Stuvia 778383 primary care art and science of advanced practice nursing an interprofessional approach 5th edition dunphy test bank

Primary Care: Art and Science of Advanced Practice Nursing - An Interprofessional Approach 5th edition Dunphy Test Bank

written by

smarttutor

Primary Care: Art and Science of Advanced Practice Nursing - An Interprofessional Approach 5th edition Dunphy Test Bank

Chapter 1. Primary Care in the Twenty-First Century: A Circle of Caring

1. A nurse has conducted a literature review in an effort to identify the effect of handwashing on the incidence of nosocomial (hospital-acquired) infections in acute care settings. An article presented findings at a level of significance of <0.01. This indicates that

A) the control group and the experimental group were more than 99% similar.

B) the findings of the study have less than 1% chance of being attributable to chance.

C) the effects of the intervention were nearly zero.

D) the clinical significance of the findings was less than 1:100.

Ans: B

Feedback: The level of significance is the level at which the researcher believes that the study results most likely represent a nonchance event. A level of significance of <0.01 indicates that there is less than 1% probability that the result is due to chance.

2. A nurse has read a qualitative research study in order to understand the lived experience of parents who have a neonatal loss. Which of the following questions should the nurse prioritize when appraising the results of this study?

A) How well did the authors capture the personal experiences of these parents?

B) How well did the authors control for confounding variables that may have affected the findings?

C) Did the authors use statistical measures that were appropriate to the phenomenon in question?

D) Were the instruments that the researchers used statistically valid and reliable?

Ans: A

Feedback: Qualitative studies are judged on the basis of how well they capture and convey the subjective experiences of individuals. Statistical measures and variables are not dimensions of a qualitative methodology.

3. A nurse has expressed skepticism to a colleague about the value of nursing research, claiming that nursing research has little relevance to practice. How can the nurses colleague best defend the importance of nursing research?

A) The existence of nursing research means that nurses are now able to access federal grant money, something that didnt use to be the case.

B) Nursing research has allowed the development of masters and doctoral programs and has greatly increased the credibility of the profession.

C) The growth of nursing research has caused nursing to be viewed as a true profession, rather than simply as a trade or a skill.

D) The application of nursing research has the potential to improve nursing practice and patient outcomes.

Ans: D

Feedback: The greatest value of nursing research lies in the potential to improve practice and, ultimately, to improve patient outcomes. This supersedes the contributions of nursing research to education programs, grant funding, or the public view of the profession.

4. Tracy is a nurse with a baccalaureate degree who works in the labor and delivery unit of a busy urban hospital. She has noticed that many new mothers abandon breast-feeding their babies when they experience early challenges and wonders what could be done to encourage more women to continue breast-feeding. What role is Tracy most likely to play in a research project that tests an intervention aimed at promoting breast-feeding?

A) Applying for grant funding for the research project

B) Posing the clinical problem to one or more nursing researchers

C) Planning the methodology of the research project

D) Carrying out the intervention and submitting the results for publication

Ans: B

Feedback: A major role for staff nurses is to identify questions or problems for research. Grant applications, methodological planning, and publication submission are normally carried out by nurses who have advanced degrees in nursing.

5. A patient signed the informed consent form for a drug trial that was explained to patient by a research assistant. Later, the patient admitted to his nurse that he did not understand the research assistants explanation or his own role in the study. How should this patients nurse respond to this revelation?

A) Explain the research process to the patient in greater detail.

B) Describe the details of a randomized controlled trial for the patient.

C) Inform the research assistant that the patients consent is likely invalid.

D) Explain to the patient that his written consent is now legally binding.

Ans: C

Feedback: Just as the staff nurse is not responsible for medical consent, the staff nurse is not responsible for research consent. If patients who have agreed to participate exhibit ambivalence or uncertainty about participating, do not try to convince them to participate. Ask the person from the research team who is managing consents to speak with concerned patients about the study, even after a patient has signed the consent forms.

Multiple Selection

6. A nurse leader is attempting to increase the awareness of evidence-based practice (EBP) among the nurses on a unit. A nurse who is implementing EBP integrates which of the following? (Select all that apply.)

A) Interdisciplinary consensus

B) Nursing tradition

C) Research studies

D) Patient preferences and values

E) Clinical expertise

Ans: C, D, E

Feedback: Fineout-Overholt, Melnyk, Stillwell, and Williamson define EBP as a problem-solving approach to the delivery of healthcare that integrates the best evidence from studies and patient care data with clinician expertise and patient preferences and values.

Multiple Choice

7. Mrs. Mayes is a 73-year-old woman who has a diabetic foot ulcer that has been extremely slow to heal and which now poses a threat of osteomyelitis. The wound care nurse who has been working with Mrs. Mayes applies evidence-based practice (EBP) whenever possible and has proposed the use of maggot therapy to debride necrotic tissue. Mrs. Mayes, however, finds the suggestion repugnant and adamantly opposes this treatment despite the sizable body of evidence supporting it. How should the nurse reconcile Mrs. Mayes views with the principles of EBP?

A) The nurse should explain that reliable and valid research evidence overrides the patients opinion.

B) The nurse should explain the evidence to the patient in greater detail.

C) The nurse should integrate the patients preferences into the plan of care.

D) The nurse should involve the patients family members in the decision-making process.

Ans: C

Feedback: Patient preferences should be integrated into EBP and considered alongside research evidence and the nurses clinical expertise; evidence does not trump the patients preferences. The family should be involved, but this is not an explicit dimension of EBP. Similarly, explaining the evidence in more detail is not a demonstration of EBP.

8. The administrators of a long-term care facility are considered the use of specialized, pressure-reducing mattresses in order to reduce the incidence of pressure ulcers among residents. They have sought input from the nurses on the unit, all of whom are aware of the need to implement the principles of evidence-based practice (EBP) in this decision. Which of the following evidence sources should the nurses prioritize?

A) A qualitative study that explores the experience of living with a pressure ulcer

B) A case study that describes the measures that nurses on a geriatric unit took to reduce pressure ulcers among patients

C) Testimonials from experienced clinicians about the effectiveness of the mattress in question

D) A randomized controlled trial that compared the pressure-reducing mattress with standard mattresses

Ans: D

Feedback: The most reliable evidence is considered RCTs. Qualitative studies, case studies, and expert opinion are low on the hierarchy of evidence.

9. Hospital administrators are applying the principles of evidence-based practice (EBP) in their attempt to ascertain the most efficient and effective way to communicate between nurses who are on different units, a project that will consider many types of evidence. Which of the following information sources should the administrators prioritize?

A) A systematic review about communication in nursing contexts

B) Nurses ideas about communication methods

C) The results of a chart review

D) The hospitals accreditation status

Ans: A

Feedback: Systematic reviews are assigned a high value in EBP. Reviews would be prioritized over nurses ideas or a chart review, though both are potential considerations. The hospitals accreditation status is not a relevant consideration.

10. A nurse has resolved to apply the evidence-based practice (EBP) process to the way that admission assessments are conducted and documented on a unit. How should the nurse begin the process of establishing EBP?

A) Gather evidence showing the shortcomings of current practices

B) Formulate a clear and concise question to be addressed

C) Elicit support from the nurses who are most often responsible for admissions

D) Search the literature for evidence that is potentially relevant to the practice need

Ans: B

Feedback: The first step in applying EBP is to ask a clear, focused question. This should precede a search of the literature or the recruitment of participants. An assessment of the shortcomings of the current system is not an explicit component of the EBP process.

11. Which of the following questions best exemplifies the PICOT format for asking evidence-based questions?

A) What affect does parents alcohol use have on the alcohol use of their teenage children?

B) Among postsurgical patients, what role does meditation rather than benzodiazepines have on anxiety levels during the 48 hours following surgery?

C) Among high school students, what is the effectiveness of a sexual health campaign undertaken during the first 4 weeks of the fall semester as measured by incidence of new sexually transmitted infections?

D) In children aged 68, is the effectiveness of a descriptive pain scale superior to a numeric rating scale in the emergency room context?

Feedback: The correct answer includes a population (postsurgical patients), intervention (meditation), comparison (benzodiazepines), outcome (anxiety levels), and a time frame (48 hours). No other option contains each of the five elements of a PICOT question.

12. A nurse has made plans to implement the University of North Carolina (UNC) model of 5 As during the process of applying evidence-based practice (EBP) to a practice problem. What is the final step that the nurse will take in applying this model?

A) Analyze the results of the EBP process

B) Advocate for others to embrace the identified change

C) Adopt the changes identified in the review process

D) Assess the outcomes of the new practice

Ans: D

Feedback: The final step in the UNC rubric is to Assess the change using the quality improvement process in place in the institution.

13. A nurse has been asked to make a presentation to a group of high school students on the subject of sexual health. However, the nurse does not have a background in this practice area and requires rapid access to evidence-based guidelines. Which of the following strategies is most likely to provide the nurse with valid and reliable evidence in a time-efficient manner?

A) Search the Cochrane Library of Systematic Reviews

B) Google search terms such as sexual health teens and sexual education

C) Search Medline using PubMed and order relevant articles

D) Scan the most recent issues of nursing journals that address this area of practice

Feedback: For some problems, a systematic review may be available from a source such as the Cochrane Library. Often this review is done by an expert panel providing excellent information on which to base decisions. This approach is more likely to produce valid and reliable results than a Google search and is more efficient than searching journal manually or ordering articles through PubMed.

14. The nurses at a university hospital have been informed that a computerized record system will be implemented over the next 12 months. The nurses should be aware that such as system presents particular challenges in the area of

A) vulnerability to errors in charting and the inability to make changes.

B) patient privacy and confidentiality of records.

C) enforcing compliance with the system on the part of nurses.

D) ensuring compatibility with different computer operating systems.

Ans: B

Feedback: Concerns about privacy become magnified when information is available to many people in many sites far removed from where the patient is located, a situation that exists when

computerized records are used. This is usually considered a more important concern than issues of compliance, compatibility, or vulnerability to errors.

15. A nurse is nervous about the impeding introduction of computerized nursing care records at the hospital because he does not consider himself to be technologically adept. How should this nurse best respond to this situation?

A) Take courses in advanced practice nursing to build his knowledge.

B) Explore employment opportunities in settings that use written documentation systems.

C) Advocate for a delay in the introduction of the proposed system.

D) Seek out opportunities to learn the relevant knowledge and practice the necessary skills.

Ans: D

Feedback: A nurse who lacks technological knowledge or skills should seek out opportunities to expand these. This is preferable to finding a job elsewhere, studying advanced practice nursing, or attempting to delay the change.

Chapter 2. Caring and the Advanced Practice Nurse

Multiple Choice

1. A goal of community nursing is to provide primary prevention from disease. Which of the following nursing actions reflect this goal?

A) A nurse creates a pamphlet discussing heart-healthy foods and distributes it in the neighborhood community center.

B) A nurse starts an intravenous line on a dehydrated baby who has been brought to the emergency department.

C) A nurse performs range-of-motion exercises for a patient in traction.

D) A nurse repositions an elderly patient confined to a wheelchair to avoid the formation of pressure ulcers.

Ans: A

Feedback: Primary prevention involves the efforts to prevent disease from ever occurring. Primary prevention can be aimed at stopping the cause of disease. Generalized efforts to educate people regarding healthy diets are aimed at this type of primary prevention. Tertiary prevention focuses on preventing long-term disability and restoring functional capacity, as exemplified by repositioning an immobile patient, rehydrating a patient, or assisting with exercises.

2. A nurse decides to pursue a career in community-based nursing. Which of the following statements represents the environment in which the nurse will be working?

A) Community-based nursing is limited to work in public clinics, schools, and industry.

B) The key to community-based settings is that the nurse is in charge.

C) The nurse serves as an educator, guide, and resource person and determines the action taken by the client.

D) Care in the community is cost-effective.

Ans: D

Feedback: Care in the community is cost-effective and often more acceptable to the client because it causes less disruption in life. It takes place in a wide variety of settings and involves the nurse entering into a collaborative relationship with clients.

3. The movement of a client from acute care to a long-term nursing care facility involves planning to provide continuity of care. What is the term for this type of planning?

A) Discharge planning

B) Comprehensive planning

C) Ongoing planning

D) Transition planning

Ans: D

Feedback: Transitions are the movement of the patient from one care environment to another. Transition planning refers to the planning process that takes place to assure that the patients well- being is maintained throughout the time of transition. Organizing this transition from one care setting to another is not termed discharge planning, comprehensive planning, or ongoing planning.

4. A nurse is called into work to perform triage in the aftermath of an earthquake. Which of the following are the expected responsibilities of this nurse?

A) Set up and monitor IV lines.

B) Prepare the emergency room for multiple victims.

C) Screen victims to prioritize treatment.

D) Check available blood products and assist with transfusions.

Ans: C

Feedback: Triage involves the initial screening of victims for the purpose of prioritizing treatment and making the most effective and efficient use of both human and material resources. The other noted tasks are within the scope of disaster nursing but are not triage activities.

5. A client asks a nurse for help in obtaining an alternative healthcare provider. Which of the following is an accurate fact regarding alternative care that the nurse should share with this client?

A) Most alternative healthcare practitioners do not have education-based credentials to practice their medicine.

B) Alternative providers are not usually included in the federal HIPAA legislation that mandates confidentiality in conventional healthcare settings.

C) The cost of alternative therapy is never covered by insurance carriers or healthcare plans.

D) It is easy to find accurate safety and efficacy data for alternative medicine on the Internet.

Ans: B

Feedback: Alternative providers are not normally included in the federal Health Insurance Portability and Accountability Act of 1996 legislation that mandates confidentiality in conventional healthcare settings. Alternative practitioners do not necessarily lack credentials. Accurate online information can be difficult to find and costs for treatment may be covered by some insurance plans.

6. There is an increasing trend for nursing care to move from the hospital setting into the community. Nurses who are to provide excellent care in a community setting should prioritize which of the following?

A) Integrating culture and family into the planning and delivery of care

B) Becoming more assertive in client education and the planning of client care

C) Encouraging clients to limit their interactions with physicians

D) Teaching clients to replace biomedical interventions with complementary therapies

Ans: A

Feedback: The move to community care heightens the importance of family-centered, culturally- competent nursing. Community nursing does not necessarily require that a nurse become more assertive with client. It would be simplistic, and in most cases inappropriate, to guide clients to replace biomedical interventions or avoid doctors.

7. In spite of the important role that hospitals play in American healthcare, there is growing importance of community-based healthcare and community-based nursing. Which of the following statements best conveys a central aspect of the philosophy of community care?

A) The client is in charge of his or her health and healthcare in the community.

B) Nurses maximize their scope of practice in noninstitutional settings.

C) Community settings allow for the greatest number and variety of treatment options.

D) The nurse becomes the key member of the healthcare team in a community setting.

Ans: A

Feedback: A central premise of community healthcare is the fact that patients/clients are in charge. The move toward community care is not motivated by an increased role for nurses. There are a greater number of treatment options in hospitals than in the community, but this fact does not negate the importance of community care.

8. Mr. Hammond is a 70-year-old man with a diagnosis of type 1 diabetes who developed a diabetic foot ulcer earlier this year. He has recently been discharged from the hospital and now requires regular wound care. Karen is a community health nurse who provides wound care for Mr. Hammond twice weekly. Which of Karens actions is most likely to empower Mr. Hammond?

A) Encourage Mr. Hammond to acknowledge his contribution to the development of his wound.

B) Provide information to Mr. Hammond that matches his expressed needs.

C) Encourage Mr. Hammond to involve members of his family in his care.

D) Delegate wound care to Mr. Hammond and reduce the frequency of her visits.

Ans: B

Feedback: Client empowerment is often fostered by assessing and meeting a clients need for information. Encouraging an acknowledgement of the clients contribution to his or her current health state is beneficial in many circumstances, but it less likely to make the client feel empowered.
Similarly, family involvement can be beneficial but does not directly foster empowerment. Empowerment does not necessarily mean that the nurse does less and the client performs his or her own care; delegation may not be appropriate.

9. An elderly female client who resides in the community tends to defer decisions regarding her care to her eldest son. How should the community health nurse respond to the clients reluctance to make independent decisions?

A) Discuss this observation with the client and her son in an open manner and explore alternatives.

B) Organize care so that it takes place at times when the son is not present in the home.

C) Accommodate this aspect of the clients family dynamics when planning and carrying out care.

D) Teach the client assertiveness skills that she can apply in her interactions with her son.

Ans: C

Feedback: The nurse should respect the clients desire to organize her care in the way that she prefers. It is not the responsibility of the nurse to reorganize or overcome this familys dynamics.

10. A client with a long-standing diagnosis of chronic obstructive pulmonary disease (COPD) has been enrolled in a disease management program. Which of the following activities will be prioritized in this program?

A) Providing comprehensive and evidence-based care of the clients COPD

B) Creating collaborative relationships between the client and the care team

C) Ensuring that the client qualifies for Medicare and Medicaid

D) Liaising between the client and his health maintenance organization (HMO)

Ans: A

Feedback: Disease management focuses on providing the best evidence-based care for an individual with a specific chronic illness. This does not necessitate enrollment in an HMO, Medicare, or Medicaid. Collaborative relationships facilitate effective disease management but this is a means to the end of positive health outcomes rather than an end in itself.

11. One of the expressed goals of Healthy People 2020 is to achieve health equity and eliminate disparities. What health indicator can most accurately gauge whether this goal is being achieved?

A) Environmental quality

B) Injury and violence

C) Mental health

D) Access to healthcare services

Ans: D

Feedback: Health equity is achieved when all Americans have equitable access to health services and there a fewer disparities in health access and health outcomes. Environmental quality, mental health and injury, and violence are important health indicators but these are less directly indicative of health equity and the elimination of disparities.

12. Nurses have the potential to positively impact the health of communities. Which of the following actions is most likely to improve the health of a community?

A) Publicizing the consequences of unhealthy lifestyles

B) Advocating politically for laws and policies that foster community health

C) Ensuring that nurses are practicing to the full extent of their scope of practice

D) Providing nursing care to individuals who are not patients or clients

Ans: B

Feedback: One important role of nurses in the promotion of healthy communities is as a supporter and advocate for political measures that would improve the health of the community. Publicizing negative health outcomes is appropriate in some contexts but this is likely less effective than promoting broad change politically. It is not normally appropriate to provide nursing care for individuals who are not patients or clients. Practicing to the full extent of ones scope of practice is not likely to impact community health in a direct way.

13. A nurse who provides care in an acute medical unit is aware of the importance of thorough discharge planning. The discharge planning process should begin

A) once the patient has stabilized and is assured of positive outcomes.

B) as soon as possible after the patient is admitted.

C) once the patient has received a discharge order from his or her primary care provider.

D) 48 to 72 hours before the projected date of discharge.

Ans: B

Feedback: If possible, discharge planning should begin immediately upon admission.

14. A hospital patient has discussed with the nurse her use of visualization, biofeedback, and relaxation exercises in managing the chronic pain that results from her fibromyalgia. The nurse should recognize this patients use of what category of complementary/alternative medicine (CAM)?

A) Biologically-based practices

B) Manipulative practices

C) Traditional indigenous medicine

D) Mind-body medicine

Ans: D

Feedback: Examples of mind-body medicine include relaxation exercises, hypnosis, meditation, dance, prayer, visualization, and biofeedback. Biologically-based practices focus on food and dietary supplements while indigenous medicine applies the collective health knowledge of a particular culture. Manipulative practices involve the systematic application of touch.

15. A hospital patient who suffered a spinal cord injury has expressed an interest in exploring complementary/alternative therapies. The nurse should encourage the patient to begin this process by doing which of the following activities?

A) Asking practitioners of different therapies to provide lists of satisfied clients

B) Asking the patients primary care provider for permission to explore nonbiomedical treatments

C) Finding reliable evidence regarding the safety and effectiveness of therapies

D) Determining whether the patients health insurance would cover the cost of alternative/complementary therapies

Ans: C

Feedback: The first step for an individual interested in complementary/alternative therapies is to assess the safety and effectiveness of the therapy in relationship to his or her own condition. This must precede the identification of specific practitioners or making financial arrangements.
Communication with the care team is important, but the patient does not need to seek permission before exploring treatment alternatives.

Chapter 3. Health Promotion

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which of the following is a primary prevention measure for a 76-year-old man newly diagnosed with a testosterone deficiency?
   a. Calcium supplementation
   b. Testicular self-examination
   c. Bone density test
   d. Digital rectal examination

____ 2. Which of the following is an example of secondary prevention in a 50-year-old woman?
   a. Yearly mammogram
   b. Low animal fat diet
   c. Use of seat belt
   d. Daily application of sunscreen

____ 3. Which of the following is an example of tertiary prevention in a patient with chronic renal failure?
   a. Fluid restriction
   b. Hemodialysis 4 days a week
   c. High-protein diet
   d. Maintenance of blood pressure at 120/80

____ 4. Immunizations are an example of which type of prevention?
   a. Primary
   b. Secondary
   c. Tertiary

True/False
Indicate whether the statement is true or false.

____ 1. Prevalence is the number of new cases of a particular disease.

____ 2. The number of cases of a particular disease for the past 5 years is an example of the incidence rate.

____ 3. "There are 1,185,000 cases of HIV/AIDS in the United States" is an example of the morbidity rate.

____ 4. *Endemic* is the term used when the presence of an event is constant.

____ 5. The "bird" flu of 2005 to 2006 is considered a sporadic outbreak.

____ 6. A pandemic affects many communities in a short period of time.

Chapter 3. Health Promotion
Answer Section

MULTIPLE CHOICE

1. ANS: A PTS: 1
2. ANS: A PTS: 1
3. ANS: B PTS: 1
4. ANS: A PTS: 1

TRUE/FALSE

1. ANS: F PTS: 1
2. ANS: F PTS: 1
3. ANS: T PTS: 1
4. ANS: T PTS: 1
5. ANS: F PTS: 1
6. ANS: T PTS: 1

Chapter 4. The Art of Diagnosis and Treatment

MULTIPLE CHOICE

1. An 85-year-old man has come in for a physical examination, and the nurse notices that he uses a cane. When documenting general appearance, the nurse should document this information under the section that covers:

a. Posture.
b. Mobility.
c. Mood and affect.
d. Physical deformity.

ANS: B

Use of assistive devices would be documented under the mobility section. The other responses are all other categories of the general appearance section of the health history.

2. The nurse is performing a vision examination. Which of these charts is most widely used for vision examinations?

a. Snellen
b. Shetllen
c. Smoollen
d. Schwellon

ANS: A

The Snellen eye chart is most widely used for vision examinations. The other options are not tests for vision examinations.

3. After the health history has been obtained and before beginning the physical examination, the nurse should first ask the patient to:

a. Empty the bladder.

b. Completely disrobe.
c. Lie on the examination table.
d. Walk around the room.

ANS: A

Before beginning the examination, the nurse should ask the person to empty the bladder (save the specimen if needed), disrobe except for underpants, put on a gown, and sit with the legs dangling off side of the bed or table.

4. During a complete health assessment, how would the nurse test the patients hearing?

a. Observing how the patient participates in normal conversation
b. Using the whispered voice test
c. Using the Weber and Rinne tests
d. Testing with an audiometer

ANS: B

During the complete health assessment, the nurse should test hearing with the whispered voice test. The other options are not correct.

5. A patient states, Whenever I open my mouth real wide, I feel this popping sensation in front of my ears. To further examine this, the nurse would:

a. Place the stethoscope over the temporomandibular joint, and listen for bruits.
b. Place the hands over his ears, and ask him to open his mouth really wide.
c. Place one hand on his forehead and the other on his jaw, and ask him to try to open his mouth.
d. Place a finger on his temporomandibular joint, and ask him to open and close his mouth.

ANS: D

The nurse should palpate the temporomandibular joint by placing his or her fingers over the joint as the person opens and closes the mouth.

6. The nurse has just completed an examination of a patients extraocular muscles. When documenting the findings, the nurse should document the assessment of which cranial nerves?

a. II, III, and VI
b. II, IV, and V
c. III, IV, and V
d. III, IV, and VI

ANS: D

Extraocular muscles are innervated by cranial nerves III, IV, and VI.

7. A patients uvula raises midline when she says ahh, and she has a positive gag reflex. The nurse has just tested which cranial nerves?

a. IX and X
b. IX and XII
c. X and XII
d. XI and XII

ANS: A

Cranial nerves IX and X are being tested by having the patient say ahh, noting the mobility of the uvula, and when assessing the patients gag reflex.

8. During an examination, the nurse notices that a patient is unable to stick out his tongue. Which cranial nerve is involved with the successful performance of this action?

a. I
b. V
c. XI

d. XII

ANS: D

Cranial nerve XII enables the person to stick out his or her tongue.

9. A patient is unable to shrug her shoulders against the nurses resistant hands. What cranial nerve is involved with successful shoulder shrugging?

a. VII
b. IX
c. XI
d. XII

ANS: C

Cranial nerve XI enables the patient to shrug her shoulders against resistance.

10. During an examination, a patient has just successfully completed the finger-to-nose and the rapid-alternating-movements tests and is able to run each heel down the opposite shin. The nurse will conclude that the patients_____function is intact.

a. Occipital
b. Cerebral
c. Temporal
d. Cerebellar

ANS: D

The nurse should test cerebellar function of the upper extremities by using the finger-to-nose test or rapid-alternating-movements test. The nurse should test cerebellar function of the lower extremities by asking the person to run each heel down the opposite shin.

11. When the nurse performs the confrontation test, the nurse has assessed:

a. Extraocular eye muscles (EOMs).
b. Pupils (pupils equal, round, reactive to light, and accommodation [PERRLA]).
c. Near vision.
d. Visual fields.

ANS: D

The confrontation test assesses visual fields. The other options are not tested with the confrontation test.

12. Which statement is *true* regarding the complete physical assessment?

a. The male genitalia should be examined in the supine position.
b. The patient should be in the sitting position for examination of the head and neck.
c. The vital signs, height, and weight should be obtained at the end of the examination.
d. To promote consistency between patients, the examiner should not vary the order of the assessment.

ANS: B

The head and neck should be examined in the sitting position to best palpate the thyroid and lymph nodes. The male patient should stand during an examination of the genitalia. Vital signs are measured early in the assessment. The sequence of the assessment may need to vary according to different patient situations.

13. Which of these is included in an assessment of general appearance?

a. Height
b. Weight
c. Skin color
d. Vital signs

ANS: C

General appearance includes items such as level of consciousness, skin color, nutritional status, posture, mobility, facial expression, mood and affect, speech, hearing, and personal hygiene. Height, weight, and vital signs are considered measurements.

14. The nurse should wear gloves for which of these examinations?

a. Measuring vital signs
b. Palpation of the sinuses
c. Palpation of the mouth and tongue
d. Inspection of the eye with an ophthalmoscope

ANS: C

Gloves should be worn when the examiner is exposed to the patients body fluids.

15. The nurse should use which location for eliciting deep tendon reflexes?

a. Achilles
b. Femoral
c. Scapular
d. Abdominal

ANS: A

Deep tendon reflexes are elicited in the biceps, triceps, brachioradialis, patella, and Achilles heel.

16. During an inspection of a patients face, the nurse notices that the facial features are symmetric. This finding indicates which cranial nerve is intact?

a. VII
b. IX
c. XI
d. XII

ANS: A

Cranial nerve VII is responsible for facial symmetry.

17. During inspection of the posterior chest, the nurse should assess for:

a. Symmetric expansion.
b. Symmetry of shoulders and muscles.
c. Tactile fremitus.
d. Diaphragmatic excursion.

ANS: B

During an inspection of the posterior chest, the nurse should inspect for symmetry of shoulders and muscles, configuration of the thoracic cage, and skin characteristics. Symmetric expansion and tactile fremitus are assessed with palpation; diaphragmatic excursion is assessed with percussion.

18. During an examination, the patient tells the nurse that she sometimes feels as if objects are spinning around her. The nurse would document that she occasionally experiences:

a. Vertigo.
b. Tinnitus.
c. Syncope.
d. Dizziness.

ANS: A

Vertigo is the sensation of a person moving around in space (subjective) or of the person sensing objects moving around him or her (objective) and is a result of a disturbance of equilibratory apparatus

19. A patient tells the nurse, Sometimes I wake up at night and I have real trouble breathing. I have to sit up in bed to get a good breath. When documenting this information, the nurse would note:

a. Orthopnea.

b. Acute emphysema.
c. Paroxysmal nocturnal dyspnea.
d. Acute shortness of breath episode.

ANS: C

Paroxysmal nocturnal dyspnea occurs when the patient awakens from sleep with shortness of breath and needs to be upright to achieve comfort

20. During the examination of a patient, the nurse notices that the patient has several small, flat macules on the posterior portion of her thorax. These macules are less than 1 cm wide. Another name for these macules is:

a. Warts.
b. Bullae.
c. Freckles.
d. Papules.

ANS: C

A macule is solely a lesion with color change, flat and circumscribed, less than 1 cm. Macules are also known as *freckles*

21. During an examination, the nurse notices that a patients legs turn white when they are raised above the patients head. The nurse should suspect:

a. Lymphedema.
b. Raynaud disease.
c. Chronic arterial insufficiency.
d. Chronic venous insufficiency.

ANS: C

Elevational pallor (striking) indicates arterial insufficiency

22. The nurse documents that a patient has coarse, thickened skin and brown discoloration over the lower legs. Pulses are present. This finding is probably the result of:

a. Lymphedema.
b. Raynaud disease.
c. Chronic arterial insufficiency.
d. Chronic venous insufficiency.

ANS: D

Chronic venous insufficiency would exhibit firm brawny edema, coarse thickened skin, normal pulses, and brown discoloration

23. The nurse notices that a patient has ulcerations on the tips of the toes and on the lateral aspect of the ankles. This finding indicates:

a. Lymphedema.
b. Raynaud disease.
c. Arterial insufficiency.
d. Venous insufficiency.

ANS: C

Ulcerations on the tips of the toes and lateral aspect of the ankles are indicative of arterial insufficiency

24. The nurse has just recorded a positive iliopsoas test on a patient who has abdominal pain. This test is used to confirm a(n):

a. Inflamed liver.
b. Perforated spleen.
c. Perforated appendix.
d. Enlarged gallbladder.

ANS: C

An inflamed or perforated appendix irritates the iliopsoas muscle, producing pain in the RLQ.

25. The nurse will measure a patients near vision with which tool?

a. Snellen eye chart with letters
b. Snellen E chart
c. Jaeger card
d. Ophthalmoscope

ANS: C

The Jaeger card is used to measure near vision

26. If the nurse records the results to the Hirschberg test, the nurse has:

a. Tested the patellar reflex.
b. Assessed for appendicitis.
c. Tested the corneal light reflex.
d. Assessed for thrombophlebitis.

ANS: C

The Hirschberg test assesses the corneal light reflex

27. During the examination of a patients mouth, the nurse observes a nodular bony ridge down the middle of the hard palate. The nurse would chart this finding as:

a. Cheilosis.
b. Leukoplakia.
c. Ankyloglossia.
d. Torus palatinus.

ANS: D

A normal variation of the hard palate is a nodular bony ridge down the middle of the hard palate; this variation is termed *torus palatinus*

28. During examination, the nurse finds that a patient is unable to distinguish objects placed in his hand. The nurse would document:

a. Stereognosis.
b. Astereognosis.
c. Graphesthesia.
d. Agraphesthesia.

ANS: B

29. After the examination of an infant, the nurse documents opisthotonos. The nurse recognizes that this finding often occurs with:

a. Cerebral palsy.
b. Meningeal irritation.
c. Lower motor neuron lesion.
d. Upper motor neuron lesion.

ANS: B

Opisthotonos is a form of spasm in which the head is arched back, and a stiffness of the neck and an extension of the arms and legs are observed. Opisthotonus occurs with meningeal or brainstem irritation

30. After assessing a female patient, the nurse notices flesh-colored, soft, pointed, moist, papules in a cauliflower-like patch around her introitus. This finding is most likely:

a. Urethral caruncle.
b. Syphilitic chancre.
c. Herpes simplex virus.
d. Human papillomavirus.

ANS: D

Human papillomavirus appears in a flesh-colored, soft, moist, cauliflower-like patch of papules

31. While recording in a patients medical record, the nurse notices that a patients Hematest results are positive. This finding means that there is(are):

a. Crystals in his urine.
b. Parasites in his stool.
c. Occult blood in his stool.
d. Bacteria in his sputum.

ANS: C

32. While examining a 48-year-old patients eyes, the nurse notices that he had to move the handheld vision screener farther away from his face. The nurse would suspect:

a. Myopia.
b. Omniopia.
c. Hyperopia.
d. Presbyopia.

ANS: D

Presbyopia, the decrease in power of accommodation with aging, is suggested when the handheld vision screener card is moved farther away.

Chapter 5. Evidence-Based Care

Multiple Choice

Identify the choice that best completes the statement or answers the question.

____ 1. Which of the following are parts of evidence-based practice?
   a. Clinician
   b. Patient
   c. Evidence
   d. All of the above

____ 2. Which is the most important question to ask in nursing research?
   a. What findings constitute evidence?
   b. How will the findings be used?
   c. Is this a randomized controlled trial?
   d. What theory is being utilized?

____ 3. Nursing research should be utilized by:
   a. Nurses at the bedside
   b. Advanced practice nurses
   c. Nurse researchers
   d. Nurses at all levels of practice

____ 4. Applying evidence at the point of care requires:
   a. Readily available evidence-based resources
   b. Ability to review research literature
   c. Single articles in journals
   d. Current textbooks

____ 5. Practice guidelines are designed to:
   a. Be inflexible
   b. Be utilized in every circumstance
   c. Provide a reference point for decision making
   d. Be created by a professional organization to guide the practice of a profession

____ 6. Which of the following is a crucial element of developing a guideline?
   a. Creating a physician expert panel
   b. Reviewing the literature with ratings of available evidence
   c. Conducting an external review of a guideline
   d. Developing evidence-based tables

____ 7. Which of the following would be considered the research design for Level I evidence?
   a. Single, well-designed randomized clinical trial
   b. Systematic review of randomized clinical trial studies
   c. Well-designed controlled trials without randomization
   d. Systematic reviews of descriptive or qualitative studies

____ 8. Which of the following would be considered the research design for Level II evidence?
   a. Single descriptive or qualitative study
   b. Well-designed case control or cohort studies
   c. Single, well-designed, randomized clinical trial
   d. Systematic review of randomized clinical trial studies

____ 9. Which of the following would be considered the research design for Level III evidence?
   a. Well-designed controlled trials without randomization
   b. Systematic reviews of descriptive or qualitative studies
   c. Systematic review of randomized clinical trial studies
   d. Opinion of authorities and expert committees

____ 10. Which of the following would be considered the research design for Level IV evidence?
   a. Single descriptive or qualitative study
   b. Opinion of authorities and expert committees
   c. Systematic review of randomized clinical trial studies
   d. Well-designed controlled trials without randomization

____ 11. Which of the following would be considered the research design for Level V evidence?
   a. Systematic review of randomized clinical trial studies
   b. Well-designed controlled trials without randomization
   c. Systematic reviews of descriptive or qualitative studies
   d. Single descriptive or qualitative study

____ 12. Which of the following would be considered the research design for Level VI evidence?
   a. Systematic reviews of descriptive or qualitative studies
   b. Opinion of authorities and expert committees
   c. Well-designed case control or cohort studies
   d. Single descriptive or qualitative study

____ 13. Which of the following would be considered the research design for Level VII evidence?
   a. Well-designed controlled trials without randomization
   b. Opinion of authorities and expert committees

c. Well-designed case control or cohort studies
d. Single descriptive or qualitative study

Chapter 5. Evidence-Based Care
Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: B PTS: 1
3. ANS: D PTS: 1
4. ANS: A PTS: 1
5. ANS: C PTS: 1
6. ANS: B PTS: 1
7. ANS: B PTS: 1
8. ANS: C PTS: 1
9. ANS: A PTS: 1
10. ANS: D PTS: 1
11. ANS: C PTS: 1
12. ANS: C PTS: 1
13. ANS: B PTS: 1

Chapter 6. Common Neurological Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which statement about confusion is true?
a. Confusion is a disease process.
b. Confusion is always temporary.
c. Age is a reliable predictor of confusion.
d. Polypharmacy is a major contributor to confusion in older adults.

__ 2. Sondra's peripheral vestibular disease causes dizziness and vertigo. Which of the following medications will help to decrease edema in the labyrinth of the ear?
a. Meclizine
b. Diphenhydramine
c. Diamox
d. Promethazine

____ 3. The hallmark of an absence seizure is:
a. No activity at all
b. A blank stare
c. Urine is usually voided involuntarily
d. The attack usually lasts several minutes

__ 4. How often should drug levels be monitored when a seizure medication has controlled the seizures, and the drug level is adequate?
a. Every 3 months
b. Every 6 months
c. Annually
d. Whenever there is a problem

____ 5. Which of the following persons fits the classic description of a patient with multiple sclerosis (MS)?
a. A teenage male
b. A 65-year-old male
c. A 25-year-old female
d. A 60-year-old female

____ 6. Which of the following is a specific test to MS?
a. Magnetic resonance imaging (MRI)
b. Computed tomography (CT) scan

c. A lumbar puncture
d. There is no specific test.

____ 7. Which drug for Alzheimer's disease should be administered beginning at the time of diagnosis?
a. Cholinesterase inhibitors
b. Anxiolytics
c. Antidepressants
d. Atypical antipsychotics

__ 8. Which hematoma occurs along the temporal cranial wall and results from tears in the middle meningeal artery?
a. Epidural hematoma
b. Subdural hematoma
c. Subarachnoid hematoma
d. Intraparenchymal hemorrhage

__ 9. Which cranial nerve is affected in a patient with a cerebrovascular accident who has difficulty chewing?
a. CN V
b. CN VII
c. CN IX
d. CN X

____ 10. Which statement best describes a carotid bruit?
a. It is felt with the middle three fingers over the carotid artery.
b. A bruit becomes audible when the lumen is narrowed to 1 mm or less.
c. A low-pitched bruit is a medical emergency.
d. The higher the pitch of the bruit, the higher the degree of stenosis.

____ 11. Which patient is more likely to have a cluster headache?
a. A female in her reproductive years
b. A 40-year-old African American male
c. A 55-year-old female who drinks 10 cups of coffee daily
d. A 45-year-old male awakened at night

____ 12. Inattention and a sleep-wake cycle disturbance are the hallmark symptoms of?
a. Dementia
b. Alzheimer's disease
c. Parkinson's disease
d. Delirium

____ 13. Which type of meningitis is more benign, self-limiting, and caused primarily by a virus?
a. Purulent meningitis
b. Chronic meningitis
c. Aseptic meningitis
d. Herpes meningitis

____ 14. Which is the most sensitive neuroimaging test to evaluate patients with encephalitis?
a. MRI
b. CT
c. Electroencephalogram (EEG)
d. An initial lumbar puncture

___ 15. What is usually the first sign or symptom that a patient would present with that would make you suspect herpes zoster?
a. A stabbing pain on one small area of the body
b. A vesicular skin lesion on one side of the body
c. A pain that is worse upon awakening
d. A lesion on the exterior ear canal

___ 16. Gabby, aged 22, has Bell's palsy on the right side of her face. Her mouth is distorted, and she is concerned about permanent paralysis and pain. What do you tell her?
a. "Most patients have complete recovery in 3 to 6 months."
b. "Unfortunately, you'll probably have a small amount of residual damage."
c. "Don't worry, I'll take care of everything."
d. "You may have a few more episodes over the course of your lifetime but no permanent damage."

____ 17. Sam, aged 65, is started on L-dopa for his Parkinson's disease (PD). He asks why this is necessary. You tell him:
a. "L-dopa is neuroprotective."
b. "The primary goal of therapy is to replace depleted stores of dopamine."
c. "This is the only drug that can provide symptomatic benefit."
d. "This is the initial monotherapy drug."

____ 18. Which of the following signs is seen in a patient with more advanced PD?
a. Resting tremor
b. Bradykinesia
c. Rigidity
d. Postural instability

____ 19. Which of the following is the most commonly experienced symptom of migraine?
a. Light sensitivity
b. Pulsatile pain
c. Sound sensitivity
d. Experiencing an aura

____ 20. Which of the following characteristics differentiates peripheral vertigo from central vertigo?
a. The duration of central vertigo is shorter than that of peripheral vertigo.
b. There is an auditory-associated symptom with peripheral vertigo and a visual-associated symptom with central vertigo.
c. Central vertigo is positional, and peripheral vertigo is not.
d. The onset of central vertigo is more sudden than that of peripheral vertigo.

___ 21. Carotid endarterectomy should be considered only for symptomatic patients with greater than what percentage of stenosis?
a. Greater than 25%
b. Greater than 50%
c. Greater than 75%
d. Only for 100% occlusion

____ 22. What antiplatelet agent is most widely used for secondary prevention of stroke?
a. Aspirin
b. Ticlopidine
c. Clopidogrel
d. Aspirin and clopidogrel

___ 23. Which adjunctive diagnostic test should be used in the work-up of a patient with suspected Creutzfeldt-Jakob disease or transient epileptic amnesia?
a. MRI
b. CT
c. Cerebrospinal fluid analysis
d. EEG

____ 24. Which herbal preparation may cause delirium and should be avoided in an elderly patient?
a. Sam-e
b. Saint John's Wort
c. Melatonin
d. Saw Palmetto

____ 25. Which of the following activities is part of the functional activities questionnaire?
a. Asking the patient to unravel a Rubik's cube
b. Determining if the patient can drive on the highway
c. Asking the patient about a news event from the current week
d. Seeing if the patient can keep his or her home clean

____ 26. About 90% of all headaches are?
a. Tension
b. Migraine
c. Cluster
d. Without pathological cause

____ 27. Which statement is true regarding driving and patients with a seizure disorder?
a. Once diagnosed with a seizure disorder, patients must never drive again.
b. After being seizure free for 6 months, patients may drive.
c. Each state has different laws governing driving for individuals with a seizure disorder.
d. These persons may drive but never alone.

____ 28. Julie has relapsing-remitting muscular sclerosis. She has not had a good response to interferon. Which medication might help given intravenously once a month?
a. Glatiramer acetate
b. Natalizumab
c. Fingolimod
d. Glucocorticoids

____ 29. The 'freezing phenomenon' is a cardinal feature of?
a. Parkinson's disease
b. Alzheimer's disease
c. A CVA
d. Bell's palsy

____ 30. A ratchet-like rhythmic contraction, especially in the hand, during passive stretching is known as?
a. Spinothalamic dysfunction
b. Ratcheting
c. Cogwheeling
d. Hand tremors

__ 31. Clinical features of insidious onset, slow progression, and a lack of other findings to explain the symptoms are fairly diagnostic of which condition?

a. Guillain-Barré syndrome
b. Parkinson's disease
c. Alzheimer's disease
d. Huntington's disease

__ 32. Which condition is characterized by the impaired ability to learn new information along with either a cognitive disturbance in language, function, or perception?

a. Guillain-Barré syndrome
b. Parkinson's disease
c. Alzheimer's disease
d. Delirium

____ 33. A score of 20 to 25 on this test indicates early-stage Alzheimer's disease:

a. SLUMS
b. MoCA
c. FAST
d. MMSE

__ 34. Intravenous thrombolytic therapy following an ischemic CVA should be given within how many hours of symptom onset?

a. 1 hour
b. 3 hours
c. 6 hours
d. 12 hours

____ 35. When administered at the beginning of an attack, oxygen therapy may help this kind of headache?

a. Tension
b. Migraine
c. Cluster
d. Stress

Chapter 6. Common Neurological Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: C PTS: 1
3. ANS: B PTS: 1
4. ANS: B PTS: 1
5. ANS: C PTS: 1
6. ANS: D PTS: 1
7. ANS: A PTS: 1
8. ANS: A PTS: 1
9. ANS: A PTS: 1
10. ANS: D PTS: 1
11. ANS: D PTS: 1
12. ANS: D PTS: 1
13. ANS: C PTS: 1
14. ANS: A PTS: 1
15. ANS: B PTS: 1
16. ANS: A PTS: 1
17. ANS: B PTS: 1
18. ANS: D PTS: 1
19. ANS: B PTS: 1
20. ANS: B PTS: 1
21. ANS: B PTS: 1

22. ANS: A PTS: 1

23. ANS: D PTS: 1

24. ANS: B PTS: 1

25. ANS: C PTS: 1

26. ANS: D PTS: 1

27. ANS: C PTS: 1

28. ANS: B PTS: 1

29. ANS: A PTS: 1

30. ANS: C PTS: 1

31. ANS: B PTS: 1

32. ANS: C PTS: 1

33. ANS: D PTS: 1

34. ANS: B PTS: 1

35. ANS: C PTS: 1

Chapter 7. Seizure Disorders

1. A client asks the nurse to explain symptoms that would indicate the presence of a brain tumor. Which of the following should the nurse respond to this client? (Select all that apply.)

1.	There are no symptoms specific to a brain tumor.
2.	Dizziness is a common symptom.
3.	Ringing or buzzing in the ears can occur.
4.	Seizures may occur.
5.	A headache that gets worse in the afternoon is specific to a brain tumor..
6.	A headache is usually experienced by 50% of all people diagnosed with a brain tumor.

ANS: 2, 3, 4, 6
Symptoms of a brain tumor include dizziness, ringing or buzzing in the ears, seizures, and a headache. The headache of a brain tumor is usually worse in the morning and not the afternoon. There are symptoms associated with a brain tumor.

2. The nurse is instructing a client diagnosed with a brain tumor on symptoms to immediately report to her physician. Which of the following should be included in these instructions? (Select all that apply.)

1.	New onset of seizures
2.	One-sided weakness
3.	Loss of balance
4.	Problems with vision
5.	Inability to talk
6.	Loss of appetite

ANS: 1, 2, 3, 4, 5

Brain tumor symptoms that require immediate attention include new onset of seizures, slow progressing hemiparesis, gait or balance disturbances, visual problems, hearing loss, and aphasia. Loss of appetite is not a brain tumor symptom.

3.A client is diagnosed with seizures occurring because of hepatic encephalopathy. The nurse realizes that the cause for this clients seizures would be:

1.	physiological.
2.	iatrogenic.
3.	idiopathic.
4.	psychokinetic.

ANS: 1

The three major causes for seizures are physiological, iatrogenic, and idiopathic. Physiological seizures include those that occur with an acquired metabolic disorder such as hepatic encephalopathy. Iatrogenic causes include new medications or drug or alcohol use. Idiopathic causes include fevers, fatigue, or strong emotions. Psychokinetic is not a cause for seizures.

4.A client tells the nurse that he sees flashing lights that occur prior to the onset of a seizure. Which of the following phases of a seizure is this client describing to the nurse?

1.	Prodromal phase
2.	Aural phase
3.	Ictal phase
4.	Postictal phase

ANS: 2

In the aural phase a sensation or warning occurs, which the patient often remembers. This warning can be visual, auditory, gustatory, or visceral in nature. The prodromal phase of a seizure includes the signs or activity before the seizure such as a headache or feeling depressed. The ictal phase of a seizure is the actual seizure. The postictal phase is the period immediately following the seizure.

5.A client is experiencing a grand mal seizure. Which of the following should the nurse do during this seizure?

1. Protect the clients head.

2. Leave the client alone.

3. Give water to the client to avoid dehydration.

4. Place a finger in the clients mouth to avoid swallowing the tongue.

ANS: 1

One of the most important interventions for a nurse to perform during a seizure is to protect the clients head from injury. Never give a client a drink during a seizure. Placing a finger in the clients mouth could be very dangerous to the client and the nurse. Do not leave the client unattended during a seizure

6.A client is prescribed phenytoin (Dilantin) for a seizure disorder. Which of the following would indicate that the client is adhering to the medication schedule?

1. The client is sleepy.

2. The client is not experiencing seizures.

3. The client no longer has headaches.

4. The client is eating more food.

ANS: 2

Phenytoin (Dilantin) is a medication to control seizures. The absence of seizures indicates that the client is adhering to the medication schedule. Sleepiness, lack of headaches, or improved appetite are not indications that the medication is being used as prescribed.

7.The nurse is unable to insert an intravenous access line into a client who is currently experiencing a seizure. Which of the following routes can the nurse use to provide medication to the client at this time?

1. Oral

2. Intranasal

3.	Rectal
4.	Intramuscular

ANS: 2

For a client experiencing a seizure, oral medications and sharp objects can be dangerous and should not be used. Intranasally administered drugs are rapid and effective in treating a client experiencing an acute seizure. Intranasal delivery is more effective than rectal.

8.One of the most important things a nurse can teach a client about seizure control is to:

1.	take the medication every day as prescribed by the doctor.
2.	eat a balanced diet.
3.	get lots of exercise.
4.	take naps during the day.

ANS: 1

Medication is effective only if it is taken as prescribed, and suddenly stopping the medication can trigger an increase in seizure activity. Diet and exercise are important to a healthy lifestyle but do little to control seizure activity.

9.A client is diagnosed with tonic-clonic seizures. Which are the characteristics of these types of seizures? (Select all that apply.)

1.	Progressing through all of the seizure phases
2.	Beginning before age 5
3.	Lasting 2 to 3 minutes
4.	Causing injury to the client
5.	Occurring at any time, day or night

6. Being highly variable

ANS: 1, 3, 4, 5, 6

Tonic-clonic seizures are the most common type of generalized seizure. The seizure will progress through all of the seizure phases and last 2 to 3 minutes. Because these seizures begin suddenly, there is an increased incidence of injury associated with them. These seizures can occur any time of the day or night, whether the client is awake or not. Seizure frequency is highly variable.

Chapter 8. Degenerative Disorders

MULTIPLE CHOICE

1.A client is diagnosed with a headache from a secondary cause. The nurse realizes this type of headache can be caused by:
1.a tumor.
2.tension.
3.a migraine.
4.cluster
ANS: 1
Primary headaches are identified when no organic cause can be found. A tumor headache is caused by a tumor and is classified as a secondary headache.

2.The nurse should instruct a client diagnosed with migraine headaches to be careful not to overdose on acetaminophen (Tylenol). Which drug should the nurse tell the patient to avoid?
1.Aleve
2.Aspirin
3.Ibuprofen
4.Vicodin
ANS: 4
Vicodin, although a narcotic analgesic, also contains acetaminophen (Tylenol). It is very easy to overdose on the acetaminophen (Tylenol) component, which can lead to kidney damage. Aleve does not contain acetaminophen (Tylenol). Aspirin and ibuprofen do not contain acetaminophen (Tylenol).

3.A client is diagnosed with seizures occurring because of hepatic encephalopathy. The nurse realizes that the cause for this clients seizures would be:
1.physiological.
2.iatrogenic.
3.idiopathic.
4.psychokinetic.
ANS: 1
The three major causes for seizures are physiological, iatrogenic, and idiopathic. Physiological seizures include those that occur with an acquired metabolic disorder such as hepatic encephalopathy. Iatrogenic causes include new medications or drug or alcohol use. Idiopathic causes include fevers, fatigue, or strong emotions. Psychokinetic is not a cause for seizures.

4.A client tells the nurse that he sees flashing lights that occur prior to the onset of a seizure. Which of the following phases of a seizure is this client describing to the nurse?

1.Prodromal phase
2.Aural phase
3.Ictal phase
4.Postictal phase
ANS: 2
In the aural phase a sensation or warning occurs, which the patient often remembers. This warning can be visual, auditory, gustatory, or visceral in nature. The prodromal phase of a seizure includes the signs or activity before the seizure such as a headache or feeling depressed. The ictal phase of a seizure is the actual seizure. The postictal phase is the period immediately following the seizure.
5.A client is experiencing a grand mal seizure. Which of the following should the nurse do during this seizure?
1.Protect the clients head.
2.Leave the client alone.
3.Give water to the client to avoid dehydration.
4.Place a finger in the clients mouth to avoid swallowing the tongue.
ANS: 1
One of the most important interventions for a nurse to perform during a seizure is to protect the clients head from injury. Never give a client a drink during a seizure. Placing a finger in the clients mouth could be very dangerous to the client and the nurse. Do not leave the client unattended during a seizure
6.A client is prescribed phenytoin (Dilantin) for a seizure disorder. Which of the following would indicate that the client is adhering to the medication schedule?
1.The client is sleepy.
2.The client is not experiencing seizures.
3.The client no longer has headaches.
4.The client is eating more food.
ANS: 2
Phenytoin (Dilantin) is a medication to control seizures. The absence of seizures indicates that the client is adhering to the medication schedule. Sleepiness, lack of headaches, or improved appetite are not indications that the medication is being used as prescribed.
7.The nurse is unable to insert an intravenous access line into a client who is currently experiencing a seizure. Which of the following routes can the nurse use to provide medication to the client at this time?
1.Oral
2.Intranasal
3.Rectal
4.Intramuscular
ANS: 2
For a client experiencing a seizure, oral medications and sharp objects can be dangerous and should not be used. Intranasally administered drugs are rapid and effective in treating a client experiencing an acute seizure. Intranasal delivery is more effective than rectal.
8.One of the most important things a nurse can teach a client about seizure control is to:
1.take the medication every day as prescribed by the doctor.
2.eat a balanced diet.
3.get lots of exercise.
4.take naps during the day.
ANS: 1
Medication is effective only if it is taken as prescribed, and suddenly stopping the medication can trigger an

increase in seizure activity. Diet and exercise are important to a healthy lifestyle but do little to control seizure activity.
9.The nurse is instructing a client newly diagnosed with multiple sclerosis (MS). To determine the effectiveness of his teaching, the nurse would expect the client to state:
1.It is best for me to be in a cold environment.
2.I should avoid taking a hot bath.
3.I should eat foods low in salt.
4.I should be better in a week.
ANS: 2
The clinical manifestations of MS can be exacerbated by being in a hot, humid environment or by taking a hot bath. A cold environment and low-salt foods do not impact the symptoms of multiple sclerosis. If the client states that they will improve in a week, instruction has not been effective.
10.An adult female in her 30s complains of numbness and tingling in the hands, fatigue, loss of coordination, incontinence, nystagmus, and ataxia. Which of the following health problems do these symptoms suggest to the nurse?
1.Brain tumor
2.Myasthenia gravis
3.Multiple sclerosis
4.Diabetes
ANS: 3
Multiple sclerosis is more common in women of this age. These are symptoms, along with the age and sex of the patient, that are common to MS. These symptoms are not necessarily associated with a brain tumor. Weakness is the primary symptom associated with myasthenia gravis. Symptoms of diabetes include weight loss, blurred vision, excessive urination, thirst, and hunger.
11.For a client diagnosed with Parkinsons disease, which of the following might be contraindicated?
1.Performing range-of-motion exercises
2.Drinking bottled water
3.Instituting fall precautions
4.Taking naps
ANS: 2
Some clients diagnosed with Parkinsons disease develop swallowing difficulties. Powders to thicken liquids and using an upright position will help with these difficulties. Clients diagnosed with Parkinsons disease will benefit from range-of-motion exercises and resting. The client diagnosed with Parkinsons disease should be placed on fall precautions.

12.A client diagnosed with Parkinsons disease is beginning medication therapy. The nurse realizes that the goal of treatment for Parkinsons disease is to:
1.improve sleep.
2.reduce appetite.
3.control tremor and rigidity.
4.reduce the need for joint replacement surgery.
ANS: 3
The goal of pharmacologic treatment for the client diagnosed with Parkinsons disease is to control tremor and rigidity and to improve the clients ability to carry out the activities of daily living. Medications for Parkinsons disease are not provided to improve sleep, reduce appetite, or reduce the need for joint replacement surgery.

13.A client presents complaining of abnormal muscle weakness and fatigability. The physician suspects myasthenia gravis. Which drug can be used to test for this disease?
1.pyridostigmine (Mestinon)
2.Neostigmine (Prostigmin)
3.Ambenonium (Mytelase)
4.Edrophonium (Tensilon)
ANS: 4
Tensilon, a short-acting anticholinesterase agent, is the drug of choice for diagnosing myasthenia gravis. The clients response is a rapid improvement of manifestations within 15 to 30 seconds that last 5 minutes. The other medications are used to treat clients diagnosed with myasthenia gravis.

MULTIPLE RESPONSE
1.A client is diagnosed with tonic-clonic seizures. Which are the characteristics of these types of seizures? (Select all that apply.)
1.Progressing through all of the seizure phases
2.Beginning before age 5
3.Lasting 2 to 3 minutes
4.Causing injury to the client
5.Occurring at any time, day or night
6.Being highly variable
ANS: 1, 3, 4, 5, 6
Tonic-clonic seizures are the most common type of generalized seizure. The seizure will progress through all of the seizure phases and last 2 to 3 minutes. Because these seizures begin suddenly, there is an increased incidence of injury associated with them. These seizures can occur any time of the day or night, whether the client is awake or not. Seizure frequency is highly variable.
2.Which of the following nursing interventions would be appropriate for a client diagnosed with Alzheimers disease? (Select all that apply.)
1.Make changes to the room often to stimulate memory function.
2.Assign simple tasks to be completed by the client.
3.Assist the client with any needs associated with activities of daily living (ADLs).
4.Have personal/familiar items around the client.
5.Do complex games and puzzles to improve memory.
ANS: 2, 3, 4
Alzheimers disease progressively alters the clients ability to function in the normal ways of living. Personal and familiar items help to keep the client oriented, and simple tasks keep the client functioning at the highest levels as long as possible.
3.A client has been diagnosed with Parkinsons disease. Which of the following will the nurse most likely assess in this client? (Select all that apply.)
1.Tremor
2.Muscle rigidity
3.Akinesia
4.Mask-like face
5.Dysphagia
6.Reduced appetite
ANS: 1, 2, 3, 4, 5
Signs and symptoms of Parkinsons disease include tremor, muscle rigidity, akinesia, mask-like face, and

dysphagia. Reduced appetite is not a sign or symptom of Parkinsons disease.
4.The nurse is planning care for a client diagnosed with myasthenia gravis. Which of the following should be included in this clients plan of care? (Select all that apply.)
1.Monitor activities frequently and assist as needed.
2.Encourage progressive increase in activities.
3.Determine the best communication method.
4.Monitor weight.
5.Restrict fluids.
6.Instruct in energy conservation measures.
ANS: 1, 3, 4, 6
Care for the client diagnosed with myasthenia gravis includes frequent monitoring of activities and assisting as needed, determining the best communication method, monitoring weight, and instructing in energy conservation methods. Encouraging a progressive increase in activities and restricting fluids are not appropriate interventions for a client diagnosed with myasthenia gravis.
5.The nurse is instructing a client and family regarding the diagnosis of amyotrophic lateral sclerosis. Which of the following should be included in this teaching? (Select all that apply.)
1.The length of the curative treatment
2.That exercise and physical therapy can help the patient maximize function
3.The physical, emotional, and social aspects of the disease
4.End-of-life issues
5.The use of devices to prevent aspiration pneumonia
6.The use of a speech therapist to aid with communication
ANS: 2, 3, 4, 5, 6
Currently, no cure for this disease exists. Because of the progressive, degenerative nature of the disease, the supportive and educative role of the nurse is important. End-of-life issues need to be discussed before an emergency situation occurs. Other topics of instruction should include the purpose of physical therapy and speech therapy; the use of devices to prevent aspiration; and the emotional and social aspects of the disease.
6.The nurse is caring for a client diagnosed with Huntingtons disease. Which of the following are considered hallmark clinical manifestations of this disorder? (Select all that apply.)
1.Intellectual decline
2.Weight loss
3.Decreased appetite
4.Reduced blood pressure
5.Nausea
6.Abnormal movements
ANS: 1, 6
The hallmark clinical manifestations of Huntingtons disease are intellectual decline and abnormal movements. Weight loss, decreased appetite, reduced blood pressure, and nausea are not clinical manifestations of this disorder.

Chapter 9. Cerebrovascular Accident (Stroke) MULTIPLE CHOICE

1.For the client who is at risk for stroke, the most important guideline the nurse should teach is to:

1.	increase drinks with caffeine.
2.	monitor blood pressure.
3.	increase amounts of sodium in the diet.
4.	monitor weight and activity.

ANS: 2

Monitoring weight and activity is important, but the highest priority is monitoring the blood pressure. This is a modifiable risk factor that, when controlled, will decrease the risk of stroke.

2.The family of a client diagnosed with a stroke asks the nurse if this health problem is very common. The nurse should respond that in the United States a person has a stroke every:

1.	40 seconds.
2.	1 minutes.
3.	2 minutes.
4.	5 minutes.

ANS: 1

In the United States, a person has a stroke every 40 seconds, and 700,000 new or recurrent strokes each year. Strokes are the third leading cause of death in the United States behind heart disease and cancer and are the leading cause of long-term disability.

3.A client is being evaluated for a stroke. The nurse knows that one of the easiest and most common diagnostic tests used to differentiate between strokes is:

1.	computed tomography (CT).

2.	magnetic resonance imaging (MRI).
3.	electrocardiography (EEG).
4.	positron emission tomography (PET).

ANS: 1

The CT scan is widely available in most hospitals and is an important tool to differentiate between ischemic strokes and hemorrhagic stroke. It is the most common tool used to diagnose a stroke. An MRI is contraindicated in clients with metal implants or pacemakers, and it can exacerbate claustrophobia. An EEG will determine the presence of brain waves, and it is not a diagnostic test for a stroke. A PET scan determines brain tissue functioning but, it will not be able to differentiate between the types of strokes.

4.While instructing a client on stroke prevention, the nurse mentions medications that are useful in stroke prevention. The following medications are effective in preventing a stroke, EXCEPT:

1.	anticoagulants.
2.	antiplatelets.
3.	anticholinergics.
4.	neuroprotective agents.

ANS: 3

Although anticholinergic drugs have a variety of uses, stroke prevention is not one of them. All the other medications are used in a variety of ways to help with stroke prevention.

5.A client is being seen in the emergency department experiencing symptoms of a stroke. The nurse realizes that the administration of a medication to break clots, such as tPA, should be administered within how many minutes of the client presenting to the emergency department?

1.	30 minutes
2.	60 minutes

3.	90 minutes
4.	120 minutes

ANS: 2

Medications like tPA should be given within 60 minutes of the clients arrival to the emergency department. This is why health care teams must have a plan to deal with stroke clients quickly and efficiently.

6.A client diagnosed with an embolic stroke is not a candidate for tPA. The nurse realizes that the client might be eligible for which of the following forms of treatment?

1.	Carotid stenting
2.	Antiarrhythmic medication
3.	Intravenous fluid therapy
4.	Carotid endarterectomy

ANS: 1

In clients who are ineligible for tPA therapy, catheter-based treatment such as stenting may be an option. Carotid endarterectomy is used to prevent a stroke. Antiarrhythmic medication does not prevent a stroke. Intravenous fluid therapy does not prevent a stroke.

7.A client, being tested for a stroke, is not a candidate for tPA. Which of the following would be contraindicated for the use of tPA? (Select all that apply.)

1.	Minor ischemic stroke within 30 days
2.	Glucose level 120 mg/dL
3.	Blood pressure 190/120 mmHg
4.	Lumbar puncture 2 days ago

5.	Stroke onset 5 hours ago
6.	INR 1.0

ANS: 1, 3, 4, 5

Contraindications of tPA to treat an embolic stroke include minor ischemic stroke within the last 30 days, blood pressure greater an 185 mmHg systolic or greater than 110 mmHg diastolic, lumbar puncture within the last 3 days, and onset of stroke greater than 3 hours. Glucose level of 120 mg/dL and INR of 1.0 would not be contraindications for tPA therapy.

1. A patient with a temporary loss of motor function is diagnosed with a transient ischemic attack (TIA). What should the nurse include when assisting in the teaching about this health problem?

a.	You had a small hemorrhage in your brain.
b.	Your brain was temporarily deprived of oxygen.
c.	The neurons in your brain are tangled, so messages get mixed up.
d.	You have a vessel that is occluded, blocking the blood supply to your brain.

ANS:B

TIA is a temporary impairment of the cerebral circulation causing neurological impairment that lasts less than 24 hours. A. A hemorrhage would cause a hemorrhagic stroke. D. A fully occluded vessel causes an ischemic stroke. C. Tangled messages refer to Alzheimers disease.

_____ 2. The nurse is assisting with teaching a patient who has had a transient ischemic attack (TIA). On which understanding should the nurse base teaching?

a.	TIAs are not serious, and the patient should have no further problems.
b.	A TIA is predictive that the patient will have a heart attack within 1 year.
c.	A TIA is a medical emergency that requires immediate surgical intervention.
d.	A TIA is a forewarning that the patient is at risk for a cerebrovascular accident (stroke).

ANS

About a third of patients who experience a TIA will have a stroke in the future. A. Urgent evaluation of TIA is essential in order to decrease the risk of stroke. B. There are no data related to myocardial infarction (MI) prediction. C. It is not a surgical problem.

_____ 3. The nurse is planning care for a client with right-sided weakness and aphasia from a transient ischemic attack (TIA). Which area of the brain should the nurse realize was affected in this client?

a.	Medulla
b.	Occipital lobe
c.	Left hemisphere
d.	Right hemisphere

ANS:C

Symptom onset is sudden and generally involves one side of the bodythe side of the body opposite to the damaged area. A. B. The manifestations of right-sided weakness and aphasia would not be present if the TIA occurred in the medulla or occipital lobe. D. The client would have left-sided manifestations if the TIA occurred in the right hemisphere.

_____ 4. A patient with a cerebrovascular accident (stroke) has left-sided flaccidity and is unable to speak but seems to understand everything the nurse says. Which term should the nurse use to document the patients communication impairment?

a.	Sensory aphasia
b.	Motor dysphagia
c.	Expressive aphasia
d.	Receptive dysphagia

ANS:C

Aphasia may be expressive, in which the patient knows what he or she wants to say but cannot speak or make sense. D. Receptive aphasia is an inability to understand spoken or written words. The patient experiencing receptive aphasia is unable to understand language. B. Dysphagia refers to difficulty swallowing. A. Sensory aphasia is not a type of communication impairment.

_____ 5. The nurse is documenting care provided to a patient with left-sided flaccidity caused by a stroke. Which term should the nurse use to document this patients motor status?

a.	Ipsilateral paraplegia
b.	Ipsilateral hemiparesis
c.	Contralateral hemiplegia
d.	Contralateral quadriparesis

.ANS:C

A patient with a stroke has symptoms on the opposite side of the stroke, which is called contralateral. One-sided flaccidity is called hemiplegia. A. Ipsilateral means the same side. Para refers to the lower extremities. D. Quad refers to all four extremities; B. Hemiparesis is another term for hemiplegia.

_____ 6. A patient comes into the emergency department with symptoms of a stroke. Which medication should the nurse expect may be given to the patient if diagnostic testing confirms an ischemic stroke?

a.	Heparin
b.	Clopidogrel (Plavix)
c.	Warfarin (Coumadin)
d.	Tissue-type plasminogen activator (tPA)

ANS D

tPA is a thrombolytic agent that can break down the thrombus causing the occlusion, which can potentially prevent or completely reverse the symptoms of an ischemic stroke. A. B. C. Heparin, warfarin, and clopidogrel can help prevent clots but are not effective in breaking up an existing clot.

_____ 7. A patient is prescribed an antiplatelet agent to prevent strokes. Which agent was this patient most likely prescribed?

a.	Aspirin
b.	Warfarin (Coumadin)
c.	Acetaminophen (Tylenol)
d.	Tissue-type plasminogen activator (tPA)

ANS:A

Aspirin is a platelet aggregation inhibitor. C. Tylenol is an analgesic but does not affect platelet function. B. Warfarin is an anticoagulant. D. tPA is a thrombolytic agent.

8. A patient with symptoms of impending stroke is scheduled to have a cerebral angiogram. Which statement should the nurse include when assisting with patient teaching?

a.	This test is designed to detect vascular lesions in the brain.
b.	The angiogram is done to help identify swelling in the brain.
c.	We need to do this to evaluate electrical function of the brain.
d.	This test is done to examine cerebrospinal fluid for signs of bleeding.

ANS:A

A cerebral angiogram may be completed to determine the patency of cerebral vessels and the status of any collateral circulation. D. A lumbar puncture is done to examine cerebrospinal fluid (CSF). B. Edema may be identified by radiography. C. An electroencephalogram (EEG) shows electrical function.

9. The nurse is caring for a hospitalized patient who has had a stroke and is waiting to be transferred to a rehabilitation facility. What nursing action can best maximize the patients rehabilitation potential while awaiting the transfer?

a.	Teach the patient what to expect at the rehabilitation facility.
b.	Keep the patient on bedrest to conserve energy for rehabilitation.
c.	Call the physical therapist for bedside rehabilitation until the transfer.
d.	Turn the patient every 2 hours to prevent pressure ulcers and contractures.

ANS:C

Rehabilitation should begin as soon as the patient is stable. Waiting until the patient is at the rehabilitation facility to begin therapy wastes valuable time. A. Teaching the patient what to expect at the rehabilitation facility will not maximize the patients rehabilitation potential. B. Keeping the patient on bedrest could cause further mobility issues. D. Turning the patient every 2 hours to prevent ulcer formation and contractures will not necessarily maximize the patients rehabilitation potential.

_____ 10. The nurse is assisting in preparing a patient for transfer to a rehabilitation facility after a stroke. What should the nurse explain as the goal for rehabilitation?

a.	To monitor neurological status
b.	To cure any effects of the stroke
c.	To maximize remaining abilities
d.	To determine the extent of neurological deficits

ANS:C

Rehabilitation can help the patient maximize remaining abilities. A. D. At this point, the patients neurological status should be stable, and all the diagnostic work has been completed. B. Cure is not realistic.

11. A patient is admitted to the hospital with a severe headache and photophobia. A lumbar puncture confirms a bleeding aneurysm. What nursing interventions should the nurse anticipate assisting with to prevent increased intracranial pressure (ICP) during the acute phase of illness?

a. Morphine, dark glasses, and expectorants

b. Quiet room, head of bed up, and stool softeners

c. Coughing and deep breathing exercises and tranquilizers

d. Range of motion exercises, bedside commode, and suctioning as needed

ANS:B

A quiet room with minimal stressors, elevated head, and stool softeners can help reduce ICP. A. C. Morphine and tranquilizers are not usually recommended because they can make neurological assessment difficult. A. C. Expectorants can promote coughing, which can raise ICP. C. D. Exercises, moving, and suctioning can also raise ICP.

12. A client with a subarachnoid bleed refuses to use a bedpan and becomes angry when denied permission to walk to the bathroom. While waiting to hear from the health care provider (HCP), which action should the nurse take?

a. Help the patient to get up on a bedside commode

b. Wait for the neurosurgeon to call back with orders

c. Page security to restrain the patient from harming the nurse

d. Administer an as-needed dose of a sedative that is ordered

ANS D

Patients with subarachnoid hemorrhage are at risk for rebleeding. A. Straining to have a bowel movement and agitation both increase the risk of rebleeding. B. The patient may need to be sedated until the physician can be contacted. C. Bringing in security will be upsetting to the patient and can also increase the risk of raising the BP and bleeding.

13. A patient is experiencing bilateral hemiparesis, dysphasia, visual changes, and altered level of consciousness, ataxia, and dysphagia. Which artery was most likely affected in this patients stroke?

a. Carotid

b. Middle cerebral

c. Posterior cerebral

d. Vertebrobasilar/cerebellar

ANS D

These are symptoms of vertebrobasilar/cerebellar occlusion. A. B. C. Carotid and middle or posterior cerebral occlusions are not associated with ataxia or dysphagia.

14. The patient is diagnosed with a cerebral vascular accident that has the slowest rate of recovery and the highest probability of causing extensive neurological deficits. For which type of stroke should the nurse plan care for this patient?

a.	Thrombotic stroke
b.	Cerebral aneurysm
c.	Subarachnoid hemorrhage (SAH)
d.	Reversible ischemic neurological deficit (RIND)

ANS:C

SAH is caused by rupture of blood vessels on the surface of the brain. This type of infarct has the slowest rate of recovery and the highest probability of leaving the patient with extensive neurological deficits. B. Aneurysms are often asymptomatic if they do not bleed. D. RIND is reversible. A. A thrombotic stroke does not have the slowest rate of recovery.

15.A patient enters the emergency department with right-sided weakness and vision changes. What assessment finding should be communicated to the registered nurse (RN) or HCP immediately?

a.	Blood glucose 150 mg/dL
b.	Blood pressure 148/92 mm Hg
c.	Onset of symptoms occurred 90 minutes ago
d.	History of transient ischemic attack (TIA) 3 months ago

ANS:C

All the data are significant. However, the onset of symptoms is within the time frame for the patient to receive a thrombolytic. If the nurse acts quickly, the patients stroke may be able to be reversed.

16. The nurse is reviewing teaching provided to a patient with transient ischemic attack (TIA). Which statement indicates that further teaching is required?

a.	The risk factors and symptoms of a TIA are just like those of a stroke.
b.	I need to stop smoking to help lower my chances of this happening again.
c.	My risk for Alzheimers disease is increased now, so Ill have to stop driving.
d.	I recognize how important it is to take my anti-hypertension medications regularly.

ANS:C

There is no association between TIA and the development of Alzheimers disease. A. The risk factors, causes, and symptoms of a TIA are identical to a cerebrovascular accident (CVA). Patients who have had a TIA have an increased risk of having a stroke. Treatment, therefore, is mostly

focused on minimizing the patients risk factors for a stroke. B. D. Modifiable risk factors are those risks that can be changed by treatment, such as treating high blood pressure, or by lifestyle modification, such as stopping smoking.

17. A patient began experiencing manifestations of a stroke at 0800 hours. By which time should thrombolytic medications be provided to reverse stroke symptoms?

a.	0900 hours
b.	1250 hours
c.	1400 hours
d.	1660 hours

ANS:B

If a patient experiencing ischemic stroke symptoms receives treatment within 4.5 hours of symptom onset, medication can be provided to resolve the deficits. A. A patient needs to be treated within 4.5 hours and not 1 hour. C. D. This is too long to wait to provide medication to treat the symptoms of a stroke.

18. A patient is diagnosed with a stroke that occurred at 12 noon the previous day. When should the nurse plan to begin bedside physical therapy with this patient?

a.	After 5 days
b.	Within 2 to 3 days
c.	By 12 noon on the current day
d.	At least one week after the occurrence

.ANS:C

Patients should be mobilized within 24 hours if possible to prevent complications of immobility. Physical and occupational therapy are provided to maximize functioning and to progress the patient toward a return to baseline functioning. A. B. D. Waiting to begin physical therapy could reduce the patients success with physical rehabilitation.

19. The nurse is planning care for a patient with an intracerebral hemorrhage. What should be identified as a goal for this patient?

a.	Maintain blood pressure below 120/80 mm Hg
b.	Resume activities of daily living as soon as possible
c.	Expect to experience transient numbness and tingling

d.	Receive thrombolytic medication therapy within an hour

ANS:A

An intracerebral hemorrhage is usually caused by uncontrolled hypertension. Maintaining blood pressure below 120/80 mm Hg should be the goal for these patients. B. These patient cannot resume activities of daily living until the bleeding is controlled within the brain. C. Transient numbness and tingling could indicate additional brain damage from bleeding. D. Thrombolytic therapy is not indicated for an intracerebral hemorrhage.

Chapter 10. Infectious and Inflammatory Neurological Disorders

1.What should the nurse do when the child arrives on the floor with the diagnosis of bacterial meningitis?

a.	Arrange for humidified oxygen per mask
b.	Place the child in respiratory isolation
c.	Inquire about drug allergy
d.	Hold NPO until orders arrive

ANS: B

Persons with bacterial meningitis are placed in respiratory isolation until the pathogen can no longer be cultured, usually 24 hours.

2.What should the nurse do when the child arrives on the floor with the diagnosis of bacterial meningitis?

a.	Arrange for humidified oxygen per mask
b.	Place the child in respiratory isolation
c.	Inquire about drug allergy
d.	Hold NPO until orders arrive

ANS: B

Persons with bacterial meningitis are placed in respiratory isolation until the pathogen can no longer be cultured, usually 24 hours.

Chapter 11.Common Skin Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. Simon presents with alopecia areata with well-circumscribed patches of hair loss on the crown of his head. How do you respond when he asks you the cause?
a. "You must be under a lot of stress lately."
b. "It is hereditary. Did your father experience this also?"
c. "The cause is unknown, but we suspect it is due to an immunologic mechanism."
d. "We'll have to do some tests."

____ 2. Which of the following is "a linear crack extending from the epidermis to the dermis?"
a. An ulcer
b. A fissure
c. Lichenification
d. An excoriation

____ 3. A bulla is:
a. A vesicle larger than 1 cm in diameter
b. An elevated solid mass with a hard texture; the shape and borders can be regular or irregular
c. A superficial elevated lesion filled with purulent fluid
d. Thinning of the skin (epidermis and dermis) that appears white or translucent

____ 4. An example of ecchymosis is:
a. A hematoma
b. A keloid
c. A bruise
d. A patch

__ 5. When looking under the microscope to diagnose an intravaginal infection, you see a cluster of small and oval to round shapes. What do you suspect they are?
a. Spores
b. Leukocytes
c. Pseudohyphae
d. Epithelial cells

__ 6. Your patient is in her second trimester of pregnancy and has a yeast infection. Which of the following is a treatment that you usually recommend/order in nonpregnant patients, but is listed as a Pregnancy category D?

a. Vagistat vaginal cream
b. Monistat combination pack
c. Terazol vaginal cream
d. Diflucan, 150 mg

____ 7. Tinea unguium is also known as:
a. Onychomycosis
b. Tinea versicolor
c. Tinea manuum
d. Tinea corporis

___ 8. Sally, age 25, presents with impetigo that has been diagnosed as infected with *Staphylococcus.* The clinical presentation is pruritic tender, red vesicles surrounded by erythema with a rash that is ulcerating. Her recent treatment has not been adequate. Which type of impetigo is this?
a. Bullous impetigo
b. Staphylococcal scalded skin syndrome (SSSS)
c. Nonbullous impetigo
d. Ecthyma

___ 9. Mark has necrotizing fasciitis of his left lower extremity. Pressure on the skin reveals crepitus due to gas production by which anaerobic bacteria?
a. Staphylococcal aureus
b. Clostridium perfringens
c. S. pyrogenes
d. Streptococcus

___ 10. When using the microscope for an intravaginal infection, you see something translucent and colorless. What do you suspect?
a. A piece of hair or a thread
b. Hyphae
c. Leukocytes
d. Spores

___ 11. Marci has a wart on her hand. She says she heard something about “silver duct tape therapy.” What do you tell her about his?
a. It is an old wives’ tale.
b. It is used as a last resort.
c. Salicylic acid is more effective.
d. It is a simple treatment that should be tried first.

____ 12. Which is the most potent and irritating dose of tretinoin?

a. 0.05% liquid formulation
b. 0.1% cream
c. 1% foam
d. 0.02% cream

___ 13. Of the following types of cellulitis, which is a streptococcal infection of the superficial layers of the skin that does not involve the subcutaneous layers?

a. Necrotizing fasciitis
b. Periorbital cellulitis
c. Erysipelas
d. "Flesh-eating" cellulitis

___ 14. Mandy presents with a cauliflower-like wart in her anogenital region. You suspect it was sexually transmitted and document this as a:

a. Filiform/digitate wart
b. Dysplastic cervical lesion
c. Condyloma acuminata
d. Koilocytosis

___ 15. Jeffrey has atopic dermatitis. You are prescribing a low-dose topical corticosteroid for him. Which would be a good choice?

a. Betamethasone dipropionate 0.05%
b. Hydrocortisone base 2.5%
c. Halcinonide 0.1%
d. Desonide 0.05%

___ 16. Harvey has a rubbery, smooth, round mass on his chest that is compressible and has a soft-to-very- firm texture. What do you diagnose this as?

a. A lipoma
b. A nevi
c. A skin tag
d. A possible adenoma

___ 17. Which of the following statements is accurate when you are removing a seborrheic keratosis lesion using liquid nitrogen?

a. Do not use lidocaine as it may potentiate bleeding.
b. Pinch the skin taut together.
c. Use gel foam to control bleeding.
d. This should be performed by a dermatologist only.

____ 18. The “B” in the ABCDEs of assessing skin cancer represents:
a. Biopsy
b. Best practice
c. Boundary
d. Border irregularity

__ 19. The majority of HSV-1 and HSV-2 infections are asymptomatic so that only which elevated antibody titer shows evidence of previous infection?
a. IgA
b. IgE
c. IgG
d. IgM

____ 20. Eighty percent of men have noticeable hair loss by what age?
a. 35
b. 50
c. 70
d. 85

____ 21. Prevalence of psoriasis is highest in which group?
a. Scandinavians
b. African Americans
c. Asians
d. Native Americans

____ 22. The most common precancerous skin lesion found in Caucasians is:
a. A skin tag
b. Actinic keratosis
c. A melanoma
d. A basal cell lesion

__ 23. Ian, age 62, presents with a wide, diffuse area of erythematous skin on his lower left leg that is warm and tender to palpation. There is some edema involved. You suspect:
a. Necrotizing fasciitis
b. Kaposi’s sarcoma
c. Cellulitis
d. A diabetic ulcer

____ 24. Josh, aged 22, has tinea versicolor. Which description is the most likely for this condition?

a. There are round, hypopigmented macules on his back.
b. Josh has red papules on his face.
c. There are crusted plaques in Josh's groin area.
d. There are white streaks on his neck.

___ 25. Tori is on systemic antifungals for a bad tinea infection. You are aware that the antifungals may cause:
a. Renal failure
b. Skin discoloration
c. Breathing difficulties
d. Hepatotoxicity

____ 26. Which scalp problem can be caused by a fever and certain drugs?
a. Telogen effluvium (TE)
b. Trichotillomania
c. Psoriasis
d. Alopecia areata

____ 27. Why do people of African descent have a lower incidence of non-melanoma skin cancer?
a. They have an increased number of melanocytes.
b. Their darker skin protects from ultraviolet radiation.
c. Their skin is thicker.
d. Their immune system is stronger.

____ 28. Which statement is true regarding chloasma, the 'mask of pregnancy'?
a. It is caused by a decrease in the melanocyte-stimulating hormone during pregnancy.
b. This condition only occurs on the face.
c. Exposure to sunlight will even out the discoloration.
d. It is caused by increased levels of estrogen and progesterone.

____ 29. When instructing your elderly client about treating her xerosis, what do you tell her?
a. A daily hot bath may help the associated pruritus.
b. Rub the skin briskly to make sure it is completely dry after bathing.
c. Only take short tepid showers.
d. Use a gel that is alcohol-based after bathing to soften the skin.

____ 30. Which medication used for scabies is safe for children 2 months and older?
a. Permethrin cream
b. Lindane

c. Crotamiton lotion and cream
d. Ivermectin

____ 31. Which of the following is an infraorbital fold skin manifestation in a patient with atopic dermatitis?
a. Keratosis pilaris
b. Dennie's sign
c. Keratoconus
d. Pityriasis alba

____ 32. Which of the following statements about performing cryosurgery for actinic keratosis is true?
a. It is better to slightly overfreeze the area, so you only have to do it once.
b. Using liquid nitrogen, freeze each lesion for at least 30 seconds.
c. Every lesion should be biopsied after using liquid nitrogen.
d. The 'freeze balls' should be approximately one-and-a-half times as wide as they are deep.

____ 33. An example of a primary skin lesion is a/an:
a. Bulla
b. Scale
c. Excoriation
d. Fissure

____ 34. Which statement regarding necrotizing fasciitis is true?
a. The hallmark of this infection is its slow and steady progression.
b. Once the border of the infection is "established," it does not spread.
c. Loss of life or limb is a potential complication.
d. The lesion is most dangerous, because it is painless.

