

Advanced Health Assessment and Diagnostic Reasoning

3rd edition Rhoads

TEST BANK

Chapter **1** Interview and History Taking Strategies

MULTIPLE CHOICE

1. The nurse is conducting an interview with a woman who has recently learned that she is pregnant and who has come to the clinic today to begin prenatal care. The woman states that she and her husband are excited about the pregnancy but have a few questions. She looks nervously at her hands during the interview and sighs loudly. Considering the concept of communication, which statement does the nurse know to be *most* accurate? The woman is:

- a. Excited about her pregnancy but nervous about the labor.
- b. Exhibiting verbal and nonverbal behaviors that do not match.
- c. Excited about her pregnancy, but her husband is not and this is upsetting to her.
- d.

Not excited about her pregnancy but believes the nurse will negatively respond to her if she states this.

ANS: B

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

2. Receiving is a part of the communication process. Which receiver is most likely to misinterpret a message sent by a health care professional?

- a. Well-adjusted adolescent who came in for a sports physical
- b. Recovering alcoholic who came in for a basic physical examination
- c. Man whose wife has just been diagnosed with lung cancer
- d.

Man with a hearing impairment who uses sign language to communicate and who has an interpreter with him

ANS: C

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

3. The nurse makes which adjustment in the physical environment to promote the success of an interview?

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

ANS: A

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

4. In an interview, the nurse may find it necessary to take notes to aid his or her memory later. Which statement is *true* regarding note-taking?

a. Note-taking may impede the nurses observation of the patients nonverbal behaviors.

b.

Note-taking allows the patient to continue at his or her own pace as the nurse records what is said.

c.

Note-taking allows the nurse to shift attention away from the patient, resulting in an increased comfort level.

d.

Note-taking allows the nurse to break eye contact with the patient, which may increase his or her level of comfort.

ANS: A

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

5. The nurse asks, I would like to ask you some questions about your health and your usual daily activities so that we can better plan your stay here. This question is found at the _____ phase of the interview process.

a. Summary

b. Closing

c. Body

d. Opening or introduction

ANS: D

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

6. A woman has just entered the emergency department after being battered by her husband. The nurse needs to get some information from her to begin treatment. What is the best choice for an opening phase of the interview with this patient?

a. Hello, Nancy, my name is Mrs. C.

b. Hello, Mrs. H., my name is Mrs. C. It sure is cold today!

c. Mrs. H., my name is Mrs. C. How are you?

d. Mrs. H., my name is Mrs. C. Ill need to ask you a few questions about what happened.

ANS: D

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

7. During an interview, the nurse states, You mentioned having shortness of breath. Tell me more about that. Which verbal skill is used with this statement?

a. Reflection

b. Facilitation

c. Direct question

d. Open-ended question

ANS: D

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

8. A patient has finished giving the nurse information about the reason he is seeking care. When reviewing the data, the nurse finds that some information about past hospitalizations is missing. At this point, which statement by the nurse would be most appropriate to gather these data?

- a. Mr. Y., at your age, surely you have been hospitalized before!
- b. Mr. Y., I just need permission to get your medical records from County Medical.
- c.

Mr. Y., you mentioned that you have been hospitalized on several occasions.
Would you tell me more about that?

- d.

Mr. Y., I just need to get some additional information about your past hospitalizations.
When was the last time you were admitted for chest pain?

ANS: D

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

9. In using verbal responses to assist the patients narrative, some responses focus on the patients frame of reference and some focus on the health care providers perspective. An example of a verbal response that focuses on the health care providers perspective would be:

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

ANS: D

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

10. When taking a history from a newly admitted patient, the nurse notices that he often pauses and expectantly looks at the nurse. What would be the nurses best response to this behavior?

- a. Be silent, and allow him to continue when he is ready.
- b.

Smile at him and say, Dont worry about all of this. Im sure we can find out why youre having these pains.

- c. Lean back in the chair and ask, You are looking at me kind of funny; there isnt anything wrong, ishere
- d.

Stand up and say, I can see that this interview is uncomfortable for you.
We can continue it another time.

ANS: A

Silent attentiveness communicates that the person has time to think and to organize what he or she wishes to say without an interruption from the nurse. Health professionals most often interrupt this *thinking silence*. The other responses are not conducive to ideal communication.

11. A woman is discussing the problems she is having with her 2-year-old son. She says, He wont go to sleep at night, and during the day he has several fits. I get so upset when that happens. The nurses best verbal response would be:

- a. Go on, Im listening.
- b. Fits? Tell me what you mean by this.
- c. Yes, it can be upsetting when a child has a fit.
- d. Dont be upset when he has a fit; every 2 year old has fits.

ANS: B

The nurse should use clarification when the persons word choice is ambiguous or confusing (e.g., Tell me what you mean by *fits*.). Clarification is also used to summarize the persons words or to simplify the words to make them clearer; the nurse should then ask if he or she is on the right track.

12. A 17-year-old single mother is describing how difficult it is to raise a 3-year-old child by herself. During the course of the interview she states, I cant believe my boyfriend left me to do this by myself! What a terrible thing to do to me! Which of these responses by the nurse uses empathy?

- a. You feel alone.
- b. You cant believe he left you alone?
- c. It must be so hard to face this all alone.
- d. I would be angry, too; raising a child alone is no picnic.

ANS: C

An empathetic response recognizes the feeling and puts it into words. It names the feeling, allows its expression, and strengthens rapport. Other empathetic responses are, This must be very hard for you, I understand, or simply placing your hand on the persons arm. Simply reflecting the persons words or agreeing with the person is not an empathetic response.

13. A man has been admitted to the observation unit for observation after being treated for a large cut on his forehead. As the nurse works through the interview, one of the standard questions has to do with alcohol, tobacco, and drug use. When the nurse asks him about tobacco use, he states, I quit smoking after my wife died 7 years ago. However, the nurse notices an open pack of cigarettes in his shirt pocket. Using confrontation, the nurse could say:

- a. Mr. K., I know that you are lying.
- b. Mr. K., come on, tell me how much you smoke.
- c. Mr. K., I didnt realize your wife had died. It must be difficult for you at this time. Please tell me more about that.
- d.

Mr. K., you have said that you dont smoke, but I see that you have an open pack of cigarettes in your pocket.

ANS: D

In the case of confrontation, a certain action, feeling, or statement has been observed, and the nurse now focuses the patients attention on it. The nurse should give honest feedback about what is seen or felt. Confrontation may focus on a discrepancy, or the nurse may confront the patient when parts of the story are inconsistent. The other statements are not appropriate.

14. The nurse has used interpretation regarding a patients statement or actions. After using this technique, it would be best for the nurse to:

- a. Apologize, because using interpretation can be demeaning for the patient.

- b. Allow time for the patient to confirm or correct the inference.
- c. Continue with the interview as though nothing has happened.
- d. Immediately restate the nurses conclusion on the basis of the patients nonverbal response.

ANS: B

Interpretation is not based on direct observation as is confrontation, but it is based on ones inference or conclusion. The nurse risks making the wrong inference. If this is the case, then the patient will correct it. However, even if the inference is correct, interpretation helps prompt further discussion of the topic.

15. During an interview, a woman says, I have decided that I can no longer allow my children to live with their fathers violence, but I just cant seem to leave him. Using interpretation, the nurses best response would be:

- a. You are going to leave him?
- b. If you are afraid for your children, then why cant you leave?
- c. It sounds as if you might be afraid of how your husband will respond.
- d. It sounds as though you have made your decision. I think it is a good one.

ANS: C

This statement is not based on ones inference or conclusion. It links events, makes associations, or implies cause. Interpretation also ascribes feelings and helps the person understand his or her own feelings in relation to the verbal message. The other statements do not reflect interpretation.

16. A pregnant woman states, I just know labor will be so painful that I wont be able to stand it. I know it sounds awful, but I really dread going into labor. The nurse responds by stating, Oh, dont worry about labor so much. I have been through it, and although it is painful, many good medications are available to decrease the pain. Which statement is *true* regarding this response?

The nurses reply was a:

- a. Therapeutic response. By sharing something personal, the nurse gives hope to this woman.
- b.

Nontherapeutic response. By providing false reassurance, the nurse actually cut off further discussion of the womans fears.

c.

Therapeutic response. By providing information about the medications available, the nurse is giving information to the woman.

d. Nontherapeutic response. The nurse is essentially giving the message to the woman that labor cannot be tolerated without medication.

ANS: B

By providing false assurance or reassurance, this *courage builder* relieves the womans anxiety and gives the nurse the false sense of having provided comfort. However, for the woman, providing false assurance or reassurance actually closes off communication, trivializes her anxiety, and effectively denies any further talk of it.

17. During a visit to the clinic, a patient states, The doctor just told me he thought I ought to stop smoking. He doesnt understand how hard Ive tried. I just dont know the best way to do it. What should I do? The nurses most appropriate response in this case would be:

- a. Id quit if I were you. The doctor really knows what he is talking about.
- b. Would you like some information about the different ways a person can quit smoking?
- c. Stopping your dependence on cigarettes can be very difficult. I understand how you feel.
- d.

Why are you confused? Didn't the doctor give you the information about the smoking cessation program we offer?

ANS: B

Clarification should be used when the persons word choice is ambiguous or confusing. Clarification is also used to summarize the persons words or to simplify the words to make them clearer; the nurse should then ask if he or she is on the right track. The other responses give unwanted advice or do not offer a helpful response.

18. As the nurse enters a patients room, the nurse finds her crying. The patient states that she has just found out that the lump in her breast is cancer and says, Im so afraid of, um, you know. The nurses most therapeutic response would be to say in a gentle manner:

- a. Youre afraid you might lose your breast?
- b. No, Im not sure what you are talking about.
- c. Ill wait here until you get yourself under control, and then we can talk.
- d. I can see that you are very upset. Perhaps we should discuss this later.

ANS: A

Reflection echoes the patients words, repeating part of what the person has just said. Reflection can also help express the feelings behind a persons words.

19. A nurse is taking complete health histories on all of the patients attending a wellness workshop. On the history form, one of the written questions asks, You dont smoke, drink, or take drugs, do you? This question is an example of:

- a. Talking too much.
- b. Using confrontation.
- c. Using biased or leading questions.
- d. Using blunt language to deal with distasteful topics.

ANS: C

This question is an example of using leading or biased questions. Asking, You dont smoke, do you? implies that one answer is *better* than another. If the person wants to please someone, then he or she is either forced to answer in a way that corresponds to his or her implied values or is made to feel guilty when admitting the other answer.

20. When observing a patients verbal and nonverbal communication, the nurse notices a discrepancy. Which statement is *true* regarding this situation? The nurse should:

- a. Ask someone who knows the patient well to help interpret this discrepancy.
- b. Focus on the patients verbal message, and try to ignore the nonverbal behaviors.
- c. Try to integrate the verbal and nonverbal messages and then interpret them as an average.
- d.

Focus on the patients nonverbal behaviors, because these are often more reflective of a patients true feelings.

ANS: D

When nonverbal and verbal messages are congruent, the verbal message is reinforced. When they are incongruent, the nonverbal message tends to be the true one because it is under less conscious control. Thus studying the nonverbal messages of the patients and examiners and understanding their meanings are important. The other statements are not true.

21. During an interview, a parent of a hospitalized child is sitting in an open position. As the interviewer begins to discuss his sons treatment, however, he suddenly crosses his arms against

his chest and crosses his legs. This changed posture would suggest that the parent is:

- a. Simply changing positions.
- b. More comfortable in this position.
- c. Tired and needs a break from the interview.
- d. Uncomfortable talking about his sons treatment.

ANS: D

The persons position is noted. An open position with the extension of large muscle groups shows relaxation, physical comfort, and a willingness to share information. A closed position with the arms and legs crossed tends to look defensive and anxious. Any change in posture should be noted. If a person in a relaxed position suddenly tenses, then this change in posture suggests possible discomfort with the new topic.

22. A mother brings her 28-month-old daughter into the clinic for a well-child visit. At the beginning of the visit, the nurse focuses attention away from the toddler, but as the interview progresses, the toddler begins to warm up and is smiling shyly at the nurse. The nurse will be most successful in interacting with the toddler if which is done next?

- a. Tickle the toddler, and get her to laugh.
- b. Stoop down to her level, and ask her about the toy she is holding.
- c. Continue to ignore her until it is time for the physical examination.
- d.

Ask the mother to leave during the examination of the toddler, because toddlers often fuss less if their parent is not in view.

