lungs.

ANS: B
The costal cartilages become calcified with aging, resulting in a less mobile thorax. Chest expansion may be somewhat decreased, and the chest cage commonly shows an increased anteroposterior diameter.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 438
MSC: Client Needs: Health Promotion and Maintenance
18. A mother brings her 3-month-old infant to the clinic for evaluation of a cold. She tells the nurse that he has had a runny nose for a week. When performing the physical assessment, the nurse notes that the child has nasal flaring and sternal and intercostal retractions. The nurses next action should be to:

a.	Assure the mother that these signs are normal symptoms of a cold.
b.	Recognize that these are serious signs, and contact the physician.
c.	Ask the mother if the infant has had trouble with feedings.
d.	Perform a complete cardiac assessment because these signs are probably indicative of early heart failure.

ANS: B
The infant is an obligatory nose breather until the age of 3 months. Normally, no flaring of the nostrils and no sternal or intercostal retraction occurs. Significant retractions of the sternum and intercostal muscles and nasal flaring indicate increased inspiratory effort, as in pneumonia, acute airway obstruction, asthma, and atelectasis; therefore, immediate referral to the physician is warranted. These signs do not indicate heart failure, and an assessment of the infants feeding is not a priority at this time.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 437
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
19. When assessing the respiratory system of a 4-year-old child, which of these findings would the nurse expect?

a.	Crepitus palpated at the costochondral junctions
b.	No diaphragmatic excursion as a result of a childs decreased inspiratory volume
c.	Presence of bronchovesicular breath sounds in the peripheral lung fields
d.	Irregular respiratory pattern and a respiratory rate of 40 breaths per minute at rest

ANS: C
Bronchovesicular breath sounds in the peripheral lung fields of the infant and young child up to age 5 or 6 years are normal findings. Their thin chest walls with underdeveloped musculature do not dampen the sound, as do the thicker chest walls of adults; therefore, breath sounds are loud and harsh.

DIF: Cognitive Level: Applying (Application) REF: p. 437
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. When inspecting the anterior chest of an adult, the nurse should include which assessment?

a.	Diaphragmatic excursion
b.	Symmetric chest expansion
c.	Presence of breath sounds
d.	Shape and configuration of the chest wall

ANS: D
Inspection of the anterior chest includes shape and configuration of the chest wall; assessment of the patients level of consciousness and the patients skin color and condition; quality of respirations; presence or absence of retraction and bulging of the intercostal spaces; and use of accessory muscles. Symmetric chest expansion is assessed by palpation. Diaphragmatic excursion is assessed by percussion of the posterior chest. Breath sounds are assessed by auscultation.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 432
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. The nurse knows that auscultation of fine crackles would most likely be noticed in:

a.	A healthy 5-year-old child.
b.	A pregnant woman.
c.	The immediate newborn period.
d.	Association with a pneumothorax.

ANS: C
Fine crackles are commonly heard in the immediate newborn period as a result of the opening of the airways and a clearing of fluid. Persistent fine crackles would be noticed with pneumonia, bronchiolitis, or atelectasis.

DIF: Cognitive Level: Applying (Application) REF: p. 438
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
22. During an assessment of an adult, the nurse has noted unequal chest expansion and recognizes that this occurs in which situation?

a.	In an obese patient
b.	When part of the lung is obstructed or collapsed
c.	When bulging of the intercostal spaces is present
d.	When accessory muscles are used to augment respiratory effort

ANS: B
Unequal chest expansion occurs when part of the lung is obstructed or collapsed, as with pneumonia, or when guarding to avoid postoperative incisional pain.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 432
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
23. During auscultation of the lungs of an adult patient, the nurse notices the presence of bronchophony. The nurse should assess for signs of which condition?

a.	Airway obstruction
b.	Emphysema
c.	Pulmonary consolidation
d.	Asthma

ANS: C
Pathologic conditions that increase lung density, such as pulmonary consolidation, will enhance the transmission of voice sounds, such as bronchophony (see Table 18-7).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 449
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
24. The nurse is reviewing the characteristics of breath sounds. Which statement about bronchovesicular breath sounds is *true*? Bronchovesicular breath sounds are:

a.	Musical in quality.
b.	Usually caused by a pathologic disease.

c.	Expected near the major airways.
d.	Similar to bronchial sounds except shorter in duration.

ANS: C
Bronchovesicular breath sounds are heard over major bronchi where fewer alveoli are located posteriorlybetween the scapulae, especially on the right; and anteriorly, around the upper sternum in the first and second intercostal spaces. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 430
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
25. The nurse is listening to the breath sounds of a patient with severe asthma. Air passing through narrowed bronchioles would produce which of these adventitious sounds?

a.	Wheezes
b.	Bronchial sounds
c.	Bronchophony
d.	Whispered pectoriloquy

ANS: A
Wheezes are caused by air squeezed or compressed through passageways narrowed almost to closure by collapsing, swelling, secretions, or tumors, such as with acute asthma or chronic emphysema.

CHAPTER 9 The Cardiovascular System
MULTIPLE CHOICE
1. The sac that surrounds and protects the heart is called the:

a.	Pericardium.
b.	Myocardium.
c.	Endocardium.

d.	Pleural space.

ANS: A
The pericardium is a tough, fibrous double-walled sac that surrounds and protects the heart. It has two layers that contain a few milliliters of serous pericardial fluid.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 460
MSC: Client Needs: General
2. The direction of blood flow through the heart is best described by which of these?

a.	Vena cava right atrium right ventricle lungs pulmonary artery left atrium left ventricle
b.	Right atrium right ventricle pulmonary artery lungs pulmonary vein left atrium left ventricle
c.	Aorta right atrium right ventricle lungs pulmonary vein left atrium left ventricle vena cava
d.	Right atrium right ventricle pulmonary vein lungs pulmonary artery left atrium left ventricle

ANS: B
Returning blood from the body empties into the right atrium and flows into the right ventricle and then goes to the lungs through the pulmonary artery. The lungs oxygenate the blood, and it is then returned to the left atrium through the pulmonary vein. The blood goes from there to the left ventricle and then out to the body through the aorta.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 461|p. 463
MSC: Client Needs: General
3. The nurse is reviewing the anatomy and physiologic functioning of the heart. Which statement best describes what is meant by *atrial kick*?

a.	The atria contract during systole and attempt to push against closed valves.
b.	Contraction of the atria at the beginning of diastole can be felt as a palpitation.
c.	Atrial kick is the pressure exerted against the atria as the ventricles contract during systole.
d.	The atria contract toward the end of diastole and push the remaining blood into the ventricles.

ANS: D

Toward the end of diastole, the atria contract and push the last amount of blood (approximately 25% of stroke volume) into the ventricles. This active filling phase is called *presystole*, or atrial systole, or sometimes the*atrial kick*.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 463
MSC: Client Needs: General
4. When listening to heart sounds, the nurse knows the valve closures that can be heard best at the base of the heart are:

a.	Mitral and tricuspid.
b.	Tricuspid and aortic.
c.	Aortic and pulmonic.
d.	Mitral and pulmonic.

ANS: C
The second heart sound (S2) occurs with the closure of the semilunar (aortic and pulmonic) valves and signals the end of systole. Although it is heard over all the precordium, the S2 is loudest at the base of the heart.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 464
MSC: Client Needs: General
5. Which of these statements describes the closure of the valves in a normal cardiac cycle?

a.	The aortic valve closes slightly before the tricuspid valve.
b.	The pulmonic valve closes slightly before the aortic valve.
c.	The tricuspid valve closes slightly later than the mitral valve.
d.	Both the tricuspid and pulmonic valves close at the same time.

ANS: C
Events occur just slightly later in the right side of the heart because of the route of myocardial depolarization. As a result, two distinct components to each of the heart sounds exist, and sometimes they can be heard separately. In the first heart sound, the mitral component (M1) closes just before the tricuspid component (T1).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 463
MSC: Client Needs: General
6. The component of the conduction system referred to as *the pacemaker of the heart* is the:

a.	Atrioventricular (AV) node.
b.	Sinoatrial (SA) node.
c.	Bundle of His.
d.	Bundle branches.

ANS: B
Specialized cells in the SA node near the superior vena cava initiate an electrical impulse. Because the SA node has an intrinsic rhythm, it is called the *pacemaker of the heart.*

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 464
MSC: Client Needs: General
7. The electrical stimulus of the cardiac cycle follows which sequence?

a.	AV node SA node bundle of His
b.	Bundle of His AV node SA node
c.	SA node AV node bundle of His bundle branches
d.	AV node SA node bundle of His bundle branches

ANS: D
Specialized cells in the SA node near the superior vena cava initiate an electrical impulse. The current flows in an orderly sequence, first across the atria to the AV node low in the atrial septum. There it is delayed slightly, allowing the atria the time to contract before the ventricles are stimulated. Then the impulse travels to the bundle of His, the right and left bundle branches, and then through the ventricles.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 464
MSC: Client Needs: General
8. The findings from an assessment of a 70-year-old patient with swelling in his ankles include

jugular venous pulsations 5 cm above the sternal angle when the head of his bed is elevated 45 degrees. The nurse knows that this finding indicates:

a.	Decreased fluid volume.
b.	Increased cardiac output.
c.	Narrowing of jugular veins.
d.	Elevated pressure related to heart failure.

ANS: D
Because no cardiac valve exists to separate the superior vena cava from the right atrium, the jugular veins give information about the activity on the right side of the heart. They reflect filling pressures and volume changes. Normal jugular venous pulsation is 2 cm or less above the sternal angle. Elevated pressure is more than 3 cm above the sternal angle at 45 degrees and occurs with heart failure.

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 466-467
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
9. When assessing a newborn infant who is 5 minutes old, the nurse knows which of these statements to be *true*?

a.	The left ventricle is larger and weighs more than the right ventricle.
b.	The circulation of a newborn is identical to that of an adult.
c.	Blood can flow into the left side of the heart through an opening in the atrial septum.
d.	The foramen ovale closes just minutes before birth, and the ductus arteriosus closes immediately after.

ANS: C
First, approximately two thirds of the blood is shunted through an opening in the atrial septum, the foramen ovale, into the left side of the heart, where it is pumped out through the aorta. The foramen ovale closes within the first hour after birth because the pressure in the right side of the heart is now lower than in the left side.

DIF: Cognitive Level: Applying (Application) REF: p. 467
MSC: Client Needs: Health Promotion and Maintenance

10. A 25-year-old woman in her fifth month of pregnancy has a blood pressure of 100/70 mm Hg. In reviewing her previous examination, the nurse notes that her blood pressure in her second month was 124/80 mm Hg. In evaluating this change, what does the nurse know to be *true*?

a.	This decline in blood pressure is the result of peripheral vasodilatation and is an expected change.
b.	Because of increased cardiac output, the blood pressure should be higher at this time.
c.	This change in blood pressure is not an expected finding because it means a decrease in cardiac output.
d.	This decline in blood pressure means a decrease in circulating blood volume, which is dangerous for the fetus.

ANS: A
Despite the increased cardiac output, arterial blood pressure decreases in pregnancy because of peripheral vasodilatation. The blood pressure drops to its lowest point during the second trimester and then rises after that.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 467
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
11. In assessing a 70-year-old man, the nurse finds the following: blood pressure 140/100 mm Hg; heart rate 104 beats per minute and slightly irregular; and the split S2 heart sound. Which of these findings can be explained by expected hemodynamic changes related to age?

a.	Increase in resting heart rate
b.	Increase in systolic blood pressure
c.	Decrease in diastolic blood pressure
d.	Increase in diastolic blood pressure

ANS: B
With aging, an increase in systolic blood pressure occurs. No significant change in diastolic pressure and no change in the resting heart rate occur with aging. Cardiac output at rest is does not changed with aging.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 469
MSC: Client Needs: Health Promotion and Maintenance
12. A 45-year-old man is in the clinic for a routine physical examination. During the recording of

his health history, the patient states that he has been having difficulty sleeping. Ill be sleeping great, and then I wake up and feel like I cant get my breath. The nurses best response to this would be:

a.	When was your last electrocardiogram?
b.	Its probably because its been so hot at night.
c.	Do you have any history of problems with your heart?
d.	Have you had a recent sinus infection or upper respiratory infection?

ANS: C
Paroxysmal nocturnal dyspnea (shortness of breath generally occurring at night) occurs with heart failure. Lying down increases the volume of intrathoracic blood, and the weakened heart cannot accommodate the increased load. Classically, the person awakens after 2 hours of sleep, arises, and flings open a window with the perception of needing fresh air.

DIF: Cognitive Level: Applying (Application) REF: p. 472
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
13. In assessing a patients major risk factors for heart disease, which would the nurse want to include when taking a history?

a.	Family history, hypertension, stress, and age
b.	Personality type, high cholesterol, diabetes, and smoking
c.	Smoking, hypertension, obesity, diabetes, and high cholesterol
d.	Alcohol consumption, obesity, diabetes, stress, and high cholesterol

ANS: C
To assess for major risk factors of coronary artery disease, the nurse should collect data regarding elevated serum cholesterol, elevated blood pressure, blood glucose levels above 100 mg/dL or known diabetes mellitus, obesity, any length of hormone replacement therapy for post menopausal women, cigarette smoking, and low activity level.

DIF: Cognitive Level: Applying (Application) REF: p. 473
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

14. The mother of a 3-month-old infant states that her baby has not been gaining weight. With further questioning, the nurse finds that the infant falls asleep after nursing and wakes up after a short time, hungry again. What other information would the nurse want to have?

a.	Infants sleeping position
b.	Sibling history of eating disorders
c.	Amount of background noise when eating
d.	Presence of dyspnea or diaphoresis when sucking

ANS: D
To screen for heart disease in an infant, the focus should be on feeding. Fatigue during feeding should be noted. An infant with heart failure takes fewer ounces each feeding, becomes dyspneic with sucking, may be diaphoretic, and then falls into exhausted sleep and awakens after a short time hungry again.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 473
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. In assessing the carotid arteries of an older patient with cardiovascular disease, the nurse would:

a.	Palpate the artery in the upper one third of the neck.
b.	Listen with the bell of the stethoscope to assess for bruits.
c.	Simultaneously palpate both arteries to compare amplitude.
d.	Instruct the patient to take slow deep breaths during auscultation.

ANS: B
If cardiovascular disease is suspected, then the nurse should auscultate each carotid artery for the presence of a bruit. The nurse should avoid compressing the artery, which could create an artificial bruit and compromise circulation if the carotid artery is already narrowed by atherosclerosis. Excessive pressure on the carotid sinus area high in the neck should be avoided, and excessive vagal stimulation could slow down the heart rate, especially in older adults. Palpating only one carotid artery at a time will avoid compromising arterial blood to the brain.

DIF: Cognitive Level: Applying (Application) REF: p. 476
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
16. During an assessment of a 68-year-old man with a recent onset of right-sided weakness, the nurse hears a blowing, swishing sound with the bell of the stethoscope over the left carotid artery. This finding would indicate:

a.	Valvular disorder.
b.	Blood flow turbulence.
c.	Fluid volume overload.
d.	Ventricular hypertrophy.

ANS: B
A bruit is a blowing, swishing sound indicating blood flow turbulence; normally, none is present.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 476
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. During an inspection of the precordium of an adult patient, the nurse notices the chest moving in a forceful manner along the sternal border. This finding most likely suggests a(n):

a.	Normal heart.
b.	Systolic murmur.
c.	Enlargement of the left ventricle.
d.	Enlargement of the right ventricle.

ANS: D
Normally, the examiner may or may not see an apical impulse; when visible, it occupies the fourth or fifth intercostal space at or inside the midclavicular line. A heave or lift is a sustained forceful thrusting of the ventricle during systole. It occurs with ventricular hypertrophy as a result of increased workload. A right ventricular heave is seen at the sternal border; a left ventricular heave is seen at the apex.

DIF: Cognitive Level: Applying (Application) REF: p. 479
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. During an assessment of a healthy adult, where would the nurse expect to palpate the apical impulse?

a.	Third left intercostal space at the midclavicular line
b.	Fourth left intercostal space at the sternal border
c.	Fourth left intercostal space at the anterior axillary line
d.	Fifth left intercostal space at the midclavicular line

ANS: D
The apical impulse should occupy only one intercostal space, the fourth or fifth, and it should be at or medial to the midclavicular line.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 479
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. The nurse is examining a patient who has possible cardiac enlargement. Which statement about percussion of the heart is *true*?

a.	Percussion is a useful tool for outlining the hearts borders.
b.	Percussion is easier in patients who are obese.
c.	Studies show that percussed cardiac borders do not correlate well with the true cardiac border.
d.	Only expert health care providers should attempt percussion of the heart.

ANS: C
Numerous comparison studies have shown that the percussed cardiac border correlates *only moderately* with the true cardiac border. Percussion is of limited usefulness with the female breast tissue, in a person who is obese, or in a person with a muscular chest wall. Chest x-ray images or echocardiographic examinations are significantly more accurate in detecting heart enlargement.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 480
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. The nurse is preparing to auscultate for heart sounds. Which technique is *correct*?

a.	Listening to the sounds at the aortic, tricuspid, pulmonic, and mitral areas
b.	Listening by inching the stethoscope in a rough Z pattern, from the base of the heart across and down, then over to the apex
c.	Listening to the sounds only at the site where the apical pulse is felt to be the strongest
d.	Listening for all possible sounds at a time at each specified area

ANS: B
Auscultation of breath sounds should not be limited to only four locations. Sounds produced by the valves may be heard all over the precordium. The stethoscope should be inched in a rough Z pattern from the base of the heart across and down, then over to the apex; or, starting at the apex, it should be slowly worked up (see Figure 19-22). Listening selectively to one sound at a time is best.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 481
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. While counting the apical pulse on a 16-year-old patient, the nurse notices an irregular rhythm. His rate speeds up on inspiration and slows on expiration. What would be the nurses response?

a.	Talk with the patient about his intake of caffeine.
b.	Perform an electrocardiogram after the examination.
c.	No further response is needed because sinus arrhythmia can occur normally.
d.	Refer the patient to a cardiologist for further testing.

ANS: C
The rhythm should be regular, although sinus arrhythmia occurs normally in young adults and children. With sinus arrhythmia, the rhythm varies with the persons breathing, increasing at the peak of inspiration and slowing with expiration.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 481
MSC: Client Needs: Health Promotion and Maintenance
22. When listening to heart sounds, the nurse knows that the S1:

a.	Is louder than the S2 at the base of the heart.
b.	Indicates the beginning of diastole.
c.	Coincides with the carotid artery pulse.
d.	Is caused by the closure of the semilunar valves.

ANS: C
The S1 coincides with the carotid artery pulse, is the start of systole, and is louder than the S2 at the apex of the heart; the S2 is louder than the S1 at the base. The nurse should gently feel the carotid artery pulse while auscultating at the apex; the sound heard as each pulse is felt is the S1.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 482
MSC: Client Needs: General
23. During the cardiac auscultation, the nurse hears a sound immediately occurring after the S2 at the second left intercostal space. To further assess this sound, what should the nurse do?

a.	Have the patient turn to the left side while the nurse listens with the bell of the stethoscope.
b.	Ask the patient to hold his or her breath while the nurse listens again.
c.	No further assessment is needed because the nurse knows this sound is an S3.
d.	Watch the patients respirations while listening for the effect on the sound.

ANS: D
A split S2 is a normal phenomenon that occurs toward the end of inspiration in some people. A split S2 is heard only in the pulmonic valve area, the second left interspace. When the split S2 is first heard, the nurse should not be tempted to ask the person to hold his or her breath so that the nurse can concentrate on the sounds. Breath holding will only equalize ejection times in the right and left sides of the heart and cause the split to go away. Rather, the nurse should concentrate on the split while watching the persons chest rise up and down with breathing.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 483
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
24. Which of these findings would the nurse expect to notice during a cardiac assessment on a 4-year-old child?

a.	S3 when sitting up
b.	Persistent tachycardia above 150 beats per minute
c.	Murmur at the second left intercostal space when supine
d.	Palpable apical impulse in the fifth left intercostal space lateral to midclavicular line

ANS: C
Some murmurs are common in healthy children or adolescents and are termed *innocent* or *functional*. The innocent murmur is heard at the second or third left intercostal space and disappears with sitting, and the young person has no associated signs of cardiac dysfunction.

DIF: Cognitive Level: Applying (Application) REF: p. 488
MSC: Client Needs: Health Promotion and Maintenance
25. While auscultating heart sounds on a 7-year-old child for a routine physical examination, the nurse hears an S3, a soft murmur at the left midsternal border, and a venous hum when the child is standing. What would be a correct interpretation of these findings?

a.	S3 is indicative of heart disease in children.
b.	These findings can all be normal in a child.
c.	These findings are indicative of congenital problems.
d.	The venous hum most likely indicates an aneurysm.