__ 35. When staging a malignant melanoma using Clark's levels, which level extends into the papillary dermis?
a. Level I
b. Level II
c. Level III
d. Level IV

Chapter 11.Common Skin Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: C PTS: 1
2. ANS: B PTS: 1
3. ANS: A PTS: 1
4. ANS: C PTS: 1
5. ANS: A PTS: 1
6. ANS: D PTS: 1
7. ANS: A PTS: 1
8. ANS: D PTS: 1
9. ANS: B PTS: 1
10. ANS: B PTS: 1
11. ANS: D PTS: 1
12. ANS: A PTS: 1
13. ANS: C PTS: 1
14. ANS: C PTS: 1
15. ANS: B PTS: 1
16. ANS: A PTS: 1
17. ANS: C PTS: 1
18. ANS: D PTS: 1
19. ANS: C PTS: 1
20. ANS: D PTS: 1
21. ANS: A PTS: 1

22. ANS: B PTS: 1

23. ANS: C PTS: 1

24. ANS: A PTS: 1

25. ANS: D PTS: 1

26. ANS: A PTS: 1

27. ANS: B PTS: 1

28. ANS: D PTS: 1

29. ANS: C PTS: 1

30. ANS: A PTS: 1

31. ANS: B PTS: 1

32. ANS: D PTS: 1

33. ANS: A PTS: 1

34. ANS: C PTS: 1

35. ANS: C PTS: 1

Chapter 12. Parasitic Skin Infestations

1.The school nurse recognizes the signs of scabies when a child presents with:

a.	small fluid filled blisters that sting when scratched.
b.	dry scaly patches in body creases that itch.
c.	wavy threadlike lines on the body and pruritus.
d.	cluster of papular lesions with pruritus.

ANS: C

Scabies is manifested by brown threadlike lines on the body, especially the hands, anus, and body folds. Pruritus is severe.

2.Which of the following are nursing interventions and patient teaching for the treatment of head lice and scabies? (Select all that apply.)

a.	Clothing, linens, and bath articles thoroughly cleaned in hot water
b.	Stress nature and transmission of the disease
c.	Special carbohydrate diet to promote healing
d.	Complete isolation from the public

ANS: A, B

Identify involved contacts while stressing importance of preventing transmission of disease. Washable and clothing items should be cleaned in hot water to prevent reinfection. No special diet is required. Isolation is not necessary once medical management is completed.

3.The nurse is caring for a patient with lesions on the skin. Which assessment finding should cause the nurse to suspect scabies?
a. Large, fluid-filled blisters
b. Short, wavy, brownish black lines
c. Reddish brown dots at the base of hairs
d. Gray blue macules on the thighs and axillae
ANS: B
The scabies parasite burrows into the superficial layer of the skin. These burrows appear as short, wavy, brownish black lines. C. Pediculosis pubis causes black or reddish brown dots (lice excreta) at the base of hairs or in underclothing. D. Gray blue macules may also be noted on the trunk, thighs, and axillae; this is the result of the insects saliva mixing with bilirubin. A. Large, fluid-filled blisters occur in pemphigus.

Chapter 13. Fungal Skin Infections
1. A client is experiencing a circular lesion with an advancing, red, scaly border on the abdomen. The nurse recognizes this lesion as being:

1	tinea capitis.
2	tinea corporis.
3	tinea cruris.
4	tinea pedis.

ANS: 2

Tinea corporis is a fungal infection that involves the face, trunk, and limbs. Tinea pedis is a common infection of the feet. Tinea cruris occurs in the groin and inner thigh, and tinea capitis involves the scalp.

2.A client is diagnosed with tinea versicolor. Which of the following should the nurse instruct this client regarding the care for this skin condition?

1	Do nothing since there is no treatment.
2	Utilize shampoo with selenium.
3	Utilize an oral antifungal preparation as prescribed.
4	Apply warm compresses to the affected areas.

ANS: 2

Treatment for tinea versicolor includes the use of selenium shampoo. The nurse should not instruct the client to do nothing since treatment does exist for this condition. Oral antifungal preparations are not necessary for this condition. Warm compresses will not help this condition.

3.A school nurse assesses a child who has an erythematous circular patch of vesicles on her scalp with alopecia and complains of pain and pruritus. Why would the nurse use a Woods lamp?

a.	To dry out the lesions
b.	To reduce the pruritus
c.	To kill the fungus
d.	To cause fluorescence of the infected hairs

ANS: D

Tinea capitis is commonly known as ringworm of the scalp. *Microsporum audouinii* is the major fungal pathogen. The use of the diagnostic Woods lamp causes the infected hairs to turn a brilliant blue green.

Chapter 14. Bacterial Skin Infections

1.A client has what appears to be a bacterial infection or warts on her fingertips. This can be a sign of:

1	herpes gladiatorum.
2	herpes simplex.
3	herpes zoster.
4	herpetic whitlow.

ANS: 4

Herpetic whitlow usually occurs on the fingertips and can resemble a bacterial infection or warts. Herpes gladiatorum is most frequently found in athletes who participate in contact sports. The appearance of herpes zoster is usually down a single dermatome. Herpes simplex is usually seen orally or on the genitals.

2.A school-age child is experiencing pruritic vesicles around the mouth. The lesions have a honey-colored crust. The nurse realizes that the child is most likely experiencing:

1	candidiasis.
2	herpes simplex.
3	impetigo.
4	tinea corporis.

ANS: 3

Impetigo is a common, superficial skin infection beginning as a focal erythema and progressing to pruritic vesicles, erosions, and honey-colored crusts. Oral herpes simplex would look like a cold sore. Tinea corporis has a circular, red, scaly border, and candidiasis is a proliferation of the normal yeast flora.

3.A client is diagnosed with severe nodulocystic acne. The nurse should instruct the client on which of the following types of treatments? (Select all that apply.)

1	Oral antibiotics
2	Benzoyl peroxide
3	Sulfur
4	Intralesional injections
5	Soap and water
6	Topical therapy

ANS: 1, 4, 6

Treatment for severe nodulocystic acne includes oral antibiotics, intralesional injections, and topical therapy. Benzoyl peroxide is indicated for mild and moderate acne. Sulfur is indicated for moderate acne. Soap and water is indicated for mild acne.

4.Which patient statement indicates that more teaching is needed regarding antibiotic therapy for the treatment of cellulitis?

a.	My skin is cleared up. I dont think I need the medication anymore.
b.	Cellulitis can come back at any time.
c.	If I had washed that scratch with soap and water, I probably would not have gotten cellulitis.
d.	Cellulitis is contagious.

ANS: A

The entire amount of antibiotic medication should be completed even if the symptoms have abated to ensure the eradication of the infectious agent.

5. The nurse is participating in planning care for a patient with pemphigus. What nursing diagnosis should the nurse recommend be used to guide this patients care?
a. Risk for Infection
b. Fluid Volume Excess
c. Self-Care Deficit: Skin Care
d. Imbalanced Nutrition: Less Than Body Requirements
ANS: A
The major complication of pemphigus is a secondary bacterial infection. C. D. Nutrition and self-

care deficit would be determined based on assessment findings. B. Fluid volume deficit would be more likely than excess because of the oozing blisters.

6. A patient is prescribed vitamin A acid (Retin-A) as treatment of acne vulgaris. What should the nurse instruct the patient about the purpose of this medication? (Select all that apply.)
a. It decreases scarring.
b. It loosens pore plugs.
c. It kills bacteria in follicles.
d. It stabilizes hormone levels.
e. It stimulates the immune system.
f. It prevents occurrence of comedomes.
ANS: B, F
Vitamin A acid (Retin-A, tretinoin) loosens pore plugs and prevents occurrence of new comedones. C. Antibiotics kill bacteria. D. Estrogen therapy stabilizes hormone levels. A. Dermabrasion can treat scarring. E. This medication does not stimulate the immune system.

Chapter 15. Viral Skin Infections

1.A client is diagnosed with a viral skin infection. The nurse realizes that which of the following medications may be prescribed for this client? (Select all that apply.)

1	Nystatin (Mycostatin)
2	Docosanol (Abreva)
3	Boric acid
4	Penciclovir (Denavir)
5	Hydrogen peroxide
6	Acyclovir (Zovirax)

ANS: 2, 4, 6

Antiviral medications include docosanol (Abreva), penciclovir (Denavir), and acyclovir (Zovirax). Nystatin (Mycostatin) is an antifungal medication. Boric acid is an antipruritic solution. Hydrogen peroxide is an antiseptic solution.

2.A client is diagnosed with genital herpes simplex virus. The nurse know that symptoms of the primary infection occur:

1	1 to 4 days after exposure.
2	3 to 7 days after exposure.
3	5 to 9 days after exposure.
4	7 to 11 days after exposure.

ANS: 2

Symptoms of the primary herpes simplex infection occur 3 to 7 days after exposure. The other choices do not describe the length of time before symptoms of the primary herpes simplex infection occur.

3.What should a patient be assessed for upon the diagnosis of genital herpes?

a.	Hepatitis B
b.	Syphilis
c.	Human immunodeficiency virus (HIV).
d.	Cirrhosis

ANS: C

Persons with genital herpes should be assessed for HIV because the therapy for herpes is suppressive; persons with HIV are not candidates for suppressant therapy.

4. The nurse is care for a patient with shingles. Which statement should the nurse include in patient teaching?
a. Herpes simplex 2 causes shingles.
b. Shingles is caused by herpes simplex 1 virus.
c. Varicella zoster is the virus responsible for shingles.
d. Herpes zoster is a virus that is common in older patients.

ANS: C

Herpes zoster, or shingles, is caused by the varicella zoster virus. B. Herpes simplex 1 causes cold sores. A. Herpes simplex 2 causes genital herpes. C. This disease occurs most commonly in older patients or in those who have a diminished resistance, such as the patient with AIDS, the patient on immunosuppressant agents, or the patient with a malignancy or injury to the spine or a cranial nerve.

Chapter 16. Dermatitis

1.Which of the following should the nurse instruct a client who is prescribed a topical medication for a skin condition?

1	Apply directly to broken or irritated skin.
2	Apply before bathing.
3	Apply after bathing.
4	Cover the area with an occlusive dressing.

ANS: 3

The client should be instructed to apply the medication to the skin after bathing since hydration of the area will increase absorption of the medication. The medication should not be applied directly to broken or irritated skin. The medication should not be applied before bathing. The area should not be covered with an occlusive dressing.

2.A client is diagnosed with a dermatologic condition causing pruritis and inflammation. Which of the following should the nurse instruct this client?

1	Use regular perfumed lotion to moisturize the skin.
2	Use scented soap to bathe the skin daily.
3	Apply skin oil daily.
4	Apply a body moisturizer to the skin within 3 to 5 minutes after bathing.

ANS: 4

Regular usage of body moisturizers, particularly within 3 to 5 minutes after bathing or showering, will aid in the prevention of dry, flaking, and itching skin. Perfumed lotions and scented soaps

contain alcohol, which will exacerbate pruritis and inflammation. Skin oil does not penetrate into the skin.

3.What is the initial intervention for relief of the pruritus of dermatitis venenata?

a.	Apply baking soda to lesions
b.	Wash area with copious amounts of water
c.	Apply cool compresses continuously
d.	Expose area to air

ANS: B

In dermatitis venenata (poison oak or ivy), the patient should wash the affected part immediately after contact with the offending allergen.

4.A patient developed a severe contact dermatitis of the hands, arms, and lower legs after spending an afternoon picking strawberries. The patient states that the itching is severe and cannot keep from scratching. Which instruction would be most helpful in managing the pruritus?

a.	Use cool, wet dressings and baths to promote vasoconstriction.
b.	Trim the fingernails short to prevent skin damage from scratching.
c.	Expose the areas to the sun to promote drying and healing of the lesions.
d.	Wear cotton gloves and cover all other affected areas with clothing to prevent environmental irritation.

ANS: A

Wet dressings and using Burows solution help promote the healing process. Cold compresses may be applied to decrease circulation to the area (vasoconstriction). Short nails prevent skin damage, but not pruritus.

Chapter 17. Skin Lesions

1.A client is experiencing a circular lesion with an advancing, red, scaly border on the abdomen. The nurse recognizes this lesion as being:

1	tinea capitis.
2	tinea corporis.
3	tinea cruris.
4	tinea pedis.

ANS: 2

Tinea corporis is a fungal infection that involves the face, trunk, and limbs. Tinea pedis is a common infection of the feet. Tinea cruris occurs in the groin and inner thigh, and tinea capitis involves the scalp.

2.A middle-aged construction worker has a raised lesion with a pearly border on his arm that bleeds easily. The nurse realizes that this client most likely is experiencing a(n):

1	actinic keratosis.
2	basal cell carcinoma.
3	malignant melanoma.
4	melanoma in situ.

ANS: 2

Basal cell carcinoma in its nodular form appears as a pearly, translucent bump that bleeds easily. Actinic keratosis is seen or palpated on the face, scalp, arms, and ears. It can have a color from tan to red or have the patients normal skin tone. Malignant melanoma is a lesion that has changed its color and shape, has gotten bigger, or has an irregular border. Melanoma in situ presents with flat or raised lesions with histologic features of melanoma.

3.A client is experiencing elevated fluid-filled lesions on the skin. The nurse would document these lesions as being:

1.	macules.
2.	nodules.
3.	vesicles.
4.	wheals.

ANS: 3

Vesicles are elevated, fluid-containing lesions. Macules are flat, circumscribed changes of the skin. Nodules are elevated, solid lesions. Wheals are solid elevations formed by local, superficial, transient edema, usually in response to a pruritic condition.

4.A client has a nonpalpable skin lesion that is causing a change in skin color greater than 1 cm in diameter. The nurse would document this finding as being a(n):

1.	patch.
2.	macule.
3.	wheal.
4.	vesicle.

ANS: 1

A patch is a localized change in skin color of greater than 1 cm in diameter. A macule is a localized change in skin color of less than 1 cm in diameter. A wheal is localized edema in the epidermis causing irregular elevation that may be red or pale. A vesicle is an accumulation of fluid between the upper layers of the skin.

5.The nurse is assessing a client for primary skin lesions. Which of the following would be considered primary lesions of the skin? (Select all that apply.)

1.	Crust
2.	Scales

3.	Tumors
4.	Nodules
5.	Macules
6.	Plaques

ANS: 3, 4, 5, 6

Primary skin lesions include tumors, nodules, macules, and plaques. Secondary skin lesions include crust and scales.

6.The nurse is describing the distribution and configuration of lesions. Which of the following can be used for this description? (Select all that apply.)

1.	Iris
2.	Annular
3.	Linear
4.	Keratosis
5.	Wheal
6.	Bullae

ANS: 1, 2, 3, 4

When describing the distribution and configuration of lesions, the terms iris, annular, linear, and keratosis can be used. Wheal and bullae describe primary lesions.

7.The nurse assesses a linear lesion along the length of a clients leg. Which diagnosis does the nurse realize is associated with linear lesions? (Select all that apply.)

1.	Drug reaction

2.	Herpes zoster
3.	Herpes simplex
4.	Hookworm
5.	Dermatitis
6.	Poison ivy

ANS: 4, 5, 6

Linear lesions are associated with poison ivy, dermatitis, or hookworm. Polycyclic lesions are associated with drug reactions. Linear lesions along a nerve root are associated with herpes zoster. Grouped or clustered lesions are associated with herpes simplex.

8.The home health nurse assessing skin lesions uses the PQRST mnemonic as a guide. What does the S in this guide indicate?

a.	Severity of the symptoms
b.	Site of the lesions
c.	Symptomatology of the lesions
d.	Surface area of the lesions

ANS: A

The mnemonic PQRST stands for Provocative factors (causes), Quantity, Region of the body, Severity of the symptoms, Time (length of time the disorder has been present).

Chapter 18. Common Eye Complaints MULTIPLE

CHOICE

1.A client is diagnosed with strabismus. Which of the following will the client most likely experience with this disorder?

1.Nystagmus 2.Diplopia
3.Aphakic vision 4.Ptosis

ANS: 2

Diplopia, or double vision, is the primary symptom of strabismus. Nystagmus is a disorder that causes involuntarily rhythmic movements in the eye. Aphakic vision occurs when the lens of the eye is removed. Ptosis is drooping of the eyelid.

2.A client is experiencing a gradual blurring of vision in both eyes not associated with any pain. The nurse suspects the client is experiencing:

1.glaucoma. 2.cataracts.
3.macular degeneration.
4.retinal detachment.

ANS: 2

Cataracts occur as the opacity of the lens becomes cloudy, blurring the vision. It occurs in both eyes but is usually worse in one eye. Gradual eye blurring is not associated with glaucoma, macular degeneration, or retinal detachment.

3.The nurse should instruct a client, diagnosed with glaucoma, that the purpose of medication is to: 1.help dry up excess secretions.
2.lower the intraocular pressure. 3.strengthen the muscles of the eye. 4.improve the vision in the eye.

ANS: 2

Glaucoma is a disease that relates to the increase of intraocular pressure. The medication given will decrease this intraocular pressure. Medication for glaucoma is not used to help dry up excess secretions, strengthen the eye muscles, or improve vision.

4.After surgery to remove a cataract, which of the following should the nurse instruct the client? 1.Be sure to follow the schedule for the prescribed eyedrop medication.
2.Sleep on the right side to promote drainage.
3.It is okay to rub the eye because the surgery was on the inside.
4.This is an outpatient procedure, and there are no instructions for the patient.

ANS: 1

Client education is extremely important in the aftercare of cataract surgery. There is a need to emphasize the postoperative care of eyedrop instillation. The client should not place any pressure near or on the eye. Postoperative instructions are highly important for the client having an outpatient surgical procedure.

5.A tonometry test has been performed with a client and the results are 25 mmHg. The nurse know that:

1.the reading is low and there is no problem.
2.the reading is normal and nothing needs to be done at this time.
3.the results are high and follow-up readings and tests are needed.
4.the results are high and there is no cure to bring the pressure down.

ANS: 3

Several reading need to be taken throughout the day to establish the highest reading to be the treated pressure. Normal intraocular pressure ranges from 12 to 16 mmHg. The reading of 25 mmHg is not low or normal. Medication can be prescribed to reduce the pressure.

6.A client has been diagnosed with cataracts. The nurse realizes that the only treatment for this disorder is?

1.Medical management with eyedrops 2.Surgical removal of the lens

3.Cryopexy 4.Phototherapy

ANS: 2

Surgical treatment for cataracts begins when vision is sufficiently impaired. The lens is removed and the replacement artificial intraocular lens is put in place. Cataracts cannot be treated with medication alone. Cryopexy and phototherapy are not used to treat cataracts.

7.Which of the following should the nurse assess in a client diagnosed with open-angle glaucoma? 1.Degree of lost vision
2.Severity of headaches 3.Amount of blurred vision 4.Date of onset

ANS: 1

Open-angle glaucoma is characterized by a gradual increase in pressure and a gradual loss of vision. Closed-angle glaucoma presents with a sudden onset causing headache, blurred vision, and eye pain.

8.A client is experiencing little flashes of lights and things floating in the visual field. The nurse suspects:

1.cataracts.
2.glaucoma.
3.conjunctivitis.
4.retinal detachment.

ANS: 4

Retinal detachment is clinically manifested by flashes and floaters in the visual field. Flashes of light and floaters are not associated with cataracts, glaucoma, or conjunctivitis.

9.A client tells the nurse that she sees a shadow that is slowing getting worse in her left eye. Which of the following should the nurse do?

1.Instruct the client to return home to rest in bed.
2.Encourage the client to continue with normal daily activities.
3.Notify an ophthalmologist.

4.Encourage fluids and normal saline eyedrops. ANS: 3

The nurse should notify an ophthalmologist with the clients symptoms. The onset of a shadow in the field of vision that will not dissipate is an indication of a detached retina. Retinal detachments rarely self-repair, and the client will need surgery. The nurse should not instruct the client to return home to rest in bed. The client should not be encouraged to continue with normal daily activities. Fluids and saline eyedrops will not help a detached retina.

10.A client is experiencing a loss of central vision but not a loss of peripheral vision. The nurse realizes the client should be evaluated for:

1.detached retina syndrome. 2.nystagmus.
3.macular degeneration.
4.conjunctivitis.

ANS: 3

Macular degeneration is a deterioration of part of the retina, causing loss of central vision but not affecting peripheral vision. The loss of central vision is not typically seen in a detached retina, nystagmus, or conjunctivitis.

11.A client is experiencing redness, burning, itching, and pain of the eyes. The nurse suspects the client is experiencing:

1.blepharitis. 2.conjunctivitis.
3.keratitis.
4.iritis. ANS: 2

Clinical manifestations of conjunctivitis (pink eye) include watery eyes, redness, itching, and burning pain. Blepharitis is associated with a sticky exudate. Keratitis is associated with photophobia. Iritis is associated with blurred vision and photophobia.

12.A client has been diagnosed as being legally blind. The nurse realizes this clients vision is:

1.20/200 or less in the better eye with correction. 2.20/200 or less in the worse eye without correction. 3.20/100 or less in the better eye without correction. 4.20/100 or less in the worse eye with correction.

ANS: 1

Legal blindness is defined as vision of 20/200 or less on a Snellen chart in the better eye with correction. The eye needs to have correction in order to be diagnosed as legally blind; therefore, the choice of 20/200 in the worse eye without correction would be incorrect. The vision measurements of the other choices can be corrected with lenses and would not be categorized as legal blindness.

13.The nurse realizes that the best medication treatment for open-angle glaucoma would be: 1.timolol

(Timoptic) eyedrops.
2.latanoprost (Xalatan) eyedrops.
3.timolol (Timoptic) and Latanoprost (Xalatan) eyedrops.
4.metoprolol oral medication.

ANS: 3

For the best effect in the treatment of open-angle glaucoma, timolol (Timoptic) and latanoprost (Xalatan) should be prescribed together. Metoprolol is not prescribed for open-angle glaucoma.

MULTIPLE RESPONSE

1.A client tells the nurse that he does not want to develop macular degeneration like his mother. Which of the following should the nurse instruct the client as being risk factors for the development of this disorder? (Select all that apply.)

1.There is greater risk as people age. 2.Women are at greater risk than men.
3.African Americans are at greater risk than Caucasians. 4.Family history of macular degeneration increases risk. 5.Smoking does not increase risk.
6.Alcohol prevents the onset of this disorder. ANS: 1, 2, 4

Recent statistics show that macular degeneration is age related and that women are at greater risk than men. Family history and smoking are also significant risk factors. Caucasians are at greater risk than African Americans. Alcohol does not prevent the onset of this disorder.

2.A client is receiving tests to diagnose glaucoma. Which of the following diagnostic tests will be used to identify this disorder in the client? (Select all that apply.)

1.Visual acuity 2.Visual field test
3.Tonometry 4.Weber test
5.Rinne test
6.Electroencephalogram ANS: 1, 2, 3

Glaucoma is determined through a comprehensive eye exam including a visual acuity test, visual fields test, dilated eye exam, and tonometry. The Weber and Rinne tests are used in an ear assessment. An electroencephalogram is not used to diagnose glaucoma.

3.A client is diagnosed with ocular cancer. The nurse realizes this client could be treated with: (Select all that apply.)

1.Enucleation 2.Laser surgery
3.Plaque brachytherapy 4.Block
incision 5.Trabeculoplasty
6.Trabeculectomy

ANS: 1, 3, 4

Surgical options for a client diagnosed with ocular cancer include enucleation, plaque brachytherapy, or block incision. Laser surgery, trabeculoplasty, and trabeculectomy would be used to treat glaucoma.

4.A client, diagnosed with keratoconus, asks the nurse what caused the disorder to develop. The nurse should instruct the client on which of the following as risk factors for the development of this disorder? (Select all that apply.)

1.Sun exposure 2.Ocular allergies
3.Wearing rigid contact lenses 4.Vigorous eye rubbing 5.Herpes simplex virus
6.Dry eyes ANS: 2, 3, 4

Risk factors for the development of keratoconus include ocular allergies, rigid contact lens wear, and vigorous eye rubbing. Sun exposure, herpes simplex virus, and dry eyes are not risk factors for this disorder.

5.The nurse is planning instruction for a client experiencing dry eyes. Which of the following should be included in these instructions? (Select all that apply.)

1.Drink 8 to 10 glasses of water each day. 2.Apply petroleum jelly to the eyelids.
3.Blink more frequently.
4.Avoid sun exposure.
5.Avoid rubbing the eyes.
6.Avoid dry air.

ANS: 1, 3, 5, 6

Interventions to improve dry eyes include drink 8 to 10 glasses of water each day; blink more frequently; avoid rubbing the eyes; and know that dry air makes the condition worse. Petroleum jelly is not a treatment for dry eyes. Avoiding the sun is good advice; however, it is not proven to help with dry eyes.

6.Which of the following should the nurse instruct a client diagnosed with type 2 diabetes mellitus regarding vision care? (Select all that apply.)

1.Maintain good glucose control. 2.Stop smoking.
3.Limit exercise. 4.Reduce reading.
5.Frequently rest the eyes. 6.Rub eyes daily.

ANS: 1, 2

To preserve vision and reduce the onset of diabetic retinopathy, the nurse should instruct the client to control blood glucose level, manage other complications, and stop smoking. The client should not be instructed to limit exercise, reduce reading, rest the eyes, or rub the eyes to prevent the onset of diabetic retinopathy.

Chapter 19. Lid and Conjunctival Pathology

1. When examining the eye, the nurse notices that the patients eyelid margins approximate completely. The nurse recognizes that this assessment finding:

a. Is expected.
b. May indicate a problem with extraocular muscles.
c. May result in problems with tearing.
d. Indicates increased intraocular pressure.

ANS: A
The palpebral fissure is the elliptical open space between the eyelids, and, when closed, the lid margins approximate completely, which is a normal finding.

2. During ocular examinations, the nurse keeps in mind that movement of the extraocular muscles is:

a. Decreased in the older adult.
b. Impaired in a patient with cataracts.
c. Stimulated by cranial nerves (CNs) I and II.
d. Stimulated by CNs III, IV, and VI.

ANS: D
Movement of the extraocular muscles is stimulated by three CNs: III, IV, and VI.

3. The nurse is performing an external eye examination. Which statement regarding the outer layer of the eye is *true*?

a. The outer layer of the eye is very sensitive to touch.
b. The outer layer of the eye is darkly pigmented to prevent light from reflecting internally.
c. The trigeminal nerve (CN V) and the trochlear nerve (CN IV) are stimulated when the outer surface of the eye is stimulated.
d. The visual receptive layer of the eye in which light waves are changed into nerve impulses is located in the outer layer of the eye.

ANS: A
The cornea and the sclera make up the outer layer of the eye. The cornea is very sensitive to touch. The middle layer, the choroid, has dark pigmentation to prevent light from reflecting internally. The trigeminal nerve (CN V) and the facial nerve (CN VII) are stimulated when the outer surface of the eye is stimulated. The retina, in the inner layer of the eye, is where light waves are changed into nerve impulses.
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

4. When examining a patients eyes, the nurse recalls that stimulation of the sympathetic branch of the autonomic nervous system:

a. Causes pupillary constriction.
b. Adjusts the eye for near vision.
c. Elevates the eyelid and dilates the pupil.
d. Causes contraction of the ciliary body.

ANS: C
Stimulation of the sympathetic branch of the autonomic nervous system dilates the pupil and elevates the eyelid. Parasympathetic nervous system stimulation causes the pupil to constrict. The muscle fibers of the iris contract the pupil in bright light to accommodate for near vision. The ciliary body controls the thickness of the lens.
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

5. The nurse is reviewing causes of increased intraocular pressure. Which of these factors determines intraocular pressure?

a. Thickness or bulging of the lens
b. Posterior chamber as it accommodates increased fluid
c. Contraction of the ciliary body in response to the aqueous within the eye
d. Amount of aqueous produced and resistance to its outflow at the angle of the anterior chamber

ANS: D
Intraocular pressure is determined by a balance between the amount of aqueous produced and the resistance to its outflow at the angle of the anterior chamber. The other responses are incorrect.
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

6. The nurse is conducting a visual examination. Which of these statements regarding visual pathways and visual fields is *true*?

a. The right side of the brain interprets the vision for the right eye.
b. The image formed on the retina is upside down and reversed from its actual appearance in the outside world.
c. Light rays are refracted through the transparent media of the eye before striking the pupil.
d. Light impulses are conducted through the optic nerve to the temporal lobes of the brain.

ANS: B
The image formed on the retina is upside down and reversed from its actual appearance in the outside world. The light rays are refracted through the transparent media of the eye before striking the retina, and the nerve impulses are conducted through the optic nerve tract to the visual cortex of the occipital lobe of the brain. The left side of the brain interprets vision for the right eye.
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

7. The nurse is testing a patients visual accommodation, which refers to which action?

a. Pupillary constriction when looking at a near object
b. Pupillary dilation when looking at a far object
c. Changes in peripheral vision in response to light

d. Involuntary blinking in the presence of bright light

ANS: A

The muscle fibers of the iris contract the pupil in bright light and accommodate for near vision, which also results in pupil constriction. The other responses are not correct.

8. A patient has a normal pupillary light reflex. The nurse recognizes that this reflex indicates that:

a. The eyes converge to focus on the light.

b. Light is reflected at the same spot in both eyes.

c. The eye focuses the image in the center of the pupil.

d. Constriction of both pupils occurs in response to bright light.

ANS: D

The pupillary light reflex is the normal constriction of the pupils when bright light shines on the retina. The other responses are not correct.

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. A mother asks when her newborn infants eyesight will be developed. The nurse should reply:

a. Vision is not totally developed until 2 years of age.

b. Infants develop the ability to focus on an object at approximately 8 months of age.

c. By approximately 3 months of age, infants develop more coordinated eye movements and can fixate on an object.

d. Most infants have uncoordinated eye movements for the first year of life.

ANS: C

Eye movements may be poorly coordinated at birth, but by 3 to 4 months of age, the infant should establish binocularity and should be able to fixate simultaneously on a single image with both eyes.

10. The nurse is reviewing in age-related changes in the eye for a class. Which of these physiologic changes is responsible for presbyopia?

a. Degeneration of the cornea

b. Loss of lens elasticity

c. Decreased adaptation to darkness

d. Decreased distance vision abilities

ANS: B

The lens loses elasticity and decreases its ability to change shape to accommodate for near vision. This condition is called *presbyopia*.

MSC: Client Needs: Health Promotion and Maintenance

11. Which of these assessment findings would the nurse expect to see when examining the eyes of a black patient?

a. Increased night vision

b. Dark retinal background

c. Increased photosensitivity

d. Narrowed palpebral fissures

ANS: B

An ethnically based variability in the color of the iris and in retinal pigmentation exists, with darker irides having darker retinas behind them.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. A 52-year-old patient describes the presence of occasional *floaters* or *spots* moving in front of his eyes. The nurse should:

a. Examine the retina to determine the number of floaters.

b. Presume the patient has glaucoma and refer him for further testing.

c. Consider these to be abnormal findings, and refer him to an ophthalmologist.

d. Know that floaters are usually insignificant and are caused by condensed vitreous fibers.

ANS: D

Floaters are a common sensation with myopia or after middle age and are attributable to condensed vitreous fibers. Floaters or spots are not usually significant, but the acute onset of floaters may occur with retinal detachment.

MSC: Client Needs: Health Promotion and Maintenance

13. The nurse is preparing to assess the visual acuity of a 16-year-old patient. How should the nurse proceed?

a. Perform the confrontation test.

b. Ask the patient to read the print on a handheld Jaeger card.

c. Use the Snellen chart positioned 20 feet away from the patient.

d. Determine the patients ability to read newsprint at a distance of 12 to 14 inches.

ANS: C

The Snellen alphabet chart is the most commonly used and most accurate measure of visual acuity. The confrontation test is a gross measure of peripheral vision. The Jaeger card or newspaper tests are used to test near vision.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. A patients vision is recorded as 20/30 when the Snellen eye chart is used. The nurse interprets these results to indicate that:

a. At 30 feet the patient can read the entire chart.

b. The patient can read at 20 feet what a person with normal vision can read at 30 feet.

c. The patient can read the chart from 20 feet in the left eye and 30 feet in the right eye.

d. The patient can read from 30 feet what a person with normal vision can read from 20 feet.

ANS: B

The top number indicates the distance the person is standing from the chart; the denominator gives the distance at which a normal eye can see.

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. A patient is unable to read even the largest letters on the Snellen chart. The nurse should take which action next?

a. Refer the patient to an ophthalmologist or optometrist for further evaluation.

b. Assess whether the patient can count the nurses fingers when they are placed in front of his or her eyes.

c. Ask the patient to put on his or her reading glasses and attempt to read the Snellen chart again.

d. Shorten the distance between the patient and the chart until the letters are seen, and record that distance.

ANS: D
If the person is unable to see even the largest letters when standing 20 feet from the chart, then the nurse should shorten the distance to the chart until the letters are seen, and record that distance (e.g., 10/200). If visual acuity is even lower, then the nurse should assess whether the person can count fingers when they are spread in front of the eyes or can distinguish light perception from a penlight. If vision is poorer than 20/30, then a referral to an ophthalmologist or optometrist is necessary, but the nurse must first assess the visual acuity.
MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
16. A patients vision is recorded as 20/80 in each eye. The nurse interprets this finding to mean that the patient:

a. Has poor vision.

b. Has acute vision.

c. Has normal vision.

d. Is presbyopic.

ANS: A
Normal visual acuity is 20/20 in each eye; the larger the denominator, the poorer the vision.

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation
17. When performing the corneal light reflex assessment, the nurse notes that the light is reflected at 2 oclock in each eye. The nurse should:

a. Consider this a normal finding.

b. Refer the individual for further evaluation.

c. Document this finding as an asymmetric light reflex.

d. Perform the confrontation test to validate the findings.

ANS: A
Reflection of the light on the corneas should be in exactly the same spot on each eye, or symmetric. If asymmetry is noted, then the nurse should administer the cover test.
MSC: Client Needs: Safe and Effective Care Environment: Management of Care
18. The nurse is performing the diagnostic positions test. Normal findings would be which of these results?

a. Convergence of the eyes

b. Parallel movement of both eyes

c. Nystagmus in extreme superior gaze

d. Slight amount of lid lag when moving the eyes from a superior to an inferior position

ANS: B

A normal response for the diagnostic positions test is parallel tracking of the object with both eyes. Eye movement that is not parallel indicates a weakness of an extraocular muscle or dysfunction of the CN that innervates it.
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. During an assessment of the sclera of a black patient, the nurse would consider which of these an expected finding?

a. Yellow fatty deposits over the cornea
b. Pallor near the outer canthus of the lower lid
c. Yellow color of the sclera that extends up to the iris
d. Presence of small brown macules on the sclera

ANS: D
Normally in dark-skinned people, small brown macules may be observed in the sclera.
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. A 60-year-old man is at the clinic for an eye examination. The nurse suspects that he has ptosis of one eye. How should the nurse check for this?

a. Perform the confrontation test.
b. Assess the individuals near vision.
c. Observe the distance between the palpebral fissures.
d. Perform the corneal light test, and look for symmetry of the light reflex.

ANS: C
Ptosis is a drooping of the upper eyelid that would be apparent by observing the distance between the upper and lower eyelids. The confrontation test measures peripheral vision. Measuring near vision or the corneal light test does not check for ptosis.
MSC: Client Needs: Health Promotion and Maintenance

21. During an examination of the eye, the nurse would expect what normal finding when assessing the lacrimal apparatus?

a. Presence of tears along the inner canthus
b. Blocked nasolacrimal duct in a newborn infant
c. Slight swelling over the upper lid and along the bony orbit if the individual has a cold
d. Absence of drainage from the puncta when pressing against the inner orbital rim

ANS: D
No swelling, redness, or drainage from the puncta should be observed when it is pressed. Regurgitation of fluid from the puncta, when pressed, indicates duct blockage. The lacrimal glands are not functional at birth.
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

22. When assessing the pupillary light reflex, the nurse should use which technique?

a. Shine a penlight from directly in front of the patient, and inspect for pupillary constriction.
b. Ask the patient to follow the penlight in eight directions, and observe for bilateral pupil constriction.

c. Shine a light across the pupil from the side, and observe for direct and consensual pupillary constriction.

d. Ask the patient to focus on a distant object. Then ask the patient to follow the penlight to approximately 7 cm from the nose.

ANS: C

To test the pupillary light reflex, the nurse should advance a light in from the side and note the direct and consensual pupillary constriction.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. The nurse is assessing a patients eyes for the accommodation response and would expect to see which normal finding?

a. Dilation of the pupils

b. Consensual light reflex

c. Conjugate movement of the eyes

d. Convergence of the axes of the eyes

ANS: D

The accommodation reaction includes pupillary constriction and convergence of the axes of the eyes. The other responses are not correct.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. In using the ophthalmoscope to assess a patients eyes, the nurse notices a red glow in the patients pupils. On the basis of this finding, the nurse would:

a. Suspect that an opacity is present in the lens or cornea.

b. Check the light source of the ophthalmoscope to verify that it is functioning.

c. Consider the red glow a normal reflection of the ophthalmoscope light off the inner retina.

d. Continue with the ophthalmoscopic examination, and refer the patient for further evaluation.

ANS: C

The red glow filling the persons pupil is the red reflex and is a normal finding caused by the reflection of the ophthalmoscope light off the inner retina. The other responses are not correct. MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. The nurse is examining a patients retina with an ophthalmoscope. Which finding is considered normal?

a. Optic disc that is a yellow-orange color

b. Optic disc margins that are blurred around the edges

c. Presence of pigmented crescents in the macular area

d. Presence of the macula located on the nasal side of the retina

ANS: A

The optic disc is located on the nasal side of the retina. Its color is a creamy yellow-orange to a pink, and the edges are distinct and sharply demarcated, not blurred. A pigmented crescent is black and is due to the accumulation of pigment in the choroid.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

26. A 2-week-old infant can fixate on an object but cannot follow a light or bright toy. The nurse would:

a. Consider this a normal finding.
b. Assess the pupillary light reflex for possible blindness.
c. Continue with the examination, and assess visual fields.
d. Expect that a 2-week-old infant should be able to fixate and follow an object.

ANS: A
By 2 to 4 weeks an infant can fixate on an object. By the age of 1 month, the infant should fixate and follow a bright light or toy.
MSC: Client Needs: Health Promotion and Maintenance
27. The nurse is assessing color vision of a male child. Which statement is correct? The nurse should:

a. Check color vision annually until the age of 18 years.
b. Ask the child to identify the color of his or her clothing.
c. Test for color vision once between the ages of 4 and 8 years.
d. Begin color vision screening at the childs 2-year checkup.

ANS: C
Test boys only once for color vision between the ages of 4 and 8 years. Color vision is not tested in girls because it is rare in girls. Testing is performed with the Ishihara test, which is a series of polychromatic cards.
MSC: Client Needs: Health Promotion and Maintenance
28. The nurse is performing an eye-screening clinic at a daycare center. When examining a 2-year-old child, the nurse suspects that the child has a lazy eye and should:

a. Examine the external structures of the eye.
b. Assess visual acuity with the Snellen eye chart.
c. Assess the childs visual fields with the confrontation test.
d. Test for strabismus by performing the corneal light reflex test.

ANS: D
Testing for strabismus is done by performing the corneal light reflex test and the cover test. The Snellen eye chart and confrontation test are not used to test for strabismus.
MSC: Client Needs: Health Promotion and Maintenance
29. The nurse is performing an eye assessment on an 80-year-old patient. Which of these findings is considered abnormal?

a. Decrease in tear production
b. Unequal pupillary constriction in response to light
c. Presence of arcus senilis observed around the cornea
d. Loss of the outer hair on the eyebrows attributable to a decrease in hair follicles

ANS: B

Pupils are small in the older adult, and the pupillary light reflex may be slowed, but pupillary constriction should be symmetric. The assessment findings in the other responses are considered normal in older persons.

30. The nurse notices the presence of periorbital edema when performing an eye assessment on a 70-year-old patient. The nurse should:

a. Check for the presence of exophthalmos.
b. Suspect that the patient has hyperthyroidism.
c. Ask the patient if he or she has a history of heart failure.
d. Assess for blepharitis, which is often associated with periorbital edema.

ANS: C

Periorbital edema occurs with local infections, crying, and systemic conditions such as heart failure, renal failure, allergy, and hypothyroidism. Periorbital edema is not associated with blepharitis.

31. When a light is directed across the iris of a patients eye from the temporal side, the nurse is assessing for:

a. Drainage from dacryocystitis.
b. Presence of conjunctivitis over the iris.
c. Presence of shadows, which may indicate glaucoma.
d. Scattered light reflex, which may be indicative of cataracts.

ANS: C

The presence of shadows in the anterior chamber may be a sign of acute angle-closure glaucoma. The normal iris is flat and creates no shadows. This method is not correct for the assessment of dacryocystitis, conjunctivitis, or cataracts.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. In a patient who has anisocoria, the nurse would expect to observe:

a. Dilated pupils.
b. Excessive tearing.
c. Pupils of unequal size.
d. Uneven curvature of the lens.

ANS: C

Unequal pupil size is termed *anisocoria*. It normally exists in 5% of the population but may also be indicative of central nervous system disease.

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

33. A patient comes to the emergency department after a boxing match, and his left eye is swollen almost shut. He has bruises on his face and neck. He says he is worried because he cant see well from his left eye. The physician suspects retinal damage. The nurse recognizes that signs of retinal detachment include:

a. Loss of central vision.
b. Shadow or diminished vision in one quadrant or one half of the visual field.
c. Loss of peripheral vision.
d. Sudden loss of pupillary constriction and accommodation.

ANS: B

With retinal detachment, the person has shadows or diminished vision in one quadrant or one half of the visual field. The other responses are not signs of retinal detachment.

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

34. A patient comes into the clinic complaining of pain in her right eye. On examination, the nurse sees a pustule at the lid margin that is painful to touch, red, and swollen. The nurse recognizes that this is a:

a. Chalazion.
b. Hordeolum (stye).
c. Dacryocystitis.
d. Blepharitis.

ANS: B

A hordeolum, or stye, is a painful, red, and swollen pustule at the lid margin. A chalazion is a nodule protruding on the lid, toward the inside, and is nontender, firm, with discrete swelling. Dacryocystitis is an inflammation of the lacrimal sac. Blepharitis is inflammation of the eyelids

Chapter 20. Visual Disturbances and Impaired Vision MULTIPLE

CHOICE

1.A client is diagnosed with an inability to recognize visual information. The nurse realizes that which of the following cranial nerves is involved in the transmitting of visual stimuli to the brain for interpretation?

1.CN II
2.CN III
3.CN IV
4.CN VI

ANS: 1

The optic nerve is the second cranial nerve and is responsible for the transmitting of visual stimuli. Cranial Nerves III, IV, and VI control extraocular eye movements.

2.A client is diagnosed with a vision disorder. The nurse realizes that the client will experience an alteration in sensory information because the eyes transmit what percentage of all sensory information to the brain?

1.30%

2.50%
3.70%
4.90%

ANS: 3

Approximately 70% of all sensory information reaches the brain through the eyes.The other percentages are incorrect.

3.The nurse is performing an assessment on a client. To test the optic nerves function, what should the nurse do?

1.Check for extraocular movement. 2.Check the pupils for reaction to light. 3.Check to see if the patient can blink. 4.Use a Snellen chart.

ANS: 4

A Snellen chart is used to assess visual acuity of the optic nerve. Extraocular movements assess cranial nerves III, IV, and VI. Pupil reaction to light and eye blinking are not functions of the optic nerve.

4.The nurse realizes that a client, diagnosed with chronic dry eyes, may have a disorder of the lacrimal gland because it:

1.covers the eye for protection. 2.produces tears to lubricate the eye. 3.helps the eye keep its shape. 4.provides blood to the eye.

ANS: 2

The lacrimal gland moistens the eye by producing and distributing tears to lubricate the eye. The lacrimal gland does not cover the eye for protection, help the eye keep its shape, or provide blood to the eye.

5.When assessing the corneal reflex, the nurse realizes this reflex is a function of which cranial nerve (CN)?

1.CN II
2.CN III
3.CN IV
4.CN V

ANS: 4

The stimulation of the trigeminal nerve (CN V) causes the corneal reflex, a protective blink. Cranial nerves II, III, or IV do not control the corneal reflex.

6.A client is having difficulty perceiving different colors. The nurse realizes the client may have a disorder that affects the photosensitive receptor cells of the retina, which makes the perception of color possible, or a disorder that affects the:

1.rods. 2.cones. 3.optic discs. 4.irises.

ANS: 2

Other neurosensory elements located in the retina are cones, which mediate color vision. Rods mediate black-and-white vision. The optic disc and iris are not responsible for color vision.

7.A client was assessed as having normal intraocular pressure. The nurse would document this clients pressure as being:

1.5 mmHg 3 mmHg.
2.15 mmHg 3 mmHg.
3.30 mmHg 3 mmHg.
4.50 mmHg 3 mmHg.

ANS: 2

Normal intraocular pressure is about 15 mmHg 3 mmHg. An intraocular pressure of 5 mmHg would be too low. A pressure of 30 to 50 mmHg would be considered critical.

Chapter 21. Common Ear, Nose, and Throat Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. An acutely presenting, erythematous, tender lump within the eyelid is called:
a. Blepharitis
b. Hordeolum
c. Chalazion
d. Iritis

__ 2. The clinician is seeing a patient complaining of red eye. The clinician suspects conjunctivitis. The presence of mucopurulent discharge suggests which type of conjunctivitis?
a. Viral conjunctivitis
b. Keratoconjunctivitis
c. Bacterial conjunctivitis
d. Allergic conjunctivitis

__ 3. Which subtype of cataracts is characterized by significant nearsightedness and a slow indolent course?
a. Nuclear cataracts
b. Cortical cataracts
c. Posterior cataracts
d. Immature cataracts

__ 4. Which of the following statements is true concerning the use of bilberry as a complementary therapy for cataracts?
a. The body converts bilberry to vitamin A, which helps to maintain a healthy lens.
b. Bilberry blocks an enzyme that leads to sorbitol accumulation that contributes to cataract formation in diabetes.
c. Bilberry boosts oxygen and blood delivery to the eye.
d. Bilberry is a good choice for patients with diabetes as it does not interact with antidiabetic drugs.

__ 5. A 65-year-old man presents to the clinician with complaints of increasing bilateral peripheral vision loss, poor night vision, and frequent prescription changes that started 6 months previously. Recently, he has also been seeing halos around lights. The clinician suspects chronic open-angle glaucoma.
Which of the following statements is true concerning the diagnosis of chronic open-angle glaucoma?
a. The presence of increased intraocular pressure measured by tonometry is definitive for the diagnosis of open-angle glaucoma.
b. The clinician can definitively diagnosis open-angle glaucoma based on the subjective complaints of the patient.

c. Physical diagnosis relies on gonioscopic evaluation of the angle by an ophthalmologist.
d. Early diagnosis is essential in order to reverse any damage that has occurred to the optic nerve.

__ 6. Acute angle-closure glaucoma involves a sudden severe rise in intraocular pressure. Which of the following ranges represents normal intraocular pressure?

a. 0 to 7 mm Hg
b. 8 to 21 mm Hg
c. 22 to 40 mm Hg
d. 40 to 80 mm Hg

__ 7. As diabetic retinopathy progresses, the presence of 'cotton wool' spots can be detected. Cotton wool spots refer to:

a. Nerve fiber layer infarctions
b. Blood vessel proliferation
c. Venous beading
d. Retinal hemorrhage

____ 8. Which of the following is an example of sensorineural hearing loss?

a. Perforation of the tympanic membrane
b. Otosclerosis
c. Cholesteatoma
d. Presbycusis

__ 9. The clinician is assessing a patient complaining of hearing loss. The clinician places a tuning fork over the patient's mastoid process, and when the sound fades away, the fork is placed without restriking it over the external auditory meatus. The patient is asked to let the clinician know when the sound fades away. This is an example of which type of test?

a. Weber test
b. Schwabach test
c. Rinne test
d. Auditory brainstem response (ABR) test

__ 10. A patient presents to the clinician complaining of ear pain. On examination, the clinician finds that the patient has tenderness on traction of the pinna as well as when applying pressure over the tragus. These findings are classic signs of which condition?

a. Otitis media
b. Meniere's disease
c. Tinnitus
d. Otitis externa

____ 11. Otitis media is considered chronic when:
a. Inflammation persists more than 3 months with intermittent or persistent otic discharge.
b. There are more than six occurrences of otitis media in a 1-year period.
c. Otitis media does not resolve after two courses of antibiotics.
d. All of the above

____ 12. The *most* significant precipitating event leading to otitis media with effusion is:
a. Pharyngitis
b. Allergies
c. Viral upper respiratory infection (URI)
d. Perforation of the eardrum

__ 13. Patients with acute otitis media should be referred to a specialist in which of the following situations?
a. Concurrent vertigo or ataxia
b. Failed closure of a ruptured tympanic membrane
c. If symptoms worsen after 3 or 4 days of treatment
d. All of the above

____ 14. Which immunoglobulin mediates the type 1 hypersensitivity reaction involved in allergic rhinitis?
a. IgA
b. IgE
c. IgG
d. IgM

____ 15. Fluctuations and reductions in estrogen may be a contributing factor in which type of rhinitis?
a. Vasomotor rhinitis
b. Rhinitis medicamentosum
c. Atrophic rhinitis
d. Viral rhinitis

__ 16. Sinusitis is considered chronic when there are episodes of prolonged inflammation with repeated or inadequately treated acute infection lasting greater than:
a. 4 weeks
b. 8 weeks
c. 12 weeks
d. 16 weeks

__ 17. Which of the following antibiotics provides the best coverage in acute or chronic sinusitis when gram-negative organisms are suspected?

a. Penicillin V
b. Amoxicillin
c. Levofloxacin
d. Clindamycin

____ 18. In which of the following situations would referral to a specialist be needed for sinusitis?

a. Recurrent sinusitis
b. Allergic sinusitis
c. Sinusitis that is refractory to antibiotic therapy
d. All of the above

____ 19. Which type of stomatitis results in necrotic ulceration of the oral mucous membranes?

a. Vincent's stomatitis
b. Allergic stomatitis
c. Apthous stomatitis
d. Herpetic stomatitis

__ 20. The presence of hairy leukoplakia in a person with no other symptoms of immune suppression is strongly suggestive of which type of infection?

a. HSV type 2
b. HIV
c. Pneumonia
d. Syphilis

__ 21. Heart valve damage resulting from acute rheumatic fever is a long-term sequelae resulting from infection with which of the following pathogens?

a. Coxsackievirus
b. Cytomegalovirus
c. Francisella tularensis
d. Group A streptococcus

__ 22. A patient presents with the following signs and symptoms: gradual onset of low-grade fever, marked fatigue, severe sore throat, and posterior cervical lymphadenopathy. Based on the signs and symptoms alone, which of the following conditions is most likely the cause?

a. Gonorrhea
b. Mononucleosis
c. Influenza
d. Herpes zoster

__ 23. A patient presents to the clinician with a sore throat, fever of 100.7°F, and tender anterior cervical lymphadenopathy. The clinician suspects strep throat and performs a rapid strep test that is negative. What would the next step be?

a. The patient should be instructed to rest and increase fluid intake as the infection is most likely viral and will resolve without antibiotic treatment.
b. Because the patient does not have strep throat, the clinician should start broad spectrum antibiotics in order to cover the offending pathogen.
c. A throat culture should be performed to confirm the results of the rapid strep test.
d. The patient should be treated with antibiotics for strep throat as the rapid strep test is not very sensitive.

__ 24. Which of the following medications used in the treatment of glaucoma works by constricting the pupils to open the angle and allow aqueous fluid to escape?

a. Pilocarpine
b. Timolol
c. Brinzolamide
d. Acetazolamide

__ 25. You have a patient who is a positive for Strep on rapid antigen testing (rapid strep test). You order amoxacillin after checking for drug allergies (patient is negative) but he returns 3 days later, reporting that his temperature has gone up, not down (101.5 F in office). You also note significant adenopathy, most notably in the posterior and anterior cervical chains, some hepatomegaly, and a diffuse rash. You decide:

a. to refer the patient.
b. that he is having an allergic response and needs to be changed to a macrolide antibiotic.
c. that his antibiotic dosage is not sufficient and should be changed.
d. that he possibly has mononucleosis concurrent with his strep infection.

6. You are in the park playing with your children when you see that your friend is screaming for help. Her toddler has fallen and there is a stick lodged in his eye. The child is kicking and screaming and grabbing for the stick. You:

a. instruct his mother to hold him securely and not allow him to touch the stick, then carefully remove the stick from the eye.
b. stabilize the foreign object and accompany the mother and child to the local ER.
c. find a water fountain, hold the child to the water, and flush the eye.
d. call 911.

True/False

Indicate whether the statement is true or false.

____ 1. Severe pain associated with acute otitis media signifies perforation of the tympanic membrane.

Chapter 21. Common Ear, Nose, and Throat Complaints Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: C PTS: 1
3. ANS: A PTS: 1
4. ANS: C PTS: 1
5. ANS: C PTS: 1
6. ANS: B PTS: 1
7. ANS: A PTS: 1
8. ANS: D PTS: 1
9. ANS: C PTS: 1
10. ANS: D PTS: 1
11. ANS: A PTS: 1
12. ANS: C PTS: 1
13. ANS: D PTS: 1
14. ANS: B PTS: 1
15. ANS: A PTS: 1
16. ANS: C PTS: 1
17. ANS: C PTS: 1
18. ANS: D PTS: 1
19. ANS: A PTS: 1
20. ANS: B PTS: 1
21. ANS: D PTS: 1

22. ANS: B PTS: 1

23. ANS: C PTS: 1

24. ANS: A PTS: 1

25. ANS: D PTS: 1

26. ANS: B PTS: 1

TRUE/FALSE

1. ANS: F PTS: 1

Chapter 22. Hearing and Balance Disorders MULTIPLE

CHOICE

1.A client is not able to successfully pass the whisper test. Which of the following would be indicated for this client?

1.Head CT scan
2.Audiometry
3.MRI of the brain
4.Electroencephalogram ANS: 2

Failure to pass the whisper test would indicate the need for formal audiometry testing. The client would not need a head CT or MRI at this time. An electroencephalogram is not necessary.

2.A client is prescribed a medication that is ototoxic. The nurse realizes that this medication may cause:

1.permanent or temporary vision loss. 2.permanent or temporary hearing loss. 3.nausea and vomiting.
4.central nervous system (CNS) depression. ANS: 2

Although many drugs cause nausea and vomiting and central nervous system (CNS) depression, ototoxic drugs cause hearing loss and the risks must be considered prior to suggesting these types of medications.

3.The nurse is trying to communicate with a hearing-impaired client. The best way to do this is to: 1.write down all of the message.
2.shout in the impaired ear.
3.speak slowly and clearly while facing the client.
4.talk in a regular voice in the good ear.

ANS: 3

When trying to communicate with the hearing-impaired client, the nurse should speak slowly and clearly while facing the client to give her the opportunity to see and hear the words being spoken. The nurse should not write down all of the messages. Shouting in the impaired ear will not improve the clients hearing. Talking in a regular voice into the good ear will not improve hearing.

4.A client is diagnosed with a conductive hearing loss. The nurse realizes type of hearing loss is *not* associated with:

1.cerumen. 2.brain damage.
3.otitis media. 4.otosclerosis.

ANS: 2

Conductive hearing loss results in a blockage of sound waves in the external or middle portions of the ear. Wax (cerumen) buildup and infections are a large part of conductive hearing loss.
Otosclerosis is associated with conductive hearing loss. Brain damage is not a cause of conductive hearing loss.

5.A client is complaining of dizziness, unilateral ringing in the ear, feeling of pressure or fullness in the ear, and unilateral hearing loss. The nurse would suspect the client is experiencing:

1.Mnires disease.

2.osteosclerosis.
3.otitis media.
4.mastoiditis.

ANS: 1

All of the clients complaints are signs and symptoms of Mnires disease. Although hearing disorders may have similar signs and symptoms, they do not include all of them.

6.A client complains of a slight itching, slight pain, and a scratching sound in the ear. The nurse suspects that an insect may have entered the ear. Which of the following should *not* be done?

1.Add water to flush out the insect. 2.Add mineral oil to kill the insect. 3.Add lidocaine to kill the insect. 4.Call an otologist for a referral.

ANS: 1

Avoid placing water in the ear canal, which will only make the insect swell, thereby making it more difficult to remove. An otologist should be called for the removal. The audiologist may prescribe mineral oil or lidocaine to be applied to the ear canal.

7.The hearing of an unresponsive client needs to be assessed. Which of the following will be used to assess the hearing of this client?

1.Audiometer
2.Brainstem auditory evoked responses (BAER) test
3.Rinne test
4.Weber test ANS: 2

The BAER test calculates the ability to hear in a client who is unresponsive. The BAER measures the sound impulse needed to evoke a brain response, which will indicate the clients ability to hear. The other tests need the cooperation of the client and cannot be done at this time.

8.The nurse is planning to assess a client diagnosed with conductive hearing loss. When performing the Weber test, the nurse would expect which of the following findings?

1.The sound will be louder in the affected ear. 2.The sound will be louder in the good ear.
3.Air conduction is shorter than bone conduction. 4.No sounds will be heard.

ANS: 1

During a Weber test, which tests bone conduction, a client with a conductive hearing loss hears louder sounds on the affected side. Hearing louder sounds on the unaffected side is sensorineural loss. The Rinne test compares bone with air conduction. The client will hear sounds louder in the affected ear.

9.The nurse is performing postoperative teaching with a client recovering from a stapedectomy. Which of the following instructions would the nurse want to include in the teaching?

1.It is okay to resume exercise the next day. 2.It is okay to resume work the same day.
3.It is okay to shower and shampoo the next day.
4.It is okay to blow the nose gently one side at a time.

ANS: 4

Care must be taken not to disturb the ossicles from their position, so exercise and work should not be resumed until healing is complete. It is also important to keep the ear dry. The client should be taught to blow the nose gently on one side at a time so as not to increase the pressure in the ear.

10.After a mastoidectomy, the most important complication for the nurse to assess for is: 1.vomiting.
2.headache.
3.fever.
4.stiff neck.

ANS: 3

All are complications that can occur following this type of surgery. Fever is of extra importance because of its possible link to infection. The mastoid bone is in direct contact with the brain, and therefore any infection can travel to the brain.

11.When instructing a client on cleaning the ear, the nurse should instruct the client to clean:

1.only the outer ear.
2.all the way to the middle ear.
3.all parts of the ear outer, middle, and inner ear.
4.just the tympanic membrane.

ANS: 1

Only the outer portion of the ear should be cleaned. Inserting different objects into the ear canal may result in injury and damage.

12.Which of the following would prohibit an elderly client from wanting to obtain and use a hearing aid?

1.Fears sounds will be too loud
2.Thinks not necessary for a temporary problem
3.Fears the cost
4.Prefers silence ANS: 3

Some of the problems encountered by clients obtaining hearing aids include appearance, cost, education, unrealistic expectations, and difficulty with the care and maintenance of the hearing aids. The other choices are not problems encountered by clients obtaining hearing aids.

13.Which of the following should the nurse instruct a client who is being fitted for a hearing aid? 1.Keep the appliance turned on at all times.
2.Store the hearing aid in a warm, moist place. 3.Batteries last for at least 1 month.
4.Clean ear molds at least once a week. ANS: 4

The nurse should instruct the client to turn off the appliance when not in use; store in a cool, dry place; change the batteries at least once per week; and clean ear molds at least once per week.

MULTIPLE RESPONSE

1.The nurse is instructing a client diagnosed with otitis media on management during the acute phase. Which of the following should the nurse include in the teaching? (Select all that apply.)

1.Take the antibiotics as ordered.
2.Take over-the-counter analgesics for mild pain as recommended.
3.It is okay to go swimming.
4.It is okay to go on vacation and trips that require flying. 5.If excruciating pain develops, seek medical care.
6.Limit fluids. ANS: 1, 2, 5

Clients must complete the medication as ordered to kill the infection. Mild analgesics for pain are often needed. If excruciating ear pain develops, the client should seek medical care to rule out perforation of the eardrum. It is important to keep the ear dry, so the client should not swim at this time. Flying is not recommended at this time. Limiting fluids is not necessary with otitis media.

2.When caring for a client with total hearing loss, the nurse is instructing the client about the many options that are available to function in a hearing world. Which of the following should the nurse include? (Select all that apply.)

1.Flashing lights for alarms 2.TV with closed captions 3.Talking computer
4.Lip reading and sign language 5.Cell phones with headsets 6.Loud ringers on telephones

ANS: 1, 2, 4

Patients who have no hearing have access to various mechanisms to alert them to various sounds. Flashing lights for alarms to phones and doorbells, TV with closed captions for the hearing impaired, and classes in lip reading and sign language are some options. Talking computers and cell phones with headsets are advancements for the hearing, not for the hearing impaired. Loud ringers on telephones would also be helpful to the client with some hearing and not a total hearing loss.

3.A client is diagnosed with a congenital hearing loss. Which causes does the nurse realize are reasons for this type of hearing loss? (Select all that apply.)

1.Genetics 2.Natal infections
3.Physical deformities 4.Noise levels

5.Maternal ototoxic drugs 6.Maternal TORCH infections

ANS: 1, 2, 3, 5, 6

Congenital hearing loss can be derived from genetics, natal infections, or physical deformities of the ear in addition to maternal ototoxic drug use and maternal TORCH infections that include toxoplasmosis, rubella, cytomegalovirus, and herpes virus type 2. Noise levels do not cause a congenital hearing loss.

4.A client with a family history of hearing loss asks the nurse what he can do to prevent this disorder as he ages. Which of the following should the nurse instruct this client? (Select all that apply.)

1.Turn down radio and television volume. 2.Avoid noisy areas such as rock concerts. 3.Wear protective devices. 4.Use plain cotton balls in the ears. 5.Avoid sun exposure.
6.Flush the ears daily with mineral oil. ANS: 1, 2, 3

Measures to prevent hearing loss include turning down the volume on the radio and television, avoiding noisy areas such as rock concerts, and wearing protective devices. Using cotton balls in the ears does not decrease noise from reaching the middle ear. Sun exposure does not impact hearing.
Flushing the ears daily with mineral oil might decrease the buildup of cerumen; however, it will not improve hearing.

5.Which of the following are indications that a client has been exposed to excessive noise? (Select all that apply.)

1.Raising the voice to talk in normal conversation 2.Clear drainage from the ears
3.Inability to hear a conversation 2 feet away 4.Sounds are muffled
5.Ringing of the ears
6.Short periods of pain in the ears

ANS: 1, 3, 4, 5, 6

Warning signs of excessive noise exposure include raising the voice to talk in normal conversation, inability to hear a conversation 2 feet away, muffled sounds, ear ringing, and short periods of ear pain. Clear drainage from the ears does not occur with excessive noise exposure.

Chapter 23. Inflammatory and Infectious Disorders of the Ear MULTIPLE CHOICE

1. The nurse needs to pull the portion of the ear that consists of movable cartilage and skin down and back when administering eardrops. This portion of the ear is called the:

a. Auricle.
b. Concha.
c. Outer meatus.
d. Mastoid process.

ANS: A
The external ear is called the *auricle* or *pinna* and consists of movable cartilage and skin.

2. The nurse is examining a patients ears and notices cerumen in the external canal. Which of these statements about cerumen is *correct*?

a. Sticky honey-colored cerumen is a sign of infection.
b. The presence of cerumen is indicative of poor hygiene.
c. The purpose of cerumen is to protect and lubricate the ear.
d. Cerumen is necessary for transmitting sound through the auditory canal.

ANS: C
The ear is lined with glands that secrete cerumen, which is a yellow waxy material that lubricates and protects the ear.

3. When examining the ear with an otoscope, the nurse notes that the tympanic membrane should appear:

a. Light pink with a slight bulge.
b. Pearly gray and slightly concave.
c. Pulled in at the base of the cone of light.
d. Whitish with a small fleck of light in the superior portion.

ANS: B
The tympanic membrane is a translucent membrane with a pearly gray color and a prominent cone of light in the anteroinferior quadrant, which is the reflection of the otoscope light. The tympanic membrane is oval and slightly concave, pulled in at its center by the malleus, which is one of the middle ear ossicles.

4. The nurse is reviewing the structures of the ear. Which of these statements concerning the eustachian tube is *true*?

a. The eustachian tube is responsible for the production of cerumen.

b. It remains open except when swallowing or yawning.

c. The eustachian tube allows passage of air between the middle and outer ear.

d. It helps equalize air pressure on both sides of the tympanic membrane.

ANS: D

The eustachian tube allows an equalization of air pressure on each side of the tympanic membrane so that the membrane does not rupture during, for example, altitude changes in an airplane. The tube is normally closed, but it opens with swallowing or yawning.

5. A patient with a middle ear infection asks the nurse, What does the middle ear do? The nurse responds by telling the patient that the middle ear functions to:

a. Maintain balance.

b. Interpret sounds as they enter the ear.

c. Conduct vibrations of sounds to the inner ear.

d. Increase amplitude of sound for the inner ear to function.

ANS: C

Among its other functions, the middle ear conducts sound vibrations from the outer ear to the central hearing apparatus in the inner ear. The other responses are not functions of the middle ear.

6. The nurse is reviewing the function of the cranial nerves (CNs). Which CN is responsible for conducting nerve impulses to the brain from the organ of Corti?

a.I

b.III

c.VIII

d.XI

ANS: C

The nerve impulses are conducted by the auditory portion of CN VIII to the brain.

7. The nurse is assessing a patient who may have hearing loss. Which of these statements is *true*concerning air conduction?

a. Air conduction is the normal pathway for hearing.

b. Vibrations of the bones in the skull cause air conduction.

c. Amplitude of sound determines the pitch that is heard.

d. Loss of air conduction is called *a conductive hearing loss*.

ANS: A

The normal pathway of hearing is air conduction, which starts when sound waves produce vibrations on the tympanic membrane. Conductive hearing loss results from a mechanical dysfunction of the external or middle ear. The other statements are not true concerning air conduction.

8. A patient has been shown to have a sensorineural hearing loss. During the assessment, it would be important for the nurse to:

a. Speak loudly so the patient can hear the questions.

b. Assess for middle ear infection as a possible cause.

c. Ask the patient what medications he is currently taking.

d. Look for the source of the obstruction in the external ear.

ANS: C

A simple increase in amplitude may not enable the person to understand spoken words. Sensorineural hearing loss may be caused by presbycusis, which is a gradual nerve degeneration that occurs with aging and by ototoxic drugs, which affect the hair cells in the cochlea.

9. During an interview, the patient states he has the sensation that everything around him is spinning. The nurse recognizes that the portion of the ear responsible for this sensation is the:

a. Cochlea.

b. CN VIII.

c. Organ of Corti.

d. Labyrinth.

ANS: D

If the labyrinth ever becomes inflamed, then it feeds the wrong information to the brain, creating a staggering gait and a strong, spinning, whirling sensation called *vertigo*.

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. A patient in her first trimester of pregnancy is diagnosed with rubella. Which of these statements is *correct* regarding the significance of this in relation to the infants hearing?

a. Rubella may affect the mothers hearing but not the infants.

b. Rubella can damage the infants organ of Corti, which will impair hearing.

c. Rubella is only dangerous to the infant in the second trimester of pregnancy.

d. Rubella can impair the development of CN VIII and thus affect hearing.

ANS: B

If maternal rubella infection occurs during the first trimester, then it can damage the organ of Corti and impair hearing.

11. The mother of a 2-year-old is concerned because her son has had three ear infections in the past year. What would be an appropriate response by the nurse?

a. It is unusual for a small child to have frequent ear infections unless something else is wrong.

b. We need to check the immune system of your son to determine why he is having so many ear infections.

c. Ear infections are not uncommon in infants and toddlers because they tend to have more cerumen in the external ear.

d. Your sons eustachian tube is shorter and wider than yours because of his age, which allows for infections to develop more easily.

ANS: D

The infants eustachian tube is relatively shorter and wider than the adults eustachian tube, and its position is more horizontal; consequently, pathogens from the nasopharynx can more easily migrate through to the middle ear. The other responses are not appropriate.

MSC: Client Needs: Health Promotion and Maintenance

12. A 31-year-old patient tells the nurse that he has noticed a progressive loss in his hearing. He says that it does seem to help when people speak louder or if he turns up the volume of a television or radio. The most likely cause of his hearing loss is:

a. Otosclerosis.
b. Presbycusis.
c. Trauma to the bones.
d. Frequent ear infections.

ANS: A

Otosclerosis is a common cause of conductive hearing loss in young adults between the ages of 20 and 40 years. Presbycusis is a type of hearing loss that occurs with aging. Trauma and frequent ear infections are not a likely cause of his hearing loss.

13. A 70-year-old patient tells the nurse that he has noticed that he is having trouble hearing, especially in large groups. He says that he cant always tell where the sound is coming from and the words often sound mixed up. What might the nurse suspect as the cause for this change?

a. Atrophy of the apocrine glands
b. Cilia becoming coarse and stiff
c. Nerve degeneration in the inner ear
d. Scarring of the tympanic membrane

ANS: C

Presbycusis is a type of hearing loss that occurs in 60% of those older than 65 years of age, even in those living in a quiet environment. This sensorineural loss is gradual and caused by nerve degeneration in the inner ear. Words sound garbled, and the ability to localize sound is also impaired. This communication dysfunction is accentuated when background noise is present.

14. During an assessment of a 20-year-old Asian patient, the nurse notices that he has dry, flaky cerumen in his canal. What is the significance of this finding? This finding:

a. Is probably the result of lesions from eczema in his ear.
b. Represents poor hygiene.
c. Is a normal finding, and no further follow-up is necessary.
d. Could be indicative of change in cilia; the nurse should assess for hearing loss.

ANS: C

Asians and Native Americans are more likely to have dry cerumen, whereas Blacks and Whites usually have wet cerumen.

15. The nurse is taking the history of a patient who may have a perforated eardrum. What would be an important question in this situation?

a. Do you ever notice ringing or crackling in your ears?
b. When was the last time you had your hearing checked?
c. Have you ever been told that you have any type of hearing loss?
d. Is there any relationship between the ear pain and the discharge you mentioned?

ANS: D

Typically with perforation, ear pain occurs first, stopping with a popping sensation, and then drainage occurs.

16. A 31-year-old patient tells the nurse that he has noticed pain in his left ear when people speak loudly to him. The nurse knows that this finding:

a. Is normal for people of his age.
b. Is a characteristic of recruitment.
c. May indicate a middle ear infection.
d. Indicates that the patient has a cerumen impaction.

ANS: B

Recruitment is significant hearing loss occurring when speech is at low intensity, but sound actually becomes painful when the speaker repeats at a louder volume. The other responses are not correct.

17. While discussing the history of a 6-month-old infant, the mother tells the nurse that she took a significant amount of aspirin while she was pregnant. What question would the nurse want to include in the history?

a. Does your baby seem to startle with loud noises?
b. Has your baby had any surgeries on her ears?
c. Have you noticed any drainage from her ears?
d. How many ear infections has your baby had since birth?

ANS: A

Children at risk for a hearing deficit include those exposed in utero to a variety of conditions, such as maternal rubella or to maternal ototoxic drugs.

18. The nurse is performing an otoscopic examination on an adult. Which of these actions is *correct*?

a. Tilting the persons head forward during the examination
b. Once the speculum is in the ear, releasing the traction
c. Pulling the pinna up and back before inserting the speculum
d. Using the smallest speculum to decrease the amount of discomfort

ANS: C

The pinna is pulled up and back on an adult or older child, which helps straighten the S-shape of the canal. Traction should not be released on the ear until the examination is completed and the otoscope is removed.

19. The nurse is assessing a 16-year-old patient who has suffered head injuries from a recent motor vehicle accident. Which of these statements indicates the most important reason for assessing for any drainage from the ear canal?

a. If the drum has ruptured, then purulent drainage will result.
b. Bloody or clear watery drainage can indicate a basal skull fracture.
c. The auditory canal many be occluded from increased cerumen.
d. Foreign bodies from the accident may cause occlusion of the canal.

ANS: B

Frank blood or clear watery drainage (cerebrospinal leak) after a trauma suggests a basal skull fracture and warrants immediate referral. Purulent drainage indicates otitis externa or otitis media.

20. In performing a voice test to assess hearing, which of these actions would the nurse perform?

a. Shield the lips so that the sound is muffled.

b. Whisper a set of random numbers and letters, and then ask the patient to repeat them.

c. Ask the patient to place his finger in his ear to occlude outside noise.

d. Stand approximately 4 feet away to ensure that the patient can really hear at this distance.

ANS: B

With the head 30 to 60 cm (1 to 2 feet) from the patients ear, the examiner exhales and slowly whispers a set of random numbers and letters, such as 5, B, 6. Normally, the patient is asked to repeat each number and letter correctly after hearing the examiner say them.

21. In performing an examination of a 3-year-old child with a suspected ear infection, the nurse would:

a. Omit the otoscopic examination if the child has a fever.

b. Pull the ear up and back before inserting the speculum.

c. Ask the mother to leave the room while examining the child.

d. Perform the otoscopic examination at the end of the assessment.

ANS: D

In addition to its place in the complete examination, eardrum assessment is mandatory for any infant or child requiring care for an illness or fever. For the infant or young child, the timing of the otoscopic examination is best toward the end of the complete examination.

22. The nurse is preparing to perform an otoscopic examination of a newborn infant. Which statement is *true* regarding this examination?

a. Immobility of the drum is a normal finding.

b. An injected membrane would indicate an infection.

c. The normal membrane may appear thick and opaque.

d. The appearance of the membrane is identical to that of an adult.

ANS: C

During the first few days after the birth, the tympanic membrane of a newborn often appears thickened and opaque. It may look *injected* and have a mild redness from increased vascularity. The other statements are not correct.

23. The nurse assesses the hearing of a 7-month-old by clapping hands. What is the expected response? The infant:

a. Turns his or her head to localize the sound.

b. Shows no obvious response to the noise.

c. Shows a startle and acoustic blink reflex.

d. Stops any movement, and appears to listen for the sound.

ANS: A

With a loud sudden noise, the nurse should notice the infant turning his or her head to localize the sound and to respond to his or her own name. A startle reflex and acoustic blink reflex is expected in newborns; at age 3 to 4 months, the infant stops any movement and appears to listen.

24. The nurse is performing an ear examination of an 80-year-old patient. Which of these findings would be considered normal?

a. High-tone frequency loss
b. Increased elasticity of the pinna
c. Thin, translucent membrane
d. Shiny, pink tympanic membrane

ANS: A

A high-tone frequency hearing loss is apparent for those affected with presbycusis, the hearing loss that occurs with aging. The pinna loses elasticity, causing earlobes to be pendulous. The eardrum may be whiter in color and more opaque and duller in the older person than in the younger adult.

25. An assessment of a 23-year-old patient reveals the following: an auricle that is tender and reddish-blue in color with small vesicles. The nurse would need to know additional information that includes which of these?

a. Any change in the ability to hear
b. Any recent drainage from the ear
c. Recent history of trauma to the ear
d. Any prolonged exposure to extreme cold

ANS: D

Frostbite causes reddish-blue discoloration and swelling of the auricle after exposure to extreme cold. Vesicles or bullae may develop, and the person feels pain and tenderness.

26. While performing the otoscopic examination of a 3-year-old boy who has been pulling on his left ear, the nurse finds that his left tympanic membrane is bright red and that the light reflex is not visible. The nurse interprets these findings to indicate a(n):

a. Fungal infection.
b. Acute otitis media.
c. Perforation of the eardrum.
d. Cholesteatoma.

ANS: B

Absent or distorted light reflex and a bright red color of the eardrum are indicative of acute otitis media. (See Table 15-5 for descriptions of the other conditions.)

27. The mother of a 2-year-old toddler is concerned about the upcoming placement of tympanostomy tubes in her sons ears. The nurse would include which of these statements in the teaching plan?

a. The tubes are placed in the inner ear.
b. The tubes are used in children with sensorineural loss.
c. The tubes are permanently inserted during a surgical procedure.
d. The purpose of the tubes is to decrease the pressure and allow for drainage.

ANS: D

Polyethylene tubes are surgically inserted into the eardrum to relieve middle ear pressure and to promote drainage of chronic or recurrent middle ear infections. Tubes spontaneously extrude in 6 months to 1 year.

28. In an individual with otitis externa, which of these signs would the nurse expect to find on assessment?

a. Rhinorrhea
b. Periorbital edema
c. Pain over the maxillary sinuses
d. Enlarged superficial cervical nodes

ANS: D

The lymphatic drainage of the external ear flows to the parotid, mastoid, and superficial cervical nodes. The signs are severe swelling of the canal, inflammation, and tenderness. Rhinorrhea, periorbital edema, and pain over the maxillary sinuses do not occur with otitis externa.

29. When performing an otoscopic examination of a 5-year-old child with a history of chronic ear infections, the nurse sees that his right tympanic membrane is amber-yellow in color and that air bubbles are visible behind the tympanic membrane. The child reports occasional hearing loss and a popping sound with swallowing. The preliminary analysis based on this information is that the child:

a. Most likely has serous otitis media.
b. Has an acute purulent otitis media.
c. Has evidence of a resolving cholesteatoma.
d. Is experiencing the early stages of perforation.

ANS: A

An amber-yellow color to the tympanic membrane suggests serum or pus in the middle ear. Air or fluid or bubbles behind the tympanic membrane are often visible. The patient may have feelings of fullness, transient hearing loss, and a popping sound with swallowing. These findings most likely suggest that the child has serous otitis media. The other responses are not correct.

30. The nurse is performing an assessment on a 65-year-old man. He reports a crusty nodule behind the pinna. It intermittently bleeds and has not healed over the past 6 months. On physical assessment, the nurse finds an ulcerated crusted nodule with an indurated base. The preliminary analysis in this situation is that this:

a. Is most likely a benign sebaceous cyst.
b. Is most likely a keloid.
c. Could be a potential carcinoma, and the patient should be referred for a biopsy.
d. Is a tophus, which is common in the older adult and is a sign of gout.

ANS: C

An ulcerated crusted nodule with an indurated base that fails to heal is characteristic of a carcinoma. These lesions fail to heal and intermittently bleed. Individuals with such symptoms should be referred for a biopsy). The other responses are not correct.

31. The nurse suspects that a patient has otitis media. Early signs of otitis media include which of these findings of the tympanic membrane?

a. Red and bulging

b. Hypomobility

c. Retraction with landmarks clearly visible

d. Flat, slightly pulled in at the center, and moves with insufflation

ANS: B

An early sign of otitis media is hypomobility of the tympanic membrane. As pressure increases, the tympanic membrane begins to bulge.

32. The nurse is performing a middle ear assessment on a 15-year-old patient who has had a history of chronic ear infections. When examining the right tympanic membrane, the nurse sees the presence of dense white patches. The tympanic membrane is otherwise unremarkable. It is pearly, with the light reflex at 5 oclock and landmarks visible. The nurse should:

a. Refer the patient for the possibility of a fungal infection.

b. Know that these are scars caused from frequent ear infections.

c. Consider that these findings may represent the presence of blood in the middle ear.

d. Be concerned about the ability to hear because of this abnormality on the tympanic membrane.

ANS: B

Dense white patches on the tympanic membrane are sequelae of repeated ear infections. They do not necessarily affect hearing.

33. The nurse is preparing to do an otoscopic examination on a 2-year-old child. Which one of these reflects the *correct* procedure?

a. Pulling the pinna down

b. Pulling the pinna up and back

c. Slightly tilting the childs head toward the examiner

d. Instructing the child to touch his chin to his chest

ANS: A

For an otoscopic examination on an infant or on a child under 3 years of age, the pinna is pulled down. The other responses are not part of the correct procedure.

34. The nurse is conducting a child safety class for new mothers. Which factor places young children at risk for ear infections?

a. Family history

b. Air conditioning

c. Excessive cerumen

d. Passive cigarette smoke

ANS: D

Exposure to passive and gestational smoke is a risk factor for ear infections in infants and children.

35. During an otoscopic examination, the nurse notices an area of black and white dots on the tympanic membrane and the ear canal wall. What does this finding suggest?

a. Malignancy

b. Viral infection

c. Blood in the middle ear

d. Yeast or fungal infection

ANS: D

A colony of black or white dots on the drum or canal wall suggests a yeast or fungal infection (otomycosis).

36. A 17-year-old student is a swimmer on her high schools swim team. She has had three bouts of otitis externa this season and wants to know what to do to prevent it. The nurse instructs her to:

a. Use a cotton-tipped swab to dry the ear canals thoroughly after each swim.

b. Use rubbing alcohol or 2% acetic acid eardrops after every swim.

c. Irrigate the ears with warm water and a bulb syringe after each swim.

d. Rinse the ears with a warmed solution of mineral oil and hydrogen peroxide.

ANS: B

With otitis externa (swimmers ear), swimming causes the external canal to become waterlogged and swell; skinfolds are set up for infection. Otitis externa can be prevented by using rubbing alcohol or 2% acetic acid eardrops after every swim.

37. During an examination, the patient states he is hearing a buzzing sound and says that it is driving me crazy! The nurse recognizes that this symptom indicates:

a. Vertigo.

b. Pruritus.

c. Tinnitus.

d. Cholesteatoma.

ANS: C

Tinnitus is a sound that comes from within a person; it can be a ringing, crackling, or buzzing sound. It accompanies some hearing or ear disorders.

38. During an examination, the nurse notices that the patient stumbles a little while walking, and, when she sits down, she holds on to the sides of the chair. The patient states, It feels like the room is spinning! The nurse notices that the patient is experiencing:

a. Objective vertigo.

b. Subjective vertigo.

c. Tinnitus.

d. Dizziness.

ANS: A

With objective vertigo, the patient feels like the room spins; with subjective vertigo, the person feels like he or she is spinning. Tinnitus is a sound that comes from within a person; it can be a ringing, crackling, or buzzing sound. It accompanies some hearing or ear disorders. Dizziness is not the same as true vertigo; the person who is dizzy may feel unsteady and lightheaded.

39. A patient has been admitted after an accident at work. During the assessment, the patient is having trouble hearing and states, I dont know what the matter is. All of a sudden, I cant hear you out of my left ear! What should the nurse do next?

a. Make note of this finding for the report to the next shift.

b. Prepare to remove cerumen from the patients ear.
c. Notify the patients health care provider.
d. Irrigate the ear with rubbing alcohol.

ANS: C

Any sudden loss of hearing in one or both ears that is not associated with an upper respiratory infection needs to be reported at once to the patients health care provider. Hearing loss associated with trauma is often sudden. Irrigating the ear or removing cerumen is not appropriate at this time. MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

MULTIPLE RESPONSE

1. The nurse is testing the hearing of a 78-year-old man and is reminded of the changes in hearing that occur with aging that include which of the following? *Select all that apply*.

a. Hearing loss related to aging begins in the mid 40s.
b. Progression of hearing loss is slow.
c. The aging person has low-frequency tone loss.
d. The aging person may find it harder to hear consonants than vowels.
e. Sounds may be garbled and difficult to localize.
f. Hearing loss reflects nerve degeneration of the middle ear.

ANS: B, D, E

Presbycusis is a type of hearing loss that occurs with aging and is found in 60% of those older than 65 years. It is a gradual sensorineural loss caused by nerve degeneration in the inner ear or auditory nerve, and it slowly progresses after the age of 50 years. The person first notices a high-frequency tone loss; it is harder to hear consonants (high-pitched components of speech) than vowels, which makes words sound garbled. The ability to localize sound is also impaired.

Chapter 24. Inflammatory and Infectious Disorders of the Nose, Sinuses, Mouth, and Throat

1.A child is diagnosed with severe allergic rhinitis. Which of the following manifestations would the nurse most likely assess in this client?

1.Edematous neck glands 2.Reduced hearing 3.Pruritis
4.Frequent wiping of the nose with the palm of the hand ANS: 4

Frequent wiping of the nose with the palm of the hand is one symptom seen in the client diagnosed with severe allergic rhinitis. Edematous neck glands, reduced hearing, and pruritis are not manifestations of severe allergic rhinitis.