ANS: B

Although most of the communication is with the parent, the nurse should not completely ignore the child. Making contact will help ease the toddler later during the physical examination. The nurse should begin by asking about the toys the child is playing with or about a special doll or teddy bear brought from home. Does your doll have a name? or What can your truck do? Stoop down to meet the child at his or her eye level.

23. During an examination of a 3-year-old child, the nurse will need to take her blood pressure. What might the nurse do to try to gain the child's full cooperation?

- a. Tell the child that the blood pressure cuff is going to give her arm a big hug.
- b. Tell the child that the blood pressure cuff is asleep and cannot wake up.
- c. Give the blood pressure cuff a name and refer to it by this name during the assessment.
- d. Tell the child that by using the blood pressure cuff, we can see how strong her muscles are.

ANS: D

Take the time to give a short, simple explanation with a concrete explanation for any unfamiliar equipment that will be used on the child. Preschoolers are animistic; they imagine inanimate objects can come alive and have human characteristics. Thus a blood pressure cuff can wake up and bite or pinch.

24. A 16-year-old boy has just been admitted to the unit for overnight observation after being in an automobile accident. What is the nurse's best approach to communicating with him?

- a. Use periods of silence to communicate respect for him.
- b. Be totally honest with him, even if the information is unpleasant.
- c. Tell him that everything that is discussed will be kept totally confidential.
- d. Use slang language when possible to help him open up.

ANS: B

Successful communication with an adolescent is possible and can be rewarding. The guidelines are simple. The first consideration is one's attitude, which must be one of respect. Second, communication must be totally honest. An adolescent's intuition is highly tuned and can detect phoniness or the withholding of information. Always tell him or her the truth.

25. A 75-year-old woman is at the office for a preoperative interview. The nurse is aware that the interview may take longer than interviews with younger persons. What is the reason for this?

- a. An aged person has a longer story to tell.
- b. An aged person is usually lonely and likes to have someone with whom to talk.
- c. Aged persons lose much of their mental abilities and require longer time to complete an interview.
- d.

As a person ages, he or she is unable to hear; thus the interviewer usually needs to repeat much of what is said.

ANS: A

The interview usually takes longer with older adults because they have a longer story to tell. It is not necessarily true that all older adults are lonely, have lost mental abilities, or are hard of hearing.

26. The nurse is interviewing a male patient who has a hearing impairment. What techniques would be most beneficial in communicating with this patient?

- a. Determine the communication method he prefers.
- b. Avoid using facial and hand gestures because most hearing-impaired people find this degrading.
- c. Request a sign language interpreter before meeting with him to help facilitate the communication.
- d.

Speak loudly and with exaggerated facial movement when talking with him because doing so will help him lip read.

ANS: A

The nurse should ask the deaf person the preferred way to communicate by signing, lip reading, or writing. If the person prefers lip reading, then the nurse should be sure to face him squarely and have good lighting on the nurse's face. The nurse should not exaggerate lip movements because this distorts words. Similarly, shouting distorts the reception of a hearing aid the person may wear. The nurse should speak slowly and supplement his or her voice with appropriate hand gestures or pantomime.

27. During a prenatal check, a patient begins to cry as the nurse asks her about previous pregnancies. She states that she is remembering her last pregnancy, which ended in miscarriage. The nurse's best response to her crying would be:

- a. I'm so sorry for making you cry!
- b. I can see that you are sad remembering this. It is all right to cry.
- c. Why don't I step out for a few minutes until you're feeling better?
- d. I can see that you feel sad about this; why don't we talk about something else?

ANS: B

A beginning examiner usually feels horrified when the patient starts crying. When the nurse says something that makes the person cry, the nurse should not think he or she has hurt the person. The nurse has simply hit on an important topic; therefore, moving on to a new topic is essential.

The nurse should allow the person to cry and to express his or her feelings fully. The nurse can offer a tissue and wait until the crying subsides to talk.

28. A female nurse is interviewing a man who has recently immigrated. During the course of the interview, he leans forward and then finally moves his chair close enough that his knees are nearly touching the nurses knees. The nurse begins to feel uncomfortable with his proximity.

Which statement most closely reflects what the nurse should do next?

a. The nurse should try to relax; these behaviors are culturally appropriate for this person.

b.

The nurse should discreetly move his or her chair back until the distance is more comfortable, and then continue with the interview.

c.

These behaviors are indicative of sexual aggression, and the nurse should confront this person about his behaviors.

d.

The nurse should laugh but tell him that he or she is uncomfortable with his proximity and ask him to move away.

ANS: A

Both the patients and the nurses sense of spatial distance are significant throughout the interview and physical examination, with culturally appropriate distance zones varying widely. Some cultural groups value close physical proximity and may perceive a health care provider who is distancing him or herself as being aloof and unfriendly.

29. A female American Indian has come to the clinic for follow-up diabetic teaching. During the interview, the nurse notices that she never makes eye contact and speaks mostly to the floor.

Which statement is *true* regarding this situation?

a. The woman is nervous and embarrassed.

b. She has something to hide and is ashamed.

c. The woman is showing inconsistent verbal and nonverbal behaviors.

d. She is showing that she is carefully listening to what the nurse is saying.

ANS: D

Eye contact is perhaps among the most culturally variable nonverbal behaviors. Asian, American Indian, Indochinese, Arabian, and Appalachian people may consider direct eye contact impolite or aggressive, and they may avert their eyes during the interview. American Indians often stare at the floor during the interview, which is a culturally appropriate behavior, indicating that the listener is paying close attention to the speaker.

30. The nurse is performing a health interview on a patient who has a language barrier, and no interpreter is available. Which is the best example of an appropriate question for the nurse to ask in this situation?

a. Do you take medicine?

b. Do you sterilize the bottles?

c. Do you have nausea and vomiting?

d. You have been taking your medicine, havent you?

ANS: A

In a situation during which a language barrier exists and no interpreter is available, simple words should be used, avoiding medical jargon. The use of contractions and pronouns should also be avoided. Nouns should be repeatedly used, and one topic at a time should be discussed.

31. A man arrives at the clinic for his annual wellness physical. He is experiencing no acute health problems. Which question or statement by the nurse is most appropriate when beginning the interview?

- a. How is your family?
- b. How is your job?
- c. Tell me about your hypertension.
- d. How has your health been since your last visit?

ANS: D

Open-ended questions are used for gathering narrative information. This type of questioning should be used to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

32. The nurse makes this comment to a patient, I know it may be hard, but you should do what the doctor ordered because she is the expert in this field. Which statement is correct about the nurses comment?

- a. This comment is inappropriate because it shows the nurses bias.
- b.

This comment is appropriate because members of the health care team are experts in their area of patient care.

c.

This type of comment promotes dependency and inferiority on the part of the patient and is best avoided in an interview situation.

d.

Using authority statements when dealing with patients, especially when they are undecided about an issue, is necessary at times.

ANS: C

Using authority responses promotes dependency and inferiority. Avoiding the use of authority is best. Although the health care provider and patient do not have equal professional knowledge, both have equally worthy roles in the health process. The other statements are not correct.

33. A female patient does not speak English well, and the nurse needs to choose an interpreter. Which of the following would be the most appropriate choice?

- a. Trained interpreter
- b. Male family member
- c. Female family member
- d. Volunteer college student from the foreign language studies department

ANS: A

Whenever possible, the nurse should use a trained interpreter, preferably one who knows medical terminology. In general, an older, more mature interpreter is preferred to a younger, less experienced one, and the same gender is preferred when possible.

34. During a follow-up visit, the nurse discovers that a patient has not been taking his insulin on a regular basis. The nurse asks, Why havent you taken your insulin? Which statement is an appropriate evaluation of this question?

- a. This question may place the patient on the defensive.
- b. This question is an innocent search for information.
- c. Discussing his behavior with his wife would have been better.
- d. A direct question is the best way to discover the reasons for his behavior.

ANS: A

The adults use of why questions usually implies blame and condemnation and places the person on the defensive. The other statements are not correct.

35. The nurse is nearing the end of an interview. Which statement is appropriate at this time?

- a. Did we forget something?
- b. Is there anything else you would like to mention?
- c. I need to go on to the next patient. Ill be back.
- d. While Im here, lets talk about your upcoming surgery.

ANS: B

This question offers the person a final opportunity for self-expression. No new topic should be introduced. The other questions are not appropriate.

36. During the interview portion of data collection, the nurse collects _____ data.

- a. Physical
- b. Historical
- c. Objective
- d. Subjective

ANS: D

The interview is the first, and really the most important, part of data collection. During the interview, the nurse collects subjective data; that is, what the person says about him or herself.

37. During an interview, the nurse would expect that most of the interview will take place at what distance?

- a. Intimate zone
- b. Personal distance
- c. Social distance
- d. Public distance

ANS: C

Social distance, 4 to 12 feet, is usually the distance category for most of the interview. Public distance, over 12 feet, is too much distance; the intimate zone is inappropriate, and the personal distance will be used for the physical assessment.

38. A female nurse is interviewing a male patient who is near the same age as the nurse. During the interview, the patient makes an overtly sexual comment. The nurses best reaction would be:

- a. Stop that immediately!
- b. Oh, you are too funny. Lets keep going with the interview.
- c. Do you really think I would be interested?
- d. It makes me uncomfortable when you talk that way. Please stop.

ANS: D

The nurses response must make it clear that she is a health professional who can best care for the person by maintaining a professional relationship. At the same time, the nurse should communicate that he or she accepts the person and understands the persons need to be selfassertive

but that sexual advances cannot be tolerated.

MULTIPLE RESPONSE

1. The nurse is conducting an interview. Which of these statements is *true* regarding open-ended questions? *Select all that apply.*

- a. Open-ended questions elicit cold facts.

- b. They allow for self-expression.
- c. Open-ended questions build and enhance rapport.
- d. They leave interactions neutral.
- e. Open-ended questions call for short one- to two-word answers.
- f. They are used when narrative information is needed.

ANS: B, C, F

Open-ended questions allow for self-expression, build and enhance rapport, and obtain narrative information. These features enhance communication during an interview. The other statements are appropriate for closed or direct questions.

2. The nurse is conducting an interview in an outpatient clinic and is using a computer to record data. Which are the *best* uses of the computer in this situation? *Select all that apply.*

- a. Collect the patients data in a direct, face-to-face manner.
- b. Enter all the data as the patient states them.
- c. Ask the patient to wait as the nurse enters the data.
- d. Type the data into the computer after the narrative is fully explored.
- e. Allow the patient to see the monitor during typing.

ANS: A, D, E

The use of a computer can become a barrier. The nurse should begin the interview as usual by greeting the patient, establishing rapport, and collecting the patients narrative story in a direct, face-to-face manner. Only after the narrative is fully explored should the nurse type data into the computer. When typing, the nurse should position the monitor so that the patient can see it.

Chapter 2 Physical Examination Strategies

MULTIPLE CHOICE

1. When performing a physical assessment, the first technique the nurse will always use is:
- a. Palpation.

ANS: A, D, E

The use of a computer can become a barrier. The nurse should begin the interview as usual by greeting the patient, establishing rapport, and collecting the patients narrative story in a direct, face-to-face manner. Only after the narrative is fully explored should the nurse type data into the computer. When typing, the nurse should position the monitor so that the patient can see it.

Chapter 2 Physical Examination Strategies

MULTIPLE CHOICE

1. When performing a physical assessment, the first technique the nurse will always use is:
- a. Palpation.
 - b. Inspection.
 - c. Percussion.
 - d. Auscultation.

ANS: B

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

2. The nurse is preparing to perform a physical assessment. Which statement is *true* about the

physical assessment? The inspection phase:

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

ANS: B

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

3. The nurse is assessing a patients skin during an office visit. What part of the hand and technique should be used to best assess the patients skin temperature?

- a. Fingertips; they are more sensitive to small changes in temperature.
- b. Dorsal surface of the hand; the skin is thinner on this surface than on the palms.
- c.

Ulnar portion of the hand; increased blood supply in this area enhances temperature sensitivity.

d.

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

ANS: B

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

4. Which of these techniques uses the sense of touch to assess texture, temperature, moisture, and swelling when the nurse is assessing a patient?

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

ANS: A

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

5. The nurse is preparing to assess a patients abdomen by palpation. How should the nurse proceed?

a.

Palpation of reportedly tender areas are avoided because palpation in these areas may cause pain.

b. Palpating a tender area is quickly performed to avoid any discomfort that the patient may experience.

c.