ANS: B
A physiologic S3 is common in children. A venous hum, caused by turbulence of blood flow in the jugular venous system, is common in healthy children and has no pathologic significance. Heart murmurs that are innocent (or functional) in origin are very common through childhood.

CHAPTER 10 The Breasts and Axillae
MULTIPLE CHOICE
1. Which of the following statements is *true* regarding the internal structures of the breast? The breast is made up of:

a.	Primarily muscle with very little fibrous tissue.

b.	Fibrous, glandular, and adipose tissues.
c.	Primarily milk ducts, known as *lactiferous ducts.*
d.	Glandular tissue, which supports the breast by attaching to the chest wall.

ANS: B
The breast is made up of glandular, fibrous (including the suspensory ligaments), and adipose tissues.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 386
MSC: Client Needs: General
2. In performing a breast examination, the nurse knows that examining the upper outer quadrant of the breast is especially important. The reason for this is that the upper outer quadrant is:

a.	The largest quadrant of the breast.
b.	The location of most breast tumors.
c.	Where most of the suspensory ligaments attach.
d.	More prone to injury and calcifications than other locations in the breast.

ANS: B
The upper outer quadrant is the site of most breast tumors. In the upper outer quadrant, the nurse should notice the axillary tail of Spence, the cone-shaped breast tissue that projects up into the axilla, close to the pectoral group of axillary lymph nodes.

DIF: Cognitive Level: Applying (Application) REF: p. 386
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. In performing an assessment of a womans axillary lymph system, the nurse should assess which of these nodes?

a.	Central, axillary, lateral, and sternal
b.	Pectoral, lateral, anterior, and sternal

c.	Central, lateral, pectoral, and subscapular
d.	Lateral, pectoral, axillary, and suprascapular

ANS: C
The breast has extensive lymphatic drainage. Four groups of axillary nodes are present: (1) central, (2) pectoral (anterior), (3) subscapular (posterior), and (4) lateral.

DIF: Cognitive Level: Applying (Application) REF: p. 387
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. If a patient reports a recent breast infection, then the nurse should expect to find _____ node enlargement.

a.	Nonspecific
b.	Ipsilateral axillary
c.	Contralateral axillary
d.	Inguinal and cervical

ANS: B
The breast has extensive lymphatic drainage. Most of the lymph, more than 75%, drains into the ipsilateral, or same side, axillary nodes.

DIF: Cognitive Level: Applying (Application) REF: p. 387
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
5. A 9-year-old girl is in the clinic for a sport physical examination. After some initial shyness she finally asks, Am I normal? I dont seem to need a bra yet, but I have some friends who do. What if I never get breasts? The nurses best response would be:

a.	Dont worry, you still have plenty of time to develop.
b.	I know just how you feel, I was a late bloomer myself. Just be patient, and they will grow.
c.	You will probably get your periods before you notice any significant growth in your breasts.

d.	I understand that it is hard to feel different from your friends. Breasts usually develop between 8 and 10 years of age.

ANS: D
Adolescent breast development usually begins between 8 and 10 years of age. The nurse should not belittle the girls feelings by using statements like dont worry or by sharing personal experiences. The beginning of breast development precedes menarche by approximately 2 years.

DIF: Cognitive Level: Applying (Application) REF: p. 388
MSC: Client Needs: Health Promotion and Maintenance
6. A patient contacts the office and tells the nurse that she is worried about her 10-year-old daughter having breast cancer. She describes a unilateral enlargement of the right breast with associated tenderness. She is worried because the left breast is not enlarged. What would be the nurses best response? Tell the mother that:

a.	Breast development is usually fairly symmetric and that the daughter should be examined right away.
b.	She should bring in her daughter right away because breast cancer is fairly common in preadolescent girls.
c.	Although an examination of her daughter would rule out a problem, her breast development is most likely normal.
d.	It is unusual for breasts that are first developing to feel tender because they havent developed much fibrous tissue.

ANS: C
Occasionally, one breast may grow faster than the other, producing a temporary asymmetry, which may cause some distress; reassurance is necessary. Tenderness is also common.

DIF: Cognitive Level: Applying (Application) REF: p. 388
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
7. A 14-year-old girl is anxious about not having reached menarche. When taking the health history, the nurse should ascertain which of the following? The age that:

a.	The girl began to develop breasts.
b.	Her mother developed breasts.
c.	She began to develop pubic hair.
d.	She began to develop axillary hair.

ANS: A
Full development from stage 2 to stage 5 takes an average of 3 years, although the range is 1 to 6 years. Pubic hair develops during this time, and axillary hair appears 2 years after the onset of pubic hair. The beginning of breast development precedes menarche by approximately 2 years. Menarche occurs in breast development stage 3 or 4, usually just after the peak of the adolescent growth spurt, which occurs around age 12 years (see Figure 17-6).

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 388-389
MSC: Client Needs: Health Promotion and Maintenance
8. A woman is in the family planning clinic seeking birth control information. She states that her breasts change all month long and that she is worried that this is unusual. What is the nurses best response? The nurse should tell her that:

a.	Continual changes in her breasts are unusual. The breasts of nonpregnant women usually stay pretty much the same all month long.
b.	Breast changes in response to stress are very common and that she should assess her life for stressful events.
c.	Because of the changing hormones during the monthly menstrual cycle, cyclic breast changes are common.
d.	Breast changes normally occur only during pregnancy and that a pregnancy test is needed at this time.

ANS: C
Breasts of the nonpregnant woman change with the ebb and flow of hormones during the monthly menstrual cycle. During the 3 to 4 days before menstruation, the breasts feel full, tight, heavy, and occasionally sore. The breast volume is smallest on days 4 to 7 of the menstrual cycle.

DIF: Cognitive Level: Applying (Application) REF: p. 389
MSC: Client Needs: Health Promotion and Maintenance
9. A woman has just learned that she is pregnant. What are some things the nurse should teach her about her breasts?

a.	She can expect her areolae to become larger and darker in color.
b.	Breasts may begin secreting milk after the fourth month of pregnancy.
c.	She should inspect her breasts for visible veins and immediately report these.

d.	During pregnancy, breast changes are fairly uncommon; most of the changes occur after the birth.

ANS: A
The areolae become larger and grow a darker brown as pregnancy progresses, and the tubercles become more prominent. (The brown color fades after lactation, but the areolae never return to their original color). A venous pattern is an expected finding and prominent over the skin surface and does not need to be reported. After the fourth month of pregnancy, colostrum, a thick, yellow fluid (precursor to milk), may be expressed from the breasts.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 389
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
10. The nurse is teaching a pregnant woman about breast milk. Which statement by the nurse is *correct*?

a.	Your breast milk is immediately present after the delivery of your baby.
b.	Breast milk is rich in protein and sugars (lactose) but has very little fat.
c.	The colostrum, which is present right after birth, does not contain the same nutrients as breast milk.
d.	You may notice a thick, yellow fluid expressed from your breasts as early as the fourth month of pregnancy.

ANS: D
After the fourth month, colostrum may be expressed. This thick yellow fluid is the precursor of milk, and it contains the same amount of protein and lactose but practically no fat. The breasts produce colostrum for the first few days after delivery. It is rich with antibodies that protect the newborn against infection; therefore, breastfeeding is important.

DIF: Cognitive Level: Applying (Application) REF: p. 389
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
11. A 65-year-old patient remarks that she just cannot believe that her breasts sag so much. She states it must be from a lack of exercise. What explanation should the nurse offer her? After menopause:

a.	Only women with large breasts experience sagging.
b.	Sagging is usually due to decreased muscle mass within the breast.

c.	A diet that is high in protein will help maintain muscle mass, which keeps the breasts from sagging.
d.	The glandular and fat tissue atrophies, causing breast size and elasticity to diminish, resulting in breasts that sag.

ANS: D
After menopause, the glandular tissue atrophies and is replaced with connective tissue. The fat envelope also atrophies, beginning in the middle years and becoming significant in the eighth and ninth decades of life. These changes decrease breast size and elasticity; consequently, the breasts droop and sag, looking flattened and flabby.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 389
MSC: Client Needs: Health Promotion and Maintenance
12. In examining a 70-year-old male patient, the nurse notices that he has bilateral gynecomastia. Which of the following describes the nurses best course of action?

a.	Recommend that he make an appointment with his physician for a mammogram.
b.	Ignore it. Benign breast enlargement in men is not unusual.
c.	Explain that this condition may be the result of hormonal changes, and recommend that he see his physician.
d.	Explain that gynecomastia in men is usually associated with prostate enlargement and recommend that he be thoroughly screened.

ANS: C
Gynecomastia may reappear in the aging man and may be attributable to a testosterone deficiency.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 389
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. During an examination of a 7-year-old girl, the nurse notices that the girl is showing breast budding. What should the nurse do next?

a.	Ask the young girl if her periods have started.
b.	Assess the girls weight and body mass index (BMI).
c.	Ask the girls mother at what age she started to develop breasts.

d.	Nothing; breast budding is a normal finding.

ANS: B
Research has shown that girls with overweight or obese BMI levels have a higher occurrence of early onset of breast budding (before age 8 years for black girls and age 10 years for white girls) and early menarche.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 389
MSC: Client Needs: Health Promotion and Maintenance
14. The nurse is reviewing statistics regarding breast cancer. Which woman, aged 40 years in the United States, has the highest risk for developing breast cancer?

a.	Black
b.	White
c.	Asian
d.	American Indian

ANS: A
The incidence of breast cancer varies within different cultural groups. White women have a higher incidence of breast cancer than black women starting at age 45 years; but black women have a higher incidence before age 45 years. Asian, Hispanic, and American Indian women have a lower risk for development of breast cancer (American Cancer Society, 2009-2010).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 389
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
15. The nurse is preparing for a class in early detection of breast cancer. Which statement is *true* with regard to breast cancer in black women in the United States?

a.	Breast cancer is not a threat to black women.
b.	Black women have a lower incidence of regional or distant breast cancer than white women.
c.	Black women are more likely to die of breast cancer at any age.
d.	Breast cancer incidence in black women is higher than that of white women after age 45.

ANS: C
Black women have a higher incidence of breast cancer before age 45 years than white women and are more likely to die of their disease. In addition, black women are significantly more likely to be diagnosed with regional or distant breast cancer than are white women. These racial differences in mortality rates may be related to an insufficient use of screening measures and a lack of access to health care.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 389
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
16. During a breast health interview, a patient states that she has noticed pain in her left breast. The nurses most appropriate response to this would be:

a.	Dont worry about the pain; breast cancer is not painful.
b.	I would like some more information about the pain in your left breast.
c.	Oh, I had pain like that after my son was born; it turned out to be a blocked milk duct.
d.	Breast pain is almost always the result of benign breast disease.

ANS: B
Breast pain occurs with trauma, inflammation, infection, or benign breast disease. The nurse will need to gather more information about the patients pain rather than make statements that ignore the patients concerns.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 391
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. During a health history interview, a female patient states that she has noticed a few drops of clear discharge from her right nipple. What should the nurse do next?

a.	Immediately contact the physician to report the discharge.
b.	Ask her if she is possibly pregnant.
c.	Ask the patient some additional questions about the medications she is taking.
d.	Immediately obtain a sample for culture and sensitivity testing.

ANS: C
The use of some medications, such as oral contraceptives, phenothiazines, diuretics, digitalis, steroids, methyldopa, and calcium channel blockers, may cause clear nipple discharge. Bloody or blood-tinged discharge from the nipple, not clear, is significant, especially if a lump is also present. In the pregnant female, colostrum would be a thick, yellowish liquid, and it would be normally expressed after the fourth month of pregnancy.

DIF: Cognitive Level: Applying (Application) REF: p. 391
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. During a physical examination, a 45-year-old woman states that she has had a crusty, itchy rash on her breast for approximately 2 weeks. In trying to find the cause of the rash, which question would be important for the nurse to ask?

a.	Is the rash raised and red?
b.	Does it appear to be cyclic?
c.	Where did the rash first appearon the nipple, the areola, or the surrounding skin?
d.	What was she doing when she first noticed the rash, and do her actions make it worse?

ANS: C
The location where the rash first appeared is important for the nurse to determine. Paget disease starts with a small crust on the nipple apex and then spreads to the areola. Eczema or other dermatitis rarely starts at the nipple unless it is a result of breastfeeding. It usually starts on the areola or surrounding skin and then spreads to the nipple (see Table 17-6).

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 391
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
19. A patient is newly diagnosed with benign breast disease. The nurse recognizes which statement about benign breast disease to be *true*? The presence of benign breast disease:

a.	Makes it hard to examine the breasts.
b.	Frequently turns into cancer in a womans later years.
c.	Is easily reduced with hormone replacement therapy.
d.	Is usually diagnosed before a woman reaches childbearing age.

ANS: A
The presence of benign breast disease (formerly fibrocystic breast disease) makes it hard to examine the breasts; the general lumpiness of the breast conceals a new lump. The other statements are not true.

DIF: Cognitive Level: Applying (Application) REF: p. 391
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. During an annual physical examination, a 43-year-old patient states that she does not perform monthly breast self-examinations (BSEs). She tells the nurse that she believes that mammograms do a much better job than I ever could to find a lump. The nurse should explain to her that:

a.	BSEs may detect lumps that appear between mammograms.
b.	BSEs are unnecessary until the age of 50 years.
c.	She is correctmammography is a good replacement for BSE.
d.	She does not need to perform BSEs as long as a physician checks her breasts annually.

ANS: A
The monthly practice of BSE, along with clinical breast examination and mammograms, are complementary screening measures. Mammography can reveal cancers too small to be detected by the woman or by the most experienced examiner. However, interval lumps may become palpable between mammograms.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 392
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
21. During an interview, a patient reveals that she is pregnant. She states that she is not sure whether she will breastfeed her baby and asks for some information about this. Which of these statements by the nurse is *accurate*?

a.	Breastfed babies tend to be more colicky.
b.	Breastfeeding provides the perfect food and antibodies for your baby.
c.	Breastfed babies eat more often than infants on formula.
d.	Breastfeeding is second nature, and every woman can do it.

ANS: B
Exclusively breastfeeding for 6 months provides the perfect food and antibodies for the baby, decreases the risk of ear infections, promotes bonding, and provides relaxation.

DIF: Cognitive Level: Applying (Application) REF: p. 393
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
22. The nurse is reviewing risk factors for breast cancer. Which of these women have risk factors that place them at a higher risk for breast cancer?

a.	37 year old who is slightly overweight
b.	42 year old who has had ovarian cancer
c.	45 year old who has never been pregnant
d.	65 year old whose mother had breast cancer

ANS: D
Risk factors for breast cancer include having a first-degree relative with breast cancer (mother, sister, or daughter) and being older than 50 years of age. (Refer to Table 17- 2 for other risk factors.)

DIF: Cognitive Level: Applying (Application) REF: p. 393
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
23. During an examination of a woman, the nurse notices that her left breast is slightly larger than her right breast. Which of these statements is *true* about this finding?

a.	Breasts should always be symmetric.
b.	Asymmetry of breast size and shape is probably due to breastfeeding and is nothing to worry about.
c.	Asymmetry is not unusual, but the nurse should verify that this change is not new.
d.	Asymmetry of breast size and shape is very unusual and means she may have an inflammation or growth.

ANS: C
The nurse should notice symmetry of size and shape. It is common to have a slight asymmetry in size; often the left breast is slightly larger than the right. A sudden increase in the size of one

breast signifies inflammation or new growth.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 394
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
24. The nurse is assisting with a BSE clinic. Which of these women reflect abnormal findings during the inspection phase of breast examination?

a.	Woman whose nipples are in different planes (deviated).
b.	Woman whose left breast is slightly larger than her right.
c.	Nonpregnant woman whose skin is marked with linear striae.
d.	Pregnant woman whose breasts have a fine blue network of veins visible under the skin.

ANS: A
The nipples should be symmetrically placed on the same plane on the two breasts. With deviation in pointing, an underlying cancer may cause fibrosis in the mammary ducts, which pulls the nipple angle toward it. The other examples are normal findings (see Table 17-3).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 395
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
25. During the physical examination, the nurse notices that a female patient has an inverted left nipple. Which statement regarding this is *most* accurate?

a.	Normal nipple inversion is usually bilateral.
b.	Unilateral inversion of a nipple is always a serious sign.
c.	Whether the inversion is a recent change should be determined.
d.	Nipple inversion is not significant unless accompanied by an underlying palpable mass.

ANS: C
The nurse should distinguish between a recently retracted nipple from one that has been inverted for many years or since puberty. Normal nipple inversion may be unilateral or bilateral and usually can be pulled out; that is, if it is not fixed. Recent nipple retraction signifies acquired disease .

CHAPTER 11 The Abdomen
MULTIPLE CHOICE
1. The nurse is percussing the seventh right intercostal space at the midclavicular line over the liver. Which sound should the nurse expect to hear?

a.	Dullness
b.	Tympany
c.	Resonance
d.	Hyperresonance

ANS: A
The liver is located in the right upper quadrant and would elicit a dull percussion note.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 550
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
2. Which structure is located in the left lower quadrant of the abdomen?

a.	Liver
b.	Duodenum
c.	Gallbladder
d.	Sigmoid colon

ANS: D
The sigmoid colon is located in the left lower quadrant of the abdomen.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 540
MSC: Client Needs: General
3. A patient is having difficulty swallowing medications and food. The nurse would document that this patient has:

a.	Aphasia.

b.	Dysphasia.
c.	Dysphagia.
d.	Anorexia.

ANS: C
Dysphagia is a condition that occurs with disorders of the throat or esophagus and results in difficulty swallowing. Aphasia and dysphasia are speech disorders. Anorexia is a loss of appetite.

DIF: Cognitive Level: Applying (Application) REF: p. 542
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. The nurse suspects that a patient has a distended bladder. How should the nurse assess for this condition?

a.	Percuss and palpate in the lumbar region.
b.	Inspect and palpate in the epigastric region.
c.	Auscultate and percuss in the inguinal region.
d.	Percuss and palpate the midline area above the suprapubic bone.

ANS: D
Dull percussion sounds would be elicited over a distended bladder, and the hypogastric area would seem firm to palpation.

DIF: Cognitive Level: Applying (Application) REF: p. 540
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
5. The nurse is aware that one change that may occur in the gastrointestinal system of an aging adult is:

a.	Increased salivation.
b.	Increased liver size.
c.	Increased esophageal emptying.

d.	Decreased gastric acid secretion.

ANS: D
Gastric acid secretion decreases with aging. As one ages, salivation decreases, esophageal emptying is delayed, and liver size decreases.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 541
MSC: Client Needs: Health Promotion and Maintenance
6. A 22-year-old man comes to the clinic for an examination after falling off his motorcycle and landing on his left side on the handle bars. The nurse suspects that he may have injured his spleen. Which of these statements is *true*regarding assessment of the spleen in this situation?

a.	The spleen can be enlarged as a result of trauma.
b.	The spleen is normally felt on routine palpation.
c.	If an enlarged spleen is noted, then the nurse should thoroughly palpate to determine its size.
d.	An enlarged spleen should not be palpated because it can easily rupture.

ANS: D
If an enlarged spleen is felt, then the nurse should refer the person and should not continue to palpate it. An enlarged spleen is friable and can easily rupture with overpalpation.

DIF: Cognitive Level: Applying (Application) REF: p. 558
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
7. A patients abdomen is bulging and stretched in appearance. The nurse should describe this finding as:

a.	Obese.
b.	Herniated.
c.	Scaphoid.
d.	Protuberant.

ANS: D

A protuberant abdomen is rounded, bulging, and stretched (see Figure 21-7). A scaphoid abdomen caves inward.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 546
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
8. The nurse is describing a scaphoid abdomen. To the horizontal plane, a scaphoid contour of the abdomen depicts a_____profile.

a.	Flat
b.	Convex
c.	Bulging
d.	Concave

ANS: D
Contour describes the profile of the abdomen from the rib margin to the pubic bone; a scaphoid contour is one that is concave from a horizontal plane (see Figure 21-7).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 546
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
9. While examining a patient, the nurse observes abdominal pulsations between the xiphoid process and umbilicus. The nurse would suspect that these are:

a.	Pulsations of the renal arteries.
b.	Pulsations of the inferior vena cava.
c.	Normal abdominal aortic pulsations.
d.	Increased peristalsis from a bowel obstruction.

ANS: C
Normally, the pulsations from the aorta are observed beneath the skin in the epigastric area, particularly in thin persons who have good muscle wall relaxation.