2.A client tells the nurse that she experiences a stuffy nose, nasal pain, and postnasal drip every time she works in her companys office. Which of the following types of allergic rhinitis is this client most likely experiencing?

1.Infectious 2.Perennial
3.Occupational 4.Seasonal

ANS: 3

Occupational allergic rhinitis occurs from airborne substances in the workplace. Seasonal allergic rhinitis occurs during a specific time of the year. Perennial allergic rhinitis occurs in response to exposure to environmental allergens that can occur throughout the year. Infectious rhinitis is a nonallergic type of rhinitis.

3.A client asks the nurse if there is an antihistamine that does not cause drowsiness. Which of the following medications would this client most likely prefer to treat allergic rhinitis?

1.Diphenhydramine 2.Chlorpheniramine
maleate 3.Clemastine 4.Fexofenadine

ANS: 4

Fexofenadine (Allegra) is a second-generation antihistamine, and second-generation antihistamines exhibit less sedation than first-generation medications such as diphenhydramine, chlorpheniramine maleate, and clemastine.

4.A client diagnosed with hypertension is experiencing allergic rhinitis. The nurse realizes that the medication that would *not* be indicated for this client would be:

1.loratadine. 2.montelukast.

3.pseudoephedrine. 4.zafirlukast.

ANS: 3

Pseudoephedrine can be contraindicated for the patient with hypertension. Loratadine, montelukast, and zafirlukast should be used cautiously for patients with hepatic impairment.

5.A 16-year-old client is being prescribed a medication to treat acute sinusitis. The nurse realizes that this client should *not* be prescribed:

1.amoxicillin. 2.cefuroxime.
3.ciprofloxacin.
4.erythromycin.

ANS: 3

Quinolones such as ciprofloxacin (Cipro) and levofloxacin (Levaquin) are contraindicated in children younger than 17 years of age.

6.The nurse is caring for a client diagnosed with acute sinusitis. Which of the following symptoms is the client most likely experiencing?

1.Anosmia 2.Fever 3.Halitosis
4.Metallic taste

ANS: 1

Clients often complain of unilateral face pain, purulent nasal discharge, pain during mastication, anosmia (absence of smell), and headache. Less common symptoms include fever, nasal congestion, halitosis, toothache, metallic taste, and cough.

7.The nurse is planning care for the client diagnosed with viral rhinitis. Which of the following would be the best goal of care for this client?

1.Prevent secondary bacterial infection. 2.Prevent rhinitis medicamentosa.

3.Refrain from use of analgesics.
4.Encourage complete participation in activities.

ANS: 1

Treatment of acute rhinitis, or the common cold, is aimed at decreasing the impact of the symptoms and preventing secondary bacterial infection. Rhinitis medicamentosa occurs from misuse of nasal decongestants. Acetaminophen or a nonsteroidal anti-inflammatory agent is useful for fever, aches, and pain. Rest is encouraged.

8.The nurse is instructing the mother of a client recovering from a tonsillectomy. Which of the following should the nurse instruct the mother to report?

1.Difficulty swallowing 2.Difficulty talking 3.Excessive swallowing 4.Pain

ANS: 3

Excessive swallowing is a sign of bleeding and should be reported. Pain and difficulty talking and swallowing are expected.

9.Which of the following should the nurse instruct a client recovering from a tonsillectomy? 1.Drink milk to promote healing.
2.Gargle with salt water.
3.Maintain good hydration.
4.Use a straw to drink.

ANS: 3

Drinking milk does not promote healing and may encourage production of mucus. Gargling and drinking with a straw may disrupt the clot at the operative site and cause bleeding. Maintaining good hydration and eating soft foods are encouraged.

11.A client has been diagnosed with stage IV cancer of the larynx. The nurse realizes that which of the following surgeries is recommended for this type of cancer?

1.Hemilaryngectomy

2.Partial laryngectomy
3.Supraglottic laryngectomy
4.Total laryngectomy

ANS: 4

In clients diagnosed with invasive or infiltrating tumors such as those of stage III or stage IV, the entire larynx is removed. The other surgeries only remove portions of the larynx and would be appropriate for lesser stages of the disease.

12.A client is recovering from a total laryngectomy with the placement of a tracheostomy. The nurse should include which of the following instructions to this client?

1.Clean the tracheostomy tube with soap and water daily. 2.Limit protein in the diet.
3.Restrict fluids.
4.The nasogastric tube will be in for 2 weeks.

ANS: 4

Clients recovering from a laryngectomy are unable to take nutrition orally for about 10 to 14 days. During this time the client will receive nutrition via intravenous fluids, enteral feedings through a nasogastric tube, or parenteral nutrition. Protein and fluids are not limited. The tracheostomy tube is not cleaned with soap and water.

13.A client diagnosed with viral rhinitis tells the nurse that she has been using a decongestant nasal spray for several weeks and the symptoms are getting worse. Which of the following does the nurse suspect is occurring with this client?

1.Developing pneumonia 2.Subacute rhinitis 3.Rhinitis medicamentosa
4.Chronic otitis media

ANS: 3

Rhinitis medicamentosa can occur with overuse of decongestant nasal sprays, and it leads to rebound nasal congestion that is often worse that the original nasal congestion. The use of nasal sprays does not cause pneumonia, subacute rhinitis, or chronic otitis media.

MULTIPLE RESPONSE

1.The nurse is teaching a client how to use a nasal spray. Which of the following should be included in these instructions? (Select all that apply.)

1.Blow the nose before instilling the spray.
2.Tilt the head back and angle the tip of the bottle to the side of the nostril.
3.Use a finger to occlude the nostril that is not receiving the spray.
4.Inhale gently and evenly while discharging the spray into the nostril. 5.If a second spray is recommended, immediately repeat the procedure. 6.Blow the nose after administration of the spray.

ANS: 1, 3, 4

For the steps to be correct, the head should be slightly forward, the second spray should be given 15 to 20 seconds after the spray, and the client should not blow the nose after the administration of the spray. The client should be instructed to blow the nose before instilling the spray, to use a finger to occlude the nostril that is not receiving the spray, and to gently inhale while the spray is being delivered into the nostril.

2.A client has been diagnosed with allergic rhinitis. Which of the following should the nurse instruct the client regarding strategies to avoid this disorder? (Select all that apply.)

1.Remove home carpeting
2.Reduce the use of an air conditioner
3.Remove pets from the home
4.Open windows in the spring and summer 5.Use feather pillows
6.Wash bed linens in cold water ANS: 1, 3

Strategies to reduce the symptoms of allergic rhinitis include removing home carpeting and removing pets from the home. The client should be instructed to use an air conditioner, keep windows closed during allergy season, avoid feather pillows, and wash bed linens in hot water.

3.A client is demonstrating signs of chronic sinusitis. Which of the following will the nurse most likely assess in this client? (Select all that apply.)

1.Facial pain

2.Fever
3.Headache
4.Toothache
5.Fatigue
6.Swollen neck glands ANS: 1, 3, 4, 5

Manifestations of chronic sinusitis include facial pain, headache, toothache, and fatigue. Fever and swollen neck glands would indicate the disorder has spread beyond the sinuses.

4.With which of the following can the nurse instruct a client who is experiencing pain from a sore throat? (Select all that apply.)

1.Gargle with warm salt water. 2.Eat salty foods.
3.Suck on hard candy.
4.Drink fluids.
5.Avoid citrus fruits.
6.Suck on popsicles.

ANS: 1, 3, 4, 6

Interventions to reduce the pain from a sore throat include gargling with warm salt water, sucking on throat lozenges or hard candy, sucking on flavored frozen desserts or popsicles, using a humidifier in the bedroom, and drinking fluids. The client should not be instructed to eat salty foods or avoid citrus fruits.

5.A client is demonstrating signs of peritonsillar abscess. Which of the following will the nurse most likely assess in this client? (Select all that apply.)

1.Bradypnea
2.Drop in blood pressure
3.Hot potato voice
4.Trismus
5.Dysphagia 6.Sore throat

ANS: 3, 4, 5, 6

Assessment findings consistent with peritonsillar abscess include: hot potato voice; trismus, or difficulty fully opening the mouth; dysphagia, or painful swallowing; and sore throat. Bradypnea and drop in blood pressure are not assessment findings consistent with peritonsillar abscess.

Chapter 25. Epistaxis

1.A client is experiencing epistaxis. Which of the following interventions would the nurse complete?

1.	Call the doctor.
2.	Check laboratory test results.
3.	Obtain an emesis basin.
4.	Show the patient how to pinch the nose.

ANS: 4

The initial intervention for a client with epistaxis is to show the client how to lean forward and pinch the nose against the nasal septum for about 5 to 10 minutes continuously. The other interventions are not necessary at this time.

2. A woman who is in the second trimester of pregnancy mentions that she has had more nosebleeds than ever since she became pregnant. The nurse recognizes that this is a result of:

a.	A problem with the patients coagulation system.
b.	Increased vascularity in the upper respiratory tract as a result of the pregnancy.
c.	Increased susceptibility to colds and nasal irritation.
d.	Inappropriate use of nasal sprays.

ANS: B

Nasal stuffiness and epistaxis may occur during pregnancy as a result of increased vascularity in the upper respiratory tract.

Chapter 26. Temporomandibular Disorders

1. 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.

2. 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.

3. Bones classified as irregular would include:

a. skull bones.
b. the mandible.
c. wrist bones.
d. the femur.

ANS: B

4. 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.

5. 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.

56 A patient states, Whenever I open my mouth real wide, I feel this popping sensation in front of my ears. To further examine this, the nurse would:

a. Place the stethoscope over the temporomandibular joint, and listen for bruits.

b. Place the hands over his ears, and ask him to open his mouth really wide.

c. Place one hand on his forehead and the other on his jaw, and ask him to try to open his mouth.

d. Place a finger on his temporomandibular joint, and ask him to open and close his mouth.

ANS: D

The nurse should palpate the temporomandibular joint by placing his or her fingers over the joint as the person opens and closes the mouth.

Chapter 27. Dysphonia

1. 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.

2. The nurse is assessing voice sounds during a respiratory assessment. Which of these findings indicates a normal assessment? *Select all that apply*.

a. Voice sounds are faint, muffled, and almost inaudible when the patient whispers one, two, three in a very soft voice.
b. As the patient repeatedly says ninety-nine, the examiner clearly hears the words ninety-nine.
c. When the patient speaks in a normal voice, the examiner can hear a sound but cannot exactly distinguish what is being said.
d. As the patient says a long ee-ee-ee sound, the examiner also hears a long ee-ee-ee sound.
e. As the patient says a long ee-ee-ee sound, the examiner hears a long aaaaaa sound.

ANS: A, C, D

As a patient repeatedly says ninety-nine, normally the examiner hears voice sounds but cannot distinguish what is being said. If a clear ninety-nine is auscultated, then it could indicate increased lung density, which enhances the transmission of voice sounds, which is a measure of bronchophony. When a patient says a long ee-ee-ee sound, normally the examiner also hears a long ee-ee-ee sound through auscultation, which is a measure of egophony. If the examiner hears a long aaaaaa sound instead, this sound could indicate areas of consolidation or compression. With whispered pectoriloquy, as when a patient whispers a phrase such as one-two-three, the normal response when auscultating voice sounds is to hear sounds that are faint, muffled, and almost inaudible. If the examiner clearly hears the whispered voice, as if the patient is speaking through the stethoscope, then consolidation of the lung fields may exist.

Chapter 28. Common Respiratory Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. A chronic cough lasts longer than:
a. 3 weeks
b. 1 month
c. 6 months
d. 1 year

__ 2. You are doing a cerumen extraction and touch the external meatus of your patient's ear. He winces and starts coughing. What is the name of this reflex?
a. Baker phenomenon
b. Arnold reflex
c. Cough reflex
d. Tragus reflex

____ 3. Julie has a postnasal drip along with her cough. You assess her for:
a. Asthma
b. Sinusitis
c. Allergic or vasomotor rhinitis
d. Influenza

__ 4. A patient with hypertension comes in and insists that one of his new medications is causing him to cough. When looking at his list of medications, you think the cough must be from:
a. Metoprolol
b. Clopidogrel
c. Tadalafil
d. Captopril

__ 5. African American patients seem to have a negative reaction to which of the following asthma medications?
a. Inhaled corticosteroids
b. Long-term beta-agonist bronchodilators
c. Leukotriene receptor agonists
d. Oral corticosteroids

__ 6. Sam, age 78, presents to the clinic with respiratory symptoms. His pulmonary function tests are as follows: a normal total lung capacity, a decreased PaO_2, and an increased $PaCO_2$. On assessment, you auscultate coarse crackles and forced expiratory wheezes. What is your diagnosis?

a. Asthma
b. Emphysema
c. Chronic bronchitis
d. Influenza

__ 7. You are using the CURB-65 clinical prediction tool to decide whether Mabel, whom you have diagnosed with community-acquired pneumonia (CAP), should be hospitalized or treated at home. Her score is 3. What should you do?

a. Consider home treatment.
b. Plan for a short inpatient hospitalization.
c. Closely supervise her outpatient treatment.
d. Hospitalize and consider admitting her to the intensive care unit.

__ 8. Why do you suspect that your patient may have a decreased response to the tuberculin skin test (TBT)?

a. She is on a high-protein diet.
b. She is an adolescent.
c. She has been on long-term corticosteroid therapy.
d. She just got over a cold.

__ 9. Marci has been started on a tuberculosis (TB) regimen. Because isoniazid (INH) may cause peripheral neuropathy, you consider ordering which of the following drugs prophylactically?

a. Pyridoxine
b. Thiamine
c. Probiotic
d. Phytonadione

____ 10. Jolene has breast cancer that has been staged as T1, N0, M0. What might this mean?

a. The tumor size cannot be evaluated; the cancer has not spread to the lymph nodes; and the distant spread cannot be evaluated.
b. The cancer is in situ; it is spreading into the lymph nodes, but the spread cannot be evaluated otherwise.
c. The cancer is less than 2 cm in size and has not spread to the lymph nodes or other parts of the body.
d. The cancer is about 5 cm in size; nearby lymph nodes cannot be evaluated; and there is no evidence of distant spreading.

__ 11. Nathan, a 32-year-old policeman, has a 15-pack-a-year history of smoking and continues to smoke heavily. During every visit, he gets irate when you try to talk to him about quitting. What should you do?

a. Hand him literature about smoking cessation at every visit.

b. Wait until he is ready to talk to you about quitting.
c. Document in the record that he is not ready to quit.
d. Continue to ask him at every visit if he is ready to quit.

__ 12. Your patient has decided to try to quit smoking with Chantix. You are discussing his quit date, and he will begin taking the medicine tomorrow. When should he plan to quit smoking?

a. He should stop smoking today.
b. He should stop smoking tomorrow.
c. His quit date should be in 1 week.
d. He will be ready to quit after the first 30 days.

__ 13. Which information should be included when you are teaching your patient about the use of nicotine gum?

a. The gum must be correctly chewed to a softened state and then placed in the buccal mucosa.
b. Patients should not eat for 30 minutes prior to or during the use of the gum.
c. Initially, one piece is chewed every 30 minutes while awake.
d. Acidic foods and beverages should be encouraged during nicotine therapy.

__ 14. Your patient states he has a strep throat infection. Which of the following symptoms makes you consider a viral etiology instead?

a. Fever
b. Headache
c. Exudative pharyngitis
d. Rhinorrhea

____ 15. What is the first-line recommended treatment against Group A β-hemolytic streptococci (GABHS), the most common cause of bacterial pharyngitis?

a. Penicillin
b. Quinolone
c. Cephalosporin
d. Macrolide

__ 16. Cydney presents with a history of asthma. She has not been treated for a while. She complains of daily but not continual symptoms, greater than 1 week and at nighttime. She has been using her rescue inhaler. Her FEV_1 is 60% to 80% predicted. How would you classify her asthma severity?

a. Mild intermittent
b. Mild persistent
c. Moderate persistent
d. Severe persistent

__ 17. Joyce is taking a long-acting beta agonist for her asthma. What additional medication should she be taking?
a. Inhaled corticosteroid
b. Leukotriene receptor antagonist
c. Systemic corticosteroid
d. Methyl xanthenes

____ 18. Your patient is on Therabid for his asthma. You want to maintain his serum levels between:
a. 0 to 5 mcg/mL
b. 5 to 10 mcg/mL
c. 5 to 15 mcg/mL
d. 10 to 20 mcg/mL

__ 19. George has chronic obstructive pulmonary disease (COPD) and an 80% forced expiratory volume in 1 second. How would you classify the severity of his COPD?
a. Stage 1 mild COPD
b. Stage 2 moderate COPD
c. Stage 3 severe COPD
d. Stage 5 very severe COPD

____ 20. Most nosocomial pneumonias are caused by:
a. Fungi
b. Viruses
c. Gram-negative bacteria
d. Pneumococcal pneumonia

____ 21. Which of the following statements regarding TST is true?
a. Tests should be read 48 hours after the injection.
b. The size of the TST reaction has nothing to do with erythema but is based solely on induration.
c. It is a type V T cell-mediated immune response.
d. The diameter of the induration is measured in centimeters.

____ 22. Which obstructive lung disease is classified as reversible?
a. Asthma
b. Chronic bronchitis
c. Emphysema
d. COPD

___ 23. You have taught Jennifer, age 15, about using a flow meter to assess how to manage her asthma exacerbations. She calls you today because her peak expiratory flow rate is 65%. What would you tell her?

a. "Take your short-acting beta-2 agonist, remain quiet, and call back tomorrow."
b. "Use your rescue inhaler, begin the prescription of oral glucocorticoids you have, and call back tomorrow."
c. "Drive to the emergency room now."
d. "Call 911."

____ 24. Which statement about adenocarcinoma of the lung is accurate?

a. It is the least common type of lung cancer, representing approximately 5% to 10% of cases.
b. It is the most prevalent carcinoma of the lungs in both sexes and in nonsmokers, representing 35% to 40% of all tumors.
c. It is more common in men than in women and occurs almost entirely in cigarette smokers.
d. It is aggressive, with rapid growth and early local and distant metastases via the lymphatic and blood vessels.

____ 25. Jason, age 62, has obstructive sleep apnea. What do you think is one of his contributing factors?

a. He is a recovering alcoholic of 6 years.
b. His collar size is 17 inches.
c. He is the only person in his family who has this.
d. He is extremely thin.

____ 26. The forced vital capacity is decreased in:

a. Asthma
b. Chronic bronchitis
c. Emphysema
d. Restrictive disease

____ 27. The most common cause of CAP is?

a. Streptococcus pneumoniae
b. Klebsiella pneumoniae
c. Legionella pneumoniae
d. Pseudomonas aeruginosa

____ 28. Which of the following patients would you expect to have a decreased response to TST?

a. Julie, a 50-year-old postal worker
b. Sandy, a 40-year-old patient who recently survived a fire that left 40% of her total body surface covered in burns

c. Jill, a 16-year-old cheerleader
d. Mark, a 29-year-old tennis player

____ 29. Which of the following is a possible consequence of sleep apnea?
a. Asthma
b. Increased white blood cells
c. Insulin resistance
d. Hyperactivity

____ 30. Which of the following conditions is associated with cigarette smoking?
a. Glaucoma
b. Increased sperm quality
c. Bladder cancer
d. Eczema

____ 31. Marta is taking TB drugs prophylactically. How do you instruct her to take them?
a. Take them on an empty stomach to facilitate absorption.
b. Take them with aspirin (ASA) to prevent flushing.
c. Take them with ibuprofen to prevent a headache.
d. Take them with food to prevent nausea.

____ 32. Which of the following statements regarding pulmonary function is true?
a. Cigarette smoking accelerates the decline in pulmonary function tenfold.
b. Smoking cessation can reverse most pathological changes.
c. Cigarette smoking decreases mucus production.
d. There is a normal age-related decline in pulmonary function.

____ 33. The barrel chest characteristic of emphysema is a result of:
a. Chronic coughing
b. Hyperinflation
c. Polycythemia
d. Pulmonary hypertension

__ 34. Supplemental oxygen for how many hours per day has been shown to improve the mortality associated with COPD?
a. 3 to 5 hours
b. 6 to 10 hours
c. 11 to 14 hours
d. 15 to 18 hours

____ 35. Which ethnic group has the highest lung cancer incidence and mortality rates?
a. African American men
b. Scandinavian men and women
c. Caucasian women
d. Asian men

Chapter 28. Common Respiratory Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: A PTS: 1
2. ANS: B PTS: 1
3. ANS: C PTS: 1
4. ANS: D PTS: 1
5. ANS: B PTS: 1
6. ANS: C PTS: 1
7. ANS: D PTS: 1
8. ANS: C PTS: 1
9. ANS: A PTS: 1
10. ANS: C PTS: 1
11. ANS: D PTS: 1
12. ANS: C PTS: 1
13. ANS: A PTS: 1
14. ANS: D PTS: 1
15. ANS: A PTS: 1
16. ANS: C PTS: 1
17. ANS: A PTS: 1
18. ANS: C PTS: 1
19. ANS: A PTS: 1
20. ANS: C PTS: 1
21. ANS: B PTS: 1

22. ANS: A PTS: 1

23. ANS: B PTS: 1

24. ANS: B PTS: 1

25. ANS: B PTS: 1

26. ANS: D PTS: 1

27. ANS: A PTS: 1

28. ANS: B PTS: 1

29. ANS: C PTS: 1

30. ANS: C PTS: 1

31. ANS: A PTS: 1

32. ANS: D PTS: 1

33. ANS: B PTS: 1

34. ANS: D PTS: 1

35. ANS: A PTS: 1

Chapter 29. Sleep Apnea

1. The use of a continuous positive airway pump in the treatment of sleep apnea will:

a.	reduce bronchospasm.
b.	force expansion of pleural membranes.
c.	maintain an open airway.
d.	awaken the person and increase respirations.

ANS: C

2.A client diagnosed with chronic obstructive pulmonary disease is experiencing pneumonia. The nurse applies oxygen at 2 L/min via nasal cannula. When the nurse leaves the room, a family member increases the oxygen to 5 L. Which complication may occur?

a.Angina b.Apnea
c.Metabolic acidosis d.Respiratory alkalosis

ANS: B

The COPD clients drive to breathe is hypoxia. Increasing the oxygen removes this drive and leads to apnea. Angina occurs because of decreased oxygen to the myocardial tissues. Neither respiratory alkalosis nor metabolic acidosis would occur with the increased oxygen level.

3. Jason, age 62, has obstructive sleep apnea. What do you think is one of his contributing factors?
a. He is a recovering alcoholic of 6 years.
b. His collar size is 17 inches.
c. He is the only person in his family who has this.
d. He is extremely thin.
ANS: B

4. Which of the following is a possible consequence of sleep apnea?
a. Asthma
b. Increased white blood cells

c. Insulin resistance
d. Hyperactivity

ANS: C

Chapter 30. Infectious Respiratory Disorders MULTIPLE

CHOICE

1.The nurse is reviewing clients for risk factors in the development of pneumonia. Which of the following clients would be at the highest risk for developing this disorder?

1.A 48-year-old client experiencing menopause 2.An 18-year-old client with abdominal pain
3.A 23-year-old client diagnosed with sickle-cell anemia and a cough
4.A 3-year-old client with fever ANS: 3

High-risk groups for acquiring pneumonia are people with diabetes, infants 6- to 23-months old, and those with a chronic illness such as sickle-cell anemia. Menopause and abdominal pain are not symptoms associated with pneumonia. Fever in a 3-year-old client could be caused by many disorders and not necessarily pneumonia.

2.A client diagnosed with chronic obstructive pulmonary disease is experiencing pneumonia. The nurse applies oxygen at 2 L/min via nasal cannula. When the nurse leaves the room, a family member increases the oxygen to 5 L. Which complication may occur?

1.Angina 2.Apnea
3.Metabolic acidosis 4.Respiratory alkalosis

ANS: 2

The COPD clients drive to breathe is hypoxia. Increasing the oxygen removes this drive and leads to apnea. Angina occurs because of decreased oxygen to the myocardial tissues. Neither respiratory alkalosis nor metabolic acidosis would occur with the increased oxygen level.

3.The nurse has a positive PPD during the last testing cycle for tuberculosis. Which of the following is indicated for this nurse?

1.Nothing
2.Chest x-rays every 2 months
3.Pharmacological treatment
4.Admission for inpatient treatment

ANS: 3

Latent tuberculosis infection occurs when a person exposed to the mycobacterium has a positive PPD test. This person is without an active clinical picture and has a 10% chance of developing TB if preventive pharmacological treatment is not initiated. The nurse needs pharmacological treatment.
Doing nothing could result in active disease. The nurse does not need chest x-rays every 2 months or admission for inpatient treatment.

4.A client undergoes a purified protein derivative (PPD) test. The test should be read: 1.immediately

after the test.
2.24 to 48 hours after the test.
3.48 to 72 hours after the test. 4.anytime after
72 hours.

ANS: 3

A small amount of tuberculin is injected directly under the skin at the site and is read 48 to 72 hours after the test. The test should not be read immediately afterwards or within 24 to 48 hours. If the test is read after 72 hours, the test may need to be repeated.

5.The nurse is instructing a client on ways to reduce the transmission of tuberculosis. Which of the following should be included in these instructions?

1.The disease is transmitted by inhaling droplets exhaled by an infected person.

2.The disease is transmitted by not fully cooking foods.
3.The disease is transmitted by not washing hands.
4.The disease is transmitted by sexual contact. ANS: 1

Tuberculosis is transmitted by inhaling the bacillus present in the air. The bacillus is present in the air after an infected person has coughed, sneezed, or expectorated.Tuberculosis is not transmitted through poorly cooked foods, poor handwashing, or sexual contact.

6.A client receiving oral medications for the treatment of tuberculosis develops hepatitis. Which of the following medications would be indicated for the client at this time?

1.Ethambutol 2.Isoniazid
3.Rifampin 4.Streptomycin

ANS: 4

Streptomycin is a medication that can be used until the cause of hepatitis is identified or the liver tissue heals. It is also given for those who have a first-line drug intolerance. First-line drugs are isoniazid (INH), rifampin (RIF), ethambutol (EMB), and pyrazinamide (PZA).

7.The spouse of a client diagnosed with tuberculosis is to begin isoniazid prophylactic therapy. Which of the following should the nurse instruct the spouse regarding length of time to take this medication? The medication should be taken for:

1.10 to 24 days.
2.1 to 3 months.
3.4 to 7 months.
4.6 to 12 months.

ANS: 4

Isoniazid therapy lasts 6 to 12 months. Taking the medication less than 6 months can be ineffective. The spouse should not be instructed to take the medication for 10 to 24 hours, 1 to 3 months, or 4 to 7 months.

8.A client diagnosed with a lung abscess is being prescribed antibiotic therapy. Which of the following medications would be indicated if this client has a history of penicillin allergy?

1.Metronidazole 2.Clindamycin
3.Ampicillin 4.Steroid

ANS: 2

Clients allergic to penicillin are often given clindamycin since this medication is not part of the penicillin family. Metronidazole and ampicillin should not be administered to this client. Steroid is not an antibiotic.

9.A client diagnosed with a hemothorax has had a chest tube inserted and attached to a portable water-seal drainage system. Which of the following interventions would be *inappropriate* for this client?

1.Clamp the tubing when ambulating.
2.Date and mark the amount of drainage in the collection chamber every shift.
3.Monitor the suction chamber for continuous bubbling.
4.Watch the water-seal chamber for fluctuation. ANS: 1

The chest tube should not be clamped or raised above the chest when ambulating. All other options are appropriate.

10.A clients chest tube has been accidentally dislodged while the client was being transferred from the bed to a stretcher. Which of the following should the nurse do to help this client?

1.Cover the site with occlusive petroleum jelly gauze and tape to four sides. 2.Cover the site with occlusive petroleum jelly gauze and tape to three sides. 3.Cover the site with occlusive petroleum jelly gauze and tape to two sides. 4.Cover the site with occlusive petroleum jelly gauze and tape to one side.

ANS: 2

In the case of accidental dislodging of the chest tube, the site should be covered with occlusive petroleum jelly gauze and taped on three sides to prevent the development of a tension

pneumothorax. If the gauze is taped on all four sides, the client can develop a tension pneumothorax. Taping the gauze on one or two sides will not be effective to support this client and should not be done.

11.A client is diagnosed with fractured ribs. Which of the following should the nurse instruct this client?

1.Engage in routine activities of daily living after taking pain medication. 2.Splint the rib cage when deep breathing and coughing.
3.Restrict fluids.
4.Stay on bed rest until the ribs heal.

ANS: 2

Nursing care for a client recovering from fractured ribs include splinting the rib cage when deep breathing and coughing. The client should be encouraged to avoid dangerous activities when taking pain medication. Fluids should not be restricted. Bed rest would not be necessary for fractured ribs.

12.A client is prescribed a diuretic for treatment of pulmonary hypertension. Which of the following should the nurse instruct the client regarding this medication?

1.This medication expands the blood vessels.
2.This medication causes smooth muscle relaxation to reduce pulmonary engorgement.
3.This medication reduces the amount of water in the body.
4.This medication keeps the blood from clotting. ANS: 3

Diuretics in the treatment of pulmonary hypertension are used to reduce the amount of water in the body. Vasodilators expand the blood vessels. Sildenafil causes smooth muscle relaxation to reduce pulmonary engorgement. Anticoagulants keep the blood from clotting.

13.The nurse is assessing a client experiencing manifestations of cor pulmonale. Which of the following will the nurse most likely assess in this client?

1.Low blood pressure 2.Low heart rate 3.Hoarseness 4.Lumbar pain

ANS: 3

Manifestations of cor pulmonale include hoarseness, chest pain, distended neck veins, liver enlargement, peripheral edema, abnormal heart sounds. Low blood pressure, low heart rate, and lumbar pain are not manifestations of cor pulmonale.

MULTIPLE RESPONSE

1.The nurse is caring for a client diagnosed with pneumonia. Which of the following signs and symptoms would the nurse most likely assess in this client? (Select all that apply.)

1.Abdominal pain 2.Anorexia
3.Cough 4.Dyspnea 5.Fever
6.Frequent wiping of the nose ANS: 1, 2, 3,

4, 5

Specific symptoms suggestive of pneumonia include fever, chills or rigor, sweats, new cough (with or without sputum), pleuritic chest pain, and dyspnea. Nonspecific symptoms include malaise, fatigue, abdominal pain, headaches, anorexia, and worsening of an underlying illness. Frequent wiping of the nose is a sign of allergic rhinitis.

2.The nurse is planning to administer the pneumococcus vaccination to a client. Which of the following would indicate that a client is a candidate for this vaccination? (Select all that apply.)

1.Age 70
2.Age 55
3.Diagnosis of heart failure
4.Recovering from knee replacement surgery
5.Diagnosis of asthma
6.Recovering from an appendectomy ANS: 1, 3, 5

Criteria for the pneumococcus vaccination include high-risk groups such as people over age 65, diagnosed with chronic heart disease, and diagnosed with asthma. Age 55, recovering from knee

replacement surgery; and recovering from an appendectomy are not criteria for the pneumococcus vaccination.

3.The nurse is planning care for a client diagnosed with bronchiolectasis. Which of the following would be goals for this clients care? (Select all that apply.)

1.Treat the infection. 2.Reduce the heart rate. 3.Minimize further damage. 4.Improve urine output.
5.Promote breathing.
6.Remove secretions.

ANS: 1, 3, 5, 6

Treatment goals for the client diagnosed with bronchiolectasis include treat the infection, minimize further damage, promote effective airway breathing, and remove secretions. Treatment goals do not include reducing heart rate and improving urine output.

4.The nurse, planning care for a client diagnosed with a pneumothorax, identifies which types of pneumothorax? (Select all that apply.)

1.Spontaneous 2.Radical
3.Traumatic 4.Incomplete
5.Iatrogenic 6.Tension

ANS: 1, 3, 5, 6

The four types of pneumothorax are spontaneous, traumatic, iatrogenic, and tension. Radical and incomplete are not types of pneumothorax.

5.Which of these instructions are for a client diagnosed with a pneumothorax? (Select all that apply.) 1.Remove air from the pleural space.
2.Correct acid-base imbalances. 3.Treat infection.
4.Minimize damage.
5.Reexpand the lung.

6.Improve fluid balance.

ANS: 1, 2, 4, 5

Treatment goals for pneumothorax include removing the air and fluid from the pleural space, correcting acid-base imbalance, minimizing further damage, and reexpanding the lung. Treating infection and improving fluid balance are not treatment goals for a pneumothorax.

Chapter 31. Inflammatory Respiratory Disorders

1.How does pursed lip breathing assist patients with asthma during an attack?

a.	It distracts the patient with breathing technique to reduce anxiety.
b.	It gets rid of CO_2 faster.
c.	It opens bronchioles by backflow air pressure.
d.	It increases $PACO_2$..

ANS: C

The resistance or the expiration through the pursed lips causes a backflow of air and helps to open the bronchioles.

2.How do leukotriene modifiers reduce the symptoms of asthma?

a.	By drying up mucus
b.	By causing bronchodilation and anti-inflammation effects
c.	By suppressing cough
d.	By liquefying mucus

ANS: B

Leukotriene modifiers reduce the symptoms of asthma by causing bronchodilation and anti-inflammatory processes.

3.How should a patient be positioned after a thoracentesis is completed and the dressing applied?

a.	High Fowler
b.	Semi-Fowler
c.	Side lying on unaffected side

d. Prone

ANS: C

After a thoracentesis the patient is placed in a side-lying position on the unaffected side. 4.What should the nurse do to keep the chest tubes from becoming occluded?

a. Irrigate tubes as needed
b. Prevent dependent loops
c. Loop the tube over the bed rail
d. Milk the tube frequently

ANS: B

To keep the tubes patent, the tubes should be kept straight without dependent loops. These tubes are not irrigated and should not be milked frequently.

5.Which patient assessment indicates the most severe respiratory distress?

a. Nasal flaring, symmetrical chest wall expansion, SaO_2 88%
b. Abdominal breathing, SaO_2 97%
c. Substernal retraction, SaO_2 84%
d. Substernal retraction, SaO_2 90%

ANS: C

Observe the patients facial expressions and signs of respiratory distress, such as flaring nostrils, substernal or clavicular retractions, asymmetrical chest wall expansion, and abdominal breathing. The lower the SaO_2, the more severe the respiratory distress.

MULTIPLE RESPONSE

6.Which preoperative teaching should a nurse include for a person scheduled for a partial laryngectomy? (Select all that apply.)

a. Tracheal suction will be frequent
b. The presence of a temporary tracheotomy
c. That isolation will be required for 24 hours
d. The surgery involves removal of a diseased vocal cord
e. Some speech will be retained
f. The sense of smell and taste will be lost

ANS: A, B, D, E

A partial laryngectomy involves the removal of the diseased cord and possible thyroid cartilage. There will be a temporary tracheostomy that will be closed once edema is under control. Tracheal suctioning will be done frequently. There will be some vocal ability retained. Isolation is not required. Sense of smell and taste are lost with a total laryngectomy.

7.Which independent nursing measures are effective in aiding a patient to expectorate? (Select all that apply.)

a.	Positioning in orthopneic position
b.	Suctioning
c.	Assisting to cough
d.	Providing hydration
e.	Starting IV fluids
f.	Starting mucolytic agents

ANS: A, B, C, D

Independent nursing intervention to help a patient to expectorate would include positioning, assisting to cough, suctioning, and providing hydration IV therapy; provision of a mucolytic agent requires a physicians order and is not an independent nursing action..

8.Identify the purposes of chest drainage. (Select all that apply.)

a.	Drains air, blood, and fluid from pleural space
b.	Restores positive pressure in chest cavity
c.	Restores negative intrapleural pressure
d.	Allows lung to collapse and rest
e.	Allows route for medication administration

ANS: A, C

A chest tube or tubes may be inserted for continuous drainage of fluid, blood, or air from the pleural cavity and for medication instillation. To prevent the lung from collapsing, a closed drainage system is used, which maintains the lung cavitys normal negative pressure. The chest tubes are connected to a pleural drainage system with collection, water seal, and suction control chambers to drain secretions and reestablish negative pressure in the pleural space.

9.What are age-related changes in the older adult that make them at risk for respiratory diseases? (Select all that apply.)

a.	Moist mucous membranes
b.	Kyphosis
c.	Decrease in pulmonary blood flow
d.	Stasis pooling of secretions

e.	Reduced number of cilia

ANS: B, C, D, E

Age-related changes that affect the respiratory system are dryer mucous membranes, which reduce ability to humidify inspired air, kyphosis, which restricts the expansion of the lung, stasis pooling of respiratory secretions, and reduced number of cilia, which make infection of the upper and lower airway more likely.

10.The nurse explains to the person with pneumonia in the left lung that being positioned in the good lung down offers the advantage of (select all that apply):

a.	PaO_2 rising in the good lung.
b.	blood flow to bad lung being increased.
c.	the dependent lung being better perfused.
d.	dyspnea disappearing.
e.	decreased hypoxia.

ANS: A, C, E

The good lung down position increases the PaO_2 in the good lung and also allows for better perfusion, consequently decreasing hypoxia, although dyspnea may still be evident.

11.How would the nurse examining a patient with pleurisy document a low-pitched grating lung sound?

a.	Sonorous wheeze
b.	Friction rub
c.	Coarse crackles
d.	Crackles

ANS: B

A low-pitched grating sound in the presence of an inflammatory disorder is a friction rub.

12.The nurse describes the pathophysiologic process of an asthma attack. Place the events in their proper sequence. (Separate letters by a comma and space as follows: A, B, C, D)

a. Inflammatory process in the mast cells of the lungs

b. Increase in edema and mucus production in the bronchioles

c. Release of histamine

d. Narrowing of the airways

e. Exposure to allergen

ANS:

E, A, C, B, D

The allergen activates the mast cells in the lungs, which release histamine, causing an increase in edema and mucus production that narrows the airways and causes the classic signs of asthma.

Chapter 32. Lung Cancer MULTIPLE

CHOICE

1.A client states, I dont know why I should quit smoking. It cant improve anything. The nurse responds by informing the client about the decrease in lung cancer rates over time after a person quits smoking. Which of the following is correct?

1. The lung cancer rate corresponds to that of nonsmokers 1 year after quitting smoking.
2. The lung cancer rate corresponds to that of nonsmokers 2 years after quitting smoking.
3. The lung cancer rate corresponds to that of nonsmokers 5 years after quitting smoking.
4. The lung cancer rate corresponds to that of nonsmokers 10 years after quitting smoking.

ANS: 4

Ten years after quitting smoking, the clients lung cancer rate will correspond to a nonsmokers rate. After 1 year of no smoking, the risk of coronary heart disease decreases to half that of a smoker.
After 2 years of no smoking, the risk of coronary heart disease equals that of a nonsmoker. After 5 years of no smoking, the lung cancer rate drops by half.

2. A patient with lung cancer is receiving chemotherapy. Why should the nurse closely monitor the patients white blood cell (WBC) count?
a. Chemotherapy drugs cause polycythemia and can precipitate thrombosis.
b. Chemotherapy drugs attack WBCs and shorten their life span, which increases risk for infection.
c. Chemotherapy drugs cause proliferation of blood cells, which can lead to sluggish circulation.
d. Chemotherapy drugs depress the bone marrow, which can lead to infection and an increase in WBC count.

ANS D. Chemotherapy is toxic to the bone marrow, where the blood cells are produced. Numbers of blood cells, especially WBCs, drop after approximately 7 to 14 days, depending on the drug. A. Chemotherapy is more likely to cause bleeding because of lack of platelets, not thrombosis. B.

Chemotherapy does not directly attack WBCs. C. Chemotherapy does not cause proliferation of cells, although excess immature cells may be present.

3. The nurse is caring for a patient with lung cancer who is receiving chemotherapy. Which assessment finding suggests that the patient is experiencing pericardial effusion?
a. Bruising and tarry stools
b. Edema and shortness of breath
c. Nausea and decreased bowel sounds
d. Peripheral numbness and tingling
ANS: B

B. Pericardial effusion, or cardiac tamponade, is a condition usually caused by direct invasion of the cancer, causing the pericardial sac to fill with fluid. Nursing care for the patient with cardiac tamponade includes monitoring respiratory status, vital signs, and intake and output; keeping the head of the bed elevated for maximum lung expansion; and assessing for edema.

Chapter 33. Smoking Addiction

1.A client has been smoking for the last 40 years and has a history of emphysema. Which of the following findings would the nurse *not* expect to find?

1.	Decreased forced vital capacity (FVC)
2.	Increased anterior-posterior chest diameter
3.	Increased forced expiratory volume (FEV_1)
4.	Pursed lip breathing

ANS: 3

The FEV_1 does not increase; it decreases. The FVC does decrease, and the client can exhibit increased anterior-posterior chest diameter and pursed lip breathing.

Chapter 34. Common Cardiovascular Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which group would most benefit from statins?
a. Those with a low density lipoprotein-cholesterol greater than 100 mg/dL
b. Individuals with clinical arteriosclerotic cardiovascular disease
c. Individuals with a 10-year risk greater than 10%
d. Individuals of all ages with diabetes mellitus (DM)

__ 2. If chest pain can be alleviated with time, analgesics, and heat applications, what might the differential diagnosis be?
a. Peptic ulcer
b. Hiatal hernia
c. Costochondritis
d. Pericarditis

__ 3. Sandra has palpitations that occur with muscle twitching, paresthesia, and fatigue. What specific diagnostic test might help determine the cause?
a. Serum calcium
b. Electrocardiogram (ECG)
c. Thyroid-stimulating hormone test
d. Complete blood cell count

____ 4. A blood pressure (BP) of 150/90 is considered:
a. Stage 2 hypertension
b. Hypertensive
c. Normal in healthy older adults
d. Acceptable if the patient has DM

____ 5. Lifestyle modifications to manage hypertension (HTN) include:
a. Maintaining a body mass index of 17
b. Restricting dietary sodium to 2 grams per day
c. Engaging in exercise or physical activity for 90 minutes a day
d. Limiting beer intake to 24 ounces per day

__ 6. Mary has hypertension and previously had a stroke. Which hypertensive drug would you order for her?
a. Angiotensin converting enzyme inhibitor
b. Calcium channel blocker

c. Angiotensin II receptor blocker
d. Beta blocker

____ 7. Which high-density lipoprotein (HDL) level is considered cardioprotective?
a. Greater than 30
b. Greater than 40
c. Greater than 50
d. Greater than 60

__ 8. You are assessing Sigred for metabolic syndrome. Which of her parameters is indicative of this syndrome?
a. Her waist is 36 inches.
b. Her triglyceride level is 140 mg/dL.
c. Her BP is 128/84.
d. Her fasting blood sugar (BS) is 108 mg/dL.

__ 9. Which type of angina do you suspect in Harvey, who complains of chest pain that occurs during sleep and most often in the early morning hours?
a. Stable angina
b. Unstable angina
c. Variant (Prinzmetal's angina)
d. Probably not angina but hiatal hernia

____ 10. Which ECG change is typical of cardiac ischemia?
a. T-wave inversion
b. ST-segment elevation
c. Significant Q wave
d. U-wave

__ 11. In which type of arterioventricular (AV) block does the pulse rate (PR) interval lengthen until a beat is dropped?
a. First-degree AV block
b. Second-degree Mobitz I AV block
c. Second-degree Mobitz II AV block
d. Third-degree AV block

____ 12. A Delta wave on the ECG may be present in which condition?
a. Prinzmetal's angina
b. Bundle branch block
c. Wolff-Parkinson-White syndrome

d. Aortic stenosis

__ 13. Which heart sound may be heard with poorly controlled hypertension, angina, and ischemic heart disease?
a. A physiologic split S2
b. A fixed split S2
c. S3
d. S4

__ 14. Samuel is going to the dentist for some work and must take endocarditis prophylaxis because of his history of:
a. Severe asthma
b. A common valvular lesion
c. Severe hypertension
d. A prosthetic heart valve

. George, age 64, has cardiovascular disease (CVD), a total cholesterol of 280 mg/dL, and a systolic BP of 158. He is being treated for hypertension. You are doing a Framingham Risk Assessment on him. Which assessment factor would give him the highest number of points on the scale?
a. His age
b. His cholesterol level
c. His systolic BP
d. The fact that he is on antihypertensive medication

____ 16. Which pain characteristic is usually indicative of cardiac pathology?
a. Fleeting
b. Moving
c. Diffuse
d. Localized

__ 17. What percentage of patients with angina pectoris will have simultaneous dyspnea, caused by transient increase in pulmonary venous pressures that accompany ventricular stiffening during an episode of myocardial ischemia?
a. About 20%
b. About 30%
c. About 50%
d. Almost all

__ 18. Nitroglycerine (NTG) is given for a patient having ischemic chest pain. One tablet or one spray should be used under the tongue every 5 minutes for three doses. What should be done if the pain has not been relieved after three doses?

a. 911 should be called, and the patient should be transported immediately to the emergency department.
b. One more dose of NTG may be tried.
c. The person should be given two aspirin to chew.
d. A portable defibrillator should be located to ascertain the cardiac rhythm.

__ 19. For the best therapeutic effect after a myocardial infarction (MI), thrombolytics should be administered within the first 3 hours (ideally 30 minutes) of symptom onset. Studies have shown, however, that thrombolytic therapy can be of benefit up to how many hours after the initial presentation of MI symptoms?

a. 6 hours
b. 8 hours
c. 10 hours
d. 12 hours

__ 20. When teaching post MI patients about their NTG tablets, the clinician should stress that the tablets should remain in the light-resistant bottle in which they are packaged and should not be put in another pill box or remain in areas that are or could become warm and humid. Once opened, the bottle must be dated and discarded after how many months?

a. 1 month
b. 3 months
c. 6 months
d. As long as the tablets are kept in this special bottle, they will last forever.

__ 21. There are four stages of heart failure, classified as A to D, that describe the evolution and progression of disease. In which stage are patients hospitalized or treated with specialized interventions or hospice care for refractory symptoms of heart failure despite medical therapy?

a. Stage A
b. Stage B
c. Stage C
d. Stage D

__ 22. Which of the following is abundant in the heart and rapidly rises in the bloodstream in the presence of heart failure, making it a good diagnostic test?

a. B-type natriuretic peptide
b. C-reactive protein
c. Serum albumin
d. Erythrocyte sedimentation rate

____ 23. Which test has long been considered the gold standard for a diagnosis of venous thromboembolism?
a. Ultrasound
b. Magnetic resonance imaging (MRI)
c. Ascending venogram
d. D-dimer

____ 24. Statins are approved for which age group?
a. Children over the age of 2
b. Children over the age of 6
c. Children over the age of 10
d. Only adolescents and adults

__ 25. The American College of Cardiology/American Heart Association states which of the following regarding the use of non-statin lipid-lowering agents?
a. Nicotinic acid derivatives are effective for lowering LDL and triglycerides (TGs).
b. Bile acid sequestrates increase HDL.
c. Cholesterol absorption inhibitors decrease LDL.
d. There is no sufficient evidence to use non-statin lipid-drugs.

____ 26. Which of the following medications can cause hyperlipidemia?
a. Diuretics
b. NSAIDs
c. Opioids
d. Insulin

__ 27. Jamie, age 55, has just started on a statin after having his liver function tests (LFTs) come back normal. He now asks you how often he has to have the LFTs repeated. What do you tell him?
a. Initially in 6 weeks
b. Every 3 months
c. Every 6 months
d. It's no longer necessary for his statin regimen.

____ 28. In the CHADS2 Index for the stroke risk score for AF, the 'A' stands for:
a. Anticoagulation
b. Autoimmune disease
c. Age
d. Antihypertension

____ 29. Which murmurs are usually 'watch and wait'?

a. Systolic murmurs
b. Diastolic murmurs
c. They both are dangerous and need immediate attention.
d. You can 'watch and wait' for both of them.

____ 30. Which of the following statements about dabigatran is true?
a. It is difficult to keep the patient in therapeutic range.
b. Anticoagulation cannot be immediately reversed.
c. It allows for the use of tPA if the patient has a stroke despite anticoagulation.
d. None of the statements are true.

____ 31. What value on the ankle-brachial index diagnoses peripheral artery disease?
a. Less than 0.25
b. Less than 0.50
c. Less than 0.90
d. Greater than 1

____ 32. Your patient with permanent afib asks when he can discontinue his warfarin. You tell him:
a. When your internalized normalized ratio reaches 3.0, you can stop taking your warfarin permanently.
b. When you no longer feel ill
c. One month after your symptoms dissipate
d. You'll probably be on it indefinitely.

___ 33. You just started Martha on HTN therapy. The Eighth Joint National Committee recommends that if her goal BP is not reached in what length of time, you should increase the initial drug or add a second drug to it?
a. 1 month
b. 3 months
c. 6 months
d. 1 year

Chapter 34. Common Cardiovascular Problems
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: C PTS: 1
3. ANS: A PTS: 1
4. ANS: C PTS: 1
5. ANS: D PTS: 1
6. ANS: A PTS: 1
7. ANS: D PTS: 1
8. ANS: A PTS: 1
9. ANS: C PTS: 1
10. ANS: A PTS: 1
11. ANS: B PTS: 1
12. ANS: C PTS: 1
13. ANS: D PTS: 1
14. ANS: D PTS: 1
15. ANS: B PTS: 1
16. ANS: C PTS: 1
17. ANS: B PTS: 1
18. ANS: A PTS: 1
19. ANS: D PTS: 1
20. ANS: C PTS: 1
21. ANS: D PTS: 1

22. ANS: A PTS: 1

23. ANS: C PTS: 1

24. ANS: C PTS: 1

25. ANS: D PTS: 1

26. ANS: A PTS: 1

27. ANS: D PTS: 1

28. ANS: C PTS: 1

29. ANS: A PTS: 1

30. ANS: B PTS: 1

31. ANS: C PTS: 1

32. ANS: D PTS: 1

33. ANS: A PTS: 1

Chapter 35. Cardiac and Associated Risk Disorders MULTIPLE

CHOICE

1.The nurse suspects a clients heart is failing when which of the following heart sounds is assessed?

1. S_1
2. S_2
3. S_3
4. S_4

ANS: 3

An auscultated S_3 is a sign that increased blood volume remains in the ventricle with each beat and that the heart is beginning to fail. S_1 and S_2 sounds are the first and second sounds heard when auscultating the heart. An S_4 sound may indicate increased resistance to ventricular filling.

2.A client is diagnosed with heart failure. Which of the following diagnostic tests is useful to determine the degree of the failure?

1.Brain natriuretic peptide level 2.Blood cultures 3.Sedimentation rate
4.Arterial blood gas ANS: 1

Brain natriuretic peptide is a hormone found in the left ventricle; it is used to help diagnose and grade the severity of heart failure. Blood cultures are used to diagnose carditis. Sedimentation rate is used to diagnose pericarditis. Arterial blood gasses are not used to determine the degree of heart failure.

3.A nurse is instructing a client regarding medications and substances contraindicated for the client with heart failure. Which of the following would *not* be contraindicated?

1.Alcohol 2.Furosemide
3.Metformin 4.Pioglitazone

ANS: 2

Loop diuretics (e.g., furosemide) are part of the recommended medications for heart failure. Alcohol, metformin, and pioglitazone (a thiazolidinedione) are contraindicated.

4.The nurse is determining nursing diagnoses appropriate for a client demonstrating productive cough with pink frothy sputum, shortness of breath, and crackles. Which of the following nursing diagnoses is of the most importance?

1.Activity intolerance 2.Anxiety
3.Impaired gas exchange
4.Risk for ineffective respiratory function

ANS: 3

The first priority is to maintain adequate oxygenation. The next diagnoses in priority would be risk for ineffective respiratory function. Activity intolerance would be the third diagnosis. Anxiety would be the last diagnosis in order of priority.

5.In planning the care for a client diagnosed with heart failure, which of the following would be an appropriate goal?

1.Reduce myocardial contractility. 2.Increase cardiac workload.
3.Decrease ejection fraction. 4.Increase activity levels.

ANS: 4

An increase in activity levels would be an appropriate goal for the client diagnosed with heart failure. The other options would be a decrease in ability, function, or management of the heart failure patient.

6.The nurse is instructing a client diagnosed with mild heart failure on dietary modifications. Which of the following client statements indicates that the instruction has been effective?

1.I will avoid green beans.
2.I will avoid orange juice.
3.I will avoid soy sauce.
4.I will avoid apple sauce.

ANS: 3

Soy sauce is a high-sodium food choice; all the other choices are low sodium. Treatment for mild symptoms of heart failure includes dietary restriction of salt.

7.A client is undergoing diagnostic testing for infective endocarditis. Which of the following laboratory tests would be most useful in diagnosis?

1.Basic metabolic panel 2.Blood cultures 3.Reticulocyte count
4.Prothrombin time

ANS: 2

Blood cultures identify the causative organisms. A basic metabolic panel gives the current status of the clients acid/base balance and electrolytes. The reticulocyte count determines bone marrow function and evaluates erythropoietic activity. The prothrombin time is useful in monitoring anticoagulant therapy.

8.Which of the following would the nurse most likely assess in a client diagnosed with right-sided heart failure?

1.Distended neck veins 2.Oliguria
3.Cough with frothy blood-tinged sputum 4.Syncope

ANS: 1

An assessment finding in a client diagnosed with right-sided heart failure is distended neck veins. Oliguria, cough with frothy blood-tinged sputum, and syncope are all clinical manifestations of left- sided heart failure.

9.Which of the following diagnostic tests is useful to diagnose mitral valve prolapse?

1.Electrocardiogram
2.Echocardiogram 3.Cardiac
angiography
4.Transesophageal echocardiography ANS: 4

Transesophageal echocardiography is useful in the assessment of cardiac murmurs, stenosis, and regurgitation of all four cardiac valves. An electrocardiogram, echocardiogram, and cardiac angiography may or may not be useful when diagnosing mitral valve prolapse.

10.A client diagnosed with mitral valve prolapse is experiencing palpitations. Which of the following should the nurse instruct this client?

1.Avoid tobacco
2.Ingest alcohol in moderation
3.Avoid weight loss
4.Limit caffeine intake

ANS: 1

Clients with palpitations associated with mitral valve prolapse should be instructed to avoid caffeine, alcohol, and tobacco. Weight loss should be encouraged in overweight clients.

11.A client tells the nurse that she had rheumatic heart disease as a child. For which of the following valvular disorders should this client be assessed?

1.Mitral valve prolapse 2.Mitral stenosis 3.Aortic regurgitation 4.Aortic stenosis

ANS: 2

Mitral stenosis is most commonly caused by rheumatic heart disease. Rheumatic heart disease has not been linked to mitral valve prolapse, aortic regurgitation, or aortic stenosis.

12.A client, recovering from surgery to replace a calcified aortic valve with a mechanical valve, should be instructed that which of the following medications will be needed long term?

1.ACE inhibitor 2.Beta-blocker
3.Antibiotic 4.Anticoagulant

ANS: 4

The mechanical valve requires long-term anticoagulation therapy to prevent the risk of thromboembolism. ACE inhibitors, beta-blockers, and antibiotics are not indicated as long-term therapy for this surgery.

13.A client is scheduled for annuloplasty surgery to the aortic valve. Which of the following will most likely occur during this clients procedure?

1.A catheter will be inserted through the femoral vein.
2.A heart bypass machine will be used. 3.Local anesthesia will be provided.
4.A balloon will inflate and stretch the valve open.

ANS: 2

For an annuloplasty, the client will receive general anesthesia and a heart bypass machine will be used. A balloon valvuloplasty is done by inserting a catheter through the femoral vein or artery and stretching the valve open with a balloon. The client needs general anesthesia for an annuloplasty and not a local anesthetic.

MULTIPLE RESPONSE

1.The nurse suspects a client is experiencing left-sided heart failure when which of the following is assessed? (Select all that apply.)

1.Decreased basilar lung sounds 2.Distended neck veins
3.Extra heart sounds 4.Lung crackles 5.Tachycardia 6.Weight gain

ANS: 1, 3, 4, 5

Signs of left-sided heart failure are dysrhythmic heart rate, tachycardia, heart murmurs, extra heart sounds, lung crackles, and decreased basilar lung sounds. Distended neck veins and weight gain are symptoms of right-sided heart failure.

2.A client diagnosed with heart failure is prescribed furosemide (Lasix). Which of the following should this client be monitored for because of this medication? (Select all that apply.)

1.Dehydration
2.Rebound fluid volume overload
3.Hyponatremia
4.Hypokalemia 5.Hypernatremia
6.Hyperkalemia

ANS: 1, 3, 4

Any client prescribed diuretics should be monitored for dehydration, hyponatremia, and hypokalemia. Rebound fluid volume overload is not possible with diuretic therapy. Hypernatremia and hyperkalemia are also not possible with diuretic therapy.

3.The nurse is reviewing the medications prescribed for a client diagnosed with dilated cardiomyopathy. Which of the following medications are commonly prescribed for this disease process? (Select all that apply.)

1.ACE Inhibitor 2.Beta-blocker
3.Diuretic 4.Anticoagulant
5.Antiarrhythmic 6.Antibiotic

ANS: 1, 2, 3, 4, 5

Pharmacological management of dilated cardiomyopathy includes ACE inhibitor to prevent further dilation of the heart, beta-blocker to reduce the strain that heart failure produces on the heart muscle, diuretics to decrease the amount of circulating fluid, anticoagulants to decrease blood clots, and antiarrhythmics to maintain the normal electrical stimulation of the heart. Antibiotics are not routinely prescribed for a client diagnosed with dilated cardiomyopathy.

4.Which of the following should the nurse instruct a client diagnosed with hypertrophic cardiomyopathy? (Select all that apply.)

1.Follow recommended activity level 2.Avoid all alcohol
3.Take hot tub baths routinely 4.Avoid overexertion 5.Avoid dehydration
6.Unexplained breathlessness is a common symptom ANS: 1, 4, 5

The nurse should instruct the client diagnosed with hypertrophic cardiomyopathy to follow the recommended activity level, avoid overexertion, and avoid dehydration. The client should be instructed to use alcohol in moderation, to avoid hot tub baths or showers, and to report unexplained breathlessness to a health care provider.

5.The nurse determines that a client diagnosed with pericarditis is demonstrating the classic signs of the Beck triad. What are the signs of the Beck triad? (Select all that apply.)

1.Fever 2.Dyspnea
3.Muffled heart sounds 4.Elevated jugular vein
pressure 5.Hypotension
6.Abdominal pain ANS: 3, 4, 5

The symptoms of Beck triad include muffled heart sounds, elevated jugular vein pressure, and hypotension. Fever, dyspnea, and abdominal pain are not considered findings within the Beck triad.

Chapter 36. Dysrhythmias and Valvular Disorders MULTIPLE

CHOICE

1.A client is experiencing an alteration in heart rate. The nurse realizes this client is experiencing a disorder of which part of the heart?

1.Atrioventricular node 2.Bundle
branches 3.Purkinje fibers 4.Sinoatrial
node

ANS: 4

The sinoatrial node is the dominant pacemaker of the heart. The sinoatrial node has an inherent rate of 60 to 100 bpm. The atrioventricular node has an intrinsic rate of 40 to 60 bpm. The impulse enters the right and left bundle branches and then enters the Purkinje fibers. Impulses at this level are at 15 to 40 times per minute.

2.A client is suspected of having cardiac damage. The nurse realizes that which of the following diagnostic tests is most commonly used to help diagnose this clients possible cardiac damage or disease?

1.12-lead electrocardiogram 2.Arterial blood gases 3.Cardiac angiogram 4.Cardiac enzymes

ANS: 1

A 12-lead electrocardiogram is a quick and accurate diagnostic tool used to evaluate heart damage and disease. The other diagnostic tests require a longer time for results and/or are invasive procedures requiring some preparation.

3.The nurse is analyzing a clients electrocardiogram tracing. Which of the following complexes is not normally seen on an electrocardiogram tracing?

1.P wave 2.QRS complex
3.T wave
4.U wave ANS: 4

A U wave is not always seen and can be very small. It can indicate electrolyte imbalance, medication effects, and ischemia. The P wave, QRS complex, and T wave are normally seen in the electrocardiogram tracing.

4.The nurse is analyzing a clients electrocardiogram tracing and realizes that each small square on the paper is equal to:

1.0.04 second.
2.0.12 second.
3.0.20 second.
4.0.40 second.

ANS: 1

The small square on the ECG graph paper equals 0.04 second. The large square equals 0.20 second. The PR interval is 0.12 to 0.20 second. Two large squares would be equal to 0.40 second.

5.The nurse is reading an ECG rhythm strip and notes that there are nine QRS complexes in a 6-second strip. The heart rate is:

1.36.
2.54.
3.81.
4.90.

ANS: 4

A heart rate can be determined by multiplying the QRS complexes in a 6-second strip by 10. The heart rate is 90. This method of calculating the heart rate is the most common method used because it is quick and can be used when the heart rate is irregular.

6.The nurse notes that on a clients electrocardiogram tracing, there is one P wave for every QRS complex and a delay in the impulse transmission at the AV node. This regular rhythm is identified as:

1.first-degree AV block. 2.second-degree AV block type I.
3.second-degree AV block type II. 4.complete heart block.

ANS: 1

First-degree atrioventricular (AV) block occurs when there is a delay in the impulse transmission at the AV node. This delay occurs with every impulse and can be seen on every beat on the recorded rhythm strip. Second-degree and complete heart block have differences with the P wave and the associated QRS complexes.

7.A client is unresponsive and has no pulse. The nurse notes that the electrocardiogram tracing shows continuous large and bizarre QRS complexes measured greater than 0.12 each. This rhythm is identified as:

1.premature ventricular complexes. 2.torsades de pointes.
3.ventricular fibrillation. 4.ventricular tachycardia.

ANS: 4

Ventricular tachycardia occurs when the patient experiences sustained consecutive premature ventricular complexes. Torsades de pointes is characterized by a wide-to-narrow pattern of the QRS complexes. Ventricular fibrillation shows a coarse wavy baseline.

8.An elderly client is demonstrating a change in heart rate that occurs with respirations. When planning care for the client, the nurse knows that treatment may include:

1.Oxygen therapy 2.Analgesics
3.Antibiotics 4.Pacemaker insertion

ANS: 4

A change in heart rate that occurs with respirations defines a sinus arrhythmia. If the client becomes symptomatic during periods of bradycardia, treatment will include atropine sulfate or pacemaker insertion. Treatment for sinus arrhythmia might include oxygen if the client is symptomatic.

Treatment for this arrhythmia does not include analgesics or antibiotics.

9.A clients electrocardiogram tracing shows a sawtooth pattern with F waves. The nurse realizes this client is demonstrating:

1.atrial flutter.
2.atrial fibrillation.
3.premature atrial contractions.
4.atrial tachycardia.

ANS: 1

Atrial flutter is characterized by F waves that occur in a characteristic sawtooth pattern. Atrial fibrillation is characterized by coarse waves with the baseline between the QRS complexes as being rough and uneven. Premature atrial contractions occur when an electrical impulse is generated in an area of the atria outside of the SA node. Atrial tachycardia is three or more premature atrial contractions. Neither premature atrial contractions or atrial tachycardia have an F wave on the tracing.

10.The electrocardiogram tracing for a client shows premature junctional complexes. Which of the following should the nurse do to assist this client?

1.Administer oxygen 2.Increase intravenous
fluids
3.Check on the serum digoxin level 4.Assist the client to
a side-lying position

ANS: 3

The most common cause of premature junctional complexes is digitalis toxicity. The nurse should check on the clients serum digoxin level. Oxygen, intravenous fluids, or position changes will not help treat this rhythm.

11.Which of the following should the nurse instruct a client who has been diagnosed with an arrhythmia?

1.Exercise level
2.Avoidance of calorie-dense foods
3.How to take his own pulse
4.Reasons why fatigue is expected

ANS: 3

Instructions for a client diagnosed with an arrhythmia include symptom management, how to take own pulse, and substances to avoid the onset of an arrhythmia. The nurse may or may not instruct on exercise level. The client does not need to avoid calorie-dense foods. Fatigue is a symptom that should be reported to a health care provider.

12.A client is diagnosed with supraventricular tachycardia. The nurse should prepare to administer which of the following medications?

1.Procainamide 2.Amiodarone
3.Verapamil 4.Adenosine

ANS: 4

Adenosine has a short half-life, is given intravenous push, and is used to abruptly stop supraventricular tachycardia. Procainamide is used for tachyarrhythmias and ventricular ectopy.

Amiodarone is helpful to treat ventricular fibrillation. Verapamil helps slow the heart rate with atrial fibrillation.

13.A client is recovering from insertion of a pacemaker to pace the activity of the ventricles. At which point on the electrocardiogram tracing will the nurse assess pacer spikes?

1.Before the QRS complex 2.Before the P wave 3.After the QRS complex 4.After the P wave

ANS: 1

If the ventricles are being paced, there will be a pacer spike just prior to the QRS complex. If the atria are being paced, there will be a pacer spike just before the P wave. Pacer spikes that occur after the QRS complex or P wave would indicate pacemaker malfunction and should be addressed immediately.

MULTIPLE RESPONSE

1.A client with a heart rate of 40 who is experiencing shortness of breath and nausea is diagnosed with second-degree AV block type II. Which of the following will be included in this clients treatment? (Select all that apply.)

1.Administer digoxin 2.Administer antiemetic 3.Administer atropine sulfate 4.Insert external pacemaker 5.Decrease intravenous fluids 6.Lower the head of the bed

ANS: 3, 4

For second-degree AV block type II, treatment will almost always consist of external pacemaker insertion. Atropine sulfate may be used to increase the heart rate until the pacemaker can be inserted. Digitalis toxicity can cause this heart rhythm so digoxin should not be administered to this client. An antiemetic will not solve the clients underlying problem. The client may or may not need additional fluids. Lowering the head of the bed could compromise this clients respiratory status and should not be done.

2.A clients electrocardiogram rhythm strip is a straight line. Which of the following should the nurse do to help this client? (Select all that apply.)

1.Assess for loose leads.
2.Assess for power to the monitor.
3.Assess the strip for possible fine ventricular fibrillation.
4.Begin cardiopulmonary resuscitation once verified the client has no pulse.
5.Raise the head of the bed.
6.Stop intravenous fluid infusion. ANS: 1, 2, 3, 4

The absence of electrical activity will create the rhythm of asystole. The rhythm strip is a straight line. The nurse should confirm that the straight line is not due to another reason such as loose leads, lack of power to the monitor, or fine ventricular fibrillation. Once it is confirmed that the client has no pulse, cardiopulmonary resuscitation should be implemented. Raising the head of the bed or stopping intravenous fluid infusions is not going to help the client experiencing asystole.

3.The nurse is assessing a client who is diagnosed with pulseless electrical activity. Which of the following will the nurse include in this assessment? (Select all that apply.)

1.Hypovolemia 2.Hypoxia
3.Hypothermia 4.Tamponade
5.Thrombosis 6.Throat pain

ANS: 1, 2, 3, 4, 5

Assessment of pulseless electrical activity includes a review of the 5 Hs and the 5 Ts. The 5 Hs are: hypovolemia, hypoxia, hydrogen ion status, hyperkalemia/hypokalemia, and hypothermia. The 5 Ts include tablets, tamponade, tension pneumothorax, thrombosis coronary, and thrombosis pulmonary. Throat pain does not cause pulseless electrical activity.

4.Which of the following should be implemented to ensure the safe use of a defibrillator? (Select all that apply.)

1.Do not place over monitoring electrodes. 2.Do not place
over an implanted pacemaker.

3.Place the paddles at inch from the implanted pacemaker site. 4.Apply transdermal medication to the chest before using the paddles. 5.Insert an oral airway before using the paddles.
6.Have another person hold the clients airway open while using the paddles. ANS: 1, 2

The safe use of defibrillator paddles include: do not place over monitoring electrodes or implanted devices. Paddles should be at least 1 inch away from an implanted device. Transdermal medication should be removed from the clients chest before using the paddles. An oral airway is not needed before using the paddles. No one should be touching the client when using the paddles.

5.Which of the following interventions would be appropriate for a client recovering from a pacemaker insertion? (Select all that apply.)

1.Monitor vital signs every 15 minutes until stable. 2.Assess for chest pain.
3.Restrict movement of affected extremity. 4.Monitor electrocardiogram every 8 hours. 5.Begin intravenous fluid infusion at 150 mL/hr. 6.Reinforce dressing with excessive bleeding.

ANS: 1, 2, 3

Interventions appropriate for a client recovering from a pacemaker insertion include monitoring vital signs every 15 minutes until stable, assessing for chest pain, restricting movement of the affected extremity, monitoring electrocardiogram ongoing and post a strip every 4 hours, and report excessive bleeding from the surgical site to the health care provider. Intravenous fluids at the rate of 150 mL/hr may or may not be needed.

Chapter 37. Disorders of the Vascular System

MULTIPLE CHOICE

1.Which of the following should the nurse instruct a client in order to reduce the risk factors for developing arteriosclerosis?

1.Limit diet to contain less than 40% fat 2.Restrict exercise
3.Stop smoking
4.Avoid prescription medications

ANS: 3

To reduce the risk for arteriosclerosis, the nurse should instruct the client to stop smoking. The diet should be limited to less than 30% of fat. Exercise should be encouraged. Prescription medications are often prescribed for clients with symptoms of arteriosclerosis.

2.The nurse is concerned that an elderly client has evidence of arteriosclerosis since the clients capillary refill is greater than:

1.3 seconds.
2.4 seconds.
3.5 seconds.
4.6 seconds.

ANS: 3

Elderly patients have a greater capillary refill time due to aging. Capillary refill greater than 5 seconds is significant. Capillary refill in non-elderly clients should be 3 seconds. Capillary refill in a non-elderly client of 4 seconds would be an abnormal finding. Capillary refill of 6 seconds for all clients is an abnormal assessment finding.

3.When instructing a client on ways to lower his cholesterol levels, which of the following should the nurse include?

1.Eat more meat and eggs. 2.Consume less meat and eggs.

3.Incorporate more vegetables. 4.Limit fruits.

ANS: 2

Cholesterol is located in animal sources, so decreasing meat and eggs will lower cholesterol levels. The client should not be instructed to eat more meat and eggs. Vegetables and fruits do not impact the cholesterol level.

4.A client diagnosed with arteriosclerosis is prescribed an anticoagulant. For which of the following should the nurse assess in this client?

1.Respiratory distress 2.Skin breakdown
3.Decreased urine output 4.Bruising and bleeding

ANS: 4

A client who is prescribed blood-thinning medication is at a greater risk of bleeding and bruising. Anticoagulant therapy does not increase a clients risk for developing respiratory distress, skin breakdown, or decreased urine output.

5.The nurse is assessing a client diagnosed with an abdominal aortic aneurysm. Which of the following sounds did the nurse auscultate during the assessment?

1.Pleural rub
2.Hyperactive bowel sounds
3.Crackles
4.Bruit ANS: 4

The nurse may auscultate a bruit at the site of the aneurysm. Pleural rib and crackles are adventitious sounds heard during the assessment of the lungs. Hyperactive bowel sounds may be heard when assessing the abdomen.

6.A client is admitted with abdominal aortic aneurysm. For which of the following complications should the nurse be concerned?

1.Hypotension 2.Cardiac arrhythmias
3.Aneurysm rupture 4.Loss of bowel sounds

ANS: 3

Aneurysm rupture is a life-threatening occurrence and the highest risk for the client until it can be repaired. Hypotension, cardiac arrhythmias, and loss of bowel sounds are all significant potential complications; however, they are not life threatening.

7.A client who has experienced signs of Virchows triad has developed a deep vein thrombosis. Which of the following is not a part of this triad?

1.Venous stasis 2.Vessel wall injury
3.Alteration in blood clotting 4.Pregnancy

ANS: 4

Pregnancy is a risk factor for thrombus, but it is not part of Virchows triad.Virchows triad includes venous stasis, vessel wall injury, and alteration of blood coagulation.

8.A client is diagnosed with Buergers disease. Which of the following should the nurse instruct the client regarding this disorder?

1.It is a common disorder.
2.It appears in women more than in men.
3.Smoking exacerbates the disease.
4.It is more common in African Americans. ANS: 3

Smoking cessation halts the disease progress, but continuation of smoking exacerbates the progression of the disease. Buergers disease is a rare disorder. It is more common in men than women. It is more common in Asians and rare among African Americans.

9.A client is diagnosed with Raynauds disease. Which of the following will the nurse most likely assess in this client?

1.Elevated blood pressure
2.Pain, cyanosis, and numb, cold extremities
3.Absent peripheral pulses
4.Increase in varicose veins ANS: 2

Clinical manifestations of Raynauds disease include venospasms; pain; cyanosis; redness; numb, cold extremities; and swelling. Elevated blood pressure, absent peripheral pulses, and varicose veins are not associated with this disorder.

10.A client is diagnosed with acute peripheral arterial occlusion. The nurse should prepare to provide which of the following interventions for this client?

1.Administer oxygen.
2.Assist with ambulation.
3.Administer heparin as prescribed.
4.Restrict fluids.

ANS: 3

In the treatment of acute peripheral arterial occlusion, intravenous heparin therapy is usually the first intervention. Oxygen is not the first intervention for this client. The client will most likely be on bed rest and will not ambulate. Restricting fluids would not be indicated for acute peripheral arterial occlusion.

11.A client receiving a heparin infusion is demonstrating signs of acute bleeding. Which of the following should the nurse prepare to administer to this client?

1.Aspirin 2.Vitamin K 3.Protamine sulfate 4.Narcan

ANS: 3

Protamine sulfate is the heparin antagonist used for excessive bleeding. Vitamin K is the antagonist for warfarin. Aspirin and narcan are not used for bleeding associated with a heparin infusion.

12.A clients blood pressure measurements have a 20 mmHg difference between the upper extremity readings. Which of the following does this assessment finding suggest to the nurse?

1.Arteriosclerosis 2.Aortic aneurysm
3.Deep vein thrombosis
4.Subclavian steal syndrome ANS: 4

A difference of greater than 20 mmHg when assessing bilateral blood pressure measurements is considered a significant finding in the diagnosis of subclavian steal syndrome. This blood pressure discrepancy is not a finding with arteriosclerosis, aortic aneurysm, or deep vein thrombosis.

13.The nurse is assessing a client for risks in the development of varicose veins. Which of the following findings would increase this clients risk?

1.Normal weight 2.Prolonged standing
3.Engages in golf three times a week
4.Eats several servings of fruits and vegetables each day

ANS: 2

Risk factors for the development of varicose veins include thrombophlebitis, obesity, prolonged standing, pregnancy, and liver or pancreas dysfunction. Normal weight, activity, and balanced diet are not risk factors for the development of varicose veins.

MULTIPLE RESPONSE

1.A client is having laboratory tests conducted to confirm a diagnosis of arteriosclerosis. Which of the following laboratory values would support this clients medical diagnosis? (Select all that apply.)

1.Serum cholesterol 300 mg/dL 2.LDL 125
mg/dL
3.Blood glucose 90 mg/dL 4.HDL 45
mg/dL
5.Triglycerides 400 mg/dL 6.Serum potassium
4.0 mEq/L

ANS: 1, 2, 4, 5

Diagnostic tests used to support the medical diagnosis of arteriosclerosis include cholesterol, LDL, HDL, and triglycerides. A serum cholesterol of 300 mg/dL, LDL of 125 mg/dL, HDL of 45 mg/dL, and triglycerides of 400 mg/dL all support the diagnosis of arteriosclerosis. Blood glucose and potassium levels are not used to diagnose arteriosclerosis.

2.The nurse is assessing a client diagnosed with a peripheral arterial occlusion. Which of the following will the nurse assess in this client? (Select all that apply.)

1.Pulselessness 2.Pain
3.Pallor 4.Paresthesia
5.Paralysis 6.Petechiae

ANS: 1, 2, 3, 4, 5

The nurse would assess a client diagnosed with peripheral arterial disease for the six Ps: pulseless, pain, pallor, paresthesia, paralysis, and poikilocythemia. Petechiae is not a part of the six Ps assessment.

3.The nurse is instructing a client recovering from arterial aneurysm repair. Which of the following should be included in these instructions? (Select all that apply.)

1.Do not lift anything heavier than 15 to 20 lbs. 2.Limit activity for up to 8 weeks after the surgery. 3.Use a pillow to splint when coughing.
4.Driving is permitted 1 week after surgery.
5.Notify the physician for pain, redness, or swelling around the incision.
6.Avoid pain medication.

ANS: 1, 2, 3, 5

Instructions appropriate after surgery to repair an arterial aneurysm include limit lifting to 15 to 20 lbs; limit activity for up to 8 weeks after the surgery; use a pillow to splint when coughing; and notify the physician for pain, redness, or swelling around the incision. Driving may be restricted for several weeks. Pain medication will be prescribed and encouraged to be used.

4.The nurse is utilizing the Wells Scale to assess a client for deep vein thrombosis. Which of the following is assessed when using this scale? (Select all that apply.)

1.Treatment for cancer
2.Recent immobility for greater than 3 days
3.Recovery from surgery with general anesthesia within 12 weeks
4.Entire leg edematous
5.Pitting edema of the symptomatic leg 6.Blood pressure 130/86 mmHg

ANS: 1, 2, 3, 4, 5

The Wells Scale is a tool used to assess a client for the presence of a deep vein thrombosis. Areas assessed include treatment or diagnosis of cancer, recent immobility for greater than 3 days, recovery from surgery during which the client received general or regional anesthesia within 12 weeks, entire leg swollen, and pitting edema confined to the symptomatic leg. Blood pressure is not a criteria used on this scale.

5.A client is diagnosed with a venous stasis ulcer on the foot. Which of the following will be included in this clients plan of care? (Select all that apply.)

1.Administer oral antibiotics if infection is present. 2.Keep the foot open to the air.
3.Cover the foot with a hydrocolloidal dressing. 4.Provide pain medication with debridement.
5.Restrict fluids.
6.Instruct the client to ambulate without shoes.

ANS: 1, 3, 4

Nursing care of a client diagnosed with a venous stasis ulcer includes provide with oral antibiotics if infection is present, cover the wound with hydrocolloidal dressing if indicated to promote the formation of granulation tissue, provide pain medication with debridement. The wound should not be kept open to the air. The client does not need a fluid restriction. The client should be instructed to never ambulate without appropriate foot protection.

MULTIPLE CHOICE

1.Which of the following should the nurse instruct a client in order to reduce the risk factors for developing arteriosclerosis?

1.Limit diet to contain less than 40% fat 2.Restrict exercise
3.Stop smoking
4.Avoid prescription medications

ANS: 3

To reduce the risk for arteriosclerosis, the nurse should instruct the client to stop smoking. The diet should be limited to less than 30% of fat. Exercise should be encouraged. Prescription medications are often prescribed for clients with symptoms of arteriosclerosis.

2.The nurse is concerned that an elderly client has evidence of arteriosclerosis since the clients capillary refill is greater than:

1.3 seconds.
2.4 seconds.
3.5 seconds.
4.6 seconds.

ANS: 3

Elderly patients have a greater capillary refill time due to aging. Capillary refill greater than 5 seconds is significant. Capillary refill in non-elderly clients should be 3 seconds. Capillary refill in a non-elderly client of 4 seconds would be an abnormal finding. Capillary refill of 6 seconds for all clients is an abnormal assessment finding.

3.When instructing a client on ways to lower his cholesterol levels, which of the following should the nurse include?

1.Eat more meat and eggs. 2.Consume less meat and eggs. 3.Incorporate more vegetables.
4.Limit fruits.

ANS: 2

Cholesterol is located in animal sources, so decreasing meat and eggs will lower cholesterol levels. The client should not be instructed to eat more meat and eggs. Vegetables and fruits do not impact the cholesterol level.

4.A client diagnosed with arteriosclerosis is prescribed an anticoagulant. For which of the following should the nurse assess in this client?

1.Respiratory distress 2.Skin breakdown
3.Decreased urine output 4.Bruising and bleeding

ANS: 4

A client who is prescribed blood-thinning medication is at a greater risk of bleeding and bruising. Anticoagulant therapy does not increase a clients risk for developing respiratory distress, skin breakdown, or decreased urine output.

5.The nurse is assessing a client diagnosed with an abdominal aortic aneurysm. Which of the following sounds did the nurse auscultate during the assessment?

1.Pleural rub
2.Hyperactive bowel sounds
3.Crackles
4.Bruit ANS: 4

The nurse may auscultate a bruit at the site of the aneurysm. Pleural rib and crackles are adventitious sounds heard during the assessment of the lungs. Hyperactive bowel sounds may be heard when assessing the abdomen.

6.A client is admitted with abdominal aortic aneurysm. For which of the following complications should the nurse be concerned?

1.Hypotension 2.Cardiac arrhythmias
3.Aneurysm rupture 4.Loss of bowel sounds

ANS: 3

Aneurysm rupture is a life-threatening occurrence and the highest risk for the client until it can be repaired. Hypotension, cardiac arrhythmias, and loss of bowel sounds are all significant potential complications; however, they are not life threatening.

7.A client who has experienced signs of Virchows triad has developed a deep vein thrombosis. Which of the following is not a part of this triad?

1.Venous stasis 2.Vessel wall injury
3.Alteration in blood clotting 4.Pregnancy

ANS: 4

Pregnancy is a risk factor for thrombus, but it is not part of Virchows triad.Virchows triad includes venous stasis, vessel wall injury, and alteration of blood coagulation.

8.A client is diagnosed with Buergers disease. Which of the following should the nurse instruct the client regarding this disorder?

1.It is a common disorder.
2.It appears in women more than in men.
3.Smoking exacerbates the disease.
4.It is more common in African Americans. ANS: 3

Smoking cessation halts the disease progress, but continuation of smoking exacerbates the progression of the disease. Buergers disease is a rare disorder. It is more common in men than women. It is more common in Asians and rare among African Americans.

9.A client is diagnosed with Raynauds disease. Which of the following will the nurse most likely assess in this client?

1.Elevated blood pressure
2.Pain, cyanosis, and numb, cold extremities
3.Absent peripheral pulses
4.Increase in varicose veins

ANS: 2

Clinical manifestations of Raynauds disease include venospasms; pain; cyanosis; redness; numb, cold extremities; and swelling. Elevated blood pressure, absent peripheral pulses, and varicose veins are not associated with this disorder.

10.A client is diagnosed with acute peripheral arterial occlusion. The nurse should prepare to provide which of the following interventions for this client?

1.Administer oxygen.
2.Assist with ambulation.
3.Administer heparin as prescribed.
4.Restrict fluids.

ANS: 3

In the treatment of acute peripheral arterial occlusion, intravenous heparin therapy is usually the first intervention. Oxygen is not the first intervention for this client. The client will most likely be on bed rest and will not ambulate. Restricting fluids would not be indicated for acute peripheral arterial occlusion.

11.A client receiving a heparin infusion is demonstrating signs of acute bleeding. Which of the following should the nurse prepare to administer to this client?

1.Aspirin 2.Vitamin K 3.Protamine sulfate 4.Narcan

ANS: 3

Protamine sulfate is the heparin antagonist used for excessive bleeding. Vitamin K is the antagonist for warfarin. Aspirin and narcan are not used for bleeding associated with a heparin infusion.

12.A clients blood pressure measurements have a 20 mmHg difference between the upper extremity readings. Which of the following does this assessment finding suggest to the nurse?

1.Arteriosclerosis 2.Aortic aneurysm

3.Deep vein thrombosis 4.Subclavian steal syndrome

ANS: 4

A difference of greater than 20 mmHg when assessing bilateral blood pressure measurements is considered a significant finding in the diagnosis of subclavian steal syndrome. This blood pressure discrepancy is not a finding with arteriosclerosis, aortic aneurysm, or deep vein thrombosis.

13.The nurse is assessing a client for risks in the development of varicose veins. Which of the following findings would increase this clients risk?

1.Normal weight 2.Prolonged standing
3.Engages in golf three times a week
4.Eats several servings of fruits and vegetables each day

ANS: 2

Risk factors for the development of varicose veins include thrombophlebitis, obesity, prolonged standing, pregnancy, and liver or pancreas dysfunction. Normal weight, activity, and balanced diet are not risk factors for the development of varicose veins.