The assessment begins with deep palpation, while encouraging the patient to relax and to take deep breaths.

d.

The assessment begins with light palpation to detect surface characteristics and to

accustom the patient to being touched.

ANS: D

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

6. The nurse would use bimanual palpation technique in which situation?

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

ANS: B

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

7. The nurse is preparing to percuss the abdomen of a patient. The purpose of the percussion is to assess the _____ of the underlying tissue.

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

ANS: C

Percussion yields a sound that depicts the location, size, and density of the underlying organ.

Turgor and texture are assessed with palpation.

8. The nurse is reviewing percussion techniques with a newly graduated nurse. Which technique, if used by the new nurse, indicates that more review is needed?

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

ANS: A

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

9. When percussing over the liver of a patient, the nurse notices a dull sound. The nurse should:

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

ANS: A

Percussion over relatively dense organs, such as the liver or spleen, will produce a dull sound.

The other responses are not correct.

10. The nurse is unable to identify any changes in sound when percussing over the abdomen of an obese patient. What should the nurse do next?

- a. Ask the patient to take deep breaths to relax the abdominal musculature.
- b. Consider this finding as normal, and proceed with the abdominal assessment.

- c. Increase the amount of strength used when attempting to percuss over the abdomen.
- d. Decrease the amount of strength used when attempting to percuss over the abdomen.

ANS: C

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

11. The nurse hears bilateral loud, long, and low tones when percussing over the lungs of a 4-year-old child. The nurse should:

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

ANS: D

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

12. A patient has suddenly developed shortness of breath and appears to be in significant respiratory distress. After calling the physician and placing the patient on oxygen, which of these actions is the best for the nurse to take when further assessing the patient?

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

ANS: B

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

13. The nurse is teaching a class on basic assessment skills. Which of these statements is *true* regarding the stethoscope and its use?

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

ANS: B

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

14. The nurse is preparing to use a stethoscope for auscultation. Which statement is *true* regarding the diaphragm of the stethoscope? The diaphragm:

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

ANS: A

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

sounds or murmurs.

15. Before auscultating the abdomen for the presence of bowel sounds on a patient, the nurse should:

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

ANS: D

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

16. The nurse will use which technique of assessment to determine the presence of crepitus, swelling, and pulsations?

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

ANS: A

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

17. The nurse is preparing to use an otoscope for an examination. Which statement is *true* regarding the otoscope? The otoscope:

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

ANS: D

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

18. An examiner is using an ophthalmoscope to examine a patients eyes. The patient has astigmatism and is nearsighted. The use of which of these techniques would indicate that the examination is being correctly performed?

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

ANS: D

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

19. The nurse is unable to palpate the right radial pulse on a patient. The best action would be to:
- a. Auscultate over the area with a fetoscope.
 - b. Use a goniometer to measure the pulsations.
 - c. Use a Doppler device to check for pulsations over the area.
 - d. Check for the presence of pulsations with a stethoscope.

ANS: C

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

20. The nurse is preparing to perform a physical assessment. The correct action by the nurse is reflected by which statement? The nurse:

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

ANS: D

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

21. A man is at the clinic for a physical examination. He states that he is very anxious about the physical examination. What steps can the nurse take to make him more comfortable?

- a. Appear unhurried and confident when examining him.
- b. Stay in the room when he undresses in case he needs assistance.
- c. Ask him to change into an examining gown and to take off his undergarments.
- d.

Defer measuring vital signs until the end of the examination, which allows him time to become comfortable.

ANS: A

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

22. When performing a physical examination, safety must be considered to protect the examiner and the patient against the spread of infection. Which of these statements describes the most appropriate action the nurse should take when performing a physical examination?

- a. Washing ones hands after removing gloves is not necessary, as long as the gloves are still intact.
- b. Hands are washed before and after every physical patient encounter.
- c.

Hands are washed before the examination of each body system to prevent the spread of bacteria from on part of the body to another.

d.

Gloves are worn throughout the entire examination to demonstrate to the patient concern regarding the spread of infectious diseases.

ANS: B

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

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

23. The nurse is examining a patient's lower leg and notices a draining ulceration. Which of these actions is most appropriate in this situation?

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

Washing hands, proceeding with rest of the physical examination, and then continuing with the examination of the leg ulceration

ANS: C

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

24. During the examination, offering some brief teaching about the patient's body or the examiner's findings is often appropriate. Which one of these statements by the nurse is most appropriate?

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

ANS: C

The sharing of some information builds rapport, as long as the patient is able to understand the terminology.

25. The nurse keeps in mind that the most important reason to share information and to offer brief teaching while performing the physical examination is to help the:

- a. Examiner feel more comfortable and to gain control of the situation.
- b. Examiner to build rapport and to increase the patient's confidence in him or her.
- c. Patient understand his or her disease process and treatment modalities.
- d.

Patient identify questions about his or her disease and the potential areas of patient education.

ANS: B

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

26. The nurse is examining an infant and prepares to elicit the Moro reflex at which time during the examination?

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

ANS: B

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

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

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

ANS: A

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

28. A 6-month-old infant has been brought to the well-child clinic for a check-up. She is currently sleeping. What should the nurse do first when beginning the examination?

- a. Auscultate the lungs and heart while the infant is still sleeping.
- b. Examine the infant's hips, because this procedure is uncomfortable.
- c.

Begin with the assessment of the eye, and continue with the remainder of the examination in a head-to-toe approach.

d.

Wake the infant before beginning any portion of the examination to obtain the most accurate assessment of body systems.

ANS: A

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

29. A 2-year-old child has been brought to the clinic for a well-child checkup. The best way for the nurse to begin the assessment is to:

- a. Ask the parent to place the child on the examining table.
- b. Have the parent remove all of the child's clothing before the examination.
- c. Allow the child to keep a security object such as a toy or blanket during the examination.
- d.

Initially focus the interactions on the child, essentially ignoring the parent until the child's trust has been obtained.

ANS: C

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

30. The nurse is examining a 2-year-old child and asks, May I listen to your heart now? Which critique of the nurse's technique is *most* accurate?

- a. Asking questions enhances the child's autonomy
- b. Asking the child for permission helps develop a sense of trust
- c. This question is an appropriate statement because children at this age like to have choices
- d.

Children at this age like to say, No. The examiner should not offer a choice when no choice is available

ANS: D

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

31. With which of these patients would it be most appropriate for the nurse to use games during the assessment, such as having the patient blow out the light on the penlight?

- a. Infant
- b. Preschool child
- c. School-age child
- d. Adolescent

ANS: B

When assessing preschool children, using games or allowing them to play with the equipment to reduce their fears can be helpful. Such games are not appropriate for the other age groups.

32. The nurse is preparing to examine a 4-year-old child. Which action is appropriate for this age group?

- a. Explain the procedures in detail to alleviate the child's anxiety.
- b. Give the child feedback and reassurance during the examination.
- c.

Do not ask the child to remove his or her clothes because children at this age are usually very private.

d.

Perform an examination of the ear, nose, and throat first, and then examine the thorax and abdomen.

ANS: B

With preschool children, short, simple explanations should be used. Children at this age are usually willing to undress. An examination of the head should be performed last. During the examination, needed feedback and reassurance should be given to the preschooler.

33. When examining a 16-year-old male teenager, the nurse should:

- a. Discuss health teaching with the parent because the teen is unlikely to be interested in promoting wellne b.

Ask his parent to stay in the room during the history and physical examination to answer any questions and to alleviate his anxiety.

c.

Talk to him the same manner as one would talk to a younger child because a teens level of understanding may not match his or her speech.

d.

Provide feedback that his body is developing normally, and discuss the wide variation among teenagers on the rate of growth and development.

ANS: D

During the examination, the adolescent needs feedback that his or her body is healthy and developing normally. The adolescent has a keen awareness of body image and often compares him or herself with peers. Apprise the adolescent of the wide variation among teenagers on the

rate of growth and development.

34. When examining an older adult, the nurse should use which technique?

- a. Avoid touching the patient too much.
- b. Attempt to perform the entire physical examination during one visit.
- c. Speak loudly and slowly because most aging adults have hearing deficits.
- d. Arrange the sequence of the examination to allow as few position changes as possible.

ANS: D

When examining the older adult, arranging the sequence of the examination to allow as few position changes as possible is best. Physical touch is especially important with the older person because other senses may be diminished.

35. The most important step that the nurse can take to prevent the transmission of microorganisms in the hospital setting is to:

- a. Wear protective eye wear at all times.
- b. Wear gloves during any and all contact with patients.
- c. Wash hands before and after contact with each patient.
- d. Clean the stethoscope with an alcohol swab between patients.

ANS: C

The most important step to decrease the risk of microorganism transmission is to wash hands promptly and thoroughly before and after physical contact with each patient. Stethoscopes should also be cleansed with an alcohol swab before and after each patient contact. The best routine is to combine stethoscope rubbing with hand hygiene each time hand hygiene is performed.

36. Which of these statements is *true* regarding the use of Standard Precautions in the health care setting?

- a. Standard Precautions apply to all body fluids, including sweat.
- b. Use alcohol-based hand rub if hands are visibly dirty.
- c.

Standard Precautions are intended for use with all patients, regardless of their risk or presumed infection status.

d.

Standard Precautions are to be used only when nonintact skin, excretions containing visible blood, or expected contact with mucous membranes is present.

ANS: C

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources and are intended for use for all patients, regardless of their risk or presumed infection status. Standard Precautions apply to blood and all other body fluids, secretions and excretions except sweat regardless of whether they contain visible blood, nonintact skin, or mucous membranes. Hands should be washed with soap and water if visibly soiled with blood or body fluids. Alcohol-based hand rubs can be used if hands are not visibly soiled.

37. The nurse is preparing to assess a hospitalized patient who is experiencing significant shortness of breath. How should the nurse proceed with the assessment?

- a. The patient should lie down to obtain an accurate cardiac, respiratory, and abdominal assessment.
- b.

A thorough history and physical assessment information should be obtained from the patient's family member.

c.

A complete history and physical assessment should be immediately performed to obtain baseline information.

d.

Body areas appropriate to the problem should be examined and then the assessment completed after the problem has resolved.

ANS: D

Both altering the position of the patient during the examination and collecting a mini database by examining the body areas appropriate to the problem may be necessary in this situation. An assessment may be completed later after the distress is resolved.

38. When examining an infant, the nurse should examine which area first?

a. Ear

b. Nose

c. Throat

d. Abdomen

ANS: D

The least-distressing steps are performed first, saving the invasive steps of the examination of the eye, ear, nose, and throat until last.

39. While auscultating heart sounds, the nurse hears a murmur. Which of these instruments should be used to assess this murmur?

a. Electrocardiogram

b. Bell of the stethoscope

c. Diaphragm of the stethoscope

d. Palpation with the nurse's palm of the hand

ANS: B

The bell of the stethoscope is best for soft, low-pitched sounds such as extra heart sounds or murmurs. The diaphragm of the stethoscope is best used for high-pitched sounds such as breath, bowel, and normal heart sounds.

40. During an examination of a patient's abdomen, the nurse notes that the abdomen is rounded and firm to the touch. During percussion, the nurse notes a drumlike quality of the sounds across the quadrants. This type of sound indicates:

a. Constipation.

b. Air-filled areas.

c. Presence of a tumor.

d. Presence of dense organs.

ANS: B

A musical or drumlike sound (tympany) is heard when percussion occurs over an air-filled viscus, such as the stomach or intestines.

41. The nurse is preparing to examine a 6-year-old child. Which action is most appropriate?

a. The thorax, abdomen, and genitalia are examined before the head.

b.

Talking about the equipment being used is avoided because doing so may increase the child's anxiety.

- c. The nurse should keep in mind that a child at this age will have a sense of modesty.
- d. The child is asked to undress from the waist up.

ANS: C

A 6-year-old child has a sense of modesty. The child should undress him or herself, leaving underpants on and using a gown or drape. A school-age child is curious to know how equipment works, and the sequence should progress from the child's head to the toes.

42. During auscultation of a patient's heart sounds, the nurse hears an unfamiliar sound. The nurse should:

- a. Document the findings in the patient's record.
- b. Wait 10 minutes, and auscultate the sound again.
- c. Ask the patient how he or she is feeling.
- d. Ask another nurse to double check the finding.

ANS: D

If an abnormal finding is not familiar, then the nurse may ask another examiner to double check the finding. The other responses do not help identify the unfamiliar sound.