DIF: Cognitive Level: Applying (Application) REF: p. 549
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. A patient has hypoactive bowel sounds. The nurse knows that a potential cause of hypoactive bowel sounds is:

a.	Diarrhea.
b.	Peritonitis.
c.	Laxative use.
d.	Gastroenteritis.

ANS: B
Diminished or absent bowel sounds signal decreased motility from inflammation as exhibited with peritonitis, with paralytic ileus after abdominal surgery, or with late bowel obstruction.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 549
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
11. The nurse is watching a new graduate nurse perform auscultation of a patients abdomen. Which statement by the new graduate shows a *correct* understanding of the reason auscultation precedes percussion and palpation of the abdomen?

a.	We need to determine the areas of tenderness before using percussion and palpation.
b.	Auscultation prevents distortion of bowel sounds that might occur after percussion and palpation.
c.	Auscultation allows the patient more time to relax and therefore be more comfortable with the physical examination.
d.	Auscultation prevents distortion of vascular sounds, such as bruits and hums, that might occur after percussion and palpation.

ANS: B
Auscultation is performed first (after inspection) because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

DIF: Cognitive Level: Applying (Application) REF: p. 548
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. The nurse is listening to bowel sounds. Which of these statements is *true* of bowel sounds? Bowel sounds:

a.	Are usually loud, high-pitched, rushing, and tinkling sounds.
b.	Are usually high-pitched, gurgling, and irregular sounds.
c.	Sound like two pieces of leather being rubbed together.
d.	Originate from the movement of air and fluid through the large intestine.

ANS: B
Bowel sounds are high-pitched, gurgling, and cascading sounds that irregularly occur from 5 to 30 times per minute. They originate from the movement of air and fluid through the small intestine.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 549
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. The physician comments that a patient has abdominal borborygmi. The nurse knows that this term refers to:

a.	Loud continual hum.
b.	Peritoneal friction rub.
c.	Hypoactive bowel sounds.
d.	Hyperactive bowel sounds.

ANS: D
Borborygmi is the term used for hyperperistalsis when the person actually feels his or her stomach growling.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 549
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. During an abdominal assessment, the nurse would consider which of these findings as normal?

a.	Presence of a bruit in the femoral area

b.	Tympanic percussion note in the umbilical region
c.	Palpable spleen between the ninth and eleventh ribs in the left midaxillary line
d.	Dull percussion note in the left upper quadrant at the midclavicular line

ANS: B
Tympany should predominate in all four quadrants of the abdomen because air in the intestines rises to the surface when the person is supine. Vascular bruits are not usually present. Normally, the spleen is not palpable. Dullness would not be found in the area of lung resonance (left upper quadrant at the midclavicular line).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 550
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
15. The nurse is assessing the abdomen of a pregnant woman who is complaining of having acid indigestion all the time. The nurse knows that esophageal reflux during pregnancy can cause:

a.	Diarrhea.
b.	Pyrosis.
c.	Dysphagia.
d.	Constipation.

ANS: B
Pyrosis, or heartburn, is caused by esophageal reflux during pregnancy. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 540
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. The nurse is performing percussion during an abdominal assessment. Percussion notes heard during the abdominal assessment may include:

a.	Flatness, resonance, and dullness.
b.	Resonance, dullness, and tympany.

c.	Tympany, hyperresonance, and dullness.
d.	Resonance, hyperresonance, and flatness.

ANS: C
Percussion notes normally heard during the abdominal assessment may include tympany, which should predominate because air in the intestines rises to the surface when the person is supine; hyperresonance, which may be present with gaseous distention; and dullness, which may be found over a distended bladder, adipose tissue, fluid, or a mass.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 550
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. An older patient has been diagnosed with pernicious anemia. The nurse knows that this condition could be related to:

a.	Increased gastric acid secretion.
b.	Decreased gastric acid secretion.
c.	Delayed gastrointestinal emptying time.
d.	Increased gastrointestinal emptying time.

ANS: B
Gastric acid secretion decreases with aging and may cause pernicious anemia (because it interferes with vitamin B12 absorption), iron-deficiency anemia, and malabsorption of calcium.

DIF: Cognitive Level: Applying (Application) REF: p. 541
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
18. A patient is complaining of a sharp pain along the costovertebral angles. The nurse is aware that this symptom is most often indicative of:

a.	Ovary infection.
b.	Liver enlargement.
c.	Kidney inflammation.

d.	Spleen enlargement.

ANS: C
Sharp pain along the costovertebral angles occurs with inflammation of the kidney or paranephric area. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 552
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
19. A nurse notices that a patient has ascites, which indicates the presence of:

a.	Fluid.
b.	Feces.
c.	Flatus.
d.	Fibroid tumors.

ANS: A
Ascites is free fluid in the peritoneal cavity and occurs with heart failure, portal hypertension, cirrhosis, hepatitis, pancreatitis, and cancer.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 553
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
20. The nurse knows that during an abdominal assessment, deep palpation is used to determine:

a.	Bowel motility.
b.	Enlarged organs.
c.	Superficial tenderness.
d.	Overall impression of skin surface and superficial musculature.

ANS: B
With deep palpation, the nurse should notice the location, size, consistency, and mobility of any palpable organs and the presence of any abnormal enlargement, tenderness, or masses.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 554
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
21. The nurse notices that a patient has had a black, tarry stool and recalls that a possible cause would be:

a.	Gallbladder disease.
b.	Overuse of laxatives.
c.	Gastrointestinal bleeding.
d.	Localized bleeding around the anus.

ANS: C
Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding. Red blood in stools occurs with localized bleeding around the anus.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 543
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
22. During an abdominal assessment, the nurse elicits tenderness on light palpation in the right lower quadrant. The nurse interprets that this finding could indicate a disorder of which of these structures?

a.	Spleen
b.	Sigmoid
c.	Appendix
d.	Gallbladder

ANS: C
The appendix is located in the right lower quadrant. When the iliopsoas muscle is inflamed, which occurs with an inflamed or perforated appendix, pain is felt in the right lower quadrant.

DIF: Cognitive Level: Applying (Application) REF: p. 560
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
23. The nurse is assessing the abdomen of an older adult. Which statement regarding the older

adult and abdominal assessment is *true*?

a.	Abdominal tone is increased.
b.	Abdominal musculature is thinner.
c.	Abdominal rigidity with an acute abdominal condition is more common.
d.	The older adult with an acute abdominal condition complains more about pain than the younger person.

ANS: B
In the older adult, the abdominal musculature is thinner and has less tone than that of the younger adult, and abdominal rigidity with an acute abdominal condition is less common in the aging person. The older adult with an acute abdominal condition often complains less about pain than the younger person.

DIF: Cognitive Level: Applying (Application) REF: p. 563
MSC: Client Needs: Health Promotion and Maintenance
24. During an assessment of a newborn infant, the nurse recalls that pyloric stenosis would be exhibited by:

a.	Projectile vomiting.
b.	Hypoactive bowel activity.
c.	Palpable olive-sized mass in the right lower quadrant.
d.	Pronounced peristaltic waves crossing from right to left.

ANS: A
Significant peristalsis, together with projectile vomiting, in the newborn suggests pyloric stenosis. After feeding, pronounced peristaltic waves cross from *left to right*, leading to projectile vomiting. One can also palpate an olive-sized mass in the right *upper* quadrant.

DIF: Cognitive Level: Applying (Application) REF: p. 572
MSC: Client Needs: Health Promotion and Maintenance
25. The nurse is reviewing the assessment of an aortic aneurysm. Which of these statements is *true* regarding an aortic aneurysm?

a.	A bruit is absent.
b.	Femoral pulses are increased.
c.	A pulsating mass is usually present.
d.	Most are located below the umbilicus.

ANS: C
Most aortic aneurysms are palpable during routine examination and feel like a pulsating mass. A bruit will be audible, and femoral pulses are present but decreased. Such aneurysms are located in the upper abdomen just to the left of midline.

CHAPTER 12 The Peripheral Vascular System
MULTIPLE CHOICE
1. Which statement is *true* regarding the arterial system?

a.	Arteries are large-diameter vessels.
b.	The arterial system is a high-pressure system.
c.	The walls of arteries are thinner than those of the veins.
d.	Arteries can greatly expand to accommodate a large blood volume increase.

ANS: B
The pumping heart makes the arterial system a high-pressure system.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 509
MSC: Client Needs: General
2. The nurse is reviewing the blood supply to the arm. The major artery supplying the arm is the _____ artery.

a.	Ulnar
b.	Radial

c.	Brachial
d.	Deep palmar

ANS: C
The major artery supplying the arm is the brachial artery. The brachial artery bifurcates into the ulnar and radial arteries immediately below the elbow. In the hand, the ulnar and radial arteries form two arches known as the superficial and deep palmar arches.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 509
MSC: Client Needs: General
3. The nurse is preparing to assess the dorsalis pedis artery. Where is the correct location for palpation?

a.	Behind the knee
b.	Over the lateral malleolus
c.	In the groove behind the medial malleolus
d.	Lateral to the extensor tendon of the great toe

ANS: D
The dorsalis pedis artery is located on the dorsum of the foot. The nurse should palpate just lateral to and parallel with the extensor tendon of the big toe. The popliteal artery is palpated behind the knee. The posterior tibial pulse is palpated in the groove between the malleolus and the Achilles tendon. No pulse is palpated at the lateral malleolus.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 509
MSC: Client Needs: General
4. A 65-year-old patient is experiencing pain in his left calf when he exercises that disappears after resting for a few minutes. The nurse recognizes that this description is most consistent with _____ the left leg.

a.	Venous obstruction of
b.	Claudication due to venous abnormalities in

c.	Ischemia caused by a partial blockage of an artery supplying
d.	Ischemia caused by the complete blockage of an artery supplying

ANS: C
Ischemia is a deficient supply of oxygenated arterial blood to a tissue. A partial blockage creates an insufficient supply, and the ischemia may be apparent only during exercise when oxygen needs increase.

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 509-510
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
5. The nurse is reviewing venous blood flow patterns. Which of these statements best describes the mechanism(s) by which venous blood returns to the heart?

a.	Intraluminal valves ensure unidirectional flow toward the heart.
b.	Contracting skeletal muscles milk blood distally toward the veins.
c.	High-pressure system of the heart helps facilitate venous return.
d.	Increased thoracic pressure and decreased abdominal pressure facilitate venous return to the heart.

ANS: A
Blood moves through the veins by (1) contracting skeletal muscles that proximally milk the blood; (2) pressure gradients caused by breathing, during which inspiration makes the thoracic pressure decrease and the abdominal pressure increase; and (3) the intraluminal valves, which ensure unidirectional flow toward the heart.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 511
MSC: Client Needs: General
6. Which vein(s) is(are) responsible for most of the venous return in the arm?

a.	Deep
b.	Ulnar
c.	Subclavian

d.	Superficial

ANS: D
The superficial veins of the arms are in the subcutaneous tissue and are responsible for most of the venous return.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 510
MSC: Client Needs: General
7. A 70-year-old patient is scheduled for open-heart surgery. The surgeon plans to use the great saphenous vein for the coronary bypass grafts. The patient asks, What happens to my circulation when this vein is removed? The nurse should reply:

a.	Venous insufficiency is a common problem after this type of surgery.
b.	Oh, you have lots of veinsyou wont even notice that it has been removed.
c.	You will probably experience decreased circulation after the vein is removed.
d.	This vein can be removed without harming your circulation because the deeper veins in your leg are in good condition.

ANS: D
As long as the femoral and popliteal veins remain intact, the superficial veins can be excised without harming circulation. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 510
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
8. The nurse is reviewing the risk factors for venous disease. Which of these situations best describes a person at highest risk for the development of venous disease?

a.	Woman in her second month of pregnancy
b.	Person who has been on bed rest for 4 days
c.	Person with a 30-year, 1 pack per day smoking habit
d.	Older adult taking anticoagulant medication

ANS: B

People who undergo prolonged standing, sitting, or bed rest are at risk for venous disease. Hypercoagulable (not anticoagulated) states and vein-wall trauma also place the person at risk for venous disease. Obesity and the late months of pregnancy are also risk factors.

DIF: Cognitive Level: Applying (Application) REF: p. 512
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
9. The nurse is teaching a review class on the lymphatic system. A participant shows correct understanding of the material with which statement?

a.	Lymph flow is propelled by the contraction of the heart.
b.	The flow of lymph is slow, compared with that of the blood.
c.	One of the functions of the lymph is to absorb lipids from the biliary tract.
d.	Lymph vessels have no valves; therefore, lymph fluid flows freely from the tissue spaces into the bloodstream.

ANS: B
The flow of lymph is slow, compared with flow of the blood. Lymph flow is not propelled by the heart but rather by contracting skeletal muscles, pressure changes secondary to breathing, and contraction of the vessel walls. Lymph does not absorb lipids from the biliary tract. The vessels do have valves; therefore, flow is one way from the tissue spaces to the bloodstream.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 513
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
10. When performing an assessment of a patient, the nurse notices the presence of an enlarged right epitrochlear lymph node. What should the nurse do next?

a.	Assess the patients abdomen, and notice any tenderness.
b.	Carefully assess the cervical lymph nodes, and check for any enlargement.
c.	Ask additional health history questions regarding any recent ear infections or sore throats.
d.	Examine the patients lower arm and hand, and check for the presence of infection or lesions.

ANS: D
The epitrochlear nodes are located in the antecubital fossa and drain the hand and lower arm. The other actions are not correct for this assessment finding.

DIF: Cognitive Level: Applying (Application) REF: p. 513
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. A 35-year-old man is seen in the clinic for an infection in his left foot. Which of these findings should the nurse expect to see during an assessment of this patient?

a.	Hard and fixed cervical nodes
b.	Enlarged and tender inguinal nodes
c.	Bilateral enlargement of the popliteal nodes
d.	Pelletlike nodes in the supraclavicular region

ANS: B
The inguinal nodes in the groin drain most of the lymph of the lower extremities. With local inflammation, the nodes in that area become swollen and tender.

DIF: Cognitive Level: Applying (Application) REF: p. 513
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
12. The nurse is examining the lymphatic system of a healthy 3-year-old child. Which finding should the nurse expect?

a.	Excessive swelling of the lymph nodes
b.	Presence of palpable lymph nodes
c.	No palpable nodes because of the immature immune system of a child
d.	Fewer numbers and a smaller size of lymph nodes compared with those of an adult

ANS: B
Lymph nodes are relatively large in children, and the superficial ones are often palpable even when the child is healthy.

DIF: Cognitive Level: Applying (Application) REF: p. 514
MSC: Client Needs: Health Promotion and Maintenance
13. During an assessment of an older adult, the nurse should expect to notice which finding as a normal physiologic change associated with the aging process?

a.	Hormonal changes causing vasodilation and a resulting drop in blood pressure
b.	Progressive atrophy of the intramuscular calf veins, causing venous insufficiency
c.	Peripheral blood vessels growing more rigid with age, producing a rise in systolic blood pressure
d.	Narrowing of the inferior vena cava, causing low blood flow and increases in venous pressure resulting in varicosities

ANS: C
Peripheral blood vessels grow more rigid with age, resulting in a rise in systolic blood pressure. Aging produces progressive enlargement of the intramuscular calf veins, not atrophy. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 514
MSC: Client Needs: Health Promotion and Maintenance
14. A 67-year-old patient states that he recently began to have pain in his left calf when climbing the 10 stairs to his apartment. This pain is relieved by sitting for approximately 2 minutes; then he is able to resume his activities. The nurse interprets that this patient is most likely experiencing:

a.	Claudication.
b.	Sore muscles.
c.	Muscle cramps.
d.	Venous insufficiency.

ANS: A
Intermittent claudication feels like a cramp and is usually relieved by rest within 2 minutes. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 515
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. A patient complains of leg pain that wakes him at night. He states that he has been having problems with his legs. He has pain in his legs when they are elevated that disappears when he dangles them. He recently noticed a sore on the inner aspect of the right ankle. On the basis of this health history information, the nurse interprets that the patient is most likely experiencing:

a.	Pain related to lymphatic abnormalities.
b.	Problems related to arterial insufficiency.
c.	Problems related to venous insufficiency.
d.	Pain related to musculoskeletal abnormalities.

ANS: B
Night leg pain is common in aging adults and may indicate the ischemic rest pain of peripheral vascular disease. Alterations in arterial circulation cause pain that becomes worse with leg elevation and is eased when the extremity is dangled.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 515
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. During an assessment, the nurse uses the *profile sign* to detect:

a.	Pitting edema.
b.	Early clubbing.
c.	Symmetry of the fingers.
d.	Insufficient capillary refill.

ANS: B
The nurse should use the profile sign (viewing the finger from the side) to detect early clubbing.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 516
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
17. The nurse is performing an assessment on an adult. The adults vital signs are normal, and capillary refill time is 5 seconds. What should the nurse do next?

a.	Ask the patient about a history of frostbite.
b.	Suspect that the patient has venous insufficiency.

c.	Consider this a delayed capillary refill time, and investigate further.
d.	Consider this a normal capillary refill time that requires no further assessment.

ANS: C
Normal capillary refill time is less than 1 to 2 seconds. The following conditions can skew the findings: a cool room, decreased body temperature, cigarette smoking, peripheral edema, and anemia.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 516
MSC: Client Needs: Health Promotion and Maintenance
18. When assessing a patient, the nurse notes that the left femoral pulse as diminished, 1+/4+. What should the nurse do next?

a.	Document the finding.
b.	Auscultate the site for a bruit.
c.	Check for calf pain.
d.	Check capillary refill in the toes.

ANS: B
If a pulse is weak or diminished at the femoral site, then the nurse should auscultate for a bruit. The presence of a bruit, or turbulent blood flow, indicates partial occlusion. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 521
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. When performing a peripheral vascular assessment on a patient, the nurse is unable to palpate the ulnar pulses. The patients skin is warm and capillary refill time is normal. Next, the nurse should:

a.	Check for the presence of claudication.
b.	Refer the individual for further evaluation.
c.	Consider this finding as normal, and proceed with the peripheral vascular evaluation.

d.	Ask the patient if he or she has experienced any unusual cramping or tingling in the arm.

ANS: C
Palpating the ulnar pulses is not usually necessary. The ulnar pulses are not often palpable in the normal person. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 517
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
20. The nurse is assessing the pulses of a patient who has been admitted for untreated hyperthyroidism. The nurse should expect to find a(n)_____pulse.

a.	Normal
b.	Absent
c.	Bounding
d.	Weak, thready

ANS: C
A full, bounding pulse occurs with hyperkinetic states (e.g., exercise, anxiety, fever), anemia, and hyperthyroidism. An absent pulse occurs with occlusion. Weak, thready pulses occur with shock and peripheral artery disease.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 517
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
21. The nurse is preparing to perform a modified Allen test. Which is an appropriate reason for this test?

a.	To measure the rate of lymphatic drainage
b.	To evaluate the adequacy of capillary patency before venous blood draws
c.	To evaluate the adequacy of collateral circulation before cannulating the radial artery
d.	To evaluate the venous refill rate that occurs after the ulnar and radial arteries are temporarily occluded

ANS: C

A modified Allen test is used to evaluate the adequacy of collateral circulation before the radial artery is cannulated. The other responses are not reasons for a modified Allen test.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 518
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
22. A patient has been diagnosed with venous stasis. Which of these findings would the nurse most likely observe?

a.	Unilateral cool foot
b.	Thin, shiny, atrophic skin
c.	Pallor of the toes and cyanosis of the nail beds
d.	Brownish discoloration to the skin of the lower leg

ANS: D
A brown discoloration occurs with chronic venous stasis as a result of hemosiderin deposits (a by-product of red blood cell degradation). Pallor, cyanosis, atrophic skin, and unilateral coolness are all signs associated with arterial problems.

DIF: Cognitive Level: Applying (Application) REF: p. 520
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
23. The nurse is attempting to assess the femoral pulse in a patient who is obese. Which of these actions would be most appropriate?

a.	The patient is asked to assume a prone position.
b.	The patient is asked to bend his or her knees to the side in a froglike position.
c.	The nurse firmly presses against the bone with the patient in a semi-Fowler position.
d.	The nurse listens with a stethoscope for pulsations; palpating the pulse in an obese person is extremely difficult.

ANS: B
To help expose the femoral area, particularly in obese people, the nurse should ask the person to bend his or her knees to the side in a froglike position.

DIF: Cognitive Level: Applying (Application) REF: p. 521

MSC: Client Needs: Safe and Effective Care Environment: Management of Care
24. When auscultating over a patients femoral arteries, the nurse notices the presence of a bruit on the left side. The nurse knows that bruits:

a.	Are often associated with venous disease.
b.	Occur in the presence of lymphadenopathy.
c.	In the femoral arteries are caused by hypermetabolic states.
d.	Occur with turbulent blood flow, indicating partial occlusion.