Chapter 38. Common Abdominal Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. A 35-year-old female patient is seen in the clinic complaining of abdominal pain. Which of the following should be included in the history and physical examination?
a. Digital rectal exam
b. Pelvic exam
c. Sexual history
d. All of the above

__ 2. A patient comes to the office complaining of constipation. The patient lists all of the following medications. Which drug could be responsible for the constipation?
a. Multivitamin
b. Magnesium hydroxide
c. Pepto-Bismol®

d. Ibuprofen

__ 3. A patient is seen with complaints of diarrhea. Which of the following should be included in the patient's differential diagnosis?

a. Gastroenteritis
b. Inflammatory bowel disease
c. Lactase deficiency
d. All of the above

__ 4. Mr. J. K., 38 years old, is 5 feet 8 inches tall and weighs 189 pounds. He reports that he has had intermittent heartburn for several months and takes Tums® with temporary relief. He has been waking during the night with a burning sensation in his chest. Which additional information would lead you to believe that gastroesophageal reflux disease (GERD) is the cause of his pain?

a. The pain seems better when he smokes to relieve his nerves.
b. Coffee and fried foods don't bother him,
c. He wakes at night coughing with a bad taste in his mouth.
d. All of the above

__ 5. A 29-year-old Englishman is seen in the office with complaints of pain in his chest and belly. He has been suffering the pain for 2 weeks and gets temporary relief from Alka-Seltzer®. The burning pain wakes him at night and radiates up to his chest. Which factor favors a diagnosis of gastric ulcer?

a. His gender
b. His age
c. His use of Alka-Seltzer
d. His ethnic origin

____ 6. Which of the following is most effective in diagnosing appendicitis?

a. History and physical
b. Sedimentation rate
c. Kidney, ureter, and bladder x-ray
d. Complete blood count (CBC) with differentials

____ 7. Which of the following is associated with celiac disease (celiac sprue)?

a. Malabsorption
b. Constipation
c. Rectal bleeding
d. Esophageal ulceration

8. A 45-year-old patient presents with a chief complaint of generalized abdominal pain. Her physical examination is remarkable for left lower quadrant tenderness. At this time, which of the following should be considered in the differential diagnosis?

a. Endometriosis
b. Colon cancer
c. Diverticulitis
d. All of the above

__ 9. A 46-year-old patient is seen in the clinic with abdominal pain. Which of the following tests is essential for this patient?

a. CBC with differential
b. Urine human chorionic gonadotropin
c. Barium enema
d. Computed tomography of the abdomen

____ 10. A 25-year-old accountant is seen in the clinic complaining of crampy abdominal pain after meals. She is often constipated and takes laxatives, which are followed by a couple of days of diarrhea. She temporarily feels better after a bowel movement. She states she is embarrassed by flatulence and has abdominal distension. She has had no weight loss or blood in her stool. This problem has gone on for about 6 months. What should the next step be?

a. Obtain a complete history.
b. Order a barium enema.
c. Schedule a Bernstein's test.
d. Prescribe a trial of antispasmodics.

__ 11. A 28-year-old patient is seen in the clinic with colicky abdominal pain particular with meals. She has frequent constipation, flatulence, and abdominal distension. Which of the data make a diagnosis of diverticulitis unlikely?

a. Her age
b. Frequent constipation
c. Flatulence
d. Colicky abdominal pain

__ 12. A 28-year-old patient is seen with complaints of diarrhea. Which of the following responses to the history questions would help the primary care physician (PCP) establish the diagnosis of irritable bowel syndrome?

a. Feels relief after a bowel movement
b. Sometimes is constipated
c. Does not defecate in the middle of the night
d. All of the above

13. A patient is diagnosed with GERD, and his endoscopic report reveals the presence of Barrett's epithelium. Which of the following should the PCP include in the explanation of the pathology report?

a. This is a premalignant tissue.
b. This tissue is resistant to gastric acid.
c. This tissue supports healing of the esophagus.
d. All of the above

____ 14. Which of the following dietary instructions should be given to a patient with GERD?

a. Eliminate coffee.
b. Drink peppermint tea to relieve stomach distress.
c. Recline and rest after meals.
d. Limit the amount of antacids.

____ 15. The patient with GERD should be instructed to eliminate which of these activities?

a. Swimming
b. Weight lifting
c. Golfing
d. Walking

___ 16. A patient is diagnosed with giardia after a backpacking trip in the mountains. Which of the following would be an appropriate treatment?

a. Vancomycin
b. Penicillin
c. Metronidazole
d. Bactrim

___ 17. A 22-year-old is seen complaining of vague belly pain. This type of pain is seen at what point in appendicitis?

a. Very early
b. 3 to 4 hours after perforation
c. Late in inflammation
d. Appendicitis never presents with vague pain.

___ 18. The nurse practitioner (NP) suspects a patient has a peptic ulcer. Which of the following items on the history would lead the NP to this conclusion?

a. Use of NSAIDs
b. Cigarette smoker
c. Ethanol consumption
d. All of the above

____ 19. A patient is seen with dark-colored urine, and the urine dipstick reveals a high level of bilirubin. Which of the following could be a cause of this problem?

a. Increased breakdown of red blood cells
b. Inadequate hepatocyte function
c. Biliary obstruction
d. All of the above

___ 20. A 21-year-old student presents with complaints of fatigue, headache, anorexia, and a runny nose, all of which began about 2 weeks ago. She started taking vitamins and over-the-counter cold preparations but feels worse. The smell of food makes her nauseated. Her boyfriend had mononucleosis about a month ago, and she wonders if she might have it also. Examination reveals cervical adenopathy and an enlarged liver and spleen. Which of the following labs would be most helpful in the differential diagnosis at this point?

a. Stool culture
b. Liver enzymes
c. Antihepatitis D virus
d. Thyroid-stimulating hormone test

___ 21. On further questioning, the 21-year-old patient with complaints of fatigue, headache, anorexia, and a runny nose explains that she is sexually active only with her boyfriend, does not use injectable drugs, and works as an aide in a day-care center. Which of the following tests would be most helpful in confirming your diagnosis?

a. Hepatitis A virus (HAV) IgM
b. HAV IgG
c. Anti-HAcAg
d. Anti-HAsAg

___ 22. A patient is seen in the clinic with right upper quadrant pain that is radiating to the middle of the back. The NP suspects acute cholelithiasis. The NP should expect which of the following laboratory findings?

a. Decreased alanine aminotransferase and decreased aspartate aminotransferase
b. Elevated alkaline phosphatase
c. Elevated indirect bilirubin
d. Decreased white blood cells

___ 23. A patient has acute pancreatitis with seven of the diagnostic criteria from Ranson's criteria. In order to plan care, the NP must understand that this criteria score has which of the following meanings?

a. A high mortality rate
b. An increased chance of recurrence
c. A 7% chance of the disease becoming chronic
d. All of the above

____ 24. A patient is seen in the office with complaints of six to seven liquid bowel movements per day. Which of the following assessment findings would lead the NP to a diagnosis of inflammatory bowel disease?

a. Intermittent constipation with periods of diarrhea
b. Wakens at night with diarrhea
c. History of international travel
d. All of the above

____ 25. Which of the following is part of the treatment plan for the patient with irritable bowel syndrome?

a. High fiber diet
b. Tylenol with codeine
c. Daily laxatives
d. All of the above

Chapter 38. Common Abdominal Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: C PTS: 1
3. ANS: D PTS: 1
4. ANS: C PTS: 1
5. ANS: C PTS: 1
6. ANS: A PTS: 1
7. ANS: A PTS: 1
8. ANS: D PTS: 1
9. ANS: B PTS: 1
10. ANS: A PTS: 1
11. ANS: A PTS: 1
12. ANS: D PTS: 1
13. ANS: D PTS: 1
14. ANS: A PTS: 1
15. ANS: B PTS: 1
16. ANS: C PTS: 1
17. ANS: A PTS: 1
18. ANS: D PTS: 1
19. ANS: C PTS: 1
20. ANS: C PTS: 1
21. ANS: A PTS: 1

22. ANS: B PTS: 1

23. ANS: A PTS: 1

24. ANS: C PTS: 1

25. ANS: A PTS: 1

Chapter 39. Infectious Gastrointestinal Disorders MULTIPLE CHOICE

1.In caring for a client diagnosed with a small bowel obstruction, what would the nurse expect to do first?

1.Prepare to put in a nasogastric (NG) tube. 2.Give pain medication.
3.Draw lab work.
4.Start an intravenous (IV) line.

ANS: 4

Starting an IV to give fluids and electrolytes would be the first step in caring for this client. Although an NG tube will be ordered, fluid balance is more important. Administering pain medication may make the problem worse. Drawing lab work would not be the first intervention needed for this client.

2.The nurse, instructing a client about malabsorption syndrome, should include that food is absorbed in the:

1.mouth.
2.bloodstream.
3.stomach.
4.small intestine.

ANS: 4

The mouth and stomach are used mostly for digestion. The small intestine is where most of the absorption of food nutrients occurs. Food is not directly absorbed into the bloodstream.

3.A client is diagnosed with appendicitis. One of the laboratory tests the nurse would expect to monitor would be:

1.serum sodium.
2.white blood cell (WBC) count.
3.hemoglobin (Hgb) and hematocrit (Hct).
4.bilirubin level.

ANS: 2

Infection often accompanies the inflammation of the appendix. The nurse would be looking for an elevated WBC count. Serum sodium, hemoglobin, hematocrit, and bilirubin levels are not necessarily indicated in the care of a client diagnosed with appendicitis.

4.When assessing the pain in a client diagnosed with appendicitis, the nurse would expect to assess: 1.extreme pain with slight palpation anywhere on the abdomen.
2.pain in the upper back when the right lower quadrant is palpated. 3.more pain when the pressure is released in the right lower quadrant. 4.no pain when the abdomen is palpated.

ANS: 3

Typically rebound pain is associated with appendicitis. Rebound pain is described as more pain when pressure is released than when pressure is applied. Appendicitis pain is not associated with pain anywhere on the abdomen upon slight palpation. Appendicitis pain is not typically assessed in the upper back. Appendicitis is associated with pain.

5.A client is being evaluated for symptoms associated with diverticular disease. The nurse realizes that the best diagnostic test to be used to aid in this diagnosis would be:

1.computed tomography (CT) scan. 2.barium enema.
3.ultrasound.
4.x-ray study.

ANS: 1

A CT scan is the best method of detecting abscesses and complications evidenced in diverticulitis. Barium enema is contraindicated in acute diverticulitis because of the risk of contamination if there is an existing perforation. An ultrasound or x-rays would not adequately diagnose the presence of the disorder.

6.An elderly client has noted blood in her stool for the past few months. Which information in the medical history would strongly suggest colorectal cancer?

1.Increased bouts of vomiting 2.Change in bowel habits 3.Recent infection in the blood 4.Decrease in appetite

ANS: 2

Change in bowel habits is one of the seven danger signals for cancer. Changes in bowel habits and blood in the stool are common signs of colorectal cancer. Vomiting, decreased appetite, or recent blood infection could be symptoms of other health problems, but they are not necessarily colorectal cancer.

7.The nurse is caring for a client diagnosed with irritable bowel syndrome (IBS) who is experiencing diarrhea. What medication would the nurse expect to administer?

1.Loperamide (Imodium) 2.Docusate sodium (Colace) 3.Lorazepam (Ativan) 4.Haloperidol (Haldol)

ANS: 1

Antidiarrheal agents like Imodium can be given prophylactically or symptomatically on an as- needed basis. Docusate sodium (Colace), lorazepam (Ativan), and haloperidon (Haldol) are not indicated to treat this disorder.

8.A client complains of acute gastrointestinal distress. While obtaining a health history, the nurse asks about the family history. Which disorder has a familial basis?

1.Hepatitis 2.Ulcerative colitis

3.Appendicitis 4.Bowel obstructions

ANS: 2

Genetic factors have been identified as susceptibility factors for the development of ulcerative colitis. None of the other choices have a genetic predisposition for developing the disorder.

9.A client diagnosed with appendicitis asks the nurse why this illness occurred. The nurse should respond that the most common cause of appendicitis is:

1.ulcerative colitis. 2.obstruction of the
appendix. 3.low-fat diet.
4.infection.

ANS: 2

An infection may occur with appendicitis, but the most common cause of infection is an obstruction of the appendix. The obstruction could be caused by lymph tissue, a fecalith, a foreign body, or worms. Ulcerative colitis, low-fat diet, or infection does not cause appendicitis.

10.A young client is experiencing acute abdominal pain. The nurse realizes that the most common cause for this type of pain would be:

1.appendicitis. 2.biliary tract disease.
3.kidney stones.
4.urinary tract infection. ANS: 1

The most common cause of acute abdominal pain is appendicitis. Biliary tract disease is the most common disorder in the elderly, causing pain in the right upper quadrant. Kidney stones and urinary tract infections do not necessarily cause abdominal pain.

11.A client experiencing abdominal pain and diarrhea tells the nurse that he used to smoke. Which of the following gastrointestinal disturbances is this client most likely experiencing?

1.Irritable bowel syndrome

2.Crohns disease
3.Acute appendicitis
4.Small bowel obstruction ANS: 2

Current and former smokers appear to have a greater risk of developing Crohns disease than nonsmokers. Not smoking will not cause irritable bowel syndrome, acute appendicitis, or small bowel obstruction.

12.A client has a history of being treated for ulcerative colitis. The nurse realizes that a life-threatening complication of this disorder is:

1.Crohns disease.
2.small bowel obstruction.
3.peptic ulcer disease.
4.toxic megacolon.

ANS: 4

Toxic megacolon is a life-threatening complication of ulcerative colitis, and it requires immediate surgical intervention. Crohns disease, small bowel obstruction, and peptic ulcer disease are not life- threatening complications of ulcerative colitis.

13.The nurse assesses no bowel sounds with occasional splashing sounds over the large intestines. Which of the following do these assessment findings suggest to the nurse?

1.Ulcerative colitis 2.Irritable bowel
syndrome 3.Appendicitis
4.Bowel obstruction ANS: 4

Obstruction can be detected with absent bowel sounds and borborygmi or a splashing sound heard over the large intestine. Absent bowel sounds and borborygmi are not associated with ulcerative colitis, irritable bowel syndrome, or appendicitis.

14.The nurse is instructing a client on diagnostic tests used to screen for colorectal cancer. Which of the following should be included in these instructions?

1.A digital rectal exam should be done annually.
2.A test for fecal occult blood should be done annually.
3.A flexible sigmoidoscopy should be done annually.
4.A colonoscopy should be done every 5 years after age 40.

ANS: 2

The nurse should instruct the client to have a fecal occult blood test done annually. A digital rectal exam is not a recommendation for this disease process. A flexible sigmoidoscopy should be done every 5 years after age 50. A colonoscopy should be done every 10 years after age 50.

MULTIPLE RESPONSE

1.Laparoscopic surgery is scheduled for a client diagnosed with appendicitis. Which of the following may be a result of laparoscopic surgery? (Select all that apply.)

1.No risk of infection 2.Less pain
3.Faster recovery times 4.Maybe more
complications 5.Shorter hospital stays
6.Better visualization of the abdominal organs ANS: 2, 3, 5

Laparoscopic surgery has less pain and faster recovery times. There are fewer complications, less bleeding, and less risk of infection so the client has a shorter hospital stay. A risk of infection is present with all surgical procedures. Laparoscopic surgery does not cause a better visualization of the abdominal organs.

2.The nurse is assessing a client diagnosed with diverticulitis. Which of the following are clinical manifestations associated with this disorder? (Select all that apply.)

1.Constipation or diarrhea
2.Left lower quadrant abdominal pain
3.Low-grade fever
4.Increased excitability

5.Changes in level of consciousness
6.Thirst

ANS: 1, 2, 3

In diverticulitis, there may be a chronic asymptomatic condition two-thirds of the time. If there are manifestations, they would likely be constipation or diarrhea, lower abdominal pain in the left lower quadrant, and low-grade fever. Increased excitability, changes in level of consciousness, and thirst are not clinical manifestations of diverticulitis.

3.The nurse is assessing a client diagnosed with irritable bowel syndrome (IBS). Which of the following characteristics are associated with this disorder? (Select all that apply.)

1.Recurrent abdominal pain
2.Abdominal pain that improves with defecation
3.Pain associated with a change in stool frequency
4.Pain associated with a change in stool appearance
5.Pain that occurs only during defecation
6.Pain associated with passing flatus ANS: 1, 2, 3, 4

IBS is relatively common and is a motility disorder of the gastrointestinal tract. It is characterized by recurrent abdominal pain that improves with defecation. The pain will also appear with a change in stool frequency. The pain is also associated with a change in stool appearance. The pain of IBS does not occur only during defecation and is not associated with passing flatus.

4.A client, diagnosed with a vitamin B-12 deficiency, tells the nurse that she does not want to receive injections every month to treat the disorder. Which of the following should the nurse instruct the client regarding the effects of vitamin B-12 deficiency? (Select all that apply.)

1.Paresthesias in the hands 2.Paresthesias
in the feet 3.Ataxia
4.Spinal cord degeneration 5.Loss of
memory
6.Loss of the sense of smell ANS: 1, 2, 3, 4

Vitamin B-12 deficiency produces neurological abnormalities such as symmetrical paresthesias in the hands and feet, diminished vibratory and proprioceptive sense, ataxia, and spinal cord degeneration. Vitamin B-12 deficiency does not produce memory loss or loss of smell.

5.The nurse is planning care for a client diagnosed with an acute abdomen. Which of the following nursing diagnoses would be appropriate for this client? (Select all that apply.)

1.Fear
2.Deficient fluid volume
3.Ineffective coping
4.Acute pain
5.Risk of infection 6.Altered self-perception

ANS: 1, 2, 4, 5

Nursing diagnoses appropriate for a client diagnosed with an acute abdomen include fear, deficient fluid volume, acute pain, and risk of infection. Ineffective coping and altered self-perception would not apply to this client.

Chapter 40. Gastric and Intestinal Disorders MULTIPLE CHOICE

1.Before administering an antacid, the nurse should instruct a client that this medication works in the:

1.blood.
2.stomach.
3.small intestine.
4.esophagus.

ANS: 2

Antacids work in the stomach to neutralize stomach acids. They do not work in the esophagus or small intestines. Antacids do not work in the blood.

2.The nurse is assessing a client diagnosed with gastroesophageal reflux disease. Which of the following should be included in this assessment?

1.Degree of mouth burning 2.Difficulty swallowing 3.Presence of pyrosis 4.Painful swallowing

ANS: 3

Mouth burning is not a symptom of gastroesophageal reflux disease. Difficulty swallowing or dysphagia is not associated with gastroesophageal reflux disease. Pain when swallowing is associated with esophagitis, not acid reflux disease. Presence of pyrosis or heartburn should be assessed in this client.

3.During an assessment, the nurse determines a client is at risk for ulcerative stomatitis and gum disease because the client has a history of:

1.alcohol intake. 2.smoking.
3.kissing.
4.eating.

ANS: 2

Clients who smoke have seven times the risk of developing gum disease. Alcohol intake increases the risk of throat cancer. Ulcerative stomatitis and gum disease is not associated with kissing or eating.

4.A client is diagnosed with a swallowing disorder. The nurse realizes that which type of diet would be indicated for this client? ?

1.Regular diet 2.Clear liquid diet
3.Mechanical soft diet 4.Low-fat diet

ANS: 3

Some clients may need a pureed diet or mechanical soft diet, especially if their swallowing difficulty is with the oral phase. Some clients may have difficulty swallowing thin liquids and foods that are tough. The client will most likely have difficulty with a regular or low-fat diet.

5.To support the nutritional needs of a client with dysphagia, the nurse realizes that all of the following are mechanisms to provide enteral feeding EXCEPT:

1.nasogastric tube.
2.percutaneous endoscopic gastrostomy (PEG) tube.
3.jejunostomy tube.
4.hyperalimentation.

ANS: 4

Hyperalimentation is associated with parenteral nutrition, not enteral nutrition. The others are forms of administration of nutrients into the gastrointestinal tract.

6.A client is scheduled for diagnostic tests to determine the ability to swallow. Which of the following diagnostic tests will provide the best information regarding this clients status?

1.Pulse oximetry with water 2.Esophageal transit scintigraphy 3.Videofluoroscopy 4.Esophageal manometry

ANS: 3

The gold standard for evaluation of dysphagia is videofluoroscopy or a modified barium swallow. This test demonstrates the swallowing mechanism. The other tests may be prescribed; however, they do not provide as much information as the videofluoroscopy.

7.A client, diagnosed with a hiatal hernia, will experience which of the following symptoms most frequently?

1.Nausea 2.Vomiting
3.Diarrhea 4.Heartburn

ANS: 4

With a hiatal hernia, stomach acids reflux into the esophagus, causing pain and irritation that the patient will associate with heartburn. Nausea, vomiting, and diarrhea are not symptoms typically associated with a hiatal hernia.

8.The nurse is instructing a client diagnosed with a hiatal hernia on ways to reduce the symptoms. Which of the following should be included in these instructions?

1.Eat large meals to keep the stomach full.
2.Drink lots of liquids so that the stomach does not have to work so hard.
3.Avoid lying down after meals.
4.Lie down after eating.

ANS: 3

Sitting upright or sleeping with the head of the bed elevated helps keep the stomach contents in the stomach. The meal size should be smaller, and meals should be eaten more often so as not to overfill the stomach.

9.A client is diagnosed with burning mouth syndrome. Which of the following interventions should be included in this clients plan of care?

1.Assess the condition of the clients teeth. 2.Collect a saliva specimen for analysis. 3.Tell the client to avoid vitamin supplements.
4.Teach the client how to conduct an oral self-assessment daily. ANS: 1

Interventions for a client diagnosed with burning mouth syndrome include assessing the condition of the teeth. A saliva specimen is not used to diagnose this disorder. Vitamin supplements do not contribute to this disorder. An oral self-assessment does not need to be completed every day.

10.During an assessment, the nurse learns that a client is inhaling while swallowing food. Which of the following does this assessment finding suggest to the nurse?

1.The client is recovering from a stroke. 2.The client is at risk for aspiration.
3.The client will experience dyspepsia. 4.The client has esophageal reflux disease.

ANS: 2

In clients with dysphagia, inspiration commonly occurs during swallowing. This increases the risk for aspiration. This assessment finding does not indicate that the client is recovering from a stroke.

This assessment finding does not indicate that the client will experience dyspepsia or that the client has esophageal reflux disease.

11.A client is experiencing brash water. The nurse realizes this symptom is associated with: 1.oral cancer.
2.gastric ulcers.
3.dysphagia.
4.Barretts esophagus.

ANS: 4

Brash water, or the sensation of the mouth filling with saliva because of acid backflow into the esophagus, is a symptom of Barretts esophagus. Brash water is not associated with oral cancer, gastric ulcers, or dysphagia.

12.A client has been prescribed Zantac for gastroesophageal reflux disease. The nurse realizes this medication is classified as a:

1.histamine H2-receptor antagonist. 2.proton pump
inhibitor.
3.prokinetic agent.
4.antihistamine.

ANS: 1

Zantac is a histamine H2-receptor antagonist. This medication is not classified as being a proton pump inhibitor, prokinetic agent, or antihistamine.

13.A client is diagnosed with peptic ulcer disease caused by NSAID use. Which of the following would be indicated for this client?

1.Antibiotic therapy
2.Treatment similar to a client with peptic ulcer disease
3.Preparation for surgery
4.Insertion of a nasogastric tube for gastric lavage ANS: 2

For clients diagnosed with peptic ulcer disease caused by NSAID use, the anti-inflammatory medication should be discontinued and the client should receive treatment similar to that of peptic ulcer disease. Surgery is not indicated. Antibiotics are not indicated. Gastric lavage is not indicated.

MULTIPLE RESPONSE

1.The nurse is instructing a client about symptoms associated with peptic ulcer disease. Which of the following should be included in these instructions? (Select all that apply.)

1.Abdominal pain
2.Pain in the middle of the night
3.Weight loss
4.Poor appetite 5.Bloating
6.Constipation

ANS: 1, 2, 3, 4, 5

Symptoms of peptic ulcer disease include abdominal pain, pain in the middle of the night; weight loss; poor appetite; and bloating. Constipation is not a symptom of peptic ulcer disease.

2.The nurse is planning care for a client diagnosed with oral ulcers. Which of the following should be included in this clients plan of care? (Select all that apply.)

1.Encourage frequent oral hygiene. 2.Rinse mouth with chlorhexidine. 3.Increase consumption of hot fluids.
4.Instruct in the use of topical corticosteroids. 5.Encourage the client to limit smoking.
6.Avoid the use of dental floss. ANS: 1, 2, 4

Good oral hygiene is essential, and rinsing the mouth with chlorhexidine is recommended. Topical corticosteroids can promote resolution of the ulcers. Drinking hot fluids and smoking may aggravate oral ulcerations and are not included in the plan of care. The client should be instructed to not smoke at all. Dental floss will not cause oral ulcers.

3.The nurse is instructing a client on conducting an oral self-assessment. Which of the following should be included in the nurses instructions? (Select all that apply.)

1.Check the face for symmetry. 2.Check skin on the face for changes.
3.Check the neck for swellings or lumps. 4.Check inside of cheeks for tenderness. 5.Check the tongue for changes.
6.Check urine for change in color. ANS: 1, 2, 3, 4,

5

When instructing a client on an oral self-assessment, the nurse should include having the client check the face for symmetry; the skin on the face for changes; the neck for swellings or lumps; the inside of the cheeks for tenderness; and the tongue for changes. The urine is not checked when doing an oral self-assessment.

4.The nurse is assisting a client with indirect techniques to improve swallowing. Which of the following are techniques included in the nurses assistance? (Select all that apply.)

1.Tongue mobility exercises 2.Application of ice 3.Repetitive head lift exercises
4.Positioning
5.Range-of-motion exercises for the neck 6.Range-of-motion exercises for the shoulders

ANS: 1, 2, 3

Indirect techniques to improve swallowing include tongue mobility exercises, application of ice, and repetitive head lift exercises. Positioning is a compensatory mechanism. Range-of-motion exercises for the neck or shoulders does not help improve swallowing.

5.A client is diagnosed with esophageal pain. Which of the following medications would be indicated for this client? (Select all that apply.)

1.Vasodilators
2.Calcium channel blockers
3.Isosorbide dinitrate
4.Antibiotics

5.Antipyretics 6.Antihistamines

ANS: 1, 2, 3

The first line of treatment for esophageal pain is often the same medications used to treat angina of cardiac origin and would include vasodilators, calcium channel blockers, and isosorbide dinitrate. Antibiotics, antipyretics, and antihistamines are not medications used to treat esophageal pain.

Chapter 41. Gallbladder and Pancreatic Disorders MULTIPLE

CHOICE

1.A child care worker complains of flu-like symptoms. On further assessment, hepatitis is suspected. The nurse realizes that this individual is at risk for which type of hepatitis?

1.Hepatitis A
2.Hepatitis B
3.Hepatitis C
4.Hepatitis D

ANS: 1

Hepatitis A virus (HAV) is spread through the fecal-oral route. Child care workers are at greater risk because of potentially poor hygiene practices. Child care workers are not at the same risk for contracting hepatitis B, C, or D.

2.An older male is diagnosed with cirrhosis of the liver. The nurse knows that the most likely cause of this problem is:

1.being in the military. 2.traveling to a foreign country. 3.drinking excessive alcohol. 4.eating bad food.

ANS: 3

The destruction to the liver from alcohol often progresses from fatty liver to alcoholic hepatitis and culminates in alcoholic cirrhosis. Alcoholic cirrhosis accounts for a great number of individuals

diagnosed with this disease. Cirrhosis is not associated with being in the military, traveling to a foreign country, or eating bad food.

3.When the liver is seriously damaged, ammonia levels can rise in the body. One of the treatments for this is:

1.administering intravenous (IV) neomycin. 2.giving vitamin K.
3.giving lactulose.
4.starting the patient on insulin.

ANS: 3

Lactulose is a laxative that works by pulling water into the stool. It also helps pull ammonia from the blood into the colon for expulsion. IV antibiotics do not reduce serum ammonia levels. Vitamin K controls bleeding, but it does not reduce ammonia levels. Insulin is not used to reduce ammonia levels.

4.A client is scheduled for a liver biopsy. The nurse realizes that the most important sign to assess for is:

1.infection. 2.bleeding.
3.pain.
4.nausea and vomiting.

ANS: 2

After a liver biopsy, the client is monitored for bleeding or hemorrhage. Infection and pain are of concern, but they are not the most important signs to be monitored. Nausea and vomiting are not typically associated with a liver biopsy.

5.The nurse realizes that the organ which is a major site for metastases, harboring and growing cancerous cells that originated in some other part of the body, is the:

1.spleen. 2.gallbladder.
3.liver.
4.stomach.

ANS: 3

In most developed countries, this secondary type of liver cancer is more common than cancer that originates in the liver itself. The spleen, gallbladder, and stomach are not major sites for metastases.

6.A school age child is placed on a waiting list for a liver transplant. The nurse knows that the most common reason for children to need this type of transplant is because of:

1.cirrhosis due to hepatitis C. 2.biliary atresia.
3.diabetes.
4.Crohns disease.

ANS: 2

Biliary atresia is the most common reason for children to have a liver transplant. Cirrhosis due to hepatitis C is the reason for most adults to have a transplant. Children do not typically need a liver transplant for diabetes or Crohns disease.

7.Because health care workers are at a greater risk of hepatitis B infection, it is recommended that all health care workers:

1.wash their hands often.
2.avoid foreign travel.
3.become vaccinated.
4.drink bottled water only.

ANS: 3

Because of the risk of blood and body fluid exposure, it is recommended that all health care workers be vaccinated against hepatitis B virus. All health care workers should engage in frequent handwashing, but handwashing is not the primary mechanism to prevent the onset of hepatitis B. Avoiding foreign travel and drinking bottled water only will not reduce the risk of hepatitis B.

8.A client who usually smokes a pack of cigarettes a day tells the nurse that he cannot stand the smell of smoke. The nurse realizes that this client is in which phase of hepatitis?

1.Preicteric 2.Icteric

3.Posticteric 4.Recovery

ANS: 1

In the preicteric phase of hepatitis, some smokers will have an aversion to smoking as a first sign of the disease. Smoking is not affected with the icteric or posticteric phases of the disease. Recovery is not a phase of hepatitis.

9.A female client is surprised to learn that she has been diagnosed with hemochromatosis. Which of the following should the nurse respond to this client?

1.It doesnt affect people until they are in their 50s.
2. I would ask the doctor if hes sure about the diagnosis.
3.Females often do not experience the effects of the disease until menopause.
4.All women have the disorder but not the symptoms.

ANS: 3

Women do not experience the effects of hemochromatosis until menopause when the regular loss of blood stops. This disorder is a genetic disorder and can affect individuals of all ages. The nurse should not doubt the physicians diagnosis. All women do not have this disorder.

10.A client is diagnosed with liver disease. Which of the following is one impact of this disorder on a clients fluid and electrolyte status?

1.Hyperkalemia
2.Hypercalcemia
3.Hypernatremia
4.Hyponatremia

ANS: 4

Liver disease effects the fluid and electrolyte status by causing ascites, edema, hypokalemia, hypocalcemia, and hyponatremia. Liver disease does not cause hyperkalemia, hypercalcemia, or hypernatremia.

11.The nurse, caring for a client recovering from the placement of a shunt to treat portal hypertension, should assess the client for which of the following complications associated with this surgery?

1.Myocardial infarction 2.Pulmonary emboli
3.Pulmonary edema 4.Decreased peripheral pulses

ANS: 3

Complications after shunt surgery include the development of pulmonary edema. Myocardial infarction, pulmonary emboli, and decreased peripheral pulses are not complications associated with this type of surgery.

12.A client is diagnosed with macrovesicular fatty liver. Which of the following should the nurse instruct this client?

1.Expect to develop jaundice. 2.Avoid all alcohol.
3.Increase exercise.
4.Treatment includes antibiotic therapy.

ANS: 2

The client diagnosed with macrovesicular fatty liver should be instructed to avoid all alcohol. Jaundice is a symptom of microvesicular fatty liver. The client should be instructed to rest.
Antibiotic therapy is not indicated for macrovesicular fatty liver.

MULTIPLE RESPONSE

1.A client diagnosed with cirrhosis is experiencing the complication of ascites. Which of the following would be considered treatment for this complication? (Select all that apply.)

1.Fluid restriction 2.Low-sodium diet 3.Increased exercise 4.Diuretic therapy 5.Pain medication 6.Bed rest

ANS: 1, 2, 4

Ascites is the accumulation of fluid in the peritoneal cavity. Treatment strategies include fluid restriction (1000 to 1500 mL/day), low-sodium diet (200 to 500 mg/day), and diuretic therapy to remove the excessive fluid. Increased exercise, pain medication, and bed rest are not included as treatments for this complication.

2.A client is recovering from an endoscopic retrograde cholangiopancreatogram (ERCP). Which of the following should the nurse assess as possible complications from this procedure? (Select all that apply.)

1.Perforation of the stomach 2.Perforated duodenum 3.Pancreatitis
4.Aspiration of gastric contents 5.Anaphylactic reaction to the contrast dye 6.Perforated bladder

ANS: 1, 2, 3, 4, 5

Potential complications of an ERCP are perforated stomach and duodenum, pancreatitis, anaphylactic reaction to the contrast diet, aspiration of gastric contents, and reaction to anesthesia. A perforated bladder is a possible complication from a paracentesis.

3.A client is demonstrating yellow pigmentation of the skin and sclera. Which of the following can be used to describe this clients symptoms? (Select all that apply.)

1.Jaundice 2.Dyspepsia
3.Icterus 4.Sclerosis
5.Kernicterus 6.Cirrhosis

ANS: 1, 3, 5

Terms used to describe yellow pigmentation of the skin and sclera include jaundice, icterus, and kernicterus. Dyspepsia, sclerosis, and cirrhosis are not terms used to describe the yellow pigmentation of the skin and sclera.

4.The nurse is providing dietary instruction to a client diagnosed with Wilsons disease. Which of the following should be included in these instructions? (Select all that apply.)

1.Avoid liver. 2.Avoid shellfish.
3.Eat soy products.
4.Use avocados in salads.
5.Avoid nectarines.
6.Avoid mushrooms.

ANS: 1, 2, 5, 6

Dietary instruction for a client diagnosed with Wilsons disease include reducing the intake of foods high in copper. This includes avoiding liver, shellfish, soy products, avocado, nectarines, and mushrooms.

5.A client is diagnosed with a disorder of the liver. The nurse realizes this client might experience which of the following? (Select all that apply.)

1.Low vitamin A levels 2.Increased bleeding 3.Poor digestion of fats
4.Insulin resistance
5.Elevated levels of vitamin E 6.Nerve damage

ANS: 1, 2, 3, 4, 6

Effects of a liver disorder on a client are many. Some of the functions affected by this disorder include low levels of fat soluble vitamins, including A and E; poor synthesis of clotting factors, leading to increased bleeding; poor digestion of fats; insulin resistance; and nerve damage.

6.A client is diagnosed with portal hypertension. The nurse should assess the client for which of the following disorders associated with this diagnosis? (Select all that apply.)

1.Esophageal varices 2.Splenomegaly
3.Hemorrhoids 4.Caput medusae
5.Gastritis 6.Gallstone formation

ANS: 1, 2, 3, 4

Portal hypertension can lead to the development of esophageal varices, splenomegaly, hemorrhoids, and caput medusae. Portal hypertension does not lead to gastritis or gallstone formation.

Chapter 42. Cirrhosis and Liver Failure MULTIPLE

CHOICE

1.The nurse clarifies that unconjugated bilirubin, which is made up of broken-down red cells, is:

a.	stored in the gallbladder to make bile.
b.	water insoluble bilirubin that must be converted by the liver.
c.	a by-product which is excreted directly into the bowel for excretion.
d.	necessary for digestion of fats.

ANS: B

Unconjugated bilirubin is a water-insoluble product that must be converted in the liver to conjugated bilirubin (water soluble) so that it may be excreted through the bowel.

2.The patient with cirrhosis has an albumin of 2.8 g/dL. The nurse is aware that normal is 3.5 g/dL to 5 g/dL. Based on these findings, what would the nurse expect the patient to exhibit?

a.	Jaundice
b.	Edema
c.	Copious urine output
d.	Pallor

ANS: B

Low serum albumin levels result also from excessive loss of albumin into urine or into third-space volumes, causing ascites or edema.

3.Which nursing intervention should be completed immediately after the physician has performed a needle liver biopsy?

a.	Assisting to ambulate for the bathroom
b.	Keeping the patient on the right side for a minimum of 2 hours
c.	Taking vital signs every 4 hours
d.	Keeping the patient on the left side for a minimum of 4 hours

ANS: B

Keep the patient lying on the right side for minimum of 2 hours to splint the puncture site. It compresses the liver capsule against the chest wall to decrease the risk of hemorrhage or bile leak. Vital signs are taken every 15 minutes for 30 minutes, then every 30 minutes for 2 hours.

4.Immediately following a liver biopsy, the patient becomes dyspneic, the pulse increases to 100, and no breath sounds can be heard on the affected side. What should the nurse suspect?

a.	Peritonitis
b.	Pneumothorax
c.	Hemorrhage of the liver
d.	Pleural effusion

ANS: B

Pneumothorax is a possible complication of paracentesis. The patients head of the bed should be raised slightly, but kept on the right side. Oxygen should be administered and the assessment reported to the charge nurse and documented.

5.The patients cirrhosis of the liver has also caused a dilation of the veins of the lower esophagus secondary to portal hypertension, resulting in the development of the complication of:

a.	esophageal varices.
b.	diverticulosis.
c.	Crohn disease.
d.	esophageal reflux (GERD).

ANS: A

Esophageal varices (a complex of longitudinal, tortuous veins at the lower end of the esophagus) enlarge and become edematous as the result of portal hypertension.

6.The patient with cirrhosis has a rising ammonia level and is becoming disoriented. The patient waves to the nurse as she enters the room. How should the nurse interpret this?

a.	As an attempt to get the nurses attention
b.	As asterixis
c.	As an indication of respiratory obstruction from varices
d.	As spasticity

ANS: B

Asterixis is the flapping tremor seen as the patient deteriorates into ammonia intoxication or hepatic encephalopathy.

7.How does the administration of neomycin (Mycifradin) reduce the production of ammonia?

a. By assisting the hepatic cells to regenerate

b. By reducing ascites

c. By decreasing the bacteria in the gut

d. By helping to digest fats and proteins

ANS: C

The buildup of ammonia can be prevented with the use of lactulose (Chronulac) and neomycin. Ammonia is produced in the gut by bacterial action. By reducing the bacteria, less ammonia is produced.

8.The nurse explains that the use of cyclosporine as an immunosuppressant has been successful in the reduction of rejection of liver transplants because the drug:

a. increases the rate of the regeneration of liver cells.

b. can overcome complications presented by hepatitis C.

c. increases blood supply to transplant.

d. does not suppress bone marrow.

ANS: D

Cyclosporine is an immunosuppressant that does not cause bone marrow suppression nor does it impede healing.

9.A family member of a patient asks the nurse about the protein-restricted diet ordered because of advanced liver disease with hepatic encephalopathy. What statement by the nurse would best explain the purpose of the diet?

a. The liver cannot rid the body of ammonia that is made by the breakdown of protein in the digestive system.

b. The liver heals better with a high-carbohydrate diet rather than with a diet high in protein.

c. Most people have too much protein in their diets. The amount in this diet is better for liver healing.

d. Because of portal hypertension, the blood flows around the liver, and ammonia made from protein collects in the brain, causing hallucinations.

ANS: A

The patient with hepatic encephalopathy is on a very low-protein to no-protein diet. The goal of management of hepatic encephalopathy is the reduction of ammonia formation in the intestines.

10.The nurse would make provisions in the plan of care for a person who has had a liver transplant to prevent:

a. fluid congestion.

b.	fatigue.
c.	infection.
d.	urinary retention.

ANS: C

A critical aspect of nursing care following liver transplantation is monitoring for infection. The major postoperative complications of a liver transplant are rejection and infection.

11. The nurse clarifies that deterioration progresses through stages before presenting with liver disease. Place the stages in order. (Separate letters by a comma and space as follows: A, B, C, D)

a. Liver disease

b. Inflammation

c. Hepatic insufficiency

d. Destruction

e. Fibrotic regeneration

ANS:

D, B, E, C, A

Liver deterioration follows a pattern of stages: destruction, inflammation, fibrotic regeneration; hepatic insufficiency then presents as liver disease.

12. What are the indications for a liver transplant? (Select all that apply.)

a.	Congenital biliary abnormalities
b.	Hepatic malignancy
c.	Chronic hepatitis
d.	Cirrhosis due to alcoholism
e.	Gallbladder disease

ANS: A, B, C

Indications for liver transplantation include congenital biliary abnormalities, inborn errors of metabolism, hepatic malignancy (confined to the liver), sclerosing cholangitis, and chronic end-stage liver disease.

Chapter 43. Common Urinary Complaints

1.An intravenous pyelogram confirms the presence of a 4-mm renal calculus in the proximal left ureter of a newly admitted patient. Physician orders include meperidine (Demerol) 100 mg IM q4h PRN, strain all urine, and encourage fluids to 4000 mL/day. What should be the nurses highest priority when planning care for this patient?

a.	Pain related to irritation of a stone
b.	Anxiety related to unclear outcome of condition
c.	Ineffective health maintenance related to lack of knowledge about prevention of stones
d.	Risk for injury related to disorientation

ANS: A

Nursing diagnoses directed at pain control are of primary importance at the early stages of care. Opioid medications manage the pain well.

2.A patient is receiving chlorothiazide (Diuril), a thiazide diuretic for hypertension. What nursing action is most important for prevention of complications?

a.	Measure output
b.	Increase fluid intake
c.	Assess for hypokalemia
d.	Assess for hypernatremia

ANS: C

The thiazide diuretic, chlorothiazide (Diuril), affects electrolytes to cause hypokalemia (extreme potassium depletion in blood).

3.A patient with cystitis is receiving phenazopyridine (Pyridium) for pain and is voiding a bright red-orange urine. What should the nurse do?

a.	Report this immediately
b.	Explain to the patient that this is normal
c.	Increase fluid intake
d.	Collect a specimen

ANS: B

Pyridium will turn the urine reddish-orange.

4.The patient, age 43, has cancer of the urinary bladder. He has received a cystectomy with an ileal conduit. Which characteristics would be considered normal for his urine?

a.	Hematuria
b.	Clear amber with mucus shreds
c.	Dark bile-colored
d.	Dark amber

ANS: B

There will be mucus present in the urine from the intestinal secretions.

5.A patient, age 78, has been admitted to the hospital with dehydration and electrolyte imbalance. She is confused and incontinent of urine on admission. Which nursing intervention does the nurse include in developing a plan of care?

a.	Restrict fluids after the evening meal
b.	Insert an indwelling catheter
c.	Assist the patient to the bathroom every 2 hours
d.	Apply absorbent incontinence pads

ANS: D

Use of protective undergarments may help to keep the patient and the patients clothing dry. Confused patients are high risk for falls. Restricting fluids will only decrease incontinence during the night and will exacerbate the dehydration and electrolyte imbalance.

6.The home health nurse suggests the use of complementary and alternative therapies to prevent and/or treat urinary tract infections (UTIs). Which of the following is an example of such therapies?

a.	Grape juice
b.	Caffeine
c.	Tea
d.	Cranberry juice

ANS: D

Cranberry (Cranberry Plus, Ultra Cranberry) has been used to prevent urinary tract infections (UTIs), particularly in women prone to recurrent infection. It has also been used to treat acute UTI. Monitor patients for lack of therapeutic effect. Caffeine and tea will increase diuresis but not prevent UTI.

7.Which action can reduce the risk of skin impairment secondary to urinary incontinence?

a.	Decreasing fluid intake
b.	Catheterization of the elderly patient
c.	Limiting the use of medication (diuretics, etc.)

d. Frequent toileting and meticulous skin care

ANS: D

Frequent toileting of the incontinent patient will prevent retained moisture in undergarments and bed linens and will preserve the integrity of the skin.

8.Why are pediatric patients, especially girls, susceptible to urinary tract infections?

a. Genetically females have a weaker immune system

b. Females have a short and proximal urethra in relation to the vagina

c. Girls are more sexually active than males

d. Girls have a weakened musculature and sphincter tone

ANS: B

Pediatric patients, especially girls, are susceptible to urinary tract infections because of the short urethra.

9.Which foods should the home health nurse counsel hypokalemic patients to include in their diet?

a. Bananas, oranges, cantaloupe

b. Carrots, summer squash, green beans

c. Apples, pineapple, watermelon

d. Winter squash, cauliflower, lettuce

ANS: A

The use of most diuretics, with the exception of the potassium-sparing diuretics, requires adding daily potassium sources (e.g., baked potatoes, raw bananas, apricots, or navel oranges, cantaloupe, winter squash).

10.To help a patient control incontinence, what should the nurse recommend the patient avoid?

a. Spicy foods

b. Citrus fruits

c. Organ meats

d. Shellfish

ANS: A

Incontinence may be improved by omitting spicy foods, alcohol, and caffeine from the diet. 11.What should the nurse counsel the young man with chronic prostatitis to avoid?

a. Cessation of intercourse

b.	Warm baths
c.	Stool softeners
d.	Continuing antibiotics when symptoms abate

ANS: A

Frequent intercourse may be beneficial to the treatment of chronic prostatitis. Warm baths, stool softeners, and antibiotic therapy are also part of the medical treatment.

MULTIPLE RESPONSE

12.The nurse reassures the patient recovering from acute glomerulonephritis that after all other signs and symptoms of the disease subside, it is normal to have some residual (select all that apply):

a.	proteinuria
b.	oliguria
c.	hematuria
d.	anasarca
e.	oliguria

ANS: A, C

Proteinuria and hematuria may exist microscopically even when other symptoms subside. 13.Why are urinary tract infections (UTI) common in older adults? (Select all that apply.)

a.	Older adults have weakened musculature in the bladder and urethra.
b.	Older adults have urinary stasis.
c.	Older adults have increased bladder capacity.
d.	Older adults have diminished neurologic sensation.
e.	The effects of medications such as diuretics that many older adults take.

ANS: A, B, D, E

Urinary frequency, urgency, nocturia, retention, and incontinence are common with aging. These occur because of weakened musculature in the bladder and urethra, diminished neurologic sensation combined with decreased bladder capacity, and the effects of medications such as diuretics. Older women are at risk for stress incontinence because of hormonal changes and weakened pelvic musculature. Inadequate fluid intake (less than 1000 to 2000 mL per 24 hours) can lead to urinary stasis.

14.Which of the following are signs of fluid overload in the patient with nephrosis? (Select all that apply.)

a.	Increase in pulse rate
b.	Increase in daily weight
c.	Clear lung sounds
d.	Edema
e.	Labored respirations

ANS: A, B, D, E

Signs and symptoms of fluid overload: changes in pulse rate, respirations, cardiac sounds, and lung fields. Increase in daily morning weights.

15.The nurse is reviewing the urinalysis report on an assigned patient. The nurse recognizes which findings to be normal? (Select all that apply.)

a.	Turbidity clear
b.	pH 6.0
c.	Glucose negative
d.	Red blood cells, 15 to 20
e.	White blood cells

ANS: A, C

The type and size of urinary catheter are determined by the location and cause of the urinary tract problem.

COMPLETION

16.Exercises to increase muscle tone of the pelvic floor are known as_____exercises.

ANS:

Kegel

Women with weakened structures of the pelvic floor are prone to stress incontinence. For the female patient, Kegel exercises are helpful; 10 repetitions, 5 to 10 times a day, are suggested to improve muscle tone.

17.In the nephrotic syndrome, the glomeruli are damaged by inflammation and allow small _____ to pass through into the urine.

ANS:

proteins

In nephrotic syndrome, the glomeruli are damaged by inflammation and allow small proteins such as albumin to enter the urine. This creates a deficit of protein in the circulation volume (hypoalbuminemia), which leads to massive edema.

Chapter 44. Urinary Tract Disorders MULTIPLE

CHOICE

1.A client is being evaluated for a lower urinary tract infection. Which of the following symptoms would the nurse expect to find?

1.Cloudy urine
2.Flank pain
3.Nausea
4.Temperature 102.9F

ANS: 1

Symptoms of a lower urinary tract infection include dysuria, frequency, urgency, hesitancy, cloudy urine, lower abdominal pain, chills, malaise, and mild fever (less than 101F). The other options are symptoms of upper urinary tract infection.

2.An elderly client is diagnosed with a urinary tract infection. Which of the following will the nurse most likely assess in this client?

1.Jaundice 2.Vomiting
3.Poor eating habits 4.Change in mental status

ANS: 4

The elderly tend to have symptoms of fever or hypothermia, poor appetite, lethargy, and a change in mental status. Newborns demonstrate jaundice. Infants can experience vomiting. Children tend to have poor eating habits.

3.A nurse is collecting a post-void residual urine volume for a client. Which of the following volumes would be abnormal?

1.30 mL
2.60 mL
3.95 mL

4.125 mL ANS: 4

A residual volume of greater than 100 mL is abnormal. The other volumes would be considered within normal limits.

4.A client is prescribed trimethoprim-sulfamethoxazole for a urinary tract infection. Which of the following instructions would *not* be appropriate for this medication?

1.Complete all the medication even if you feel better. 2.Drink extra water during the day.
3.Take on an empty stomach with water. 4.Take with an antacid.

ANS: 4

This medication does not need to be taken with an antacid. Trimethoprim-sulfamethoxazole (Bactrim) should be taken on an empty stomach with water. The client should consume extra water to prevent sedimentation in the urine and calculus formation. All medication should be taken to treat and eliminate the infection.

5.A client with a urinary tract infection is being discharged with a prescription for ciprofloxacin. The nurse should include which of the following discharge instructions?

1.Do not take within 2 hours of antacid use. 2.Limit fluids.
3.Restrict activity
4.Expect to be nauseated with this medication.

ANS: 1

Ciprofloxacin should not be administered within 2 hours of taking an antacid. The client does not need to limit fluids or restrict activity. Nausea is not always a side effect of this medication.

6.A client is recovering from a cystoscopy. The nurse would expect to assess which of the following regarding the clients urine after the procedure?

1.Anuria 2.Blood clots

3.Hematuria 4.Pink-tinged

ANS: 4

The bladder and urethra are usually irritated as a result of the procedure. This causes pink-tinged urine. Large amounts of blood in the urine, anuria, or blood clots are not expected findings after this procedure.

7.A client is being treated for interstitial cystitis. Which of the following medications would *not* be prescribed for this client?

1.Cortisone acetate (Cortone) 2.Dimethyl sulfoxide (DMSO) 3.Pimecrolimus (Elidel) 4.Polysulfate sodium (Elmiron)

ANS: 3

Pimecrolimus (Elidel) is for the treatment of atopic dermatitis. The other options are medications that could be prescribed for a client diagnosed with interstitial cystitis.

8.After being diagnosed, a client asks the nurse What is pyelonephritis? The nurse should respond:

1.Pyelonephritis is an infection of the bladder.
2.Pyelonephritis is an infection of the urethra.
3.Pyelonephritis is an infection of the prostate.
4.Pyelonephritis is a common infection that needs to be treated to prevent complications.

ANS: 4

Pyelonephritis is an infection of the upper urinary tract. It may involve the ureters, the renal pelvis, and the papillary tips of the collecting ducts. Without treatment, pyelonephritis can cause renal damage. Pyelonephritis is not an infection of the bladder, urethra, or prostate.

9.The nurse is reviewing the health history of a client diagnosed with glomerulonephritis. Which of the medical conditions would be a risk factor for developing glomerulonephritis?

1.Asthma 2.Hypertension

3.Recent strep throat 4.Renal failure

ANS: 3

Recent *Streptococcus* infection can lead to the development of glomerulonephritis. Hypertension and renal failure does not cause glomerulonephritis, but they can result from glomerulonephritis. Asthma is unrelated.

10.The nurse is assessing a client diagnosed with glomerulonephritis. Which of the following findings is consistent with this disorder?

1.Brown urine 2.Hip pain
3.Hypotension 4.Bradycardia

ANS: 1

Brown-, tea-, or cola-colored urine; flank pain; and periorbital edema are expected findings. Hypotension, hip pain, and bradycardia are not associated with this disorder.

11.A client is diagnosed with nephrotic syndrome. Which of the following is the nurse most likely going to assess in this client?

1.Glucosuria 2.Proteinuria
3.Hematuria 4.Oliguria

ANS: 2

In the client diagnosed with nephrotic syndrome, there is an increase in protein in the urine. Hematuria and oliguria are uncommon assessment findings in this disorder. Glucosuria would be associated with a client diagnosed with diabetes mellitus.

12.A client is surprised to learn that his acute pain is caused by a kidney stone. The nurse should instruct the client that the most common type of renal calculi is composed of:

1.calcium.

2.cystine.
3.struvite.
4.uric acid.

ANS: 1

Calcium-based stones (renal calculi) are the most common type of stone. Dietary measures should be taken to decrease the potential of developing another stone. Struvite stones are made of magnesium, phosphate, and ammonium and are usually staghorn in nature. Only 5% of renal stones are from uric acid. Cystine stones are associated with hereditary factors.

13.A client is hospitalized with kidney trauma resulting in lacerations to the parenchyma. Which of the following would be included in the management of this clients care?

1.Bed rest with antibiotic therapy 2.Restrict
fluids
3.Encourage early ambulation 4.Nephrectomy

ANS: 1

In the case of parenchymal lacerations to the kidney, the client should be hospitalized, kept on bed rest, and provided with antibiotics until the urine clears. Restricting fluids and encouraging early ambulation would not be appropriate for this clients injuries. A nephrectomy is not indicated for this type of kidney trauma.

14.The nurse is reviewing a clients risk factors for the development of renal cancer. Which of the following would be considered a risk factor for the development of this disease?

1.Cigarette smoking 2.Being
underweight 3.History of hypotension
4.History of type 2 diabetes mellitus ANS: 1

Cigarettes smoking doubles the risk of renal cell carcinoma. Obesity, not being underweight, is a risk factor. Hypertension, not hypotension, is a risk factor. Type 2 diabetes mellitus is not a risk factor for the development of the disease.

15.A client is scheduled for surgery to remove the bladder and create a urinary diversion. If the client has a history of complications after surgery, the type of urinary diversion that might be indicated would be:

1.continent diversion with a surgical opening to the abdomen. 2.continent diversion with a replacement bladder made out of intestine.
3.noncontinent diversion with anastomose of the ureters to the anterior wall. 4.noncontinent diversion with anastomose of the ureters to the rectum.

ANS: 3

Noncontinent urinary diversions are considered less technically demanding and are associated with the fewest postoperative complications. This type of diversion is performed by anastomosing the ureters to the anterior body wall. The rectum is not used as a site to anastomose the ureters.

Continent diversions have more postoperative complications.

MULTIPLE RESPONSE

1.The nurse is instructing a client on ways to prevent urinary tract infections. Which of the following should be included in these instructions? (Select all that apply.)

1.Drink cranberry juice. 2.Drink eight glasses of water.
3.Take baths instead of showers. 4.Urinate before and after intercourse.
5.In women, wipe back to front after voiding.
6.Take the prescribed medication until the symptoms subside

ANS: 1, 2, 4

Interventions to reduce the onset of urinary tract infections include drinking cranberry juice and 6 to 8 glasses of water each day. The client should be instructed to urinate before and after intercourse. Women should wipe front to back when completing perineal care because of the close proximity of the urethra to the vagina and anus. Taking showers instead of baths helps prevent bacteria from entering the urethra while bathing. The client should be instructed to take the entire course of the prescribed medication and not just until the symptoms subside.

2.A client is diagnosed with an upper urinary tract infection. Which structures are affected by this infection? (Select all that apply.)

1.Bladder 2.Kidney
3.Prostate 4.Ureters
5.Urethra 6.Rectum

ANS: 2, 4

Upper urinary tract infections are of the ureters or kidney. Lower urinary tract infections are infections of the urethra, bladder, or prostate. The rectum is not affected by an upper urinary tract infection.

3.The nurse is instructing a client on ways to reduce formation of future kidney stones. Which of the following should be included in these instructions? (Select all that apply.)

1.Drink plenty of fluids. 2.Drink soft drinks.
3.Limit the intake of spinach.
4.Take a vitamin B-12 supplement or eat foods rich in vitamin B-12.
5.Take a magnesium citrate supplement or eating foods rich in magnesium citrate.
6.Adjust calcium intake.

ANS: 1, 3, 5, 6

Instructions to reduce the formation of kidney stones in the future include: drink plenty of fluids; avoid soft drinks; limit the intake of spinach to reduce urinary oxalate levels; vitamin B6 helps reduce the formation of kidney stones; magnesium citrate helps prevent the formation of kidney stones; and calcium intake should be adjusted to prevent the formation of kidney stones.

4.A client is diagnosed with renal vein thrombosis. The nurse realizes that which of the following could be indicated in this clients plan of care? (Select all that apply.)

1.Corticosteroids 2.Nephrectomy
3.Anticoagulants 4.Antihypertensives
5.Surgical intervention 6.Antibiotics

ANS: 1, 3, 5

Management of the client diagnosed with renal vein thrombosis includes corticosteroids, anticoagulants, and surgical removal of the thrombi. Nephrectomy, antihypertensives, and antibiotics are not indicated in the treatment of this disorder.

5.The nurse is assessing a client for type of urinary incontinence. Which of the following are considered types of this disorder? (Select all that apply.)

1.Stress 2.Radical 3.Urge
4.Temporary 5.Overflow
6.Functional

ANS: 1, 3, 5, 6

The four types of incontinence are stress, urge, overflow, and functional. Radical and temporary are not types of bladder incontinence.

Chapter 45. Kidney and Bladder Disorders

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. A patient is seen in the clinic with a chief complaint of hematuria. To make a differential diagnosis, which of the following questions should be asked?
a. "Do you have a history of liver disease?"
b. "What medications are you currently taking?"
c. "Have you noticed swelling in your ankles?"
d. All of the above

__ 2. The result of the patient's 24-hour urine for protein was 4.2 g/day. The clinician should take which of the following actions?
a. Repeat the test.
b. Refer to a nephrologist.
c. Measure the serum protein.
d. Obtain a blood urea nitrogen (BUN) and creatinine.

__ 3. A patient is seen complaining of "leaking urine when I sneeze." Which of the following actions should the clinician take first?

a. Order a cystometrogram.
b. Obtain a computed tomography scan.
c. Instruct the patient on Kegel exercises.
d. Prescribe imipramine.

__ 4. A patient is seen in the clinic with hematuria confirmed on microscopic examination. The clinician should inquire about the ingestion of which of these substances that might be the cause of hematuria?

a. NSAIDs
b. Beets
c. Vitamin A
d. Red meat

__ 5. A 27-year-old female presents with a chief complaint of burning and pain on urination. She has no previous history of urinary tract infection (UTI). What are some additional symptoms consistent with a diagnosis of lower UTI?

a. Back and abdominal pain
b. Fever, chills, costovertebral angle (CVA) tenderness
c. Blood in urine and frequency
d. Foul-smelling discharge, perineal itch

__ 6. A 30-year-old patient presents with pain on urination. The urine microscopy of unspun urine shows greater than 10 leukocytes/mL, and a dipstick is positive for nitrites. What is the probable diagnosis?

a. Lower urinary tract infection
b. Chlamydia infection
c. Candidiasis
d. Pyelonephritis

____ 7. A patient presents with CVA tenderness and a several-day history of high fever, chills, and dysuria. Which of the following diagnoses is most likely given the above information?

a. Pyelonephritis
b. Cystitis
c. Renal calculi
d. Bladder tumor

__ 8. Which of the following information is essential before prescribing Bactrim DS to a 24-year-old woman with a UTI?

a. Last menstrual period
b. Method of birth control
c. Last unprotected sexual contact
d. All of the above

__ 9. A patient is seen in the office complaining of severe flank pain. The clinician should assess this patient for which risk factor for kidney stones?

a. Hypertension
b. Constipation
c. Tubal ligation
d. Diabetes

__ 10. A patient is diagnosed with urge incontinence. Before prescribing Detrol XL, the provider should question the patient about which of these contraindications to this medication?

a. Diarrhea
b. Parkinson's disease
c. Closed-angle glaucoma
d. Breast cancer

__ 11. A patient is diagnosed with overactive bladder. Which of the following instructions should be given to this woman?

a. "Limit the amount of water that you drink."
b. "Eliminate caffeine from your diet."
c. "Wear panty liners."
d. All of the above

__ 12. A 34-year-old patient was treated for a UTI and has not responded to antibiotic therapy. Which of the following actions should be taken next?

a. Send a urine specimen for microscopy and evaluate for fungal colonies.
b. Increase the dose of antibiotic.
c. Order a cytoscopy.
d. Order a different antibiotic.

____ 13. Which of the following are predisposing factors for pyelonephritis?

a. Pregnancy
b. Dehydration
c. Smoking
d. Alkaline urine

__ 14. A 42-year-old woman is seen in the clinic with fever, chills, vomiting, and severe dysuria. She is diagnosed with acute pyelonephritis. How should this patient be managed?

a. 3-day course of oral antibiotics
b. Hospitalization
c. Encourage cranberry juice intake.
d. 6-week course of antibiotics

__ 15. A patient is seen with a sudden onset of flank pain accompanied by nausea, vomiting, and diaphoresis. In addition to nephrolithiasis, which of the following should be added to the list of differential diagnoses?

a. Pancreatitis
b. Peptic ulcer disease
c. Diverticulitis
d. All of the above

____ 16. Which of the following instructions should be given to the patient with nephrolithiasis?

a. Take ibuprofen, 600 mg every 8 hours.
b. Take Tums for stomach upset.
c. Drink more black tea.
d. Increase intake of vegetables, like spinach.

____ 17. Which of the following patients is at risk for developing urinary tract cancer?

a. The 45-year-old woman who is 100 lbs overweight
b. The 78-year-old man who smokes three packs of cigarettes a day
c. The 84-year-old man who worked in the asbestos mines
d. All of the above

__ 18. A patient is seen in the clinic and diagnosed with Stage I renal cancer. The provider should refer the patient to a nephrologist for which of these treatments?

a. Chemotherapy
b. Nephrectomy
c. Palliative treatment
d. Radiation

__ 19. An 86-year-old woman is seen in the clinic for recurrent hematuria. The provider suspects bladder cancer. Which of the following data from the history is considered a risk factor for this type of cancer?

a. History of alcoholism
b. Sedentary lifestyle
c. Obesity
d. 65-year smoking history

___ 20. Which of the following diagnostic tests should be ordered for a patient suspected of having bladder cancer?

a. Kidneys, ureter, bladder x-ray
b. Cystoscopy with biopsy
c. Magnetic resonance imaging
d. Urine tumor marker (NMP22)

____ 21. A 78-year-old man is diagnosed with Stage D bladder cancer and asks the provider what that means. Which is the best response?

a. "There is no such thing as Stage D cancer."
b. "You have cancer that has spread to the surrounding tissue."
c. "Your cancer has spread to other organs."
d. "Your cancer can be cured by removing your bladder."

___ 22. The patient is diagnosed with acute renal failure (ARF). Which of the following data obtained from the history should alert the provider that this is a case of prerenal azotemia?

a. Recent heat stroke
b. Nephrolithiasis
c. Recent infection where gentamicin was used in treatment
d. All of the above

____ 23. The patient is diagnosed with ARF. Which of the following conditions is the most common cause?

a. Renal calculi
b. Acute tubular necrosis
c. Cardiac failure
d. Acute glomerulonephritis

___ 24. An 82-year-old woman with renal failure is seen in the clinic. The provider should question the patient about the intake of which of these substances that can cause renal toxicity?

a. Ibuprofen
b. Captopril
c. Losartan
d. All of the above

____ 25. Which of the following clinical manifestations are consistent with a patient in ARF?

a. Pruritis
b. Glycosuria
c. Irritability
d. Hypotension

__ 26. Which of the following examination findings should be expected in a patient with chronic renal failure (CRF)?

a. Weak, thready pulse
b. Auscultatory crackles
c. Hypotension
d. Pleural friction rub

__ 27. Which of the following tests is most useful in determining renal function in a patient suspected of CRF?

a. BUN and creatinine
b. Electrolytes
c. Creatinine clearance
d. Urinalysis

____ 28. Which of the following foods should be limited in a patient with CRF?

a. Milk
b. Bananas
c. Soy sauce
d. All of the above

True/False

Indicate whether the statement is true or false.

____ 1. The urine osmolality is greater than 500 mOsm/L in patients with postrenal ARF.

____ 2. Cigarette smoking is a risk factor for CRF.

Chapter 45. Kidney and Bladder Disorders
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: B PTS: 1
3. ANS: C PTS: 1
4. ANS: A PTS: 1
5. ANS: C PTS: 1
6. ANS: A PTS: 1
7. ANS: A PTS: 1
8. ANS: D PTS: 1
9. ANS: A PTS: 1
10. ANS: C PTS: 1
11. ANS: B PTS: 1
12. ANS: A PTS: 1
13. ANS: A PTS: 1
14. ANS: B PTS: 1
15. ANS: D PTS: 1
16. ANS: A PTS: 1
17. ANS: D PTS: 1
18. ANS: B PTS: 1
19. ANS: D PTS: 1
20. ANS: B PTS: 1

21. ANS: C PTS: 1

22. ANS: A PTS: 1

23. ANS: B PTS: 1

24. ANS: D PTS: 1

25. ANS: A PTS: 1

26. ANS: B PTS: 1

27. ANS: C PTS: 1

28. ANS: D PTS: 1

TRUE/FALSE

1. ANS: F PTS: 1

2. ANS: T PTS: 1

Chapter 46. Common Reproductive System Complaints MULTIPLE CHOICE

1.A male client asks the nurse about the purpose of the prostate gland. The nurse should respond that it is a structure that:

1.secretes an alkaline substance that neutralizes residual acidic urine in the urethra.
2.provides a milky alkaline substance that neutralizes the acidity of the male urethra and the female vagina.
3.secretes a fluid for the health and nutrition of sperm. 4.propels sperm into the ejaculatory duct.

ANS: 2

The prostate gland produces a milky alkaline fluid that helps neutralize the acidity of the male urethra and female vagina. The bulbourethral (Cowpers) gland secretes an alkaline substance that neutralizes any residual acidic urine in the urethra. The seminal vesicles secrete a fluid for the health and nutrition of sperm. The vas deferens is a duct that propels sperm into the ejaculatory duct.

2.A 50-year-old male client has had a prostate-specific antigen test. The nurse realizes that the normal range for this test would be:

1.0 to 2 ng/mL.
2.0 to 3 ng/mL.
3.0 to 4 ng/mL.
4.0 to 5 ng/mL. ANS: 3

The prostate-specific antigen is used to test for both benign and malignant diseases of the prostate. A PSA reading of 4 nanograms and below is considered normal.

3.A male client, having difficulty voiding, tells the nurse that he thinks something is wrong with his penis. The nurse reviews the structures of the penis with the client and explains that the structure that surrounds the urethra is the:

1.corpus cavernosa.
2.corpus spongiosum.
3.glans penis.
4.prepuce.

ANS: 2

The corpus spongiosum surrounds the urethra. The corpus cavernosa lies near the top of the penis. The glans penis is the erectile tip of the penis, and the prepuce is the foreskin.

4.The nurse is preparing to discuss the male reproductive system with a group of adolescent school students. Which of the following would the nurse *not* include as a primary function of the male reproductive system?

1.Frequent erectile functioning and increased libido 2.Production of sperm
3.Secretion of testosterone 4.Transportation and depositing of sperm

ANS: 1

The primary functions of the male reproductive system are the production of sperm, the transportation and depositing of sperm in the female reproductive tract, and the secretion of testosterone. Frequent erectile functioning and increased libido are not primary functions.

5.A male client is diagnosed as being infertile. The nurse realizes which of the following structures of the clients reproductive system is affected?

1.Epididymis 2.Rete testes
3.Seminal vesicles
4.Seminiferous tubules ANS: 4

The seminiferous tubules produce spermatozoa. The rete testes and epididymis store sperm. The seminal vesicles secrete a fluid for the health and nutrition of sperm.

6.The nurse, preparing to discuss the female reproductive system with a group of adolescent females, would include that which of the following is *not* a primary function of the female reproductive system?

1.Breastfeeding 2.Hormone secretion
3.Pregnancy 4.Sensory innervation

ANS: 4

The primary functions of the female reproductive system are the production of ova, the secretion of hormones, pregnancy and birth of a fetus, and breastfeeding. Sensory innervation is not a primary function of the female reproductive system.

7.A young adult female client is concerned that she does not have enough eggs since she has not yet become pregnant. The nurse should assure her that the number of ova available to produce a pregnancy would be around:

1.500.
2.10,000.
3.300,000.

4.2,000,000.

ANS: 3

At birth the ovaries contain between 2 and 4 million ova. Most of the ova degenerate across time until there are only 300,000 to 400,000 ova present at puberty. A woman may release fewer that 500 mature ova during monthly ovulation.

8.During a gynecological exam, it is noted that a clients os is in the shape of a slit. The nurse realizes that this shape means that the client has:

1.borne children.
2.not started menses.
3.not borne any children.
4.gone through menopause.

ANS: 1

The shape of the os in women who have not borne children is circular. In women who have borne children, the os is slit-like. The shape of the cervical os does not change if a client has not started menses or has gone through menopause.

9.The nurse, reviewing the reproductive hormones needed to produce sperm and ova, realizes that which of the following hormones is *not* involved in the formation of sperm and ova?

1.Follicle-stimulating hormone 2.Gonadotropin-releasing hormone 3.Luteinizing hormone
4.Prolactin ANS: 4

Gonadotropin-releasing hormone stimulates the release of follicle-stimulating hormone and luteinizing hormone. Follicle-stimulating hormone stimulates the production of sperm and ovum. In men, luteinizing hormone stimulates the testosterone needed for sperm production, and in women, it stimulates ovulation. Prolactin is necessary for breast formation and the production of breast milk.

10.During the examination of the male testes, the nurse should instruct the client on:

1.the importance of having an annual prostate examination. 2.monthly testicular self-examinations.
3.why a colonoscopy is important every 10 years after the age of 50. 4.how a condom prevents the spread of sexually transmitted infections.

ANS: 2

When examining the testes, this portion of the examination can be used to teach the client about monthly testicular self-examination. This portion of the examination is not the best time to instruct the client regarding annual prostate examinations, colonoscopies, or the use of condoms.

11.A male client has a prostate specific antigen level of 22 nanograms. The nurse realizes that this client will most likely be scheduled for a(n):

1.bone scan 2.CT scan
3.testicular biopsy 4.duplex ultrasonography

ANS: 1

In clients with PSA levels of 20 nanograms and higher, a radionuclide bone scan is done to rule out metastasis. A CT scan detects enlarged lymph nodes, but it does not provide clear pictures of intraprostatic features. A testicular biopsy is not needed with an elevated prostate-specific antigen level. A duplex ultrasonography is used to diagnose marked arterial insufficiency as a cause of erectile dysfunction.

12.A female clients Pap test revealed atypical results. The nurse realizes that this client will most likely be scheduled for a(n):

1.culdoscopy.
2.colposcopy.
3.loop electrosurgical excision.
4.cold-knife conization.

ANS: 2

Women with atypical Pap smear results should receive further evaluation with colposcopy. A culdoscopy is the examination of the viscera of the female pelvic cavity. Loop electrosurgical

excision is a procedure to sample tissue from the cervix. Cold-knife conization is another method to take a tissue sample from the cervix.

MULTIPLE RESPONSE

1.A female client has an infection of the paraurethral glands. When asked by the client what these glands do, the nurse should respond: (Select all that apply.)

1.These glands function like the prostate gland in the male. 2.These glands secrete mucus near the vaginal opening.
3.These glands secrete mucus.
4.These glands are similar to the Cowpers glands in the male.
5.These glands are located inside the urethra.
6.These glands serve no real function. ANS: 1, 3, 5

The paraurethral glands or Skenes glands in a female are equivalent to the prostate in the male. They are located just inside of and on the posterior area of the urethra, and they secrete mucus. The bulbourethral glands or Bartholins glands in the female secrete mucus near the vaginal opening. The bulbourethral glands are similar to the Cowpers glands in the male. The paraurethral glands do serve a purpose and function.

2.The nurse is instructing a postmenopausal client in the importance of having serum lipid levels analyzed because after menopause, which of the following changes can occur? (Select all that apply.)

1.Total cholesterol increases
2.Low-density lipoprotein increases
3.Triglycerides increase
4.High-density lipoprotein decreases 5.Low-density lipoprotein decreases 6.High-density lipoprotein increases

ANS: 1, 2, 3, 4

After the age of 50 for women, total cholesterol, low-density lipoprotein cholesterol, and triglyceride levels increase after menopause. The high-density lipoprotein cholesterol levels decline, which

promotes atherosclerosis. After menopause the low-density lipoprotein levels will not decrease. After menopause, the high-density lipoprotein levels will not increase.

3.The nurse is reviewing the physiological sexual response pattern within males and females and realizes that which of the following occur in both genders? (Select all that apply.)

1.Resolution 2.Orgasm
3.Erection 4.Lubrication
5.Plateau 6.Excitement

ANS: 1, 2, 5, 6

The physiological sexual response pattern that occurs in both males and females are: excitement, plateau, orgasm, and resolution. Erection is a response in males. Lubrication is a response in females.

4.A female client is concerned that she has not had sexual intercourse with her husband for over 2 months. Which of the following can the nurse respond as causes for an alteration in sexual functioning? (Select all that apply.)

1.Chronic illnesses 2.Physical
disabilities 3.Negative body image
4.Medications 5.Surgical procedures
6.Employment status

ANS: 1, 2, 3, 4, 5

There are a variety of causes for sexual dysfunction. Some reasons include chronic illnesses, physical disabilities, negative body image, medications, and surgical procedures. Employment status is not an identified cause for sexual dysfunction.

5.The nurse is concerned that a female client might be experiencing intimate partner violence. Which of the following assessment questions can be used to gain more information from the client? (Select all that apply.)

1.In the last year have you been hit, slapped, or physically hurt by someone? 2.Are you currently sexually active?
3.Within the last year has someone made you do something sexual that you did not want to do? 4.Is sex satisfying to you?
5.Are you afraid of your partner or anyone else? 6.Do you have discomfort with intercourse?

ANS: 1, 3, 5

To assess if a client might be experiencing intimate partner violence, the nurse can ask the questions: In the last year have you been hit, slapped, or physically hurt by someone?; Within the last year has someone made you do something sexual that you did not want to do?; and Are you afraid of your partner or anyone else? The other choices are questions that are used for a sexual history.

Chapter 47. Breast Disorders MULTIPLE CHOICE

1.A client who has just given birth is planning on breastfeeding the baby. The nurse realizes that which of the following hormones influences breast milk secretion?

1.Follicle-stimulating hormone 2.Luteinizing hormone 3.Oxytocin
4.Prolactin ANS: 4

Prolactin is necessary for breast formation and the production of breast milk. Oxytocin is responsible for uterine contractions and the breast milk let down. Follicle-stimulating hormone stimulates the production of sperm and ova. In men, luteinizing hormone stimulates testosterone needed for sperm production, and in women, it stimulates ovulation.

2.The nurse is instructing a female client about breast self-examination. Which of the following instructions would *not* be correct for the nurse to provide?

1.A menstruating woman should check her breast monthly 8 days following her menses. 2.An inverted nipple is not a cause for alarm.
3.During menopause, you should check your breasts once a month during the same time frame.
4.Visually check the breasts in front of a mirror.

ANS: 2

An inverted nipple is not necessarily a cause for alarm if it has been present since puberty, but any change in the nipple or breast tissue should be evaluated. The other instructions would be appropriate for the nurse to provide.

3.A client who has been breastfeeding a newborn for the last 3 months is experiencing an inflammation of the breast. The nurse realizes this client is experiencing:

1.intraductal papilloma. 2.mastalgia.
3.mastitis.
4.mastodynia.

ANS: 3

Mastitis, inflammation of the breast, may be caused from irritation, injury, or infection, and it most commonly occurs within the first 3 months after childbirth. Mastalgia and mastodynia are terms that refer to breast pain. Intraductal papilloma is a small benign tumor that grows within the terminal portion of a solitary milk duct of the breast.

4.During the examination of a female clients breasts, the nurse determines that which of the following assessment findings would be normal?

1.Nipple discharge 2.Masses
3.Scaling
4.Symmetrical nipples

ANS: 4

Symmetrical nipples would be considered a normal finding. All the other options are abnormal findings.

5.The nurse is instructing a female client on the importance of having routine mammograms because mammograms:

1.can detect masses before they become palpable. 2.involves no radiation.

3.has a 25% rate of false positives. 4.combines a blood test with radiology.

ANS: 1

Mammography is a radiological procedure that is useful because it allows visualization of benign and malignant disorders before they become palpable. The rate of false positives is 5% to 10%. Mammography does use radiation. Mammography does not include a blood test.

6.The nurse is instructing a female client on what should be done if a lump is discovered while performing breast self-examination (BSE). What should the nurse instruct the client to do?

1.Call her physician and immediately schedule an appointment. 2.Call to schedule an appointment next month.
3.Take the antibiotics she has in her medicine cabinet.
4.Wait until next months BSE to make sure the lump is still there.

ANS: 1

Follow-up on a lump should begin immediately. The client should not wait to see if the lump remains or changes, and she should not medicate herself.

7.The nurse determines that a female client has a lower risk for developing breast cancer when which of the following is assessed?

1.Alcohol intake
2.Breastfeeding 3.Obesity
4.Smoking

ANS: 2

Breastfeeding has consistently been shown to decrease a womans risk of breast cancer. The other options increase a womans risk of breast cancer.

8.The nurse should instruct the client that when performing a breast self-examination, pay particular attention to which of the following areas since the greatest number of malignancies are found in this breast area?

1.Upper outer quadrant of the breast to the axilla

2.Portion of the breast closest to the xiphoid process
3.Portion of the breast closest to the abdomen
4.Portion of the breast closest to the neck

ANS: 1

The upper outer quadrant of the breast to the axilla is an area that needs to be evaluated since the greatest proportion of malignancies are found in this area of the breast. The other breast areas need to be examined; however, special attention should be given to the upper outer quadrant.

9.The nurse should instruct a client, diagnosed with mastalgia, to do which of the following? 1.Have an

immediate mammogram.
2.Expect to need a biopsy. 3.Decrease the intake
of caffeine.
4.Determine if breast augmentation surgery is desired. ANS: 3

Mastalgia refers to breast pain. Pain is not generally associated with breast cancer. Wearing a well-fitting supportive brassiere during exercise and decreasing the intake of caffeine would be beneficial. The client does not need an immediate mammogram, a biopsy, or breast augmentation.

10.A female client tells the nurse that she is planning on having plastic surgery to correct a minor facial defect and then have her breasts done. The nurse would identify which of the following nursing diagnoses as being appropriate for this client?

1.Ineffective coping 2.Anxiety
3.Hopelessness
4.Body dysmorphic disorder ANS: 4

Body dysmorphic disorder is characterized by a preoccupation with body image and the slight or imagined defect in appearance that leads to impairment or distress in functioning in social situations. Body dysmorphic disorder would be appropriate for the client who is planning on having plastic surgery for a minor facial defect and then breast augmentation surgery. The other nursing diagnoses would not be appropriate for the client at this time.

11.The nurse is determining if a female client is at risk for benign breast disease. Which of the following is a risk factor for this disorder?

1.Smoking 2.Caffeine use
3.Alcohol intake 4.Age 55

ANS: 2

Risk factors for benign breast disease include caffeine use, imbalance between estrogen and progesterone, estrogen excess, hyperprolactemia, and age between 20 to 50 years. Smoking and alcohol intake are not risk factors for benign breast disease.

12.A client is scheduled for a prophylactic mastectomy. The nurse should remind the client that skin flaps will be left after the surgery for:

1.reconstruction.
2.suturing to the chest wall.
3.possible use for other skin disorders.
4.donation for someone needing a skin transplant.

ANS: 1

The goal of a mastectomy is to remove all breast tissue, including the nipple and areola, while leaving well-perfused viable skin flaps for primary closure or reconstruction. The skin flaps will not be sutured to the chest wall. The skin flaps are not for use for other skin disorders. The skin flaps are not for donation for someone needing a skin transplant.

MULTIPLE RESPONSE

1.When instructing a client on breast self-examination, the nurse reviews the importance of visual inspection of the breasts. Which of the following should the nurse instruct the client to focus on when doing this part of the examination? (Select all that apply.)

1.Contour and symmetry of the breasts 2.Skin changes
3.Position of the nipples 4.Presence or absence
of masses 5.Pain

6.Size

ANS: 1, 2, 3, 4

Visual inspection of the breast self-examination focuses on the contour and symmetry of the breasts; skin changes such as scaling, puckering, dimpling, or scars; the position of the nipples; nipple discharge or retraction; and presence or absence of masses. This part of the examination does not include pain or size of the breasts.

2.The nurse is preparing to assess a clients nipples during a breast examination. Which of the following are considered pathological conditions that affect the nipple? (Select all that apply.)

1.Bleeding 2.Lumps
3.Discharge 4.Scars
5.Fissures 6.Large size

ANS: 1, 3, 5

The three primary pathological conditions of the nipple include bleeding, discharge, and fissures. Lumps, scars, and size are not associated with pathological conditions of the nipple.

3.Which of the following should the nurse do if a female client is experiencing nipple discharge? (Select all that apply.)

1.Note the color of the discharge.
2.Determine if the discharge is from one or both breasts.
3.Obtain a sample of the discharge with a sterile cotton-tipped swab.
4.Assess the nipple drainage for occult blood
5.Apply sterile bandages over the nipple. 6.Pad the clients bra with gauze.

ANS: 1, 2, 3, 4

If a female client is assessed with abnormal nipple discharge, the nurse should note the color of the discharge; determine if the discharge is from one or both breasts; obtain a sample of the discharge with a sterile cotton-tipped swab; and assess the drainage for occult blood. The nurse should not apply sterile bandages over the nipple nor pad the clients bra with gauze.

4.A client is experiencing galactorrhea. Which of the following should the nurse assess in this client? (Select all that apply.)

1.Recent vigorous nipple stimulation
2.Prescribed hormones, blood pressure medications, or antidepressants
3.Intake of herbal remedies such as fennel or anise
4.Use of street drugs such as opiates and marijuana 5.Recent chest trauma
6.Age of menarche ANS: 1, 2, 3,

4, 5

Galactorrhea is the secretion of a milk-like fluid in a non-lactating breast. This can occur because of recent vigorous nipple stimulation, prescribed hormones, blood pressure medication, or antidepressants; intake of herbal remedies such as fennel or anise; use of street drugs such as opiates and marijuana; and recent chest trauma. Age of menarche will not help determine the cause for the disorder.

5.A client is considering breast augmentation surgery. Which of the following postoperative complications should the nurse discuss with the client regarding this surgery? (Select all that apply.)

1.Change in sensation 2.Development of a hematoma 3.Fibrous tissue around the implant
4.Heart palpitations
5.High blood pressure 6.Arm pain

ANS: 1, 2, 3

Postoperative complications with breast augmentation include change in sensation, development of a hematoma; and formation of fibrous tissue around the implant. Heart palpitations, high blood pressure, and arm pain are not considered postoperative complications of breast augmentation surgery.