MULTIPLE RESPONSE

1. The nurse is preparing to palpate the thorax and abdomen of a patient. Which of these statements describes the correct technique for this procedure? *Select all that apply.*

- a. Warm the hands first before touching the patient.
- b. For deep palpation, use one long continuous palpation when assessing the liver.
- c. Start with light palpation to detect surface characteristics.
- d. Use the fingertips to examine skin texture, swelling, pulsation, and presence of lumps.
- e. Identify any tender areas, and palpate them last.
- f. Use the palms of the hands to assess temperature of the skin.

ANS: A, C, D, E

The hands should always be warmed before beginning palpation. Intermittent pressure rather than one long continuous palpation is used; any tender areas are identified and palpated last. Fingertips are used to examine skin texture, swelling, pulsation, and the presence of lumps. The dorsa (backs) of the hands are used to assess skin temperature because the skin on the dorsa is thinner than on the palms.

Chapter 3 Documentation Strategies

MULTIPLE CHOICE

1. The nurse is performing a general survey. Which action is a component of the general survey?
- a. Observing the patient's body stature and nutritional status
 - b. Interpreting the subjective information the patient has reported
 - c. Measuring the patient's temperature, pulse, respirations, and blood pressure
 - d. Observing specific body systems while performing the physical assessment

ANS: A

The general survey is a study of the whole person that includes observing the patient's physical appearance, body structure, mobility, and behavior.

2. When measuring a patient's weight, the nurse is aware of which of these guidelines?
- a. The patient is always weighed wearing only his or her undergarments.
 - b. The type of scale does not matter, as long as the weights are similar from day to day.

c. The patient may leave on his or her jacket and shoes as long as these are documented next to the weight.

d.

Attempts should be made to weigh the patient at approximately the same time of day, if a sequence of weights is necessary.

ANS: D

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

3. A patient's weekly blood pressure readings for 2 months have ranged between 124/84 mm Hg and 136/88 mm Hg, with an average reading of 126/86 mm Hg. The nurse knows that this blood pressure falls within which blood pressure category?

a. Normal blood pressure

b. Prehypertension

c. Stage 1 hypertension

d. Stage 2 hypertension

ANS: B

According to the Seventh Report of the Joint National Committee (JNC 7) guidelines, prehypertension blood pressure readings are systolic readings of 120 to 139 mm Hg or diastolic readings of 80 to 89 mm Hg.

4. During an examination of a child, the nurse considers that physical growth is the best index of a child's:

a. General health.

b. Genetic makeup.

c. Nutritional status.

d. Activity and exercise patterns.

ANS: A

Physical growth is the best index of a child's general health; recording the child's height and weight helps determine normal growth patterns.

5. A 1-month-old infant has a head measurement of 34 cm and has a chest circumference of 32 cm. Based on the interpretation of these findings, the nurse would:

a. Refer the infant to a physician for further evaluation.

b. Consider these findings normal for a 1-month-old infant.

c. Expect the chest circumference to be greater than the head circumference.

d. Ask the parent to return in 2 weeks to re-evaluate the head and chest circumferences.

ANS: B

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

6. The nurse is assessing an 80-year-old male patient. Which assessment findings would be considered normal?

a. Increase in body weight from his younger years

b. Additional deposits of fat on the thighs and lower legs

- c. Presence of kyphosis and flexion in the knees and hips
- d. Change in overall body proportion, including a longer trunk and shorter extremities

ANS: C

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

7. The nurse should measure rectal temperatures in which of these patients?

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

ANS: C

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

8. The nurse is preparing to measure the length, weight, chest, and head circumference of a 6-month-old infant. Which measurement technique is correct?

- a. Measuring the infants length by using a tape measure
- b. Weighing the infant by placing him or her on an electronic standing scale
- c. Measuring the chest circumference at the nipple line with a tape measure
- d. Measuring the head circumference by wrapping the tape measure over the nose and cheekbones

ANS: C

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

9. The nurse knows that one advantage of the tympanic membrane thermometer (TMT) is that:

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

ANS: A

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

10. When assessing an older adult, which vital sign changes occur with aging?

- a. Increase in pulse rate
- b. Widened pulse pressure
- c. Increase in body temperature
- d. Decrease in diastolic blood pressure

ANS: B

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

11. The nurse is examining a patient who is complaining of feeling cold. Which is a mechanism of heat loss in the body?

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

ANS: B

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

12. When measuring a patient's body temperature, the nurse keeps in mind that body temperature is influenced by:

- a. Constipation.
- b. Patient's emotional state.
- c. Diurnal cycle.
- d. Nocturnal cycle.

ANS: C

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

13. When evaluating the temperature of older adults, the nurse should remember which aspect about an older adult's body temperature?

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

ANS: A

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

14. A 60-year-old male patient has been treated for pneumonia for the past 6 weeks. He is seen today in the clinic for an unexplained weight loss of 10 pounds over the last 6 weeks. The nurse knows that:

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

ANS: C

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

15. When assessing a 75-year-old patient who has asthma, the nurse notes that he assumes a tripod position, leaning forward with arms braced on the chair. On the basis of this observation,

the nurse should:

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

ANS: D

Assuming a tripod position leaning forward with arms braced on chair arms occurs with chronic pulmonary disease. The other actions or assumptions are not correct.

16. Which of these actions illustrates the correct technique the nurse should use when assessing oral temperature with a mercury thermometer?

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

ANS: B

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

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

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

ANS: C

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

18. To assess a rectal temperature accurately in an adult, the nurse would:

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

ANS: A

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

19. Which technique is correct when the nurse is assessing the radial pulse of a patient?

The pulse is counted for:

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

ANS: A

Recent research suggests that the 30-second interval multiplied by 2 is the most accurate and

efficient technique when heart rates are normal or rapid and when rhythms are regular. If the rhythm is irregular, then the pulse is counted for 1 full minute.

20. When assessing a patient's pulse, the nurse should also notice which of these characteristics?

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

ANS: A

The pulse is assessed for rate, rhythm, and force.

21. When assessing the pulse of a 6-year-old boy, the nurse notices that his heart rate varies with his respiratory cycle, speeding up at the peak of inspiration and slowing to normal with expiration. The nurse's next action would be to:

- a. Immediately notify the physician.
- b. Consider this finding normal in children and young adults.
- c. Check the child's blood pressure, and note any variation with respiration.
- d. Document that this child has bradycardia, and continue with the assessment.

ANS: B

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

22. When assessing the force, or strength, of a pulse, the nurse recalls that the pulse:

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

ANS: C

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

23. The nurse is assessing the vital signs of a 20-year-old male marathon runner and documents the following vital signs: temperature 36°C; pulse 48 beats per minute; respirations 14 breaths per minute; blood pressure 104/68 mm Hg. Which statement is *true* concerning these results?

- a. The patient is experiencing tachycardia.
- b. These are normal vital signs for a healthy, athletic adult.
- c. The patient's pulse rate is not normal; his physician should be notified.
- d. On the basis of these readings, the patient should return to the clinic in 1 week.

ANS: B

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

24. The nurse is assessing the vital signs of a 3-year-old patient who appears to have an irregular respiratory pattern. How should the nurse assess this child's respirations?

- a. Respirations should be counted for 1 full minute, noticing rate and rhythm.
- b. Child's pulse and respirations should be simultaneously checked for 30 seconds.
- c.

Child's respirations should be checked for a minimum of 5 minutes to identify any variations in his or her respiratory pattern.

d.

Patients respirations should be counted for 15 seconds and then multiplied by 4 to obtain the number of respirations per minute.

ANS: A

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

25. A patient's blood pressure is 118/82 mm Hg. He asks the nurse, What do the numbers mean?

The nurse's best reply is:

a. The numbers are within the normal range and are nothing to worry about.

b. The bottom number is the diastolic pressure and reflects the stroke volume of the heart.

c.

The top number is the systolic blood pressure and reflects the pressure of the blood against the arteries

when the heart contracts.

d.

The concept of blood pressure is difficult to understand. The primary thing to be concerned about is the top number, or the systolic blood pressure.

ANS: C

The systolic pressure is the maximum pressure felt on the artery during left ventricular contraction, or systole. The diastolic pressure is the elastic recoil, or resting, pressure that the blood constantly exerts in between each contraction. The nurse should answer the patient's question and use terms he can understand.

26. While measuring a patient's blood pressure, the nurse recalls that certain factors, such as _____, help determine blood pressure.

a. Pulse rate

b. Pulse pressure

c. Vascular output

d. Peripheral vascular resistance

ANS: D

The level of blood pressure is determined by five factors: cardiac output, peripheral vascular resistance, volume of circulating blood, viscosity, and elasticity of the vessel walls.

27. A nurse is helping at a health fair at a local mall. When taking blood pressures on a variety of people, the nurse keeps in mind that:

a. After menopause, blood pressure readings in women are usually lower than those taken in men.

b. The blood pressure of a Black adult is usually higher than that of a White adult of the same age.

c.

Blood pressure measurements in people who are overweight should be the same as those of people who are at a normal weight.

d. A teenager's blood pressure reading will be lower than that of an adult.

ANS: B

In the United States, a Black adult's blood pressure is usually higher than that of a White adult of the same age. The incidence of hypertension is twice as high in Blacks as it is in Whites. After menopause, blood pressure in women is higher than in men; blood pressure measurements in people who are obese are usually higher than in those who are not overweight. Normally, a

gradual rise occurs through childhood and into the adult years.

28. The nurse notices a colleague is preparing to check the blood pressure of a patient who is obese by using a standard-sized blood pressure cuff. The nurse should expect the reading to:

- a. Yield a falsely low blood pressure.
- b. Yield a falsely high blood pressure.
- c. Be the same, regardless of cuff size.
- d. Vary as a result of the technique of the person performing the assessment.

ANS: B

Using a cuff that is too narrow yields a falsely high blood pressure because it takes extra pressure to compress the artery.

29. A student is late for his appointment and has rushed across campus to the health clinic. The nurse should:

- a. Allow 5 minutes for him to relax and rest before checking his vital signs.
- b.

Check the blood pressure in both arms, expecting a difference in the readings because of his recent exercise.

c.

Immediately monitor his vital signs on his arrival at the clinic and then 5 minutes later, recording any differences.

d.

Check his blood pressure in the supine position, which will provide a more accurate reading and will allow him to relax at the same time.

ANS: A

A comfortable, relaxed person yields a valid blood pressure. Many people are anxious at the beginning of an examination; the nurse should allow at least a 5-minute rest period before measuring blood pressure.

30. The nurse will perform a palpated pressure before auscultating blood pressure. The reason for this is to:

- a. More clearly hear the Korotkoff sounds.
- b. Detect the presence of an auscultatory gap.
- c. Avoid missing a falsely elevated blood pressure.
- d. More readily identify phase IV of the Korotkoff sounds.

ANS: B

Inflation of the cuff 20 to 30 mm Hg beyond the point at which a palpated pulse disappears will avoid missing an auscultatory gap, which is a period when the Korotkoff sounds disappear during auscultation.

31. The nurse is taking an initial blood pressure reading on a 72-year-old patient with documented hypertension. How should the nurse proceed?

- a. Cuff should be placed on the patient's arm and inflated 30 mm Hg above the patient's pulse rate.
- b. Cuff should be inflated to 200 mm Hg in an attempt to obtain the most accurate systolic reading.
- c. Cuff should be inflated 30 mm Hg above the point at which the palpated pulse disappears.
- d.

After confirming the patients previous blood pressure readings, the cuff should be inflated 30 mm Hg above the highest systolic reading recorded.

ANS: C

An auscultatory gap occurs in approximately 5% of the people, most often in those with hypertension. To check for the presence of an auscultatory gap, the cuff should be inflated 20 to 30 mm Hg beyond the point at which the palpated pulse disappears.

32. The nurse has collected the following information on a patient: palpated blood pressure 180 mm Hg; auscultated blood pressure 170/100 mm Hg; apical pulse 60 beats per minute; radial pulse 70 beats per minute. What is the patients pulse pressure?

- a. 10
- b. 70
- c. 80
- d. 100

ANS: B

Pulse pressure is the difference between systolic and diastolic blood pressure ($170 - 100 = 70$) and reflects the stroke volume.

33. When auscultating the blood pressure of a 25-year-old patient, the nurse notices the phase I Korotkoff sounds begin at 200 mm Hg. At 100 mm Hg, the Korotkoff sounds muffle. At 92 mm Hg, the Korotkoff sounds disappear. How should the nurse record this patients blood pressure?