ANS: D
A bruit occurs with turbulent blood flow and indicates partial occlusion of the artery. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 521
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
25. How should the nurse document mild, slight pitting edema the ankles of a pregnant patient?

a.	1+/0-4+
b.	3+/0-4+
c.	4+/0-4+
d.	Brawny edema

ANS: A
If pitting edema is present, then the nurse should grade it on a scale of 1+ (mild) to 4+ (severe). Brawny edema appears as nonpitting edema and feels hard to the touch.

CHAPTER 13 Male Genitalia and Hernias
MULTIPLE CHOICE
1. The external male genital structures include the:

a.	Testis.

b.	Scrotum.
c.	Epididymis.
d.	Vas deferens.

ANS: B
The external male genital structures include the penis and scrotum. The testis, epididymis, and vas deferens are internal structures.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 691
MSC: Client Needs: General
2. An accessory glandular structure for the male genital organs is the:

a.	Testis.
b.	Scrotum.
c.	Prostate.
d.	Vas deferens.

ANS: C
Glandular structures accessory to the male genital organs are the prostate, seminal vesicles, and bulbourethral glands.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 691
MSC: Client Needs: General
3. Which of these statements is *true* regarding the penis?

a.	The urethral meatus is located on the ventral side of the penis.
b.	The prepuce is the fold of foreskin covering the shaft of the penis.
c.	The penis is made up of two cylindrical columns of erectile tissue.
d.	The corpus spongiosum expands into a cone of erectile tissue called the *glans*.

ANS: D
At the distal end of the shaft, the corpus spongiosum expands into a cone of erectile tissue, the glans. The penis is made up of three cylindrical columns of erectile tissue. The skin that covers the glans of the penis is the prepuce. The urethral meatus forms at the tip of the glans.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 691
MSC: Client Needs: General
4. When performing a genital examination on a 25-year-old man, the nurse notices deeply pigmented, wrinkled scrotal skin with large sebaceous follicles. On the basis of this information, the nurse would:

a.	Squeeze the glans to check for the presence of discharge.
b.	Consider this finding as normal, and proceed with the examination.
c.	Assess the testicles for the presence of masses or painless lumps.
d.	Obtain a more detailed history, focusing on any scrotal abnormalities the patient has noticed.

ANS: B
After adolescence, the scrotal skin is deeply pigmented and has large sebaceous follicles and appears corrugated.

DIF: Cognitive Level: Applying (Application) REF: p. 691
MSC: Client Needs: Health Promotion and Maintenance
5. Which statement concerning the testes is *true*?

a.	The lymphatic vessels of the testes drain into the abdominal lymph nodes.
b.	The vas deferens is located along the inferior portion of each testis.
c.	The right testis is lower than the left because the right spermatic cord is longer.
d.	The cremaster muscle contracts in response to cold and draws the testicles closer to the body.

ANS: D
When it is cold, the cremaster muscle contracts, which raises the scrotal sac and brings the testes closer to the body to absorb heat necessary for sperm viability. The lymphatic vessels of the

testes drain into the inguinal lymph nodes. The vas deferens is located along the upper portion of each testis. The left testis is lower than the right because the left spermatic cord is longer.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 691
MSC: Client Needs: General
6. A male patient with possible fertility problems asks the nurse where sperm is produced. The nurse knows that sperm production occurs in the:

a.	Testes.
b.	Prostate.
c.	Epididymis.
d.	Vas deferens.

ANS: A
Sperm production occurs in the testes, not in the other structures listed.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 692
MSC: Client Needs: Physiologic Integrity
7. A 62-year-old man states that his physician told him that he has an inguinal hernia. He asks the nurse to explain what a hernia is. The nurse should:

a.	Tell him not to worry and that most men his age develop hernias.
b.	Explain that a hernia is often the result of prenatal growth abnormalities.
c.	Refer him to his physician for additional consultation because the physician made the initial diagnosis.
d.	Explain that a hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.

ANS: D
A hernia is a loop of bowel protruding through a weak spot in the musculature. The other options are not correct responses to the patients question.

DIF: Cognitive Level: Applying (Application) REF: p. 692
MSC: Client Needs: Physiologic Integrity
8. The mother of a 10-year-old boy asks the nurse to discuss the recognition of puberty. The

nurse should reply by saying:

a.	Puberty usually begins around 15 years of age.
b.	The first sign of puberty is an enlargement of the testes.
c.	The penis size does not increase until about 16 years of age.
d.	The development of pubic hair precedes testicular or penis enlargement.

ANS: B
Puberty begins sometime between age 9 for African Americans and age 10 for Caucasians and Hispanics. The first sign is an enlargement of the testes. Pubic hair appears next, and then penis size increases.

DIF: Cognitive Level: Applying (Application) REF: p. 693
MSC: Client Needs: Health Promotion and Maintenance
9. During an examination of an aging man, the nurse recognizes that normal changes to expect would be:

a.	Enlarged scrotal sac.
b.	Increased pubic hair.
c.	Decreased penis size.
d.	Increased rugae over the scrotum.

ANS: C
In the aging man, the amount of pubic hair decreases, the penis size decreases, and the rugae over the scrotal sac decreases. The scrotal sac does not enlarge.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 693
MSC: Client Needs: Health Promotion and Maintenance
10. An older man is concerned about his sexual performance. The nurse knows that in the absence of disease, a withdrawal from sexual activity later in life may be attributable to:

a.	Side effects of medications.
b.	Decreased libido with aging.
c.	Decreased sperm production.
d.	Decreased pleasure from sexual intercourse.

ANS: A
In the absence of disease, a withdrawal from sexual activity may be attributable to side effects of medications such as antihypertensives, antidepressants, sedatives, psychotropics, antispasmotics, tranquilizers or narcotics, and estrogens. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 693
MSC: Client Needs: Health Promotion and Maintenance
11. A 59-year-old patient has been diagnosed with prostatitis and is being seen at the clinic for complaints of burning and pain during urination. He is experiencing:

a.	Dysuria.
b.	Nocturia.
c.	Polyuria.
d.	Hematuria.

ANS: A
Dysuria (burning with urination) is common with acute cystitis, prostatitis, and urethritis. Nocturia is voiding during the night. Polyuria is voiding in excessive quantities. Hematuria is voiding with blood in the urine.

DIF: Cognitive Level: Applying (Application) REF: p. 695
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
12. A 45-year-old mother of two children is seen at the clinic for complaints of losing my urine when I sneeze. The nurse documents that she is experiencing:

a.	Urinary frequency.

b.	Enuresis.
c.	Stress incontinence.
d.	Urge incontinence.

ANS: C
Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing that occurs as a result to weakness of the pelvic floor. Urinary frequency is urinating more times than usual (more than five to six times per day). Enuresis is involuntary passage of urine at night after age 5 to 6 years (bed wetting). Urge incontinence is involuntary urine loss from overactive detrusor muscle in the bladder. It contracts, causing an urgent need to void.

DIF: Cognitive Level: Applying (Application) REF: p. 696
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
13. When the nurse is conducting sexual history from a male adolescent, which statement would be most appropriate to use at the beginning of the interview?

a.	Do you use condoms?
b.	You dont masturbate, do you?
c.	Have you had sex in the last 6 months?
d.	Often adolescents your age have questions about sexual activity.

ANS: D
The interview should begin with a permission statement, which conveys that it is normal and acceptable to think or feel a certain way. Sounding judgmental should be avoided.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 698
MSC: Client Needs: Health Promotion and Maintenance
14. Which of these statements is most appropriate when the nurse is obtaining a genitourinary history from an older man?

a.	Do you need to get up at night to urinate?
b.	Do you experience nocturnal emissions, or wet dreams?

c.	Do you know how to perform a testicular self-examination?
d.	Has anyone ever touched your genitals when you did not want them to?

ANS: A
The older male patient should be asked about the presence of nocturia. Awaking at night to urinate may be attributable to a diuretic medication, fluid retention from mild heart failure or varicose veins, or fluid ingestion 3 hours before bedtime, especially coffee and alcohol. The other questions are more appropriate for younger men.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 699
MSC: Client Needs: Health Promotion and Maintenance
15. When the nurse is performing a genital examination on a male patient, the patient has an erection. The nurses most appropriate action or response is to:

a.	Ask the patient if he would like someone else to examine him.
b.	Continue with the examination as though nothing has happened.
c.	Stop the examination, leave the room while stating that the examination will resume at a later time.
d.	Reassure the patient that this is a normal response and continue with the examination.

ANS: D
When the male patient has an erection, the nurse should reassure the patient that this is a normal physiologic response to touch and proceed with the rest of the examination. The other responses are not correct and may be perceived as judgmental.

DIF: Cognitive Level: Applying (Application) REF: p. 699
MSC: Client Needs: Psychosocial Integrity
16. The nurse is examining the glans and knows which finding is normal for this area?

a.	The meatus may have a slight discharge when the glans is compressed.
b.	Hair is without pest inhabitants.
c.	The skin is wrinkled and without lesions.

d.	Smegma may be present under the foreskin of an uncircumcised male.

ANS: D
The glans looks smooth and without lesions and does not have hair. The meatus should not have any discharge when the glans is compressed. Some cheesy smegma may have collected under the foreskin of an uncircumcised male.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 701
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. When performing a genitourinary assessment, the nurse notices that the urethral meatus is ventrally positioned. This finding is:

a.	Called hypospadias.
b.	A result of phimosis.
c.	Probably due to a stricture.
d.	Often associated with aging.

ANS: A
Normally, the urethral meatus is positioned just about centrally. Hypospadias is the ventral location of the urethral meatus. The position of the meatus does not change with aging. Phimosis is the inability to retract the foreskin. A stricture is a narrow opening of the meatus.

DIF: Cognitive Level: Applying (Application) REF: p. 700
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. The nurse is performing a genital examination on a male patient and notices urethral drainage. When collecting urethral discharge for microscopic examination and culture, the nurse should:

a.	Ask the patient to urinate into a sterile cup.
b.	Ask the patient to obtain a specimen of semen.
c.	Insert a cotton-tipped applicator into the urethra.
d.	Compress the glans between the examiners thumb and forefinger, and collect any discharge.

ANS: D
If urethral discharge is noticed, then the examiner should collect a smear for microscopic examination and culture by compressing the glans anteroposteriorly between the thumb and forefinger. The other options are not correct actions.

DIF: Cognitive Level: Applying (Application) REF: p. 701
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
19. When assessing the scrotum of a male patient, the nurse notices the presence of multiple firm, nontender, yellow 1-cm nodules. The nurse knows that these nodules are most likely:

a.	From urethritis.
b.	Sebaceous cysts.
c.	Subcutaneous plaques.
d.	From an inflammation of the epididymis.

ANS: B
Sebaceous cysts are commonly found on the scrotum. These yellowish 1-cm nodules are firm, nontender, and often multiple. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 702
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
20. When performing a scrotal assessment, the nurse notices that the scrotal contents show a red glow with transillumination. On the basis of this finding the nurse would:

a.	Assess the patient for the presence of a hernia.
b.	Suspect the presence of serous fluid in the scrotum.
c.	Consider this finding normal, and proceed with the examination.
d.	Refer the patient for evaluation of a mass in the scrotum.

ANS: B
Normal scrotal contents do not allow light to pass through the scrotum. However, serous fluid does transilluminate and shows as a red glow. Neither a mass nor a hernia would transilluminate.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 703
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
21. When the nurse is performing a genital examination on a male patient, which action is *correct*?

a.	Auscultating for the presence of a bruit over the scrotum
b.	Palpating for the vertical chain of lymph nodes along the groin, inferior to the inguinal ligament
c.	Palpating the inguinal canal only if a bulge is present in the inguinal region during inspection
d.	Having the patient shift his weight onto the left (unexamined) leg when palpating for a hernia on the right side

ANS: D
When palpating for the presence of a hernia on the right side, the male patient is asked to shift his weight onto the left (unexamined) leg. Auscultating for a bruit over the scrotum is not appropriate. When palpating for lymph nodes, the horizontal chain is palpated. The inguinal canal should be palpated whether a bulge is present or not.

DIF: Cognitive Level: Applying (Application) REF: p. 706
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
22. The nurse is aware of which statement to be *true* regarding the incidence of testicular cancer?

a.	Testicular cancer is the most common cancer in men aged 30 to 50 years.
b.	The early symptoms of testicular cancer are pain and induration.
c.	Men with a history of cryptorchidism are at the greatest risk for the development of testicular cancer.
d.	The cure rate for testicular cancer is low.

ANS: C
Men with undescended testicles (cryptorchidism) are at the greatest risk for the development of testicular cancer. The overall incidence of testicular cancer is rare. Although testicular cancer has no early symptoms, when detected early and treated before metastasizing, the cure rate is almost 100%.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 707

MSC: Client Needs: Health Promotion and Maintenance
23. The nurse is describing how to perform a testicular self-examination to a patient. Which statement is *most* appropriate?

a.	A good time to examine your testicles is just before you take a shower.
b.	If you notice an enlarged testicle or a painless lump, call your health care provider.
c.	The testicle is egg shaped and movable. It feels firm and has a lumpy consistency.
d.	Perform a testicular examination at least once a week to detect the early stages of testicular cancer.

ANS: B
If the patient notices a firm painless lump, a hard area, or an overall enlarged testicle, then he should call his health care provider for further evaluation. The testicle normally feels rubbery with a smooth surface. A good time to examine the testicles is during the shower or bath, when ones hands are warm and soapy and the scrotum is warm. Testicular self-examination should be performed once a month.

DIF: Cognitive Level: Applying (Application) REF: p. 704
MSC: Client Needs: Health Promotion and Maintenance
24. A 2-month-old uncircumcised infant has been brought to the clinic for a well-baby checkup. How would the nurse proceed with the genital examination?

a.	Eliciting the cremasteric reflex is recommended.
b.	The glans is assessed for redness or lesions.
c.	Retracting the foreskin should be avoided until the infant is 3 months old.
d.	Any dirt or smegma that has collected under the foreskin should be noted.

ANS: C
If uncircumcised, then the foreskin is normally tight during the first 3 months and should not be retracted because of the risk of tearing the membrane attaching the foreskin to the shaft. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 706
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. A 2-year-old boy has been diagnosed with physiologic cryptorchidism. Considering this diagnosis, during assessment the nurse will most likely observe:

a.	Testes that are hard and painful to palpation.
b.	Atrophic scrotum and a bilateral absence of the testis.
c.	Absence of the testis in the scrotum, but the testis can be milked down.
d.	Testes that migrate into the abdomen when the child squats or sits cross-legged.

ANS: C
Migratory testes (physiologic cryptorchidism) are common because of the strength of the cremasteric reflex and the small mass of the prepubertal testes. The affected side has a normally developed scrotum and the testis can be milked down. The other responses are not correct.

CHAPTER 14 Female Genitalia
MULTIPLE CHOICE
1. During a health history, a 22-year old woman asks, Can I get that vaccine for human papilloma virus (HPV)? I have genital warts and Id like them to go away! What is the nurses best response?

a.	The HPV vaccine is for girls and women ages 9 to 26 years, so we can start that today.
b.	This vaccine is only for girls who have not yet started to become sexually active.
c.	Lets check with the physician to see if you are a candidate for this vaccine.
d.	The vaccine cannot protect you if you already have an HPV infection.

ANS: D
The HPV vaccine is appropriate for girls and women age 9 to 26 years and is administered to prevent cervical cancer by preventing HPV infections before girls become sexually active. However, it cannot protect the woman if an HPV infection is already present.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 740
MSC: Client Needs: General
2. During an examination, the nurse observes a female patients vestibule and expects to see the:

a.	Urethral meatus and vaginal orifice.
b.	Vaginal orifice and vestibular (Bartholin) glands.
c.	Urethral meatus and paraurethral (Skene) glands.
d.	Paraurethral (Skene) and vestibular (Bartholin) glands.

ANS: A
The labial structures encircle a boat-shaped space, or cleft, termed the *vestibule*. Within the vestibule are numerous openings. The urethral meatus and vaginal orifice are visible. The ducts of the paraurethral (Skene) glands and the vestibular (Bartholin) glands are present but not visible.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 737
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
3. During a speculum inspection of the vagina, the nurse would expect to see what at the end of the vaginal canal?

a.	Cervix
b.	Uterus
c.	Ovaries
d.	Fallopian tubes

ANS: A
At the end of the canal, the uterine cervix projects into the vagina.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 738
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
4. The uterus is usually positioned tilting forward and superior to the bladder. This position is known as:

a.	Anteverted and anteflexed.

b.	Retroverted and anteflexed.
c.	Retroverted and retroflexed.
d.	Superiorverted and anteflexed.

ANS: A
The uterus is freely movable, not fixed, and usually tilts forward and superior to the bladder (a position labeled as *anteverted and anteflexed*).

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 738
MSC: Client Needs: General
5. An 11-year-old girl is in the clinic for a sports physical examination. The nurse notices that she has begun to develop breasts, and during the conversation the girl reveals that she is worried about her development. The nurse should use which of these techniques to best assist the young girl in understanding the expected sequence for development? The nurse should:

a.	Use the Tanner scale on the five stages of sexual development.
b.	Describe her development and compare it with that of other girls her age.
c.	Use the Jacobsen table on expected development on the basis of height and weight data.
d.	Reassure her that her development is within normal limits and tell her not to worry about the next step.

ANS: A
The Tanner scale on the five stages of pubic hair development is helpful in teaching girls the expected sequence of sexual development (see Table 26-1). The other responses are not appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 739
MSC: Client Needs: Health Promotion and Maintenance
6. A woman who is 8 weeks pregnant is in the clinic for a checkup. The nurse reads on her chart that her cervix is softened and looks cyanotic. The nurse knows that the woman is exhibiting _____ sign and_____sign.

a.	Tanner; Hegar

b.	Hegar; Goodell
c.	Chadwick; Hegar
d.	Goodell; Chadwick

ANS: D
Shortly after the first missed menstrual period, the female genitalia show signs of the growing fetus. The cervix softens (Goodell sign) at 4 to 6 weeks, and the vaginal mucosa and cervix look cyanotic (Chadwick sign) at 8 to 12 weeks. These changes occur because of increased vascularity and edema of the cervix and hypertrophy and hyperplasia of the cervical glands. Hegar sign occurs when the isthmus of the uterus softens at 6 to 8 weeks. Tanner sign is not a correct response.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 739
MSC: Client Needs: Health Promotion and Maintenance
7. Generally, the changes normally associated with menopause occur because the cells in the reproductive tract are:

a.	Aging.
b.	Becoming fibrous.
c.	Estrogen dependent.
d.	Able to respond to estrogen.

ANS: C
Because cells in the reproductive tract are estrogen dependent, decreased estrogen levels during menopause bring dramatic physical changes. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 740
MSC: Client Needs: Health Promotion and Maintenance
8. The nurse is reviewing the changes that occur with menopause. Which changes are associated with menopause?

a.	Uterine and ovarian atrophy, along with a thinning of the vaginal epithelium

b.	Ovarian atrophy, increased vaginal secretions, and increasing clitoral size
c.	Cervical hypertrophy, ovarian atrophy, and increased acidity of vaginal secretions
d.	Vaginal mucosa fragility, increased acidity of vaginal secretions, and uterine hypertrophy

ANS: A
The uterus shrinks because of its decreased myometrium. The ovaries atrophy to 1 to 2 cm and are not palpable after menopause. The sacral ligaments relax, and the pelvic musculature weakens; consequently, the uterus droops. The cervix shrinks and looks paler with a thick glistening epithelium. The vaginal epithelium atrophies, becoming thinner, drier, and itchy. The vaginal pH becomes more alkaline, and secretions are decreased, which results in a fragile mucosal surface that is at risk for vaginitis.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 740
MSC: Client Needs: Health Promotion and Maintenance
9. A 54-year-old woman who has just completed menopause is in the clinic today for a yearly physical examination. Which of these statements should the nurse include in patient education? A postmenopausal woman:

a.	Is not at any greater risk for heart disease than a younger woman.
b.	Should be aware that she is at increased risk for dyspareunia because of decreased vaginal secretions.
c.	Has only stopped menstruating; there really are no other significant changes with which she should be concerned.
d.	Is likely to have difficulty with sexual pleasure as a result of drastic changes in the female sexual response cycle.

ANS: B
Decreased vaginal secretions leave the vagina dry and at risk for irritation and pain with intercourse (dyspareunia). The other statements are incorrect.

DIF: Cognitive Level: Applying (Application) REF: p. 740
MSC: Client Needs: Health Promotion and Maintenance
10. A woman is in the clinic for an annual gynecologic examination. The nurse should plan to begin the interview with the:

a.	Menstrual history, because it is generally nonthreatening.

b.	Obstetric history, because it includes the most important information.
c.	Urinary system history, because problems may develop in this area as well.
d.	Sexual history, because discussing it first will build rapport.