Chapter 48. Vaginal, Uterine, and Ovarian Disorders

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. A 23-year-old sexually active woman presents for her first Pap smear. Her history includes nulligravida, age at first intercourse 14, and more than 10 sexual partners. Which of the following conditions should the clinician be particularly alert for during her examination?
a. Human papillomavirus (HPV)
b. Endometrial hyperplasia
c. Vagismus
d. Polycystic ovarian syndrome

____ 2. A 20-year-old woman is seen in the clinic because her boyfriend was found to have gonorrhea. Which of the following is the treatment of choice for gonorrhea?
a. Ceftriaxone
b. Doxycycline
c. Acyclovir
d. Metronidazole

__ 3. A 24-year-old woman presents to the clinic with dysuria, dyspareunia, and a mucopurulent vaginal discharge. Her boyfriend was recently treated for nongonococcal urethritis. What sexually transmitted disease has she most probably been exposed to?
a. Gonorrhea
b. HPV
c. Chlamydia
d. Trichomonas

__ 4. A 45-year-old woman is seen in the clinic with complaints of a vaginal discharge. The clinician identifies clue cells on the vaginal smear. Which of the following diagnoses is associated with this finding?
a. Trichomonas
b. Bacterial vaginosis
c. HPV
d. Herpes simplex virus

____ 5. Which of the following medications is the treatment of choice for trichomonas?
a. Metronidazole
b. Ceftriaxone
c. Diflucan
d. Doxycycline

__ 6. A 58-year-old woman presents with a breast mass. Which of the following responses by the clinician would be most appropriate?

a. "It is probably just a cyst because that is the most common breast mass."
b. "We will order a mammogram and ultrasound to help establish a diagnosis."
c. "We will go ahead and schedule you for a biopsy because that is the only way to know for sure."
d. "Because your lump is painful, it is most likely not cancer."

__ 7. A 26-year-old woman is seen with complaints of irregular vaginal bleeding. Which of the following tests should be the first priority?

a. Pregnancy test
b. Pelvic ultrasound
c. Endometrial biopsy
d. Platelet count

____ 8. A 42-year-old woman presents to the clinic with complaints of painful intercourse for the last month. Which of the following should be explored as the likely cause of her dyspareunia?

a. Menopause
b. Dehydration
c. Excess progesterone
d. Sexual trauma as a child

__ 9. A 36-year-old woman is seen with complaints of vaginal itching, burning, and discharge. On potassium hydroxide (KOH) wet mount of vaginal discharge, the clinician notices hyphae. Which of the following treatments would be appropriate?

a. Fluconazole
b. Estrogen vaginal cream
c. Metronidazole
d. Doxycycline

__ 10. A 21-year-old woman is seen in the clinic requesting birth control pills. Which of the following tests is essential before prescribing any oral contraceptive?

a. Pregnancy test
b. Complete blood cell count
c. Thyroid-stimulating hormone
d. Urine dip for protein

__ 11. A 40-year-old woman is seen for her yearly examination. She is single and not in a monogamous relationship. Her social history includes smoking cigarettes "occasionally" and drinking about two beers a day. Her body mass index (BMI) is 25. She is requesting birth control. Which of the following methods would be best for this patient?

a. Intrauterine device
b. Oral contraceptive
c. Condom
d. Vaginal contraceptive sponge

__ 12. A 44-year-old patient with breast cancer is prescribed tamoxifen by her surgeon. She is complaining about hot flashes. Which of the following responses by the clinician would be most appropriate?

a. "You must be having menopause."
b. "The hot flashes are a result of the antiestrogenic effects of tamoxifen."
c. "Tamoxifen will impact your temperature regulation center."
d. "The drug destroys your ovaries."

__ 13. A 32-year-old woman is seen in the clinic because she has been unable to get pregnant after 12 months of unprotected sex. In order to determine the cause of the infertility, the clinician should question her about which of these possible causes?

a. Pelvic inflammatory disease
b. Oral contraceptive use for 15 years
c. Early menarche
d. Diet high in soy protein

____ 14. When assessing a woman for infertility, which of the following tests should be done first?

a. Analysis of partner's sperm
b. Magnetic resonance imaging (MRI)
c. Hysterosalpingogram
d. Estrogen level

__ 15. A 15-year-old girl is seen in the clinic because she has not yet had her first period. Which of the following questions would help the clinician determine the cause?

a. "Are you sexually active?"
b. "How long have you been underweight?"
c. "Did your mother take diethylstilbestrol during her pregnancy?"
d. "Have you noticed any changes in your moods lately?"

____ 16. What is the most common cause of secondary amenorrhea?

a. Pregnancy
b. Pituitary dysfunction
c. Inadequate estrogen levels

d. Genetic disorders

__ 17. A 22-year-old woman is diagnosed with premenstrual syndrome. Which of the following lifestyle changes should the clinician suggest to help minimize the patient's symptoms?

a. At least 4 cups of green tea daily
b. Regular exercise
c. Take vitamin A supplements
d. Eat a diet high in iron

__ 18. A 25-year-old woman is seen in the clinic complaining of painful menstruation. Which of the following pelvic pathologies is the most common cause of dysmenorrhea?

a. Pelvic inflammatory disease
b. Endometriosis
c. Sexually transmitted infections
d. Ovarian cyst

__ 19. A 26-year-old woman tells the clinician that she has endometriosis, because she has frequent pelvic pain. The clinician also should consider which of these differential diagnoses?

a. Diverticulitis
b. Cholelithiasis
c. Kidney stones
d. Ovarian cysts

____ 20. Which of the following would be appropriate treatment for a woman with mild endometriosis?

a. Oral contraceptives
b. Leuprolide acetate injections
c. Nafarelin nasal spray
d. Hysterectomy

__ 21. A 45-year-old woman is seen in the clinic with abnormal uterine bleeding and pain during intercourse. The clinician should consider which of the following diagnoses?

a. Leiomyoma
b. Pregnancy
c. Ovarian cancer
d. All of the above

____ 22. A 48-year-old woman is seen in the clinic with complaints of prolonged heavy menstrual periods. She is pale and states she can no longer exercise. Pelvic exam reveals a single, very large mass. Which of the following diagnostic tests should the clinician order first?

a. Transvaginal ultrasound

b. Endometrial biopsy
c. MRI
d. Abdominal computed tomography scan

__ 23. A 45-year-old woman is seen because of irregular menstrual periods. Her follicle-stimulating hormone (FSH) level is 48 mIU/mL, and her luteinizing hormone (LH) level is elevated. She asks the clinician what this means. Which would be the best response?

a. "You are approaching menopause."
b. "You have a hormonal imbalance."
c. "Your FSH is normal, but your pituitary is making too much LH."
d. "There is an imbalance between your ovaries and pituitary."

____ 24. Which of the following tests is essential for a 46-year-old woman who the clinician suspects is perimenopausal?

a. Pregnancy
b. Estrogen level
c. Progesterone level
d. LH level

____ 25. A 60-year-old woman is seen for an annual checkup. Her obstetric history reveals para 6, gravida 6. She reports that she went through menopause at age 45. Her grandmother died at age 80 of colon cancer, and her father died of lung cancer. What in her history would be a risk factor for ovarian cancer?

a. Her numerous pregnancies
b. Her age at menopause
c. Her father's history of lung cancer
d. Her grandmother's history of colon cancer

__ 26. A 58-year-old woman, who had a total abdominal hysterectomy at the age of 45, is diagnosed with atrophic vaginitis. Which of the following is the most appropriate treatment?

a. Conjugated estrogen, 0.625 mg/day oral
b. Estradiol, 7.5 mcg/24 hr vaginal ring
c. Medroxyprogesterone, 10 mg/day oral
d. Conjugated estrogen, 0.3 mg + medroxyprogesterone 1.5 mg/day oral

True/False

Indicate whether the statement is true or false.

____ 1. Oral contraceptive pills can cause endometrial cancer.

____ 2. A woman taking estradiol is at risk for developing endometrial cancer.

____ 3. Most breast cancer cases are in women with a family history of breast cancer.

Chapter 48. Vaginal, Uterine, and Ovarian Disorders Answer Section

MULTIPLE CHOICE

1. ANS: A PTS: 1
2. ANS: A PTS: 1
3. ANS: C PTS: 1
4. ANS: B PTS: 1
5. ANS: A PTS: 1
6. ANS: B PTS: 1
7. ANS: A PTS: 1
8. ANS: A PTS: 1
9. ANS: A PTS: 1
10. ANS: A PTS: 1
11. ANS: C PTS: 1
12. ANS: B PTS: 1
13. ANS: A PTS: 1
14. ANS: A PTS: 1
15. ANS: B PTS: 1
16. ANS: A PTS: 1
17. ANS: B PTS: 1
18. ANS: B PTS: 1
19. ANS: D PTS: 1
20. ANS: A PTS: 1
21. ANS: D PTS: 1

22. ANS: A PTS: 1

23. ANS: A PTS: 1

24. ANS: A PTS: 1

25. ANS: D PTS: 1

26. ANS: B PTS: 1

TRUE/FALSE

1. ANS: F PTS: 1

2. ANS: T PTS: 1

3. ANS: F PTS: 1

Chapter 49. Prostate Disorders

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. A 63-year-old man is seen in the clinic with a chief complaint of nocturia. Which of the following should be included in the differential diagnosis?

a. Psychogenic nocturia
b. Urethral polyp
c. Irritative posterior urethral lesion
d. Benign prostatic hypertrophy

__ 2. A 76-year-old man is seen in the office for complaints of urinary incontinence. The clinician should explore which of these causes of incontinence in men?

a. Urethral polyps
b. Urinary tract infection (UTI)
c. Anticholinergic medication
d. All of the above

__ 3. A 14-year-old male is seen with complaints of severe testicular pain. The clinician suspects testicular torsion. Which of the following is the appropriate action?

a. Refer to a urologist immediately.
b. Obtain a computed tomography (CT) scan.
c. Instruct the patient to elevate the scrotum.
d. Prescribe ibuprofen.

__ 4. An 82-year-old man is seen in the primary care office with complaints of dribbling urine and difficulty starting his stream. Which of the following should be included in the list of differential diagnoses?
a. Benign prostatic hyperplasia (BPH)
b. Parkinson's disease
c. Prostate cancer
d. All of the above

____ 5. Which of the following would be an appropriate treatment for a patient with mild BPH?
a. Refer to a urologist for surgery.
b. Prescribe a trial of tamsulosin.
c. Recommend cranberry supplements.
d. Reevaluate symptoms in 1 to 3 months.

__ 6. A 30-year-old man is seen with a chief complaint of loss of libido. Which of the following laboratory tests would help establish a diagnosis?
a. Testosterone level
b. Prostate-specific antigen
c. Nocturnal penile tumescence and rigidity
d. Prolactin level

____ 7. Which of the following should be considered in a patient presenting with erectile dysfunction?
a. Diabetes mellitus
b. Hypertension
c. Atherosclerosis
d. All of the above

__ 8. A 35-year-old man presents with complaints of painful erections, and he notices his penis is crooked when erect. What is the most likely diagnosis?
a. Peyronie's disease
b. Damage to the pudendal artery
c. Scarring of the cavernosa
d. All of the above

____ 9. The patient with BPH is seen for follow-up. He has been taking finasteride (Proscar) for 6 months. The clinician should assess this patient for which of these side effects?

a. Erectile dysfunction
b. Glaucoma
c. Hypotension
d. Headache

___ 10. The clinician should prescribe an antibiotic that covers which of these organisms for a patient with acute prostatitis?

a. Gram-positive cocci
b. Gram-negative cocci
c. Gram-positive bacillus
d. Gram-negative bacillus

____ 11. The 56-year-old man with chronic prostatitis should be treated with trimethoprim 80 mg-sulfamethoxazole 400 mg (TMP-SMX, Bactrim) for how long?

a. 3 to 7 days
b. 14 to 21 days
c. 3 to 6 weeks
d. 6 to 12 weeks

___ 12. A 46-year-old man presents with urinary hesitancy and low back pain. He has no history of UTI. Digital rectal examination (DRE) reveals a normal prostate, and a diagnosis of prostatodynia is made. Which is the appropriate treatment?

a. Terazosin 2 mg PO once a day
b. Ice pack to the scrotal area
c. Saw palmetto 320 mg per day
d. All of the above

___ 13. A 23-year-old sexually active man is seen in the clinic with unilateral painful testicular swelling, and he is diagnosed with epididymitis. In order to prescribe the correct drug, the clinician must understand that which of these is the most common causative organism?

a. Escherichia coli
b. Staphylococcus aureus
c. Chlamydia trachomatis
d. Pseudomonas aeruginosa

____ 14. Which test is used to confirm a diagnosis of epididymitis?

a. Urinalysis
b. Gram stain of urethral discharge
c. Complete blood cell count with differential

d. Ultrasound of the scrotum

____ 15. Treatment for epididymitis includes which of the following?
a. Warm sitz baths
b. Scrotal elevation
c. Masturbation
d. All of the above

____ 16. Which of the following data is indicative of testicular torsion?
a. Absent cremasteric reflex
b. Pain relieved on testicular elevation
c. Testicle very low in the scrotum
d. Swollen scrotum with "red dot sign"

__ 17. A 60-year-old man presents with an enlarged scrotum. The clinician uses a penlight to transilluminate the scrotum. In a patient with a hydrocele, what would the clinician expect to find?
a. The scrotum will be dark.
b. The scrotum will appear light pink or yellow.
c. The scrotum will appear milky white.
d. The internal structures will be clearly visible.

__ 18. During a DRE on a 75-year-old man, the clinician suspects the patient has prostate cancer. What physical finding should make the clinician suspicious?
a. An enlarged rubbery gland
b. A hard irregular gland
c. A tender gland
d. A boggy gland

____ 19. A 78-year-old man is diagnosed with C2 prostate cancer, and he asks the clinician what that means. In order to answer the patient, the clinician must have which of these understandings of the Jewett rating system?
a. The cancer involves the seminal vesicles.
b. There is metastatic disease to regional lymph nodes.
c. The cancer is confined to the capsule.
d. There is metastasis to distant organs.

__ 20. A 58-year-old patient has been receiving leuprolide as treatment for prostate cancer. The clinician should instruct the patient about which of these side effects?
a. Risk of osteoporosis
b. May have hot flushes

c. May have impotence
d. All of the above

__ 21. A 22-year-old male is seen in the clinic because he found a hard lump in his testicle when performing testicular self-examination (TSE). Which of the following should be included in the list of differential diagnoses?
a. Testicular cancer
b. Inguinal hernia
c. Varicocele
d. All of the above

____ 22. What is the treatment of choice for a patient diagnosed with testicular cancer?
a. Radical orchidectomy
b. Lumpectomy
c. Radiation implants
d. All of the above

__ 23. A patient with testicular cancer is being followed after completing treatment 1 year ago. He has been symptom-free with no evidence of disease. How often should he have a CT scan?
a. Every month
b. Every 3 to 4 months
c. Every 6 to 12 months
d. Every year

True/False
Indicate whether the statement is true or false.

____ 1. Patients treated for *Neisseria gonorrhoeae* also should be treated for *Chlamydia trachomatis*.

__ 2. Hepatitis A is considered a sexually transmitted infection by the Centers for Disease Control and Prevention.

Chapter 49. Prostate Disorders

Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: B PTS: 1
3. ANS: A PTS: 1
4. ANS: D PTS: 1
5. ANS: D PTS: 1
6. ANS: A PTS: 1
7. ANS: D PTS: 1
8. ANS: A PTS: 1
9. ANS: A PTS: 1
10. ANS: D PTS: 1
11. ANS: D PTS: 1
12. ANS: A PTS: 1
13. ANS: C PTS: 1
14. ANS: D PTS: 1
15. ANS: B PTS: 1
16. ANS: A PTS: 1
17. ANS: B PTS: 1
18. ANS: A PTS: 1
19. ANS: A PTS: 1

20. ANS: D PTS: 1

21. ANS: D PTS: 1

22. ANS: A PTS: 1

23. ANS: B PTS: 1

TRUE/FALSE

1. ANS: T PTS: 1

2. ANS: T PTS: 1

Chapter 50. Penile and Testicular Disorders MULTIPLE

CHOICE

1.The nurse is instructing a client diagnosed with acute prostatitis. Which of the following instructions would be the *least* beneficial to the client?

1.Avoid alcohol and caffeine.
2.Sex should be avoided during the acute phase.
3.Sit for as long as you can.
4.Sitz baths may provide comfort. ANS: 3

The patient should be encouraged to use sitz baths for comfort but not to sit in them for long periods of time. Caffeine, alcohol, and sex should be avoided during the acute phase.

2.The nurse is documenting the health history of a client diagnosed with benign prostatic hyperplasia (BPH). In which of the following areas would the nurse take a careful history?

1.Bowel patterns 2.Eating patterns
3.Sleeping patterns 4.Urinary
patterns

ANS: 4

A careful history on urinary patterns should be taken by the nurse. The ease with which the stream of urine is started, the strength of the stream, and the perceived amount of urine eliminated with each voiding, along with the patients sense about whether the bladder is completely emptied and the presence of nocturia or dribbling, should be noted. The clients bowel, eating, and sleeping patterns are also important; however, they are not as important as the urinary patterns.

3.A client, diagnosed with benign prostatic hyperplasia (BPH), should be instructed to do which of the following?

1.Do nothing since this disorder does not require any follow-up. 2.Decrease water intake to avoid dribbling.
3.Void every 2 to 3 hours. 4.Wear scrotal support.

ANS: 3

Clients with BPH should void every 2 to 3 hours to flush the urinary tract. Water should not be decreased because this will irritate the urinary mucosa. Scrotal support is not necessary, and BPH does require follow-up visits.

4.A client, recovering from a transurethral resection of the prostate (TURP) with a continuous bladder irrigation system to a three-way indwelling urinary catheter, tells the nurse he has to void. What nursing intervention should the nurse perform?

1.Call the physician.
2.Increase the flow of the irrigant.
3.Irrigate the catheter.
4.Tell the client to void. ANS: 3

After a TURP, clots that can occlude the catheter and create a sensation to void in the client are common. The nurse should irrigate the catheter to allow the urine to flow. The nurse does not need to phone the physician, increase the flow of the irrigant, or tell the client to void.

5.A client who is 12 hours postoperative after a transurethral resection of the prostate (TURP) is concerned about the blood clots in the catheter and urinary collection bag. How should the nurse respond?

1.I need to call your physician.
2.I will need to stop the bladder irrigation.
3.Blood clots are common during this time frame and will start to decrease in a day. 4.You need to stop moving and irritating the catheter.

ANS: 3

Blood clots are common during the first 36 hours following a TURP. The irrigant should not be stopped because it is flushing the clots out of the urinary system. A large amount of bright red blood would be an indication of hemorrhage. The nurse does not need to call the physician.

6.A client is being screened for prostate cancer. What tests would be completed at this time?

1.Digital rectal examination and transrectal ultrasonography 2.Biopsy of the prostate and magnetic resonance imagery 3.Complete blood cell count and prostate-specific antigen 4.Prostate-specific antigen (PSA) and digital rectal examination

ANS: 4

Early screening for prostate cancer includes a digital rectal examination and a PSA test. Other tests may be ordered later if either the PSA or digital rectal examination are abnormal.

7.The nurse is instructing a client about testicular self-examination (TSE). Which of the following would *not* be included in these instructions?

1.The testis should feel smooth and egg-shaped. 2.Perform TSE after a bath or shower.
3.TSE should be performed monthly by every male older than age 40. 4.Any lumps and changes in the testicles should be reported.

ANS: 3

The highest risk group for testicular cancer is young men 15 to 35 years of age. TSE should be taught and performed monthly from the teenage years. The other choices are appropriate for the nurse to instruct the client.

8.A male client is diagnosed with orchitis. The nurse should assess the client for which of the following?

1.Recent infection with mumps 2.Recent diagnosis of prostatitis 3.History of type 2 diabetes mellitus 4.Diagnosis of renal insufficiency

ANS: 1

Mumps is the most common viral cause of orchitis, with the orchitis occurring 4 to 7 days after the onset of mumps. Orchitis is not associated with prostatitis, type 2 diabetes mellitus, or renal insufficiency.

9.A client is diagnosed with a spermatocele. The nurse should instruct the client on which of the following?

1.The use of heat to reduce the size of the inflamed area
2.The potential need for surgery to correct the disorder
3.The use of ice packs to reduce the size of the inflamed area
4.The importance of using antibiotics to treat the disorder

ANS: 2

Spermatoceles may become significantly uncomfortable and require treatment. Surgical correction may be done if infertility is associated with the spermatocele. Surgical removal of the spermatocele is performed under local anesthesia. Heat, ice, and antibiotics are not the first line treatments for the disorder.

10.A client is diagnosed with a varicocele. The nurse realizes that this client is likely to develop: 1.hydrocele.
2.prostate cancer.
3.prostatitis.
4.infertility. ANS: 4

Infertility or subinfertility often occurs in conjunction with varicocele because the increased blood flow in the varicocele raises the scrotal temperature about 93.2F, which is the ideal temperature for spermatogenesis. The client is not likely to develop a hydrocele, prostate cancer, or prostatitis from a varicocele.

11.A newborn male child is diagnosed with cryptorchidism. The nurse should prepare to administer which of the following to this client?

1.Intravenous fluids 2.Antipyretic medication
3.Human chorionic gonadotropin medication 4.Antibiotics

ANS: 3

Human chorionic gonadotropin may be given intramuscularly to promote bilateral testicular descent. This medication is provided 2 to 3 times a week for up to 6 weeks. Intravenous fluids, antipyretics, or antibiotics are not indicated in the treatment of this disorder.

12.A client is experiencing priapism. Which of the following should the nurse do first to help the client?

1.Apply ice packs to the perineum. 2.Prepare for emergency surgery.
3.Prepare for an aspiration of blood from the penis. 4.Apply heat to the perineum.

ANS: 1

The goal of treating priapism is to resolve the condition before permanent damage occurs that leaves the client unable to achieve an erection in the future. Ice packs to the perineum will resolve some cases of the disorder. This is what the nurse should do first. The client does not need emergency surgery. The client may need blood aspirated from the penis. Heat should not be applied to the perineum.

MULTIPLE RESPONSE

1.A client is diagnosed with testicular torsion. Which of the following might be indicated for this client? (Select all that apply.)

1.Manually untwist the testicle 2.Orchiopexy
3.Testicle removal 4.Pain management
5.Application of ice and a scrotal support

6.Prescribe medication

ANS: 1, 2, 3, 4, 5

The goal of the treatment for testicular torsion is to untwist the spermatic cord and reestablish normal blood flow to the testicle. The testicle may be manually untwisted to promote blood flow. If this is unsuccessful, the client may need an orchiopexy or a surgical procedure to untwist the testicle. If surgical treatment occurs within 6 hours of the onset of pain, the testicle is salvaged. If treatment is delayed for 12 hours or more, the testicle will begin to necrose and will need to be removed. Pain medication is needed for this disorder. Ice and a scrotal support are used for this disorder. No medications alone will cure this disorder.

2.A client is diagnosed with epididymitis. The nurse should instruct the client on which of the following as treatment for the disorder? (Select all that apply.)

1.Broad spectrum antibiotics 2.NSAIDs
3.Bed rest
4.Elevate the scrotum
5.Apply cold packs
6.Apply heat

ANS: 1, 2, 3, 4, 5

Treatment for epididymitis includes broad spectrum antibiotics, NSAIDs, bed rest, elevation of the scrotum, and application of cold packs. Heat is not recommended as treatment for this disorder.

3.Which of the following should the nurse instruct a client who is recovering from a vasectomy? (Select all that apply.)

1.Use ice packs to control postoperative bleeding. 2.Wear cotton jockey type briefs for scrotal support. 3.Use warm sitz baths to aid in comfort.
4.Recognize the signs and symptoms of postoperative infection.
5.A vasectomy protects the client from sexually transmitted illnesses. 6.Ejaculate will be reduced after the procedure.

ANS: 1, 2, 3, 4

The client recovering from a vasectomy should be instructed to use ice packs to control postoperative bleeding, wear cotton jockey type briefs for scrotal support, use warm sitz baths to aid in comfort, and recognize the signs and symptoms of postoperative infection. A vasectomy does not protect the client from sexually transmitted illnesses. Ejaculate will not be reduced after the procedure.

4.The nurse is assessing a client diagnosed with balanitis and posthitis. Which of the following will the nurse most likely assess in this client? (Select all that apply.)

1.Penile discharge 2.Hematuria
3.Pain 4.Erythema 5.Flank pain
6.Edema

ANS: 1, 3, 4, 6

The typical manifestations for balanitis and posthitis include penile discharge, pain, erythema, and edema. Hematuria and flank pain are not associated with this disorder.

5.The nurse is assessing a client who is experiencing erectile dysfunction. For which of the following should the nurse assess the client? (Select all that apply.)

1.Diagnosis of diabetes mellitus 2.Thyroid disease
3.Chronic renal failure 4.Multiple sclerosis 5.Parkinsons disease
6.Gastroesophageal reflux disease

ANS: 1, 2, 3, 4, 5

Erectile dysfunction has been associated with diabetes mellitus, thyroid disease, chronic renal failure, multiple sclerosis, and Parkinsons disease. Erectile dysfunction has not been associated with gastroesophageal reflux disease.

Chapter 51. Sexually Transmitted Infections

Multiple Choice
Identify the choice that best completes the statement or answers the question.

_____ 1. During data collection the nurse notes the presence of a chancre on a male patients penis. For which sexually transmitted infection should the nurse focus additional data collection?
a. Herpes
b. Syphilis
c. Gonorrhea
d. Chlamydia

_____ 2. A patient is diagnosed with a parasitic infection caused by close contact with another persons genitals. For which infection should the nurse plan care?
a. Phthirus pubis
b. Treponema pallidum
c. Neisseria gonorrhoeae
d. Chlamydia trachomatis

_____ 3. It is documented in the medical record that a patient has gummas. For which sexually transmitted infection should the nurse plan care?
a. Syphilis
b. Gonorrhea
c. Chlamydia
d. Genital herpes

_____ 4. The nurse is assisting with teaching a 22-year-old female patient who is diagnosed with a sexually transmitted infection (STI). She says, I dont understand. My boyfriend always wears a condom. Which understanding by the nurse should guide teaching in this situation?
a. Condoms are a reliable source of protection against STIs.
b. It is a myth that condoms provide any protection against STIs.
c. Condoms can decrease the risk of STIs, but they are not foolproof.
d. Condoms must be used with a spermicide to guarantee protection against STIs.

_____ 5. The nurse is providing care for a patient with genital herpes who has vesicular lesions. What term should the nurse use to describe these lesions to the patient?
a. Warts
b. Rashes
c. Blisters
d. Papules

_____ 6. Human papillomavirus (HPV) produces verrucous growths. What term should the nurse use to describe these lesions to the patient?
a. Warts
b. Rashes
c. Blisters
d. Papules

_____ 7. The nurse is collecting data on a patient with Chlamydia. Which assessment finding should be reported immediately to the RN or physician?
a. Painful urination

b. Red conjunctivae
c. Vaginal discharge
d. Sharp pain at the base of the ribs

_____ 8. Because Trichomonas is relatively large, unusually shaped, and diagnosed quickly, the nurse is asked to assist the physician obtain which type of specimen?

a. Culture
b. Blood test
c. Wet mount
d. Litmus paper

_____ 9. A patient diagnosed with Trichomonas asks the nurse how the diagnosis will affect her risk for cervical cancer. Which response by the nurse is best?

a. Wet-mount slides should be done yearly to help detect cervical cancer.
b. Serological testing will be done to detect tumor proteins and screen for cervical cancer.
c. Papanicolaou smears should be done more frequently because results may be altered by Trichomonas.
d. Culture and sensitivity testing is done with Papanicolaou (Pap) smears every other year to determine if you have cervical cancer.

_____ 10. A patient asks why the physician has recommended systemic interferon treatment for genital warts. Which explanation should the nurse provide to the patient?

a. Interferon can improve liver function.
b. Interferons can increase your red blood cell count.
c. Interferon treatment does not have any side effects.
d. Interferon therapy can attack warts all over the body at the same time.

_____ 11. A patient with hepatitis B virus (HBV) delivers a 6-pound 2-ounce baby boy. Which action should the nurse anticipate will be needed for the infant?

a. Intravenous antibiotics for 12 hours
b. Antiviral eye medication less than 2 hours after birth
c. There is no treatment that is safe and effective for infants.
d. HBV-immune globulin less than 12 hours after birth and then HBV vaccine series

_____ 12. The nurse must bathe a patient with herpes. What is the nurses best protection against contracting sexually transmitted infections (STIs) from patients while providing perineal hygiene?

a. Wearing gloves at all times
b. Washing hands following care
c. Practicing standard precautions
d. Avoiding touching patients who have STIs

____ 13. The nurse is caring for a pregnant woman who is fearful that her unborn child will be born blind because of having a sexually transmitted infection (STI). For which STI should the nurse plan care to prevent ophthalmia neonatorum in the newborn?

a. Syphilis
b. Gonorrhea
c. Genital warts
d. Genital herpes

_____ 14. The nurse is caring for a young woman who is newly diagnosed with genital warts. She states, I heard you can get cancer from STIs. Is that true? Which response by the nurse is correct?

a. No, you cannot get cancer from STIs.
b. Yes, most STIs can lead to cancerous changes if not treated promptly.

c. Yes, some STIs have been linked to cancer, so adequate treatment is very important.
d. No, that is not true, but a diagnosis of cancer does increase the risk of contracting an STI.

_____ 15. The nurse is identifying ways for a young adult to reduce the risk of contracting a sexually transmitted infection (STI). What should the nurse teach about the relationship between consumption of alcohol and immediate risk of contracting an STI?
a. Alcohol may reduce inhibitions.
b. Alcohol increases risk for liver disease.
c. Alcohol lowers the bodys resistance to infection.
d. Alcohol impairs the integrity of the mucous membranes, providing a portal of entry for infection.

_____ 16. The nurse reviews the ways to prevent condom breakage with a patient. Which patient statement indicates that more teaching is necessary?
a. Condoms should never be reused.
b. I should use a water-soluble lubricant.
c. Before I use a condom, I should inflate it and check it for holes and leaks.
d. I should make sure to leave a half inch extra space at the end of the condom.

_____ 17. The nurse is assisting with the admission of a known intravenous drug abuser to a medical unit. In addition to drug abuse, which disorder in the patients history is most consistent with a diagnosis of hepatitis?
a. Jaundice
b. Diabetes mellitus
c. Bowel obstruction
d. Chronic headaches

____ 18. The nurse is teaching a patient the importance of completing treatment for gonorrhea. On which information is the nurse basing this teaching?
a. Gonorrhea is not treatable.
b. Only men experience symptoms; women are usually asymptomatic.
c. Men and women may be asymptomatic and still transmit the infection.
d. Treatment is associated with many serious side effects, so compliance is low.

_____ 19. The nurse is assisting in the preparation of a teaching seminar for adolescents to prevent the development of a sexually transmitted infection (STI). Which nonsexual activity should the nurse teach that may transmit a sexually transmitted infection (STI)?
a. Sharing a cigarette
b. Borrowing a hairbrush
c. Coughing and sneezing
d. Sharing intravenous drug equipment

_____ 20. A patient asks for the best way to prevent contracting a sexually transmitted infection (STI). What response should the nurse make to this patients question?
a. Abstinence
b. Oral contraceptives
c. Condom with spermicide
d. Prophylactic oral antibiotics

_____ 21. A patient diagnosed with genital warts asks how they developed. Which pathogen should the nurse explain as causing genital warts?
a. Sarcoptes scabiei
b. Hepatitis A and B
c. Human papillomavirus

d. Chlamydia trachomatis

_____ 22. The nurse is caring for a 76-year-old retired man who is undergoing evaluation for dementia. What would be an important part of the mans history to report to the physician?

a. The patient has a history of syphilis.
b. The patient was exposed to Chlamydia.
c. The patient has a history of hepatitis B.
d. The patient has a history of genital warts.

_____ 23. A patient is undergoing treatment that involves the burning of lesions with heat or chemical agents. The nurse recognizes that this patient most likely has which condition?

a. Syphilis
b. Chlamydia
c. Hepatitis B
d. Genital warts

____ 24. The nurse is providing care for a newborn. Which intervention should the nurse make to prevent development of ophthalmia neonatorum?

a. Interferon injection
b. Antibiotic eyedrops
c. Vitamin K injection
d. Hepatitis B virus (HBV)-immune globulin

_____ 25. While reviewing a medical record the nurse notes that patient has a strawberry cervix. For which sexually transmitted infection (STI) would the nurse plan care?

a. Gonorrhea
b. Herpes simplex
c. Trichomoniasis
d. Human papillomavirus infection

_____ 26. The nurse is preparing a poster presentation identifying the frequency of sexually transmitted infections (STIs) in the United States. Which STI should the nurse highlight as being the most commonly diagnosed?

a. Gonorrhea
b. Chlamydia
c. Trichomoniasis
d. Human papillomavirus

_____ 27. While assisting a health care provider (HCP) conduct a pelvic examination, the patient complains of severe pain during the bimanual examination. For which health problem should the nurse suspect this patient is going to need care?

a. Syphilis
b. Gonorrhea
c. Pelvic inflammatory disease
d. Human papillomavirus infection

_____ 28. While assisting with care, the nurse counsels the patient diagnosed with a sexually transmitted infection (STI) about notification of sexual partners. Which patient statement indicates the need for further teaching? (Select all that apply.)

a. I can contact my sexual partners myself.
b. Reporting regulations are the same throughout the country.
c. A report form will be completed in my chart that includes a list of my sexual contacts.
d. The public health authority can notify a list of sexual contacts without including my identity.

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

_____ 29. The nurse is assisting with teaching a patient who has been exposed to hepatitis B. Which symptoms should the nurse explain may occur before jaundice appears? (Select all that apply.)
a. Rash
b. Nausea
c. Confusion
d. Dark-colored urine
e. Muscle or joint pain
f. Elevated blood glucose

____ 30. The nurse is reviewing prescribed laboratory tests for a patient demonstrating manifestations of syphilis. What diagnostic tests should the nurse expect to be prescribed for this patient? (Select all that apply.)
a. RPR
b. NAT
c. VDRL
d. ELISA
e. Culture
f. CD4 counts

_____ 31. A 24-year-old woman diagnosed with Chlamydia has been prescribed doxycycline. What should be included in the nurses teaching about the drug treatment? (Select all that apply.)
a. Take this drug with a meal.
b. Do not take with dairy products.
c. Avoid unnecessary exposure to sunlight.
d. Abstain from alcohol for at least 48 hours after treatment.
e. Use birth control methods to ensure you do not become pregnant.

_____ 32. The nurse is teaching a patient about the use of condoms to prevent sexually transmitted infections (STIs). Which information should the nurse include in this teaching? Select all that apply.
a. Condoms can decrease the risk of transmitting STDs.
b. Latex condoms are less likely to break than other types.
c. Inflating the condom prior to use allows for effective inspection.
d. Condoms should be used no more than twice and then discarded properly.
e. Use of a water-soluble lubricant with a condom increases its effectiveness in preventing the spread of an STD.
f. Use of a petroleum-based lubricant with a condom increases its effectiveness in preventing the spread of an STD.

_____ 33. The nurse is providing care for a patient recently diagnosed with Chlamydia. Which information should the nurse recommend be included in patient teaching? (Select all that apply.)
a. Women with Chlamydia may complain of a sore throat.
b. Chlamydia is characterized by the development of chancres.
c. Ophthalmia neonatorum is seen in infants born to women with Chlamydia.
d. Chlamydia can be transmitted sexually and by blood and body fluid contact.
e. The risk of ectopic pregnancy is increased in women with a history of Chlamydia.
f. The Chlamydia virus can lie dormant in the nervous system tissues and reactivate when an individual is under stress or has a compromised immune system.

____ 34. The nurse notes that a patient is diagnosed with vulvovaginitis. What should the nurse

expect when assessing this patient? (Select all that apply.)
a. Vaginal edema
b. Vaginal discharge
c. Areas of ecchymosis
d. Dark brown vaginal bleeding
e. Complaints of vaginal itching and burning

_____ 35. A patient in labor is diagnosed with mucopurulent cervicitis. For which health problems should the nurse anticipate providing care to the newborn? (Select all that apply.)
a. Pneumonia
b. Conjunctivitis
c. Irregular heart rate
d. Flaccid extremities
e. Cyanotic extremities

_____ 36. A patient diagnosed with syphilis reminds the HCP of having an allergy to penicillin. Which medications should the nurse expect to be prescribed for this patient? (Select all that apply.)
a. Gentamicin
b. Amoxicillin
c. Tetracycline
d. Doxycycline
e. Erythromycin

____ 37. While providing a bath the nurse suspects that an older female patient has a Trichomonas infection. What type of discharge did the nurse observe to come to this conclusion? (Select all that apply.)
a. Frothy discharge
b. Foul-smelling discharge
c. Yellow-green discharge
d. Open sores on the labia majora
e. Wart-like growths on the labia minora

Chapter 44. Nursing Care of Patients With Sexually Transmitted Infections
Answer Section

MULTIPLE CHOICE

1. ANS: B
The primary stage of syphilis begins with the entry of the Treponema pallidum spirochete through the skin or mucous membranes. Between 3 and 90 days later, a papule develops at the site of entry, then sloughs off, leaving a painless, red, ulcerated area called a chancre. A. Herpes is associated with vesicular skin lesions. C. D. Gonorrhea and Chlamydia are not associated with skin lesions.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

2. ANS: A
Genital parasites are not a true sexually transmitted infection (STI), but they may be transmitted during close body contact. The two most commonly seen parasites are pubic lice (Phthirus pubis,

commonly called crabs because of the shape of the lice) and scabies (Sarcoptes scabiei). B. C. D. Treponema pallidum, Neisseria gonorrhoeae, and Chlamydia trachomatis are not parasites.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

3. ANS: A
In the tertiary stage of syphilis, the spirochete may form gummas, which are tumors of a rubbery consistency that can break down and ulcerate, leaving holes in body tissues. D. Herpes is associated with vesicular skin lesions. B. C. Gonorrhea and Chlamydia are not associated with skin lesions.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

4. ANS: C
Condoms can greatly decrease the risk of STIs, but condoms can have tiny channels in the rubber (or other elastic material) that can allow microorganisms to pass through. Condoms can break, slip off, or be applied improperly. Petroleum-based lubricants may weaken latex condoms. A. Condoms do not provide a barrier for any area other than the penis and most of the vagina (or anus). B. Some STIs may still be transmitted by contact of surrounding uncovered tissues. D. Spermicide helps protect against pregnancy.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

5. ANS: C
Vesicles are small blisters. A. B. D. Warts, rashes, and papules do not have the same characteristics.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

6. ANS: A
Verrucous means wart-like. B. D. D. HPV causes wart-like growths, not rashes, blisters, or papules.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

7. ANS: D
Fitz-HughCurtis syndrome, a surface inflammation of the liver, can also be caused by C. trachomatis. This inflammation may cause nausea, vomiting, and sharp pain at the base of the ribs that sometimes refers to the right shoulder and arm. A. B. C. Vaginal discharge, painful urination, and conjunctivitis are also concerns but are not as health-threatening as liver inflammation.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis |

8. ANS: C
When wet-mount slides of Trichomonas discharge are viewed under a microscope, the organisms can be identified by their motility and whip-like flagella. A. B. D. Trichomonas is not diagnosed through a culture, blood test, or litmus paper.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

9. ANS: C
Trichomonas may produce abnormal Pap smear readings, which require that more frequent Pap smears be done to provide adequate surveillance of cellular changes. A. Wet mount can identify the organism but not cellular changes. B. D. Serological testing and culture and sensitivity testing are not performed to detect cervical changes caused by Trichomonas.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

10. ANS: D
Systemic interferon treatments attack warts all over the body at the same time, rather than individually as with topical treatments. This speeds the process of treatment. A. B. C. Interferons can produce side effects of flu-like symptoms, a drop in the number of white blood cells, and changes in liver function.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Application

11. ANS: D
It is recommended that all babies of HBV-positive mothers receive HBV immune globulin less than 12 hours after birth and then be immunized with HBV vaccine 1 week, 1 month, and 6 months after birth. A. Antibiotics are not effective against viruses. B. Eye medication may be necessary for gonorrhea or chlamydia. C. The infant needs to receive the HBV vaccination.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

12. ANS: C
A nurses best protection against catching infections from blood and body fluids of infected patients is the strict practice of standard precautions and maintaining his or her own healthy, intact skin. A. Wearing gloves at all times is not appropriate. B. Washing hands is essential but is not sufficient. D. Touching patients cannot and should not be avoided.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

13. ANS: B
Newborns born to mothers who have gonorrhea can develop ophthalmia neonatorum, which involves inflammation of the conjunctiva and deeper parts of the eye and can, ultimately, result in blindness. A. C. D. Syphilis, genital warts, and genital herpes are not associated with infant eye problems.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

14. ANS: C
Herpes, human papillomavirus (HPV), and hepatitis (not most sexually transmitted infections [STIs]) have been associated with cancers. A. Cancer has been associated with some STIs. B Most STIs do not cause cancer. D. Having a diagnosis of cancer does not increase the risk of contracting an STI.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

15. ANS: A
Consumption of alcohol or other psychoactive drugs can reduce inhibitions and may result in unintended sexual encounters, which can transmit STIs. B. C. D. Alcohol does cause liver disease and may indirectly reduce resistance, but these are not the mechanisms by which immediate STI risk increases.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

16. ANS: C
Condoms should never be inflated to test them, because this can weaken them. B. Lubrication decreases the chances of breakage during use, but only water-soluble lubricants should be used, because substances such as petroleum jelly (Vaseline) may weaken the condom. D. Either condoms with a reservoir tip or regular condoms that have been applied while holding approximately 1/2 inch of the closed end flat between the fingertips allow room for expansion by the ejaculate without creating excessive pressure, which might break the condom. A. Condoms should not be reused.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Evaluation

17. ANS: A
Jaundice is a symptom of hepatitis. D. Headaches can be associated with many disorders and are not specific to hepatitis. B. C. Diabetes and bowel obstruction are not associated with hepatitis.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation| Cognitive Level: Analysis

18. ANS: C
B. Men may be asymptomatic or may have urethritis with a yellow urethral discharge. C. Women

who have gonorrhea may have either no noticeable symptoms or have a sore throat, mucopurulent cervicitis (MPC), urethritis, or abnormal menstrual symptoms such as bleeding between periods. A. Gonorrhea is treatable with antibiotics, which have side effects, but not such serious side effects that compliance is affected.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

19. ANS: D
IV drug equipment can transmit some STIs. A. B. C. Sharing a cigarette or hairbrush or coughing and sneezing can spread various infections, but not generally STIs.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Application

20. ANS: A
Abstinence or lifelong monogamy of both sexual partners in a relationship are the only sure prevention against STIs. D. Antibiotics treat but do not prevent STIs. B. Oral contraceptives do not prevent STIs. C. Condoms may help prevent STIs, but they are not completely effective.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Application

21. ANS: C
Condylomata acuminatum (genital warts) is a common sexually transmitted viral infection, and their incidence is increasing rapidly. Infection with human papillomavirus (HPV) produces the condylomata. A, B, and D do not cause warts.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

22. ANS: A
Untreated syphilis can lead to neurosyphilis and neurological changes. B, C, and D do not cause neurological changes.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

23. ANS: D
There is presently no known cure for papillomavirus infection. The warts may be treated by freezing, burning, or chemically destroying them or by manipulating the patients immune system to attack the virus. Cryotherapy (freezing) of the warts may be done by touching each wart with a cryoprobe or a liquid nitrogensoaked swab. Warts may also be burned or electro-coagulated with an electrocautery or a laser. Heat causes the proteins to coagulate, resulting in death of the wart tissue. A. B. Syphilis and Chlamydia are treated with antibiotics. C. Hepatitis B virus may be treated with immune globulins as well as supportive treatment.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Analysis

24. ANS: B
Ophthalmia neonatorum may be prevented by use of antibiotic eye preparations, which contain silver nitrate, erythromycin, or tetracycline. D. HBV immune globulin is given to prevent HPV. C. Vitamin K prevents bleeding. A. Interferon is not used.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

25. ANS: C
Visualization of the cervix during pelvic examination shows a characteristic strawberry cervix with Trichomonas infection. A, B, and D are not associated with a strawberry cervix.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

26. ANS: B
Chlamydia is the most commonly diagnosed STI in the United States. A. C. D. Gonorrhea, Trichomoniasis, and HPV are not the most commonly diagnosed STIs in the United States.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Application

27. ANS: C
With pelvic inflammatory disease, findings during physical examination include adnexal tenderness upon palpation, and pain in the uterus and cervix when moved during a bimanual examination. A. B.
D. Pain during a bimanual examination is not associated with syphilis, gonorrhea, or human papillomavirus infection.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

28. ANS: B
The requirements for reporting STDs may vary for different states, provinces, and countries. C. The report form has spaces for listing sexual contacts who should be notified of possible STD exposure.
A. Depending on the laws of the state, province, or country, HCPs may notify identified sexual contacts or patients may do so themselves. D. Contacts may also be notified by a public health authority that they have been listed as a sexual contact by an anonymous person who has tested positive for a particular STD.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Analysis

MULTIPLE RESPONSE

29. ANS: A, B, E

Early signs of hepatitis are loss of appetite, rashes, malaise, muscle and joint pain, headaches, nausea, and vomiting. D. As the virus affects the liver, the urine may darken and the stool color lightens, liver enzymes may rise, and jaundice may appear. C. Confusion is a late sign of liver disease. F. Glucose abnormalities occur with pancreatic disease.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Application

30. ANS: A, C, D, E

Several tests for syphilis exist, and a combination may be used for accurate diagnosis. Cultures may be done but are difficult to grow. Serological (blood) tests include the Venereal Disease Research Laboratory (VDRL) test, the rapid plasma reagin (RPR) test, and the automated reagin test (ART). Treponemal enzyme-linked immunosorbent assay (ELISA), fluorescent treponemal antibody absorption (FTA-ABS), and polymerase chain reaction (PCR) tests for treponemal DNA are some newer methods that reduce the risk of false results. B. F. NAT is done for Chlamydia. CD4 and CD8 are used to evaluate HIV/AIDS.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

31. ANS: B, C, E

Do not administer doxycycline during pregnancy due to bone/teeth effects. Do not take with antacids or dairy products. Avoid unnecessary exposure to sunlight. A. Administer on an empty stomach. D. Alcohol should be avoided with metronidazole.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Application

32. ANS: A, B, E

Condoms can reduce (but not eradicate) the risk of STDs. Latex condoms are less likely to break during intercourse than other types. Lubrication decreases the chances of breakage during use, but only water-soluble lubricants should be used. F. Substances such as petroleum jelly (Vaseline) may weaken the condom. C. Condoms should never be inflated to test them, because this can weaken them. D/ Condoms should never be reused and should be discarded properly after use so that others will not come in contact with the contents.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Application

33. ANS: D, E

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the United States. It can be transmitted sexually and by blood and body fluid contact. Chlamydia is a frequent cause of pelvic inflammatory infection (PID) and infertility, and it increases the risk of ectopic pregnancy. A. Women who have gonorrhea may have either no noticeable symptoms or have a sore throat. C. Newborns born to mothers who have gonorrhea can develop ophthalmia neonatorum. F. Herpes viruses have an affinity for tissues of the skin and nervous system and can lie dormant in

nervous system tissues and then reactivate periodically when the body undergoes stress, fever, or immune system compromise/ B. Chancres can develop with syphilis.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

34. ANS: A, B, E
Vulvovaginitis is an inflammation of the vulva and vagina and can be asymptomatic or involve redness, itching, burning, excoriation, pain, swelling of the vagina and labia, and discharge. C. D. Ecchymosis and dark brown vaginal bleeding are not manifestations of this disorder.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

35. ANS: A, B
Mucopurulent cervicitis (MPC) is an inflammation of the cervix that may produce a mucopurulent yellow exudate on the cervix or may have no noticeable symptoms. MPC during pregnancy can result in conjunctivitis and pneumonia in newborn infants. C. D. E. MPC does not cause irregular heart rate, or flaccid or cyanotic extremities in the newborn.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentSafety and Infection Control | Cognitive Level: Application

36. ANS: C, D
Penicillin G is the treatment of choice for patients diagnosed with syphilis. For those who are allergic to penicillin, doxycycline and tetracycline are treatment options. A. E Gentamicin and erythromycin are not antibiotics identified to treat syphilis. B. Amoxicillin is a later generation of penicillin and should not be given.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Application

37. ANS: A, B, C
Trichomoniasis is a sexually transmitted infection caused by a protozoan parasite. It can be also be transmitted through nonsexual contact with infected articles because it can survive for a long time outside the body. Carriers of Trichomonas vaginalis can be asymptomatic for several years until changes in vaginal or urethral conditions encourage an outbreak of the infection. Symptoms include redness, swelling, itching, and burning of the genital area; pain with intercourse and voiding; and a frothy, foul-smelling discharge that can be clear, white, yellowish, or greenish. D. Trichomoniasis is not associated with open sores or wart-like growths.

Chapter 52. Common Musculoskeletal Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. One of the initial steps in assessing patients with musculoskeletal complaints is to determine whether the complaint is articular or nonarticular in origin. Which of the following is an example of an articular structure?
a. Bone
b. Synovium
c. Tendons
d. Fascia

__ 2. You have detected the presence of crepitus on examination of a patient with a musculoskeletal complaint. Additionally, there is limited range of motion (ROM) with both active and passive movement. These findings suggest that the origin of the musculoskeletal complaint is:
a. Articular
b. Inflammatory
c. Nonarticular
d. A and B

__ 3. Which of the following signs or symptoms indicate an inflammatory etiology to musculoskeletal pain?
a. Decreased C-reactive protein
b. Hyperalbuminemia
c. Morning stiffness
d. Weight gain

____ 4. Which of the following statements concerning the musculoskeletal examination is true?
a. The uninvolved side should be examined initially and then compared to the involved side.
b. The part of the body that is causing the patient pain should be examined first.
c. When possible, the patient should not be asked to perform active range-of-motion (ROM) exercises to avoid causing pain.
d. Radiographs should always be obtained prior to examination so as not to cause further injury to the patient.

__ 5. You are performing muscle strength testing on a patient presenting with musculoskeletal pain and find that the patient has complete ROM with gravity eliminated. Which numeric grade of muscle strength would you give this patient?

a. 1
b. 2
c. 3
d. 4
e. 5

____ 6. Mrs. Gray is a 55-year-old woman who presents with tightness, pain, and limited movement in her right shoulder. She denies any history of trauma. Her examination reveals a 75% reduction in both active and passive ROM of the right shoulder. Mrs. Gray also is experiencing tenderness with motion and pain at the deltoid insertion. Her medical history is significant for type 1 diabetes mellitus and hypertension. Her social history reveals that she is a secretary and that she is right-handed. Based on her examination and medical history, you suspect adhesive capsulitis, or "frozen shoulder." Which clue in Mrs. Gray's history supports this diagnosis?

a. History of hypertension
b. Her affected shoulder is also her dominant arm.
c. Her history of diabetes mellitus
d. Her work as a secretary predisposes her to repetitive motions.

____ 7. Jennifer is an 18-year-old who comes to the emergency room after a fall during a soccer game. Jennifer explains that she fell on her left side and kept her arm out straight to break her fall. She has been experiencing severe pain and limited ROM in her left shoulder. The clinician has diagnosed Jennifer with a dislocated shoulder. Which of the following statements are true concerning shoulder dislocation?

a. Posterior dislocations are more common than anterior dislocations.
b. There is a risk of neurovascular and neurosensory trauma, so the clinician should check for distal pulses.
c. Recurrent dislocations are uncommon and would require great force to result in injury.
d. Surgery is most commonly the treatment of choice.

____ 8. Mrs. Anderson is a 35-year-old woman who has been recently diagnosed with carpal tunnel syndrome. She has two young children and asks the clinician what the chances are that they also will develop carpal tunnel syndrome. Which of the following responses would be correct regarding the risk of developing carpal tunnel syndrome?

a. Carpal tunnel syndrome commonly occurs in families. Genetic factors are thought to account for about one-half the risk of developing carpal tunnel.
b. Only people with occupations that require repeated flexion extension of the wrist, use of hand tools that require forceful gripping, or use of hand tools that vibrate are at risk for developing carpal tunnel.

c. An underlying musculoskeletal disorder must be present for a person to develop carpal tunnel.
d. Carpal tunnel syndrome only occurs in the presence of a hormonal imbalance.

____ 9. Which of the following statements is true regarding the treatment of carpal tunnel syndrome?
a. The goal of treatment is to prevent flexion and extension movements of the wrist.
b. Splints are used in carpal tunnel syndrome, because they allow for free movement of the fingers and thumb while maintaining the wrist in a neutral position.
c. Corticosteroid injections are discouraged in the treatment of carpal tunnel syndrome because of the risks for median nerve damage, scarring, and infection.
d. All of the above

___ 10. Sam is a 25-year-old who has been diagnosed with low back strain based on his history of localized low back pain and muscle spasm along with a normal neurological examination. As the clinician, you explain to Sam that low back pain is a diagnosis of exclusion. Which of the following symptoms would alert the clinician to the more serious finding of a herniated nucleus pulposus or ruptured disc?
a. Morning stiffness and limited mobility of the lumbar spine
b. Unilateral radicular pain symptoms that extend below the knee and are equal to or greater than the back pain
c. Fever, chills, and elevated erythrocyte sedimentation rate
d. Pathologic fractures, severe night pain, weight loss, and fatigue

____ 11. The clinician has instructed Sam, a 25-year-old patient with low back strain, to use NSAIDs to manage his symptoms of pain and discomfort. Which of the following statements would be most appropriate when teaching Sam about the use of NSAIDs?
a. "You should start with the lowest dose that is effective in managing your pain, because long-term use of NSAIDs can result in gastrointestinal (GI) disorders such as ulcers and hemorrhage."
b. "You should start with the lowest dose that is effective in managing your pain to avoid developing tolerance to the medication."
c. "You should take the maximum recommended dose of NSAIDs so that you will not need to take narcotics to control your pain."
d. "It is important to take NSAIDs on an empty stomach in order to increase absorption."

2. Janet is a 30-year-old who has recently been diagnosed with a herniated disc at the level of L5-S1. She is currently in the emergency room with suspicion of cauda equina compression. Which of the following is a sign or symptom of cauda equina compression?
a. Gastrocnemius weakness
b. A reduced or absent ankle reflex
c. Numbness in the lateral foot

d. Paresthesia of the perineum and buttocks

__ 13. Which of the following statements is true concerning the management of the client with a herniated disc?

a. Muscle relaxants and narcotics can be used to control moderate pain but should be discontinued after 3 weeks of use.
b. An epidural injection is helpful in reducing leg pain that has persisted for at least 3 weeks after the herniation occurred.
c. Intolerable pain for more than a 3-month period is an indication for surgical intervention.
d. All of the above

__ 14. John is a 16-year-old boy who presents to the emergency room after hurting his knee in a football game. He described twisting his knee and then being unable to extend it completely. John tells the clinician that he heard a pop when the injury occurred and has been experiencing localized pain. The clinician suspects a meniscal tear. Which test would be most appropriate to assess for the presence of a meniscal tear?

a. Valgus stress test
b. McMurray circumduction test
c. Lachman test
d. Varus stress test

__ 15. The clinician suspects that a client has patellar instability. In order to test for this, the client is seated with the quadriceps relaxed, and the knee is placed in extension. Next the patella is displaced laterally, and the knee flexed to 30°. If instability is present, this maneuver displaces the patella to an abnormal position on the lateral femoral condyle, and the client will perceive pain. Testing for patellar instability in this way is known as:

a. Apprehension sign
b. Bulge sign
c. Thumb sign
d. None of the above

____ 16. The clinician is caring for Diane, a 22-year-old woman who presents with an injured ankle. Diane asks the clinician if she will need an x-ray. The clinician explains to Diane that an x-ray is not always necessary for an injured ankle and that the decision to obtain radiographs is dependent on the examination and Diane's description of her injury. Which of the following clues in Diane's examination or history would alert the clinician to the need for obtaining radiographs?

a. Inability to bear weight immediately after the injury
b. Development of marked ankle swelling and discoloration after the injury
c. Crepitation with palpation or movement of the ankle
d. All of the above

__ 17. Mr. Jackson is a 65-year-old man recently diagnosed with osteoarthritis. The clinician has explained to Mr. Jackson that the goals for managing osteoarthritis include controlling pain, maximizing functional independence and mobility, minimizing disability, and preserving quality of life. Mr.
Jackson explains to the clinician that his first choice would be to use complementary therapies to control his condition and asks what therapies are most effective in treating osteoarthritis. What would be the most appropriate response from the clinician?

a. "Complementary therapies should be considered only if surgical interventions are not successful."
b. "I am unfamiliar with the available complementary therapies for osteoarthritis and prefer to discuss more mainstream treatments, such as NSAIDs and physical therapy, to manage your condition."
c. "I would be happy to discuss all the treatment options available to you. Complementary therapies, such as acupuncture, acupressure, and tai-chi, are being studied for use in the treatment of osteoarthritis and have shown promise when used with standard medical therapy."
d. "It would be crazy to use complementary therapies to treat such a serious condition."

__ 18. Normal estrogen function is important for preventing osteoporosis in both men and women. Estrogen works to prevent osteoporosis in which of the following ways?

a. By decreasing the erosive activity of osteoclasts
b. By promoting osteoclastogenesis
c. By inhibiting osteoclast apoptosis
d. All of the above

__ 19. Which of the following tests is considered the gold standard for definitively diagnosing osteoporosis?

a. Bone alkaline phosphatase levels
b. Urinary *N*-telopeptide assay
c. Bone mass density measurement by densitometry
d. Magnetic resonance imaging

____ 20. What is the recommended daily calcium intake for adults over the age of 50 with low bone mass?

a. 1,200 mg/day
b. 1,000 mg/day
c. 1,300 mg/day
d. 1,500 mg/day

__ 21. Mrs. Allen is a 60-year-old woman who has been diagnosed with osteoporosis. She is very concerned about the risk of breast cancer associated with hormone replacement therapy and is wondering what other treatments are available to her. The clinician explains that bisphosphonates are another class of drugs used in the prevention and treatment of osteoporosis. What teaching should the clinician give Mrs. Allen in regard to taking bisphosphonates?

a. Taking bisphosphonates can result in hypercalcemia, so calcium intake should be decreased while taking this class of drugs.
b. There is potential for upper GI irritation, so these medications are contraindicated in people with abnormalities of the esophagus or delayed esophageal emptying.
c. This class of drugs can be taken at any time of the day without regard to meals.
d. None of the above

__ 22. Which stage of Paget's disease is characterized by elevated numbers of osteoblasts, resulting in abnormal increases in bone remodeling and leading to an irregular deposition of collagen fibers?

a. Lytic
b. Mixed
c. Sclerotic
d. All of the above

____ 23. Which of the following statements concerning the treatment of fibromyalgia syndrome is true?

a. There is currently no cure for the disorder; however, patients should be made aware that symptom relief is possible.
b. Treatment is directed toward controlling discomfort, improving sleep, and maintaining function.
c. Fibromyalgia syndrome can be difficult to manage, requiring a variety of approaches and multiple medications.
d. All of the above

____ 24. One of the most frequent presenting signs/symptoms of osteoporosis is:

a. Goiter
b. Abnormal serum calcium
c. Elevated urine biochemical markers
d. Bony fracture

__ 25. Mrs. Thomas was seen in the office complaining of pain and point tenderness in the area of her elbow. The pain has increased following a day of gardening one week ago. A physical finding that differentiates the diagnosis and is most consistent with lateral epicondylitis (tennis elbow) is:

a. Ecchymosis, edema, and erythema over the lateral epicondyle
b. Pain at the elbow with resisted movements at the wrist and forearm
c. Inability to supinate and pronate the arm
d. Inability to flex or extend the elbow against resistance

__ 26. A 70-year-old female has fallen 2 weeks ago and developed immediate pain in her left wrist. She thought she just bruised it but is worried because it has not improved. She has used Tylenol® and ice at home, and that has helped slightly. You examine her and find she has moderate swelling and ecchymosis but no overtly obvious deformity. Her ROM is uncomfortable and severely diminished due to the pain. No crepitus is heard or felt. Her fingers are warm; her pulse is strong; and capillary refill is less than 2 seconds. What should you do?

a. Make an immediate referral for an orthopedic evaluation without further assessment.
b. Tell her that it takes time for these bruises to improve, so she should be patient.
c. Obtain a wrist x-ray and place her wrist in a splint or prescribe a splint.
d. Send her to the emergency room for reduction of this obvious wrist fracture.

True/False

Indicate whether the statement is true or false.

____ 1. Osteoarthritis is primarily a noninflammatory condition.

____ 2. The presence of a positive rheumatoid factor is always indicative of rheumatoid arthritis.

Chapter 52. Common Musculoskeletal Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: A PTS: 1
3. ANS: C PTS: 1
4. ANS: A PTS: 1
5. ANS: B PTS: 1
6. ANS: C PTS: 1
7. ANS: B PTS: 1
8. ANS: A PTS: 1
9. ANS: D PTS: 1
10. ANS: B PTS: 1
11. ANS: A PTS: 1
12. ANS: D PTS: 1
13. ANS: C PTS: 1
14. ANS: B PTS: 1
15. ANS: A PTS: 1
16. ANS: D PTS: 1
17. ANS: C PTS: 1
18. ANS: A PTS: 1
19. ANS: C PTS: 1
20. ANS: D PTS: 1

21. ANS: B PTS: 1

22. ANS: B PTS: 1

23. ANS: D PTS: 1

24. ANS: D PTS: 1

25. ANS: B PTS: 1

26. ANS: C PTS: 1

TRUE/FALSE

1. ANS: T PTS: 1

2. ANS: F PTS: 1

Chapter 53. Spinal Disorders

1.The nurse is caring for a home health patient who had a spinal cord injury at C5 three years ago. The nurse bases the plan of care on the knowledge that the patient will be able to:

a.	feed self with setup and adaptive equipment.
b.	transfer self to wheelchair.
c.	stand erect with full leg braces.
d.	sit with good balance.

ANS: A

A cord injury at C5 allows for ability to drive an electric wheelchair with mobile hand supports and feed self with adaptive equipment.

2.A frantic family member is distressed about the flaccid paralysis of her son following a spinal cord injury several hours ago. What does the nurse know about this condition?

a.	It is an ominous indicator of permanent paralysis.
b.	It is possibly a temporary condition and will clear.
c.	It degenerates into a spastic paralysis.
d.	It will progress up the cord to cause seizures.

ANS: B

A period of flaccid paralysis following a cord injury is called areflexia, or spinal shock, and may be temporary.

3.A patient with a spinal cord injury at T1 complains of stuffiness of the nose and a headache. The nurse notes a flushing of the neck and goose flesh. What should be the primary nursing intervention based on these assessments?

a.	Place patient in flat position and check temperature
b.	Administer oxygen and check oxygen saturation
c.	Place on side and check for leg swelling
d.	Sit upright and check blood pressure

ANS: D

These are indicators of autonomic dysreflexia or hyperreflexia. It is a medical emergency. The patient should be placed in an upright position to decrease blood pressure and the blood pressure should be checked. Assessments for impaction, full bladder, or a urine infection can help to evaluate this condition.

4.The nurse is aware that the characteristic gait of the person with Parkinson disease is a propulsive gait, which causes the patient to:

a.	stagger and need support of a walker.
b.	shuffle with arms flexed.
c.	fall over to one wide when walking.
d.	take small steps balanced on the toes.

ANS: B

The propulsive gait causes the patient to shuffle with his arms flexed and with a loss of postural reflexes.

5.The newly admitted patient to the emergency room after a motorcycle accident has serosanguineous drainage coming from the nose. What is the most appropriate nursing response to this assessment?

a.	Cleanse nose with a soft cotton-tipped swab
b.	Gently suction the nasal cavity
c.	Gently wipe nose with absorbent gauze
d.	Ask patient to blow his nose

ANS: C

The patients ear and nose are checked carefully for signs of blood and serous drainage, which indicate that the meninges are torn and spinal fluid is escaping. No attempt should be made to clean

out the orifice or to blow the nose. The drainage can be wiped away. The drainage can be tested for the presence of glucose, which would confirm that the fluid is spinal fluid and not mucus.

6.How would the nurse instruct a patient with Parkinson disease to improve activity level?

a.	To use a soft mattress to relax the spine
b.	To walk with a shuffling gait to avoid tripping
c.	To walk with hands clasped behind back to help balance
d.	To sit in hard chair with arms for posture control

ANS: C

The patient with Parkinson disease can improve the activity level by sleeping on a firm mattress without a pillow to prevent spinal curvature, hold hands clasped behind to keep better balance, and keep the arms from hanging stiffly at the side. Walk with a lifting of the feet to avoid tripping and freezing.

Chapter 54. Soft-Tissue Disorders

_ 1. The nurse is contributing to the plan of care for a patient who has a right fractured femur. What intervention should the nurse include in the plan of care to prevent fat emboli?

a. Decrease dietary consumption of fats.
b. Maintain immobilization of the right leg.
c. Encourage coughing and deep breathing hourly.
d. Perform passive range of motion on the right leg.

_____ 2. A patient has an open reduction of a radial fracture and is casted. Several hours after the operation, the patient reports a throbbing pain in the arm. What nursing action is essential for the nurse to take?

a. Reposition arm.
b. Perform neurovascular checks.
c. Administer analgesics as ordered.
d. Notify the physician immediately.

_____ 3. The nurse is monitoring a patient with a casted left tibial fracture and a contusion of the thigh. The patient reports increasing pain in the left foot that has not been relieved by morphine injections. What should the nurse do?

a. Reposition the casted leg.
b. Repeat the morphine injection now.
c. Give a higher ordered dose of morphine.
d. Ensure physician is immediately notified.

_____ 4. The nurse finds a 2-day postoperative patient who had a right total hip replacement lying supine with crossed legs. What data should the nurse collect on this patient?

a. The right leg for shortening
b. The right knee for crepitation

c. The left leg for internal rotation
d. The left leg for loss of function

_____ 5. The nurse is caring for a patient who had a closed reduction of the ulna with a cast applied. Later the patient reports left arm pain. What should the nurse do first?
a. Pad the edges of the cast.
b. Notify the physician immediately.
c. Administer an analgesic as ordered.
d. Perform neurovascular check on fingers.

_____ 6. The nurse is reinforcing teaching provided to a patient recovering from right total hip replacement. Which patient statement indicates a correct understanding of the teaching?
a. Keep legs apart.
b. Lie prone in bed.
c. Move right leg closer to the left leg.
d. Do not bear any weight on the left leg.

_____ 7. A patient with a casted, fractured left leg asks why the leg has to be elevated. What should the nurse respond to this patient?
a. Decreases swelling.
b. Prevents cast cracking.
c. Increases your comfort.
d. Allows the cast to dry evenly.

_____ 8. The nurse is caring for a patient who has had a right hip replacement. For which position is the nurse attempting to achieve when a pillow is placed between the legs during turning?
a. Flexion of the knees
b. Abduction of the thighs
c. Adduction of the hip joint
d. Hyperextension of the knees

_____ 9. The nurse sees a neighbor fall and fracture a leg. What should the nurse do first for the neighbor?
a. Assess pain.
b. Transport to an emergency department.
c. Cover site of open fracture with clean dressing.
d. Immobilize the affected limb using minimal movement.

_____ 10. The nurse is reinforcing teaching provided to a patient with rheumatoid arthritis (RA). Which patient statement indicates understanding of the symptoms of RA?
a. Fatigue
b. Paralysis
c. Crepitation
d. Shortness of breath

_____ 11. A patient with a 36-hour-old fractured femur is in traction and is prescribed morphine 10 mg every 3 hours as needed. The patient received a dose 3 hours ago and is now reporting a pain level of 8. The patient is stable. Which action should the nurse take?
a. Hold medication.
b. Notify the registered nurse (RN).
c. Give pain medication as ordered.
d. Give pain medication in 30 minutes.

____ 12. The nurse is caring for a patient who has a newly casted, fractured wrist. Data collection

reveals slightly puffy fingers with good capillary refill. What should the nurse do now to prevent complications?

a. Notify the RN.
b. Apply heat to the cast.
c. Elevate the cast on pillows.
d. Remove the pillow under the cast.

_____ 13. A patient with gout has been instructed on the prescribed medication allopurinol (Zyloprim). Which patient statement indicates understanding of the action of this medication?

a. Excretes proteins.
b. Blocks formation of uric acid.
c. Increases formation of purines.
d. Increases metabolism of purines.

____ 14. The nurse is evaluating teaching provided to a patient with gout. Which patient menu selection indicates that additional teaching is required?

a. Pike
b. Bass
c. Perch
d. Sardines

____ 15. The nurse is reinforcing teaching provided to a patient with gout. Which food should the patient state will be avoided that indicates teaching has been effective?

a. Rice
b. Beets
c. Liver
d. Bananas

____ 16. The nurse is contributing to the plan of care for a patient with Pagets disease. Which outcome should the nurse identify as being appropriate for this patient?

a. Gain 5 lb weekly.
b. Intake equals output.
c. Identify coping skills.
d. Pain is relieved at a satisfactory level.

____ 17. The nurse is contributing to the plan of care for a patient who has a fractured hip and is placed in Bucks (boot) traction while awaiting surgery. What is the desired outcome for placing the patient in Bucks traction?

a. Restrain patient.
b. Realign fracture.
c. Relieve patient pain.
d. Maintain fracture reduction.

____ 18. The nurse is reinforcing teaching for a patient who has had a total hip replacement on correct sitting positions. Which position should the nurse teach the patient to avoid?

a. Crossing legs
b. Elevating legs
c. Flexing ankles
d. Extending knees

____ 19. The nurse is contributing to the plan of care for a patient who has an upper extremity amputation. Why should the nurse keep in mind that this type of amputation can be more debilitating than a lower extremity amputation when planning care?

a. The upper extremity is more visible.
b. Prosthetic fitting is easier for the leg.
c. The upper extremity is more specialized.
d. There is greater blood supply to the upper extremity.
____ 20. The nurse observes a petechial rash and respiratory distress in a patient recovering from a fractured femur. What should these findings suggest to the nurse?
a. Infection
b. Pneumonia
c. Fat embolism
d. Pleural effusion
____ 21. A patient who has a displaced mid-shaft fracture of the left femur and is in balanced suspension skeletal traction with 35 pounds of weights is experiencing calf pain with right foot dorsiflexion. Which action should the nurse take?
a. Notify the RN.
b. Check the traction setup.
c. Reduce 5 pounds of weight.
d. Encourage dorsiflexion more frequently.
____ 22. The nurse is contributing to the plan of care for a patient who is scheduled for a below-the-knee amputation. What nursing diagnosis should be recommended for the preoperative plan of care?
a. Anxiety
b. Self-Care Deficit
c. Fluid Volume Deficit
d. Ineffective Airway Clearance
____ 23. The nurse is reinforcing teaching on positioning for a patient after a right total knee replacement. Which patient statement indicates a correct understanding of the teaching?
a. Prone.
b. Side lying.
c. Supine with pillow under right knee.
d. Supine with three pillows between legs.
____ 24. The nurse is reinforcing teaching provided to a patient for carpal tunnel syndrome treatment. Which patient statement indicates a correct understanding of the teaching?
a. Bedrest.
b. Arm sling.
c. Wrist splint.
d. Hand exercises.
____ 25. A patient with a fractured pelvis and a left acetabular fracture is prescribed bedrest. When the patient asks to toilet, which measure would be appropriate?
a. Help patient up on a commode very carefully.
b. Turn patient onto right side, place the bedpan behind, and turn back.
c. Have patient sit up as high as possible and lift self up with hands pushing on the bed, then slide the bedpan underneath.
d. Ask patient to lift straight up using a trapeze mounted above the bed and slide a bedpan underneath from the right side.
____ 26. The nurse is caring for a patient with gout. Which laboratory value should the nurse review which indicates that the treatment plan is effective?
a. Uric acid: 7.9 mg/dL

b. Creatinine: 0.8 mg/dL
c. Blood urea nitrogen: 15 mg/dL
d. Low-density lipoprotein (LDL): 115 mg/dL

_____ 27. The nurse is reinforcing teaching provided to a patient who is postmenopausal, has lost 2 inches of height, and has osteoporosis. Which patient statement indicates correct understanding of the purpose of calcium supplements?

a. To decrease bone loss
b. To increase energy levels
c. To decrease serum calcium
d. To increase excretion of calcium

_____ 28. A patient is completing instructions about complications that can occur from osteoporosis. Which complication should the patient state as evidence that teaching has been effective?

a. Hip fracture.
b. Overgrowth of bone.
c. Bone spur formation.
d. Increased bone density.

_____ 29. The nurse is reviewing data collected during the health history for a patient with osteoporosis. What should the nurse identify as a risk factor for osteoporosis development?

a. Daily use of antacid
b. Walking 1 mile daily
c. Increased caffeine intake
d. Increased dairy food intake

_____ 30. The nurse reinforces medication teaching provided to a patient with rheumatoid arthritis. Which medication should the patient identify as helpful to control the symptoms of the health problem?

a. Digoxin.
b. Ibuprofen.
c. Morphine.
d. Penicillin.

_____ 31. The nurse checks a patients casted right leg resting upon a pillow and finds that the cast appears too tight. What should the nurse do?

a. Notify the RN.
b. Administer pain medication.
c. Apply an extra blanket to the leg.
d. Remove the pillow under the cast.

____ 32. The nurse is contributing to the plan of care for a patient who has a bone fracture that is splintered and has shattered into numerous fragments. Which term should the nurse use to document this type of fracture?

a. Impacted
b. Avulsion
c. Greenstick
d. Comminuted

____ 33. The nurse reinforces teaching on prevention of osteomyelitis with a patient who has an open fracture of the right leg. Which patient statement indicates that teaching has been effective?

a. Apply ice to right leg.
b. Keep leg immobilized.

c. Increase calcium intake in diet.
d. Wash hands prior to touching fracture area.

____ 34. An 87-year-old female with a history of osteoarthritis reports an average generalized pain score of 4 on a 0-to-10 scale while using acetaminophen prn. Which response about this pain level should the nurse make to the patient?

a. Do you take a daily calcium supplement?
b. Im glad the acetaminophen is working for you.
c. Are you satisfied with this level of pain control?
d. Research shows that acetaminophen is not really effective for osteoarthritis pain.

_____ 35. A patient is diagnosed with osteomyelitis of the right lower leg. What should the nurse expect to be prescribed for this patients care?

a. Anticoagulant therapy
b. Casting of the extremity
c. Fasciotomy of the wound
d. Long-term antibiotic therapy

Multiple Response

Identify one or more choices that best complete the statement or answer the question.

_____ 36. A patient 48 hours after surgery for a fractured femoral shaft is experiencing mental confusion, tachycardia, tachypnea, and dyspnea. The patients blood pressure is elevated and petechiae are present on the chest. After reporting the findings to the RN what should the nurse do while awaiting the physicians specific orders? (Select all that apply.)

a. Administer oxygen.
b. Prepare patient for arterial blood gas tests.
c. Prepare patient for chest x-ray or lung scan.
d. Maintain bedrest and keep movement to a minimum.
e. Ask patient to move affected limb to see if pain is worse.
f. Place patient in high Fowlers position or raise the head of the bed.

_____ 37. A patient asks the difference between osteoarthritis and rheumatoid arthritis. What manifestations should the nurse explain are characteristic of rheumatoid arthritis? (Select all that apply.)

a. Low-grade fever
b. Heberdens nodes
c. Autoimmune disease
d. Activity increases pain
e. Early morning stiffness
f. Involvement of other major organs

_____ 38. The nurse is collecting data from a patient suspected of developing a fat embolus from a fracture of the right femur. Which manifestations should the nurse expect? (Select all that apply.)

a. Petechiae
b. A migraine
c. Tachycardia
d. Mental confusion
e. Numbness in the right leg
f. Muscle spasms in the right thigh

_____ 39. The nurse is caring for a patient in traction. Which actions are appropriate when caring for this patient? (Select all that apply.)

a. Allow weights to hang freely in place.
b. Use assistance to reposition the patient in bed.
c. Hold weights up if the patient is shifting position in bed.
d. Remove weights if the patient is being moved up in bed.
e. Lighten weights for short periods if the patient reports pain.

_____ 40. The nurse is contributing to the plan of care for a patient recovering from total hip replacement. Which exercises should the nurse recommend to help prevent deep vein thrombosis (DVT) formation? (Select all that apply.)

a. Foot circles
b. Toe touches
c. Heel pumping
d. Deep knee bends
e. Quadriceps setting
f. Straight leg raises (SLRs)

_____ 41. A patient in the ambulatory clinic is diagnosed with a muscle strain. What actions should the nurse instruct the patient to do to treat this injury? (Select all that apply.)

a. Rest the limb.
b. Elevate the limb.
c. Apply heat for 1 hour.
d. Apply ice to the area.
e. Wrap with an elastic bandage.

_____ 42. The nurse is caring for a patient with a minor rotator cuff shoulder injury. What should the nurse emphasize when reviewing care with this patient? (Select all that apply.)

a. Apply ice
b. Rest the shoulder
c. Take NSAIDs as prescribed
d. Begin out-patient physical therapy
e. Use 2 lb hand weights for exercising

_____ 43. During a health history the nurse becomes concerned that a patient is at risk for developing osteoporosis. Which modifiable risk factors did the nurse use to come to this conclusion? (Select all that apply.)

a. Small boned
b. Postmenopausal
c. Cigarette smoking
d. Sedentary lifestyle
e. Low calcium intake

_____ 44. The nurse is assisting in the development of an educational seminar on prevention of osteoporosis for a group of community members. Which actions should the nurse suggest be included in this presentation? (Select all that apply.)

a. Drink one cup of caffeinated coffee each day
b. Ensure an adequate intake of calcium each day
c. Participate in weight-bearing exercise every day
d. Wear well-supporting nonskid shoes at all times
e. Consider participating in resistance exercise training

Chapter 54. Soft-Tissue Disorders

MULTIPLE CHOICE

1. ANS: B
Prevention of fat emboli includes keeping the fracture immobilized and hydrating the patient to help dilute and excrete any fat that may escape from the fractured bone. A. Decreasing the consumption of fat will not help prevent fat emboli. C. D. Deep breathing and coughing and performing passive range of motion will not prevent the development of fat emboli.

2. ANS: B
The nurse should begin with data collection to determine what the next action to take. For this patient the nurse should perform neurovascular checks. A. The arm might need to be positioned however this should not be done until a neurovascular check is completed. C. Administering pain medication might be indicted however should not be done until a pain assessment is completed. D. The nurse needs to determine the patients neurovascular status before notifying the physician.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

3. ANS: D
The early symptom of acute compartment syndrome is the patients report of severe, increasing pain that is not relieved with narcotics, so the physician should be notified. A. B. C. These actions might be done if prescribed by the physician.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

4. ANS: A
Crossing the legs puts the hip at risk for dislocation. Symptoms are pain in the affected hip, shortening of the leg, and possibly rotation of the surgical leg. B. The patient did not have surgery on the right knee. C. D. The patient did not have surgery to the left limb.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

5. ANS: D
The nurse should begin with data collection to determine what the next action is to take. The nurse should perform a neurovascular check. A. The edges of the cast may need to be padded if this is the cause of the patients pain. B. The physician should not be notified until neurovascular checks are performed. C. The nurse needs to assess the patients pain level before providing an analgesic.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

6. ANS: A
Prevention of dislocation is a major nursing responsibility. Correct positioning of the surgical leg is

critical. The primary goals are to prevent hip adduction which is done by keeping the legs apart. B. C. D. These actions will not prevent hip adduction.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

7. ANS: A
A casted limb is elevated for 24 to 48 hours, and ice can be applied above and below the cast to reduce swelling. B. C. D. The limb is not elevated to prevent cast cracking, promote comfort, or to allow the cast to dry evenly.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

8. ANS: B
A trapezoid-shaped abduction pillow (sometimes called a triangular pillow), splint, wedge, or regular bed pillows may be used between the legs to maintain abduction and prevent adduction. Some research, however, indicates that these precautions may not be necessary and may slow recovery. A. D. The pillow is not used to support knee flexion or hyperextension. C. Adduction of the hip joint is to be prevented.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

9. ANS: D
For emergency care of a suspected fracture, do not try to reposition the limb. Splint it as it lies and ensure that the limb is secured above and below the break to minimize movement and bone grating.
A. B. C. Then cover site, transport, and assess pain level.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

10. ANS: A
Because of the systemic nature of RA, in addition to pain and joint involvement, the patient may have a low-grade fever, malaise, depression, lymphadenopathy, weakness, fatigue, anorexia, and weight loss. B. C. D. Paralysis, crepitation, and shortness of breath are not manifestations of RA.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

11. ANS: C
The data collection findings are normal. Since it is time for the pain medication and the patient is in pain, the medication can be given. A. B. D. There is no need to hold the medication, notify the RN, or wait to give the medication in 30 minutes.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Application

12. ANS: C
A casted limb is elevated for 24 to 48 hours, and ice can be applied above and below the cast to reduce swelling. A. The RN does not need to be notified. B. Heat should not be applied at this time.
D. The pillow should not be removed from under the cast.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

13. ANS: B
Allopurinol decreases uric acid production. A. C. D. Allopurinol (Zyloprim) does not excrete proteins or increase the formation or metabolism of purines.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Analysis

14. ANS: D
The patient should avoid high-purine (protein) foods, such as organ meats, shellfish, and oily fish (e.g., sardines). A. B. C. These food items would be appropriate for the patient being treated for gout.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Analysis

15. ANS: C
The patient should be instructed to avoid high-purine (protein) foods such as organ meats, shellfish, and oily fish. A. B. D. Rice, beets, and bananas do not need to be avoided.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Analysis

16. ANS: D
Pain control is a major issue with many patients with Pagets disease. The outcome stating that pain is relieved at a satisfactory level is the most appropriate for this patient. A. B. C. Outcomes that address weight gain, intake and output, and coping skills are not necessarily appropriate for this patient.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Analysis

17. ANS: C
Bucks traction does not promote bone alignment or healing but is used instead for relief of painful muscle spasms that often accompany fractures. A. Traction is not used to restrain a patient.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Analysis

18. ANS: A
Legs should be kept abducted (away from center of body), so legs should not be crossed. B. C. D. These positions do not need to be avoided for the patient with a total hip replacement.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

19. ANS: C
Upper extremity amputations are usually more significant than lower extremity amputations as the arms and hands are necessary for performing activities of daily living. A. B. D. Upper extremity amputations are not more debilitating because the upper extremity is more visible, the prosthetic fitting is easier for the leg, or because of a greater blood supply to the upper extremities.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

20. ANS: C
The earliest manifestation of fat embolism syndrome is altered mental status from a low arterial oxygen level. The patient then experiences tachycardia, tachypnea, fever, high blood pressure, severe respiratory distress, and petechiae. A. B. D. These findings are not manifestations of infection, pneumonia, or pleural effusion.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

21. ANS: A
Calf pain on dorsiflexion can indicate a thrombophlebitis (Homans sign). The RN should be informed. B. The nurse should not take the time now to check the traction setup. C. Traction weight cannot be reduced without a physicians order. D. The patient should not be encouraged to exercise the limb now since a thrombophlebitis might be present.

PTS: 1 DIF: Moderate
KEY: Client Need: Safe and Effective Care EnvironmentManagement of Care | Cognitive Level: Application

22. ANS: A
Patients facing surgery and especially a body image changing surgery such as amputation will experience anxiety. Interventions to aid with this anxiety should be planned. B. C. D. These would be appropriate after surgery has occurred.