- a. 200/92
- b. 200/100
- c. 100/200/92
- d. 200/100/92

ANS: A

In adults, the last audible sound best indicates the diastolic pressure. When a variance is greater than 10 to 12 mm Hg between phases IV and V, both phases should be recorded along with the systolic reading (e.g., 142/98/80).

34. A patient is seen in the clinic for complaints of fainting episodes that started last week. How should the nurse proceed with the examination?

- a. Blood pressure readings are taken in both the arms and the thighs.
- b. The patient is assisted to a lying position, and his blood pressure is taken.
- c. His blood pressure is recorded in the lying, sitting, and standing positions.
- d.

His blood pressure is recorded in the lying and sitting positions; these numbers are then averaged to obtain a mean blood pressure.

ANS: C

If the person is known to have hypertension, is taking antihypertensive medications, or reports a history of fainting or syncope, then the blood pressure reading should be taken in three positions: lying, sitting, and standing.

35. A 70-year-old man has a blood pressure of 150/90 mm Hg in a lying position, 130/80 mm Hg in a sitting position, and 100/60 mm Hg in a standing position. How should the nurse evaluate these findings?

- a. These readings are a normal response and attributable to changes in the patients position.
- b. The change in blood pressure readings is called *orthostatic hypotension*.

- c. The blood pressure reading in the lying position is within normal limits.
- d. The change in blood pressure readings is considered within normal limits for the patients age.

ANS: B

Orthostatic hypotension is a drop in systolic pressure of more than 20 mm Hg, which occurs with a quick change to a standing position. Aging people have the greatest risk of this problem.

36. The nurse is helping another nurse to take a blood pressure reading on a patients thigh.

Which action is *correct* regarding thigh pressure?

- a. Either the popliteal or femoral vessels should be auscultated to obtain a thigh pressure.
- b. The best position to measure thigh pressure is the supine position with the knee slightly bent.

c.

If the blood pressure in the arm is high in an adolescent, then it should be compared with the thigh

pressure.

d.

The thigh pressure is lower than the pressure in the arm, which is attributable to the distance away from the heart and the size of the popliteal vessels.

ANS: C

When blood pressure measured at the arm is excessively high, particularly in adolescents and young adults, it is compared with thigh pressure to check for coarctation of the aorta. The popliteal artery is auscultated for the reading. Generally, thigh pressure is higher than that of the arm; however, if coarctation of the artery is present, then arm pressures are higher than thigh pressures.

37. The nurse is preparing to measure the vital signs of a 6-month-old infant. Which action by the nurse is *correct*?

- a. Respirations are measured; then pulse and temperature.
- b. Vital signs should be measured more frequently than in an adult.
- c. Procedures are explained to the parent, and the infant is encouraged to handle the equipment.
- d.

The nurse should first perform the physical examination to allow the infant to become more familiar with her and then measure the infants vital signs.

ANS: A

With an infant, the order of vital sign measurements is reversed to respiration, pulse, and temperature. Taking the temperature first, especially if it is rectal, may cause the infant to cry, which will increase the respiratory and pulse rate, thus masking the normal resting values. The vital signs are measured with the same purpose and frequency as would be measured in an adult.

38. A 4-month-old child is at the clinic for a well-baby check-up and immunizations. Which of these actions is most appropriate when the nurse is assessing an infants vital signs?

a.

The infants radial pulse should be palpated, and the nurse should notice any fluctuations resulting from activity or exercise.

b.

The nurse should auscultate an apical rate for 1 minute and then assess for any normal irregularities, such as sinus arrhythmia.

c.

The infants blood pressure should be assessed by using a stethoscope with a large diaphragm

piece to hear the soft muffled Korotkoff sounds.

d.

The infants chest should be observed and the respiratory rate counted for 1 minute; the respiratory pattern may vary significantly.

ANS: B

The nurse palpates or auscultates an apical rate with infants and toddlers. The pulse should be counted for 1 full minute to account for normal irregularities, such as sinus arrhythmia. Children younger than 3 years of age have such small arm vessels; consequently, hearing Korotkoff sounds with a stethoscope is difficult. The nurse should use either an electronic blood pressure device that uses oscillometry or a Doppler ultrasound device to amplify the sounds.

39. The nurse is conducting a health fair for older adults. Which statement is *true* regarding vital sign measurements in aging adults?

- a. The pulse is more difficult to palpate because of the stiffness of the blood vessels.
- b. An increased respiratory rate and a shallower inspiratory phase are expected findings.
- c. A decreased pulse pressure occurs from changes in the systolic and diastolic blood pressures.
- d.

Changes in the bodys temperature regulatory mechanism leave the older person more likely to develop a fever.

ANS: B

Aging causes a decrease in vital capacity and decreased inspiratory reserve volume. The examiner may notice a shallower inspiratory phase and an increased respiratory rate. An increase in the rigidity of the arterial walls makes the pulse actually easier to palpate. Pulse pressure is widened in older adults, and changes in the body temperature regulatory mechanism leave the older person less likely to have fever but at a greater risk for hypothermia.

40. In a patient with acromegaly, the nurse will expect to discover which assessment findings?

- a. Heavy, flattened facial features
- b. Growth retardation and a delayed onset of puberty
- c. Overgrowth of bone in the face, head, hands, and feet
- d. Increased height and weight and delayed sexual development

ANS: C

Excessive secretions of growth hormone in adulthood after normal completion of body growth causes an overgrowth of the bones in the face, head, hands, and feet but no change in height.

41. The nurse is performing a general survey of a patient. Which finding is considered normal?

- a. When standing, the patients base is narrow.
- b. The patient appears older than his stated age.
- c. Arm span (fingertip to fingertip) is greater than the height.
- d. Arm span (fingertip to fingertip) equals the patients height.

ANS: D

When performing the general survey, the patients arm span (fingertip to fingertip) should equal the patients height. An arm span that is greater than the persons height may indicate Marfan syndrome. The base should be wide when the patient is standing, and an older appearance than the stated age may indicate a history of a chronic illness or chronic alcoholism.

42. The nurse is assessing children in a pediatric clinic. Which statement is *true* regarding the measurement of blood pressure in children?

- a. Blood pressure guidelines for children are based on age.

- b. Phase II Korotkoff sounds are the best indicator of systolic blood pressure in children.
- c. Using a Doppler device is recommended for accurate blood pressure measurements until adolescence.
- d. The disappearance of phase V Korotkoff sounds can be used for the diastolic reading in children.

ANS: D

The disappearance of phase V Korotkoff sounds can be used for the diastolic reading in children, as well as in adults.

43. What type of blood pressure measurement error is most likely to occur if the nurse does not check for the presence of an auscultatory gap?

- a. Diastolic blood pressure may not be heard.
- b. Diastolic blood pressure may be falsely low.
- c. Systolic blood pressure may be falsely low.
- d. Systolic blood pressure may be falsely high.

ANS: C

If an auscultatory gap is undetected, then a falsely low systolic or falsely high diastolic reading may result, which is common in patients with hypertension.

44. When considering the concepts related to blood pressure, the nurse knows that the concept of mean arterial pressure (MAP) is best described by which statement?

- a. MAP is the pressure of the arterial pulse.
- b. MAP reflects the stroke volume of the heart.
- c. MAP is the pressure forcing blood into the tissues, averaged over the cardiac cycle.
- d. MAP is an average of the systolic and diastolic blood pressures and reflects tissue perfusion.

ANS: C

MAP is the pressure that forces blood into the tissues, averaged over the cardiac cycle. Stroke volume is reflected by the blood pressure. MAP is not an arithmetic average of systolic and diastolic pressures because diastole lasts longer; rather, it is a value closer to diastolic pressure plus one third of the pulse pressure.

45. A 75-year-old man with a history of hypertension was recently changed to a new antihypertensive drug. He reports feeling dizzy at times. How should the nurse evaluate his blood pressure?

- a. Blood pressure and pulse should be recorded in the supine, sitting, and standing positions.
- b.

The patient should be directed to walk around the room and his blood pressure assessed after this activity.

- c. Blood pressure and pulse are assessed at the beginning and at the end of the examination.
- d. Blood pressure is taken on the right arm and then 5 minutes later on the left arm.

ANS: A

Orthostatic vital signs should be taken when the person is hypertensive or is taking antihypertensive medications, when the person reports fainting or syncope, or when volume depletion is suspected. The blood pressure and pulse readings are recorded in the supine, sitting, and standing positions.

46. Which of these specific measurements is the best index of a child's general health?

- a. Vital signs
- b. Height and weight

- c. Head circumference
- d. Chest circumference

ANS: B

Physical growth, measured by height and weight, is the best index of a child's general health.

47. The nurse is assessing an 8-year-old child whose growth rate measures below the third percentile for a child his age. He appears significantly younger than his stated age and is chubby with infantile facial features. Which condition does this child have?

- a. Hypopituitary dwarfism
- b. Achondroplastic dwarfism
- c. Marfan syndrome
- d. Acromegaly

ANS: A

Hypopituitary dwarfism is caused by a deficiency in growth hormone in childhood and results in a retardation of growth below the third percentile, delayed puberty, and other problems. The child's appearance fits this description. Achondroplastic dwarfism is a genetic disorder resulting in characteristic deformities; Marfan syndrome is an inherited connective tissue disorder characterized by a tall, thin stature and other features. Acromegaly is the result of excessive secretion of growth hormone in adulthood.

48. The nurse is counting an infant's respirations. Which technique is correct?

- a. Watching the chest rise and fall
- b. Watching the abdomen for movement
- c. Placing a hand across the infant's chest
- d. Using a stethoscope to listen to the breath sounds

ANS: B

Watching the abdomen for movement is the correct technique because the infant's respirations are normally more diaphragmatic than thoracic. The other responses do not reflect correct techniques.

49. When checking for proper blood pressure cuff size, which guideline is correct?

- a. The standard cuff size is appropriate for all sizes.
- b. The length of the rubber bladder should equal 80% of the arm circumference.
- c. The width of the rubber bladder should equal 80% of the arm circumference.
- d. The width of the rubber bladder should equal 40% of the arm circumference.

ANS: D

The width of the rubber bladder should equal 40% of the circumference of the person's arm. The length of the bladder should equal 80% of this circumference.

50. During an examination, the nurse notices that a female patient has a round moon face, central trunk obesity, and a cervical hump. Her skin is fragile with bruises. The nurse determines that the patient has which condition?

- a. Marfan syndrome
- b. Gigantism
- c. Cushing syndrome
- d. Acromegaly

ANS: C

Cushing syndrome is characterized by weight gain and edema with central trunk and cervical obesity (buffalo hump) and round plethoric face (moon face). Excessive catabolism causes

muscle wasting; weakness; thin arms and legs; reduced height; and thin, fragile skin with purple abdominal striae, bruising, and acne.

MULTIPLE RESPONSE

1. While measuring a patients blood pressure, the nurse uses the proper technique to obtain an accurate reading. Which of these situations will result in a falsely high blood pressure reading? *Select all that apply.*

- a. The person supports his or her own arm during the blood pressure reading.
- b. The blood pressure cuff is too narrow for the extremity.
- c. The arm is held above level of the heart.
- d. The cuff is loosely wrapped around the arm.
- e. The person is sitting with his or her legs crossed.
- f. The nurse does not inflate the cuff high enough.

ANS: A, B, D, E

Several factors can result in blood pressure readings that are too high or too low. Having the patients arm held above the level of the heart is one part of the correct technique.

SHORT ANSWER

1. What is the pulse pressure for a patient whose blood pressure is 158/96 mm Hg and whose pulse rate is 72 beats per minute?

ANS:

62

The pulse pressure is the difference between the systolic and diastolic and reflects the stroke volume. The pulse rate is not necessary for pulse pressure calculations.

Chapter 4 Mental Health Disorders

MULTIPLE CHOICE

1. During an examination, the nurse can assess mental status by which activity?

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

ANS: C

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

2. The nurse is assessing the mental status of a child. Which statement about children and mental status is *true*?

- a. All aspects of mental status in children are interdependent.
- b. Children are highly labile and unstable until the age of 2 years.
- c.

Childrens mental status is largely a function of their parents level of functioning until the age of 7 years.

- d. A childs mental status is impossible to assess until the child develops the ability to concentrate.

ANS: A

Separating and tracing the development of only one aspect of mental status is difficult. All aspects are interdependent. For example, consciousness is rudimentary at birth because the

cerebral cortex is not yet developed. The infant cannot distinguish the self from the mother's body. The other statements are not true.