ANS: A
Menstrual history is usually nonthreatening and therefore a good topic with which to begin the interview. Obstetric, urinary, and sexual histories are also part of the interview but not necessarily the best topics with which to start.

DIF: Cognitive Level: Applying (Application) REF: p. 740
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
11. A patient has had three pregnancies and two live births. The nurse would record this information as grav_____, para_____, AB_____.

a.	2; 2; 1
b.	3; 2; 0
c.	3; 2; 1
d.	3; 3; 1

ANS: C
Gravida (grav) is the number of pregnancies. Para is the number of births. Abortions are interrupted pregnancies, including elective abortions and spontaneous miscarriages.

DIF: Cognitive Level: Applying (Application) REF: p. 741
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. During the interview with a female patient, the nurse gathers data that indicate the patient is perimenopausal. Which of these statements made by this patient leads to this conclusion?

a.	I have noticed that my muscles ache at night when I go to bed.
b.	I will be very happy when I can stop worrying about having a period.

c.	I have been noticing that I sweat a lot more than I used to, especially at night.
d.	I have only been pregnant twice, but both times I had breast tenderness as my first symptom.

ANS: C
Hormone shifts occur during the perimenopausal period, and associated symptoms of menopause may occur, such as hot flashes, night sweats, numbness and tingling, headache, palpitations, drenching sweats, mood swings, vaginal dryness, and itching. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 741
MSC: Client Needs: Health Promotion and Maintenance
13. A 50-year-old woman calls the clinic because she has noticed some changes in her body and breasts and wonders if these changes could be attributable to the hormone replacement therapy (HRT) she started 3 months earlier. The nurse should tell her:

a.	HRT is at such a low dose that side effects are very unusual.
b.	HRT has several side effects, including fluid retention, breast tenderness, and vaginal bleeding.
c.	Vaginal bleeding with HRT is very unusual; I suggest you come into the clinic immediately to have this evaluated.
d.	It sounds as if your dose of estrogen is too high; I think you may need to decrease the amount you are taking and then call back in a week.

ANS: B
Side effects of HRT include fluid retention, breast pain, and vaginal bleeding. The other responses are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 741
MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies
14. A 52-year-old patient states that when she sneezes or coughs she wets herself a little. She is very concerned that something may be wrong with her. The nurse suspects that the problem is:

a.	Dysuria.
b.	Stress incontinence.
c.	Hematuria.

d.	Urge incontinence.

ANS: B
Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing. Dysuria is pain or burning with urination. Hematuria is bleeding with urination. Urge incontinence is involuntary urine loss that occurs as a result of an overactive detrusor muscle in the bladder that contracts and causes an urgent need to void.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 742
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. During the interview, a patient reveals that she has some vaginal discharge. She is worried that it may be a sexually transmitted infection. The nurses most appropriate response to this would be:

a.	Oh, dont worry. Some cyclic vaginal discharge is normal.
b.	Have you been engaging in unprotected sexual intercourse?
c.	Id like some information about the discharge. What color is it?
d.	Have you had any urinary incontinence associated with the discharge?

ANS: C
Questions that help the patient reveal more information about her symptoms should be asked in a nonthreatening manner. Asking about the amount, color, and odor of the vaginal discharge provides the opportunity for further assessment. Normal vaginal discharge is small, clear or cloudy, and always nonirritating.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 742
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. A woman states that 2 weeks ago she had a urinary tract infection that was treated with an antibiotic. As a part of the interview, the nurse should ask, Have you noticed any:

a.	Changes in your urination patterns?
b.	Excessive vaginal bleeding?
c.	Unusual vaginal discharge or itching?

d.	Changes in your desire for intercourse?

ANS: C
Several medications may increase the risk of vaginitis. Broad-spectrum antibiotics alter the balance of normal flora, which may lead to the development of vaginitis. The other questions are not appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 742
MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies
17. Which statement would be *most* appropriate when the nurse is introducing the topic of sexual relationships during an interview?

a.	Now, it is time to talk about your sexual history. When did you first have intercourse?
b.	Women often feel dissatisfied with their sexual relationships. Would it be okay to discuss this now?
c.	Women often have questions about their sexual relationship and how it affects their health. Do you have any questions?
d.	Most women your age have had more than one sexual partner. How many would you say you have had?

ANS: C
The nurse should begin with an open-ended question to assess individual needs. The nurse should include appropriate questions as a routine part of the health history, because doing so communicates that the nurse accepts the individuals sexual activity and believes it is important. The nurses comfort with the discussion prompts the patients interest and, possibly, relief that the topic has been introduced. The initial discussion establishes a database for comparison with any future sexual activities and provides an opportunity to screen sexual problems.

DIF: Cognitive Level: Applying (Application) REF: p. 742
MSC: Client Needs: Psychosocial Integrity
18. A 22-year-old woman has been considering using oral contraceptives. As a part of her health history, the nurse should ask:

a.	Do you have a history of heart murmurs?
b.	Will you be in a monogamous relationship?
c.	Have you carefully thought this choice through?

d.	If you smoke, how many cigarettes do you smoke per day?

ANS: D
Oral contraceptives, together with cigarette smoking, increase the risk for cardiovascular side effects. If cigarettes are used, then the nurse should assess the patients smoking history. The other questions are not appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 743
MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies
19. A married couple has come to the clinic seeking advice on pregnancy. They have been trying to conceive for 4 months and have not been successful. What should the nurse do first?

a.	Ascertain whether either of them has been using broad-spectrum antibiotics.
b.	Explain that couples are considered infertile after 1 year of unprotected intercourse.
c.	Immediately refer the woman to an expert in pelvic inflammatory diseasethe most common cause of infertility.
d.	Explain that couples are considered infertile after 3 months of engaging in unprotected intercourse and that they will need a referral to a fertility expert.

ANS: B
Infertility is considered after 1 year of engaging in unprotected sexual intercourse without conceiving. The other actions are not appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 743
MSC: Client Needs: Psychosocial Integrity
20. A nurse is assessing a patients risk of contracting a sexually transmitted infection (STI). An appropriate question to ask would be:

a.	You know that its important to use condoms for protection, right?
b.	Do you use a condom with each episode of sexual intercourse?
c.	Do you have a sexually transmitted infection?
d.	You are aware of the dangers of unprotected sex, arent you?

ANS: B

In reviewing a patients risk for STIs, the nurse should ask in a nonconfrontational manner whether condoms are being used during each episode of sexual intercourse. Asking a person whether he or she has an infection does not address the risk.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 743
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
21. When the nurse is interviewing a preadolescent girl, which opening question would be least threatening?

a.	Do you have any questions about growing up?
b.	What has your mother told you about growing up?
c.	When did you notice that your body was changing?
d.	I remember being very scared when I got my period. How do you think youll feel?

ANS: C
Open-ended questions such as, When did you ? rather than Do you ? should be asked. Open-ended questions are less threatening because they imply that the topic is normal and unexceptional.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 743
MSC: Client Needs: Psychosocial Integrity
22. When the nurse is discussing sexuality and sexual issues with an adolescent, a permission statement helps convey that it is normal to think or feel a certain way. Which statement is the best example of a permission statement?

a.	It is okay that you have become sexually active.
b.	Girls your age often have questions about sexual activity. Do you have any questions?
c.	If it is okay with you, Id like to ask you some questions about your sexual history.
d.	Girls your age often engage in sexual activities. It is okay to tell me if you have had intercourse.

ANS: B
The examiner should start with a permission statement such as, Girls your age often experience A permission statement conveys the idea that it is normal to think or feel a certain way, and

implying that the topic is normal and unexceptional is important.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 743
MSC: Client Needs: Psychosocial Integrity
23. The nurse is preparing to interview a postmenopausal woman. Which of these statements is *true* as it applies to obtaining the health history of a postmenopausal woman?

a.	The nurse should ask a postmenopausal woman if she has ever had vaginal bleeding.
b.	Once a woman reaches menopause, the nurse does not need to ask any history questions.
c.	The nurse should screen for monthly breast tenderness.
d.	Postmenopausal women are not at risk for contracting STIs; therefore, these questions can be omitted.

ANS: A
Postmenopausal bleeding warrants further workup and referral. The other statements are not true.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 744
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
24. During the examination portion of a patients visit, she will be in lithotomy position. Which statement reflects some things that the nurse can do to make this position more comfortable for her?

a.	Ask her to place her hands and arms over her head.
b.	Elevate her head and shoulders to maintain eye contact.
c.	Allow her to choose to have her feet in the stirrups or have them resting side by side on the edge of the table.
d.	Allow her to keep her buttocks approximately 6 inches from the edge of the table to prevent her from feeling as if she will fall off.

ANS: B
The nurse should elevate her head and shoulders to maintain eye contact. The patients arms should be placed at her sides or across the chest. Placing her hands and arms over her head only tightens the abdominal muscles. The feet should be placed into the stirrups, knees apart, and buttocks at the edge of the examining table. The stirrups are placed so that the legs are not abducted too far.

DIF: Cognitive Level: Applying (Application) REF: p. 745
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
25. An 18-year-old patient is having her first pelvic examination. Which action by the nurse is appropriate?

a.	Inviting her mother to be present during the examination
b.	Avoiding the lithotomy position for this first time because it can be uncomfortable and embarrassing
c.	Raising the head of the examination table and giving her a mirror so that she can view the examination
d.	Fully draping her, leaving the drape between her legs elevated to avoid embarrassing her with eye contact

ANS: C
The techniques of the educational or mirror pelvic examination should be used. This is a routine examination with some modifications in attitude, position, and communication. First, the woman is considered an active participant, one who is interested in learning and in sharing decisions about her own health care. The woman props herself up on one elbow, or the head of the table is raised. Her other hand holds a mirror between her legs, above the examiners hands. The young woman can see all that the examiner is doing and has a full view of her genitalia. The mirror works well for teaching normal anatomy and its relationship to sexual behavior. The examiner can ask her if she would like to have a family member, friend, or chaperone present for the examination. The drape should be pushed down between the patients legs so that the nurse can see her face.

CHAPTER 15 The Anus, Rectum, and Prostate
MULTIPLE CHOICE
1. Which statement concerning the anal canal is *true*? The anal canal:

a.	Is approximately 2 cm long in the adult.
b.	Slants backward toward the sacrum.
c.	Contains hair and sebaceous glands.
d.	Is the outlet for the gastrointestinal tract.

ANS: D
The anal canal is the outlet for the gastrointestinal tract and is approximately 3.8 cm long in the

adult. It is lined with a modified skin that does not contain hair or sebaceous glands, and it slants forward toward the umbilicus.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 721
MSC: Client Needs: General
2. Which statement concerning the sphincters is *correct*?

a.	The internal sphincter is under voluntary control.
b.	The external sphincter is under voluntary control.
c.	Both sphincters remain slightly relaxed at all times.
d.	The internal sphincter surrounds the external sphincter.

ANS: B
The external sphincter surrounds the internal sphincter but also has a small section overriding the tip of the internal sphincter at the opening. The external sphincter is under voluntary control. Except for the passing of feces and gas, the sphincters keep the anal canal tightly closed.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 721
MSC: Client Needs: General
3. The nurse is performing an examination of the anus and rectum. Which of these statements is *correct* and important to remember during this examination?

a.	The rectum is approximately 8 cm long.
b.	The anorectal junction cannot be palpated.
c.	Above the anal canal, the rectum turns anteriorly.
d.	No sensory nerves are in the anal canal or rectum.

ANS: B
The anal columns are folds of mucosa that extend vertically down from the rectum and end in the anorectal junction. This junction is not palpable but is visible on proctoscopy. The rectum is 12 cm long; just above the anal canal, the rectum dilates and turns posteriorly.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 721

MSC: Client Needs: Safe and Effective Care Environment: Management of Care
4. The structure that secretes a thin, milky alkaline fluid to enhance the viability of sperm is the:

a.	Cowper gland.
b.	Prostate gland.
c.	Median sulcus.
d.	Bulbourethral gland.

ANS: B
In men, the prostate gland secretes a thin milky alkaline fluid that enhances sperm viability. The Cowper glands (also known as *bulbourethral glands*) secrete a clear, viscid mucus. The median sulcus is a groove that divides the lobes of the prostate gland and does not secrete fluid.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 722
MSC: Client Needs: General
5. A 46-year-old man requires an assessment of his sigmoid colon. Which instrument or technique is *most* appropriate for this examination?

a.	Proctoscope
b.	Ultrasound
c.	Colonoscope
d.	Rectal examination with an examining finger

ANS: C
The sigmoid colon is 40 cm long, and the nurse knows that it is accessible to examination only with the colonoscope. The other responses are not appropriate for an examination of the entire sigmoid colon.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 722
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
6. The nurse is caring for a newborn infant. Thirty hours after birth, the infant passes a dark green meconium stool. The nurse recognizes this is important because the:

a.	Stool indicates anal patency.
b.	Dark green color indicates occult blood in the stool.
c.	Meconium stool can be reflective of distress in the newborn.
d.	Newborn should have passed the first stool within 12 hours after birth.

ANS: A
The first stool passed by the newborn is dark green meconium and occurs within 24 to 48 hours of birth, indicating anal patency. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 723
MSC: Client Needs: Health Promotion and Maintenance
7. During the assessment of an 18-month-old infant, the mother expresses concern to the nurse about the infants inability to toilet train. What would be the nurses best response?

a.	Some children are just more difficult to train, so I wouldnt worry about it yet.
b.	Have you considered reading any of the books on toilet training? They can be very helpful.
c.	This could mean that there is a problem in your babys development. Well watch her closely for the next few months.
d.	The nerves that will allow your baby to have control over the passing of stools are not developed until at least 18 to 24 months of age.

ANS: D
The infant passes stools by reflex. Voluntary control of the external anal sphincter cannot occur until the nerves supplying the area have become fully myelinated, usually around 1 to 2 years of age. Toilet training usually starts after the age of 2 years.

DIF: Cognitive Level: Applying (Application) REF: p. 723
MSC: Client Needs: Health Promotion and Maintenance
8. A 60-year-old man has just been told that he has benign prostatic hypertrophy (BPH). He has a friend who just died from cancer of the prostate. He is concerned this will happen to him. How should the nurse respond?

a.	The swelling in your prostate is only temporary and will go away.

b.	We will treat you with chemotherapy so we can control the cancer.
c.	It would be very unusual for a man your age to have cancer of the prostate.
d.	The enlargement of your prostate is caused by hormonal changes, and not cancer.

ANS: D
The prostate gland commonly starts to enlarge during the middle adult years. BPH is present in 1 in 10 men at the age of 40 years and increases with age. It is believed that the hypertrophy is caused by hormonal imbalance that leads to the proliferation of benign adenomas. The other responses are not appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 723
MSC: Client Needs: Health Promotion and Maintenance
9. A 30-year-old woman is visiting the clinic because of pain in my bottom when I have a bowel movement. The nurse should assess for which problem?

a.	Pinworms
b.	Hemorrhoids
c.	Colon cancer
d.	Fecal incontinence

ANS: B
Having painful bowel movements, known as *dyschezia*, may be attributable to a local condition (hemorrhoid or fissure) or constipation. The other responses are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 723
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
10. A patient who is visiting the clinic complains of having stomach pains for 2 weeks and describes his stools as being soft and black for approximately the last 10 days. He denies taking any medications. The nurse is aware that these symptoms are mostly indicative of:

a.	Excessive fat caused by malabsorption.
b.	Increased iron intake, resulting from a change in diet.

c.	Occult blood, resulting from gastrointestinal bleeding.
d.	Absent bile pigment from liver problems.

ANS: C
Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding or nontarry from ingestion of iron medications (not diet). Excessive fat causes the stool to become frothy. The absence of bile pigment causes clay-colored stools.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 724
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
11. After completing an assessment of a 60-year-old man with a family history of colon cancer, the nurse discusses with him early detection measures for colon cancer. The nurse should mention the need for a(n):

a.	Annual proctoscopy.
b.	Colonoscopy every 10 years.
c.	Fecal test for blood every 6 months.
d.	DREs every 2 years.

ANS: B
Early detection measures for colon cancer include a DRE performed annually after age 50 years, an annual fecal occult blood test after age 50 years, a sigmoidoscopic examination every 5 years or a colonoscopy every 10 years after age 50 years, and a PSA blood test annually for men over 50 years old, except beginning at age 45 years for black men (American Cancer Society, 2006).

DIF: Cognitive Level: Applying (Application) REF: p. 725
MSC: Client Needs: Health Promotion and Maintenance
12. The mother of a 5-year-old girl tells the nurse that she has noticed her daughter scratching at her bottom a lot the last few days. During the assessment, the nurse finds redness and raised skin in the anal area. This finding most likely indicates:

a.	Pinworms.
b.	Chickenpox.

c.	Constipation.
d.	Bacterial infection.

ANS: A
In children, pinworms are a common cause of intense itching and irritated anal skin. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 725
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
13. The nurse is examining only the rectal area of a woman and should place the woman in what position?

a.	Lithotomy
b.	Prone
c.	Left lateral decubitus
d.	Bending over the table while standing

ANS: C
The nurse should place the female patient in the lithotomy position if the genitalia are being examined as well. The left lateral decubitus position is used for the rectal area alone.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 725
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. While performing an assessment of the perianal area of a patient, the nurse notices that the pigmentation of anus is darker than the surrounding skin, the anal opening is closed, and a skin sac that is shiny and blue is noted. The patient mentioned that he has had pain with bowel movements and has occasionally noted some spots of blood. What would this assessment and history *most* likely indicate?

a.	Anal fistula
b.	Pilonidal cyst
c.	Rectal prolapse

d.	Thrombosed hemorrhoid

ANS: D
The anus normally looks moist and hairless, with coarse folded skin that is more pigmented than the perianal skin, and the anal opening is tightly closed. The shiny blue skin sac indicates a thrombosed hemorrhoid.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 726
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. The nurse is preparing to palpate the rectum and should use which of these techniques? The nurse should:

a.	Flex the finger, and slowly insert it toward the umbilicus.
b.	First instruct the patient that this procedure will be painful.
c.	Insert an extended index finger at a right angle to the anus.
d.	Place the finger directly into the anus to overcome the tight sphincter.

ANS: A
The nurse should gently place the pad of the index finger against the anal verge. The nurse will feel the sphincter tighten and then relax. As it relaxes, the nurse should flex the tip of the finger and slowly insert it into the anal canal in a direction toward the umbilicus. The nurse should never approach the anus at right angles with the index finger extended; doing so would cause pain. The nurse should instruct the patient that palpation is not painful but may feel like needing to move the bowels.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 726
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
16. While performing a rectal examination, the nurse notices a firm, irregularly shaped mass. What should the nurse do next?

a.	Continue with the examination, and document the finding in the chart.
b.	Instruct the patient to return for a repeat assessment in 1 month.
c.	Tell the patient that a mass was felt, but it is nothing to worry about.

d.	Report the finding, and refer the patient to a specialist for further examination.

ANS: D
A firm or hard mass with an irregular shape or rolled edges may signify carcinoma. Any mass that is discovered should be promptly reported for further examination. The other responses are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 734
MSC: Client Needs: Health Promotion and Maintenance
17. During an assessment of the newborn, the nurse expects to see which finding when the anal area is slightly stroked?

a.	Jerking of the legs
b.	Flexion of the knees
c.	Quick contraction of the sphincter
d.	Relaxation of the external sphincter

ANS: C
To assess sphincter tone, the nurse should check the anal reflex by gently stroking the anal area and noticing a quick contraction of the sphincter. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 729
MSC: Client Needs: Health Promotion and Maintenance
18. A 13-year-old girl is visiting the clinic for a sports physical examination. The nurse should remember to include which of these tests in the examination?

a.	Testing for occult blood
b.	Valsalva maneuver
c.	Internal palpation of the anus
d.	Inspection of the perianal area

ANS: D

The perianal region of the school-aged child and adolescent should be inspected during the examination of the genitalia. Internal palpation is not routinely performed at this age. Testing for occult blood and performing the Valsalva maneuver are also not necessary.

DIF: Cognitive Level: Applying (Application) REF: p. 729
MSC: Client Needs: Health Promotion and Maintenance
19. During an assessment of a 20-year-old man, the nurse finds a small palpable lesion with a tuft of hair located directly over the coccyx. The nurse knows that this lesion would most likely be a:

a.	Rectal polyp.
b.	Pruritus ani.
c.	Carcinoma.
d.	Pilonidal cyst.