PTS: 1 DIF: Moderate
KEY: Client Need: Psychosocial Integrity | Cognitive Level: Application

23. ANS: C
The patient lies supine with pillow under right knee if a continuous passive motion (CPM) machine is not used after a total knee replacement. A. B. D. The patient recovering from a total knee replacement does not need to be placed in the prone, side lying, or supine position with pillows between the legs.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Analysis

24. ANS: C
The wrist is rested to reduce inflammation, and a wrist splint may be prescribed to do this. A. B. D. Bedrest, an arm sling, and hand exercises are not indicated for treatment of this syndrome.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Analysis

25. ANS: D
The nurse should ask the patient to lift straight up using a trapeze mounted above the bed and slide a bedpan underneath from the right side to avoid the left fracture. A. The patient is on bedrest so a bedside commode is not appropriate. B. The patient should not be turned. C. The patient should be instructed to use the trapeze and not attempt to push self up using the bed.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Application

26. ANS: A
The diagnosis of gout is based on an elevated serum uric acid level which is a waste product resulting from the breakdown of proteins. Urate crystals, formed because of excessive uric acid buildup, are deposited in joints and other connective tissues, causing severe inflammation. B. C. D. Creatinine, blood urea nitrogen, and lipoprotein levels are not used in the diagnosis or treatment of gout.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

27. ANS: A
If serum calcium falls below normal levels, the parathyroid glands stimulate the bone to release calcium into the bloodstream. The result is demineralized bone. Therefore, calcium supplements are used. B. C. D. Calcium is not taken to increase energy levels, decrease serum calcium, or to increase the excretion of calcium.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Analysis

28. ANS: A
Osteoporotic bone may cause a pathological fracture in which the hip breaks before the fall. For other patients, a fall can cause a hip or other fracture. B. C. D. Bone overgrowth, spurs, or increases in bone density are not complications of osteoporosis.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

29. ANS: C
A risk factor for osteoporosis is excessive caffeine intake or alcohol. A. B. D. Antacids, walking, and dairy intake are not risk factors for the development of osteoporosis.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Application

30. ANS: B
Ibuprofen (an NSAID) blocks activity of the enzyme cyclooxygenase, which makes prostaglandins that produce inflammation, fever, and pain found in rheumatoid arthritis. A. Digoxin is a cardiac medication. C. Morphine is an opioid which may not help reduce inflammation. D. Penicillin is an antibiotic, used to treat bacterial infections.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPharmacological and Parenteral Therapies | Cognitive Level: Analysis

31. ANS: A
The nurse should notify the RN. A serious complication of a cast being too tight is compartment syndrome. The physician needs to be contacted for orders to cut the cast with a cast cutter to relieve pressure and prevent pressure necrosis of the underlying skin. B. There is no information to support that the patient is in pain. C. There is no information to support that the limb is cool. D. The limb should be elevated or supported with pillows.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

32. ANS: D
A bone splintered or shattered into numerous fragments is a comminuted fracture that often occurs in crushing injuries. A. Impacted describes a bone that is forcibly pushed together, resulting in bone being pushed into bone. B. Avulsion describes a piece of bone that is torn away from the main bone while still attached to a ligament or tendon. C. Greenstick describes a bone that is bent and fractures on the outer arc of the bend.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Application

33. ANS: D
Washing hands prior to touching a fracture area is the best way to help prevent osteomyelitis. C. Calcium is related to osteoporosis prevention. B. Keeping the leg immobilized relates to fat emboli reduction. A. Ice is applied to reduce swelling.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Analysis

34. ANS: C
Acetaminophen can be helpful in reducing pain associated with osteoarthritis, so the nurse should assess whether the patient is satisfied with the current level of pain control. A. Calcium supplementation is not related to pain control. B. D. These statements miss the opportunity to assess whether the patient is both comfortable and functional with the current pain management.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityBasic Care and Comfort | Cognitive Level: Application

35. ANS: D
Long-term antibiotic therapy (4-6 weeks) is the treatment of choice for patients with osteomyelitis.

A. Anticoagulant therapy is prescribed for a thromboembolism. B. Casting is indicated for a fracture. C. Fasciotomy may be indicated to treat compartment syndrome.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Application MULTIPLE

RESPONSE

36. ANS: A, B, C, D, F
The patient is likely experiencing a fat emboli. The patient should be placed in a high Fowlers position to aid breathing, diagnostic tests will be done, and the patient is kept on bedrest to reduce oxygenation needs and clot movement. Oxygen may be started per agency policy to aid in respiration. E. Limb should not be moved to prevent further release of fat.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

37. ANS: A, C, E, F
Rheumatoid arthritis is a systemic autoimmune disease with morning stiffness, low-grade fever, and organ involvement. B. Heberdens nodes are seen in osteoarthritis. D. Pain increases with activity in osteoarthritis.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Application

38. ANS: A, C, D
The earliest manifestation of fat emboli syndrome (FES) is altered mental status from a low arterial oxygen level. The patient then experiences tachycardia, tachypnea, fever, high blood pressure, severe respiratory distress, and petechiae. B. E. F. These are not manifestations of fat emboli.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityPhysiological Adaptation | Cognitive Level: Analysis

39. ANS: A, B
Weights are to hang unobstructed. Assistance should be used to pull the patient up in bed to protect the health care worker from injury. C. D. E. Weights should never touch the floor or be removed or lifted.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

40. ANS: A, C, E, F
Because most DVTs occur in the lower extremities, leg exercises are started in the immediate postoperative period and include heel pumping, foot circles, and SLRs. The patient also performs quadriceps-setting exercises (quad sets). B. D. Deep knee bends and toe touches are not standard postoperative exercises and would be restricted in a patient with a total hip replacement due to restricted hip flexion.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

41. ANS: A, B, D, E
RICE is an acronym for rest, ice, compression, and elevation which is the therapy for strain injuries. Immediately after a strain, the injured area should be rested to protect it. Ice should be applied to decrease pain, swelling, and inflammation. Applying an elastic bandage for compression and elevating the affected area provide support and minimize swelling. C. After inflammation subsides, heat application (15 to 30 minutes four times a day) brings increased blood flow to the injured area for healing. Heat should not be immediately applied for 1 hour.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

42. ANS: A, B, C, D
For minor rotator cuff injury, resting the shoulder, ice, NSAIDs, and physical therapy are recommended. E. The use of hand weights will be determined by the physical therapist.

PTS: 1 DIF: Moderate
KEY: Client Need: Physiological IntegrityReduction of Risk Potential | Cognitive Level: Application

43. ANS: C, D, E
Modifiable risk factors for the development of osteoporosis include cigarette smoking, sedentary lifestyle, and low calcium intake. A. B. Bone structure and menopausal status are non-modifiable risk factors for the health problem.

PTS: 1 DIF: Moderate
KEY: Client Need: Health Promotion and Maintenance | Cognitive Level: Analysis

44. ANS: B, C, D, E
Actions to prevent the development of osteoporosis include ensuring an adequate intake of calcium each day, participating in weight-bearing exercise such as walking each day, wearing well-supporting, nonskid shoes at all times, and participating in resistance exercise such as weight training. A. Caffeine is a modifiable risk factor for the development of osteoporosis.

9. What is a sign of a dislocation?

a. Crepitus

b. Pain and tenderness

c. Increased range of motion at a joint

d. Deformity at a joint

ANS: D

13. How is Duchennes muscular dystrophy inherited?

a. Autosomal recessive gene

b. X-linked recessive gene

c. Autosomal dominant gene

d. Codominant gene

ANS: B

14. Which of the following is true about Duchennes muscular dystrophy?

a. There is difficulty climbing stairs or standing up at 2 to 3 years of age.

b. It involves only the legs and pelvis.

c. Skeletal muscle atrophy can be seen in the legs of a toddler.

d. It cannot be detected in any carriers.

ANS: A

15. The most common type of joint, which are freely movable, are called:

a. Synarthroses

b. Amphiarthroses

c. Anarthroses

d. Diarthroses

ANS: D

16. Which of the following is characteristic of osteoarthritis?

a. Inflammation and fibrosis develop at the joints.

b. Degeneration of articulating cartilage occurs in the large joints.

c. It progresses bilaterally through the small joints.

d. There are no changes in the bone at the affected joints.

ANS: B

17. What is a typical characteristic of the pain caused by osteoarthritis?

a. Decreases over time

b. Quite severe in the early stages

c. Aggravated by general muscle aching

d. Increased with weight-bearing and activity

ANS: D

20. What is the typical joint involvement with rheumatoid arthritis?

a. Random single joints, progressing to involve other joints

b. Bilateral small joints, symmetrical progression to other joints

c. Abused or damaged joints first, then joints damaged by compensatory movement

d. Progressive degeneration in selected joints

ANS: B

21. What is the basic pathology of rheumatoid arthritis?

a. Degenerative disorder involving the small joints

b. Chronic inflammatory disorder affecting all joints

c. Systemic inflammatory disorder due to an autoimmune reaction

d. Inflammatory disorder causing damage to many organs

ANS: C

22. How is the articular cartilage damaged in rheumatoid arthritis?

a. Enzymatic destruction by the pannus

b. Inflamed synovial membrane covers the cartilage

c. Fibrous tissue connects the ends of the bones

d. Blood supply to the cartilage is lost

ANS: A

23. How does the joint appear during an exacerbation of rheumatoid arthritis?

a. Relatively normal

b. Enlarged, firm, crepitus with movement

c. Deformed, pale, and nodular

d. Red, warm, swollen, and tender to touch

ANS: D

18. What limits joint movement in osteoarthritis?

a. The osteophytes and irregular cartilage surface

b. The wider joint space

c. Decreased amount of synovial fluid in the cavity

d. Fibrosis involving the joint capsule and ligaments

ANS: A

19. Joints affected by osteoarthritis can sometimes affect healthy joints by:

a. causing enzymes to be released that travel to other joints.

b. bacteria traveling from the affected join to a healthy one through the bloodstream.

c. inflammation and edema affecting the entire limb.

d. the affected individuals exerting stress on the normal joint to protect the damaged one.

ANS D

25. Systemic effects of rheumatoid arthritis are manifested as:

a. nodules in various tissues, severe fatigue, and anorexia.

b. headache, leukopenia, and high fever.

c. swelling and dysfunction in many organs.

d. progressive damage to a joint.

ANS: A

26. What is a common effect of long-term use of glucocorticoids to treat rheumatoid arthritis?

a. Leukocytosis

b. Osteoporosis

c. Severe anemia

d. Orthostatic hypotension

ANS: B

27. Juvenile rheumatoid arthritis (JRA) differs from the adult form in that:

a. only small joints are affected.

b. rheumatoid factor is not present in JRA, but systemic effects are more severe.

c. onset is more insidious in JRA.

d. deformity and loss of function occur in most children with JRA.

ANS: B

28. Which of the following distinguishes septic arthritis?

a. Multiple joints that are swollen, red, and painful at one time

b. Presence of mild fever, fatigue, and leukocytosis

c. Purulent synovial fluid present in a single, swollen joint

d. Presence of many antibodies in the blood

ANS: C

29. Which of the following may precipitate an attack of gout?

a. A sudden increase in serum uric acid levels

b. Severe hypercalcemia

c. Mild trauma to the toes

d. Development of a tophus

ANS: A

30. Where does inflammation usually begin in an individual with ankylosing spondylitis?

a. Costovertebral joints with progression down the spine

b. Cervical and thoracic vertebrae, causing kyphosis

c. Sacroiliac joints with progression up the spine

d. Peripheral joints and then proceeds to the vertebrae

ANS: C

31. What is a common outcome of fibrosis, calcification, and fusion of the spine in ankylosing spondylitis?

a. Damage to the spinal nerves and loss of function

b. Frequent fractures of long bones

c. Impaired heart function

d. Rigidity, postural changes, and osteoporosis

ANS: D

32. Which statement applies to menisci?

a. They are found in the hip joints.

b. They are secretory membranes in joints.

c. They prevent excessive movement of joints.

d. They are found in the shoulder joint.

ANS: C

33. Which factors delay healing of bone fractures?

1. Lack of movement of the bone

2. Prolonged inflammation and ischemia

3. Presence of osteomyelitis

4. Close approximation of bone ends

a.	1, 2
b.	1, 3
c.	2, 3
d.	3, 4

ANS: C

34. What is the likely immediate result of fat emboli from a broken femur?

a.	Additional ischemia in the broken bone
b.	Nonunion or malunion of the fracture
c.	Pulmonary inflammation and obstruction
d.	Abscess and infection at a distant site

ANS: C

35. A sprain is a tear in a:

a.	ligament.
b.	tendon.
c.	skeletal muscle.
d.	meniscus.

ANS: A

Chapter 55. Osteoarthritis and Osteoporosis

1.When a patient recovering from a fractured tibia asks what callus formation is, the nurse tells her it is:

a.	when blood vessels of the bone are compressed.
b.	a part of the bone healing process after a fracture when new bone is being formed over the fracture site.
c.	the formation of a clot over the fracture site.
d.	when the hematoma becomes organized and a fibrin meshwork is formed.

ANS: B

Callus formation occurs when the osteoblasts continue to lay the network for bone buildup and osteoclasts destroy dead bone.

2.Which patient statement indicates the need for additional teaching for a patient with rheumatoid arthritis who is taking meloxicam (Mobic)?

a.	I am keeping a daily record of my blood pressure.
b.	I take aspirin before I go to bed.
c.	I know I can take meloxicam with or without regard to meals.
d.	I weigh every day so I will be aware of any weight gain.

ANS: B

Aspirin or products containing aspirin should be avoided while taking meloxicam.

3.Which foods should the home health nurse suggest for the patient with osteoporosis to help slow the disease?

a.	Leafy green vegetables
b.	Foods high in sodium
c.	Tea and coffee
d.	Vitamin A

ANS: A

To slow the bone loss, a patient with osteoporosis should eat green leafy vegetables, foods low in sodium, and also avoid caffeine. Vitamin A does not help with the absorption of calcium.

4.What should the nurse include in the teaching plan for a patient who is taking alendronate (Fosamax)?

a. Take drug with any meal

b. Take drug first thing in the morning

c. Drink at least 5 oz of milk before taking drug

d. Take drug with an antacid to avoid heartburn

ANS: B

Alendronate (Fosamax) should be taken on an empty stomach first thing in the morning with 6 oz of water, accompanied by no other medication.

5.What should the nurse do when a patient with osteomyelitis is admitted with an open wound that is draining?

a. Enforce a low calorie diet

b. Initiate drainage and secretion precautions

c. Frequently do passive ROM on the elbow

d. Ambulate several times daily

ANS: B

The patient with osteomyelitis should be at least in drainage and secretion precaution. The limb should be positioned for maximum comfort and left at rest. These patients are usually on bed rest and require a high-calorie, high-protein diet.

6.A 16-year-old male patient presents in the emergency room with a pathologic fracture of the left femur and complains of pain on weight bearing. These are cardinal indicators of:

a. osteogenic sarcoma.

b. osteoporosis.

c. rheumatoid arthritis.

d. osteochondroma.

ANS: A

Osteogenic sarcoma occurs in young men aged 10 to 25. They are malignant bone tumors that can cause a pathologic fracture and they are accompanied by pain on weight bearing. Osteochondromas are benign and usually do not cause fractures.

7.How is rheumatoid arthritis distinguished from osteoarthritis?

a. Rheumatoid arthritis is an autoimmune, systemic disease; osteoarthritis is a degenerative disease of the joints.

b. Rheumatoid arthritis is an autoimmune, degenerative disease; osteoarthritis is a systemic inflammatory disease.

c.	People with osteoarthritis are considered to be genetically predisposed; there is no known genetic component to rheumatoid arthritis.
d.	Osteoarthritis is often caused by a virus; viruses play no part in the pathogenesis of rheumatoid arthritis.

ANS: A

RA is thought to be an autoimmune disorder. Degenerative joint disease is also known as osteoarthritis.

8.Which patient is most likely to develop osteoporosis?

a.	43-year-old African American woman
b.	57-year-old white woman
c.	48-year-old African American man
d.	62-year-old Latino woman

ANS: B

White and Asian women have a higher incidence of osteoporosis than African American women or Hispanic women because of the greater bone density in the African American.

9.The patient, age 58, is diagnosed with osteoporosis after densitometry testing. She has been menopausal for 5 years and has been concerned about her risk for osteoporosis because her mother has osteoporosis. In teaching her about her osteoporosis, which information does the nurse include?

a.	Even with a family history of osteoporosis, the calcium loss from bones can be slowed by increased calcium intake and exercise.
b.	Estrogen replacement therapy must be started to prevent rapid progression of her osteoporosis.
c.	With a family history of osteoporosis, there is no way to prevent or slow bone reabsorption.
d.	Continuous, low-dose corticosteroid treatment is effective in stopping the course of osteoporosis.

ANS: A

To prevent osteoporosis, women are advised to have an adequate daily intake of calcium and vitamin D; exercise regularly; avoid smoking; decrease coffee intake; decrease excess protein in the diet; and engage in regular moderate activity such as walking, bike riding, or swimming at least 3 days a week. A contributing factor may be use of steroids.

10.Calcium is a mineral found in many foods that can slow bone loss during the aging process. Which food is high in calcium?

a.	Oranges
b.	Bananas

c.	Spinach
d.	Eggs

ANS: C

Spinach and green vegetables, as well as yogurt, are considered calcium-rich foods. Fresh oranges, bananas, and eggs are not good calcium choices.

11.A 56-year-old female patient is being seen for osteoarthritis of the knee in the clinic. What should the nurse recommend when discussing strengthening exercises?

a.	Jogging
b.	Walking rapidly on a treadmill
c.	Bicycling
d.	Aerobic exercises

ANS: C

Bicycling or swimming is recommended for osteoarthritis of the hip or knee. Jogging would put undue stress on knee joints. Climbing stairs should be avoided. Walking should be done on level ground, not up or down elevations.

12.The characteristics of osteoarthritis that should be included in a teaching plan would include that osteoarthritis (select all that apply):

a.	will cause the formation of Heberden nodes.
b.	can involve other organs.
c.	results from wear and tear.
d.	may affect only one side of the body.
e.	may cause constitutional symptoms of fatigue and fever.
f.	will cause marked erythema and edema of hands.

ANS: A, C, D

Osteoarthritis is a disease caused by wear and tear of the joints, causing the appearance of Heberden nodes on the fingers without marked edema or erythema. The disease may only affect one side of the body and does not cause constitutional symptoms.

Chapter 56.Common Endocrine/Metabolic Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. A patient is 66 inches in height, weighing 200 pounds, and newly diagnosed with type 2 diabetes mellitus (DM). Her fasting plasma glucose level is 215 mg/dL. What is the best initial treatment?
a. No treatment at this time
b. Diet and exercise for 6-week trial
c. Diet, exercise, and oral medication
d. Diet, exercise, and exogenous insulin

__ 2. The clinician suspects that a client seen in the office has hyperthyroidism. Which of the following tests should the clinician order on the initial visit?
a. High sensitivity thyroid-stimulating hormone (TSH) and free T4
b. Free T4 and serum calcium
c. Free T3 and T4
d. TSH and thyroxin antibodies

__ 3. A patient with type 2 diabetes asks the clinician why she needs to exercise. In order to answer her, the clinician must understand that exercise has what effect on the patient with type 2 diabetes?
a. Reduces postprandial blood glucose
b. Reduces triglycerides and increases high-density lipoprotein (HDL)
c. Reduces total cholesterol
d. All of the above

__ 4. A patient with type 1 diabetes comes to the clinic complaining of feeling nervous and clammy. He states that he took his insulin this morning but was late for work and did not eat breakfast. Which action should the clinician take first?
a. Check his blood sugar.
b. Have him drink 4 ounces of juice.
c. Call 911.
d. Ask him about his usual eating habits.

__ 5. A patient with type 2 diabetes comes to the clinic after reading about metformin in a magazine. Which of the following conditions that the patient also has would be a contraindication to taking metformin?
a. Ketoacidosis
b. Cirrhosis
c. Hypoglycemic episodes
d. All of the above

__ 6. A 25-year-old patient presents to the clinic with fatigue, cold intolerance, weight gain, and constipation for the past 3 months. On physical examination, the clinician notices a sinus bradycardia; muscular stiffness; coarse, dry hair; and a delay in relaxation in deep tendon reflexes. Which of the following tests should be ordered next?

a. Serum calcium
b. TSH
c. Electrolytes
d. Urine specific gravity

__ 7. The clinician has been doing diabetic teaching for a patient with type 1 diabetes. Which of the following statements by the patient would indicate that teaching has been effective?

a. "As long as I don't need glasses, I don't have to worry about going blind."
b. "I know I need to have my eyes checked every year."
c. "My optometrist checks my eyes."
d. "I will see my eye doctor when my vision gets blurry."

8. A 64-year-old man with type 2 diabetes presents to the clinic with the complaint of "my feet feel like they are on fire." He has a loss of vibratory sense, +1 Achilles reflex, and a tack embedded in his left heel. Which of the following would be an appropriate treatment?

a. Tricyclic antidepressants
b. Capsaicin cream
c. Vitamin B12 injections
d. Insulin

____ 9. After removing a tack from a type 2 diabetic's heel and evaluating the site for infection, what is the best plan for this patient?

a. Suggest she use a heating pad to improve circulation.
b. Refer to a podiatrist for a foot care treatment plan.
c. Send her for acupuncture treatments.
d. All of the above

__ 10. Joyce is seen in the clinic complaining of vague symptoms of nervousness and irritability. She says that her hair will not hold a permanent wave anymore. On physical examination, the clinician finds an irregular heartbeat and brisk reflexes. The differential diagnosis should include which of the following conditions?

a. Myxedema
b. Thyrotoxicosis
c. Cushing's syndrome
d. Pan-hypopituitarism

___ 11. The patient is prescribed radioactive iodine (RAI) and asks the clinician how this drug works. The clinician's response should include which of the following data?

a. RAI prevents the peripheral conversion of T4 to T3.
b. RAI binds free T4.
c. RAI destroys thyroid tissue.
d. RAI reduces freely circulating iodine.

___ 12. A patient is diagnosed with hypothyroidism. Which of the following electrocardiogram changes should the clinician expect as a manifestation of the disease?

a. Sinus bradycardia
b. Atrial fibrillation
c. Supraventricular tachycardia
d. U waves

___ 13. After 6 months of Synthroid therapy, the clinician should expect which of the following in the repeat thyroid studies?

a. Elevated TSH
b. Normal TSH
c. Low TSH
d. Undetectable TSH

___ 14. Which of the following laboratory findings should the clinician expect in a patient with untreated Graves' disease?

a. Elevated TSH
b. Elevated T4
c. Elevated thyrotropin-releasing hormone (TRH)
d. All of the above

___ 15. The clinician prescribes glipizide (Glucotrol) for a diabetic patient. Which statement made by the patient would indicate that your teaching has been effective?

a. "I'll take my pill at least 30 minutes before breakfast."
b. "I'll take my Glucotrol before bedtime."
c. "It is important to take my medication right after I eat."
d. "Since I only like to eat two meals a day, I can take the pill between my meals."

___ 16. A diabetic patient asks the clinician why he needs to check his blood sugar at home even when he feels good. Which of the following responses would be most appropriate?

a. "Control of glucose will help postpone or delay complications."
b. "Regularly checking blood sugar will help establish a routine."
c. "Monitoring glucose will promote a sense of control."
d. All of the above

____ 17. How often should the clinician examine the feet of a person with diabetes?

a. Once a year
b. Every 6 months
c. Every 3 months
d. Every visit

__ 18. The clinician sees a patient who is 5 feet tall and weighs 150 pounds. How would the clinician classify this patient?

a. Overweight
b. Mild obesity
c. Moderate obesity
d. Morbid obesity

19. Mr. S presents in the clinic with pain, tenderness, erythema, and swelling of his left great toe. The clinician suspects acute gout. Which of the following should the clinician expect in the initial test results for this patient?

a. Elevated uric acid level
b. Elevated blood urea nitrogen
c. Decreased urine pH
d. Decreased C-reactive protein

__ 20. Mr. W, 53 years old, is seen in the clinic with concerns about his left foot. He has a 40-year history of type 1 diabetes with "fairly good" control on twice-daily insulin. He denies injury but states that he tripped a few months ago and that his foot is sore when he walks. Physical examination reveals an edematous, erythremic, and warm foot. There is a superficial ulcer on the plantar surface. Which of the following is the most likely diagnosis?

a. Fallen arch
b. Arthritis
c. Charcot joint
d. Sprained ankle

____ 21. Which of the following tests should you order to confirm Mr. W's diagnosis?

a. Bone scan
b. Computed tomography (CT) scan
c. X-ray of the foot
d. Culture of the ulcer

__ 22. A vegetarian patient with gout asks the clinician about food he should avoid. The clinician should advise the patient to avoid which of the following foods?

a. Rice
b. Carrots
c. Spinach
d. Potatoes

__ 23. The clinician should question the patient with suspected gout about use of which of these medications?
a. Low-dose aspirin
b. Thiazide diuretics
c. Ethambutol
d. All of the above

__ 24. The clinician finds numerous nodules on the thyroid of a 65-year-old woman. The clinician suspects thyroid cancer. Which of the following data would be most significant for this patient?
a. A history of tonsillectomy in the 1940s
b. Recent exposure to mumps
c. Vegetarian diet
d. Allergy to iodine

____ 25. Which of the following is essential for diagnosing thyroid cancer?
a. Fine needle aspiration
b. Thyroid ultrasound
c. CT scan
d. Magnetic resonance imaging

____ 26. Which of the following are common signs of type 2 DM?
a. Anorexia
b. Recurrent yeast infection
c. Weight gain
d. Elevated HDL cholesterol

____ 27. Which of the following medications can cause hyperglycemia?
a. Prednisone
b. Metformin
c. Synthroid
d. Cephalexin

____ 28. Which of the following is diagnostic for diabetes mellitus?
a. A1C 7.0 on one occasion
b. Fasting blood sugar (FBS) of 100 mg/dL on two occasions

c. Random glucose of 200 mg/dL on two occasions
d. Two-hour post-load plasma glucose of 300 mg/dL on one occasion

__ 29. Which of the following medications for type 2 diabetes mellitus should not be prescribed during pregnancy?

a. Insulin
b. Metformin
c. Glucotrol
d. Precose

__ 30. A 35-year-old woman presents with symptoms of hypoglycemia. There is no history of diabetes mellitus. Which of the following should be included in the differential diagnosis?

a. Anxiety disorder
b. Pheochromocytoma
c. Psychosis
d. All of the above

True/False

Indicate whether the statement is true or false.

____ 1. Metformin is the first line of pharmacologic treatment for type 2 DM.

____ 2. Fruit juice with added sugar is the treatment of choice for anyone experiencing hypoglycemia.

____ 3. Lifestyle modification is the treatment of choice for metabolic syndrome.

____ 4. A BMI of 29 kg/m^2 is considered obesity.

____ 5. Urine-free cortisol is one of four diagnostic tests recommended for Cushing's syndrome.

Chapter 56.Common Endocrine/Metabolic Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: A PTS: 1
3. ANS: D PTS: 1
4. ANS: B PTS: 1
5. ANS: D PTS: 1
6. ANS: B PTS: 1
7. ANS: B PTS: 1
8. ANS: A PTS: 1
9. ANS: B PTS: 1
10. ANS: B PTS: 1
11. ANS: C PTS: 1
12. ANS: A PTS: 1
13. ANS: B PTS: 1
14. ANS: D PTS: 1
15. ANS: A PTS: 1
16. ANS: D PTS: 1
17. ANS: D PTS: 1
18. ANS: B PTS: 1
19. ANS: A PTS: 1
20. ANS: C PTS: 1

21. ANS: C PTS: 1

22. ANS: C PTS: 1

23. ANS: D PTS: 1

24. ANS: A PTS: 1

25. ANS: A PTS: 1

26. ANS: B PTS: 1

27. ANS: A PTS: 1

28. ANS: C PTS: 1

29. ANS: C PTS: 1

30. ANS: B PTS: 1

TRUE/FALSE

1. ANS: T PTS: 1

2. ANS: F PTS: 1

3. ANS: T PTS: 1

4. ANS: F PTS: 1

5. ANS: T PTS: 1

Chapter 57. Glandular Disorders

1.Why would a patient with hyperthyroidism be prescribed the drug methimazole (Tapa-zole)?

a.	To limit the effect of the pituitary on the thyroid
b.	To destroy part of the hyperactive thyroid tissue
c.	To stimulate the pineal gland
d.	To block the production of thyroid hormones

ANS: D

Medical management for hyperthyroidism may include administration of drugs that block the production of thyroid hormones, such as propylthiouracil or methimazole. 2.To which diet

should a patient with Cushing syndrome adhere?

a.	Less sodium
b.	More calories
c.	Less potassium
d.	More carbohydrates

ANS: A

The diet should be lower in sodium to help decrease edema.

3.A patient has returned to his room after a thyroidectomy with signs of thyroid crisis. During thyroid crisis, exaggerated hyperthyroid manifestations may lead to the development of the potentially lethal complication of:

a.	severe nausea and vomiting.
b.	bradycardia.
c.	delirium with restlessness.
d.	congestive heart failure.

ANS: D

In thyroid crisis, all the signs and symptoms of hyperthyroidism are exaggerated. The patient may develop congestive heart failure and die.

4.The purpose of the use of radioactive iodine in the treatment of hyperthyroidism is to:

a.	stimulate the thyroid gland.

b.	depress the pituitary.
c.	destroy some of the thyroid tissue.
d.	alter the stimulus from the pituitary.

ANS: C

Radioactive iodine 131 destroys some of the hyperactive thyroid gland to produce a more normally functioning gland.

5.Which precaution(s) should the nurse take when caring for a patient who is being treated with radioactive iodine 131 (RAIU)?

a.	Initiate radioactive safety precautions
b.	Avoid assigning any young woman to the patient
c.	Wait three days after dose before assigning a pregnant nurse to care for this patient
d.	Advise visitors to sit at least 10 feet away from the patient

ANS: C

The dose is patient specific and at a very low level. No radioactive safety precautions are necessary and pregnant nurses can be assigned 3 days after the dose. RAIU is not harmful to nonpregnant women.

6.Why would a patient with hyperthyroidism be prescribed the drug methimazole (Tapa-zole)?

a.	To limit the effect of the pituitary on the thyroid
b.	To destroy part of the hyperactive thyroid tissue
c.	To stimulate the pineal gland
d.	To block the production of thyroid hormones

ANS: D

Medical management for hyperthyroidism may include administration of drugs that block the production of thyroid hormones, such as propylthiouracil or methimazole. MSC:

NCLEX: Physiological Integrity

7.What is the postoperative position for a person who has had a thyroidectomy?

a.	Prone
b.	Semi-Fowler
c.	Side-lying
d.	Supine

ANS: B

Postoperative management of this patient includes keeping the bed in a semi-Fowler position, with pillows supporting the head and shoulders. There should be a suction apparatus and tracheotomy tray available for emergency use.

8.What extra equipment should the nurse provide at the bedside of a new postoperative thyroidectomy patient?

a.	Large bandage scissors
b.	Tracheotomy tray
c.	Ventilator
d.	Water-sealed drainage system

ANS: B

There should be a suction apparatus and tracheotomy tray available for emergency use.

9.As the nurse is shaving a patient who is 2 days postoperative from a thyroidectomy, the patient has a spasm of the facial muscles. What should the nurse recognize this as?

a.	Chvostek sign
b.	Montgomery sign
c.	Trousseau sign
d.	Homans sign

ANS: A

The spasm of facial muscles when stimulated is the Chvostek sign, an indication of hypocalcemic tetany.

10.A patient has undergone tests that indicate a deficiency of the parathyroid hormone secretion. She should be informed of which potential complication?

a.	Osteoporosis
b.	Lethargy
c.	Laryngeal spasms
d.	Kidney stones

ANS: C

Decreased parathyroid hormone levels in the blood stream cause a decreased calcium level. Severe hypocalcemia may result in laryngeal spasm, stridor, cyanosis, and increased possibility of asphyxia.

11.A 27-year-old patient with hypothyroidism is referred to the dietitian for dietary consultation. What should nutritional interventions include?

a. Frequent small meals high in carbohydrates
b. Calorie-restricted meals
c. Caffeine-rich beverages
d. Fluid restrictions

ANS: B

12.What instructions should be included in the discharge instructions for a 47-year-old patient with hypothyroidism?

a. Taking medication whenever symptoms cause discomfort
b. Decreasing fluid and fiber intake
c. Consuming foods rich in iron
d. Seeing the physician regularly for follow-up care

ANS: D

Regular checkups are essential, because drug dosage may have to be adjusted from time to time.

13.How should the nurse administer insulin to prevent lipohypertrophy?

a. At room temperature
b. At body temperature
c. Straight from the refrigerator
d. After rolling bottle between hands to warm

ANS: A

In fact, it is now believed that insulin should be administered at room temperature, not straight from the refrigerator, to help prevent insulin lipohypertrophy.

14.A patient with a history of Graves disease is admitted to the unit with shortness of breath. The nurse notes the patients vital signs: T 103 F, P 160, R 24, BP 160/80. The nurse also notes distended neck veins. What does the patient most likely have?

a. Pulmonary embolism
b. Hypertensive crisis
c. Thyroid storm
d. Cushing crisis

ANS: C

In a thyroid crisis, all the signs and symptoms of hyperthyroidism are exaggerated. Additionally, the patient may develop nausea, vomiting, severe tachycardia, severe hypertension, and occasionally

hyperthermia up to 41 C (106 F). Extreme restlessness, cardiac arrhythmia, and delirium may also occur. The patient may develop heart failure and may die.

15. What is the master gland of the endocrine system?

a.	Thyroid
b.	Parathyroid
c.	Pancreas
d.	Pituitary

ANS: D

The pituitary gland, located in the brain, is the master gland of the endocrine system. It has been called the master gland because through the negative feedback system, it exerts its control over the other endocrine glands.

16. What information should be obtained from the patient before an iodine-131 test?

a.	Presence of metal in the body
b.	Allergy to sulfa drugs
c.	Status of possible pregnancy
d.	Use of prescription drugs for hypertension

ANS: C

Iodine-131 is not a radiation hazard to the nonpregnant patient but is absolutely contraindicated during pregnancy. Pregnant nurses should not care for this patient for several days.

17. The patient being treated for hypothyroidism should be instructed to eat well-balanced meals including intake of iodine. Which of the following foods contains iodine?

a.	Eggs
b.	Pork
c.	White bread
d.	Skinless chicken

ANS: A

The hypothyroid diet should be adequate in intake of iodine, in foods such as saltwater fish, milk, and eggs; fluids should be increased to help prevent constipation.

18. The nurse is caring for a patient who is receiving calcium gluconate for treatment of hypoparathyroid tetany. Which assessment would indicate an adverse reaction to the drug?

a.	Increase in heart rate
b.	Flushing of face and neck

c.	Drop in blood pressure
d.	Urticaria

ANS: C

Indications of an adverse effect of calcium gluconate are dyspnea, bradycardia, and hypotension.

19.The adrenal cortex secretes glucocorticoids. The most important is cortisol. What is it involved in? (Select all that apply.)

a.	Glucose metabolism
b.	Releasing androgens and estrogens
c.	Providing extra reserve energy during stress
d.	Decreasing the level of potassium in the blood stream
e.	Increasing retention of sodium in the blood stream

ANS: A, C

Cortisol is involved in glucose metabolism and provides extra reserve energy in times of stress.

Chapter 58. Diabetes Mellitus

1.Which diagnostic test for diabetes mellitus provides a measure of glucose levels for the previous 8 to 12 weeks?

a.	Fasting blood sugar (FBS)
b.	Oral glucose tolerance test (OGT)
c.	Glycosylated hemoglobin (HbA_{1c})
d.	Postprandial glucose test (PPBG)

ANS: C

Glycosylated hemoglobin (HbA_{1c})This blood test measures the amount of glucose that has become incorporated into the hemoglobin within an erythrocyte. Because glycosylation occurs constantly during the 120-day life span of the erythrocyte, this test reveals the effectiveness of diabetes therapy for the preceding 8 to 12 weeks.

2.Which test will furnish immediate feedback for a newly diagnosed diabetic who is not yet under control?

a.	Fasting blood sugar (FBS)

b.	Glycosylated hemoglobin (HgbA1c)
c.	Oral glucose tolerance test (OGTT)
d.	Clinitest

ANS: A

Diabetics should do a fingerstick blood glucose level test before each meal and at bedtime each day until their disease is under control. The $HgbA_{1c}$ serum test reveals the effectiveness of diabetes therapy for the preceding 8 to 12 weeks.

3.The patient is a 20-year-old college student who has type 1 diabetes and normally walks each evening as part of an exercise regimen. The patient plans to enroll in a swimming class. Which adjustment should be made based on this information?

a.	Time the morning insulin injection so that the peak action will occur during swimming class.
b.	Delete normal walks on swimming class days.
c.	Delay the meal before the swimming class until the session is over.
d.	Monitor glucose level before, during, and after swimming to determine the need for alterations in food or insulin.

ANS: D

Exercise can reduce insulin resistance and increase glucose uptake for as long as 72 hours, as well as reducing blood pressure and lipid levels. However, exercise can carry some risks for patients with diabetes, including hypoglycemia.

4.What is a long-term complication of diabetes mellitus?

a.	Diverticulitis
b.	Renal failure
c.	Hypothyroidism
d.	Hyperglycemia

ANS: B

Long-term complications of diabetes include blindness, cardiovascular problems, and renal failure. 5.In diabetes insipidus, a deficiency of which hormone causes clinical manifestations?

a.	antidiuretic hormone (ADH)
b.	follicle-stimulating hormone (FSH)
c.	thyroid-stimulating hormone (TSH)
d.	adrenocorticotropic hormone (ACTH)

ANS: A

Diabetes insipidus is a transient or permanent metabolic disorder of the posterior pituitary in which ADH is deficient.

6. What should the nurse caution a type I diabetic about excessive exercise?

a.	It can increase the need for insulin and may result in hyperglycemia.
b.	It can decrease the need for insulin and may result in hypoglycemia.
c.	It can increase muscle bulk and may result in malabsorption of insulin.
d.	It can decrease metabolic demand and may result in metabolic acidosis.

ANS: B

The patient with diabetes should exercise regularly. Exercise can reduce insulin resistance and increase glucose uptake for as long as 72 hours, as well as reducing blood pressure and lipid levels. However, exercise can carry some risks for patients with diabetes, including hypoglycemia.

7. The nurse caring for a 75-year-old man who has developed diabetes insipidus following a head injury will include in the plan of care provisions for:

a.	limiting fluids to 1500 mL a day.
b.	encouraging physical exercise.
c.	protecting patient from injury.
d.	discouraging daytime naps.

ANS: C

The patients need protection from injury because they are often exhausted from sleep deprivation and having to get up frequently at night. Fluids should not be limited and their energy should be preserved.

8. The physician orders an 1800-calorie diabetic diet and 40 units of (Humulin N) insulin U-100 subcutaneously daily for a patient with diabetes mellitus. Why would a mid-afternoon snack of milk and crackers be given?

a.	To improve nutrition
b.	To improve carbohydrate metabolism
c.	To prevent an insulin reaction
d.	To prevent diabetic coma

ANS: C

Humulin N insulin starts to peak in 4 hours. The nurse should be alert for signs of hypoglycemia (a less-than-normal amount of glucose in the blood, usually caused by administration of too much insulin, excessive secretion of insulin by the islet cells of the pancreas, or dietary deficiency) at the peak of action of whatever type of insulin the patient is taking.

9.The nurse teaching a patient with type 1 diabetes mellitus (IDDM) about early signs of insulin reaction would include information about:

a. abdominal pain and nausea.
b. dyspnea and pallor.
c. flushing of the skin and headache.
d. hunger and a trembling sensation.

ANS: D

The patient should be instructed to notify a member of the nursing staff if any signs of hypoglycemic (low insulin) reaction occur: excessive perspiration or trembling.

10.The nurse discovers the type 1 diabetic (IDDM) patient drowsy and tremulous, the skin is cool and moist, and the respirations are 32 and shallow. These are signs of:

a. hypoglycemic reaction; give 6 oz of orange juice.
b. hyperglycemic reaction; give ordered regular insulin.
c. hyperglycemic hyperosmolar nonketotic reaction; squeeze glucagon gel in buccal cavity.
d. hypoglycemic reaction; give ordered insulin.

ANS: A

Hypoglycemic reaction is due to not enough food for the insulin. Quick acting carbohydratessuch as orange juice or longer acting foods such as milk, crackers, and cheeseare beneficial. 11.What instructions should a nurse give to a diabetic patient to prevent injury to the feet?

a. Soak feet in warm water every day.
b. Avoid going barefoot and always wear shoes with soles.
c. Use of commercial keratolytic agents to remove corns and calluses are preferred to cutting off corns and calluses.
d. Use a heating pad to warm feet when they feel cool to the touch.

ANS: B

Sturdy, properly fitting shoes should be worn. Use of corn removers and heating pads is not beneficial to preserve the health of a diabetics feet.

12.The physician prescribes glyburide (Micronase, DiaBeta, Glynase) for a patient, age 57, when diet and exercise have not been able to control type 2 diabetes. What should the nurse include in the teaching plan about this medication?

a. It is a substitute for insulin and acts by directly stimulating glucose uptake into the cell.
b. It does not cause the hypoglycemic reactions that may occur with insulin use.

c. It is thought to stimulate insulin production and increase sensitivity to insulin at receptor sites.

d. It lowers blood sugar by inhibiting glucagon release from the liver, preventing gluconeogenesis.

ANS: C

Oral hypoglycemics are compounds that stimulate the beta cells in the pancreas to increase insulin release.

13.The nurse is administering long-acting insulin once a day, which provides insulin coverage for 24 hours. This insulin is_____.

ANS:

Lantus

Lantus is a long-acting synthetic (recombinant DNA origin, human-made) human insulin. It is used once a day at bedtime and works around the clock for 24 hours.

14.Another term for hyperglycemic reaction is _____ _____.

ANS:

diabetic ketoacidosis (DKA) diabetic

ketoacidosis

DKA

Hyperglycemic reactionthe body eliminates the excess glucose by the kidneys releasing it in the urine. Diabetic ketoacidosis (DKA) (acidosis accompanied by an accumulation of ketones in the blood), formerly called diabetic coma, may develop and the patient could die. DKA is a severe metabolic disturbance caused by an acute insulin deficiency, decreased peripheral glucose use, and increased fat mobilization and ketogenesis.

15.Only_____insulin can be administered intravenously.

ANS:

regular

Insulin is given subcutaneously, although intravenous (IV) administration of regular insulin can be done when immediate onset of action is desired.

Chapter 59. Metabolic Disorders

MULTIPLE CHOICE

1. What kind of control mechanism is indicated when increased blood glucose levels stimulate increased secretion of insulin?

a. Control by releasing hormones

b. Control by tropic hormones

c. Negative feedback control

d. Hypothalamus/hypophysis coordination

ANS: C

2. What is the most common cause of endocrine disorders?

a. Malignant neoplasm

b. Infection

c. Congenital defect

d. Benign tumor

ANS: D

3. Choose the statement that applies to type 1 diabetes mellitus.

a. Onset often occurs during childhood.

b. Relative insufficiency of insulin or insulin resistance develops.

c. It can be treated by diet, weight control and exercise, or oral hypoglycemics.

d. Complications rarely occur.

ANS: A

4. Why does polyuria develop with diabetes mellitus?

a. Increased thirst and hypoglycemia

b. Ketoacidosis

c. Osmotic pressure due to glucose

d. Diabetic nephropathy

ANS: C

5. What is the cause of diabetic ketoacidosis?

a. Excess insulin in the body

b. Loss of glucose in the urine

c. Failure of the kidney to excrete sufficient acids

d. Increased catabolism of fats and proteins

ANS: D

6. What is a precipitating factor for diabetic ketoacidosis?

a. Skipping a meal

b. Anorexia

c. Serious infection

d. Insulin overdose

ANS: C

7. Which of the following may cause insulin shock to develop?

a. Strenuous exercise

b. Missing an insulin dose

c. Eating excessively large meals

d. Sedentary lifestyle

ANS: A

8. Which of the following indicates hypoglycemia in a diabetic?

a. Deep, rapid respirations

b. Flushed dry skin and mucosa

c. Thirst and oliguria

d. Staggering gait, disorientation, and confusion

ANS: D

9. Which of the following are signs of diabetic ketoacidosis in an unconscious person?

a. Pale moist skin

b. Thirst and poor skin turgor

c. Deep rapid respirations and fruity breath odor

d. Tremors and strong rapid pulse

ANS: C

10. Immediate treatment for insulin shock may include:

a. administration of bicarbonates.

b. consumption of fruit juice or candy.

c. induced vomiting.

d. consumption of large amounts of water.

ANS: B

11. What causes loss of consciousness in a person with diabetic ketoacidosis?

a. Toxic effects of excessive insulin

b. Excessive glucose in the blood

c. Metabolic acidosis

d. Lack of glucose in brain cells

ANS: C

12. Which of the following does NOT usually develop as a complication of diabetes?

a. Osteoporosis

b. Nephropathy

c. Impotence

d. Peripheral neuropathy

ANS: A

13. How do many oral hypoglycemic drugs act?

a. To replace insulin in patients with insulin-dependent diabetes mellitus (IDDM)

b. To transport glucose into body cells

c. To prevent gluconeogenesis

d. To stimulate the pancreas to produce more insulin

ANS: D

14. Diabetes may cause visual impairment through damage to the lens; this is referred to as:

a. cataracts.

b. macular degeneration.

c. myopia.

d. strabismus.

ANS: A

15. Which of the following applies to diabetic macro-angiography?

1. It affects the small arteries and arterioles.

2. It is related to elevated serum lipids.

3. It leads to increased risk of myocardial infarction and peripheral vascular disease.

4. It frequently causes damage to the kidneys.

a. 1, 3

b. 1, 4

c. 2, 3

d. 2, 4

ANS: C

16. Why is amputation frequently a necessity in diabetics?

a. Necrosis and gangrene in the feet and legs

b. Lack of glucose to the cells in the feet and legs

c. Severe dehydration in the tissues

d. Elevated blood glucose increasing blood viscosity

ANS: A

17. A type of diabetes that may develop during pregnancy and disappear after delivery is called:

a. temporary maternal diabetes.

b. fetal diabetes.

c. acute developmental diabetes.

d. gestational diabetes.

ANS: D

18. Which one of the following develops hypoglycemia more frequently?

a. Type 1 diabetic patients

b. Type 2 diabetic patients

c. Patients with a poor stress response

d. Patients with a regular exercise and meal plan

ANS: A

19. Which of the following hormonal imbalances causes Addisons disease?

a. Increased glucocorticoids

b. Decreased glucocorticoids

c. Deficit of antidiuretic hormone (ADH)

d. Deficit of T_3 and T_4

ANS: B

20. Which of the following hormonal imbalances causes myxedema?

a. Increased glucocorticoids

b. Decreased glucocorticoids

c. Deficit of ADH

d. Deficit of T_3 and T_4

ANS: D

21. Which of the following hormonal imbalances causes diabetes insipidus?

a. Increased insulin

b. Decreased glucocorticoids

c. Deficit of ADH

d. Deficit of T_3 and T_4

ANS: C

22. What is caused by hyperparathyroidism?

a. Hypocalcemia

b. Tetany

c. Bone demineralization

d.	Deficit of vitamin D

ANS: C

23. What is caused by hypocalcemia due to hypoparathyroidism?

1. Skeletal muscle twitching or spasm

2. Weak cardiac contraction

3. Increased secretion of parathyroid hormone (PTH)

4. Decreased serum phosphate level

a.	1, 2
b.	1, 3
c.	2, 3
d.	3, 4

ANS: A

24. Which of the following applies to acromegaly?

a.	It occurs in infants and children.
b.	It causes excessive longitudinal bone growth.
c.	It results from excessive secretion of growth hormone (GH).
d.	It does not change soft tissue growth.

ANS: C

25. Which of the following may cause goiter?

1. Hyperthyroidism

2. Hypothyroidism

3. Lack of iodine in the diet

4. Pheochromocytoma

a.	1, 4
b.	2, 3
c.	1, 2, 3
d.	1, 2, 3, 4

ANS: C

26. Which signs are typical of Graves disease?

a.	Facial puffiness, bradycardia, and lethargy
b.	Exophthalmos and tachycardia
c.	delayed physical and intellectual development
d.	Goiter and decreased basal metabolic rate (BMR)

ANS: B

27. Characteristics of Cushings syndrome include all of the following EXCEPT:

a.	Heavy body and round face
b.	Atrophied skeletal muscle in the limbs
c.	Staring eyes with infrequent blinking
d.	Atrophy of the lymph nodes

ANS: C

28. Which of the following is an effect of long-term glucocorticoid therapy?

a.	Decreased secretion from the adrenal cortex gland

b. An increased inflammatory response to irritants

c. Hypotension and poor circulation

d. Increased number of hypersensitivity reactions

ANS: A

29. Which of the following is an effect of Addisons disease?

a. Elevated blood glucose levels

b. High blood pressure

c. Low serum potassium levels

d. Poor stress response

ANS: D

30. What is the most common cause of type 1 diabetes mellitus?

a. Increased glucose production in the liver

b. Destruction of pancreatic cells by an autoimmune reaction

c. Increased resistance of body cells to insulin action

d. Chronic obesity

ANS: B

31. Why does glucosuria occur in diabetics?

a. Excess ketoacids displace glucose into the filtrate.

b. Excess water in the filtrate draws more glucose into the urine.

c. The amount of glucose in the filtrate exceeds the renal tubule transport limit.

d. Sufficient insulin is not available for glucose reabsorption.

ANS: C

32. Which of the following are common early signs of a pituitary adenoma?

1. Persistent headaches

2. Hemianopia

3. Hypertension

4. Papilledema

a. 1, 4

b. 2, 3

c. 1, 2

d. 1, 3, 4

ANS: C

33. Which of the following does NOT apply to inappropriate ADH syndrome?

a. The cause is excess ADH secretion.

b. Severe hyponatremia results.

c. Excessive sodium is retained.

d. Fluid retention increases.

ANS: C

34. What is/are the effect(s) of thyrotoxic crisis?

a. Hyperthermia and heart failure

b. Hypotension and hypoglycemia

c. Toxic goiter and hypometabolism

d. Decreased stress response

ANS: A

35. Which of the following conditions may precipitate or exacerbate hyperglycemia?

a. Hypothyroidism

b. Cushings disease

c. Addisons disease

d. Growth hormone deficit

ANS: B

36. Which of the following conditions may cause immunosuppression?

a. Graves disease

b. Acromegaly

c. Cushings disease

d. Diabetes insipidus

ANS: C

37. Hyperosmolar hyperglycemic nonketotic coma (HHNC) more frequently develops in patients with:

a. type 1 diabetes.

b. type 2 diabetes.

c. Graves disease.

d. hyperparathyroidism.

ANS: B

38. Which of the following is recommended for immediate treatment of hypoglycemic shock?

1. If conscious, immediately give sweet fruit juice, honey, candy, or sugar.

2. If unconscious, give nothing by mouth (require intravenous glucose 50%).

3. Treat immediately with insulin.

4. Give large quantity of clear fluids for shock.

a. 1, 2

b. 1, 3

c. 2, 3

d. 1, 3, 4

ANS: A

39. All these tissues use glucose without the aid of insulin EXCEPT:

a. liver.

b. digestive system.

c. exercising skeletal muscle.

d. brain.

ANS: A

40. Differences between type 1 and type 2 diabetes include which of the following?

a. Type 1 diabetes weight gain is common, and type 2 weight loss often occurs.

b. Type 1 diabetes leads to fewer complications than does type 2 diabetes.

c. Type 1 diabetes may be controlled by adjusting dietary intake and exercise, but type 2 diabetes requires insulin replacement.

d. Type 1 diabetes occurs more frequently in children and adolescents, and type 2 diabetes occurs more often in adults.

ANS: D

41. Complications of diabetes mellitus include:

a. peripheral neuropathy.

b. frequent infections.

c. cataracts.

d. A, B, and C.

ANS: D

42. Which of the following often causes hyperparathyroidism?

a. A malignant tumor in the parathyroid glands

b. End-stage renal failure

c. Osteoporosis

d. Radiation involving the thyroid gland and neck area

ANS: D

43. Dwarfism is caused by:

a. excessive levels of somatotropin (GH).

b. a deficit of somatotropin (GH).

c. excessive levels of insulin.

d. excessive levels of parathyroid hormone.

ANS: B

44. Which of the following results from a deficit of antidiuretic hormone (ADH)?

a. Inappropriate ADH syndrome

b. Gigantism

c. Diabetes insipidus

d. Myxedema

ANS: C

45. Goiters occur more frequently in persons living in the:

a. Great Lakes or mountainous regions.

b. southwest United States.

c. temperate regions.

d. areas bordering the oceans.

ANS: A

46. Which of the following is caused by Graves disease?

a. Hypermetabolism

b. Decreased size of thyroid gland

c. Bradycardia and hypothermia

d. Decreased blood levels of T_3, T_4, and TSH

ANS: A

47. Goiters may be caused by:

a. hypothyroid conditions only.

b. either hypothyroid or hyperthyroid conditions.

c. hyperthyroid conditions only.

d. fungal infections such as candidiasis.

ANS: B

48. Severe impairment of all aspects of growth and development, including difficulty feeding, mental retardation, and stunted skeletal growth, are associated with:

a. myxedema.

b. Cushings syndrome.

c. diabetes insipidus.

d. cretinism.

e. Graves disease.

ANS: D

49. A benign tumor of the adrenal medulla that secretes epinephrine and norepinephrine is called:

a. pheochromocytoma.

b. Cushings syndrome.

c. Graves disease.

d. Addisons disease.

ANS: A

50. The anterior pituitary gland secretes all of the following hormones EXCEPT:

a. prolactin (PRL).

b. glucagon.

c. adrenocorticotropic hormone (ACTH).

d. growth hormone (GH).

ANS: B

Chapter 60. Common Hematologic and Immunological Problems

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. Sandra is 42 years old and has just been diagnosed with leukemia. She is complaining of bone and joint pain. Which type of leukemia is most likely the culprit?
a. Acute lymphocytic leukemia
b. Acute myelogenous leukemia
c. Chronic myelogenous leukemia
d. Chronic lymphocytic leukemia

____ 2. Which type of bone marrow transplant is obtained from an identical twin?
a. Autogenic
b. Autologous
c. Allogeneic
d. Syngeneic

____ 3. During treatment for anaphylaxis, what site is used for the initial injection of epinephrine?

a. IV
b. Abdomen
c. Upper lateral thigh
d. Deltoid

____ 4. After the initial treatment for anaphylaxis, which medication should be added to prevent late-phase anaphylactic reactions?
a. Albuterol
b. Diphenhydramine
c. An H2 blocker
d. Corticosteroids

__ 5. When analyzing synovial fluid, if it is opaque, white, or translucent; has 5,000 leukocytes/Ml; 80% polymorphonuclear leukocytes (PMN); and a low red blood cell count, it may be indicative of which of the following conditions?
a. This is a normal result.
b. Scleroderma
c. Rheumatoid arthritis
d. Sickle cell disease

____ 6. Which of the following disease-modifying antirheumatic drugs is a folic acid antagonist?
a. Methotrexate (Rheumatrex)
b. Etanercept (Enbrel)
c. Rituximab (Rituxan)
d. Anakinra (Kineret)

__ 7. Which statement about HIV postexposure prophylaxis (PEP) for health-care workers is the most accurate?
a. PEP should be started within hours of exposure.
b. PEP should be started within 72 hours of exposure.
c. Renal and hepatic function tests should be done 6 weeks after beginning PEP.
d. PEP will prevent potential hepatitis C infection if present.

____ 8. Which household solution should be used to clean a bathroom if sharing with a friend who has HIV?
a. 100% bleach
b. 50% bleach and 50% vinegar
c. Nine parts H_2O to one part bleach
d. The friend must have his or her own bathroom.

__ 9. Reuben, age 24, has HIV and just had a routine viral load test done. The results show a falling viral load. What does this indicate?

a. A favorable prognostic trend
b. Disease progression
c. The need to be more aggressive with Reuben's medications
d. The eradication of the HIV

__ 10. If the international normalized ratio (INR) result is above the therapeutic range in a patient with atrial fibrillation on warfarin, what might the clinician do?

a. Stop the warfarin for 1 week, and then repeat the INR.
b. Withhold one or more days of anticoagulant therapy.
c. Restart therapy at a lower dose immediately.
d. The prothrombin time and INR should be reevaluated within 1 month of the dosage adjustments.

__ 11. Which of the following is identified as an eating disorder in which a person craves food substitutes, such as clay, ice chips, and cotton, and is considered an objective finding associated with severe iron deficiency?

a. Ferritin
b. Porter's syndrome
c. Hypochromasia
d. Pica

__ 12. As a rule of thumb, the estimated level of hematocrit is how many times the value of the hemoglobin?

a. Two
b. Three
c. Four
d. Five

____ 13. What is the most common cause of microcytic anemia?

a. Anemia of chronic disease
b. Sideroblastic anemia
c. Iron-deficiency anemia
d. Thalassemia

____ 14. The cardinal subjective symptom of sickle cell crisis is which of the following?

a. Pain
b. Nausea
c. Light-headedness
d. Palpitations

__ 15. In the United States, what is the second most common connective tissue disease and the most destructive to the joints?

a. Osteoarthritis
b. Systemic lupus erythematosus (SLE)
c. Rheumatoid arthritis
d. Sjögren's syndrome

__ 16. Which blood test is a nonspecific method and most helpful for evaluating the severity and course of an inflammatory process?

a. Erythrocyte sedimentation rate
b. White blood cell count
c. Polymorphonuclear cells
d. C-reactive protein (CRP)

____ 17. Infectious mononucleosis results from an acute infection with which of the following?

a. Epstein-Barr virus
b. Acute HIV infection
c. Guillain-Barré
d. Hepatitis

____ 18. What is the most common cause of generalized musculoskeletal pain in women ages 20 to 55?

a. Chronic fatigue syndrome (CFS)
b. Anemia
c. Fibromyalgia syndrome (FMS)
d. Sports-related injuries

__ 19. After returning from visiting his grandchildren in England, George, age 59, complains of a flulike illness, including fever, chills, and myalgia. He reports having discovered a rash or red spot that grew in size on his right leg. What disease are you considering?

a. A viral syndrome
b. Lyme disease
c. Rocky Mountain spotted fever
d. Relapsing fever

____ 20. Dryness of the eyes and mouth is typical of which condition?

a. Sjögren's syndrome
b. CFS
c. FMS
d. Hypothyroidism

__ 21. Triggering factors for acute exacerbations of which of the following conditions include exposure to ultraviolet (UV)-B and UV-A rays?

a. Rheumatoid arthritis
b. Scleroderma
c. SLE
d. Sjögren's syndrome

____ 22. The current goal of treatment for a patient with HIV infection is which of the following?

a. Viral suppression of HIV to undetectable levels in the peripheral blood
b. Compete eradication of the virus
c. Encouraging the person to have no contact with uninfected individuals
d. Complete abstinence

____ 23. The most cost-effective screening test for determining HIV status is which of the following?

a. Western blot
b. Enzyme-linked immunosorbent assay
c. Venereal Disease Research Laboratory test
d. Viral load

__ 24. An important complication of antiretroviral (ARV) therapy in patients with advanced AIDS is which of the following?

a. Immune reconstitution inflammatory syndrome
b. Improvement in opportunistic infections
c. Restoration of immune system to preinfection status
d. Progression to AIDS

__ 25. Which drug category of ARV therapy is generally effective in crossing the blood–brain barrier and may be useful in managing HIV-associated dementia?

a. Nucleoside reverse transcriptase inhibitors
b. Protease inhibitors
c. Integrase inhibitors
d. Nonnucleoside reverse transcriptase inhibitors

____ 26. Spontaneous bruising may be seen with platelet counts below what level?

a. 100,000 cells/mL
b. 75,000 cells/mL
c. 50,000 cells/mL
d. 30,000 cells/ml

__ 27. Which type of the following is characterized by fatigue on awakening that may improve with exercise?
a. Functional fatigue
b. Fatigue with an organic origin
c. Fatigue of chronic anemia
d. Fatigue of depression and anxiety

____ 28. Early rheumatoid disease is characterized by:
a. Pain and swelling in both small and large peripheral joints
b. Rigid joints with diminished range of motion
c. Joint swelling and immobility on rising
d. A cardiac rub or pulmonary friction rub

____ 29. Which test is diagnostic of rheumatoid arthritis?
a. Rheumatoid factor
b. ESR
c. CRP
d. Anti-CCP titers

____ 30. What is the mainstay of management for infectious mononucleosis?
a. Antivirals
b. Symptom control
c. Corticosteroids
d. Isolation

____ 31. CFS tends to occur in which individuals?
a. Active, highly functional adults
b. Depressed middle-aged persons
c. Individuals with a depressed immune system
d. Individuals who are hypochondriacs

____ 32. The exanthem of Lyme disease is:
a. Erythema infectiosum
b. Laterothoracic exanthem
c. Erythema migrans
d. Morbilli exanthem

____ 33. If left untreated, this condition will progress to complaints that include multiple joint arthritis.
a. Sjögren's syndrome

b. HIV/AIDS
c. Guillain-Barré
d. Lyme disease

____ 34. Keratoconjunctivitis sicca is a classic sign of which condition?
a. SLE
b. Sjögren's syndrome
c. CFS/FMS
d. Lyme disease

____ 35. Which person is four times more likely to develop SLE than a Caucasian?
a. Persons of African descent
b. Asians
c. Hispanics
d. Middle Eastern Jews

Chapter 60. Common Hematologic and Immunological Problems
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: D PTS: 1
3. ANS: C PTS: 1
4. ANS: D PTS: 1
5. ANS: C PTS: 1
6. ANS: A PTS: 1
7. ANS: A PTS: 1
8. ANS: C PTS: 1
9. ANS: A PTS: 1
10. ANS: B PTS: 1
11. ANS: D PTS: 1
12. ANS: B PTS: 1
13. ANS: C PTS: 1
14. ANS: A PTS: 1
15. ANS: C PTS: 1
16. ANS: D PTS: 1
17. ANS: A PTS: 1
18. ANS: C PTS: 1
19. ANS: B PTS: 1
20. ANS: A PTS: 1
21. ANS: C PTS: 1

22. ANS: A PTS: 1

23. ANS: B PTS: 1

24. ANS: A PTS: 1

25. ANS: D PTS: 1

26. ANS: C PTS: 1

27. ANS: A PTS: 1

28. ANS: C PTS: 1

29. ANS: D PTS: 1

30. ANS: B PTS: 1

31. ANS: A PTS: 1

32. ANS: C PTS: 1

33. ANS: D PTS: 1

34. ANS: B PTS: 1

35. ANS: A PTS: 1

Chapter 61. Hematologic Disorders

MULTIPLE CHOICE

1.What is the process by which certain cells engulf and digest microorganisms and cellular debris?

a.	Erythrocytosis
b.	Hematocrit
c.	Phagocytosis
d.	Hemostasis

ANS: C

Phagocytosis is the process by which bacteria, cellular debris, and solid particles are destroyed and removed.

KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

2.The nurse explains that because it is a reliable and predictable indicator of the bodys level of infection or recovery the_____is a common diagnostic tool.

a.	Hemoglobin
b.	Hematocrit
c.	Mean cell volume (MCV)
d.	Differential

ANS: D

A differential white blood cell count is an examination in which the different kinds of WBCs are counted and reported as percentages of the total examined. It is a common diagnostic tool because of its reliability and the predictability of the bodys response to infection or its progress in recovery.

MSC: NCLEX: Physiological Integrity

3.The nurse assessing a differential sees an increase in immature neutrophils (bands) and is aware that this indicates:

a.	a significant hemorrhage.
b.	aplastic anemia.
c.	an overwhelming bacterial infection.
d.	beginning recovery from an infection.

ANS: C

An increase in immature neutrophils (bands) is called bandemia, and it indicates an overwhelming bacterial infection.

MSC: NCLEX: Physiological Integrity

4.B cells and T cells fit under which classification?

a.	Erythrocytes
b.	Basophils
c.	Lymphocytes
d.	Monocytes

ANS: C

B cells and T cells, the major players in the antigen/antibody conflict, are both lymphocytes. KEY: Nursing

Process Step: Assessment MSC: NCLEX: Physiological Integrity

5.The nurse explains that in the event of an invasion of an allergen, the basophils release a strong vasodilator, which is:

a.	lysozyme.
b.	prothrombin.
c.	hematocrit.
d.	histamine.

ANS: D

Histamine is released by the basophils during the invasion of an allergen.

6.The presence of excess bands in the peripheral blood that indicate severe infection is called:

a.	shift to the left.
b.	shift to the right.
c.	bone marrow aspiration.
d.	thrombocytosis.

ANS: A

The presence of excess bands in the peripheral blood is called a shift to the left (i.e., a shift toward immature cells) and indicates severe infection.

7.A patient who had a Schilling test shows a 20% excretion of the radioactive vitamin B_{12}. What would this indicate?

a.	The patient has a low reserve of iron and has iron deficiency anemia.
b.	The patient has a normal finding and does not have pernicious anemia.
c.	The patient has a deficiency of thrombocytes and has a clotting disorder.
d.	The patient has an excess of RBCs and has polycythemia.

ANS: B

The Schilling test is a laboratory blood test for diagnosing pernicious anemia. The normal reading 24 hours after the administration of radioactive vitamin B_{12} is 8% to 40%. The test measures the absorption of radioactive vitamin B_{12}.

8.In an adult, where are erythrocytes continuously produced?

a.	Yellow bone marrow
b.	Lymphatic system
c.	Spleen
d.	Red bone marrow

ANS: D

Erythrocytes are continuously produced in the red bone marrow, principally in the vertebrae, ribs, and sternum.

9.What does the elevation in the eosinophil count to 10% indicate?

a.	Anemia
b.	Allergy
c.	Infection
d.	Hypoxia

ANS: B

Normal values of eosinophils are 1% to 4%. An elevation to 10% would indicate the presence of an allergic reaction.

10.What would a nurse include in a teaching plan for a home health patient with a hemoglobin of 8.4 mg?

a.	Exercising for periods of 30 minutes daily
b.	Limiting fluid intake
c.	Alternating activity with rest periods
d.	Avoiding the use of oxygen

ANS: C

Severely anemic persons need to conserve their energy. Observing a rest period after a period of activity will reduce hypoxia. Oxygen may be used as necessary.

11.Approximately how much blood is stored in the spleen that can be released in a hypovolemic emergency?

a.	100 mL
b.	300 mL
c.	500 mL
d.	1000 mL

ANS: C

The spleen stores 1 pint of blood, approximately 500 mL, which can be released during emergencies. 12.The nurse caring for a patient with pernicious anemia should make provisions for:

a.	frequent iced drinks.
b.	lightweight blanket.
c.	a fan to circulate the air.

d. reverse isolation.

ANS: B

Persons with pernicious anemia are especially sensitive to cold. The provision of a light blanket is beneficial.

KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

13.When instructing the patient taking an oral liquid iron preparation, what should the nurse include?

a. Information relative to taking the iron with milk

b. Information relative to the bowel movement color changing to dark red

c. Information relative to taking preparation through a straw to prevent staining of teeth

d. Information relative to taking a drug with meals or a snack

ANS: C

Liquid iron preparations should be drunk through a straw to prevent tooth staining. All oral iron preparations should be taken before meals. Dairy products interfere with the absorption of iron.

14.When the 14-year-old African American boy comes into the emergency room in sickle cell crisis, what should be the primary focus of care?

a. Instruct patient about transfusion procedure

b. Starting of IV fluids

c. Pain control

d. Relief of dyspnea

ANS: C

Pain control during the crisis is the focus. Continuous opioids are the mainstay of pain management. Certainly IV fluids to reduce viscosity of blood and oxygen for relief of dyspnea are important, but pain control is paramount in the acute phase.

15.The mother of a 4-year-old child with leukemia says to the nurse, I dont understand why he is crying about his legs hurting. The nurses most informative response would be based on the information that bone pain is related to:

a. Elevated WBCs in differential

b. Long periods of inactivity

c. Splenomegaly

d. Bone marrow congested with white cells

ANS: D

Long bone pain is the result of bone marrow that is congested with immature white cells. 16.What must a patient undergo before a bone marrow transplant?

a.	A thorough nutritional plan to support new marrow
b.	Total body irradiation to kill all the marrow cells
c.	A physical therapy program to strengthen the body
d.	Inhalation therapy to reduce possible pathogens in the lungs

ANS: B

Before the actual marrow transplant, the patient must undergo total body irradiation or chemotherapy to kill all the marrow cells and the leukemic cells. The patient is at a major risk for infection at this time.

17.The 9-year-old child with leukemia who is on palliative care has drawn a picture of a boy under a huge black cloud that has lightning coming out of it. Which of the following would be an appropriate intervention for the nurse?

a.	What is this picture about?
b.	Are you afraid of lightning?
c.	I bet this is a picture of you, isnt it?
d.	Is it about to rain in your picture?

ANS: A

Asking what the child has drawn is a neutral and nonthreatening question. Drawings can give a clue to perceptions and emotions that a young child may not be able to verbalize. The nurse should not try to interpret the drawing.

18.The home health nurse recommends to the mother of a 12-year-old child with leukemia that the child should have:

a.	the series for prevention of hepatitis B.
b.	an annual influenza vaccine.
c.	an annual pneumococcal vaccine.
d.	vitamin B_{12} shots.

ANS: B

Children with leukemia should have an annual influenza vaccine and a pneumococcal vaccine every 5 years.

19.Which patient statement from a 15-year-old girl with thrombocytopenia would require more assessment to report to the charge nurse?

a. I think these red spots on my skin are going away.

b. I am so bored lying in bed I could scream.

c. My bowel movement is brown and stinks.

d. I have this really weird Coke-colored urine.

ANS: D

Coke-colored urine is hematuria that should be documented and reported to the charge nurse. The purpura will fade as they are absorbed. Boredom and smelly stools are normal for a 14-year-old.

20.A 23-year-old male patient with hemophilia A says, How can I keep my children from having hemophilia A? Which of the following is the most informative response?

a. You need to select a very dependable mode of birth control.

b. You can only pass hemophilia B to your sons.

c. Your daughter may be a carrier and her children may have hemophilia A. Your son is not at risk.

d. Your sons should have coagulation studies.

ANS: C

Hemophilia A is an X-linked trait. Females are carriers; therefore, the patients daughter could pass the disease to her sons. The patients sons are not at risk for hemophilia A. MSC: NCLEX:

Physiological Integrity

21.The nurse caring for a child with hemophilia who is hospitalized with hemarthrosis should include which of the following in the plan of care?

a. Splint the affected leg to maintain anatomic alignment

b. Apply warm compresses to reduce hemorrhage in the joint

c. Use analgesia sparingly

d. Encourage vigorous ROM exercises several times a day to keep knee flexible

ANS: A

Splinting the affected knee is necessary to retain anatomic alignment while the pain is severe. Analgesia should be given as needed. Physical therapy and ROM are appropriate after pain has subsided.

22.In caring for a patient with multiple myeloma, what should the nurse include in the daily care?

a. Provisions for limiting fluid intake to less than 1000 mL/day

b. Provisions for close supervision and assistance when ambulating

c. Provisions for straining all urine

d. Provisions for limiting use of an analgesic

ANS: B

Because of the constant threat of pathologic fractures, ambulation should be carefully supervised and assisted. Uric acid is increased and may crystalize in the kidney, but straining is not necessary. Analgesia is necessary for relief of bone pain.

23.The nurse is aware that a person with Hodgkin disease, who has two or more abnormal lymph nodes on the same side of the diaphragm and involvement of extranodal involvement on the same side of the diaphragm, would be in:

a.	stage I
b.	stage II
c.	stage III
d.	stage IV

ANS: B

Stage II indicates that there are two or more abnormal lymph nodes on the same side of the diaphragm and extranodal involvement on the same side of the diaphragm.

24.The nurse explains that a positron emission tomography (PET) has been ordered to:

a.	assess bone marrow depression.
b.	measure bone density.
c.	radiate and destroy diseased lymph nodes.
d.	measure lymph node response to therapy.

ANS: D

The PET can measure the effect of therapy on diseased nodes.

25.Which of the following foods would the nurse recommend to a person with iron deficiency anemia as an excellent meat source for erythropoiesis?

a.	Dark meat of chicken
b.	Cured ham
c.	Pork chops
d.	Processed meat

ANS: A

The dark meat of poultry is a good meat source for erythropoiesis. 26.The

peripheral smear is a diagnostic test that:

a. assesses the level of hemoglobin.
b. measures antibody production.
c. examines the shape and structure of RBCs.
d. identifies infection.

ANS: C

The peripheral smear allows the study of the size, structure, and shape of RBCs.

27.The typical medical treatment of polycythemia vera involves repeated phlebotomies and medications such as busulfan (Myleran) in order to:

a. stimulate bone marrow.
b. inhibit bone marrow activity.
c. increase hemoglobin.
d. reduce gout.

ANS: B

Repeated phlebotomy decreases blood viscosity, and myelosuppressive agents such as busulfan (Myleran) are often given to inhibit bone marrow activity.

28.Which of the following would the nurse explain as the most common type of leukemia that affects children?

a. Chronic lymphocytic leukemia (CLL)
b. Acute myeloid leukemia (AML)
c. Acute lymphocytic leukemia (ALL)
d. Chronic myeloid leukemia (CML)

ANS: C

The most common type of leukemia that affects children is the fast-advancing ALL. This leukemia can also affect adults.

Implementation

MSC: NCLEX: Physiological Integrity

29.The nurse is aware that persons of the Jehovahs Witness faith accept which types of blood transfusions?

a. No type of blood transfusion
b. Blood that has been blessed by their religious leader
c. Transfusions only for persons who have not yet been baptized

d. Autologous blood transfusions

ANS: D

Jehovahs Witness followers are accepting of autologous blood transfusions and some will accept volume expanders such as colloids.

30.Which mandatory practice is the most effective and significant nursing practice to prevent the spread of infection?

a. Strict and frequent handwashing by all people having contact with the patient
b. Placement of patients in private rooms with high-efficiency particulate air (HEPA) filtration
c. Administration of combinations of prophylactic antibiotics
d. Creation of a sterile environment for the patient with the use of laminar airflow rooms

ANS: A

Meticulous handwashing by medical and nursing personnel and strict asepsis are mandatory.

MSC:NCLEX: Safe, Effective Care Environment 31.What is the

average life span of an erythrocyte?

a. 7 days
b. 60 days
c. 120 days
d. Up to several years

ANS: C

The life span of an RBC is 120 days. A WBCs life span is days to several years. Platelets live 5 to 9 days.

32.Because older adults suffer from conditions such as colonic diverticula, hiatal hernia, and ulcerations that can cause occult bleeding, the nurse should assess for symptoms of:

a. leukemia.
b. iron deficiency anemia.
c. sickle cell anemia.
d. polycythemia.

ANS: B

Blood loss is a major cause of iron deficiency in adults. The major sources of chronic blood loss are from the GI and genitourinary systems.

33.The nurse explains that the treatment of hemophilia A has been revolutionized with the advent of the use of:

a.	corticosteroids.
b.	large doses of testosterone.
c.	recombinant factor VIII.
d.	transfusion with packed red cells.

ANS: C

Recombinant factor VIII has been a major forward step in the treatment of hemophilia A.

MSC: NCLEX: Health Promotion and Maintenance

34.From which location would the bone marrow sample come in the aspiration of a 25-year-old patient?

a.	Sternum
b.	Posterior superior iliac crest
c.	Posterior iliac crest
d.	Femur

ANS: C

The preferred site for bone marrow aspiration puncture in adults is the posterior iliac crest. MSC:

NCLEX: Physiological Integrity

MULTIPLE RESPONSE

35.What are the most likely matches for a bone marrow transplant to a 10-year-old with leukemia? (Select all that apply.)

a.	Uncle
b.	Self
c.	Mother
d.	Brother
e.	Sister
f.	Father

ANS: B, D, E

Specimens from twins, siblings, or self (autologous) while in remission are preferred. KEY: Nursing

Process Step: Planning MSC: NCLEX: Physiological Integrity

36.The spleen is a highly vascularized organ located in the left upper quadrant of the abdominal cavity. What are the main functions of the spleen? (Select all that apply.)

a.	Serve as reservoir for blood
b.	Destroy worn-out RBCs
c.	Promote phagocytosis
d.	Responsible for development of T lymphocytes
e.	Continuously produce RBCs during lifetime

ANS: A, B, C

The spleen stores 1 pint of blood, which can be released during emergencies, such as hemorrhage, in less than 60 seconds. The main functions of the spleen are (1) to serve as a reservoir for blood; (2) to form lymphocytes, monocytes, and plasma cells; (3) to destroy worn-out RBCs; (4) to remove bacteria by phagocytosis (engulfing and digesting); and (5) to produce RBCs before birth (the spleen is believed to produce RBCs after birth only in cases of extreme hemolytic anemia).

37.The nurse examines the complete blood count (CBC) to assess (select all that apply):

a.	hematocrit.
b.	red cell count.
c.	differential white cell count.
d.	plasma level.
e.	blood type.
f.	hemoglobin.

ANS: A, B, C, F

The CBC gives information relative to RBC, WBC, hematocrit, hemoglobin, erythrocyte indexes, WBC differential, and examination of the peripheral blood cells.

38.Which of the following are necessary factors that support healthy erythropoiesis? (Select all that apply.)

a.	Dietary magnesium
b.	Healthy bone marrow
c.	Adequate oxygen source
d.	Vitamin B_{12}
e.	Amino acids
f.	Vitamin B_2

ANS: B, D, E, F

Erythropoiesis, red blood cell production, is dependent on the availability of healthy bone marrow, dietary supply of copper and iron, amino acids, vitamins B_{12} and B_2, folic acid, and pyridoxine.

39.The nurse caring for a patient in the emergency room with suspected internal injuries will assess for hypovolemic shock, which is evidenced by (select all that apply):

a.	irritability.
b.	restlessness.
c.	slow bounding pulse.
d.	decreased respirations.
e.	pallor.
f.	hypotension.

ANS: A, B, E, F

Indicators of hypovolemia are restlessness, irritability, rapid thready pulse, increasing respirations, pale, cool moist skin, and hypotension, Should the blood loss continue, the patient could go into hypovolemic shock.

40.Which of the following are B symptoms of a patient with Hodgkin disease? (Select all that apply.)

a.	Hematuria
b.	Night sweats
c.	Severe diarrhea
d.	Weight gain from edema
e.	Fever
f.	Persistent dry cough

ANS: B, E

The B symptoms of Hodgkin disease are night sweats, fever, and weight loss. These symptoms are associated with a poor prognosis.

COMPLETION

41._____ are leukocytes that destroy and remove cellular waste, bacteria, and solid particles.

ANS:

Neutrophils

Neutrophils (granular circulating leukocytes essential for phagocytosis, the process by which bacteria, cellular debris, and solid particles are destroyed and removed) ingest bacteria and dispose of dead tissue.

42.The person with aplastic anemia is said to be_____because all three major blood elements (RBCs, WBCs, and platelets) are diminished or absent.

ANS:

pancytopenic

Persons with aplastic anemia are deficient in all three of the major blood elements, a condition known as pancytopenia.

43.The nurse clarifies that _____ _____ replaces iron stores needed for red blood cell production.

ANS:

ferrous sulfate

Ferrous sulfate replaces iron stores needed for red blood cell production. 44.Neutrophils release_,

an enzyme that destroys certain bacteria. ANS:

lysozyme

Lysozyme is an enzyme released by the neutrophils that kills certain bacteria when the bacteria is recognized in the body.

45.The Reed-Sternberg cell is the hallmark diagnostic indicator for _____ _____.

ANS:

Hodgkin disease

The Reed-Sternberg cell, large abnormal multinucleated cells in the lymph nodes, is diagnostic of Hodgkin disease.

OTHER

46.Arrange the process of hemostasis in sequence. (Separate letters by a comma and space as follows: A, B, C, D)

a. Release of clotting factor from injured tissue

b. Formation of thrombin

c. Formation of fibrin

d. Trapping of RBC and platelets

e. Clot

f. Release of thromboplastin

ANS:

A, F, B, C, D, E

Clotting factors are released from the injured tissue causing the release of thromboplastin, which acts with calcium to form thrombin; fibrin is formed, which traps red cells and platelets to make the clot.

47.Outline the sequence of the process that stimulates the increase in the production of red blood cells. (Separate letters by a comma and space as follows: A, B, C, D)

a. Kidneys release erythropoietic factor

b. Increase in red blood cell production

c. Enzyme stimulates red bone marrow

d. Oxygen delivery increased to the tissues

e. Oxygen delivery decreased to the tissues

f, Decrease in red blood cell production

ANS:

E, A, C, B, D, F

When the tissues of the body register a decrease of oxygen, the kidneys release the erythropoietic factor that stimulates the bone marrow to produce more RBCs, which increases the oxygen delivery to the tissues which then signals the bone marrow to decrease the RBC production.

Chapter 62. Immunological Disorders MULTIPLE

CHOICE

1.Which of the following is an example of immunocompetence?

a.	A child that is immune to measles because of an inoculation
b.	A person who has seasonal allergies every fall
c.	When the symptoms of a common cold disappear in 1 day
d.	A neonate having a natural immunity from maternal antibodies

ANS: C

Immunocompetence is demonstrated by the immune system responding appropriately to a foreign stimulus and the bodys integrity is maintained as with cold symptoms that resolve with residual illness.

MSC: NCLEX: Physiological Integrity

2.An anxious patient enters the emergency room with angioedema of the lips and tongue, dyspnea, urticaria, and wheezing after having eaten a peanut butter sandwich. What should be the nurses first intervention?

a.	Apply cool compresses to urticaria
b.	Provide oxygen per non-rebreathing mask
c.	Cover patient with a warm blanket
d.	Prepare for venipuncture for the delivery of IV medication

ANS: B

Provision of oxygen is the initial primary intervention. Anaphylaxis may advance very rapidly and the patient may have to be intubated. Covering the patient with a warm blanket is not wrong, but not an initial intervention.

MSC: NCLEX: Physiological Integrity

3.What is the etiology of autoimmune diseases based on?

a.	Reaction to a superantigen
b.	Immune system producing no antibodies at all
c.	T cells destroying B cells
d.	B and T cells producing autoantibodies

ANS: D

Autoimmune disorders are failures of the tolerance to self. B and T cells produce autoantibodies that can cause pathophysiologic tissue damage. Autoimmune disorders may be described as an immune attack on the self and result from the failure to distinguish self protein from foreign protein.

MSC: NCLEX: Physiological Integrity

4.A patient is admitted with a secondary immunodeficiency from chemotherapy. The nursing plan of care should include provisions for:

a.	infection control.
b.	supporting self-care.
c.	nutritional education.
d.	maintaining high fluid intake.

ANS: A

Immune deficient persons are at risk for infection and need to be protected aggressively for contagion.

5.The nurse takes into consideration that when the antigen and antibody react, the complement system is activated which:

a.	toughens the cell wall.
b.	generates more T cells.
c.	attracts phagocytes.
d.	makes the antigen resistant.

ANS: C

The complement system is a group of plasma proteins that are dormant until there is an antigen-antibody interaction. The proteins destroy the cell membrane and attract phagocytes.

6.How does normal aging change the immune system?

a.	Depresses bone marrow
b.	T cells become hyperactive
c.	B cells show deficiencies in activity
d.	Increase in the size of the thymus

ANS: C

Normal aging causes deficiencies in both B and T cell activation, but the bone marrow is essentially uncompromised. The thymus decreases in size.

7.What would the nurse recommend for a 94-year-old home health patient with deteriorated cell-mediated immunity?

a.	Avoiding the influenza vaccine
b.	Getting pneumonia vaccine
c.	Having skin tests for all antigens
d.	Taking large doses of beta-carotene

ANS: B

As the older adult loses some of the cell-mediated immunity, especially against pneumonia and influenza, it is recommended that they acquire the immunization.