3. The nurse is assessing a 75-year-old man. As the nurse begins the mental status portion of the assessment, the nurse expects that this patient:

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

Will exhibit had a decrease in his response time because of the loss of language and a decrease in general knowledge.

ANS: C

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

4. When assessing aging adults, the nurse knows that one of the first things that should be assessed before making judgments about their mental status is:

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

ANS: D

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

5. The nurse is preparing to conduct a mental status examination. Which statement is *true* regarding the mental status examination?

- a. A patient's family is the best resource for information about the patient's coping skills.
- b. Gathering mental status information during the health history interview is usually sufficient.
- c.

Integrating the mental status examination into the health history interview takes an enormous amount of extra time.

d.

To get a good idea of the patient's level of functioning, performing a complete mental status examination is usually necessary.

ANS: B

The full mental status examination is a systematic check of emotional and cognitive functioning. The steps described, however, rarely need to be taken in their entirety. Usually, one can assess

mental status through the context of the health history interview.

6. A woman brings her husband to the clinic for an examination. She is particularly worried because after a recent fall, he seems to have lost a great deal of his memory of recent events. Which statement reflects the nurses best course of action?

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

ANS: A

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

7. The nurse is conducting a patient interview. Which statement made by the patient should the nurse more fully explore during the interview?

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

ANS: C

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

8. A patient is admitted to the unit after an automobile accident. The nurse begins the mental status examination and finds that the patient has dysarthric speech and is lethargic. The nurses best approach regarding this examination is to:

- a. Plan to defer the rest of the mental status examination.
- b. Skip the language portion of the examination, and proceed onto assessing mood and affect.
- c. Conduct an in-depth speech evaluation, and defer the mental status examination to another time.
- d.

Proceed with the examination, and assess the patient for suicidal thoughts because dysarthria is often

accompanied by severe depression.

ANS: A

In the mental status examination, the sequence of steps forms a hierarchy in which the most basic functions (consciousness, language) are assessed first. The first steps must be accurately assessed to ensure validity of the steps that follow. For example, if consciousness is clouded, then the person cannot be expected to have full attention and to cooperate with new learning. If language is impaired, then a subsequent assessment of new learning or abstract reasoning (anything that requires language functioning) can give erroneous conclusions.

9. A 19-year-old woman comes to the clinic at the insistence of her brother. She is wearing black combat boots and a black lace nightgown over the top of her other clothes. Her hair is dyed pink with black streaks throughout. She has several pierced holes in her nares and ears and is wearing an earring through her eyebrow and heavy black makeup. The nurse concludes that:

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

ANS: D

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

10. A patient has been in the intensive care unit for 10 days. He has just been moved to the medical-surgical unit, and the admitting nurse is planning to perform a mental status examination. During the tests of cognitive function, the nurse would expect that he:

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

ANS: C

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

11. During a mental status examination, the nurse wants to assess a patients affect. The nurse should ask the patient which question?

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

ANS: A

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

12. The nurse is planning to assess new memory with a patient. The best way for the nurse to do this would be to:

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

ANS: C

Ask questions that can be corroborated, which screens for the occasional person who confabulates or makes up answers to fill in the gaps of memory loss. The Four Unrelated Words

Test tests the persons ability to lay down new memories and is a highly sensitive and valid memory test.

13. A 45-year-old woman is at the clinic for a mental status assessment. In giving her the Four Unrelated Words Test, the nurse would be concerned if she could not ____ four unrelated words ____.

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

ANS: C

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

14. During a mental status assessment, which question by the nurse would best assess a persons judgment?

- a. Do you feel that you are being watched, followed, or controlled?
- b. Tell me what you plan to do once you are discharged from the hospital.
- c. What does the statement, People in glass houses shouldnt throw stones, mean to you?
- d. What would you do if you found a stamped, addressed envelope lying on the sidewalk?

ANS: B

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

15. Which of these individuals would the nurse consider at highest risk for a suicide attempt?

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

gun

ANS: D

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

16. The nurse is performing a mental status assessment on a 5-year-old girl. Her parents are undergoing a bitter divorce and are worried about the effect it is having on their daughter. Which action or statement might lead the nurse to be concerned about the girls mental status?

- a. She clings to her mother whenever the nurse is in the room.
- b. She appears angry and will not make eye contact with the nurse.
- c. Her mother states that she has begun to ride a tricycle around their yard.
- d.

Her mother states that her daughter prefers to play with toddlers instead of kids her own age while in daycare.

ANS: D

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

17. The nurse is assessing orientation in a 79-year-old patient. Which of these responses would lead the nurse to conclude that this patient is oriented?

- a. I know my name is John. I couldn't tell you where I am. I think it is 2010, though.
- b. I know my name is John, but to tell you the truth, I get kind of confused about the date.
- c. I know my name is John; I guess I'm at the hospital in Spokane. No, I don't know the date.
- d.

I know my name is John. I am at the hospital in Spokane. I couldn't tell you what date it is, but I know that

it is February of a new year 2010.

ANS: D

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

18. The nurse is performing the Denver II screening test on a 12-month-old infant during a routine well-child visit. The nurse should tell the infant's parents that the Denver II:

- a. Tests three areas of development: cognitive, physical, and psychological
- b. Will indicate whether the child has a speech disorder so that treatment can begin.
- c. Is a screening instrument designed to detect children who are slow in development.
- d.

Is a test to determine intellectual ability and may indicate whether problems will develop later in school.

ANS: C

The Denver II is a screening instrument designed to detect developmental delays in infants and preschoolers. It tests four functions: gross motor, language, fine motor-adaptive, and personal-social.

The Denver II is not an intelligence test; it does not predict current or future intellectual

ability. It is not diagnostic; it does not suggest treatment regimens.

19. A patient drifts off to sleep when she is not being stimulated. The nurse can easily arouse her by calling her name, but the patient remains drowsy during the conversation. The best description of this patient's level of consciousness would be:

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

ANS: A

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

20. A patient has had a cerebrovascular accident (stroke). He is trying very hard to communicate. He seems driven to speak and says, I buy obie get spirding and take my train. What is the best description of this patient's problem?

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

ANS: D

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

21. A patient repeatedly seems to have difficulty coming up with a word. He says, I was on my way to work, and when I got there, the thing that you step into that goes up in the air was so full that I decided to take the stairs. The nurse will note on his chart that he is using or experiencing:

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

ANS: C

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

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

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

ANS: C

Flight of ideas is demonstrated by an abrupt change, rapid skipping from topic to topic, and

practically continuous flow of accelerated speech. Topics usually have recognizable associations or are plays on words.

23. A patient describes feeling an unreasonable, irrational fear of snakes. His fear is so persistent that he can no longer comfortably look at even pictures of snakes and has made an effort to identify all the places he might encounter a snake and avoids them. The nurse recognizes that he:

- a. Has a snake phobia.
- b. Is a hypochondriac; snakes are usually harmless.
- c. Has an obsession with snakes.
- d.

Has a delusion that snakes are harmful, which must stem from an early traumatic incident involving snakes.

ANS: A

A phobia is a strong, persistent, irrational fear of an object or situation; the person feels driven to avoid it.

24. A patient has been diagnosed with schizophrenia. During a recent interview, he shows the nurse a picture of a man holding a decapitated head. He describes this picture as horrifying but then laughs loudly at the content. This behavior is a display of:

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

ANS: D

An inappropriate affect is an affect clearly discordant with the content of the person's speech.

25. During reporting, the nurse hears that a patient is experiencing hallucinations. Which is an example of a hallucination?

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

ANS: A

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

26. A 20-year-old construction worker has been brought into the emergency department with heat stroke. He has delirium as a result of a fluid and electrolyte imbalance. For the mental status examination, the nurse should first assess the patient's:

- a. Affect and mood
- b. Memory and affect
- c. Language abilities
- d. Level of consciousness and cognitive abilities

ANS: D

Delirium is a disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention. Delirium is not an alteration in mood,

affect, or language abilities.

27. A patient states, I feel so sad all of the time. I cant feel happy even doing things I used to like to do. He also states that he is tired, sleeps poorly, and has no energy. To differentiate between a dysthymic disorder and a major depressive disorder, the nurse should ask which question?

- a. Have you had any weight changes?
- b. Are you having any thoughts of suicide?
- c. How long have you been feeling this way?
- d. Are you having feelings of worthlessness?

ANS: C

Major depressive disorder is characterized by one or more major depressive episodes, that is, at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression. Dysthymic disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms.

28. A 26-year-old woman was robbed and beaten a month ago. She is returning to the clinic today for a follow-up assessment. The nurse will want to ask her which one of these questions?

- a. How are things going with the trial?
- b. How are things going with your job?
- c. Tell me about your recent engagement!
- d. Are you having any disturbing dreams?

ANS: D

In posttraumatic stress disorder, the person has been exposed to a traumatic event. The traumatic event is persistently reexperienced by recurrent and intrusive, distressing recollections of the event, including images, thoughts, or perceptions; recurrent distressing dreams of the event; and acting or feeling as if the traumatic event were recurring.

29. The nurse is performing a mental status examination. Which statement is *true* regarding the assessment of mental status?

- a. Mental status assessment diagnoses specific psychiatric disorders.
- b. Mental disorders occur in response to everyday life stressors.
- c. Mental status functioning is inferred through the assessment of an individuals behaviors.
- d.

Mental status can be directly assessed, similar to other systems of the body (e.g., heart sounds, breath sounds).

ANS: C

Mental status functioning is inferred through the assessment of an individuals behaviors. It cannot be directly assessed like the characteristics of the skin or heart sounds.

30. A 23-year-old patient in the clinic appears anxious. Her speech is rapid, and she is fidgety and in constant motion. Which of these questions or statements would be most appropriate for the nurse to use in this situation to assess attention span?

- a. How do you usually feel? Is this normal behavior for you?
- b. I am going to say four words. In a few minutes, I will ask you to recall them.
- c. Describe the meaning of the phrase, Looking through rose-colored glasses.
- d. Pick up the pencil in your left hand, move it to your right hand, and place it on the table.

ANS: D

Attention span is evaluated by assessing the individuals ability to concentrate and complete a

thought or task without wandering. Giving a series of directions to follow is one method used to assess attention span.

31. The nurse is planning health teaching for a 65-year-old woman who has had a cerebrovascular accident (stroke) and has aphasia. Which of these questions is most important to use when assessing mental status in this patient?

- a. Please count backward from 100 by seven.
- b. I will name three items and ask you to repeat them in a few minutes.
- c. Please point to articles in the room and parts of the body as I name them.
- d. What would you do if you found a stamped, addressed envelope on the sidewalk?

ANS: C

Additional tests for persons with aphasia include word comprehension (asking the individual to point to articles in the room or parts of the body), reading (asking the person to read available print), and writing (asking the person to make up and write a sentence).

32. A 30-year-old female patient is describing feelings of hopelessness and depression. She has attempted self-mutilation and has a history of suicide attempts. She describes difficulty sleeping at night and has lost 10 pounds in the past month. Which of these statements or questions is the nurses best response in this situation?

- a. Do you have a weapon?
- b. How do other people treat you?
- c. Are you feeling so hopeless that you feel like hurting yourself now?
- d. People often feel hopeless, but the feelings resolve within a few weeks.

ANS: C

When the person expresses feelings of hopelessness, despair, or grief, assessing the risk of physical harm to him or herself is important. This process begins with more general questions. If the answers are affirmative, then the assessment continues with more specific questions.

33. The nurse is providing instructions to newly hired graduates for the minimal state examination (MMSE). Which statement best describes this examination?

- a. Scores below 30 indicate cognitive impairment.
- b. The MMSE is a good tool to evaluate mood and thought processes.
- c.

This examination is a good tool to detect delirium and dementia and to differentiate these from psychiatric mental illness.

d.

The MMSE is useful tool for an initial evaluation of mental status. Additional tools are needed to evaluate cognition changes over time.

ANS: C

The MMSE is a quick, easy test of 11 questions and is used for initial and serial evaluations and can demonstrate a worsening or an improvement of cognition over time and with treatment. It evaluates cognitive functioning, not mood or thought processes. MMSE is a good screening tool to detect dementia and delirium and to differentiate these from psychiatric mental illness.

34. The nurse discovers speech problems in a patient during an assessment. The patient has spontaneous speech, but it is mostly absent or is reduced to a few stereotypical words or sounds. This finding reflects which type of aphasia?