ANS: D
A pilonidal cyst or sinus is a hair-containing cyst or sinus located in the midline over the coccyx or lower sacrum. It often opens as a dimple with a visible tuft of hair and, possibly, an erythematous halo. (See Table 25-1 for more information, and also for the description of a pruritus ani. See Table 25-2 for the descriptions of rectal polyps and carcinoma.)

DIF: Cognitive Level: Applying (Application) REF: p. 732
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
20. During an examination, the nurse asks the patient to perform the Valsalva maneuver and notices that the patient has a moist, red, doughnut-shaped protrusion from the anus. The nurse knows that this finding is consistent with a:

a.	Rectal polyp.
b.	Hemorrhoid.
c.	Rectal fissure.
d.	Rectal prolapse.

ANS: D

In rectal prolapse, the rectal mucous membrane protrudes through the anus, appearing as a moist red doughnut with radiating lines. It occurs after a Valsalva maneuver, such as straining at passing stool or with exercising (see Table 25-1). (See Table 25-2 for a description of rectal polyps and Table 25-1 for the descriptions of a rectal fissure and hemorrhoids.)

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 733
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

21. A 70-year-old man is visiting the clinic for difficulty in passing urine. In the health history, he indicates that he has to urinate frequently, especially at night. He has burning when he urinates and has noticed pain in his back. Considering this history, what might the nurse expect to find during the physical assessment?

a.	Asymmetric, hard, and fixed prostate gland
b.	Occult blood and perianal pain to palpation
c.	Symmetrically enlarged, soft prostate gland
d.	Soft nodule protruding from the rectal mucosa

ANS: A
Subjective symptoms of carcinoma of the prostate include frequency, nocturia, hematuria, weak stream, hesitancy, pain or burning on urination, and continuous pain in lower back, pelvis, and thighs. Objective symptoms of carcinoma of the prostate include a malignant neoplasm that often starts as a single hard nodule on the posterior surface, producing asymmetry and a change in consistency. As it invades normal tissue, multiple hard nodules appear, or the entire gland feels stone hard and fixed.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 735
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

22. A 40-year-old black man is in the office for his annual physical examination. Which statement regarding the PSA blood test is *true*, according to the American Cancer Society? The PSA:

a.	Should be performed with this visit.
b.	Should be performed at age 45 years.
c.	Should be performed at age 50 years.

d.	Is only necessary if a family history of prostate cancer exists.

ANS: B
According to the American Cancer Society (2006), the PSA blood test should be performed annually for black men beginning at age 45 years and annually for all other men over age 50 years.

DIF: Cognitive Level: Applying (Application) REF: p. 725
MSC: Client Needs: Health Promotion and Maintenance
23. A 62-year-old man is experiencing fever, chills, malaise, urinary frequency, and urgency. He also reports urethral discharge and a dull aching pain in the perineal and rectal area. These symptoms are most consistent with which condition?

a.	Prostatitis
b.	Polyps
c.	Carcinoma of the prostate
d.	BPH

ANS: A
The common presenting symptoms of prostatitis are fever, chills, malaise, and urinary frequency and urgency. The individual may also have dysuria, urethral discharge, and a dull aching pain in the perineal and rectal area. These symptoms are not consistent with polyps. (See Table 25-3 for the descriptions of carcinoma of the prostate and BPH.)

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 735
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
24. During a discussion for a mens health group, the nurse relates that the group with the highest incidence of prostate cancer is:

a.	Asian Americans.
b.	Blacks.
c.	American Indians.

d.	Hispanics.

ANS: B
According to the American Cancer Society (2010), black men have a higher rate of prostate cancer than other racial groups.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 723
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
25. Which characteristic of the prostate gland would the nurse recognize as an abnormal finding while palpating the prostate gland through the rectum?

a.	Palpable central groove
b.	Tenderness to palpation
c.	Heart shaped
d.	Elastic and rubbery consistency

ANS: B
The normal prostate gland should feel smooth, elastic, and rubbery; slightly movable; heart-shaped with a palpable central groove; and not be tender to palpation.

CHAPTER 16 The Musculoskeletal System
MULTIPLE CHOICE
1. A patient is being assessed for range-of-joint movement. The nurse asks him to move his arm in toward the center of his body. This movement is called:

a.	Flexion.
b.	Abduction.
c.	Adduction.
d.	Extension.

ANS: C
Moving a limb toward the midline of the body is called *adduction*; moving a limb away from the

midline of the body is called *abduction*. *Flexion* is bending a limb at a joint; and *extension* is straightening a limb at a joint.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 578
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
2. A patient tells the nurse that she is having a hard time bringing her hand to her mouth when she eats or tries to brush her teeth. The nurse knows that for her to move her hand to her mouth, she must perform which movement?

a.	Flexion
b.	Abduction
c.	Adduction
d.	Extension

ANS: A
Flexion, or bending a limb at a joint, is required to move the hand to the mouth. *Extension* is straightening a limb at a joint. Moving a limb toward the midline of the body is called *adduction*; *abduction* is moving a limb away from the midline of the body.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 578
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
3. The functional units of the musculoskeletal system are the:

a.	Joints.
b.	Bones.
c.	Muscles.
d.	Tendons.

ANS: A
Joints are the functional units of the musculoskeletal system because they permit the mobility needed to perform the activities of daily living. The skeleton (bones) is the framework of the body. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 577
MSC: Client Needs: General
4. When reviewing the musculoskeletal system, the nurse recalls that hematopoiesis takes place in the:

a.	Liver.
b.	Spleen.
c.	Kidneys.
d.	Bone marrow.

ANS: D
The musculoskeletal system functions to encase and protect the inner vital organs, to support the body, to produce red blood cells in the bone marrow (hematopoiesis), and to store minerals. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 577
MSC: Client Needs: General
5. Fibrous bands running directly from one bone to another that strengthen the joint and help prevent movement in undesirable directions are called:

a.	Bursa.
b.	Tendons.
c.	Cartilage.
d.	Ligaments.

ANS: D
Fibrous bands running directly from one bone to another that strengthen the joint and help prevent movement in undesirable directions are called *ligaments*. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 577
MSC: Client Needs: General
6. The nurse notices that a woman in an exercise class is unable to jump rope. The nurse is aware

that to jump rope, ones shoulder has to be capable of:

a.	Inversion.
b.	Supination.
c.	Protraction.
d.	Circumduction.

ANS: D
Circumduction is defined as moving the arm in a circle around the shoulder. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 578
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
7. The articulation of the mandible and the temporal bone is known as the:

a.	Intervertebral foramen.
b.	Condyle of the mandible.
c.	Temporomandibular joint.
d.	Zygomatic arch of the temporal bone.

ANS: C
The articulation of the mandible and the temporal bone is the temporomandibular joint. The other responses are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 578
MSC: Client Needs: General
8. To palpate the temporomandibular joint, the nurses fingers should be placed in the depression _____ of the ear.

a.	Distal to the helix

b.	Proximal to the helix
c.	Anterior to the tragus
d.	Posterior to the tragus

ANS: C
The temporomandibular joint can be felt in the depression anterior to the tragus of the ear. The other locations are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 578
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
9. Of the 33 vertebrae in the spinal column, there are:

a.	5 lumbar.
b.	5 thoracic.
c.	7 sacral.
d.	12 cervical.

ANS: A
There are 7 cervical, 12 thoracic, 5 lumbar, 5 sacral, and 3 to 4 coccygeal vertebrae in the spinal column.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 579
MSC: Client Needs: General
10. An imaginary line connecting the highest point on each iliac crest would cross the _____ vertebra.

a.	First sacral
b.	Fourth lumbar
c.	Seventh cervical

d.	Twelfth thoracic

ANS: B
An imaginary line connecting the highest point on each iliac crest crosses the fourth lumbar vertebra. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 579
MSC: Client Needs: General
11. The nurse is explaining to a patient that there are *shock absorbers* in his back to cushion the spine and to help it move. The nurse is referring to his:

a.	Vertebral column.
b.	Nucleus pulposus.
c.	Vertebral foramen.
d.	Intervertebral disks.

ANS: D
Intervertebral disks are elastic fibrocartilaginous plates that cushion the spine similar to shock absorbers and help it move. The vertebral column is the spinal column itself. The nucleus pulposus is located in the center of each disk. The vertebral foramen is the channel, or opening, for the spinal cord in the vertebrae.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 580
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
12. The nurse is providing patient education for a man who has been diagnosed with a rotator cuff injury. The nurse knows that a rotator cuff injury involves the:

a.	Nucleus pulposus.
b.	Articular processes.
c.	Medial epicondyle.
d.	Glenohumeral joint.

ANS: D
A rotator cuff injury involves the glenohumeral joint, which is enclosed by a group of four powerful muscles and tendons that support and stabilize it. The nucleus pulposus is located in the center of each intervertebral disk. The articular processes are projections in each vertebral disk that lock onto the next vertebra, thereby stabilizing the spinal column. The medial epicondyle is located at the elbow.

DIF: Cognitive Level: Applying (Application) REF: p. 581
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
13. During an interview the patient states, I can feel this bump on the top of both of my shouldersit doesnt hurt but I am curious about what it might be. The nurse should tell the patient that it is his:

a.	Subacromial bursa.
b.	Acromion process.
c.	Glenohumeral joint.
d.	Greater tubercle of the humerus.

ANS: B
The bump of the scapulas acromion process is felt at the very top of the shoulder. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 581
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
14. The nurse is checking the range of motion in a patients knee and knows that the knee is capable of which movement(s)?

a.	Flexion and extension
b.	Supination and pronation
c.	Circumduction
d.	Inversion and eversion

ANS: A

The knee is a hinge joint, permitting flexion and extension of the lower leg on a single plane. The knee is not capable of the other movements listed.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 583
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
15. A patient is visiting the clinic for an evaluation of a swollen, painful knuckle. The nurse notices that the knuckle above his ring on the left hand is swollen and that he is unable to remove his wedding ring. This joint is called the_____joint.

a.	Interphalangeal
b.	Tarsometatarsal
c.	Metacarpophalangeal
d.	Tibiotalar

ANS: C
The joint located just above the ring on the finger is the metacarpophalangeal joint. The interphalangeal joint is located distal to the metacarpophalangeal joint. The tarsometatarsal and tibiotalar joints are found in the foot and ankle. (See Figure 22-10 for a diagram of the bones and joints of the hand and fingers.)

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 582
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. The nurse is assessing a patients ischial tuberosity. To palpate the ischial tuberosity, the nurse knows that it is best to have the patient:

a.	Standing.
b.	Flexing the hip.
c.	Flexing the knee.
d.	Lying in the supine position.

ANS: B
The ischial tuberosity lies under the gluteus maximus muscle and is palpable when the hip is flexed. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 582
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
17. The nurse is examining the hip area of a patient and palpates a flat depression on the upper, lateral side of the thigh when the patient is standing. The nurse interprets this finding as the:

a.	Ischial tuberosity.
b.	Greater trochanter.
c.	Iliac crest.
d.	Gluteus maximus muscle.

ANS: B
The greater trochanter of the femur is palpated when the person is standing, and it appears as a flat depression on the upper lateral side of the thigh. The iliac crest is the upper part of the hip bone; the ischial tuberosity lies under the gluteus maximus muscle and is palpable when the hip is flexed; and the gluteus muscle is part of the buttocks.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 582
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
18. The ankle joint is the articulation of the tibia, fibula, and:

a.	Talus.
b.	Cuboid.
c.	Calcaneus.
d.	Cuneiform bones.

ANS: A
The ankle or tibiotalar joint is the articulation of the tibia, fibula, and talus. The other bones listed are foot bones and not part of the ankle joint.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 583
MSC: Client Needs: General
19. The nurse is explaining the mechanism of the growth of long bones to a mother of a toddler.

Where does lengthening of the bones occur?

a.	Bursa
b.	Calcaneus
c.	Epiphyses
d.	Tuberosities

ANS: C
Lengthening occurs at the epiphyses, or growth plates. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 584
MSC: Client Needs: Health Promotion and Maintenance
20. A woman who is 8 months pregnant comments that she has noticed a change in her posture and is having lower back pain. The nurse tells her that during pregnancy, women have a posture shift to compensate for the enlarging fetus. This shift in posture is known as:

a.	Lordosis.
b.	Scoliosis.
c.	Ankylosis.
d.	Kyphosis.

ANS: A
Lordosis compensates for the enlarging fetus, which would shift the center of balance forward. This shift in balance, in turn, creates a strain on the low back muscles, felt as low back pain during late pregnancy by some women. Scoliosis is lateral curvature of portions of the spine; ankylosis is extreme flexion of the wrist, as observed with severe rheumatoid arthritis; and kyphosis is an enhanced thoracic curvature of the spine.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 584
MSC: Client Needs: Health Promotion and Maintenance
21. An 85-year-old patient comments during his annual physical examination that he seems to be getting shorter as he ages. The nurse should explain that decreased height occurs with aging because:

a.	Long bones tend to shorten with age.
b.	The vertebral column shortens.
c.	A significant loss of subcutaneous fat occurs.
d.	A thickening of the intervertebral disks develops.

ANS: B
Postural changes are evident with aging; decreased height is most noticeable and is due to shortening of the vertebral column. Long bones do not shorten with age. Intervertebral disks actually get thinner with age. Subcutaneous fat is not lost but is redistributed to the abdomen and hips.

DIF: Cognitive Level: Applying (Application) REF: pp. 584-585
MSC: Client Needs: Health Promotion and Maintenance
22. A patient has been diagnosed with osteoporosis and asks the nurse, What is osteoporosis? The nurse explains that osteoporosis is defined as:

a.	Increased bone matrix.
b.	Loss of bone density.
c.	New, weaker bone growth.
d.	Increased phagocytic activity.

ANS: B
After age 40 years, a loss of bone matrix (resorption) occurs more rapidly than new bone formation. The net effect is a gradual loss of bone density, or osteoporosis. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 584
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
23. The nurse is teaching a class on preventing osteoporosis to a group of perimenopausal women. Which of these actions is the *best* way to prevent or delay bone loss in this group?

a.	Taking calcium and vitamin D supplements
b.	Taking medications to prevent osteoporosis
c.	Performing physical activity, such as fast walking
d.	Assessing bone density annually

ANS: C
Physical activity, such as fast walking, delays or prevents bone loss in perimenopausal women. The faster the pace of walking, the higher the preventive effect is on the risk of hip fracture. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 585
MSC: Client Needs: Health Promotion and Maintenance
24. A teenage girl has arrived complaining of pain in her left wrist. She was playing basketball when she fell and landed on her left hand. The nurse examines her hand and would expect a fracture if the girl complains of a:

a.	Dull ache.
b.	Deep pain in her wrist.
c.	Sharp pain that increases with movement.
d.	Dull throbbing pain that increases with rest.

ANS: C
A fracture causes sharp pain that increases with movement. The other types of pain do not occur with a fracture.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 586
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
25. A patient is complaining of pain in his joints that is worse in the morning, better after he moves around for a while, and then gets worse again if he sits for long periods. The nurse should assess for other signs of what problem?

a.	Tendinitis

b.	Osteoarthritis
c.	Rheumatoid arthritis
d.	Intermittent claudication

ANS: C
Rheumatoid arthritis is worse in the morning when a person arises. Movement increases most joint pain, except the pain with rheumatoid arthritis, which decreases with movement. The other options are not correct.

CHAPTER 17 The Nervous System
MULTIPLE CHOICE
1. The two parts of the nervous system are the:

a.	Motor and sensory.
b.	Central and peripheral.
c.	Peripheral and autonomic.
d.	Hypothalamus and cerebral.

ANS: B
The nervous system can be divided into two partscentral and peripheral. The central nervous system includes the brain and spinal cord. The peripheral nervous system includes the 12 pairs of cranial nerves (CNs), the 31 pairs of spinal nerves, and all of their branches.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 633
MSC: Client Needs: General
2. The wife of a 65-year-old man tells the nurse that she is concerned because she has noticed a change in her husbands personality and ability to understand. He also cries very easily and becomes angry. The nurse recalls that the cerebral lobe responsible for these behaviors is the _____ lobe.

a.	Frontal
b.	Parietal

c.	Occipital
d.	Temporal

ANS: A
The frontal lobe has areas responsible for personality, behavior, emotions, and intellectual function. The parietal lobe has areas responsible for sensation; the occipital lobe is responsible for visual reception; and the temporal lobe is responsible for hearing, taste, and smell.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 633
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
3. Which statement concerning the areas of the brain is *true*?

a.	The cerebellum is the center for speech and emotions.
b.	The hypothalamus controls body temperature and regulates sleep.
c.	The basal ganglia are responsible for controlling voluntary movements.
d.	Motor pathways of the spinal cord and brainstem synapse in the thalamus.

ANS: B
The hypothalamus is a vital area with many important functions: body temperature controller, sleep center, anterior and posterior pituitary gland regulator, and coordinator of autonomic nervous system activity and emotional status. The cerebellum controls motor coordination, equilibrium, and balance. The basal ganglia control autonomic movements of the body. The motor pathways of the spinal cord synapse in various areas of the spinal cord, not in the thalamus.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 634
MSC: Client Needs: General
4. The area of the nervous system that is responsible for mediating reflexes is the:

a.	Medulla.
b.	Cerebellum.
c.	Spinal cord.

d.	Cerebral cortex.

ANS: C
The spinal cord is the main highway for ascending and descending fiber tracts that connect the brain to the spinal nerves; it is responsible for mediating reflexes.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 635
MSC: Client Needs: General
5. While gathering equipment after an injection, a nurse accidentally received a prick from an improperly capped needle. To interpret this sensation, which of these areas must be intact?

a.	Corticospinal tract, medulla, and basal ganglia
b.	Pyramidal tract, hypothalamus, and sensory cortex
c.	Lateral spinothalamic tract, thalamus, and sensory cortex
d.	Anterior spinothalamic tract, basal ganglia, and sensory cortex

ANS: C
The spinothalamic tract contains sensory fibers that transmit the sensations of pain, temperature, and crude or light touch. Fibers carrying pain and temperature sensations ascend the lateral spinothalamic tract, whereas the sensations of crude touch form the anterior spinothalamic tract. At the thalamus, the fibers synapse with another sensory neuron, which carries the message to the sensory cortex for full interpretation. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 635
MSC: Client Needs: General
6. A patient with a lack of oxygen to his heart will have pain in his chest and possibly in the shoulder, arms, or jaw. The nurse knows that the *best* explanation why this occurs is which one of these statements?

a.	A problem exists with the sensory cortex and its ability to discriminate the location.
b.	The lack of oxygen in his heart has resulted in decreased amount of oxygen to the areas experiencing the pain.
c.	The sensory cortex does not have the ability to localize pain in the heart; consequently, the pain is felt elsewhere.

d.	A lesion has developed in the dorsal root, which is preventing the sensation from being transmitted normally.

ANS: C
The sensory cortex is arranged in a specific pattern, forming a corresponding map of the body. Pain in the right hand is perceived at a specific spot on the map. Some organs, such as the heart, liver, and spleen, are absent from the brain map. Pain originating in these organs is referred because no felt image exists in which to have pain. Pain is felt *by proxy*, that is, by another body part that does have a felt image. The other responses are not correct explanations.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 636
MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort
7. The ability that humans have to perform very skilled movements such as writing is controlled by the:

a.	Basal ganglia.
b.	Corticospinal tract.
c.	Spinothalamic tract.
d.	Extrapyramidal tract.

ANS: B
Corticospinal fibers mediate voluntary movement, particularly very skilled, discrete, and purposeful movements, such as writing. The corticospinal tract, also known as the *pyramidal tract*, is a newer, higher motor system that humans have that permits very skilled and purposeful movements. The other responses are not related to skilled movements.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 636
MSC: Client Needs: General
8. A 30-year-old woman tells the nurse that she has been very unsteady and has had difficulty in maintaining her balance. Which area of the brain that is related to these findings would concern the nurse?

a.	Thalamus
b.	Brainstem

c.	Cerebellum
d.	Extrapyramidal tract

ANS: C
The cerebellar system coordinates movement, maintains equilibrium, and helps maintain posture. The thalamus is the primary relay station where sensory pathways of the spinal cord, cerebellum, and brainstem form synapses on their way to the cerebral cortex. The brainstem consists of the midbrain, pons, and medulla and has various functions, especially concerning autonomic centers. The extrapyramidal tract maintains muscle tone for gross automatic movements, such as walking.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 637
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
9. Which of these statements about the peripheral nervous system is *correct*?

a.	The CNs enter the brain through the spinal cord.
b.	Efferent fibers carry sensory input to the central nervous system through the spinal cord.
c.	The peripheral nerves are inside the central nervous system and carry impulses through their motor fibers.
d.	The peripheral nerves carry input to the central nervous system by afferent fibers and away from the central nervous system by efferent fibers.