8.A patient who works in a plant nursery and has suffered an allergic reaction to a bee sting is stabilized and prepared for discharge from the clinic. During discussion of prevention and management of further allergic reactions, the nurse identifies a need for additional teaching based on which comment?

a.	I need to think about a change in my occupation.
b.	I will learn to administer epinephrine so that I will be prepared if I am stung again.

c. I should wear a Medic-Alert bracelet indicating my allergy to insect stings.

d. I will need to take maintenance doses of corticosteroids to prevent reactions to further stings.

ANS: D

The nurses responsibilities in patient education are as follows: Teach the patient preparation and administration of epinephrine subcutaneously. There is no need for the patient to take maintenance doses of corticosteroids because this was a short, rapid reaction.

9.What is the substance released by the T cells that stimulates the lymphocytes to attack an inflammation?

a. Lymphokine

b. Epinephrine

c. B cells

d. Histamine

ANS: A

Lymphokines help attract macrophages to the site of the inflammation.

10.Immediately after the nurse administers an intradermal injection of a suspected antigen during allergy testing, the patient complains of itching at the site, weakness, and dizziness. Which action by the nurse is most appropriate initially?

a. Elevate the arm above the shoulder

b. Administer subcutaneous epinephrine

c. Apply a warm compress to area

d. Apply a local anti-inflammatory cream to the site

ANS: B

Injection of subcutaneous epinephrine should be given at the first sign of allergy.

MSC: NCLEX: Physiological Integrity

11.Which person is most at risk for a hypersensitivity reaction?

a. 26-year-old receiving his second desensitization injection

b. 35-year-old starting back on birth control tablets

c. The 52-year-old started on a new series of Pyridium for cystitis

d. The 84-year-old receiving penicillin for an annually recurring respiratory infection

ANS: D

The 84-year-old with the deteriorated immune system is a prime candidate for a delayed hypersensitivity reaction.

12.The nurse recommends to the busy mother of three that the antihistamine fexofenadine (Allegra) would be more beneficial than diphenhydramine (Benadryl) because Allegra:

a.	is inexpensive.
b.	contains a stimulant for an energy boost.
c.	does not dry out the mucous membranes.
d.	does not induce drowsiness.

ANS: D

Allegra does not induce drowsiness as does Benadryl.

MSC: NCLEX: Physiological Integrity

13.The patient who had an asthma-like reaction to a desensitization shot was medicated with a subcutaneous injection of epinephrine. What effect should the nurse assure the anxious patient this will have?

a.	Cause vasodilation
b.	Produce bronchodilation
c.	Cause productive coughing
d.	Reduction of pulse rate

ANS: B

The drug epinephrine is given in the case of anaphylaxis because it is a quick-acting drug that produces bronchodilation and vasoconstriction, which relieves respiratory distress. The drug can be ordered to be repeated every 20 minutes. The patient may experience an increase in heart rate.

14.Health care facilities have reduced the incidence of serious latex reactions by:

a.	Having local and injectable corticosteroids on hand for employees
b.	Desensitizing staff who are allergic
c.	Supplying extra handwashing stations in the halls
d.	Using only powder-free gloves

ANS: D

Powder inside gloves can become aerosolized and cause inhalant reactions.

MSC:NCLEX: Safe, Effective Care Environment

15.What should the nurse include to assess for in the plan of care for a patient undergoing plasmapheresis?

a.	Hypotension
b.	Hypersensitivity
c.	Urticaria
d.	Flank pain

ANS: A

Hypotension occurs during plasmapheresis because of transient volume changes in the blood.

16.A patient is undergoing immunotherapy on a perennial basis. With this form of treatment, what should the patient receive?

a.	Larger doses each week
b.	Higher concentrations each week
c.	Increased amounts and concentrations in 6-week cycles
d.	The same amount and concentration each visit

ANS: C

Perennial therapy is most widely accepted, because it allows for a higher cumulative dose, which produces a better effect. Perennial therapy usually begins with 0.05 mL of 1:10,000 dilution and increases to 0.5 mL in a 6-week period.

17.What is the term for transplantation of tissue between members of the same species?

a.	Allograft
b.	Autograft
c.	Isograft
d.	Homograft

ANS: A

The allograft is the transplantation of tissues between members of the same species, such as a graft for full-thickness burns.

18.In which patient should the nurse be most concerned about immunodeficiency disorder?

a.	The patient taking desensitization injections (immunotherapy)
b.	The patient on long-term radiation therapy for cancer
c.	The overweight patient
d.	The patient recently diagnosed with lupus erythematosus

ANS: B

Radiation destroys lymphocytes and depletes the stem cells. Prolonged radiation depresses the bone marrow.

19.What is the purpose of plasmapheresis in the treatment of rheumatoid arthritis?

a.	To add corticosteroids to relieve pain
b.	To remove pathologic substances present in the plasma
c.	To remove waste products such as urea and albumin
d.	To add antinuclear antibodies

ANS: B

Plasmapheresis is the removal of plasma-containing components causing or thought to cause disease.

20.The nurse explains that when the patient received tetanus antitoxin with the antibodies in it, the patient received a_____type of immunity.

a.	Active natural
b.	Passive natural
c.	Active artificial
d.	Passive artificial

ANS: D

When a person receives an inoculation of antibodies from another source, as with tetanus antitoxin, it is considered a passive artificial immunity.

21.Because the older adult has decreased production of saliva and gastric secretions, they are at risk for:

a.	mouth ulcers.
b.	fissures in corners of the mouth.
c.	gastrointestinal infections.
d.	bloating.

ANS: C

Deficient saliva and gastric secretions make the older adult prone to gastrointestinal infections. 22.What is the major negative effect of cell-mediated immunity?

a.	Depression of bone marrow
b.	Rejection of transplanted tissue
c.	Activation of the T cells
d.	Stimulation of the B cells

ANS: B

Cell-mediated immunity has the negative effect of rejection of transplanted tissue. Activation of T cells and stimulation of B cells are the positive basis of the cell-mediated immunity.

MSC: NCLEX: Physiological Integrity 23.What is B-cell

proliferation dependent on?

a.	Presence of NK (natural killer) cells
b.	Complement system
c.	Antigen stimulation
d.	Lymphokines

ANS: C

Antigen stimulation is the sole focus of B-cell proliferation.

MSC: NCLEX: Physiological Integrity

24.What timeframe must blood be transfused within once it has been removed from refrigeration?

a.	2 hours
b.	4 hours
c.	6 hours
d.	3 hours

ANS: B

Blood must be administered within 4 hours after removal from refrigeration, and blood components within 6 hours of removal.

25.The LPN/LVN has arrived at the patients bedside with a unit of packed cells to be connected to an IV that is infusing. When the RN arrives, what is the first thing the nurses must do?

a.	Check to ensure that the donor and recipient numbers match according to policy
b.	Request the patient to sign the card on the packed cells
c.	Immediately administer the packed cells
d.	Check the patients ID bracelet and then administer the packed cells

ANS: A

Donor and recipient numbers are specific and must be thoroughly checked and the patient identified with an armband.

MSC:NCLEX: Safe, Effective Care Environment

26.The nurse arrives at the bedside of a patient who has had a unit of packed cells infusing in his right arm for 35 minutes. He is complaining of chills, itching, and shortness of breath. What should be the nurses initial action?

a.	Cover with a warm blanket
b.	Take the patients temperature
c.	Elevate the head of the bed
d.	Stop the transfusion and continue with saline

ANS: D

Mild transfusion reaction signs and symptoms include dermatitis, diarrhea, fever, chills, urticaria, and cough The initial intervention should be to stop the transfusion and continue with saline. Elevation of the head, taking vital signs, and covering with a warm blanket are not wrong, but are not of primary importance at this time.

MSC: NCLEX: Physiological Integrity

27.Which symptom would be classified as a mild transfusion reaction?

a.	Orthopnea
b.	Tachycardia
c.	Hypotension
d.	Wheezing

ANS: A

Mild transfusion reaction signs and symptoms include dermatitis, diarrhea, fever, chills, urticaria, cough, and orthopnea.

28.What should the nurse do because of the increasing strength of the dose in the injections for immunotherapy?

a.	Observe the patient for at least 20 minutes after administration
b.	Take the vital signs every 10 minutes for an hour
c.	Have the patient lie down quietly for an hour
d.	Place a warm compress on the area to speed its absorption

ANS: A

The patient should be observed for 20 minutes after the increased dose of the allergen. If anaphylaxis is going to occur, it will do so within that time frame.

KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

29.If a nurse is sensitive to latex gloves, what potential food sensitivities might the nurse develop? (Select all that apply.)

a.	Peanuts
b.	Avocados
c.	Milk
d.	Bananas
e.	Tomatoes
f.	Potatoes

ANS: B, D, E, F

A person sensitive to latex may also be sensitive to certain foods, including avocados, kiwi, guava, bananas, water chestnuts, hazelnuts, tomatoes, potatoes, peaches, grapes, and apricots.

30.Which of the following provide the body with innate immunity? (Select all that apply.)

a.	Skin and mucous membranes
b.	Lungs
c.	Heart
d.	Tears and saliva
e.	Natural intestinal and vaginal flora
f.	Stomach acid

ANS: A, D, E, F

The innate immune system is composed of the skin and mucous membranes, cilia, stomach acid, tears, saliva, sebaceous glands, and secretions and flora of the intestine and vagina. These organs, tissues, and secretions provide biochemical and physical barriers to disease.

Chapter 63. Infectious Disorders

1. How do antiviral drugs act?

a. They interfere with cell wall development.

b. They decrease cell membrane permeability.

c. They destroy new, immature viral particles.

d. They reduce the rate of viral replication.

ANS: D

2. Which statement applies to yeasts?

a. They are usually considered to be pathogenic.

b. They seldom contain a distinct nucleus.

c. They may cause opportunistic infection in the body.

d. They are normally not found in large numbers in resident flora.

ANS: C

3. Fungi reproduce by:

1. budding.

2. extension of hyphae.

3. binary fission.

4. production of spores.

a. 1, 2

b. 2, 4

c. 1, 2, 4

d. 2, 3, 4

ANS: C

4. Which of the following is NOT classified as a protozoan agent of disease?

a. Plasmodium vivax

b. Trichomonas vaginalis

c. Tinea pedis

d. Entamoeba histolytica

ANS: C

5. Which of the following is a characteristic of rickettsia?

a. It is a very small gram-negative intracellular microbe.

b. It exists in three forms.

c. It causes sexually transmitted disease.

d. It reproduces by budding.

ANS: A

6. Entamoeba histolytica is transmitted by which of the following?

a. Mosquitoes (bites)

b. Inhaling contaminated particles

c. Sexual intercourse

d. Cysts in feces

ANS: D

7. Which of the following is a characteristic of resident or normal flora (microflora)?

a. It exists in all areas of the body.

b. Different species inhabit various areas of the body.

c. It is of no benefit to the human host.

d. It consists only of bacteria.

ANS: B

8. Which of the following is normally considered sterile?

a. Urine

b. Pharynx

c. Distal urethra

d. Vagina

ANS: A

9. The term *nosocomial infection* means:

a. transmission involves an insect or animal host.

b. acquired in a hospital or medical facility.

c. transmitted by a fomite.

d. spread by direct contact with secretions from an open lesion.

ANS: B

10. Transmission of microbes by direct contact includes:

a. touching a contaminated countertop.

b. sexual intercourse.

c. drinking contaminated water.

d. inhaling dust-borne microbes.

ANS: B

11. What does the term *carrier* mean?

a. A person with active infection who acts as a reservoir for microbes

b. Animals, insects, objects, or surfaces contaminated by pathogens

c. An individual who is contagious through infected secretions on the hands

d. An asymptomatic person whose body harbors pathogens and can transmit them to others

ANS: D

12. Opportunistic infection may develop when:

a. pathogens enter the body but cannot colonize the site of entry.

b. an imbalance occurs in the normal resident flora.

c. host resistance increases, and the balance of resident flora is restored.

d. contaminated food or water is unknowingly ingested.

ANS: B

13. Host resistance is promoted by all of the following EXCEPT:

a. prescribed immunizations.

b. chronic respiratory disease.

c. vitamin and mineral supplements.

d. appropriate inflammatory or immune response.

ANS: B

14. Which of the following factors would NOT increase the virulence of a specific microbe?

a. Secretion of endotoxin

b. Presence of a bacterial capsule

c. Production of interferons

d. Secretion of invasive enzymes

ANS: C

15. That time in the course of an infection when the infected person may experience a headache or fatigue and senses he or she is coming down with something is referred to as which of the following?

a. Subclinical period

b. Eclipse period

c. Prodromal period

d. Presymptomatic period

ANS: C

16. The principle of Universal Precautions is based on:

a. using disinfectants at all times to eliminate cross-infections.

b. not touching any open or bleeding lesions.

c. sterilizing all instruments and equipment after each use.

d. assuming that all body fluids from all individuals are possible sources of infection.

ANS: D

17. The incubation period refers to the time period between:

a. entry of the pathogen into the body and the first signs of infectious disease.

b. the onset of the prodromal period and the peak of the acute infection.

c. the onset of clinical signs and signs of recovery from infection.

d. the acute period and establishment of chronic infection.

ANS: A

18. What does bacteremia refer to?

a. Numerous pathogens circulating and reproducing in the blood

b. Uncontrolled sepsis throughout the body

c. Multiple infections, primary and secondary, established in the body

d. Microbes present in the blood

ANS: D

19. Which of the following is a local sign of infection?

a. Fever and leukocytosis

b. Headache and anorexia

c. Pain, erythema, and swelling

d. Nausea, weight loss, and fatigue

ANS: C

20. What are culture and sensitivity tests used for?

a. To determine the type of microbe present in an exudate

b. To provide a specific medium that supports maximum microbial growth

c. To identify the causative microbe and the effective antimicrobial agent for it

d. To provide living host cells for microbes requiring such for replication

ANS: C

21. A broad-spectrum bactericidal agent would be expected to:

a. destroy many gram-positive and gram-negative bacteria.

b. destroy all pathogenic microbes in contact with the agent.

c. reduce the replication of many bacteria.

d. inhibit the growth of most spores and acid-fast bacteria.

ANS: A

22. How does penicillin act as a bactericidal agent?

a. It interferes with cell-wall synthesis.

b. It blocks protein synthesis.

c. It increases cell membrane permeability.

d. It prevents DNA replication.

ANS: A

23. Secondary infection may occur with administration of antibacterial drugs because the:

a. patient is allergic to the drug.

b. balance of species in the resident flora is upset.

c. mucosa of the stomach is irritated.

d. infecting microbes spread to adjacent areas.

ANS: B

24. All of the following are mechanisms of antiviral drug action EXCEPT:

a. interference with attachment to host cell.

b. block assembly of viral particles.

c. interference with mitosis.

d. shedding of protein coat.

ANS: C

25. Secondary bacterial infections occur frequently during influenza epidemics primarily because:

a. antiviral drugs lower host resistance.

b. the virus causes extensive tissue inflammation and necrosis.

c. respiratory droplets transmit infections.

d. the viral infection is usually self-limiting.

ANS: B

26. The primary pathological effect of influenza virus is:

a. destruction of the mucosa in the lower respiratory tract.

b. replication of the virus in respiratory secretions.

c. destruction of leukocytes and macrophages in the lungs.

d. inflammation and necrosis of the upper respiratory epithelium.

ANS: D

27. What does leukocytosis frequently indicate?

a. Immunosuppression

b. Bone marrow damage

c. Presence of bacterial infection

d. An allergic or autoimmune reaction

ANS: C

28. When an infection or inflammation is suspected, what does leucopenia often indicate?

a. Bacterial infection

b. Viral infection

c. Allergic reaction

d. Septicemia

ANS: B

29. Which of the following statements applies to *Chlamydia*?

a. The microbe exists as a chain of cells.

b. It causes a common STD.

c.	It possesses many flagella.
d.	It is excreted in feces.

ANS: B

30. Which of the following microbes is classified as an obligate intracellular parasite?

a.	Fungus
b.	Bacterium
c.	Virus
d.	Protozoa

ANS:

31. Which of the following are characteristics of influenza virus?

1. It is an obligate intracellular parasite.

2. It contains RNA.

3. It usually causes nausea and vomiting.

4. There are three subtypes: A, B, C.

a.	1, 4
b.	1, 3
c.	2, 3, 4
d.	1, 2, 4

ANS: D

32. The widespread necrosis of respiratory mucosa caused by an influenza infection often gives rise to:

a. severe anemia.

b. secondary infections.

c. asthma.

d. emphysema.

ANS: B

33. Prions cannot be cultured in a PETRI plate of media because:

a. they take so long to grow.

b. they require extensive amounts of specialized nutrients.

c. they are proteinaceous particles, not living organisms.

d. they are viruses that dont grow on conventional media.

ANS: C

34. Which of the following statements applies to Influenza A H1N1?

a. It alters human chromosomes to cause manifestations.

b. It usually causes severe respiratory distress and high fever.

c. Infection is common in the elderly.

d. It contains genetic material from avian, swine, and human viruses.

ANS: D

35. Which of the following does NOT directly determine the virulence of a microbe?

a. Capacity for opportunism

b. Production of toxins

c. Ability to mutate

d. Invasive qualities

ANS: A

36. Which of the following is a function of interferons?

a. They block the invasion of pathogenic bacteria.

b. They reduce the inflammatory response to local infection.

c. They increase host cell resistance to viral invasion.

d. They may facilitate the spread of some cancer cells.

ANS: C

37. Inflamed tissue is likely to become infected because:

a. the immune system is not effective in inflamed tissue.

b. the increased fluid and protein in the inflamed area supports microbial growth.

c. phagocytes cannot penetrate the inflamed areas.

d. capillaries are less permeable in the affected area.

ANS: B

38. When an infectious disease is occurring globally at a higher rate than usual, it may be designated as a/an:

a. sporadic occurrence.

b. epidemic.

c. pandemic.

d. emerging disease.

ANS: C

39. Which of the following is the primary difference between an antiseptic and a disinfectant?

a. Antiseptic is used on living tissue, whereas disinfectant is designed for nonliving surfaces.

b. Antiseptic is much stronger than the potency of a disinfectant.

c. Antiseptic often causes allergic skin reactions, whereas disinfectant is always hypoallergenic.

d. Antiseptic is effective against endospores; disinfectants are not effective against endospores.

ANS: A

40. Drugs that are designed to inhibit or slow down growth of microbes but not necessarily kill them are considered:

a. ineffective.

b. bacteriostatic.

c. narrow-spectrum.

d. bactericidal.

ANS: B

Chapter 64. Common Psychosocial Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. The effectiveness of benzodiazepines in treating anxiety disorders suggests that which of the following neurotransmitters plays a role in anxiety?
a. Acetylcholine
b. Gamma-aminobutyric acid (GABA)
c. Dopamine
d. Serotonin

____ 2. The criteria for diagnosing generalized anxiety disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (text revision)* state that excessive worry or apprehension must be present more days than not for at least:
a. 1 month
b. 3 months
c. 6 months
d. 12 months

____ 3. A patient presents to the clinician after experiencing four episodes in the last month of sweating, palpitations, chest pain, nausea, and shaking. Each episode lasted about 10 minutes. The patient is now becoming very fearful of future events and has been reluctant to leave the house. The clinician suspects panic disorder but wants to rule out any possible medical causes. Which of the following medical conditions can mimic the symptoms of a panic attack?
a. Pheochromocytoma
b. Hyperthyroidism
c. Cardiac arrhythmias
d. All of the above

____ 4. Which of the following is considered first-line treatment for panic disorders?
a. Benzodiazepines
b. Selective serotonin reuptake inhibitors (SSRIs)
c. Tricyclic antidepressants
d. Cognitive behavioral therapy

__ 5. Which of the following symptoms is *not* part of the diagnostic criteria for post-traumatic stress disorder (PTSD)?
a. Hypersomnolence
b. Blunted feelings
c. Loss of interest in significant activities
d. Intrusive recurrent recollections of the event

____ 6. Which of the following neuroendocrine abnormalities is implicated in depression?

a. Decrease in adrenal size
b. Increased cortisol and corticotrophin-releasing hormone
c. An exaggerated response of thyrotropin (TRH) to infusion of thyroid-releasing hormone
d. Increased inhibitory response of glucocorticoids to dexamethasone

__ 7. The clinician has chosen to prescribe an SSRI instead of a tricyclic antidepressant (TCA) for a patient fitting the diagnostic criteria for depression. Which of the following is *not* true concerning SSRIs in comparison to tricyclic antidepressants?

a. SSRIs are more effective than TCAs.
b. SSRIs take less time to work than TCAs.
c. SSRIs have a more favorable side-effect profile than TCAs.
d. SSRIs are not lethal in overdose.

__ 8. After discontinuing fluoxetine, how long must a person wait before starting a monoamine oxidase inhibitor?

a. 2 weeks
b. 3 weeks
c. 4 weeks
d. 5 weeks

__ 9. It is important to educate patients with depression and their family members about reporting signs of increasing depression and suicidal thoughts. This is especially true during which time period?

a. Before the initiation of treatment
b. 1 to 2 weeks after the initiation of treatment
c. When switching to a different medication
d. 1 to 2 weeks after tapering off medications

__ 10. A patient is experiencing extrapyramidal side effects from his antipsychotic medications. The clinician would most likely take which of the following approaches to treating these side effects?

a. Give the patient a “drug holiday” until the symptoms resolve and then restart the medication.
b. Switch the patient to a different antipsychotic.
c. Treat the patient with anticholinergics.
d. Treat the patient with anticonvulsants.

____ 11. According to Kübler-Ross, the stages of grief occur in which order?

a. Anger, denial, depression, bargaining, acceptance

b. Anger, denial, bargaining, acceptance, depression
c. Denial, anger, depression, bargaining, acceptance
d. Denial, anger, bargaining, depression, acceptance

12. The clinician is educating a patient about the effects of marijuana. The patient stated she has been smoking for years and believes the use does not interfere with her life. What is a significant long- term sequelae of marijuana use that the clinician should educate this patient about?
a. Memory impairment
b. Sexual dysfunction
c. Dry mouth
d. There are no long-term consequences of marijuana use.

____ 13. Cocaine acts as a stimulant by blocking the reuptake of which neurotransmitter?
a. GABA
b. Acetylcholine
c. Dopamine
d. Serotonin

____ 14. What blood alcohol level corresponds with the signs of stupor and confusion?
a. 0.05
b. 0.1
c. 0.2
d. 0.3

____ 15. Rapid eye movement (REM) sleep occurs how frequently during non-REM sleep?
a. Every 30 minutes
b. Every 60 minutes
c. Every 90 minutes
d. Every 180 minutes

____ 16. Which of the following is a laboratory finding commonly found in patients with anorexia nervosa?
a. Hypercholesterolemia
b. Hypermagnesmia
c. Leukocytosis
d. Decreased TRH

__ 17. Which of the following is the only drug for bulimia approved by the U.S. Food and Drug Administration?
a. Sertraline
b. Fluoxetine

c. Citoprolam
d. Imipramine

__ 18. Which of the following would be important to monitor in a child receiving methylphenidate for treatment of attention deficit-hyperactivity disorder (ADHD)?
a. Liver function
b. Vision
c. Growth parameters
d. Renal function

____ 19. It is important for the clinician to discuss the long-term effects of sexual assault with survivors. Which of the following is the *most* common long-term effect of sexual assault?
a. Depression
b. Obsessive-compulsive disorder
c. Substance abuse
d. PTSD

__ 20. Women are at the highest risk for developing postpartum depression for up to how long after childbirth?
a. 2 weeks
b. 1 month
c. 3 months
d. 6 months

____ 21. Which is the most prevalent psychiatric condition in the United States?
a. Depression
b. Anxiety
c. Substance-related addictions
d. Gambling

____ 22. What is recorded as clinical category two of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (text revision)*?
a. Clinical disorder or focus of clinical attention
b. Personality or environmental problems
c. Environmental and psychosocial stressors
d. Global assessment of functioning

____ 23. Which of the following may be used to evaluate a person's suicide risk?
a. CAGE
b. SANE

c. SAD PERSONAS
d. DIGFAST

__ 24. Assessing for adherence with prescribed medications and developing a plan for what to do if they are stopped is a major treatment issue for which of the following diagnostic groups?

a. ADHD
b. Bipolar
c. Depression
d. Anxiety

____ 25. Bipolar disorder requires differential diagnosis from all of the following except?

a. Substance abuse and medication effects
b. Medical and neurological disorders
c. Cluster B personality disorders and depression
d. Obsessive-compulsive disorder

True/False

Indicate whether the statement is true or false.

__ 1. The use of benzodiazepines in the patient with generalized anxiety disorder and comorbid depression can exacerbate depressive symptoms.

__ 2. Depressive episodes associated with bipolar disorder are treated the same as major depressive disorder.

__ 3. Women in abusive relationships have a greater chance of being killed by their batterers when they leave the relationship than women who stay.

____ 4. Adults must show childhood onset of symptoms to receive a diagnosis of ADHD.

____ 5. Parkinson's disease and dementing illnesses may commonly manifest depressive symptoms.

____ 6. The best predictor of suicide risk is a history of suicide attempts.

____ 7. A no-suicide contract can prevent a suicide attempt.

__ 8. Depression is the most chronic disabling and economically catastrophic medical disorder of the severe mental illnesses.

__ 9. Clozapine (Clozaril) requires laboratory monitoring at specified frequencies with results reported to a national registry.

____ 10. When combined with certain other medications, serotonin-specific antidepressants can have significant liver P450-interaction effects.

Chapter 64. Common Psychosocial Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: C PTS: 1
3. ANS: D PTS: 1
4. ANS: D PTS: 1
5. ANS: A PTS: 1
6. ANS: B PTS: 1
7. ANS: A PTS: 1
8. ANS: D PTS: 1
9. ANS: B PTS: 1
10. ANS: C PTS: 1
11. ANS: D PTS: 1
12. ANS: A PTS: 1
13. ANS: C PTS: 1
14. ANS: D PTS: 1
15. ANS: C PTS: 1
16. ANS: A PTS: 1
17. ANS: B PTS: 1
18. ANS: C PTS: 1
19. ANS: D PTS: 1
20. ANS: D PTS: 1

21. ANS: B PTS: 1

22. ANS: C PTS: 1

23. ANS: C PTS: 1

24. ANS: B PTS: 1

25. ANS: D PTS: 1

TRUE/FALSE

1. ANS: T PTS: 1

2. ANS: F PTS: 1

3. ANS: T PTS: 1

4. ANS: T PTS: 1

5. ANS: T PTS: 1

6. ANS: T PTS: 1

7. ANS: F PTS: 1

8. ANS: F PTS: 1

9. ANS: T PTS: 1

10. ANS: T PTS: 1

Chapter 65. Substance Use Disorders

MULTIPLE CHOICE

1.A 60-year-old man was admitted for cholecystitis that resulted in a cholecystectomy. On his third day of hospitalization, he begins to sweat profusely, tremble, and has a blood pressure of 160/100. Based on these findings, what focused assessment should the nurse complete?

a.	Cardiac problems
b.	Respiratory problems
c.	Withdrawal problems
d.	Circulatory problems

ANS: C

Diaphoresis, tremors, and hypertension are all symptoms of withdrawal from alcohol consumption. The nurse, concerned about the patients medical condition, may not consider substance abuse until withdrawal symptoms appear.

2.What age of onset of alcohol consumption is most predictive of alcohol addiction?

a.	8 or younger
b.	10 or younger
c.	12 or younger
d.	14 or younger

ANS: D

Forty-four percent of those who start drinking at the age of 14 or younger will develop alcoholism.

3.Alcohol is involved in motor vehicle accidents, suicides, and homicides. Approximately how many deaths each year are related to alcohol consumption?

a.	50,000
b.	70,000
c.	80,000
d.	100,000

ANS: D

About 100,000 deaths each year are related to alcohol consumption.

4.What stage of dependence is described by a patient when he tells the nurse that he has tried to stop his drug habit, but he does not feel normal without it?

a.	Early
b.	Prodromal
c.	Middle
d.	Late

ANS: C

In the middle stage, the user shows signs of withdrawal with abstinence and must use the drug to feel normal.

5.What must a patient in the late stages of dependence do in order to recover?

a.	Gain insight into the addiction
b.	Receive treatment for substance abuse

c.	Pledge to lead a completely different lifestyle
d.	Seek a nondrug-oriented support system

ANS: B

Very few people in the late stage of dependence will recover without treatment. The other options may aid in the recovery, but it is the treatment that is essential for recovery.

6.What is the best response by a nurse when a patient inquires how alcohol acts so quickly on his system?

a.	Alcohol is digested quickly.
b.	Alcohol is converted to glycogen immediately.
c.	Alcohol is metabolized into ethanol rapidly.
d.	Alcohol is excreted in urine slowly.

ANS: C

Alcohol is not digested or converted into glycogen, but it is metabolized quickly by the liver to ethanol.

7.The nurse reminds a group of high school students that most states have laws limiting blood alcohol levels of drivers. What is the legal blood alcohol serum level in most states?

a.	0.08%
b.	0.20%
c.	0.40%
d.	0.50%

ANS: A

Most states designate blood alcohol serum levels of 0.08% as the legal limit for driving a motor vehicle.

8.A pregnant adolescent tells the nurse that she only drinks a little. How many drinks per day can cause an adverse effect in an infant?

a.	One drink a day
b.	Two drinks a day
c.	Three drinks a day
d.	Four drinks a day

ANS: B

As few as two drinks per day may cause adverse effects in an infant.

9.The nurse assesses an alcoholic patient carefully for signs of withdrawal. How soon after cessation of alcohol intake do withdrawal symptoms usually appear?

a.	3 hours
b.	4 hours
c.	5 hours
d.	6 hours

ANS: D

Withdrawal signs can occur as early as 6 hours after cessation of alcohol intake and sometimes last for 3 to 5 days.

10.The nurse is performing an initial assessment on an alcoholic patient. Which of the following actions by the nurse would best ensure honest answers?

a.	Not asking personal questions
b.	Having a nonjudgmental attitude
c.	Including the family
d.	Promising the patient not to tell anyone

ANS: B

Maintaining a nonjudgmental attitude may reassure the patient and allow him to be more honest in his responses to the admission assessment.

11.During the detoxification period, what does the nurse aim to achieve when designing interventions?

a.	Enroll the patient in Alcoholics Anonymous (AA)
b.	Keep the patient safe from aspiration and seizure
c.	Help the patient interact in nonaddictive activities
d.	Help the patient gain insight into the addiction

ANS: B

Care for the addicted patient starts with detoxification and is focused on keeping the patient safe from the symptoms of withdrawal. Enrolling the patient in AA, helping the patient interact in nonaddictive activities, and helping the patient gain insight into the addiction would be part of the rehabilitation process.

12.What should the entire health team focus on during the rehabilitation phase?

a.	Establishing a support system

b.	Seeking and maintaining employment
c.	Abstaining from drug use
d.	Addressing the problems related to addiction

ANS: C

The focus of rehabilitation is for the patient to abstain from drug use.

13.What should the nurse do to decrease the patients disorientation at night during the detoxification period?

a.	Place the patient in a room with another recovering patient
b.	Instruct the patient to orient himself to his surroundings at bedtime
c.	Wake the patient up every 4 hours to eat a small snack
d.	Use nightlights and remove extra furniture from the room

ANS: D

Use of nightlights and removing extra furniture that could be misidentified will reduce disorientation. The patient should not be woken up to eat, but if he is awake, small snacks can be offered. The nurse should orient the patient to his surroundings.

14.The nurse explains that Alcoholics Anonymous (AA) consists of abstinent alcoholics who help other alcoholics become and stay sober. What is the foundation of AA?

a.	Psychotherapy
b.	A 12-step program
c.	Treatment center
d.	Individual counseling

ANS: B

The foundation of AA is a 12-step program.

15.What severe side effect will occur if an alcoholic patient consumes alcohol while taking disulfiram (Antabuse)?

a.	Nausea
b.	Blackouts
c.	Headaches
d.	Hypertension

ANS: A

When a person who is taking Antabuse consumes alcohol, severe nausea, tachycardia, shortness of breath, confusion, and dizziness are experienced. The drug is used as a form of aversion therapy.

16.If the patient tells the nurse, Im not an alcoholic. I can stop whenever I want to, what should be the nurses most therapeutic response?

a.	Well, why dont you?
b.	Hasnt alcohol use interfered with your employment?
c.	A positive attitude like that is a good start.
d.	What would you call alcoholism?

ANS: B

When the addicted person presents in denial, the nurse should use techniques to set limits on that behavior.

17.When a patient denies any problems related to addiction, what is the nurses most therapeutic response?

a.	What do you call this hospitalization?
b.	How can anybody help you if you dont see a problem?
c.	Would your family agree that you have no problems?
d.	Can you think of any time your behavior created an unpleasant situation in your life?

ANS: D

When the patient denies that his behavior is problematic, the nurse should ask the patient to recount incidences when the behavior had unpleasant consequences. 18.Which drug

is often used in date rape?

a.	Dalmane
b.	Xanax
c.	Narcan
d.	Rohypnol

ANS: D

Rohypnol has been abused as a date-rape drug and has not been approved for use in the United States.

19.A patient seems bewildered when he confides in the nurse that all of his friends and leisure time have been centered on a drug culture. Which would be the best response by the nurse?

a.	What other sort of activities might you enjoy?
b.	You will need to get new friends.

c. Returning to those activities will get you back here and in trouble.

d. You need to get a hobby.

ANS: A

Encouraging the patient to imagine new activities is a start toward seeking them. Giving advice is not therapeutic.

20.When a patient is admitted with an overdose of an opioid narcotic, the nurse should anticipate an order for which drug to reverse the effects of the narcotic?

a. Clonidine

b. Narcan

c. Orlaam

d. Methadone

ANS: B

Opioid overdose treatment involves administering Narcan as prescribed to reverse the effects of the narcotic.

21.The nurse concludes that a significant goal of the care plan for an alcoholic patient has been met when the patient makes which statement?

a. I drink because Im lonely.

b. All my difficulties are related to my drinking.

c. I wouldnt need to drink if I had my family back.

d. My drinking helps me cope with the stress of my job.

ANS: B

A major goal for the successful treatment of alcoholics is to have them express responsibility for their behavior.

22.While creating a methadone protocol for a patient rehabilitating from heroin addiction, the nurse explains that the patient will take methadone for what length of time?

a. Daily for the rest of his life

b. Daily until stabilized, then gradually reduce the dose to zero

c. Weekly for at least 6 months, then decrease the dose to once a month

d. Monthly for 6 to 10 months, then decrease the dose to zero

ANS: B

Methadone is given daily until the patient is stabilized. The methadone is reduced gradually until the patient does not need to take any.

23.A 22-year-old patient presents in the emergency department with the characteristics of severe Parkinson disease. The nurse should suspect an overdose of what drug?

a.	Marijuana
b.	Cocaine
c.	Amphetamines
d.	Valium

ANS: C

Over time, dopamine depletion in the brain can cause Parkinson-like symptoms to occur in people who abuse amphetamines.

24.A college student has brought his hallucinating roommate to the college clinic. The young man says his roommate has been experimenting with phencyclidine (PCP). How long should the nurse expect the hallucinations to last?

a.	30 to 60 minutes
b.	1 to 4 hours
c.	4 to 6 hours
d.	6 to 12 hours

ANS: D

Some hallucinogenic effects of PCP can last 6 to 12 hours.

25.The mother of a young woman being treated for amphetamine overdose asks the nurse when the manifestations will subside. What would be the most correct answer by the nurse?

a.	Usually in 8 to 10 hours.
b.	She will snap out of it in a day or two.
c.	Usually in about 2 hours, but the effects will return in 2 to 3 days.
d.	The manifestations may be permanent.

ANS: D

The manifestations of overdose of amphetamines are frequently permanent.

26.What nursing intervention should be included in the plan of care for a baby born to a drug-addicted mother?

a.	Swaddle the baby closely
b.	Place the baby in a brightly lit area
c.	Hold and rock the baby frequently
d.	Place the baby in a busy part of the nursery for stimulation

ANS: A

A baby born to a drug-addicted mother should be swaddled, placed in an area of low stimulation, and minimally handled.

27.What is the greatest problem with lysergic acid diethylamide (LSD) use?

a.	The drug is addictive.
b.	The drug stimulates drug-seeking behavior.
c.	The drug causes flashbacks.
d.	The drug sets off hypertensive episodes.

ANS: C

LSD causes flashbacks, or bad trips, unpredictably, and the flashbacks may occur years after ingestion of the drug. LSD is not considered an addictive drug and does not stimulate drug-seeking behavior. Hypertension is not a typical side effect of LSD.

28.What should the nurse do to decrease the damage of bruxism seen in a patient who has been abusing the drug ecstasy?

a.	Turn the patient to his right side
b.	Elevate the head of the bed 30 degrees
c.	Provide the patient with a pacifier
d.	Administer a muscle relaxant

ANS: C

The use of an infant pacifier will reduce the damage to the teeth for a patient who is manifesting bruxism (grinding of the teeth).

29.What should the nurse do when suspecting a co-worker of abusing drugs while at work?

a.	Confront the abuser
b.	Report observations to a supervisor
c.	Call the state board of nursing
d.	Discuss the problem with another co-worker

ANS: B

The nurses observations should be reported objectively, preferably in writing, to the supervisor.

MSC: NCLEX: Health Promotion and Maintenance

30.Which statement describes the impaired nurse who is in a peer assistance program?

a.	The nurse has a revoked nursing license.

b. The nurse does not have to notify her employer.

c. The nurse will be allowed to work as a nurse under supervision.

d. The nurse will be reported to the Healthcare Integrity and Protection Data Bank.

ANS: C

The peer assistance program allows the nurse to retain licensure and continue to work under supervision, although possibly in an area where access to controlled drugs is difficult. It is necessary for the employer to have information regarding the peer assistance assignment. Action is not reported to the Healthcare Integrity and Protection Data Bank until final adverse actions are taken,

MULTIPLE RESPONSE

31.During the initial intake assessment of a drug user, the nurse should attempt to obtain which subjective data? (Select all that apply.)

a. Usual pattern of use

b. Specific drug

c. Previous arrests

d. Amount of drug used

e. Time of last use

ANS: A, B, D, E

Determining the drug, strength, frequency, last use, and pattern of use is the basic database on a substance abuser.

32.The nurse should assess a patient for which criteria of addiction? (Select all that apply.)

a. Excessive use of the substance

b. Increase in social function

c. Uncontrollable consumption

d. Increase in economic function

e. Psychological disturbances

ANS: A, C, E

Criteria for addiction include excessive use of the substance, a decrease in social function, uncontrollable consumption, a decrease in economic function, and psychological disturbances.

33.A nurse suspects her a co-worker is abusing drugs. Which of the following symptoms, noticed in the co-worker, would contribute to the suspicions?

a. Spending more time with co-workers

b. Frequently absent from the unit

c.	Rapid changes in mood and performance
d.	Increased somatic complaints
e.	Patients report they did not receive their medications

ANS: B, C, D, E

Signs of drug abuse in a nurse include the nurse becoming more isolated from co-workers, being frequently absent from the unit, rapidly changing mood and performance, increasing somatic complaints, and patients reporting they did not receive their medications.

COMPLETION

34.When assessing an alcoholic patient, the nurse notes short-term memory loss, painful extremities, footdrop, and muttered incoherent responses to questions. The nurse recognizes these symptoms as most likely related to a condition caused by long-term alcohol abuse, which is known as _____ syndrome.

ANS:

Korsakoff

Korsakoff syndrome is a permanent condition caused by long-term alcohol use. The patient mutters incoherently and experiences short-term memory loss, painful extremities, and footdrop.

35.The nurse uses the CAGE questionnaire to assess a patient. The nurse suspects the patient is an alcoholic if there are affirmative answers for_____items on the questionnaire.

ANS:

2

two

An affirmative answer on two or more questions on the CAGE questionnaire is reason to assess more closely for possible alcohol abuse.

36.The nurse cautions that a person who chronically abuses drugs may experience mental impairment. The area of the brain that can be affected and permanently damaged is the _____ _____.

ANS:

limbic system

The most commonly abused drugs act on the limbic system of the brain and can cause permanent damage.

Chapter 66. Schizophrenia Spectrum Disorders

1. The nurse is caring for a client in an inpatient mental health setting. The nurse notices that when the client is conversing with other clients, he repeats what they are saying word for word. The nurse interprets this finding and documents it as which of the following?

A) Echopraxia

B) Neologisms

C) Tangentiality

D) Echolalia

2. While caring for a hospitalized client with schizophrenia, the nurse observes that the client is listening to the radio. The client tells the nurse that the radio commentator is speaking directly to him. The nurse interprets this finding as which of the following?

A) Autistic thinking

B) Concrete thinking

C) Referential thinking

D) Illusional thinking

3. A client has been diagnosed with schizophrenia. Assessment reveals that the client lives alone. His clothing is disheveled, his hair is uncombed and matted, and his body has a strange odor. During an interview, the clients family voices a desire for the client to live with them when he is discharged. Based on the assessment findings, which nursing diagnosis would be the priority?

A) Ineffective Role Performance related to symptoms of schizophrenia.

B) Social Isolation related to auditory hallucinations.

C) Dysfunctional Family Processes related to psychosis.

D) Bathing Self-Care Deficit related to symptoms of schizophrenia.

4. The nurse is caring for an elderly client who has been taking an antipsychotic medication for 1 week. The nurse notifies the physician when he observes that the client has muscle rigidity that resembles Parkinsons disease. Which agent would the nurse expect the physician to prescribe?

A) Anticholinergic

B) Anxiolytic

C) Benzodiazepine

D) Beta-blocker

5. The nurse is caring for a hospitalized client who has schizophrenia. The client has been taking antipsychotic medications for 1 week when the nurse observes that the clients eyes are fixed on the ceiling. The nurse interprets this finding as which of the following?

A) Akathisia

B) Oculogyric crisis

C) Retrocollis

D) Tardive dyskinesia

6. A hospitalized client with schizophrenia is receiving antipsychotic medications. While assessing the client, the nurse identifies signs and symptoms of a dystonic reaction. Which agent would the nurse expect to administer?

A) Diphenhydramine (Benadryl)

B) Propranolol (Inderal)

C) Risperidone (Risperdal)

D) Aripiprazole (Abilify)

7. The nurse is caring for a client who has been receiving treatment for schizophrenia with chlorpromazine for the past year. It would be essential for the nurse to monitor the client for which of the following?

A) Weight loss

B) Torticollis

C) Hypoglycemia

D) Tardive dyskinesia

8. A client hospitalized for treatment of schizophrenia has been receiving olanzapine (Zyprexa) for the past 2 months. The nurse would be especially alert for which of the following?

A) Weight loss

B) Hypertension

C) Diarrhea

D) Diabetes

9. The nurse is caring for a client who has been taking clozapine (Clozaril) for 2 weeks. The client tells the nurse, My throat is sore, and I feel weak. The nurse assesses the clients vital signs and finds that the client has a fever. The nurse notifies the physician, expecting an order to obtain which laboratory test?

A) A white blood cell count

B) Liver function studies

C) Serum potassium level

D) Serum sodium level

10. A client is being released from the inpatient psychiatric unit with a diagnosis of schizophrenia and treatment with antipsychotic medications. After teaching the client and

family about managing the disorder, the nurse determines that the teaching was effective when they state which of the following should be reported immediately?

A) Elevated temperature

B) Tremor

C) Decreased blood pressure

D) Weight gain

11. A nurse is preparing an in-service program for a group of psychiatricmental health nurses about schizophrenia. Which of the following would the nurse include as a major reason for relapse?

A) Lack of family support

B) Accessibility to community resources

C) Non-adherence to prescribed medications

D) Stigmatization of mental illness

12. While assessing a client with schizophrenia, the client states, Everywhere I turn, the government is watching me because I know too much. They are afraid that I might go public with the information about all those conspiracies. The nurse interprets this statement as indicating which type of delusion?

A) Grandiose

B) Nihilistic

C) Persecutory

D) Somatic

13. The nurse is interviewing a client with schizophrenia when the client begins to say, Kite, night, right, height, fright. The nurse documents this as which of the following?

A) Clang association

B) Stilted language

C) Verbigeration

D) Neologisms

14. A nurse is providing care to a client just recently diagnosed with schizophrenia during an inpatient hospital stay. Throughout the day, the nurse observes the client drinking from the water fountain quite frequently as well as carrying cans of soda and bottles of water with him wherever he goes. Upon entering the clients room, the nurse sees numerous empty cups that had been filled with fluids on his table and in the trash can. The room has an odor of urine. The nurse suspects which of the following?

A) Diabetes mellitus

B) Disordered water balance

C) Tardive dyskinesia

D) Orthostatic hypotension

15. A group of nursing students is reviewing the various theories related to the etiology of schizophrenia. The students demonstrate understanding of the information when they identify which neurotransmitter as being responsible for hallucinations and delusions?

A) Dopamine

B) Serotonin

C) Norepinephrine

D) Gamma-amino butyric acid (GABA)

16. After teaching a class on antipsychotic agents, the instructor determines that the teaching was successful when the class identifies which of the following as an example of a second-generation antipsychotic agent?

A) Fluphenazine (Prolixin)

B) Thiothixene (Navane)

C) Quetiapine (Seroquel)

D) Chlorpromazine (Thorazine)

17. When assessing a client for possible disordered water balance, the nurse checks the clients urine specific gravity. Which result would lead the nurse to suspect that the client is experiencing severe disordered water balance?

A) 1.020

B) 1.011

C) 1.005

D) 1.002

18. A client with schizophrenia tells the nurse, Im being watched constantly by the FBI because of my job. Which response by the nurse would be most appropriate?

A) Tell me more about how you are being watched.

B) It must be frightening to feel like youre always been watched.

C) Youre not being watched; its all in your mind.

D) You are experiencing a delusion because of your illness.

19. A nurse is working with a group of clients diagnosed with schizophrenia in a community setting. Which of the following would least likely be a priority?

A) Improving the quality of life

B) Instilling hope

C) Managing psychosis

D) Preventing relapse

20. A client with schizophrenia is prescribed clozapine because other prescribed medications have been ineffective. After teaching the client and family about the drug, the nurse determines that the teaching was successful when they state which of the following?

A) He needs to have an electrocardiogram periodically when taking this drug.

B) Well need to make sure that he has his blood count checked at least weekly.

C) He might develop toxic levels of the drug if he smokes cigarettes.

D) We need to watch to make sure that he doesnt lose too much weight.

21. Which of the following would be most important for the nurse to keep in mind when establishing the nursepatient relationship with a client with schizophrenia to promote recovery?

A) The relationship typically develops over a short period of time.

B) Decisions about care are the responsibility of interdisciplinary team.

C) Short, time-limited interactions are best for the client experiencing psychosis.

D) Typically, clients with schizophrenia readily engage in a therapeutic relationship. A

22. nurse is developing a teaching plan for a client with schizophrenia. Which method would the nurse use to be most effective?

A) Engaging the client the trial and error learning

B) Having the client write down information after directly being given the correct information

C) Asking the client questions that encourage the client to guess at the correct answer

D) Using visual aids that are very colorful and full of descriptive graphic images

23. Assessment of a client with schizophrenia reveals that he is hearing voices that tell him that people are staring at him and illusions. When developing the plan of care for this client, which nursing diagnosis would be most appropriate?

A) Disturbed thought processes

B) Risk for self-directed violence

C) Disturbed sensory perception

D) Ineffective coping

24. A nursing instructor is preparing a class lecture about schizophrenia and outcomes focusing on recovery. Which of the following would the instructor include as a major goal?

A) Continuity of care

B) Shorter in-patient stays

C) Immediate crisis stabilization

D) Social engagement

25. After assessing a client with schizophrenia, the nurse suspects that the client is experiencing an anticholinergic crisis. Which of the following would the nurse most likely have assessed? Select all that apply.

A) Dilated reactive pupils

B) Blurred vision

C) Ataxia

D) Coherent speech

E) Facial pallor

F) Disorientation

Answer Key

1. D
2. C
3. D
4. A
5. B
6. A
7. D
8. D
9. A
10. A
11. C
12. C
13. A
14. B
15. A
16. C
17. D
18. B
19. C
20. B
21. C
22. B
23. C
24. A

25. B, C, F

1. A client who has a major depressive episode tells the nurse that for the past 2 weeks, he has been hearing voices and at times thinks that someone is following him. History reveals that he had these alternating symptoms before along with times when he has experienced neither of these symptoms and has been able to function adequately. The nurse interprets these findings as suggesting which of the following?

A) Paranoid schizophrenia

B) Undifferentiated schizophrenia

C) Brief psychotic disorder

D) Schizoaffective disorder

2. A nursing instructor is developing a class lecture that compares and contrasts schizoaffective disorder with schizophrenia. When describing one of the differences between these two diagnoses, which of the following would the instructor include as reflecting schizoaffective disorder?

A) It is episodic in nature.

B) It involves difficulties with self-care.

C) It has less severe hallucinations.

D) It is associated with a lower suicide risk.

3. The nurse is caring for a client who was diagnosed with schizoaffective disorder. Based on the nurses understanding of this disorder, the nurse develops a plan of care to address which issue as the top priority?

A) Suicide

B) Aggression

C) Substance abuse

D) Eating disorder

4. A family member of a client diagnosed with schizoaffective disorder asks a nurse what causes the disorder. Which response by the nurse would be most appropriate?

A) Dysfunctional family dynamics has been identified as a strong link.

B) Research has suggested that the cause is predominately genetic.

C) Dopamine, a substance in the brain, appears to be underactive.

D) Studies have indicated that birth order is strongly associated with this disorder.

5. The nurse is caring for a client who was just admitted with a diagnosis of schizoaffective disorder with depression. Which agent would the nurse anticipate as being prescribed for this client?

A) Lithium

B) Haloperidol

C) Chlorpromazine

D) Clozapine

6. The nurse is assessing a newly admitted client diagnosed with schizoaffective disorder. The nurse assesses the clients level of anxiety and reactions to stressful situations, obtaining this information for which reason?

A) To help determine the clients outcomes after treatment

B) To help identify whether or not the clients mental competency is intact

C) To act as a predictor of the clients risk for a suicide attempt

D) To provide a basis for evaluating the clients social skills

7. The nurse is caring for a client diagnosed with a delusional disorder. While assessing this client, which of the following would the nurse expect to find?

A) History of chronic major depression

B) Consistently disrupting behavior patterns

C) Verbalization of bizarre delusions

D) Living with one or more delusions for a period of time

8. The nurse is preparing to interview a client who has a delusional disorder. Which of the following would the nurse expect?

A) Cognitive impairment

B) Normal behavior

C) Labile affect

D) Evidence of motor symptoms

9. The nurse is preparing to document information obtained from a client diagnosed with a delusional disorder who is experiencing somatic delusions. Which of the following would the nurse most likely document?

A) Disorientation

B) Reduced attention span

C) Above average intelligence

D) Body complaints

10.10. A client with schizoaffective disorder is prescribed clozapine to treat her symptoms. Which of the following instructions would the nurse provide?

A) Keep a record of how often and how long you experience the side effect of dry mouth.

B) Monitor your urinary output and notify your doctor if your urine changes color.

C) Keep an eye on your weight, and if you gain weight rapidly, notify your doctor.

D) If you experience any drowsiness, discontinue taking this medication.

11. After teaching a group of students about the epidemiology of schizoaffective disorder, the instructor determines that the teaching was successful when the students state which of the following?

A) The disorder occurs often in children.

B) It is more likely to occur in women.

C) Most persons are African Americans.

D) The disorder is rare in family relatives.

12. A client with schizoaffective disorder is having difficulty adhering to the medication regimen that requires the use of several agents. The client also is experiencing several side effects contributing to this nonadherence. The physician plans to change the clients medication. Which agent would the nurse anticipate that the physician would prescribe?

A) Lithium

B) Aripiprazole

C) Clozapine

D) Olanzapine

13. While interviewing a client diagnosed with a delusional disorder, the client states, I have this really strange odor coming out of my mouth. I stop to brush my teeth almost every hour and then rinse with mouthwash every half hour to get rid of this smell. Ive seen so many doctors, and they cant tell me whats wrong. The nurse interprets the clients statement as reflecting which type of delusion?

A) Erotomanic

B) Grandiose

C) Somatic

D) Jealous

Answer Key

1. D
2. A
3. A
4. B
5. D
6. C
7. D
8. B
9. D
10. C

11. B
12. B
13. C

Chapter 67. Mood Disorders

1. A client diagnosed with bipolar disorder and experiencing mania is admitted to the inpatient psychiatric setting. During the acute phase of mania, which medication would the nurse expect to most likely administer?

A) Lithium carbonate (Lithium)
B) Haloperidol lactate (Haldol)
C) Fluoxetine (Prozac)
D) Paroxetine (Paxil)

2. A client asks the nurse if he needs to alter any of his activities because he is taking lithium carbonate. Which of the following responses would be most appropriate?

A) Increase your salt intake if an activity causes you to perspire heavily.
B) Wear sunscreen when you are going to be outdoors in the summer time.
C) Drink less fluid than usual now because you are taking this drug.
D) No changes are necessary for strenuous activities you do outdoors.

3. The nurse is assessing a client with bipolar disorder who is experiencing mania. The client states, Im just so beautiful. Everyone just stops and stares at how gorgeous I am. Men constantly want to have sex with me. The nurse interprets these statements as indicative of which type of mood?

A) Irritable
B) Elevated
C) Expansive
D) Euphoric

4. The nurse is reviewing the medical record of a client with bipolar disorder. The nurse would most likely expect to find a history of which of the following?

A) Panic disorder
B) Schizophrenia
C) Delusional disorder
D) Posttraumatic stress disorder

5. A nurse is developing a presentation for families who have members that have been diagnosed with bipolar disorders. When describing this condition to the group, which of the following would the nurse most likely include?

A) As the person ages, the episodes tend to decrease over time.

B) Environmental stressors are a key cause of these disorders.

C) The risk for suicide is high with either depression or mania.

D) Risk-taking behaviors are more common with a depressive episode.

6. A client is to receive lithium therapy as part of the treatment plan for bipolar disorder. When reviewing the clients medication history, which agents would alert the nurse to the possibility that a decrease in lithium dosage may be needed? Select all that apply.

A) Lisinopril

B) Hydrochlorothiazide

C) Indomethacin

D) Caffeine

E) Aspirin

7. A client with bipolar disorder is receiving divalproex sodium as part of the treatment plan. When monitoring the clients blood level for this drug, which level would alert the nurse to the need to change the dosage?

A) 30 ng/mL

B) 55 ng/mL

C) 75 ng/mL

D) 115 ng/mL

8. A client with bipolar disorder having experienced a depressive episode is prescribed lamotrigine. After teaching the client about this medication, the nurse determines that the teaching was successful when the client states which of the following?

A) I need to notify my physician if I develop a skin rash.

B) I need to have my blood tested about once a month.

C) I have to watch how much salt I use every day.

D) This drug can affect my liver function.

9. A nurse is preparing to administer medications to a female client with bipolar disorder who is experiencing acute mania. Which of the following would be most appropriate for the nurse to do?

A) Tell the client firmly that she must take her medication.

B) Allow the client to participate in the treatment decision.

C) Restrain the client before administering the medication.

D) Notify the physician about the clients refusal of the medication.

10. A client who is receiving lithium comes to the clinic for an evaluation. During the visit, the client reports a fine hand tremor. Which action by the nurse would be most appropriate?

A) Immediately obtain a specimen to determine the clients blood drug level.

B) Suggest that the client take the medication with meals or snacks.

C) Assist the client in minimizing exposure to stressors.

D) Encourage the client to elevate the affected hand on a pillow.

11. A clients blood level of carbamazepine is increased. When reviewing the clients medication history, which of the following would alert the nurse to a possible interaction?

A) Phenobarbital

B) Primidone

C) Phenytoin

D) Diltiazem

12. A client is brought to the emergency department by his brother. The client has a history of bipolar disorder for which he is taking divalproex. The brother reports that he watched his brother take the medication about 2 hours ago. He stated, A little while ago, he got very disoriented and agitated. The nurse suspects toxicity based on assessment of which of the following? Select all that apply.

A) Tachypnea

B) Bradycardia

C) Hypotension

D) Nystagmus

E) Vomiting

13. A client with bipolar disorder has a lithium drug level of 1.2 mEq/L. Which of the following would the nurse expect to assess? Select all that apply.

A) Metallic taste

B) Ataxia

C) Diarrhea

D) Slurred speech

E) Fasciculations

F) Muscle weakness

14. The nurse is preparing a teaching plan for the family of a client who has been diagnosed with bipolar disorder. After teaching them about potential indicators for relapse, the nurse determines that the teaching was effective when they identify which of the following as suggesting mania? Select all that apply.

A) Avoiding people

B) Sleeping more than usual

C) Talking faster than usual

D) Being hungry all the time

E) Reading several books at once

15. A client with bipolar disorder has had a history of multiple episodes and states, Im so frustrated with whats happened because of these episodes. Which of the following would the nurse encourage to help support this clients recovery?

A) Codependence

B) Hope

C) Self-control

D) Independent decision making

Answer Key

1. B
2. A
3. C
4. A
5. C
6. A, B, C
7. A
8. A
9. B
10. C
11. D
12. C, D, E
13. A, C, F
14. C, D, E
15. B

Chapter 68. Anxiety, Stress, and Trauma-Related Disorders

1. The nurse is planning a presentation to a group of nursing students on the topic of anxiety disorders. Which of the following would the nurse include when describing panic disorder?

A) Individuals may believe they are having a heart attack when a panic attack occurs.

B) People with panic attacks often have fewer attacks if they also have agoraphobia.

C) Typically, individuals experience this disorder after the age of 30 years.

D) Persons rarely have an underlying comorbid condition of depression.

2. A client comes to the emergency department because he thinks he is having a heart attack. Further assessment determines that the client is not having a heart attack but is having a panic attack. When beginning to interview the client, which question would be most appropriate for the nurse to use?

A) Are you feeling much better now that you are lying down?

B) What did you experience just before and during the attack?

C) Do you think you will be able to drive home?

D) What do you think caused you to feel this way?

3. A client with a panic disorder has been prescribed a benzodiazepine medication. Which of the following would the nurse emphasize as a risk associated with using this medication?

A) Dietary restrictions

B) Withdrawal symptoms

C) Agitation

D) Fecal impaction

4. A female client is diagnosed with panic disorder. The client tells the nurse that she hasnt left her house in more than a month because she was afraid of another attack. She visited the mental health clinic today only because her son brought her. Which nursing diagnosis would be a priority for this client?

A) Powerlessness related to symptoms of anxiety

B) Decisional Conflict related to fear of leaving the house

C) Ineffective Family Coping related to symptoms of anxiety

D) Social Isolation related to fear of recurrence of anxiety symptoms

5. The nurse has instructed a client with panic disorder about how to use the technique of positive self-talk. The nurse determines that the client has understood the instructions when the client verbalizes which statement to use during an impending panic attack?

A) I am feeling very nervous right now.

B) I can handle this anxiety; it will be over shortly.

C) I am taking medication to eliminate these symptoms.

D) Relax your muscles, relax your muscles.

6. A client who has been diagnosed with panic disorder visits the clinic and experiences a panic attack. The client tells the nurse, Im so nervous. My hands are shaking, and Im sweating. I feel as if Im having a stroke right now. Which of the following would the nurse do first?

A) Stay with the client while remaining calm.

B) Move the client to a safe environment.

C) Tell the client that the attack will soon pass.

D) Teach the client deep breathing techniques to calm her.

7. A client with obsessive-compulsive disorder has been taking fluoxetine for 1 month. The client tells the nurse, These pills are making me sick. I think Im getting a brain tumor because of the headaches. Which response by the nurse would be most appropriate?

A) Lets talk about how often you have been performing the rituals lately.

B) Tell me how many times you have washed your hands today.

C) Have you been practicing your deep breathing and relaxation exercises?

D) These medications have side effects that can cause increased headaches.

8. A nurse who has worked with a client diagnosed with generalized anxiety disorder (GAD) when he was an inpatient on the psychiatric unit sees the client in the waiting room of the outpatient psychiatric clinic. The client motions to the nurse to come over so he can tell the nurse how things have been going since he was discharged. While talking with the client, the nurse determines that the clients therapy has been effective when the client states which of the following?

A) I am still experiencing quite a bit of stress at home and at work; things are different at home than they were in the hospital.

B) When my mother-in-law comes over now, I go out to my workshop and work on one of my projects.

C) Im still drinking coffee; I cant quit after drinking it all these years.

D) Ive learned having a beer after I get home from work helps me relax.

9. The nurse is caring for a client who is being treated in the emergency department for a panic attack. Which of the following nursing interventions would be most appropriate?

A) Demonstrate empathy for the client by trying to mimic the clients state of anxiety.

B) Tell the client that you must leave to go report his symptoms to the psychiatrist on duty.

C) Tell the client this is an acute exacerbation with a positive prognosis and low morbidity.

D) Stay with the client, emphasizing that he is safe and that you will remain with him.

10. A nurse determines that a client who is experiencing anxiety is using relief behaviors. The nurse determines that the client is experiencing which degree of anxiety?

A) Mild

B) Moderate

C) Severe

D) Panic

11. A group of students is reviewing information about anxiety disorders in preparation for a class examination. The students demonstrate understanding of the material when they state which of the following?

A) Anxiety disorders rank second to depression in psychiatric illnesses being treated.

B) Women experience anxiety disorders more often than do men.

C) Most anxiety disorders tend to be short term with individuals achieving full recovery.

D) Anxiety disorders are more common in children than in adolescents.

12. While interviewing a client, the client reports an intense fear of spiders, stating, I cant be near them. I get so upset. I start to sweat and hyperventilate if I see one. The nurse documents this finding as which of the following?

A) Algophobia

B) Entomophobia

C) Arachnophobia

D) Cynophobia

13. After teaching a class about the biochemical theories associated with panic disorder, the instructor determines a need for additional teaching when the students identify which neurotransmitter as being implicated?

A) Dopamine

B) Serotonin

C) Norepinephrine

D) Gamma-aminobutyric acid (GABA)

14. A nurse is preparing an in-service presentation about panic disorders and associated theories related to the cause. When describing the cognitivebehavioral concepts associated with panic disorders, which of the following would the nurse expect to address?

A) Personal losses

B) Conditioned response

C) Early separation

D) Dysfunctional family communication

15. A nurse is developing the plan of care for a client with panic disorder that will include pharmacologic therapy. Which of the following would the nurse most likely expect to administer?

A) Benzodiazepine
B) Selective serotonin reuptake inhibitor (SSRI)
C) Monoamine oxidase inhibitor (MAOI)
D) Tricyclic antidepressant (TCA)

16. A client with panic disorder who has been prescribed sertraline in conjunction with alprazolam comes to the clinic for a follow-up. The client states, I stopped taking the alprazolam about 2 days ago. I was feeling really sleepy and tired. Which of the following would alert the nurse to suspect possible withdrawal? Select all that apply.

A) Metallic taste
B) Irritability
C) Dry, flushed skin
D) Tremor
E) Muscle flaccidity

17. A client with obsessive-compulsive disorder (OCD) is using cue cards to help restructure thought patterns. Which statements would be appropriate to include on a cue card? Select all that apply.

A) These are the OCD thoughts.
B) Trust myself.
C) Keep on checking.
D) Safety is the key.
E) I did it right the first time.

18. A client is diagnosed with obsessive-compulsive disorder (OCD) and is to receive medication therapy. Which of the following agents might the nurse expect to be prescribed? Select all that apply.

A) Clomipramine
B) Lithium
C) Sertraline
D) Fluvoxamine
E) Paroxetine
F) Alprazolam

19. A woman diagnosed with obsessive-compulsive disorder comes to the clinic with her husband. During the visit, the husband states, Shes always checking and rechecking to make sure that all of the appliances are turned off before we go out. Its nerve-wracking.

We can never get out of the house on time. Isnt checking once enough? An understanding of which of the following would the nurse need to incorporate into the response?

A) The client is attempting to exert control over the situation.

B) The client performs the ritual to relieve anxiety temporarily.

C) The womans behavior reflects a need for safety.

D) The woman is attempting to use thought stopping to decrease her behavior.

20. A group of students is reviewing information about the etiology of generalized anxiety disorder (GAD). The students demonstrate understanding of this information when they identify which of the following as representing the psychoanalytic theory for this disorder?

A) Inaccurate environmental danger assessment

B) Exposure to multiple stressful life events

C) Kindling caused by overstimulation

D) Unresolved unconscious conflicts

21. A nurse is developing a teaching plan for a client with generalized anxiety disorder, focusing on nutrition. Which of the following would the nurse encourage the client to avoid? Select all that apply.

A) Coffee

B) Ginseng

C) Milk products

D) Citrus juices

E) Aged cheese

22. The nurse is assessing a client with posttraumatic stress disorder (PTSD). Which of the following would the nurse categorize as reflecting intrusion? Select all that apply.

A) Irritability

B) Difficulty sleeping

C) Flashbacks

D) Short-term memory deficits

E) Dissociation

23. A group of students is reviewing information about social phobia in preparation for an oral class presentation on this topic. Which of the following would the students expect to include when describing a person with this condition? Select all that apply.

A) Fear that others will judge them negatively

B) Openly speak up in crowds to reduce fear

C) Are insensitive to others criticism

D) Demonstrate a distorted view of their own strengths

E) Exaggerate personal flaws

24. A group of students is reviewing the signs and symptoms associated with anxiety. The students demonstrate an understanding of the information when they identify which of the following as cognitive symptoms? Select all that apply.

A) Edginess

B) Feelings of unreality

C) Difficulty concentrating

D) Tunnel vision

E) Apprehensiveness

F) Speech dysfluency

25. A client is diagnosed with generalized anxiety disorder and is prescribed medication therapy. Which agent would the nurse expect to administer to the client to obtain the quickest relief from anxiety symptoms?

A) Buspirone

B) Venlafaxine

C) Alprazolam

D) Imipramine

Answer Key

1. A
2. B
3. B
4. D
5. B
6. A
7. D
8. B
9. D
10. C
11. B
12. C
13. A
14. B
15. B
16. A, B, D

17.	A, B, E
18.	A, C, D, E
19.	B
20.	D
21.	A, B
22.	C, D
23.	A, D, E
24.	B, C, D
25.	C

Chapter 69. Obsessive-Compulsive Disorders

1. When planning care for a female patient diagnosed with obsessive and compulsive behavior, Nurse Barbara and case manager Marc must recognize that the ritual:

A.	Assists the patient to understand their inability to deal with reality.
B.	Helps the patient to be in control of their anxiety.
C.	Helps the patient control the obsessive and compulsive behavior.
D.	Is used to manipulate others.

ANS: B

The rituals performed by the patient with obsessive-compulsive disorder are a substitute for the cause of the anxiety.

2.A patient is frequently late for appointments because he goes back to his room numerous times to assure himself that none of his belongings have been stolen. What does this behavior represent?

a.	Senseless behavior
b.	Controlled repetition
c.	Obsessive-compulsive
d.	Anxiety tension

ANS: C

Obsessive-compulsive disorders have two features: thoughts that are recurrent, intrusive, and senseless; and behaviors that are performed repeatedly and ritualistically.

3.A 14-year-old survivor of a school shooting screams and dives under a table when firecrackers go off. What does this behavior represent?

a.	Phobia
b.	Post-traumatic stress disorder
c.	Obsessive-compulsive disorder

d. Disordered thinking

ANS: B

Post-traumatic stress disorder describes a response to an intense traumatic experience that is beyond the usual range of human experience.

4. The nurse is working with the family of a patient with obsessive-compulsive disorder (OCD). Which concept should the nurse incorporate in the teaching plan?

a. The thoughts, images, and impulses are voluntary.
b. The family should pay immediate attention to symptoms.
c. The thoughts, images, and impulses tend to worsen with stress.
d. OCD is a chronic disorder that does not respond to treatment.

ANS: C

Stress is known to increase the intensity of OCD symptoms. Families should be taught this relationship and the need to reduce stress in the patients life as much as possible. The symptoms are not under the patients voluntary control. It is nontherapeutic to immediately focus on the symptoms, since to do so contributes to secondary gain. OCD responds well to medication and therapy.

5. The nurse has identified a nursing diagnosis of disturbed thought processes for a patient with obsessive-compulsive disorder. What abilities displayed by the patient would be related to an appropriate outcome for this problem? Select all that apply.

a. Can identify when obsessions are worsening
b. Speaks of obsessions as being embarrassing behaviors
c. Describes lessening anxiety when compulsive rituals are interrupted
d. Plans to ignore obsessive thoughts and so minimizes resulting stress
e. Limits time focusing on obsessive thoughts to 15 minutes, 4 times a day

ANS: A, C, E

It is desirable for the patient to experience a sense of being able to identify and control the obsessive thinking and the resulting anxiety. Identifying the behaviors as embarrassing is not showing control nor is ignoring the behaviors.

6. A patient checks and rechecks electrical cords related to an obsessive thought that the house may burn down. The nurse and patient explore the likelihood of an actual fire. The patient states this event is not likely. This counseling demonstrates principles of:

a. flooding.
b. desensitization.
c. relaxation technique.
d. cognitive restructuring.

ANS: D

Cognitive restructuring involves the patient in testing automatic thoughts and drawing new conclusions. Desensitization involves graduated exposure to a feared object. Relaxation training teaches the patient to produce the opposite of the stress response. Flooding exposes the patient to a large amount of an undesirable stimulus in an effort to extinguish the anxiety response.

7. 26. A nurse assesses an individual who commonly experiences anxiety. Which comment by this person indicates the possibility of obsessive-compulsive disorder?

a. I check where my car keys are eight times.

b. My legs often feel weak and spastic.

c. Im embarrassed to go out in public.

d. I keep reliving a car accident.

ANS: A

Recurring doubt (obsessive thinking) and the need to check (compulsive behavior) suggest obsessive-compulsive disorder. The repetitive behavior is designed to decrease anxiety but fails and must be repeated. Stating My legs feel weak most of the time is more in keeping with a somatic disorder. Being embarrassed to go out in public is associated with an avoidant personality disorder. Reliving a traumatic event is associated with posttraumatic stress disorder. See relationship to audience response question.

Chapter 70. Behavioral Disorders Related to Physical/Physiological Disturbances

1. The nurse is preparing to assess a client with a paranoid personality trait. The nurse integrates knowledge of this condition, anticipating that the clients affect and behavior will most likely be which of the following?

A) Angry and hostile

B) Flirtatious and seductive

C) Fearful and anxious

D) Friendly and open

2. The nurse is caring for a client with schizoid personality trait. When developing the plan of care for the client, which of the following would the nurse most likely include?

A) Social skills training

B) Anger management training

C) Relaxation techniques

D) Coping skills training

3. A nursing instructor is preparing a teaching plan for a class of nursing students about antisocial personality disorder. Which of the following would the nurse include as a term often used to describe the behaviors associated with this condition? Select all that apply.

A) Psychopath

B) Manipulator

C) Criminality

D) Sociopath

E) Psychotic

4. A nurse is reading a journal article about the various theories associated with the development of antisocial personality disorder. The article mentions difficult temperament as a possible theory. The nurse demonstrates understanding of this concept when identifying which of the following as a key behavior associated with a difficult temperament? Select all that apply.

A) Aggression

B) Inattention

C) Hyperactivity

D) Impulsivity

E) Depression

F) Paranoia

5. A nurse is developing a plan of care for a client diagnosed with an antisocial personality disorder who has been admitted to the inpatient psychiatric unit. Which of the following would the nurse most likely include? Select all that apply.

A) Developing a therapeutic relationship

B) Bargaining about the unit rules

C) Holding the client responsible for behavior

D) Discouraging client from discussing thoughts

E) Using a firm, lecture-like approach for teaching

6. A nurse is working with the family of a client who has been diagnosed with antisocial personality disorder. Which of the following would be most important for the nurse to focus on when teaching the family about this disorder?

A) Anger management

B) Boundary setting

C) Medication therapy

D) Self-responsibility

7. A group of nursing students is reviewing information about antisocial personality disorder. The students demonstrate understanding of this disorder when they state which of the following?

A) The disorder occurs more frequently in women.

B) The individual must be at least 18 years of age.

C) The disorder is found primarily in Asian individuals.

D) Alcohol abuse disorder rarely accompanies this disorder.

8. A nurse is providing care to a client with antisocial personality disorder. As part of the plan of care, the client is to participate in a problem-solving group. The nurse understands that this intervention is effective based on which rationale?

A) It requires the client to develop attachments.

B) It sets up specific boundaries for the client.

C) It helps reinforce self-responsibility.

D) It avoids confrontation about dysfunctional patterns.

9. The nurse is reviewing the medical record of a client diagnosed with antisocial personality disorder. The nurse notes that the client has had numerous episodes involving irritability, aggressiveness, and impulsivity and has exhibited callousness toward others. Based on this information, which nursing diagnosis would the nurse most likely identify as a priority?

A) Risk for Other-Directed Violence

B) Risk for Self-Injury

C) Risk for Suicide

D) Risk for Self-Directed Violence

10. A client is brought into the emergency department because of complaints from the neighbors that the client was acting strangely. The nurse assesses the client and suspects schizotypal personality disorder based on assessment of which of the following? Select all that apply.

A) Magical beliefs

B) Hallucinations

C) Paranoia

D) Avoidance of eye contact

E) Meticulous dress

11. A nurse is assessing a client diagnosed with avoidant personality disorder. Which of the following would the nurse most likely expect to find? Select all that apply.

A) Shyness

B) Feelings of inadequacy

C) Feelings of superiority

D) Perfectionism

E) Detail oriented

12. A group of nursing students is reviewing information about schizoid personality trait. The students demonstrate understanding of the information when they identify which disorder as the most common comorbid disorder?

A) Depression

B) Substance abuse

C) Avoidant personality disorder

D) Anxiety

13. A nurse is interviewing a client and suspects that the client may have narcissistic personality disorder. Which client statement would help support the nurses suspicions?

A) I have a very important position in life; everyone I know wants to be like me.

B) My wife is poisoning my food so she can get rid of me and marry her boss.

C) I like to work alone because then I can let my thoughts wander.

D) Im always the life of the party, making new friends all the time.

14. A nurse is developing a teaching plan for a client with an impulse-control disorder. The nurse is planning to explain the emotional aspects associated with the behavior as part of the plan. Which of the following would the nurse describe as occurring first before the individual commits the act?

A) Remorse

B) Tension

C) Regret

D) Pleasure

15. A nurse is reading an article about a young girl who developed gastrointestinal symptoms from a hair ball because of a ritual that she engaged in. The girl would pull out hair over several hours to relieve tension and anxiety and then eat the hair. The nurse most likely is reading an article about which of the following?

A) Kleptomania

B) Trichotillomania

C) Pyromania

D) Intermittent explosive disorder

16. A nurse is working with a client who is a compulsive gambler. Which of the following would the nurse emphasize as crucial for relapse prevention? Select all that apply

A) Medication therapy

B) Family involvement

C) Identification of triggers

D) Anger management

E) Milieu management

17. A nursing instructor is describing depressive and negativistic personality traits to a group of nursing students. The instructor determines that the teaching was successful when the students identify which of the following as characteristic of negativistic personality traits? Select all that apply.

A) Anhedonia

B) Hostility
C) Pessimism
D) Oppositionality
E) Guilt

Answer Key

1. A
2. A
3. A, D
4. A, B, C, D
5. A, C
6. B
7. B
8. C
9. A
10. A, C, D
11. A, B
12. C
13. A
14. B
15. B
16. B, C
17. B, D, E

1. The nurse is assessing a client who is diagnosed with borderline personality disorder. Which client statement indicates the client is at risk for self-injurious behavior?

A) I have felt so down lately. I dont enjoy doing anything anymore.
B) I do what I do because others tell me to do so.
C) When I feel extremely anxious, it is like my mind goes somewhere else.
D) It is almost as if as soon as I think of doing something, I immediately do it.

2. A woman with borderline personality disorder has been admitted to the inpatient unit because she has been engaging in wrist cutting. The clients sister is visiting, and the sister asks the nurse to explain why her sister sometimes does this to herself. Which response by the nurse would be most appropriate?

A) Sometimes the self-injurious behavior is undertaken to relieve stress.
B) Self-injurious behavior often calms and sedates people with this diagnosis.

C) Sometimes they do it to avoid the onslaught of delusional thinking.

D) The self-mutilation often slows the mood swings your sister experiences.

3. The nurse has explained some of the biologic theories of causation to a client diagnosed with borderline personality disorder and his family. The nurse determines that the client and family have understood the instructions when they state which of the following?

A) The disorder may be caused by increased serotonin activity.

B) The disorder is caused by decreased dopamine activity in my brain.

C) A frontal lobe dysfunction may be causing this condition.

D) A decrease in hormonal substances increases the risk for this illness.

4. The nurse is assessing a client who has borderline personality disorder. Which of the following would be a priority?

A) Nutrition patterns

B) Personal hygiene practices

C) Physical functioning

D) Somatic complaints

5. A client diagnosed with borderline personality disorder tells the nurse that she frequently spaces out. Which response by the nurse would be most appropriate?

A) Do you feel stressed most of the time?

B) Does this frighten you when it happens?

C) Whats happening around you when this occurs?

D) Do you feel as if you are out of your body?

6. The nurse is caring for a client diagnosed with borderline personality disorder. The nurse has instructed the client about using the communication triad. The nurse determines that the client has understood this technique when he states which of the following?

A) I should start by stating my feelings as an I statement.

B) Maybe I should start by describing the situation that has me upset.

C) I should first tell the other person what Id like to be different about the situation.

D) I should begin by telling the other person what has triggered my emotion.

7. A client with borderline personality disorder tells the nurse, Im afraid to get on a train because well probably get into a wreck. Which response by the nurse would be most appropriate?

A) Have you had a bad experience riding a train?

B) What are the chances of that actually happening?

C) Now you know that wont happen.

D) Have you thought about going by automobile?

8. A nursing instructor is preparing a class discussion on personality disorders and characteristics. Which term would the instructor include to differentiate personality disorders from normal personality? Select all that apply.

A) Inflexible

B) Short term

C) Pervasive

D) Unstable over time

E) Distressing

9. A group of nursing students is reviewing possible risk factors for development of borderline personality disorder. The students demonstrate understanding of the information when they identify which of the following as a risk factor? Select all that apply.

A) Childhood sexual abuse

B) Parental loss

C) Substance abuse

D) Family history

E) Genetics

10. A nurse is observing a client diagnosed with borderline personality disorder on the inpatient unit. Which of the following would the nurse most likely note?

A) Actively participating in several different groups

B) Openly verbalizing feelings

C) Participating in relationships in which the client has control

D) Adhering to the personal boundaries of others

11. A nurse is assessing a client with borderline personality disorder. Which question would be most appropriate to assess the clients level of impulsivity?

A) What things bother you and make you feel happy?

B) Have you ever felt sorry after acting as you did on the spur of the moment?

C) How do you view other people around you?

D) Have you ever felt like you were separated from your body?

12. As part of a clients treatment plan for borderline personality disorder, the client is engaged in dialectical behavior therapy. As part of the therapy, the client is learning how to control and change behavior in response to events. The nurse identifies the client as learning which type of skills?

A) Emotion regulation skills

B) Mindfulness skills

C) Distress tolerance skills

D) Self-management skills

13. A client with borderline personality disorder has difficulty maintaining boundaries of the professional relationship. Which of the following would be most effective for the nurse to do? Select all that apply.

A) Punish the client with seclusion for violating established boundaries.

B) Respond to the clients arrogance in a neutral, nonconfrontational manner.

C) Discuss the purpose of the limits in the therapeutic relationship.

D) State the parameters of the limits and boundaries clearly.

E) Ensure that any established limits are maintained consistently.

14. A nurse is engaged in role-playing with a client with borderline personality disorder to assist the client in learning how to communicate effectively. Which of the following would the nurse encourage the client to use? Select all that apply.

A) Me statements

B) Validating perceptions with others

C) Paraphrasing before responding

D) Listening passively

E) Compromising

15. A nurse is assisting a client with borderline personality disorder in how to manage transient psychotic episodes that involve auditory hallucinations. The teaching is planned for times when the client is free of these symptoms. Which of the following would the nurse instruct the client to do first?

A) Use skills to tolerate painful feelings.

B) Practice deep abdominal breathing.

C) Identify early internal cues of distress.

D) Refer to cards listing potential symptoms.

Answer Key

1. A
2. A
3. C
4. A
5. C
6. A
7. B
8. A, C, D, E
9. A, B
10. C

11.	B
12.	D
13.	B, C, D, E
14.	B, C, E
15.	B

Chapter 71. Neurodevelopmental Disorders

MULTIPLE CHOICE

1.The nurse is discussing the differences between a patient with a neurosis and one with a psychosis. What is true of the patient experiencing a neurosis?

a.	The patient experiences a flight from reality.
b.	The patient usually needs hospitalization.
c.	The patient has insight that there is an emotional problem.
d.	The patient has severe personality deterioration.

ANS: C

An individual with a neurosis has insight that he has an emotional problem. A person with psychosis is out of touch with reality and has severe personality deterioration. Treatment for neurosis is usually completed in the outpatient setting, while treatment for psychosis often requires hospitalization.

2.When the patient with a psychosis is thought to be a danger to self or others, by what method should the patient be admitted to the hospital?

a.	Probating
b.	Nurses request
c.	Physicians order
d.	Family request

ANS: A

Probating can be done if the individual is thought to be a danger to self or others. MSC:

NCLEX: Psychosocial Integrity

3.*The Diagnostic and Statistical Manual of Psychiatric Disorders, V* (*DSM-V*), is used by most hospitals and is the current tool used to examine mental health and illness. What approach does the *DSM-V* use to classify mental disorders?

a.	Holistic system

b.	Hierarchical system
c.	Multiaxial system
d.	Evaluation system

ANS: C

The DSM-V is a multiaxial system.

MSC:NCLEX: N/A

4.When all five axes of the *Diagnostic and Statistical Manual of Psychiatric Disorders, V,* are used, it provides what type of assessment approach to comprehensive care?

a.	Personalized
b.	Individualized
c.	Holistic
d.	Organic

ANS: C

Using all five axes of the *DSM-V* provides a holistic assessment.

5.A young man with malaria spikes a temperature of 105 F and begins to hallucinate. How should the nurse assess this?

a.	Delirium
b.	Psychotic break
c.	Possible stroke
d.	Anxiety disorder

ANS: A

Delirium is an organic mental disorder that is frequently brought on by a severe physical illness, such as fever.

6.A patient admitted for delirium demonstrates increased disorientation and agitation only during the evening and nighttime. What is the term applied to this type of delirium?

a.	Disordered thinking
b.	Schizophrenia
c.	Dementia
d.	Sundowning syndrome

ANS: D

A patient with sundowning syndrome displays increased disorientation and agitation only during evening and nighttime. Disordered thinking occurs when an individual is not able to interpret information being received in the brain. Disordered thinking is one characteristic of schizophrenia, which is a large group of psychotic disorders that includes nonreality-based thinking. Dementia is an altered mental state secondary to cerebral disease.

7.Dementia is an organic mental disease secondary to what problem?

a.	Chemical imbalance
b.	Emotional problems
c.	Circulatory impairment
d.	Cerebral disease

ANS: D

Dementia describes an altered mental state secondary to cerebral disease. MSC:

NCLEX: Psychosocial Integrity

8.A profound, disabling mental illness is characterized by bizarre, nonreality thinking. What is the illness?

a.	Manic depressive
b.	Schizophrenia
c.	Paranoia
d.	Bipolar

ANS: B

Schizophrenia, a thought process disorder, is one of the most profoundly disabling mental illnesses. MSC: NCLEX:

Psychosocial Integrity

9.A patient believes himself to be the president of the United States and that terrorists are trying to kidnap him. The nurse records these observations as which type of behavior?

a.	Absent behavior
b.	Positive behavior
c.	Negative behavior
d.	False behavior

ANS: B

The behaviors of schizophrenic individuals can be categorized as positive (or excessive) or negative (or absent). Examples of positive behaviors include hallucinations, delusions, and disordered thinking. Examples of negative behaviors include apathy, social withdrawal, and flat affect.