- a. Global
- b. Brocas
- c. Dysphonic
- d. Wernickes

ANS: A

Global aphasia is the most common and severe form of aphasia. Spontaneous speech is absent or reduced to a few stereotyped words or sounds, and prognosis for language recovery is poor. (Brocas aphasia and Wernickes aphasia)Dysphonic aphasia is not a valid condition.

35. A patient repeats, I feel hot. Hot, cot, rot, tot, got. Im a spot. The nurse documents this as an illustration of:

- a. Blocking
- b. Clanging
- c. Echolalia
- d. Neologism

ANS: B

Clanging is word choice based on sound, not meaning, and includes nonsense rhymes and puns.

36. During an interview, the nurse notes that the patient gets up several times to wash her hands even though they are not dirty. This behavior is an example of:

- a. Social phobia
- b. Compulsive disorder
- c. Generalized anxiety disorder
- d. Posttraumatic stress disorder

ANS: B

Repetitive behaviors, such as handwashing, are behaviors that the person feels driven to perform in response to an obsession. The behaviors are aimed at preventing or reducing distress or preventing some dreaded event or situation.

37. The nurse is administering a Mini-Cog test to an older adult woman. When asked to draw a clock showing the time of 10:45, the patient drew a clock with the numbers out of order and with an incorrect time. This result indicates which finding?

- a. Cognitive impairment
- b. Amnesia
- c. Delirium
- d. Attention-deficit disorder

ANS: A

The Mini-Cog is a newer instrument that screens for cognitive impairment, often found with dementia. The result of an abnormal drawing of a clock and time indicates a cognitive impairment.

38. During morning rounds, the nurse asks a patient, How are you today? The patient responds, You today, you today, you today! and mumbles the words. This speech pattern is an example of:

- a. Echolalia
- b. Clanging
- c. Word salad
- d. Perseveration

ANS: A

Echolalia occurs when a person imitates or repeats anothers words or phrases, often with a

mumbling, mocking, or a mechanical tone.

MULTIPLE RESPONSE

1. The nurse is assessing a patient who is admitted with possible delirium. Which of these are manifestations of delirium? *Select all that apply.*

- a. Develops over a short period.
- b. Person is experiencing apraxia.
- c. Person is exhibiting memory impairment or deficits.
- d. Occurs as a result of a medical condition, such as systemic infection.
- e. Person is experiencing agnosia.

ANS: A, C, D

Delirium is a disturbance of consciousness that develops over a short period and may be attributable to a medical condition. Memory deficits may also occur. Apraxia and agnosia occur with dementia.

Chapter 5 Integumentary Disorders

MULTIPLE CHOICE

1. The nurse educator is preparing an education module for the nursing staff on the epidermal layer of skin. Which of these statements would be included in the module? The epidermis is:

- a. Highly vascular.
- b. Thick and tough.
- c. Thin and nonstratified.
- d. Replaced every 4 weeks.

ANS: D

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

2. The nurse educator is preparing an education module for the nursing staff on the dermis layer of skin. Which of these statements would be included in the module? The dermis:

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

ANS: D

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

3. The nurse is examining a patient who tells the nurse, I sure sweat a lot, especially on my face and feet but it doesn't have an odor. The nurse knows that this condition could be related to:

- a. Eccrine glands.
- b. Apocrine glands.
- c. Disorder of the stratum corneum.
- d. Disorder of the stratum germinativum.

ANS: A

The eccrine glands are coiled tubules that directly open onto the skin surface and produce a

dilute saline solution called *sweat*. Apocrine glands are primarily located in the axillae, anogenital area, nipples, and naval area and mix with bacterial flora to produce the characteristic musky body odor. The patient's statement is not related to disorders of the stratum corneum or the stratum germinativum.

4. A newborn infant is in the clinic for a well-baby checkup. The nurse observes the infant for the possibility of fluid loss because of which of these factors?
- a. Subcutaneous fat deposits are high in the newborn.
 - b. Sebaceous glands are overproductive in the newborn.
 - c. The newborn's skin is more permeable than that of the adult.
 - d. The amount of vernix caseosa dramatically rises in the newborn.

ANS: C

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

5. The nurse is bathing an 80-year-old man and notices that his skin is wrinkled, thin, lax, and dry. This finding would be related to which factor in the older adult?
- a. Increased vascularity of the skin
 - b. Increased numbers of sweat and sebaceous glands
 - c. An increase in elastin and a decrease in subcutaneous fat
 - d. An increased loss of elastin and a decrease in subcutaneous fat

ANS: D

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

6. During the aging process, the hair can look gray or white and begin to feel thin and fine. The nurse knows that this occurs because of a decrease in the number of functioning:
- a. Metrocytes.
 - b. Fungocytes.
 - c. Phagocytes.
 - d. Melanocytes.

ANS: D

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

7. During an examination, the nurse finds that a patient has excessive dryness of the skin. The best term to describe this condition is:
- a. Xerosis.
 - b. Pruritus.
 - c. Alopecia.
 - d. Seborrhea.

ANS: A

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

8. A 22-year-old woman comes to the clinic because of severe sunburn and states, I was out in

the sun for just a couple of minutes. The nurse begins a medication review with her, paying special attention to which medication class?

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

ANS: B

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

9. A woman is leaving on a trip to Hawaii and has come in for a checkup. During the examination the nurse learns that she has diabetes and takes oral hypoglycemic agents. The patient needs to be concerned about which possible effect of her medications?

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

ANS: D

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

10. A 13-year-old girl is interested in obtaining information about the cause of her acne. The nurse should share with her that acne:

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

ANS: C

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

11. A 75-year-old woman who has a history of diabetes and peripheral vascular disease has been trying to remove a corn on the bottom of her foot with a pair of scissors. The nurse will encourage her to stop trying to remove the corn with scissors because:

- a. The woman could be at increased risk for infection and lesions because of her chronic disease.
- b. With her diabetes, she has increased circulation to her foot, and it could cause severe bleeding.
- c.

She is 75 years old and is unable to see; consequently, she places herself at greater risk for self-injury with

the scissors.

d.

With her peripheral vascular disease, her range of motion is limited and she may not be able to reach the corn safely.

ANS: A

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

12. The nurse keeps in mind that a thorough skin assessment is extremely important because the skin holds information about a persons:

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

ANS: B

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

13. A patient comes in for a physical examination and complains of freezing to death while waiting for her examination. The nurse notes that her skin is pale and cool and attributes this finding to:

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

ANS: C

A chilly or air-conditioned environment causes vasoconstriction, which results in false pallor and coolness

14. A patient comes to the clinic and tells the nurse that he has been confined to his recliner chair for approximately 3 days with his feet down and he asks the nurse to evaluate his feet. During the assessment, the nurse might expect to find:

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

ANS: C

Keeping the feet in a dependent position causes venous pooling, resulting in redness, warmth, and distended veins. Prolonged elevation would cause pallor and coolness. Immobilization or prolonged inactivity would cause prolonged capillary filling time

15. A patient is especially worried about an area of skin on her feet that has turned white. The health care provider has told her that her condition is vitiligo. The nurse explains to her that vitiligo is:

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

ANS: C

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

16. A patient tells the nurse that he has noticed that one of his moles has started to burn and bleed. When assessing his skin, the nurse pays special attention to the danger signs for pigmented lesions and is concerned with which additional finding?

- a. Color variation

- b. Border regularity
- c. Symmetry of lesions
- d. Diameter of less than 6 mm

ANS: A

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

17. A patient comes to the clinic and states that he has noticed that his skin is redder than normal. The nurse understands that this condition is due to hyperemia and knows that it can be caused by:

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

ANS: D

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

18. During a skin assessment, the nurse notices that a Mexican-American patient has skin that is yellowish-brown; however, the skin on the hard and soft palate is pink and the patients scleras are not yellow. From this finding, the nurse could probably rule out:

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

ANS: B

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

19. A black patient is in the intensive care unit because of impending shock after an accident. The nurse expects to find what characteristics in this patients skin?

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

ANS: C

Pallor attributable to shock, with decreased perfusion and vasoconstriction, in black-skinned people will cause the skin to appear ashen, gray, or dull

20. An older adult woman is brought to the emergency department after being found lying on the kitchen floor for 2 days; she is extremely dehydrated. What would the nurse expect to see during the examination?

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

ANS: B

With dehydration, mucous membranes appear dry and the lips look parched and cracked. The

other responses are not found in dehydration.

21. A 42-year-old woman complains that she has noticed several small, slightly raised, bright red dots on her chest. On examination, the nurse expects that the spots are probably:

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

ANS: C

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

22. A 65-year-old man with emphysema and bronchitis has come to the clinic for a follow-up appointment. On assessment, the nurse might expect to see which finding?

- a. Anasarca
- b. Scleroderma
- c. Pedal erythema
- d. Clubbing of the nails

ANS: D

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

23. A newborn infant has Down syndrome. During the skin assessment, the nurse notices a transient mottling in the trunk and extremities in response to the cool temperature in the examination room. The infant's mother also notices the mottling and asks what it is. The nurse knows that this mottling is called:

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

ANS: D

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

24. A 35-year-old pregnant woman comes to the clinic for a monthly appointment. During the assessment, the nurse notices that she has a brown patch of hyperpigmentation on her face. The nurse continues the skin assessment aware that another finding may be:

- a. Keratoses.
- b. Xerosis.
- c. Chloasma.
- d. Acrochordons.

ANS: C

In pregnancy, skin changes can include striae, linea nigra (a brownish-black line down the midline), chloasma (brown patches of hyperpigmentation), and vascular spiders. Keratoses are raised, thickened areas of pigmentation that look crusted, scaly, and warty. Xerosis is dry skin.

Acrochordons, or *skin tags*, occur more often in the aging adult.

25. A man has come in to the clinic for a skin assessment because he is worried he might have skin cancer. During the skin assessment the nurse notices several areas of pigmentation that look greasy, dark, and stuck on his skin. Which is the best prediction?

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

ANS: D

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

26. A 70-year-old woman who loves to garden has small, flat, brown macules over her arms and hands. She asks, What causes these liver spots? The nurse tells her, They are:

- a. Signs of decreased hematocrit related to anemia.
- b. Due to the destruction of melanin in your skin from exposure to the sun.
- c. Clusters of melanocytes that appear after extensive sun exposure.
- d. Areas of hyperpigmentation related to decreased perfusion and vasoconstriction.

ANS: C

Liver spots, or senile lentigines, are clusters of melanocytes that appear on the forearms and dorsa of the hands after extensive sun exposure. The other responses are not correct.

27. The nurse notices that a patient has a solid, elevated, circumscribed lesion that is less than 1 cm in diameter. When documenting this finding, the nurse reports this as a:

- a. Bulla.
- b. Wheal.
- c. Nodule.
- d. Papule.

ANS: D

A papule is something one can feel, is solid, elevated, circumscribed, less than 1 cm in diameter, and is due to superficial thickening in the epidermis. A bulla is larger than 1 cm, superficial, and thin walled. A wheal is superficial, raised, transient, erythematous, and irregular in shape attributable to edema. A nodule is solid, elevated, hard or soft, and larger than 1 cm.

28. The nurse just noted from the medical record that the patient has a lesion that is confluent in nature. On examination, the nurse expects to find:

- a. Lesions that run together.
- b. Annular lesions that have grown together.
- c. Lesions arranged in a line along a nerve route.
- d. Lesions that are grouped or clustered together.

ANS: A

Confluent lesions (as with urticaria [hives]) run together. Grouped lesions are clustered together. Annular lesions are circular in nature. Zosteriform lesions are arranged along a nerve route.

29. A patient has had a terrible itch for several months that he has been continuously scratching. On examination, the nurse might expect to find:

- a. A keloid.
- b. A fissure.
- c. Keratosis.
- d. Lichenification.

ANS: D

Lichenification results from prolonged, intense scratching that eventually thickens the skin and produces tightly packed sets of papules. A keloid is a hypertrophic scar. A fissure is a linear crack with abrupt edges, which extends into the dermis; it can be dry or moist. Keratoses are lesions that are raised, thickened areas of pigmentation that appear crusted, scaly, and warty.

30. A physician has diagnosed a patient with purpura. After leaving the room, a nursing student asks the nurse what the physician saw that led to that diagnosis. The nurse should say, The physician is referring to the:

- a. Blue dilation of blood vessels in a star-shaped linear pattern on the legs.
- b. Fiery red, star-shaped marking on the cheek that has a solid circular center.
- c. Confluent and extensive patch of petechiae and ecchymoses on the feet.
- d. Tiny areas of hemorrhage that are less than 2 mm, round, discrete, and dark red in color.