ANS: D
A nerve is a bundle of fibers outside of the central nervous system. The peripheral nerves carry input to the central nervous system by their sensory afferent fibers and deliver output from the central nervous system by their efferent fibers. The other responses are not related to the peripheral nervous system.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 637
MSC: Client Needs: General
10. A patient has a severed spinal nerve as a result of trauma. Which statement is *true* in this situation?

a.	Because there are 31 pairs of spinal nerves, no effect results if only one nerve is severed.
b.	The dermatome served by this nerve will no longer experience any sensation.

c.	The adjacent spinal nerves will continue to carry sensations for the dermatome served by the severed nerve.
d.	A severed spinal nerve will only affect motor function of the patient because spinal nerves have no sensory component.

ANS: C
A dermatome is a circumscribed skin area that is primarily supplied from one spinal cord segment through a particular spinal nerve. The dermatomes overlap, which is a form of biologic insurance; that is, if one nerve is severed, then most of the sensations can be transmitted by the spinal nerve above and the spinal nerve below the severed nerve.

DIF: Cognitive Level: Applying (Application) REF: p. 639
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
11. A 21-year-old patient has a head injury resulting from trauma and is unconscious. There are no other injuries. During the assessment what would the nurse expect to find when testing the patients deep tendon reflexes?

a.	Reflexes will be normal.
b.	Reflexes cannot be elicited.
c.	All reflexes will be diminished but present.
d.	Some reflexes will be present, depending on the area of injury.

ANS: A
A reflex is a defense mechanism of the nervous system. It operates below the level of conscious control and permits a quick reaction to potentially painful or damaging situations.

DIF: Cognitive Level: Applying (Application) REF: p. 637
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
12. A mother of a 1-month-old infant asks the nurse why it takes so long for infants to learn to roll over. The nurse knows that the reason for this is:

a.	A demyelinating process must be occurring with her infant.
b.	Myelin is needed to conduct the impulses, and the neurons of a newborn are not yet myelinated.
c.	The cerebral cortex is not fully developed; therefore, control over motor function gradually occurs.

d.	The spinal cord is controlling the movement because the cerebellum is not yet fully developed.

ANS: B
The infants sensory and motor development proceeds along with the gradual acquisition of myelin, which is needed to conduct most impulses. Very little cortical control exists, and the neurons are not yet myelinated. The other responses are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 640
MSC: Client Needs: Health Promotion and Maintenance
13. During an assessment of an 80-year-old patient, the nurse notices the following: an inability to identify vibrations at her ankle and to identify the position of her big toe, a slower and more deliberate gait, and a slightly impaired tactile sensation. All other neurologic findings are normal. The nurse should interpret that these findings indicate:

a.	CN dysfunction.
b.	Lesion in the cerebral cortex.
c.	Normal changes attributable to aging.
d.	Demyelination of nerves attributable to a lesion.

ANS: C
Some aging adults show a slower response to requests, especially for those calling for coordination of movements. The findings listed are normal in the absence of other significant abnormal findings. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 640
MSC: Client Needs: Health Promotion and Maintenance
14. A 70-year-old woman tells the nurse that every time she gets up in the morning or after shes been sitting, she gets really dizzy and feels like she is going to fall over. The nurses best response would be:

a.	Have you been extremely tired lately?
b.	You probably just need to drink more liquids.
c.	Ill refer you for a complete neurologic examination.

d.	You need to get up slowly when youve been lying down or sitting.

ANS: D
Aging is accompanied by a progressive decrease in cerebral blood flow. In some people, this decrease causes dizziness and a loss of balance with a position change. These individuals need to be taught to get up slowly. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 640
MSC: Client Needs: Health Promotion and Maintenance
15. During the taking of the health history, a patient tells the nurse that it feels like the room is spinning around me. The nurse would document this finding as:

a.	Vertigo.
b.	Syncope.
c.	Dizziness.
d.	Seizure activity.

ANS: A
True vertigo is rotational spinning caused by a neurologic dysfunction or a problem in the vestibular apparatus or the vestibular nuclei in the brainstem. Syncope is a sudden loss of strength or a temporary loss of consciousness. Dizziness is a lightheaded, swimming sensation. Seizure activity is characterized by altered or loss of consciousness, involuntary muscle movements, and sensory disturbances.

DIF: Cognitive Level: Applying (Application) REF: p. 641
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. When taking the health history on a patient with a seizure disorder, the nurse assesses whether the patient has an aura. Which of these would be the best question for obtaining this information?

a.	Does your muscle tone seem tense or limp?
b.	After the seizure, do you spend a lot of time sleeping?
c.	Do you have any warning sign before your seizure starts?

d.	Do you experience any color change or incontinence during the seizure?

ANS: C
Aura is a subjective sensation that precedes a seizure; it could be auditory, visual, or motor. The other questions do not solicit information about an aura.

DIF: Cognitive Level: Applying (Application) REF: p. 641
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
17. While obtaining a health history of a 3-month-old infant from the mother, the nurse asks about the infants ability to suck and grasp the mothers finger. What is the nurse assessing?

a.	Reflexes
b.	Intelligence
c.	CNs
d.	Cerebral cortex function

ANS: A
Questions regarding reflexes include such questions as, What have you noticed about the infants behavior, Are the infants sucking and swallowing seem coordinated, and Does the infant grasp your finger? The other responses are incorrect.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 642
MSC: Client Needs: Health Promotion and Maintenance
18. In obtaining a health history on a 74-year-old patient, the nurse notes that he drinks alcohol daily and that he has noticed a tremor in his hands that affects his ability to hold things. With this information, what response should the nurse make?

a.	Does your family know you are drinking every day?
b.	Does the tremor change when you drink alcohol?
c.	Well do some tests to see what is causing the tremor.
d.	You really shouldnt drink so much alcohol; it may be causing your tremor.

ANS: B
Senile tremor is relieved by alcohol, although not a recommended treatment. The nurse should assess whether the person is abusing alcohol in an effort to relieve the tremor.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 643
MSC: Client Needs: Health Promotion and Maintenance
19. A 50-year-old woman is in the clinic for weakness in her left arm and leg that she has noticed for the past week. The nurse should perform which type of neurologic examination?

a.	Glasgow Coma Scale
b.	Neurologic recheck examination
c.	Screening neurologic examination
d.	Complete neurologic examination

ANS: D
The nurse should perform a complete neurologic examination on an individual who has neurologic concerns (e.g., headache, weakness, loss of coordination) or who is showing signs of neurologic dysfunction. The Glasgow Coma Scale is used to define a persons level of consciousness. The neurologic recheck examination is appropriate for those who are demonstrating neurologic deficits. The screening neurologic examination is performed on seemingly well individuals who have no significant subjective findings from the health history.

DIF: Cognitive Level: Applying (Application) REF: p. 644
MSC: Client Needs: Health Promotion and Maintenance
20. During an assessment of the CNs, the nurse finds the following: asymmetry when the patient smiles or frowns, uneven lifting of the eyebrows, sagging of the lower eyelids, and escape of air when the nurse presses against the right puffed cheek. This would indicate dysfunction of which of these CNs?

a.	Motor component of CN IV
b.	Motor component of CN VII
c.	Motor and sensory components of CN XI
d.	Motor component of CN X and sensory component of CN VII

ANS: B
The findings listed reflect a dysfunction of the motor component of the facial nerve (CN VII).

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 646
MSC: Client Needs: Health Promotion and Maintenance
21. The nurse is testing the function of CN XI. Which statement *best* describes the response the nurse should expect if this nerve is intact? The patient:

a.	Demonstrates the ability to hear normal conversation.
b.	Sticks out the tongue midline without tremors or deviation.
c.	Follows an object with his or her eyes without nystagmus or strabismus.
d.	Moves the head and shoulders against resistance with equal strength.

ANS: D
The following normal findings are expected when testing the spinal accessory nerve (CN XI): The patients sternomastoid and trapezius muscles are equal in size; the person can forcibly rotate the head both ways against resistance applied to the side of the chin with equal strength; and the patient can shrug the shoulders against resistance with equal strength on both sides. Checking the patients ability to hear normal conversation checks the function of CN VIII. Having the patient stick out the tongue checks the function of CN XII. Testing the eyes for nystagmus or strabismus is performed to check CNs III, IV, and VI.

DIF: Cognitive Level: Applying (Application) REF: p. 646
MSC: Client Needs: Health Promotion and Maintenance
22. During the neurologic assessment of a healthy 35-year-old patient, the nurse asks him to relax his muscles completely. The nurse then moves each extremity through full range of motion. Which of these results would the nurse expect to find?

a.	Firm, rigid resistance to movement
b.	Mild, even resistance to movement
c.	Hypotonic muscles as a result of total relaxation
d.	Slight pain with some directions of movement

ANS: B
Tone is the normal degree of tension (contraction) in voluntarily relaxed muscles. It shows a mild resistance to passive stretching. Normally, the nurse will notice a mild, even resistance to movement. The other responses are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 647
MSC: Client Needs: Health Promotion and Maintenance
23. When the nurse asks a 68-year-old patient to stand with his feet together and arms at his side with his eyes closed, he starts to sway and moves his feet farther apart. The nurse would document this finding as:

a.	Ataxia.
b.	Lack of coordination.
c.	Negative Homans sign.
d.	Positive Romberg sign.

ANS: D
Abnormal findings for the Romberg test include swaying, falling, and a widening base of the feet to avoid falling. A positive Romberg sign is a loss of balance that is increased by the closing of the eyes. Ataxia is an uncoordinated or unsteady gait. Homans sign is used to test the legs for deep-vein thrombosis.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 650
MSC: Client Needs: Health Promotion and Maintenance
24. The nurse is performing an assessment on a 29-year-old woman who visits the clinic complaining of always dropping things and falling down. While testing rapid alternating movements, the nurse notices that the woman is unable to pat both of her knees. Her response is extremely slow and she frequently misses. What should the nurse suspect?

a.	Vestibular disease
b.	Lesion of CN IX
c.	Dysfunction of the cerebellum

d.	Inability to understand directions

ANS: C
When a person tries to perform rapid, alternating movements, responses that are slow, clumsy, and sloppy are indicative of cerebellar disease. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 648
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
25. During the taking of the health history of a 78-year-old man, his wife states that he occasionally has problems with short-term memory loss and confusion: He cant even remember how to button his shirt. When assessing his sensory system, which action by the nurse is *most* appropriate?

a.	The nurse would not test the sensory system as part of the examination because the results would not be valid.
b.	The nurse would perform the tests, knowing that mental status does not affect sensory ability.
c.	The nurse would proceed with an explanation of each test, making certain that the wife understands.
d.	Before testing, the nurse would assess the patients mental status and ability to follow directions.

ANS: D
The nurse should ensure the validity of the sensory system testing by making certain that the patient is alert, cooperative, comfortable, and has an adequate attention span. Otherwise, the nurse may obtain misleading and invalid results.

CHAPTER 18 Assessing Children: Infancy Through Adolescence
MULTIPLE CHOICE
1. A 5-year-old child is in the clinic for a checkup. The nurse would expect him to:

a.	Need to be held on his mothers lap.
b.	Be able to sit on the examination table.
c.	Be able to stand on the floor for the examination.
d.	Be able to remain alone in the examination room.

ANS: B
At 4 or 5 years old, a child usually feels comfortable on the examination table. Older infants and young children aged 6 months to 2 or 3 years should be positioned in the parents lap.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 794
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
2. Which statement is *true* regarding the recording of data from the history and physical examination?

a.	Use long, descriptive sentences to document findings.
b.	Record the data as soon as possible after the interview and physical examination.
c.	If the information is not documented, then it can be assumed that it was done as a standard of care.
d.	The examiner should avoid taking any notes during the history and examination because of the possibility of decreasing the rapport with the patient.

ANS: B
The data from the history and physical examination should be recorded as soon after the event as possible. From a legal perspective, if it is not documented, then it was not done. Brief notes should be taken during the examination. When documenting, the nurse should use short, clear phrases and avoid redundant phrases and descriptions.

DIF: Cognitive Level: Applying (Application) REF: p. 784
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. When assessing the neonate, the nurse should test for hip stability with which method?

a.	Eliciting the Moro reflex
b.	Performing the Romberg test
c.	Checking for the Ortolani sign
d.	Assessing the stepping reflex

ANS: C
The nurse should test for hip stability in the neonate by testing for the Ortolani sign. The other tests are not appropriate for testing hip stability.

DIF: Cognitive Level: Applying (Application) REF: p. 791
MSC: Client Needs: Health Promotion and Maintenance
4. A female patient tells the nurse that she has four children and has had three pregnancies. How should the nurse document this?

a.	Gravida 3, para 4
b.	Gravida 4, para 3
c.	This information cannot be documented using the terms *gravida* and *para*.
d.	The patient seems to be confused about how many times she has been pregnant.

ANS: A
Gravida refers to the number of pregnancies, and *para* refers to the number of children. One pregnancy was with twins.

DIF: Cognitive Level: Applying (Application) REF: p. 807
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
5. The nurse is documenting the assessment of an infant. During the abdominal assessment, the nurse noticed a very loud splash auscultated over the upper abdomen when the nurse rocked her from side to side. This finding would indicate:

a.	Epigastric hernia.
b.	Pyloric obstruction.
c.	Hypoactive bowel sounds.
d.	Hyperactive bowel sounds.

ANS: D
A succussion splash, which is unrelated to peristalsis, is a very loud splash auscultated over the upper abdomen when the infant is rocked side to side. It indicates increased air and fluid in the stomach as observed with pyloric obstruction or large hiatus hernia (see Chapter 21).

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 572
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
6. Which of these actions is most appropriate to perform on a 9-month-old infant at a well-child

checkup?

a.	Testing for Ortolani sign
b.	Assessment for stereognosis
c.	Blood pressure measurement
d.	Assessment for the presence of the startle reflex

ANS: A
Until the age of 12 months, the infant should be assessed for Ortolani sign. If Ortolani sign is present, then it could indicate the presence of a dislocated hip. The other tests are not appropriate for a 9-month-old child.

CHAPTER 19 The Pregnant Woman
MULTIPLE CHOICE
1. Which of these statements *best* describes the action of the hormone progesterone during pregnancy?

a.	Progesterone produces the hormone human chorionic gonadotropin.
b.	Duct formation in the breast is stimulated by progesterone.
c.	Progesterone promotes sloughing of the endometrial wall.
d.	Progesterone maintains the endometrium around the fetus.

ANS: D
Progesterone prevents the sloughing of the endometrial wall and maintains the endometrium around the fetus. Progesterone increases the alveoli in the breast and keeps the uterus in a quiescent state. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 807
MSC: Client Needs: General
2. A female patient has nausea, breast tenderness, fatigue, and amenorrhea. Her last menstrual period was 6 weeks ago. The nurse interprets that this patient is experiencing_____signs of pregnancy.

a.	Positive
b.	Possible
c.	Probable
d.	Presumptive

ANS: D
Presumptive signs of pregnancy are those that the woman experiences and include amenorrhea, breast tenderness, fatigue, nausea, and increased urinary frequency. Probable signs are those that are detected by the examiner, such as an enlarged uterus or changes in the cervix. Positive signs of pregnancy are those that document direct evidence of the fetus such as fetal heart tones or positive cardiac activity on ultrasound.

DIF: Cognitive Level: Applying (Application) REF: p. 807
MSC: Client Needs: Health Promotion and Maintenance
3. A woman who is 8 weeks pregnant is visiting the clinic for a checkup. Her systolic blood pressure is 30 mm Hg higher than her prepregnancy systolic blood pressure. The nurse should:

a.	Consider this a normal finding.
b.	Expect the blood pressure to decrease as the estrogen levels increase throughout the pregnancy.
c.	Consider this an abnormal finding because blood pressure is typically lower at this point in the pregnancy.
d.	Recommend that she decrease her salt intake in an attempt to decrease her peripheral vascular resistance.

ANS: C
During the seventh gestational week, blood pressure begins to drop as a result of falling peripheral vascular resistance. Early in the first trimester, blood pressure values are similar to those of prepregnancy measurements. In this case, the womans blood pressure is higher than it should be.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 808
MSC: Client Needs: Health Promotion and Maintenance
4. A patient is being seen at the clinic for her 10-week prenatal visit. She asks when she will be able to hear the babys heartbeat. The nurse should reply:

a.	The babys heartbeat is not usually heard until the second trimester.
b.	The babys heartbeat may be heard anywhere from the ninth to the twelfth week.
c.	It is often difficult to hear the heartbeat at this point, but we can try.
d.	It is normal to hear the heartbeat at 6 weeks. We may be able to hear it today.

ANS: B
Fetal heart tones can be heard with the use of the Doppler device between 9 and 12 weeks. The other responses are incorrect.

DIF: Cognitive Level: Applying (Application) REF: p. 821
MSC: Client Needs: Health Promotion and Maintenance
5. A patient who is in her first trimester of pregnancy tells the nurse that she is experiencing significant nausea and vomiting and asks when it will improve. The nurse should reply:

a.	Did your mother have significant nausea and vomiting?
b.	Many women experience nausea and vomiting until the third trimester.
c.	Usually, by the beginning of the second trimester, the nausea and vomiting improve.
d.	At approximately the time you begin to feel the baby move, the nausea and vomiting will subside.

ANS: C
The nausea, vomiting, and fatigue of pregnancy improve by the 12th week. Quickening, when the mother recognizes fetal movement, occurs at approximately 18 to 20 weeks.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 808
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
6. During the examination of a woman in her second trimester of pregnancy, the nurse notices the presence of a small amount of yellow drainage from the nipples. The nurse knows that this is:

a.	An indication that the womans milk is coming in.
b.	A sign of possible breast cancer in a pregnant woman.

c.	Most likely colostrum and considered a normal finding at this stage of the pregnancy.
d.	Too early in the pregnancy for lactation to begin and refers the woman to a specialist.

ANS: C
During the second trimester, colostrum, the precursor of milk, may be expressed from the nipples. Colostrum is yellow and contains more minerals and protein but less sugar and fat than mature milk. The other options are incorrect.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 808
MSC: Client Needs: Health Promotion and Maintenance
7. A woman in her second trimester of pregnancy complains of heartburn and indigestion. When discussing this with the woman, the nurse considers which explanation for these problems?

a.	Tone and motility of the gastrointestinal tract increase during the second trimester.
b.	Sluggish emptying of the gallbladder, resulting from the effects of progesterone, often causes heartburn.
c.	Lower blood pressure at this time decreases blood flow to the stomach and gastrointestinal tract.
d.	Enlarging uterus and altered esophageal sphincter tone predispose the woman to have heartburn.

ANS: D
Stomach displacement from the enlarging uterus plus altered esophageal sphincter and gastric tone as a result of progesterone predispose the woman to heartburn. The tone and motility of the gastrointestinal tract are decreased, not increased, during pregnancy. Emptying of the gallbladder may become more sluggish during pregnancy but is not related to indigestion. Rather, some women are predisposed to gallstone formation. A lower blood pressure may occur during the second semester, but it does not affect digestion.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 808
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
8. A patient who is 20 weeks pregnant tells the nurse that she feels more shortness of breath as her pregnancy progresses. The nurse recognizes which statement to be *true*?

a.	High levels of estrogen cause shortness of breath.
b.	Feelings of shortness of breath are abnormal during pregnancy.

c.	Hormones of pregnancy cause an increased respiratory effort.
d.	The patient should get more exercise in an attempt to increase her respiratory reserve.

ANS: C
Progesterone and estrogen cause an increase in respiratory effort during pregnancy by increasing tidal volume. Increased tidal volume causes a slight drop in partial pressure of arterial carbon dioxide (PaCO2), causing the woman to have dyspnea occasionally. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 809
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
9. The nurse auscultates a functional systolic murmur, grade II/IV, on a woman in week 30 of her pregnancy. The remainder of her physical assessment is within normal limits. The nurse would:

a.	Consider this finding abnormal, and refer her for additional consultation.
b.	Ask the woman to run briefly in place and then assess for an increase in intensity of the murmur.
c.	Know that this finding is normal and is a result of the increase in blood volume during pregnancy.
d.	Ask the woman to restrict her activities and return to the clinic in 1 week for re-evaluation.

ANS: C
Because of the increase in blood volume, a functional systolic murmur, grade II/IV or less, can be heard in 95% of pregnant women. The other actions are not appropriate.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 809
MSC: Client Needs: Health Promotion and Maintenance
10. A woman who is 28 weeks pregnant has bilateral edema in her lower legs after working 8 hours a day as a cashier at a local grocery store. She is worried about her legs. What is the nurses best response?

a.	You will be at risk for development of varicose veins when your legs are edematous.
b.	I would like to listen to your heart sounds. Edema can indicate a problem with your heart.
c.	Edema is usually the result of too much salt and fluids in your diet. You may need to cut down on salty foods.

d.	As your baby grows, it slows blood return from your legs, causing the swelling. This often occurs with prolonged standing.