10.The patient talks with his dead brother and arranges furniture so that his brother will have a place to sit. How should the nurse document this behavior?

a.	Disordered thinking
b.	Anhedonia
c.	Hallucination
d.	Alogia

ANS: C

A hallucination is a sensory experience without a stimulus trigger. Disordered thinking occurs when the individual is not able to interpret information being received in the brain. Anhedonia describes lack of expressed feelings. Alogia is reduced content of speech.

11. What is the prognosis for a schizophrenic patient who is exhibiting positive behaviors?

a.	Guarded
b.	Poor
c.	Good
d.	Repeatable

ANS: C

Prognosis for schizophrenic patients who are exhibiting positive behavior patterns is good. 12.The nurse cautions a patient to watch his step. What response indicates concrete thinking?

a.	The patient fixedly begins to watch his feet.
b.	The patient immediately examines his watch.
c.	The patient begins to watch the nurses feet.
d.	The patient stands rigidly in one place without moving.

ANS: A

Concreteness is an indication of disordered thinking. The patient is unable to translate any words except by a very concrete definition.

13.The nurse asks a patient with schizophrenia if he had any visitors on Sunday. Which response indicates loose association?

a.	No.
b.	Yes! I had 90 visitors who came from every state in the union.
c.	Sunday is the Sabbath. Do we have visitors on the Sabbath?
d.	We visited Yellowstone Park last summer.

ANS: D

Loose association is a type of disordered thinking that occurs when the individual cannot interpret information and the conversation does not flow.

14.The nurse is caring for a patient with a diagnosis of catatonic schizophrenia. What behavior is consistent with this diagnosis?

a.	Talks excitedly about going home
b.	Suspiciously watches the staff
c.	Stands on one foot for 15 minutes
d.	States he has a cat under his bed that talks to him

ANS: C

Maintaining a rigid pose for long periods of time is an example of behavior expected with catatonic schizophrenia.

15.What is the term used for the beginning stage of schizophrenia, characterized by a lack of energy and complaints of multiple physical problems?

a.	Prepsychotic
b.	Residual
c.	Acute
d.	Prodromal

ANS: D

The prodromal phase is the beginning stage of schizophrenia. Hallucinations and delusions sometimes occur in the prepsychotic stage. In the acute phase, individuals often lose touch with reality. The residual phase follows the acute phase and the symptoms of that phase are similar to those of the prodromal stage.

16.For the past 3 weeks, the nurse has observed a patient interacting with staff and other patients, helping decorate the dining room for a party, and leading the singing in the activity room. Today, the patient tearfully refuses to dress or get out of bed. The nurse recognizes these behaviors as evidence of which psychiatric disorder?

a.	Unipolar depression
b.	Dysthymic disorder
c.	Hypomanic episode
d.	Bipolar disorder

ANS: D

Bipolar disorder can cause the patient to experience a sudden shift in emotion from one extreme to the other.

17.The nurse recognizes that researchers have identified that hereditary factors account for what percentage of mood disorders?

a.	10% to 15%
b.	20% to 30%
c.	35% to 50%
d.	60% to 80%

ANS: D

Research indicates that hereditary factors account for 60% to 80% of mood disorders.

18.A home health nurse has a patient who is taking lithium. What should be included in the teaching plan?

a.	Examine her skin closely for eruptions
b.	Take her blood pressure twice a day to check for hypertension
c.	Have her drug blood level checked every month
d.	Avoid aged cheese and red wine

ANS: C

Lithium has a very narrow therapeutic window. The drug blood levels should be closely monitored.

19.The nurse alters the care plan for a patient with depression to include what type of activity?

a.	Domino game with three other patients
b.	Ping-Pong game with one other patient
c.	Group outing to view wildflowers
d.	Magazine to read alone

ANS: C

The quiet, noncompetitive trip to view wildflowers would be the best option. Depressed people should not be put in situations where they must concentrate or compete.

OBJ:5TOP:Mental illness

KEY: Nursing Process Step: Planning MSC: NCLEX: Psychosocial Integrity

20.The nurse is assessing a female patient who has become rapidly and exceedingly anxious because her fingernail polish is chipped. What type of anxiety should the nurse conclude that the patient is exhibiting?

a.	Signal anxiety
b.	General anxiety
c.	Anxiety traits
d.	Panic disorder

ANS: C

An individual with anxiety traits has anxious reactions to relatively nonstressful events. Signal anxiety is a learned response to an event such as test taking. An individual with general anxiety worries over many things. A panic attack occurs suddenly and typically peaks within 10 minutes.

21. The home health nurse assesses a patient who creates elaborate excuses for not leaving home. Further questioning reveals the patient had not left home for 6 months. How should this be documented?

a.	Mania
b.	Depression
c.	Agoraphobia
d.	Anxiety

ANS: C

Agoraphobia is a high level of anxiety in which an anxiety attack could occur in individuals who avoid other people, places, or events.

22. When a patient demonstrates accelerated heart rate, trembling, choking, and chest pain along with acute, intense, and overwhelming anxiety, the nurse should recognize that the patient is most likely experiencing what condition?

a.	Terror
b.	Fright
c.	Fear
d.	Panic

ANS: D

Panic can be defined as an attack of acute, intense, and overwhelming anxiety.

23. When a patient is experiencing a panic attack, how should the nurse best assist the patient?

a.	Assist with reality orientation
b.	Aid in decision making
c.	Assist with rational thought
d.	Coach in deep breathing

ANS: D

Coaching in relaxation techniques such as deep breathing is an effective intervention for a patient who is experiencing a panic attack.

24.A patient is frequently late for appointments because he goes back to his room numerous times to assure himself that none of his belongings have been stolen. What does this behavior represent?

a.	Senseless behavior
b.	Controlled repetition
c.	Obsessive-compulsive
d.	Anxiety tension

ANS: C

Obsessive-compulsive disorders have two features: thoughts that are recurrent, intrusive, and senseless; and behaviors that are performed repeatedly and ritualistically.

25.A 14-year-old survivor of a school shooting screams and dives under a table when firecrackers go off. What does this behavior represent?

a.	Phobia
b.	Post-traumatic stress disorder
c.	Obsessive-compulsive disorder
d.	Disordered thinking

ANS: B

Post-traumatic stress disorder describes a response to an intense traumatic experience that is beyond the usual range of human experience.

26.What should the nurse preparing a patient for a scheduled appointment for electroconvulsive therapy (ECT) remind the patient to do?

a.	Drink plenty of fluids before ECT to ensure adequate hydration.
b.	Bring a change of clothes in case of incontinence.
c.	Be prepared for visual disturbances after the treatment.
d.	Arrange for transportation to and from the appointment.

ANS: D

If the patient has not arranged for adequate transportation to and from the appointment, the treatment will be canceled because driving after ECT is dangerous. The patient is typically NPO before the procedure. Incontinence and visual disturbances are not common following the procedure.

27.The nurse is told that a patient believes he was born into the wrong body. What is the correct terminology for the desire to have the body of the opposite sex?

a.	Homosexuality
b.	Transsexualism
c.	Heterosexuality
d.	Bisexuality

ANS: B

Transsexualism is a persistent desire to be the opposite sex and to have the body of the opposite sex.

28.The patient complains of recurrent, multiple physical ailments for which there is no organic cause. How should the nurse assess this?

a.	Obsessive-compulsive disorder
b.	Phobia anxiety disorder
c.	Somatoform disorder
d.	Delusional disorder

ANS: C

Somatoform disorder is characterized by recurrent, multiple physical complaints for which there is no organic cause.

29.What disorder is a severe form of self-starvation that can lead to death?

a.	Bulimia nervosa
b.	Anorexia nervosa
c.	Teenage nervosa
d.	Obesity nervosa

ANS: B

Anorexia nervosa is a severe form of self-starvation that can lead to death.

30.The patient is concerned about confidentiality and asks the nurse not to tell anyone what is said. What is the best response by the nurse?

a.	I am required to report any intent to hurt yourself or others.
b.	Conversations between patient and nurse are confidential.
c.	What we say can be secret. What I write in the chart is available to the health team.
d.	I cant help you unless you trust me.

ANS: A

No secrets are allowed to be kept by a member of the health care team.

31.What is the term for a long-term and intense form of psychotherapy developed by Sigmund Freud that allows a patients unconscious thoughts to be brought to the surface?

a.	Adjunctive
b.	Behavior
c.	Psychoanalysis
d.	Cognitive

ANS: C

Psychoanalysis technique was developed by Sigmund Freud and is a long-term and intense therapy.

MSC:NCLEX: N/A

32.What is the typical schedule for electroconvulsive therapy (ECT)?

a.	3 treatments over 2 weeks
b.	6 treatments over 2 months
c.	8 treatments over several weeks
d.	10 treatments over several weeks

ANS: D

ECT is done as a treatment for depression, mania, and schizoaffective disorders that have not responded to other treatments. The usual protocol is 10 treatments over several weeks.

33.A patient who is taking a monoamine oxidase inhibitor (MAOI) asks the nurse about the addition of St. Johns wort to help with his depression. What would be the best response of the nurse?

a.	That is a great idea. Alternative therapies can be very helpful.
b.	You will feel better sooner if you include phenylalanine.
c.	Did you know that St. Johns wort can raise your blood pressure dramatically?
d.	You will need to drink lots of water.

ANS: C

St. Johns wort can raise blood pressure dramatically in people who are also taking MAOIs.

MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

34.Adjunctive therapies are used for which reasons? (Select all that apply.)

a.	To increase self-esteem
b.	To promote positive interaction

c.	To enhance reality orientation
d.	To stimulate communication
e.	To increase energy

ANS: A, B, C

The purpose of adjunctive therapies is to increase self-esteem, promote positive interaction, and enhance reality orientation.

MSC: NCLEX: Psychosocial Integrity

35.What are considered warning signs of suicide? (Select all that apply.)

a.	Talking about suicide
b.	Increased interactions with friends and family
c.	Drug or alcohol abuse
d.	Difficulty concentrating on work or school
e.	Personality changes

ANS: A, C, D, E

Warning signs of suicide include talking about suicide, decreased interactions with friends and family, drug/alcohol abuse, difficulty concentrating on work or school, and personality changes.

COMPLETION

36.The nurse recognizes that a woman who has experienced physical abuse and has inadequate income to care for herself and her family would be categorized under Axis_____.

ANS:

4

four

Axis 4 queries the environmental and psychosocial information of a patient.

37.The nurse instructs a patient who has just been prescribed a protocol of fluoxetine HCl (Prozac) that the drug takes_____to_____weeks to take effect.

ANS:

2, 4

two, four

Antidepressants of this type take 2 to 4 weeks before any effect is felt by the patient.

38.The nurse explains that an alternative therapy that uses essential oils and scented candles to help a patient relax and focuses on the atmosphere of the moment is_____.

ANS:

aromatherapy

Aromatherapy uses essential oils and scented candles to soothe the senses and make people aware of the here and now of the pleasant environment.

Chapter 72. Common Urgent Care Complaints

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which type of heat-related illness involves a core body temperature of at least 104.9°F, acute mental status changes, absent sweat, and tachypnea?
a. Heat cramps
b. Heat syncope
c. Heat exhaustion
d. Heat stroke

____ 2. What percentage of burns is involved using the rule of nines if both front legs are burned?
a. 9%
b. 18%
c. 24%
d. 36%

___ 3. Which drug commonly prescribed for burns is active against a wide spectrum of microbial pathogens and is the most frequently used agent for partial- and full-thickness thermal injuries?
a. Clotrimazole cream (Lotrimin)
b. Mafenide acetate (Sulfamylon)
c. Silver nitrate
d. Silver sulfadiazine (Silvadene)

___ 4. A sunscreen with a sun-protection factor of at least what number will block most harmful ultraviolet radiation?
a. 4
b. 8
c. 10
d. 15

____ 5. Which clinical feature is the first to be affected in increased intracranial pressure?
a. Decrease in level of consciousness
b. Headache
c. Nausea
d. Widening pulse pressure

____ 6. What is the normal number for the Glasgow Coma Scale?
a. 7
b. 9
c. 10
d. 15

____ 7. Which diagnostic test is the best to diagnose a subdural hematoma?
a. History
b. Positron emission tomography
c. Magnetic resonance imaging (MRI)
d. Computed tomography (CT) scan

__ 8. Patients with a spontaneous pneumothorax should be counseled that up to what percentage may experience a reoccurrence at some point?
a. 10%
b. 20%
c. 30%
d. 50%

____ 9. Most adult poisonings are:
a. Intentional and self-inflicted
b. Accidental
c. Caused by someone wishing to do harm to the person
d. Not attributed to any reason

____ 10. Which method is used to remove heavy metals, such as lead, that are ingested as poisons?
a. Chelation
b. Dialysis
c. Gastric lavage
d. Bowel irrigation

____ 11. If a previously frostbitten area becomes frostbitten again after it has healed, what might occur?
a. Permanent tissue damage may occur, resulting in necrosis to that body part.
b. The area will be super sensitive.

c. The area is prone to a repeat frostbite.
d. The area is as susceptible as any other area.

____ 12. What percentage of all visits to the emergency department (ED) are related to wounds?
a. 5%
b. 12%
c. 18%
d. 24%

____ 13. Which solution should be used when irrigating lacerated tissue over a wound on the arm?
a. Dilute povidone-iodine solution
b. Hydrogen peroxide (H_2O_2)
c. Saline solution infused with an antibiotic
d. Saline irrigation or soapy water

___ 14. Which type of burn injury results in destruction of the epidermis with most of the dermis, yet the epidermal cells lining hair follicles and sweat glands remain intact?
a. Superficial burns
b. Superficial partial-thickness burns
c. Deep partial-thickness burns
d. Full-thickness burns

___ 15. Which carboxyhemoglobin (COHb) level correlates with the clinical symptoms of confusion, lethargy, and ST-segment depression on the electrocardiogram?
a. Less than 10%
b. 20% COHb
c. 30% COHb
d. 40% to 60% COHb

____ 16. Which causes the greatest percentage of mammalian bites?
a. Dogs
b. Cats
c. Humans
d. Rodents

____ 17. Which arthropod bite can contain cytotoxic and hemolytic toxins that may destroy tissue?
a. Tick
b. Brown recluse spider
c. Wasp
d. Stinging caterpillar

____ 18. Which of the following characteristics separates anaphylaxis from a vasovagal reaction?

a. Bradycardia
b. Extreme diaphoresis
c. Severe bronchoconstriction
d. Hypotension

____ 19. Delayed serum sickness–type reactions in response to multiple bee, wasp, or fire ant stings can be managed with which of the following?

a. A corticosteroid such as prednisone (Deltasone), 60 to 100 mg, tapered over 2 weeks
b. An oral antihistamine, such as hydroxyzine, for 2 weeks
c. An H2 blocker such as cimetidine for 1 week
d. 0.1 mg (1 mL of 1:10,000 solution epinephrine) in 10 mL of normal saline and administer as a slow intravenous push over 10 minutes

__ 20. After a head injury, what is it called when air enters into the cerebrospinal fluid (CSF)–filled spaces within the head?

a. Pneumocephalus
b. Hemotympanum
c. Battle's sign
d. Raccoon sign

__ 21. Cerebrospinal fluid (CSF) may leak through the cribriform plate region of the skull following a head injury and cause which of the following?

a. Ear CSF otorrhea
b. Leakage of CSF from the eye
c. Nasal CSF rhinorrhea
d. Leakage of CSF from the mouth

____ 22. Which classic feature of an epidural hematoma may distinguish it from other skull hematomas?

a. Unilateral hemiparesis
b. Loss of speech
c. Temporary hearing loss
d. A brief loss of consciousness, then a brief "lucid" moment, followed by momentary unconsciousness minutes after the injury

__ 23. A patient with a basilar skull fracture may experience an impaired downward gaze or diplopia from which affected cranial nerve?

a. CN II

b. CN III
c. CN IV
d. CN V

__ 24. A history of overuse or excessive force, as opposed to a fall, hyperextension, or the twisting of a joint, is more likely related to which musculoskeletal injury?
a. A sprain
b. A strain
c. A partial fracture
d. A fracture

____ 25. In a healthy adult, the process of remodeling after a fracture of the humerus takes how long?
a. Approximately 4 weeks
b. 2 months
c. 3 months
d. 4 months

__ 26. A patient who sustains blunt chest trauma and/or penetrating chest trauma must have which of the following imaging examinations?
a. Upright chest x-ray film
b. Supine chest x-ray
c. Lateral chest x-ray
d. MRI

__ 27. Josie, age 30, has a pneumothorax. It may be treated conservatively without a chest tube if it is deflated by what percentage?
a. 30%
b. 45%
c. 60%
d. All pneumothoraxes require a chest tube.

____ 28. Hepatic necrosis with jaundice may occur after ingesting massive doses of which medication?
a. Phenobarbital
b. Diazepam
c. Ritalin
d. Acetaminophen

____ 29. Pink, cherry red tissues and skin may result from which type of poisoning?
a. Arsenic
b. Lead

c. Carbon monoxide
d. Strychnine

__ 30. In which type of burn is the injury more extensive than it appears, and the cardiac conduction system may be affected, leading to sudden death or arrhythmias?
a. Chemical burns
b. Electrical burns
c. Radiation burns
d. Thermal burns

____ 31. Eddie, age 4, presents to the ED with a live insect trapped in his ear canal causing a lot of distress. What should be your first step?
a. Remove the insect with tweezers.
b. Immobilize the insect with 2% lidocaine.
c. Sedate Eddie with diazepam.
d. Shine a light in the ear for the insect to "find its way out."

__ 32. When giving discharge instructions to a patient with a laceration injury to his lower leg, which is the most important one?
a. Recommend isometric exercises to prevent a deep vein thrombosis (DVT).
b. Recommend cleansing the wound every 4 hours to prevent an infection.
c. Keep the leg elevated at waist level to prevent any edema.
d. Keep the leg completely immobile to prevent extension of the laceration.

____ 33. Cerebellar function may be assessed by performing which examination/test?
a. Gag reflex
b. Pupillary response
c. Romberg's test
d. Apley's test

__ 34. In the epithelialization phase of wound healing, the wound will have only what percent of its normal tensile strength at 3 weeks?
a. Less than 15%
b. 15% to 20%
c. 25% to 40%
d. Greater than 50%

____ 35. Which of the following statements is true about antibiotic prophylaxis for most wounds?
a. It is not indicated for most wounds and does not affect the infection rate.
b. Antibiotics should always be ordered for a wound.

c. Antibiotics need to be ordered for at least 2 weeks.
d. Antibiotics should be ordered only if sutures are in place.

Chapter 72. Common Urgent Care Complaints
Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: B PTS: 1
3. ANS: D PTS: 1
4. ANS: D PTS: 1
5. ANS: A PTS: 1
6. ANS: D PTS: 1
7. ANS: C PTS: 1
8. ANS: C PTS: 1
9. ANS: A PTS: 1
10. ANS: A PTS: 1
11. ANS: A PTS: 1
12. ANS: B PTS: 1
13. ANS: D PTS: 1
14. ANS: C PTS: 1
15. ANS: C PTS: 1
16. ANS: A PTS: 1
17. ANS: B PTS: 1
18. ANS: C PTS: 1
19. ANS: A PTS: 1
20. ANS: A PTS: 1
21. ANS: C PTS: 1

22. ANS: D PTS: 1

23. ANS: C PTS: 1

24. ANS: B PTS: 1

25. ANS: B PTS: 1

26. ANS: A PTS: 1

27. ANS: A PTS: 1

28. ANS: D PTS: 1

29. ANS: C PTS: 1

30. ANS: B PTS: 1

31. ANS: B PTS: 1

32. ANS: A PTS: 1

33. ANS: C PTS: 1

34. ANS: B PTS: 1

35. ANS: A PTS: 1

Chapter 73. Common Injuries

1. A patient sustained injuries in a motor vehicle accident and is in the Emergency Department. A CT scan of the head and neck have been ordered. What part of the survey is this?

A) Primary

B) Secondary

C) Tertiary

D) Initial

2. A patient who is in the Emergency Department was attacked in a parking lot and suffered several stab wounds to various areas on the chest and abdomen; BP 100/60, heart rate 108, respiratory rate 20, pulse oximetry 98%. In order to counteract the blood loss and restore circulating volume for this patient, what priority intervention will the nurse perform?

A) Start lactated Ringers at 150 mL/hr.

B) Start dopamine at 5 mcg/kg/min.

C) Start an albumin infusion wide open.

D) Start a unit of uncrossmatched blood.

3. The nurse is assigned to a patient in the Emergency Department who exhibits paradoxical chest movement. What intervention by the nurse can help improve oxygenation in this patient?

A) Elevate the head of the bed 30 degrees.

B) Splint the chest with 3-inch surgical tape.

C) Turn the patient with the injured side down.

D) Place the patient in the prone position.

4. A patient has been involved in a motor vehicle accident. The patient, who was driving, was unrestrained by a seat belt when hitting the car in front of him. The patient is complaining of midsternal pain, restlessness, and difficulty breathing. What is the priority nursing diagnosis for this patient?

A) Anxiety

B) Impaired gas exchange

C) Impaired circulation

D) Pain

5. A patient has suffered a mild pulmonary contusion from a jet ski accident. What nursing interventions are appropriate for this patient? Select all that apply.

A) Maintenance of chest tubes

B) Frequent pulse oximetry monitoring

C) Assessment of lung sounds every 2 hours

D) Continuous epidural analgesia

E) Maintainance of ventilatory support

6. A patient sustained an injury to the right arm after falling off a motorcycle. The patient is complaining of severe pain and is unable to feel the fingers of the right hand. Radial pulse is absent. What is the priority intervention by the nurse?

A) Elevate the right arm above the level of the heart.

B) Notify the physician.

C) Apply ice packs to the affected area.

D) Place the patient in Trendelenburg position.

7. The nurse is caring for a patient with deep vein thrombosis of the left lower extremity. The patient exhibits a decrease in pulse oximetry readings from 98% to 86%, shortness of breath with a respiratory rate of 34, and is now disoriented to place. The nurse recognizes that these findings are caused by what complication?

A) Pulmonary edema

B) Cardiac tamponade

C) Pulmonary embolus

D) Tension pneumothorax

8. The nurse is assigned to care for a patient who was admitted 2 days previous after a four-wheeler accident. The patient sustained a closed fracture to the left femur and had an open reduction with internal fixation the same day. What is a priority for the nurse to assess for this patient?

A) White blood count

B) Urinary output

C) Cardiac output

D) Pulse oximetry

9. A patient has been brought into the Emergency Department via ambulance with resuscitation efforts being performed. It is unlikely that the patient will survive the severe injuries sustained. Two adult children of the patient are present and are requesting to be with the patient at this time. What is the best response by the nurse?

A) I dont think you should see your loved one like this. Wouldnt you rather remember him the way he was?

B) Our hospital doesnt allow more than one family member in with a patient. One of you can come in and one of you will have to wait in the waiting area.

C) You may come in with your parent and I will have someone stay with you to explain what is happening.

D) I have been through this many times and I promise you, it is a sight that you dont want to remember.

10.10. The nurse is caring for the patient with chest tubes. Which observation by the nurse is a priority concern?

A) 250 mL/hr of blood in drainage collection system

B) Pulse oximetry of 94%

C) Blood pressure of 104/62

D) 30 mL/hr of urine output

11. A patient is admitted to the emergency department after he was hit by a car. The car was going about 30 mph and was braking at the time of impact. The patient was struck just above the right knee, fell forward over the hood of the car, striking his anterior chest, and then slipped off the hood of the car and hit the pavement head first. Based on the mechanism of injury and transfer of force, what injuries does the nurse most expect? Select all that apply.

A) Fracture of left femur and damage to left knee

B) Fractures of thoracic and lumbar spine

C) Fractured ribs and cardiac and lung contusion

D) Bilateral radial and humerus fractures

E) Closed head injury and cervical spine fracture

F) Bilateral clavicle and scapular fractures

12. The patient has received a gunshot wound. To help predict the amount of damage, what information does the nurse collect?

A) Location of the shooting

B) Information about the shooter

C) Type of weapon and caliber of bullet

D) Whether the injury involved a felony

13. A patient was in a serious motor vehicle crash. At the scene, what is the highest priority of care?

A) Extrication from the vehicle

B) Cervical spine protection

C) Establishing two large-bore intravenous lines

D) Collecting information about the crash

14. On initial admission of a trauma victim to the emergency department, the nurse completes a primary survey. The patient is awake and tachypneic, is using accessory muscles of respiration, has unequal chest expansion, and is very anxious. There are absent breath sounds on the right and cyanosis on 100% oxygen, and the trachea is deviated to the left. What action takes the highest priority during the primary survey?

A) Jaw thrust maneuver

B) Suctioning the oral pharynx

C) Chest tube insertion

D) Assisting ventilation with bag-mask device

15. A patient has been admitted to the emergency department after being in a severe motor vehicle crash. The patient was a passenger and had a lap and seat belt in place. The patient is lethargic and moaning. Initial exposure and head-to-toe examination reveals scattered minor abrasions and contusions and bruising over the upper abdomen. The patient moans more when the abdomen is palpated, and the abdomen is rigid. Heart rate is 110, capillary refill is greater than 4 seconds, and blood pressure is 140/88 mm Hg. What is the nursing priority of care?

A) Administer intravenous opioid for pain.

B) Increase rate of intravenous crystalloid.

C) Obtain CT of the abdomen.

D) Prepare for immediate endotracheal intubation.

16. As part of a major trauma, a patient has suffered a flail chest injury. What hallmark sign of flail chest does the nurse expect to find?

A) Flail segment elevation during inhalation

B) Evidence of rib fractures on chest radiograph

C) Flail segment depression during inhalation

D) Hypoxemia evident on arterial blood gases

17. A patient is admitted to the CCU after experiencing blunt trauma to the chest. Among other injuries, the patient has a flail chest on the left and several extremity fractures. About 12 hours after admission, the patient is tachypneic and complaining of shortness of breath. Breath sounds are present bilaterally with scattered fine crackles. Chest radiograph shows an ill-defined, patchy, ground-glass area of density on the left. If the patient has a pulmonary contusion, what is the nursing priority?

A) Monitor pulse oximetry and arterial blood gases closely.

B) Place an oral endotracheal tube immediately.

C) Increase the amounts of intravenous crystalloid administration.

D) Obtain sputum culture and sensitivity and Gram stain.

18. A patient has suffered severe blunt trauma to the abdomen with bruising, diffuse pain, guarding, and rigidity evident. Damage to which structure is most likely?

A) Stomach

B) Bladder

C) Large intestine

D) Liver

19. As part of a multiple trauma injury, the patient has suffered a closed fracture of the radius. What nursing assessment finding indicates a significant complication warranting immediate treatment?

A) Swelling and pain over the fracture

B) Loss of pulses distal to the fracture

C) Ecchymosis over the fracture

D) Deformity of forearm

20. A patient has experienced multiple fractures, including pelvic and long bone fractures. After 72 hours, the patient complains of tachypnea and dyspnea and is found to have cyanosis, tachycardia, confusion, and fever. Laboratory analysis reveals a normal complete blood count except for thrombocytopenia and progressive respiratory insufficiency. What is the nursing care priority?

A) Administer oxygen and monitor pulse oximetry.

B) Initiate low-molecular-weight heparin therapy.

C) Obtain cultures of all body substances.

D) Initiate fall and seizure precautions.

21. During a motor vehicle accident, a patient sustained blunt trauma to the head and face, resulting in hairline skull fracture and a LeFort III maxillofacial fracture. The patient also has bruising across the chest and upper abdomen and multiple small superficial bleeding abrasions and lacerations. On admission to the emergency department, what is the nursing care priority?

A) Apply direct pressure to bleeding areas.

B) Assess neurologic status.

C) Perform endotracheal intubation.

D) Administer tetanus booster immunization.

22. As part of a multiple trauma injury, a patient developed hemorrhagic hypovolemic shock, necessitating fluid resuscitation with massive amounts of intravenous crystalloid fluids and blood products as well as extensive surgical repair under general anesthesia. Twenty-four hours later, the patient develops hypoxia unresponsive to oxygen therapy and diffuse white, ground-glass infiltrates of the lung fields on a chest radiograph. Development of this complication has what effect on the patients recovery?

A) Significantly greater chance of death

B) No change in outcome expectations

C) Outcome depends on treatment.

D) Lower chance of death

Answer Key

1. B
2. A

3.	C
4.	B
5.	B, C, D
6.	B
7.	C
8.	D
9.	C
10.	A
11.	A, C, E
12.	C
13.	B
14.	C
15.	B
16.	C
17.	A
18.	D
19.	B
20.	A
21.	C
22.	A

Chapter 74. Toxic Exposures

MULTIPLE CHOICE

1. Which of the following is likely to result from lead poisoning?

a. Damage to the brain and peripheral nerves

b. Inflammation and fibrosis in the lungs

c. Various cancers

d. Displacement of oxygen from hemoglobin

ANS: A

2. During the development of hyperthermia, the state of heat exhaustion is indicated when:

a. body core temperature is very high.

b. skeletal muscle spasms occur.

c. hypovolemia and fainting occur.

d. the cool-down process is too rapid.

ANS: C

3. What is/are signs of hypothermia?

a. Systemic vasodilation

b. Lethargy and confusion

c. Nausea and cramps

d. Rapid but strong pulse

ANS: B

4. Which of the following types of cells are most likely to be damaged by exposure to radiation?

a. Bone and cartilage

b. Skeletal and smooth muscle

c. Peripheral and central neurons

d. Epithelial tissue and bone marrow

ANS: D

5. Which of the following events would most likely cause a person to faint and experience difficulty breathing?

a. Exposure to gamma rays

b. Eating fish containing mercury

c. An insect sting

d. Inhalation of asbestos particles

ANS: C

6. Bites and stings cause disease in which three ways?

a. Injection of toxins, transmission of infectious agents, or allergic reactions

b. High fever and chills, transmission of infectious agents, or nausea and vomiting

c. Bone marrow damage, extensive skin rashes, or allergic reactions

d. Injection of neurotoxins, transmission of infectious agents, or kidney damage

ANS: A

7. Which statement applies to food poisoning?

1. It results from consuming contaminated food and water.

2. It often causes gastroenteritis, including vomiting and diarrhea.

3. Outbreaks occur frequently in institutions.

4. It is often caused by *Escherichia coli*, normally found in the stomach.

a.	1, 3
b.	2, 4
c.	1, 2, 3
d.	1, 3, 4

ANS: C

8. Institutions frequently have outbreaks of infection associated with poultry products contaminated by:

a.	*E. coli*
b.	*Salmonella*
c.	*Listeria*
d.	HIV

ANS: B

9. The amount of radiation absorbed by the body is measured in *rads,* or .

a.	radiation-absorbed doses.
b.	roentgen-absorbed doses.
c.	radiation-emission number.
d.	radiation ionizing rate.

ANS: A

10. The term *pica* refers to:

a. the consumption of nonfood substances such as clay.

b. diffuse edema and degeneration of neurons in the brain.

c. particulates in the respiratory tract.

d. high levels of mercury in the blood.

ANS: A

11. Inhalants can be:

a. a particulate such as asbestos.

b. gaseous, such as sulfur dioxide.

c. a solvent, such as benzene.

d. A, B, and C

ANS: D

12. Choose the correct effects of exposure of the ears to very cold temperatures:

a. Loss of sensation

b. Lethargy and confusion

c. Vascular occlusions

d. A and C

ANS: D

13. During the development of hyperthermia, the stage of heat stroke is marked by:

a. shock and coma.

b. hypervolemia and headache.

c. diaphoresis and decreasing body temperature.

d. dizziness, fainting, and headache.

ANS: A

14. Which of the following is a potential effect of a bite or sting?

a. Immediate heart failure

b. Anaphylaxis

c. Severe nausea, vomiting, and diarrhea

d. Bone marrow damage

ANS: B

15. Bites from both wild and domesticated animals may cause:

a. anaphylaxis.

b. Shigella outbreaks.

c. rabies.

d. severe pain and headache.

ANS: C

16. Which of the following is considered carcinogenic?

a. Lead

b. Carbon monoxide

c. Inhaled particulates

d. Mercury

ANS: C

17. Illness in institutions may be traced back to food handlers who:

a. are carriers of pathogens.

b. do not practice adequate hand-washing or sanitization.

c. bring in pathogens from home or the community.

d. A, B, and C

ANS: D

18. A common illness for tourists in developing countries is travelers diarrhea, often caused by:

a. *Salmonella*

b. *Shigella*

c. *E. coli*

d. *Listeria*

ANS: C

19. Radiation damage may occur from repeated exposure to:

a. ultraviolet rays.

b. X-rays.

c. radioactive substances.

d. A, B, and C

ANS: D

20. Two types of eye damage that can be caused by a laser beam are:

a. chemical and structural.

b. thermal burn and photochemical damage.

c. tissue necrosis and vascular occlusions.

d. formation of deep lesions in the optic nerve and in the sclera.

ANS: B

Chapter 75. Environmental Exposures

1. A nurse from the ICU is participating in the hospitals disaster response preparedness team. One issue that proves difficult for the team to agree on is a statement regarding the standard of medical care observed during a disaster. Which of the following do you think the nurse should recommend to the team?

A) The goal should be to provide the highest care possible, with limited resources and equipment.

B) The lack of resources should not diminish the standard of care that the hospital provides.

C) The medical staff should tend to the needs of the most critically ill first.

D) If electrical power should be lost to the facility, patients on life support should be given lowest priority.

2. A nurse learns that local law enforcement officials have informed the hospital that an imminent terrorist attack has been threatened in a building just down the street from the hospital. Which of the following are appropriate responses? Select all that apply.

A) Explain to the patients in the ICU that a terrorist attack is expected and that their care may be interrupted.

B) Begin making preparations to move all ICU patients to other hospital facilities in the area in the event of an attack.

C) Review the hospitals disaster plan and make sure that it is distributed to the rest of the medical staff.

D) Determine what her specific role in the disaster plan is.

E) Not be concerned because federal deployable medical teams will likely be sent to the hospital in the event of an attack.

F) Check the number of ventilators available in the ICU to determine whether more would be needed in the event of an attack.

3. The nurse is at the bedside of her 90-year-old patient, Ruth, who is comatose and on life support in the ICU, when she begins to feel the room shaking violently. The power suddenly fails and emergency generators have not started yet. The nurse provides bag-mask resuscitation for Ruth while she waits for the power to be restored. Moments later, the ICU is inundated with patients injured by the collapse of a nearby apartment building as a result of the earthquake. The nurse is called to help. Kevin has been impaled by a metal rod through the chest, is in a state of shock, and will die without immediate intervention. Gwyneth has compound fractures of the femur and a dislocated shoulder, is in pain, but is responsive. Mason is unconscious and unresponsive. Based on the START triage categories, whom should the nurse assist first in this situation?

A) Ruth

B) Kevin

C) Gwyneth

D) Mason

4. A patient arrives at the ICU after being injured by car bomb that exploded 20 feet away. The patient sustained only primary blast injuries. Which of the following are injuries he might have sustained? Select all that apply.

A) Perforated eardrum caused by a sudden change in atmospheric pressure

B) Laceration from a shard of glass that struck the patient

C) Concussion as a result of his body being thrown against a brick wall

D) Hemorrhagic contusion of the lungs

E) Gastrointestinal hemorrhage

F) Blunt force trauma from a piece of metal shrapnel that struck the patients head

5. A group of patients, colleagues from the same office, arrive at the ICU with symptoms of nausea, vomiting, and diarrhea. It is determined that they are suffering from radiation exposure as a result of an inconspicuous device placed in the office that leaked radiation over a period of days. The nurse suspects that which of the following was used in this terrorist attack?

A) Radiological dispersal device

B) Improvised nuclear device

C) Nuclear weapon

D) Simple radiological device

6. A patient arrives at the ICU with symptoms of radiation exposure. While in the ICU, he begins gasping for air and clutching his throat with his hand. What intervention should take priority at this point?

A) Perform CPR on the patient to restore normal respiratory function.

B) Evaluate the degree of radiation exposure in the patient using a Geiger counter.

C) Undress the patient and have him shower and wash with soap to decontaminate himself.

D) Administer potassium iodide.

7. A woman arrives at the ICU after being the victim of a terrorist attack in a nearby shopping center involving a gas that spewed from a metal canister. The woman complains of a burning sensation in her eyes, mouth, and throat, and the nurse observes blistering on her face and arms. What chemical agent should the nurse suspect, and what intervention should she implement?

A) Vesicant agent; apply lotion

B) Nerve agent; administer benzodiazepine

C) Vesicant agent; soap and water blot

D) Nerve agent; provide ventilatory support

8. A worker at a local chemical plant arrives at the ICU following an industrial accident involving a gas leak. The patient shows signs of pulmonary edema and bronchospasm. What chemical should the nurse suspect is involved, and what intervention would be most appropriate?

A) Nitrogen mustard; soap and water blot

B) Chlorine; airway management and ventilatory support

C) Tear gas; irrigation of eyes with water

D) Cyanide; sodium nitrate

9. A man presents to the ICU with a severe case of H1N1 viral infection. What would be the most appropriate intervention for this patient?

A) Administer an H1N1 vaccine.

B) Administer an antibiotic.

C) Administer an antiviral agent.

D) Administer potassium iodide.

10. A young man arrives at the ICU after being held hostage while a passenger on a commercial airplane. He sustained a bullet wound in his chest and has undergone surgery to repair his lung. He is now receiving an analgesic for his pain. The nurse observes that the patient frequently complains that he is sick to his stomach and has no appetite. His sleep is regularly interrupted by nightmares, and he is prone to outbursts of anger and grief. What is the most likely cause of these symptoms?

A) Adverse reaction to pain medication

B) Reaction to severe pain

C) Post-traumatic stress disorder

D) Delirium resulting from an infection

11. The nurse is caring for a group of patients from the same workplace who have similar symptoms of cough, respiratory distress, and nausea and vomiting. What should the nurse suspect?

A) Food poisoning at local restaurant

B) Mass exposure to an inhaled agent

C) Allergic response to a new cleaning agent

D) Acute asthma exacerbation syndrome

12. The nurse is part of a planning committee developing a disaster response plan for a hospital that serves as the major trauma center for the local area. The committee has identified that the most likely cause of a disaster in the community is a devastating tornado that significantly damages most major structures, including hospitals of all sizes, in the community. What component of the plan is least likely to be realistic?

A) Transfer all noncritical patients to smaller hospitals in the community.

B) Provide for secure storage of emergency supplies and equipment.

C) Agree with other hospitals in town to share supplies and equipment.

D) Interface with the city disaster management plan and command center.

13. The nurse is preparing to assist with triage of victims from a large mass casualty incident. The patients are sorted into categories at the door of the facility. What category will receive care last?

A) Minimal

B) Delayed

C) Immediate

D) Expectant

14. The nurse is assisting with triage in the emergency department. A large group of patients from a mass casualty incident arrive. These patients have been classified at the scene as minimal, delayed, immediate, and expectant. What is the best nursing approach?

A) Use the classifications from the scene to determine the order of treatment.

B) Reassess and reclassify patients quickly to determine the order of treatment.

C) Treat the patients in the order they arrive at the emergency department.

D) After the first 20 patients, refer all others to another emergency care facility. The

15. nurse is caring for a patient who was exposed to a high dose of external radiation. What is the least likely nursing action?

A) Assess for and facilitate treatment of life-threatening injuries.

B) Assess radiological measurements with a Geiger counter.

C) Remove clothing and shower patient as soon as possible.

D) Assist in removing penetrating radioactive materials.

16.16. The nurse is caring for a patient who has been exposed to radiation. The patient has been increasingly unstable, with decreasing lymphocytes, leukocytes, thrombocytes, and erythrocytes, along with shock, diarrhea, and altered level of consciousness for some weeks. Today, there is clear evidence of worsening shock, subnormal body temperature, and increased intracranial pressure. The family asks what the patients prognosis is. The best nursing response is based on what rationale?

A) Increased intracranial pressure following other symptoms is a sign of impending death.

B) The symptoms listed are typical of the latent phase of recovery, which lasts several weeks.

C) Full recovery from radiation exposure can take many weeks to months.

D) The absence of fever indicates the patient has entered the latent phase of recovery.

17. The nurse is caring for a patient with a suspected cyanide exposure. The patient is anxious and hyperventilating. What is the nursing priority of care?

A) Give antiseizure medications.

B) Send toxicology screen.

C) Give cyanide antidote.

D) Obtain history of exposure.

18. The nurse is assisting with the initial care and assessment of a group of patients with a massive topical toxic chemical exposure. What is the best way to decontaminate these patients?

A) Use an antidote to the chemical of exposure.

B) Use an alkaline substance for an acid contaminant.

C) Soap-and-water shower first for most chemicals

D) Administer 100% oxygen under positive pressure.

19. A worker in a tanning factory comes to the emergency department with itchy, papular lesions on his hands and arms. Some of the lesions have black eschar in the center and some are vesicular. What biological exposure is most likely?

A) Cutaneous anthrax

B) Pulmonary anthrax

C) Cutaneous smallpox

D) Pneumonic plague

20. A patient and his family have been exposed to probable anthrax spores through contaminated postal contents within the past 8 hours. Upon arrival at the emergency department, all members of the family are anxious and say they are afraid of dying. The best nursing response is based on what rationale?

A) There is no treatment for anthrax exposure and their fears are realistic.

B) A vaccine given in the first 3 days after exposure will stop the disease.

C) Antibiotic therapy is very effective for cutaneous anthrax.

D) A toxicology screen is necessary to determine whether there really was an exposure.

Answer Key

1. A
2. C, D, F
3. B
4. A, D, E
5. D
6. A
7. C
8. B
9. C
10. C
11. B
12. A
13. D
14. B
15. D
16. A
17. C
18. C
19. A
20. C

Chapter 76. Sports Physicals

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.

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.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.)

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

26. A patient states, I can hear a crunching or grating sound when I kneel. She also states that it is very difficult to get out of bed in the morning because of stiffness and pain in my joints. The nurse should assess for signs of what problem?

a. Crepitation
b. Bone spur
c. Loose tendon
d. Fluid in the knee joint

ANS: A
Crepitation is an audible and palpable crunching or grating that accompanies movement and occurs when articular surfaces in the joints are roughened, as with rheumatoid arthritis. The other options are not correct.

27. A patient is able to flex his right arm forward without difficulty or pain but is unable to abduct his arm because of pain and muscle spasms. The nurse should suspect:

a. Crepitation.
b. Rotator cuff lesions.
c. Dislocated shoulder.
d. Rheumatoid arthritis.

ANS: B
Rotator cuff lesions may limit range of motion and cause pain and muscle spasms during abduction, whereas forward flexion remains fairly normal. The other options are not correct.

28. A professional tennis player comes into the clinic complaining of a sore elbow. The nurse will assess for tenderness at the:

a. Olecranon bursa.
b. Annular ligament.
c. Base of the radius.
d. Medial and lateral epicondyle.

ANS: D

The epicondyles, the head of the radius, and the tendons are common sites of inflammation and local tenderness, commonly referred to as *tennis elbow*. The other locations are not affected.

29. The nurse suspects that a patient has carpal tunnel syndrome and wants to perform the Phalen test. To perform this test, the nurse should instruct the patient to:

a. Dorsiflex the foot.
b. Plantarflex the foot.
c. Hold both hands back to back while flexing the wrists 90 degrees for 60 seconds.
d. Hyperextend the wrists with the palmar surface of both hands touching, and wait for 60 seconds.

ANS: C

For the Phalen test, the nurse should ask the person to hold both hands back to back while flexing the wrists 90 degrees. Acute flexion of the wrist for 60 seconds produces no symptoms in the normal hand. The Phalen test reproduces numbness and burning in a person with carpal tunnel syndrome.

The other actions are not correct when testing for carpal tunnel syndrome.

30. An 80-year-old woman is visiting the clinic for a checkup. She states, I cant walk as much as I used to. The nurse is observing for motor dysfunction in her hip and should ask her to:

a. Internally rotate her hip while she is sitting.
b. Abduct her hip while she is lying on her back.
c. Adduct her hip while she is lying on her back.
d. Externally rotate her hip while she is standing.

ANS: B

Limited abduction of the hip while supine is the most common motion dysfunction found in hip disease. The other options are not correct.

31. The nurse has completed the musculoskeletal examination of a patients knee and has found a positive bulge sign. The nurse interprets this finding to indicate:

a. Irregular bony margins.
b. Soft-tissue swelling in the joint.
c. Swelling from fluid in the epicondyle.
d. Swelling from fluid in the suprapatellar pouch.

ANS: D

A positive bulge sign confirms the presence of swelling caused by fluid in the suprapatellar pouch. The other options are not correct.

32. During an examination, the nurse asks a patient to bend forward from the waist and notices that the patient has lateral tilting. When his leg is raised straight up, the patient complains of a pain going down his buttock into his leg. The nurse suspects:

a. Scoliosis.
b. Meniscus tear.
c. Herniated nucleus pulposus.
d. Spasm of paravertebral muscles.

ANS: C

Lateral tilting and sciatic pain with straight leg raising are findings that occur with a herniated nucleus pulposus. The other options are not correct.

33. The nurse is examining a 3-month-old infant. While the nurse holds his or her thumbs on the infants inner mid thighs and the fingers on the outside of the infants hips, touching the greater trochanter, the nurse adducts the legs until the his or her thumbs touch and then abducts the legs until the infants knees touch the table. The nurse does not notice any clunking sounds and is confident to record a:

a. Positive Allis test.
b. Negative Allis test.
c. Positive Ortolani sign.
d. Negative Ortolani sign.

ANS: D

Normally, this maneuver feels smooth and has no sound. With a positive Ortolani sign, however, the nurse will feel and hear a clunk, as the head of the femur pops back into place. A positive Ortolani sign also reflects hip instability. The Allis test also tests for hip dislocation but is performed by comparing leg lengths.

Chapter 77. Primary Care of Older Adults MULTIPLE CHOICE

1.When discussing aging, to whom does the term *older adulthood* apply?

a. Age 55 and above
b. Age 65 and above
c. Age 70 and above
d. Age 75 and above

ANS: B

Older adulthood begins at about age 65.

MSC: NCLEX: Health Promotion and Maintenance

2.When the nurse discusses prevention of cardiac disease, falls, and depression with a group of older adults, the benefits of what are important to stress?

a. Nutrition
b. Medications
c. Exercise
d. Sleep

ANS: C

Primary prevention stresses exercise for the prevention of cardiac disease, falls, and depression.

MSC: NCLEX: Health Promotion and Maintenance

3.When was the Social Security Act, which was the first major legislation providing financial security for older adults, passed?

a.	1930
b.	1935
c.	1940
d.	1945

ANS: B

The first major legislation to provide financial security for older adults was the Social Security Act of 1935.

MSC: NCLEX: Health Promotion and Maintenance

4.When assessing the skin of an older adult patient who is complaining of pruritus, what should the nurse advise the patient to avoid to reduce further drying of her skin?

a.	Perfumed soap
b.	Hard-milled soap
c.	Antibacterial soap
d.	Lotion soap

ANS: C

Antibacterial soap is very drying.

OBJ:8TOP:Integumentary alterations

KEY:Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity

5.Because thin skin and lack of subcutaneous fat predisposes the older adult to pressure ulcers, the nurse alters the care plan to include turning the bedfast patient how often?

a.	Once every shift
b.	Every 4 hours
c.	Each evening
d.	Every 2 hours

ANS: D

Pressure ulcers can be avoided by repositioning the patient every 2 hours.

OBJ:8TOP:Integumentary alterations

KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance

6.At mealtime, the older adult seems to be eating less food than would be adequate. Compared to the younger adult, what is a requirement for the older adult?

a.	More fluids
b.	Less calcium
c.	Fewer calories
d.	More vitamins

ANS: C

The older adult requires 30 calories per kilogram of body weight, whereas the younger adult requires 40 calories.

KEY: Nursing Process Step: Assessment MSC: NCLEX: Health Promotion and Maintenance

7.The older patient informs the nurse that food has no taste and therefore the patient has no appetite. What is this most likely caused by?

a.	Tasteless food
b.	Overuse of salt
c.	Lack of variety
d.	Loss of taste buds

ANS: D

Older adults may experience a loss of appetite. Change in taste as a result of decreased saliva production and a decreased number of taste buds may make food unappealing.

8.An older adult is having difficulty swallowing. What position should the nurse recommend to aid in swallowing?

a.	Chin parallel
b.	Chin upward
c.	Chin down
d.	Chin to the side

ANS: C

The upright position, leaning slightly forward with the chin down, improves swallowing with the assistance of gravity.

MSC: NCLEX: Physiological Integrity

9.The patient complains to the nurse about a newly developed intolerance to milk. What should the nurse suggest to fulfill calcium needs?

a.	Rye bread
b.	Yogurt
c.	Apples
d.	Raisins

ANS: B

Lactose, primarily found in milk, is a common source of food intolerance. Dairy products are an important source of calcium, which is needed to prevent osteoporosis. Lactose-intolerant individuals need to replace milk with cheese and yogurt, which are processed and digested more easily.

MSC: NCLEX: Physiological Integrity

10.The older adult patient complains to the nurse about nocturia. This problem is most likely related to:

a.	loss of bladder tone.
b.	decrease in testosterone.
c.	decrease in bladder capacity.
d.	intake of caffeine.

ANS: C

At least 50% of older men and 70% of older women must get up two or more times during the night to empty their bladders, a condition known as nocturia (excessive urination at night). The most significant age-related change is the decrease in bladder capacity.

MSC: NCLEX: Physiological Integrity

11.The older adult female patient is concerned about incontinence when she sneezes. What is the correct terminology for this type of incontinence?

a.	Urge incontinence
b.	Stress incontinence
c.	Overflow incontinence
d.	Functional incontinence

ANS: B

Stress incontinence results from increased abdominal pressure, which occurs with coughing or sneezing. Urge incontinence occurs after a sudden urge to void and is associated with cystitis, tumors, stones, and CNS disorders. Overflow incontinence is associated with diabetic neuropathy

and spinal cord injuries. Functional incontinence results from unwillingness or inability to get to the toilet.

12.A change of aging related to the circulatory system includes decreased blood vessel elasticity. For what should the nurse assess?

a.	Confusion
b.	Tachycardia
c.	Hypertension
d.	Retained secretions

ANS: C

The blood vessels become less elastic because of aging and may lead to increased blood pressure.

13.What should be suggested to a patient to aid with the pain of claudication?

a.	Rest
b.	Exercise
c.	Cross legs
d.	Stand

ANS: A

A nursing intervention to relieve pain is to recommend the patient rest periodically until the pain subsides. Exercise and standing for long periods of time can exacerbate the pain. Crossing the legs can limit blood flow to the extremities and increase pain.

MSC: NCLEX: Physiological Integrity

14.The nurse recommends a breathing technique to help a patient with chronic obstructive pulmonary disease (COPD) to empty the lungs of used air and to promote inhalation of adequate oxygen. What is this method of breathing called?

a.	Pursed-lip breathing
b.	Increased inspiration
c.	Vital capacity
d.	Decreased expiration

ANS: A

Pursed-lip breathing can help empty the lungs of used air and promote inhalation of additional oxygen.

MSC: NCLEX: Physiological Integrity

15.The nurse reminds the 80-year-old patient that her respiratory system has decreased resistance to respiratory infections. For what is this patient at increased risk?

a.	COPD
b.	Bronchitis
c.	Pneumonia
d.	Atelectasis

ANS: C

Decreased resistance to respiratory infections places older adults at higher risk for pneumonia.

16.The nurse recognizes that an older adult patient with COPD has a higher incidence of developing which age-related skeletal change that will alter the ability to exchange air effectively?

a.	Osteoporosis
b.	Arthritis
c.	Kyphosis
d.	Osteomyelitis

ANS: C

Kyphosis, usually caused by osteoporosis, is a curvature of the spine that alters respiration and air exchange.

17.What is a major difference between rheumatoid arthritis and osteoarthritis?

a.	Rheumatoid arthritis is degenerative.
b.	Rheumatoid arthritis only affects patients over 40 years of age.
c.	Rheumatoid arthritis is inflammatory.
d.	Rheumatoid arthritis is curable.

ANS: C

Rheumatoid arthritis is an inflammatory disease; osteoarthritis is degenerative. Rheumatoid arthritis can affect patients at any age. Neither type of arthritis is curable.

18.For what is the older adult patient at increased risk because of age-related changes in the musculoskeletal system?

a.	Fractures due to poor uptake of calcium
b.	Heart attacks due to increased effort to ambulate
c.	Respiratory failure due to kyphosis
d.	Falls related to posture changes

ANS: D

Falls are the leading cause of accidental death in individuals over 65, in part because of posture changes brought on by aging.

MSC: NCLEX: Health Promotion and Maintenance

19.The nurse is assisting an older adult patient out of bed when suddenly the patient begins to fall. What is the likely cause of the fall?

a.	Fever
b.	Orthostatic hypotension
c.	Dehydration
d.	A decrease in venous return

ANS: B

Orthostatic hypotension occurs when the patient changes position. In the older adult, the loss of elasticity in the vessels slows the vascular accommodation to sudden postural changes to a standing position.

20.To help prevent falls related to muscle weakness, what type of exercises should be selected for the aging patient?

a.	Daily
b.	Running
c.	Weight-bearing
d.	Aerobic

ANS: C

Appropriate interventions to increase muscle strength begin with weight-bearing exercises. They do not have to be done daily to be effective. Running and aerobic exercise would not be appropriate or effective for the aging patient.

21.What is the best test to identify the risk of osteoporosis in postmenopausal women?

a.	Skeletal x-ray
b.	Bone density scan
c.	Calcium blood level
d.	CAT scan

ANS: B

Bone density testing can identify women at risk for fractures. MSC:

NCLEX: Physiological Integrity

22. When an older female patient complains of painful sexual intercourse, what should the nurse recognize as the probable cause?

a.	Urinary incontinence
b.	Arthritic joints
c.	Kyphosis
d.	Mucosal drying

ANS: D

Sexual intercourse may be uncomfortable because of drying of the mucosa of the vagina. MSC:

NCLEX: Physiological Integrity

23. What is age-related vision change caused by the loss of elasticity of the lens called?

a.	Nearsightedness
b.	Cataracts
c.	Presbyopia
d.	Blepharitis

ANS: C

Age-related changes include presbyopia and farsightedness resulting from a loss of elasticity of the lens. Cataracts are due to opacity of the lens.

24. When communicating with an older adult patient who has difficulty hearing, how should the nurse change her speech?

a.	Speak very loudly
b.	Speak rapidly
c.	Lower the tone of the voice
d.	Raise the tone of the voice

ANS: C

To communicate with a patient with a hearing loss, the nurse should lower the tone of the voice.

MSC: NCLEX: Physiological Integrity

25. Which symptom of diabetes distorts tactile sensation?

a.	Proprioception
b.	Loss of visual acuity
c.	Progressive paresis

d.	Peripheral neuropathy

ANS: D

MSC: NCLEX: Physiological Integrity

26.What is the result of a slowing of the impulse transmission in the nervous system?

a.	Hypertension
b.	Hearing deficit
c.	Decrease in tactile sensations
d.	Longer reaction time

ANS: D

When nerve impulses in the nervous system of an older adult slow down, the result is a longer reaction time.

27.What is the most common cause of dementia?

a.	Multi-infarct
b.	Medications
c.	Alzheimer disease
d.	Parkinson disease

ANS: C

Alzheimer disease is the most common cause of dementia. MSC:

NCLEX: Health Promotion and Maintenance 28.What is one positive

aspect of Parkinson disease?

a.	The disease does not alter ability to communicate
b.	Anti-Parkinson drugs have few side effects
c.	Intellectual function is not impaired
d.	Involuntary movements can be controlled

ANS: C

Parkinson disease does not impair the intellect. The disease does alter the ability to communicate. Anti-Parkinson drugs have many side effects. The involuntary movements associated with the disease cannot be controlled.

29.When should family members of a stroke victim expect to see some of the neurologic involvement disappear?

a.	Within 2 to 3 weeks
b.	Within 1 to 2 months
c.	Within 3 to 6 months
d.	Within 6 to 9 months

ANS: C

Some of the initial neurologic deficits of a Cerebrovascular Accident may disappear in 3 to 6 months.

30.When communicating with an older adult patient, the nurse becomes aware of the fact that the patient is well satisfied with his accomplishments over a lifetime and has no regrets concerning aging. Which of Eriksons developmental stages has the patient achieved?

a.	Acceptance
b.	Withdrawal
c.	Ego integrity
d.	Interaction

ANS: C

The last stage of life is acceptance of life and it results in ego integrity.

Chapter 78. Palliative Care and Pain Management

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which of the following statements is true regarding pain?
a. If a patient complains of pain but has no physical signs, he or she is most likely exhibiting drug-seeking behaviors.
b. Acute pain is more intense and severe than chronic pain.
c. Pain is a subjective experience related to actual or potential tissue damage.
d. All of the above

____ 2. Which of the following would be a cause of visceral pain?
a. Bone metastases
b. Intra-abdominal metastases
c. Musculoskeletal inflammation
d. Postsurgical incisional pain

__ 3. According to the World Health Organization's analgesic ladder, which drug combination would be most appropriate in an opiate-naïve patient who presents with moderate pain?

a. Ibuprofen/imipramine
b. Naproxen/morphine
c. Aspirin/fentanyl
d. Indomethacin/hydrocodone

____ 4. A 75-year-old man is being treated as an outpatient for metastatic prostate cancer. Which of the following statements is true regarding the management of pain with opioids in the elderly?

a. Opioids with a long half-life, such as methadone, are a good choice, because they stay in the system longer, and patients do not have to remember to take multiple pills.
b. Serum creatinine is the best measurement of renal function in the elderly and should be done prior to the initiation of treatment with opioids.
c. Renal clearance of medications is faster in the elderly, so higher dosages of medications are needed to adequately control pain.
d. None of the above

____ 5. A patient had a transdermal fentanyl patch placed 2 hours ago and is not getting any pain relief. What would be the most appropriate intervention?

a. Remove the current patch and replace with a new fentanyl patch at a higher dose.
b. Prescribe a short-acting opioid for breakthrough pain.
c. Remove the patch and switch to a different intravenous opioid.
d. Tell the patient not to worry, as it takes about 12 hours for the patch's effects to be felt, and he will have relief at that time.

__ 6. A patient is preparing to be discharged to home with hospice. She is on a morphine patient-controlled analgesia (PCA) in the hospital. She is concerned as to whether she can stay on her morphine PCA at home even when she is not able to give herself boluses. What would be an appropriate response from the clinician?

a. "We are unable to prescribe a PCA for use at home. If you are comfortable on the PCA, you should remain in the hospital."
b. "It would be possible for your nurse or another trained family member to activate the dosing button when you are unable to do so."
c. "A PCA is not an appropriate method of pain medication delivery once you are unable to use the dosing button. I will switch you to another form of pain control."
d. "You should not be concerned about your pain management at home. It will be taken care of for you."

__ 7. A patient taking PO hydromorphone for pain control has developed dysphagia. The clinician decides to switch the patient to IV hydromorphone. What ratio of IV:PO hydromorphone does the clinician need to know to calculate the proper dose?

a. 1:1
b. 1:2
c. 1:5
d. 1:7

__ 8. A patient is receiving long-acting oxycodone for pain control. The clinician thinks that he also will benefit from a short-acting oxycodone for breakthrough pain. How will the clinician figure out what the dose of short-acting oxycodone should be?

a. The short-acting dose should be 10% to 20% of the total 24-hour long-acting dose.
b. The short-acting dose should be 40% to 50% of the total 24-hour long-acting dose.
c. The short-acting dose should be 10% to 20% of each long-acting dose.
d. The short-acting dose should be 40% to 50% of each long-acting dose.

__ 9. A patient is being switched from hydromorphone to methadone in an attempt to achieve better pain control. How much should the dose of methadone be reduced when calculating the equianalgesic dose of the two drugs?

a. 0%
b. 20%
c. 50%
d. 90%

__ 10. If a patient requires six rescue doses for breakthrough pain in a 24-hour period, what would be an appropriate intervention?

a. Increase the dose of the baseline long-acting medication.
b. Increase the dose of the rescue short-acting medication.
c. Switch to a different short-acting rescue medication.
d. Do nothing, because this is appropriate, and the patient's pain is well controlled.

__ 11. A patient with bone metastases from prostate cancer inquires whether he is a candidate for radiopharmaceuticals. Which of the following conditions would exclude him as a candidate?

a. Karnofsky performance status of 65
b. Pathologic fracture
c. Life expectancy of 5 months
d. Hypocalcemia

____ 12. Which of the following is the best description of dyspnea?

a. An oxygen saturation of less than 90%
b. Respiratory rate greater than 24

c. A psychological state resulting in the feeling of air hunger
d. A subjective feeling of breathlessness

__ 13. What would be an appropriate dose of morphine to give an opioid-naïve patient to manage tachypnea associated with dyspnea?
a. 5 mg PO every 4 hours
b. 15 mg PO every 4 hours
c. 30 mg PO every 4 hours
d. 40 mg PO every 4 hours

__ 14. Glycopyrrolate (Robinul) is one drug of choice to manage which of the following conditions that can contribute to dyspnea?
a. Copious secretions
b. Cough
c. Anxiety
d. Effusion

____ 15. Which characteristic of delirium helps to distinguish it from dementia?
a. Abrupt onset
b. Impaired attention
c. Affective changes
d. Delusions

__ 16. Which of the following classes of drugs should be used as first-line therapy for treatment of delirium?
a. Benzodiazepines
b. Antipsychotics
c. Anticonvulsants
d. Antidepressants

____ 17. Which of the following is a role of the advanced practice nurse in palliative cancer care?
a. Detecting cancer in asymptomatic patients or those with specific symptoms
b. Arranging for follow-up care, including psychosocial and spiritual support
c. Identifying and managing complications of care
d. All of the above

True/False
Indicate whether the statement is true or false.

____ 1. Patients who are receiving life-prolonging therapies do not qualify for palliative care.

____ 2. Some anticonvulsant drugs can be used as an adjuvant treatment for mild pain.

____ 3. Oxygen has shown no benefit in alleviating dyspnea in patients without hypoxemia.

Chapter 78. Palliative Care and Pain Management
Answer Section

MULTIPLE CHOICE

1. ANS: C PTS: 1
2. ANS: B PTS: 1
3. ANS: D PTS: 1
4. ANS: D PTS: 1
5. ANS: B PTS: 1
6. ANS: B PTS: 1
7. ANS: C PTS: 1
8. ANS: A PTS: 1
9. ANS: D PTS: 1
10. ANS: A PTS: 1
11. ANS: B PTS: 1
12. ANS: D PTS: 1
13. ANS: B PTS: 1
14. ANS: A PTS: 1
15. ANS: A PTS: 1
16. ANS: B PTS: 1
17. ANS: D PTS: 1

TRUE/FALSE

1. ANS: F PTS: 1
2. ANS: T PTS: 1
3. ANS: T PTS: 1

Chapter 79. Ethical and Legal Issues of a Caring-Based Practice

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which statement about the American Nurses Association Code of Ethics is accurate?
a. The state's legal requirements exceed those of the Code of Ethics.
b. The primary purpose of the Code is to show physicians that nurses are professional.
c. The Code was formulated by physicians for all nurses.
d. The Code sets forth the values and ethical principles that guide clinical decisions.

____ 2. Which ethical principle reflects respect for all persons and their self-determination?
a. Autonomy
b. Beneficence
c. Justice
d. Veracity

____ 3. When may confidentiality be overridden?
a. When personal information is available on the computer
b. When a clinician needs to share information with a billing company
c. When an insurance company wants to know the results of a breast cancer gene test
d. When a patient has a communicable disease

____ 4. In an outpatient setting, what is the most common reason for a malpractice suit?
a. Failure to treat a condition
b. Failure to diagnose correctly
c. Ordering the wrong medication
d. Failure to manage care

__ 5. Which type of liability insurance covers only situations in which the incident occurred and the claim was made while the policy was in effect?
a. Claims made policy
b. Occurrence policy
c. An employment coverage policy
d. A "tail" policy

__ 6. Which insurance plan was the first to allow members to choose nurse practitioners as their primary care provider and pay them the same rate as physicians for the same care?

a. Blue Cross/Blue Shield
b. Medicare/Medicaid
c. The Oxford Health Plan
d. United Health Insurance

____ 7. Constructing a decision tree is helpful in analyzing ethical dilemmas, because a decision tree:

a. Shows the best solution
b. Explains the ethical principles
c. Delineates the legal parameters
d. Allows all the options to be considered

__ 8. In the consensus model for Advanced Practice Registered Nurse (APRN) regulation, the "C" of LACE represents?

a. Commitment
b. Consensus
c. Certification
d. Collaboration

____ 9. The main mechanism for avoiding a lawsuit involves:

a. Good liability insurance
b. A collaborating physician
c. Good documentation
d. Open communication skills

____ 10. Paternalism in health care:

a. Assumes the physician knows what is best
b. Is never warranted
c. Is in effect after an informed consent is signed
d. Requires a court order

____ 11. The Nurse Practice Act of each state is responsible for:

a. Establishing the legal standards
b. Promoting high-quality nursing care
c. Protecting the public from unethical nursing practice
d. Exceeding the requirements of the Code of Ethics for Nurses

____ 12. Deontology is:

a. The greatest amount of happiness or the least amount of harm for the greatest number
b. The consideration of consequences and the calculation of benefits
c. The belief that the ends justify the means
d. The principle of universalizability

____ 13. A situation that requires informed consent involves:
a. Therapeutic privilege
b. An emergency situation
c. Invasive procedures
d. The therapeutic use of placebos

____ 14. Which ethical principle is the foundation on which health care rests?
a. Autonomy
b. Nonmaleficence
c. Beneficence
d. Justice

____ 15. The Joint Commission mandates that all health-care organizations have:
a. A mechanism in place for the consideration of ethical issues
b. An Ethics committee
c. A resident parish nurse
d. Legal counsel who is knowledgeable about ethics

____ 16. The relationship between ethics and law is such that:
a. What is ethical is also legal
b. What is unethical is also illegal
c. Legal actions may be both ethical and unethical
d. There is no relationship between the law and ethics

____ 17. An APRN's scope of practice includes all of the following statements EXCEPT:
a. The scope of practice defines the duties and responsibilities of the APRN
b. The scope of practice delineates the permissible boundaries of the professional practice
c. The scope of practice is defined by statute, rule, or a combination of the two
d. Each APRN defines his/her own scope of practice and includes it in their protocol

____ 18. Which board administers and defines advanced nursing practice in all states?
a. The Board of Nursing
b. The Board of Medicine

c. The Board of Pharmacy
d. It is different for each state.

____ 19. Three components must be present to establish malpractice. Which one does NOT apply?
a. The APRN must be paid for the services in question.
b. The provider must have a duty to the patient.
c. The standard of care must have been deviated from or breached.
d. Harm or damages must have occurred as a result of the duty and a breach of the standards of care.

____ 20. The Institute of Medicine stresses interprofessional collaboration between physicians and APRNs. Which statement supports this?
a. The physician supervises the APRN.
b. The physician sponsors the APRN.
c. There is a collegial relationship between the two providers.
d. The physician pays the APRN's salary.

Chapter 79. Ethical and Legal Issues of a Caring-Based Practice

Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: A PTS: 1
3. ANS: D PTS: 1
4. ANS: B PTS: 1
5. ANS: A PTS: 1
6. ANS: C PTS: 1
7. ANS: D PTS: 1
8. ANS: C PTS: 1
9. ANS: D PTS: 1
10. ANS: B PTS: 1
11. ANS: A PTS: 1
12. ANS: D PTS: 1
13. ANS: C PTS: 1
14. ANS: B PTS: 1
15. ANS: A PTS: 1
16. ANS: C PTS: 1
17. ANS: D PTS: 1
18. ANS: D PTS: 1
19. ANS: A PTS: 1
20. ANS: C PTS: 1

Chapter 80. The Business of Advanced Practice Nursing

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Identify the primary challenge for insurance carriers in today's health delivery model.
a. Preventing illness
b. Screening for disease
c. Educating the public
d. Reducing health-care spending

__ 2. Medicare benefits were offered to U.S. beneficiaries beginning in 1965. What was the service added with the Medicare D plan in 2006?
a. Health-care screening
b. Health-care education
c. Pharmaceutical coverage
d. Durable medical equipment coverage

__ 3. With the growing shortage of primary care physicians, the demand for advanced practice registered nurses (APRNs) will increase between 2014 and 2016 from:
a. 5 to 15 million
b. 15 to 35 million
c. 20 million to 30 million
d. 30 million to 40 million

__ 4. Maintaining optimum cash flow is a basic fundamental concept in all businesses. Cash flow is impacted at the initial request for appointment and is affected by practices that include:
a. Billing within 15 days of services
b. Beneficiary verification of patient
c. Timely processing of denials
d. Identifying payment below contract rate

__ 5. Patients require insurance counseling prior to accessing health-care services for the following reason:
a. Many patients do not understand policy benefits and payment responsibility.
b. Services may change across the beneficiary year.
c. Copayments and deductibles may have already been met by the patient.
d. Coding may need to be adjusted to meet the terms of the patient's benefits.

___ 6. Health-care billing is a significant reason for bankruptcy in the United States. The following provision of the Affordable Care Act (ACA) legislation was included to reduce this from occurring with insured patients:

a. Consumer assistance programs
b. Preventative care options standardized
c. Young adult coverage (under 26 years)
d. Elimination of lifetime limits

___ 7. Accounting keeps track of the financial state of a business. The accounting report that demonstrates the growth in assets is:

a. Net income statement
b. Balance sheet
c. Cash flow statement
d. Operating statement

___ 8. Medicare advantage plans, also called Medicare HMO Plans, are plans approved by the Centers for Medicare and Medicaid Services (CMS) as alternative carriers for Medicare beneficiaries. Which of the following is not a characteristic of these plans?

a. Offer additional benefits
b. Offer lower copayments
c. Follow Medicare benefit rules
d. Follow the Commercial Carriers rules

___ 9. Current procedural terminology (CPT) coding offers the uniformed language used for reporting medical services and procedures performed by physician and nonphysician practitioners. Clinicians are paid based on calculated resource costs that, in turn, are based on practice components. Which of the following is a part of the components used to calculate the per CPT code payment rate?

a. Clinician education loans
b. Clinician practice liability and malpractice expense
c. Clinician reported cost reduction efforts
d. Clinician volume of patients treated

___ 10. Beginning in 2014, all medical practices will be required by the CMS to adopt a certified electronic medical record software system for documenting and billing for medical services. What is a primary reason for this implementation mandate?

a. Allows CMS to audit all medical practices' performance
b. Standardizes the billing rules for all clinicians
c. Reduces the duplication of services noted in the current system
d. Reduces costs related to multiple billing systems

__ 11. All health-care practices should develop a compliance plan. Compliance plans offer practice safeguards that prevent which of the following?

a. Malpractice claims
b. Conflict of interest claims
c. Health Insurance Portability and Accountability Act violations
d. Occupational Safety and Health Administration violations

__ 12. Clinicians who learn how to code and document Evaluation and Management and clinician services will be more successful in gaining timely payment for care delivery. Which of the following CMS practices is designed to financially penalize clinicians who do not bill according to CMS guidelines?

a. Audits and probes
b. Add-on codes
c. Modifier codes
d. HAC guidelines

__ 13. Each state has criteria defining the level of collaboration required between the APRN and an oversight physician. Which is among the questions an APRN should seek when selecting a practice setting?

a. List of practice limitations as an APN
b. Standard hourly rate as office staff
c. Expectation for net revenue generation
d. Standard benefit package offered to office staff

____ 14. Identify one of the primary reasons for an APRN to develop a business plan?

a. To monitor monthly actual expense to budgeted expense
b. To reduce the likelihood of litigation action
c. To identify the marketing needed to grow the APRN practice
d. To assure accreditation standards are met

____ 15. Despite the growth in the numbers of advanced practice registered nurses (APRNs) over the last decades, the role of the profession is often not understood by the public. What actions should APRNs undertake to market their services to the public?

a. Request that the physician act as an APRN spokesperson.
b. Increase articles in nursing professional journals about the APRN role.
c. Personally seek out the news media to communicate their value.
d. Rely on patients to communicate their benefits to neighbors.

Chapter 80. The Business of Advanced Practice Nursing
Answer Section

MULTIPLE CHOICE

1. ANS: D PTS: 1
2. ANS: C PTS: 1
3. ANS: B PTS: 1
4. ANS: B PTS: 1
5. ANS: A PTS: 1
6. ANS: D PTS: 1
7. ANS: A PTS: 1
8. ANS: C PTS: 1
9. ANS: B PTS: 1
10. ANS: C PTS: 1
11. ANS: B PTS: 1
12. ANS: A PTS: 1
13. ANS: C PTS: 1
14. ANS: C PTS: 1
15. ANS: C PTS: 1

Chapter 81. The 15-Minute Hour: Practical Approaches to Behavioral Health for Primary Care

Multiple Choice
Identify the choice that best completes the statement or answers the question.

__ 1. According to World Health Organization data on 1,500 patients in 15 separate world sites, how many patients presenting with medical/somatic complaint had a psychiatric problem?
a. Fully one-third of all patients
b. One-quarter of all patients
c. One-half of all patients
d. 60% of all patients

__ 2. Integrating mental health techniques and approaches, such as the 15-minute hour, into the primary care patient encounter is important for a number of reasons. These include:
a. Decreasing the patient's stress and increasing your reimbursement
b. Encouraging coping strategies and increasing professional satisfaction
c. Assisting patients in reliving traumatic experiences
d. Decreasing care clinician stress

____ 3. Valliant (1979) discusses the "ubiquity of stress." Ubiquity of stress maintains that:
a. In a current and rapidly changing society, stress can be viewed as a positive.
b. Eustress is counterproductive.
c. The overwhelmed can functionally regress.
d. Dream therapy has been found to be an effective treatment of overwhelming stress.

____ 4. Basic human needs are identified as:
a. Autonomy and feeling valued by others
b. Exhilaration and productivity
c. Spirituality
d. Career success and material rewards

____ 5. Commonalities among psychotherapeutic techniques include the following:
a. Dream therapy, listening, and reflection
b. Psychodrama, group psychotherapy, and 12-step programs
c. Self-help groups
d. Obtaining external perspective and participation in a helping relationship

____ 6. The goals of the 15-minute hour approach include:
a. Enhance self-esteem, expand behavioral repertoire, prevent dire consequences, and reestablish premorbid levels of functioning

b. Emerge with a higher level of functioning and commitment to long-term psychotherapy
c. Accept need for antidepressant therapy and psychiatric referral; share concerns with primary care clinician
d. Improve family functioning and sexual performance as well as accept need for antidepressant medication

____ 7. BATHEing the patient refers to:
a. A technique used in primary care to get the patient to accept the need for psychological or psychiatric referral
b. A technique used to facilitate cultural understanding
c. A technique used to perform psychotherapy
d. A technique that is a quick screen for psychiatric issues and interventions for psychological problems

____ 8. BATHEing the patient is an advanced practice nursing intervention that allows the practitioner to:
a. Develop a therapeutic relationship without "owning" the patient's problem
b. Conduct psychological counseling within the context of the primary care encounter
c. Focus on the "process" and not the assessment
d. Make the patient and family happier

__ 9. The BATHE technique was developed more than 20 years ago and has been used extensively in primary care and family practice. The new "Positive BATHE" stresses:
a. A belief that all things are possible through positive affirmations
b. A belief that one should only refer to practitioners who embrace the viewpoint of positive psychology
c. Personal accomplishment, thankfulness, autonomy, and general positive effect
d. The patient's problems and concerns

__ 10. Which of the following scenarios best demonstrates the relationship between physical health and distress?
a. A patient's high calorie diet contributes to his diagnosis of type 2 diabetes.
b. A patient with an elevated HbA1C reports that he was recently evicted from his home.
c. A patient with depression reports an increase in suicidal thoughts.
d. A patient reports feeling "numb" after learning her malignant tumor is inoperable.

____ 11. One benefit of BATHEing a patient is that:
a. It allows providers an in-depth exploration of patient's presenting problems.
b. It assumes that ambivalence is a normal part of the change process.
c. It utilizes the therapeutic relationship to help patients in a time-sensitive approach.

d. It can be done only with extensive training in therapeutic technique.

____ 12. One benefit of motivational interviewing (MI) is:
a. It assumes that ambivalence is a normal part of the change process.
b. It can be utilized during routine office visits.
c. It is a therapeutic technique which is not necessarily time intensive.
d. All are benefits of MI.

____ 13. Which is not a basic principle of MI?
a. People often continue behaviors with negative consequences for reasons unknown to the provider.
b. The patient is the expert on his/her behavior.
c. Providers are obligated to inform each patient of the negative consequences of their behaviors.
d. Helping patients understand ambivalence for change is often more powerful than direct instruction.

____ 14. The primary purpose of the "Positive BATHE" is intended to help patients by:
a. Focusing on autonomy and accomplishment
b. Creating a stronger therapeutic alliance
c. Helping the patient change negative behaviors
d. Engaging the patient during the psychosocial assessment

Chapter 81. The 15-Minute Hour: Practical Approaches to Behavioral Health for Primary Care

Answer Section

MULTIPLE CHOICE

1. ANS: A PTS: 1
2. ANS: B PTS: 1
3. ANS: C PTS: 1
4. ANS: A PTS: 1
5. ANS: D PTS: 1
6. ANS: A PTS: 1
7. ANS: D PTS: 1
8. ANS: A PTS: 1
9. ANS: C PTS: 1
10. ANS: B PTS: 1
11. ANS: C PTS: 1
12. ANS: D PTS: 1
13. ANS: C PTS: 1
14. ANS: A PTS: 1

Chapter 82. Putting Caring into Practice: Caring for Self

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. The World Health Organization defines self-care as:
a. An important global activity for all health-care providers
b. A set of deliberate actions that all individuals, families, and communities should engage in to maintain good health
c. Essential to efficacious advanced practice nursing (APRN) practice
d. An awareness by the APRN of their self-care behaviors as related to diet, activity, and mental attitude

____ 2. Nurse theorist Dorothea Orem defines self-care activities as:
a. Attainment of professional self-development goals
b. Ability to persevere through hardship
c. Striving to attain balance and harmony in one's life
d. Comprising activities that are performed independently by an individual to promote and maintain well-being throughout life

____ 3. Self-care and personal development are built into the standards of practice of:
a. The American Holistic Nurses Association
b. The American Nurses Association
c. The American Association of Nurse Practitioners
d. The American Academy of Nursing

__ 4. There are many pressures inherent in primary care practice today for APRNs. These pressures include all of the following:
a. Electronic medical record, the Affordable Care Act, and the implementation of socialized medicine
b. Patient care outcomes being tied to reimbursement, role diffusion with physicians and physician assistants
c. Uncertainty, the team approach to care, and the need for patient-centered care
d. Availability of medical information on the internet, educational programs for patients, and Medicare drug benefits

____ 5. A new era of health care leads to:
a. Greater opportunity for independent practice, yet increased legal risk in accountability for patients
b. Lowered reimbursement for all health-care services and providers
c. Decrease in status for health-care providers
d. No ability to individualize care

____ 6. Compassion fatigue is another side-effect of today's health-care delivery system. This term means:
   a. The APRN feels sudden guilt and distress when he or she cannot rescue or save an individual, such as when bad health habits persist despite the best efforts of the APRN.
   b. This happens over time related to the need to see increasing numbers of patients in busy primary care practices.
   c. This may persist over time, even when the APRN transfers to a new and different setting.
   d. Patients' problems and circumstances can be so overwhelming that the APRN needs to set severe boundaries to maintain safe function.

____ 7. Another term used, burn out, is differentiated by:
   a. Numbness of feelings leading to substance abuse
   b. How novice APRNs feel at the end of the day in primary care
   c. Feelings of aloneness, desperation, and despair
   d. A gradual response to the inability to achieve one's goals with patients in the work setting; it is characterized by frustration and diminishing morale

____ 8. The following statement is true:
   a. APRNs are often sensitive to patients' deficiencies but not their own.
   b. APRNs always respond appropriately to patients, families, and team members.
   c. APRNs are well-equipped from their APRN educational programs to care for self.
   d. Relicensure in some states mandates continuing education units in self-care.

__ 9. Self-compassion is the ability to be compassionate to one's self and is positively correlated with emotional intelligence. Emotional intelligence is defined as:
   a. Being highly attuned to the needs of others
   b. The ability to engage in self-care
   c. Being aware of self, having the capacity to self-regulate, possessing motivation, empathy, and social skills
   d. The holistic integration of self-care and self-development practices

__ 10. APRNs need to develop their own self-management plans. Two key elements of self-management plans are:
   a. Taking vacations and keeping up with new knowledge and developments in medicine
   b. Resilience and positive intentionality
   c. Family support and a healthy diet
   d. Being physically and emotionally "fit"

____ 11. The term *resilience* implies:
   a. Ability to look to a higher power to get you through a crisis
   b. Response to difficult and adverse circumstances through positively adjusting to stressors
   c. That the APRN can weather any emergency
   d. Learning to set appropriate boundaries

____ 12. Qualities associated with resilience include:
   a. Hope, self-efficacy, and optimism
   b. Stick-to-it-ness, belief in a higher power
   c. Education, self-regulation, and use of activity to decrease stress
   d. Ability to take vacations and the availability of support systems and a secure work environment

___ 13. Patsy, a 42-year-old experienced APRN, is orienting a new APRN to the Minute Clinic, where she has worked for more than 5 years. Patsy loves her work and was concerned when the new APRN, Sue, expressed her dissatisfaction with this setting. "I hate the idea of being here on my own, with no back-up and support after orientation" was one of Sue's concerns. Sue confessed that this was the only job she could find. Patsy felt good in her independent role and felt she had worked to create a positive atmosphere for her patients at all times. She derived joy and satisfaction from her ability to do this for her patients. Patsy found Sue's endless complaints debilitating. Patsy demonstrated resiliency by using which of the following strategies?
   a. Patsy distanced Sue by listening to her as little as possible.
   b. Patsy openly shared her positive feelings about the work environment and took a risk by sharing with Sue that she found her endless complaining draining.
   c. Patsy spoke privately with their supervisor, Pamela, stating that she did not think Sue could be successful in this environment.
   d. Patsy requested that Sue be assigned to a different APRN for orientation.

____ 14. The qualities of resilience that Patsy demonstrated when responding to Sue include:
   a. Protecting her own positive attitude by lessening her contact with Sue, a negative person
   b. The ego strength to admit failure in her ability to orient Sue, a destructive person
   c. Protecting her organization by sharing Sue's deficiencies with their supervisor
   d. Asserting her positive approach and basic optimism by initiating an honest discussion with Sue and having the emotional insight to recognize Sue's negative effect on her

___ 15. According to nurse theorist Jean Watson, a focus on positive intentionality—holding caring thoughts, loving kindness, and open receptivity—enhances caring energy, which leads to healing. How can the APRN bring this to their practice?

a. Spiritual readings, centering oneself before patient encounters, engaging in behaviors that help build positive energy
b. Review of materials on primary care before going into the work environment to increase one's confidence, leading to caring energy
c. Travel to sacred places
d. Helping the poor and homeless—volunteering at a domestic violence shelter, for example—in addition to one's regular practice

Chapter 82. Putting Caring into Practice: Caring for Self
Answer Section

MULTIPLE CHOICE

1. ANS: B PTS: 1
2. ANS: D PTS: 1
3. ANS: A PTS: 1
4. ANS: B PTS: 1
5. ANS: A PTS: 1
6. ANS: A PTS: 1
7. ANS: D PTS: 1
8. ANS: A PTS: 1
9. ANS: C PTS: 1
10. ANS: B PTS: 1
11. ANS: B PTS: 1
12. ANS: A PTS: 1
13. ANS: B PTS: 1
14. ANS: D PTS: 1
15. ANS: A PTS: 1