ANS: D
Edema of the lower extremities occurs because of the enlarging fetus, which impairs venous return. Prolonged standing worsens the edema. Typically, the bilateral, dependent edema experienced with pregnancy is not the result of a cardiac pathologic condition.

DIF: Cognitive Level: Applying (Application) REF: p. 809
MSC: Client Needs: Health Promotion and Maintenance
11. When assessing a woman who is in her third trimester of pregnancy, the nurse looks for the classic symptoms associated with preeclampsia, which include:

a.	Edema, headaches, and seizures.
b.	Elevated blood pressure and proteinuria.
c.	Elevated liver enzymes and high platelet counts.
d.	Decreased blood pressure and edema.

ANS: B
The classic symptoms of preeclampsia are hypertension and proteinuria. Headaches may occur with worsening symptoms, and seizures may occur if preeclampsia is left untreated and leads to eclampsia. A serious variant of preeclampsia, the hemolysis, elevated liver enzymes, low platelet count (HELLP) syndrome, is an ominous picture. Edema is a common occurrence in pregnancy.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 817
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
12. The nurse knows that the best time to assess a womans blood pressure during an initial prenatal visit is:

a.	At the end of the examination when she will be the most relaxed.
b.	At the beginning of the interview as a nonthreatening method of gaining rapport.
c.	During the middle of the physical examination when she is the most comfortable.
d.	Before beginning the pelvic examination because her blood pressure will be higher after the pelvic examination.

ANS: A
Assessing the womans blood pressure at the end of the examination, when it is hoped that she will be most relaxed, is the best time to assess blood pressure. The other options are not correct.

DIF: Cognitive Level: Applying (Application) REF: p. 823
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
13. When examining the face of a woman who is 28 weeks pregnant, the nurse notices the presence of a butterfly-shaped increase in pigmentation on the face. The proper term for this finding in the documentation is:

a.	Striae.
b.	Chloasma.
c.	Linea nigra.
d.	Mask of pregnancy.

ANS: B
Chloasma is a butterfly-shaped increase in pigmentation on the face. It is known as the mask of pregnancy, but when documenting, the nurse should use the correct medical term, *chloasma*. *Striae* is the term for stretch marks. The *linea nigra* is a hyperpigmented line that begins at the sternal notch and extends down the abdomen through the umbilicus to the pubis.

DIF: Cognitive Level: Applying (Application) REF: p. 815
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
14. Which finding is considered normal and expected when the nurse is performing a physical examination on a pregnant woman?

a.	Palpable, full thyroid
b.	Edema in one lower leg
c.	Significant diffuse enlargement of the thyroid
d.	Pale mucous membranes of the mouth

ANS: A

The thyroid may be palpable during pregnancy. It should feel full, but smooth. Significant diffuse enlargement occurs with hyperthyroidism, thyroiditis, and hypothyroidism. Pale mucous membranes may indicate anemia. Bilateral lower extremity edema is common in pregnancy, but edema with pain in only one leg occurs with deep vein thrombosis.

DIF: Cognitive Level: Applying (Application) REF: p. 816
MSC: Client Needs: Health Promotion and Maintenance

15. When auscultating the anterior thorax of a pregnant woman, the nurse notices the presence of a murmur over the second, third, and fourth intercostal spaces. The murmur is continuous but can be obliterated by pressure with the stethoscope or finger on the thorax just lateral to the murmur. The nurse interprets this finding to be:

a.	Murmur of aortic stenosis.
b.	Most likely a mammary souffle.
c.	Associated with aortic insufficiency.
d.	Indication of a patent ductus arteriosus.

ANS: B
Blood flow through the blood vessels, specifically the internal mammary artery, can often be heard over the second, third, and fourth intercostal spaces. This finding is called a *mammary souffle*, but it may be mistaken for a cardiac murmur. The other options are incorrect.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 816
MSC: Client Needs: Health Promotion and Maintenance

16. When the nurse is assessing the deep tendon reflexes (DTRs) on a woman who is 32 weeks pregnant, which of these would be considered a normal finding on a 0 to 4+ scale?

a.	Absent DTRs
b.	2+
c.	4+
d.	Brisk reflexes and the presence of clonus

ANS: B

Normally during pregnancy, the DTRs are 1+ to 2+ and bilaterally equal. Brisk or greater than 2+ DTRs and the presence of clonus are abnormal and may be associated with an elevated blood pressure and cerebral edema in the preeclamptic woman.

DIF: Cognitive Level: Applying (Application) REF: p. 817
MSC: Client Needs: Health Promotion and Maintenance
17. When performing an examination of a woman who is 34 weeks pregnant, the nurse notices a midline linear protrusion in the abdomen over the area of the rectus abdominis muscles as the woman raises her head and shoulders off of the bed. Which response by the nurse is *correct*?

a.	The presence of diastasis recti should be documented.
b.	This condition should be discussed with the physician because it will most likely need to be surgically repaired.
c.	The possibility that the woman has a hernia attributable to the increased pressure within the abdomen from the pregnancy should be suspected.
d.	The woman should be told that she may have a difficult time with delivery because of the weakness in her abdominal muscles.

ANS: A
The separation of the abdominal muscles is called *diastasis recti* and frequently occurs during pregnancy. The rectus abdominis muscles will return together after pregnancy with abdominal exercise. This condition is not a true hernia.

DIF: Cognitive Level: Applying (Application) REF: p. 817
MSC: Client Needs: Health Promotion and Maintenance
18. The nurse is palpating the fundus of a pregnant woman. Which statement about palpation of the fundus is *true*?

a.	The fundus should be hard and slightly tender to palpation during the first trimester.
b.	Fetal movement may not be felt by the examiner until the end of the second trimester.
c.	After 20 weeks gestation, the number of centimeters should approximate the number of weeks gestation.
d.	Fundal height is usually less than the number of weeks gestation, unless an abnormal condition such as excessive amniotic fluid is present.

ANS: C
After 20 weeks gestation, the number of centimeters should approximate the number of weeks gestation. In addition, at 20 weeks gestation, the examiner may be able to feel fetal movement

and the head can be balloted.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 818
MSC: Client Needs: Health Promotion and Maintenance
19. The nurse is palpating the abdomen of a woman who is 35 weeks pregnant and notices that the fetal head is facing downward toward the pelvis. The nurse would document this as fetal:

a.	Lie.
b.	Variety.
c.	Attitude.
d.	Presentation.

ANS: D
Fetal presentation describes the part of the fetus that is entering the pelvis first. *Fetal lie* is orientation of the fetal spine to the maternal spine. *Fetal attitude* is the position of fetal parts in relation to each other, and *fetal variety* is the location of the fetal back to the maternal pelvis.

DIF: Cognitive Level: Applying (Application) REF: p. 818
MSC: Client Needs: Health Promotion and Maintenance
20. The nurse is palpating the uterus of a woman who is 8 weeks pregnant. Which finding would be considered to be most consistent with this stage of pregnancy?

a.	The uterus seems slightly enlarged and softened.
b.	It reaches the pelvic brim and is approximately the size of a grapefruit.
c.	The uterus rises above the pelvic brim and is approximately the size of a cantaloupe.
d.	It is about the size of an avocado, approximately 8 cm across the fundus.

ANS: D
The 8-week pregnant uterus is approximately the size of an avocado, 7 to 8 cm across the fundus. The 6-week pregnant uterus is slightly enlarged and softened. The 10-week pregnant uterus is approximately the size of a grapefruit and may reach the pelvic brim. The 12-week pregnant uterus will fill the pelvis. At 12 weeks, the uterus is sized from the abdomen.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 822
MSC: Client Needs: Health Promotion and Maintenance
21. Which of these correctly describes the average length of pregnancy?

a.	38 weeks
b.	9 lunar months
c.	280 days from the last day of the last menstrual period
d.	280 days from the first day of the last menstrual period

ANS: D
The average length of pregnancy is 280 days from the first day of the last menstrual period, which is equal to 40 weeks, 10 lunar months, or roughly 9 calendar months.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 807
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
22. A patients pregnancy test is positive, and she wants to know when the baby is due. The first day of her last menstrual period was June 14, and that period ended June 20. Using the Ngele rule, what is her expected date of delivery?

a.	March 7
b.	March 14
c.	March 21
d.	March 27

ANS: C
To determine the expected date of delivery using the Ngele rule, 7 days are added to the first day of the last menstrual period; then 3 months are subtracted. Therefore, adding 7 days to June 14 would be June 21 and subtracting 3 months would make the expected delivery date March 21.

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 809-810
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
23. During the assessment of a woman in her 22nd week of pregnancy, the nurse is unable to hear fetal heart tones with the fetoscope. The nurse should:

a.	Immediately notify the physician, then wait 10 minutes and try again.
b.	Ask the woman if she has felt the baby move today.
c.	Wait 10 minutes, and try again.
d.	Use ultrasound to verify cardiac activity.

ANS: D
If no fetal heart tones are heard during auscultation with a fetoscope, then the nurse should verify cardiac activity using ultrasonography. An ultrasound should be immediately done and before notifying the physician or causing the woman distress by asking about fetal movement.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 821
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
24. A patient who is 24 weeks pregnant asks about wearing a seat belt while driving. Which response by the nurse is correct?

a.	Seat belts should not be worn during pregnancy.
b.	Place the lap belt below the uterus and use the shoulder strap at the same time.
c.	Place the lap belt below the uterus but omit the shoulder strap during pregnancy.
d.	Place the lap belt at your waist above the uterus and use the shoulder strap at the same time.

ANS: B
For maternal and fetal safety, the nurse should instruct the woman to place the lap belt below the uterus and to use the shoulder strap. The other instructions are incorrect.

DIF: Cognitive Level: Applying (Application) REF: p. 814
MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential
25. During a health history interview, a 38-year-old woman shares that she is thinking about having another baby. The nurse knows which statement to be *true* regarding pregnancy after 35 years of age?

a.	Fertility does not start to decline until age 40 years.

b.	Occurrence of Down syndrome is significantly more frequent after the age of 35 years.
c.	Genetic counseling and prenatal screening are not routine until after age 40 years.
d.	Women older than 35 years who are pregnant have the same rate of pregnancy-related complications as those who are younger than 35 years.

ANS: B
The risk of Down syndrome increases as the woman ages, from approximately 1 in 1250 at age 25 years to 1 in 400 at age 35 years. Fertility declines with advancing maternal age. Women 35 years and older or with a history of a genetic abnormality are offered genetic counseling and the options of prenatal diagnostic screening tests. Because the incidence of chronic diseases increases with age, women older than 35 years who are pregnant more often have medical complications such as diabetes, obesity, and hypertension.

CHAPTER 20 The Older Adult
MULTIPLE CHOICE
1. The nurse is assessing an older adults functional ability. Which definition correctly describes ones functional ability? Functional ability:

a.	Is the measure of the expected changes of aging that one is experiencing.
b.	Refers to the individuals motivation to live independently.
c.	Refers to the level of cognition present in an older person.
d.	Refers to ones ability to perform activities necessary to live in modern society.

ANS: D
Functional ability refers to ones ability to perform activities necessary to live in modern society and can include driving, using the telephone, or performing personal tasks such as bathing and toileting.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 832
MSC: Client Needs: Health Promotion and Maintenance
2. The nurse is preparing to perform a functional assessment of an older patient and knows that a good approach would be to:

a.	Observe the patients ability to perform the tasks.

b.	Ask the patients wife how he does when performing tasks.
c.	Review the medical record for information on the patients abilities.
d.	Ask the patients physician for information on the patients abilities.

ANS: A
Two approaches are used to perform a functional assessment: (1) asking individuals about their ability to perform the tasks (self-reports), or (2) actually observing their ability to perform the tasks. For persons with memory problems, the use of surrogate reporters (proxy reports), such as family members or caregivers, may be necessary, keeping in mind that they may either overestimate or underestimate the persons actual abilities.

DIF: Cognitive Level: Applying (Application) REF: p. 832
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
3. The nurse needs to assess a patients ability to perform activities of daily living (ADLs) and should choose which tool for this assessment?

a.	Direct Assessment of Functional Abilities (DAFA)
b.	Lawton Instrumental Activities of Daily Living (IADL) scale
c.	Barthel Index
d.	Older Americans Resources and Services Multidimensional Functional Assessment QuestionnaireIADL (OMFAQ-IADL)

ANS: C
The Barthel Index is used to assess ADLs. The other options are used to measure IADLs.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 832
MSC: Client Needs: Health Promotion and Maintenance
4. The nurse is preparing to use the Lawton IADL instrument as part of an assessment. Which statement about the Lawton IADL instrument is *true*?

a.	The nurse uses direct observation to implement this tool.
b.	The Lawton IADL instrument is designed as a self-report measure of performance rather than ability.

c.	This instrument is not useful in the acute hospital setting.
d.	This tool is best used for those residing in an institutional setting.

ANS: B
The Lawton IADL instrument is designed as a self-report measure of performance rather than ability. Direct testing is often not feasible, such as demonstrating the ability to prepare food while a hospital inpatient. Attention to the final score is less important than identifying a persons strengths and areas where assistance is needed. The instrument is useful in acute hospital settings for discharge planning and continuously in outpatient settings. It would not be useful for those residing in institutional settings because many of these tasks are already being managed for the resident.

DIF: Cognitive Level: Applying (Application) REF: pp. 833-834
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
5. The nurse is assessing an older adults advanced activities of daily living (AADLs), which would include:

a.	Recreational activities.
b.	Meal preparation.
c.	Balancing the checkbook.
d.	Self-grooming activities.

ANS: A
AADLs are activities that an older adult performs such as occupational and recreational activities. Self-grooming activities are basic ADLs; meal preparation and balancing the checkbook are considered IADLs.

DIF: Cognitive Level: Applying (Application) REF: p. 835
MSC: Client Needs: Health Promotion and Maintenance
6. When using the various instruments to assess an older persons ADLs, the nurse needs to remember that a disadvantage of these instruments includes:

a.	Reliability of the tools.

b.	Self or proxy reporting of functional activities.
c.	Lack of confidentiality during the assessment.
d.	Insufficient details concerning the deficiencies identified.

ANS: B
A disadvantage of many of the ADL and IADL instruments is the self or proxy reporting of functional activities. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 835
MSC: Client Needs: Health Promotion and Maintenance
7. A patient will be ready to be discharged from the hospital soon, and the patients family members are concerned about whether the patient is able to walk safely outside alone. The nurse will perform which test to assess this?

a.	Get Up and Go Test
b.	Performance ADLs
c.	Physical Performance Test
d.	Tinetti Gait and Balance Evaluation

ANS: A
The Get Up and Go Test is a reliable and valid test to quantify functional mobility. The test is quick, requires little training and no special equipment, and is appropriate to use in many settings including hospitals and clinics. This instrument has been shown to predict a persons ability to go safely outside alone. The Performance of ADLs test has a trained observer actually observing as a patient performs various ADLs. The Physical Performance Test assesses upper body fine motor and coarse motor activities, as well as balance, mobility, coordination, and endurance. The Tinetti Gait and Balance Evaluation assesses gait and balance and provides information about fall risk.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 835
MSC: Client Needs: Health Promotion and Maintenance
8. The nurse is assessing the forms of support an older patient has before she is discharged. Which of these examples is an informal source of support?

a.	Local senior center
b.	Patients Medicare check
c.	Meals on Wheels meal delivery service
d.	Patients neighbor, who visits with her daily

ANS: D
Informal support includes family and close, long-time friends and is usually provided free of charge. Formal supports include programs such as social welfare and other social service and health care delivery agencies such as home health care.

DIF: Cognitive Level: Applying (Application) REF: p. 838
MSC: Client Needs: Psychosocial Integrity
9. An 85-year-old man has been hospitalized after a fall at home, and his 86-year-old wife is at his bedside. She tells the nurse that she is his primary caregiver. The nurse should assess the caregiver for signs of possible caregiver burnout, such as:

a.	Depression.
b.	Weight gain.
c.	Hypertension.
d.	Social phobias.

ANS: A
Caregiver burden is the perceived strain by the person who cares for an older adult or for a person who is chronically ill or disabled. Caregiver burnout is linked to the caregivers ability to cope and handle stress. Signs of possible caregiver burnout include multiple somatic complaints, increased stress and anxiety, social isolation, depression, and weight loss. Screening caregivers for depression may also be appropriate.

DIF: Cognitive Level: Applying (Application) REF: p. 838
MSC: Client Needs: Psychosocial Integrity
10. During a morning assessment, the nurse notices that an older patient is less attentive and is unable to recall yesterdays events. Which test is appropriate for assessing the patients mental status?

a.	Geriatric Depression Scale, short form
b.	Rapid Disability Rating Scale-2
c.	Mini-Cog
d.	Get Up and Go Test

ANS: C
For nurses in various settings, cognitive assessments provide continuing comparisons to the individuals baseline to detect any acute changes in mental status. The Mini-Cog is a mental status test that tests immediate and delayed recall and visuospatial abilities. The Geriatric Depression Scale, short form, assesses for depression and changes in the level of depression, not mental status. The Rapid Disability Rating Scale-2 measures what the person can *actually do* versus what he or she could do, but not mental status. The Get Up and Go Test assesses functional mobility, not mental status.

DIF: Cognitive Level: Applying (Application) REF: p. 837
MSC: Client Needs: Psychosocial Integrity
11. An older patient has been admitted to the intensive care unit (ICU) after falling at home. Within 8 hours, his condition has stabilized and he is transferred to a medical unit. The family is wondering whether he will be able to go back home. Which assessment instrument is most appropriate for the nurse to choose at this time?

a.	Lawton IADL instrument
b.	Hospital Admission Risk Profile (HARP)
c.	Mini-Cog
d.	NEECHAM Confusion Scale

ANS: B
Hospital-acquired functional decline may occur within 2 days of a hospital admission. The HARP helps identify older adults who are at greatest risk of losing their ability to perform ADLs or mobility at this critical time. The Lawton IADL measures instrumental activities of daily living, which may be difficult to observe in the hospital setting. The Mini-Cog is an assessment of mental status. The NEECHAM Confusion Scale is used to assess for delirium.

DIF: Cognitive Level: Applying (Application) REF: p. 835
MSC: Client Needs: Psychosocial Integrity
12. During a functional assessment of an older persons home environment, which statement or question by the nurse is most appropriate regarding common environmental hazards?

a.	These low toilet seats are safe because they are nearer to the ground in case of falls.
b.	Do you have a relative or friend who can help to install grab bars in your shower?
c.	These small rugs are ideal for preventing you from slipping on the hard floor.
d.	It would be safer to keep the lighting low in this room to avoid glare in your eyes.

ANS: B
Environmental hazards within the home can be a potential constraint on the older persons day-to-day functioning. Common environmental hazards, including inadequate lighting, loose throw rugs, curled carpet edges, obstructed hallways, cords in walkways, lack of grab bars in tub and shower, and low and loose toilet seats, are hazards that could lead to an increased risk of falls and fractures. Environmental modifications can promote mobility and reduce the likelihood of the older adult falling.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 840
MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control
13. When beginning to assess a persons spirituality, which question by the nurse would be most appropriate?

a.	Do you believe in God?
b.	How does your spirituality relate to your health care decisions?
c.	What religious faith do you follow?
d.	Do you believe in the power of prayer?

ANS: B
Open-ended questions provide a foundation for future discussions. The other responses are easily answered by one-word replies and are closed questions.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 842

MSC: Client Needs: Psychosocial Integrity

14. The nurse is preparing to assess an older adult and discovers that the older adult is in severe pain. Which statement about pain and the older adult is *true*?

a.	Pain is inevitable with aging.
b.	Older adults with cognitive impairments feel less pain.
c.	Alleviating pain should be a priority over other aspects of the assessment.
d.	The assessment should take priority so that care decisions can be made.

ANS: C

If the older adult is experiencing pain or discomfort, then the depth of knowledge gathered through the assessments will suffer. Alleviating pain should be a priority over other aspects of the assessment. Remembering that older adults with cognitive impairment do *not* feel less pain is paramount.

15. The nurse is assessing the abilities of an older adult. Which activities are considered IADLs? *Select all that apply*.

a.	Feeding oneself
b.	Preparing a meal
c.	Balancing a checkbook
d.	Walking
e.	Toileting
f.	Grocery shopping

ANS: B, C, F

Typically, IADL tasks include shopping, meal preparation, housekeeping, laundry, managing finances, taking medications, and using transportation. The other options listed are ADLs related to self-care.