ANS: C

Purpura is a confluent and extensive patch of petechiae and ecchymoses and a flat macular hemorrhage observed in generalized disorders such as thrombocytopenia and scurvy. The blue dilation of blood vessels in a star-shaped linear pattern on the legs describes a venous lake. The fiery red, star-shaped marking on the cheek that has a solid circular center describes a spider or star angioma. The tiny areas of hemorrhage that are less than 2 mm, round, discrete, and dark red in color describes petechiae.

31. A mother has noticed that her son, who has been to a new babysitter, has some blisters and scabs on his face and buttocks. On examination, the nurse notices moist, thin-roofed vesicles with a thin erythematous base and suspects:

- a. Eczema.
- b. Impetigo.
- c. Herpes zoster.
- d. Diaper dermatitis.

ANS: B

Impetigo is moist, thin-roofed vesicles with a thin erythematous base and is a contagious bacterial infection of the skin and most common in infants and children. Eczema is characterized by erythematous papules and vesicles with weeping, oozing, and crusts. Herpes zoster (i.e., chickenpox or varicella) is characterized by small, tight vesicles that are shiny with an erythematous base. Diaper dermatitis is characterized by red, moist maculopapular patches with poorly defined borders.

32. The nurse notices that a school-aged child has bluish-white, red-based spots in her mouth that are elevated approximately 1 to 3 mm. What other signs would the nurse expect to find in this patient?

- a. Pink, papular rash on the face and neck
- b. Pruritic vesicles over her trunk and neck
- c. Hyperpigmentation on the chest, abdomen, and back of the arms

d. Red-purple, maculopapular, blotchy rash behind the ears and on the face

ANS: D

With measles (rubeola), the examiner assesses a red-purple, blotchy rash on the third or fourth day of illness that appears first behind the ears, spreads over the face, and then over the neck, trunk, arms, and legs. The rash appears coppery and does not blanch. The bluish-white, redbased spots in the mouth are known as Koplik spots.

33. The nurse is assessing the skin of a patient who has acquired immunodeficiency syndrome (AIDS) and notices multiple patchlike lesions on the temple and beard area that are faint pink in color. The nurse recognizes these lesions as:

- a. Measles (rubeola).
- b. Kaposi sarcoma.
- c. Angiomas.
- d. Herpes zoster.

ANS: B

Kaposi sarcoma is a vascular tumor that, in the early stages, appears as multiple, patchlike, faint pink lesions over the patients temple and beard areas. Measles is characterized by a red-purple maculopapular blotchy rash that appears on the third or fourth day of illness. The rash is first observed behind the ears, spreads over the face, and then spreads over the neck, trunk, arms, and legs. Cherry (senile) angiomas are small (1 to 5 mm), smooth, slightly raised bright red dots that commonly appear on the trunk in all adults over 30 years old. Herpes zoster causes vesicles up to 1 cm in size that are elevated with a cavity containing clear fluid.

34. A 45-year-old farmer comes in for a skin evaluation and complains of hair loss on his head. His hair seems to be breaking off in patches, and he notices some scaling on his head. The nurse begins the examination suspecting:

- a. Tinea capitis.
- b. Folliculitis.
- c. Toxic alopecia.
- d. Seborrheic dermatitis.

ANS: A

Tinea capitis is rounded patchy hair loss on the scalp, leaving broken-off hairs, pustules, and scales on the skin, and is caused by a fungal infection. Lesions are fluorescent under a Wood light and are usually observed in children and farmers; tinea capitis is highly contagious.

35. A mother brings her child into the clinic for an examination of the scalp and hair. She states that the child has developed irregularly shaped patches with broken-off, stublike hair in some places; she is worried that this condition could be some form of premature baldness. The nurse tells her that it is:

- a. Folliculitis that can be treated with an antibiotic.
- b. Traumatic alopecia that can be treated with antifungal medications.
- c. Tinea capitis that is highly contagious and needs immediate attention.
- d. Trichotillomania; her child probably has a habit of absentmindedly twirling her hair.

ANS: D

Trichotillomania, self-induced hair loss, is usually due to habit. It forms irregularly shaped patches with broken-off, stublike hairs of varying lengths. A person is never completely bald. It occurs as a child absentmindedly rubs or twirls the area while falling asleep, reading, or watching television.

36. The nurse has discovered decreased skin turgor in a patient and knows that this finding is expected in which condition?

- a. Severe obesity
- b. Childhood growth spurts
- c. Severe dehydration
- d. Connective tissue disorders such as scleroderma

ANS: C

Decreased skin turgor is associated with severe dehydration or extreme weight loss.

37. While performing an assessment of a 65-year-old man with a history of hypertension and coronary artery disease, the nurse notices the presence of bilateral pitting edema in the lower legs. The skin is puffy and tight but normal in color. No increased redness or tenderness is observed over his lower legs, and the peripheral pulses are equal and strong. In this situation, the nurse suspects that the likely cause of the edema is which condition?

- a. Heart failure
- b. Venous thrombosis
- c. Local inflammation
- d. Blockage of lymphatic drainage

ANS: A

Bilateral edema or edema that is generalized over the entire body is caused by a central problem such as heart failure or kidney failure. Unilateral edema usually has a local or peripheral cause.

38. A 40-year-old woman reports a change in mole size, accompanied by color changes, itching, burning, and bleeding over the past month. She has a dark complexion and has no family history of skin cancer, but she has had many blistering sunburns in the past. The nurse would:

- a. Tell the patient to watch the lesion and report back in 2 months.
- b. Refer the patient because of the suggestion of melanoma on the basis of her symptoms.
- c. Ask additional questions regarding environmental irritants that may have caused this condition.
- d.

Tell the patient that these signs suggest a compound nevus, which is very common in young to middle-aged adults.

ANS: B

The ABCD danger signs of melanoma are asymmetry, border irregularity, color variation, and diameter. In addition, individuals may report a change in size, the development of itching, burning, and bleeding, or a new-pigmented lesion. Any one of these signs raises the suggestion of melanoma and warrants immediate referral.

39. The nurse is assessing for clubbing of the fingernails and expects to find:

- a. Nail bases that are firm and slightly tender.
- b. Curved nails with a convex profile and ridges across the nails.
- c. Nail bases that feel spongy with an angle of the nail base of 150 degrees.
- d. Nail bases with an angle of 180 degrees or greater and nail bases that feel spongy.

ANS: D

The normal nail is firm at its base and has an angle of 160 degrees. In clubbing, the angle straightens to 180 degrees or greater and the nail base feels spongy.

40. The nurse is assessing a patient who has liver disease for jaundice. Which of these assessment findings is indicative of true jaundice?

- a. Yellow patches in the outer sclera
- b. Yellow color of the sclera that extends up to the iris
- c. Skin that appears yellow when examined under low light
- d. Yellow deposits on the palms and soles of the feet where jaundice first appears

ANS: B

The yellow sclera of jaundice extends up to the edge of the iris. Calluses on the palms and soles of the feet often appear yellow but are not classified as jaundice. Scleral jaundice should not be confused with the normal yellow subconjunctival fatty deposits that are common in the outer sclera of dark-skinned persons.

41. The nurse is assessing for inflammation in a dark-skinned person. Which technique is the best?

- a. Assessing the skin for cyanosis and swelling
- b. Assessing the oral mucosa for generalized erythema
- c. Palpating the skin for edema and increased warmth
- d. Palpating for tenderness and local areas of ecchymosis

ANS: C

Because inflammation cannot be seen in dark-skinned persons, palpating the skin for increased warmth, for taut or tightly pulled surfaces that may be indicative of edema, and for a hardening of deep tissues or blood vessels is often necessary.

42. A few days after a summer hiking trip, a 25-year-old man comes to the clinic with a rash. On examination, the nurse notes that the rash is red, macular, with a bulls eye pattern across his midriff and behind his knees. The nurse suspects:

- a. Rubella.
- b. Lyme disease.
- c. Allergy to mosquito bites.
- d. Rocky Mountain spotted fever.

ANS: B

Lyme disease occurs in people who spend time outdoors in May through September. The first disease state exhibits the distinctive bulls eye and a red macular or papular rash that radiates from the site of the tick bite with some central clearing. The rash spreads 5 cm or larger, and is usually in the axilla, midriff, inguinal, or behind the knee, with regional lymphadenopathy.

43. A 52-year-old woman has a papule on her nose that has rounded, pearly borders and a central red ulcer. She said she first noticed it several months ago and that it has slowly grown larger. The nurse suspects which condition?

- a. Acne
- b. Basal cell carcinoma
- c. Melanoma
- d. Squamous cell carcinoma

ANS: B

Basal cell carcinoma usually starts as a skin-colored papule that develops rounded, pearly borders with a central red ulcer. It is the most common form of skin cancer and grows slowly. This description does not fit acne lesions.

44. A father brings in his 2-month-old infant to the clinic because the infant has had diarrhea for the last 24 hours. He says his baby has not been able to keep any formula down and that the diarrhea has been at least every 2 hours. The nurse suspects dehydration. The nurse should test

skin mobility and turgor over the infants:

- a. Sternum.
- b. Forehead.
- c. Forearms.
- d. Abdomen.

ANS: D

Mobility and turgor are tested over the abdomen in an infant. Poor turgor, or *tenting*, indicates dehydration or malnutrition. The other sites are not appropriate for checking skin turgor in an infant.

45. A semiconscious woman is brought to the emergency department after she was found on the floor in her kitchen. Her face, nail beds, lips, and oral mucosa are a bright cherry-red color. The nurse suspects that this coloring is due to:

- a. Polycythemia.
- b. Carbon monoxide poisoning.
- c. Carotenemia.
- d. Uremia.

ANS: B

A bright cherry-red coloring in the face, upper torso, nail beds, lips, and oral mucosa appears in cases of carbon monoxide poisoning.

46. A patient has been admitted for severe psoriasis. The nurse expects to see what finding in the patients fingernails?

- a. Splinter hemorrhages
- b. Paronychia
- c. Pitting
- d. Beau lines

ANS: C

Sharply defined pitting and crumbling of the nails, each with distal detachment characterize pitting nails and are associated with psoriasis

MULTIPLE RESPONSE

1. The nurse is preparing for a certification course in skin care and needs to be familiar with the various lesions that may be identified on assessment of the skin. Which of the following definitions are correct? *Select all that apply.*

- a. Petechiae: Tiny punctate hemorrhages, 1 to 3 mm, round and discrete, dark red, purple, or brown in color
- b. Bulla: Elevated, circumscribed lesion filled with turbid fluid (pus)
- c. Papule: Hypertrophic scar
- d. Vesicle: Known as a friction blister
- e. Nodule: Solid, elevated, and hard or soft growth that is larger than 1 cm

ANS: A, D, E

A pustule is an elevated, circumscribed lesion filled with turbid fluid (pus). A hypertrophic scar is a keloid. A bulla is larger than 1 cm and contains clear fluid. A papule is solid and elevated but measures less than 1 cm.

2. A patient has been admitted to a hospital after the staff in the nursing home noticed a pressure ulcer in his sacral area. The nurse examines the pressure ulcer and determines that it is a stage II ulcer. Which of these findings are characteristic of a stage II pressure ulcer? *Select all that apply.*

- a. Intact skin appears red but is not broken.
- b. Partial thickness skin erosion is observed with a loss of epidermis or dermis.
- c. Ulcer extends into the subcutaneous tissue.
- d. Localized redness in light skin will blanch with fingertip pressure.
- e. Open blister areas have a red-pink wound bed.
- f. Patches of eschar cover parts of the wound.

ANS: B, E

Stage I pressure ulcers have intact skin that appears red but is not broken, and localized redness in intact skin will blanch with fingertip pressure. Stage II pressure ulcers have partial thickness skin erosion with a loss of epidermis or also the dermis; open blisters have a red-pink wound bed. Stage III pressure ulcers are full thickness, extending into the subcutaneous tissue; subcutaneous fat may be seen but not muscle, bone, or tendon. Stage IV pressure ulcers involve all skin layers and extend into supporting tissue, exposing muscle, bone, and tendon. Slough (stringy matter attached to the wound bed) or eschar (black or brown necrotic tissue) may be present.

Chapter 6 Eye Disorders

MULTIPLE CHOICE

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 eye is stimulated.
- d.

The visual receptive layer of the eye in which light waves are changed into nerve impulses is located in 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.

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.

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.

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.

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.

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 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*.

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.

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.

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 patient's 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.

14. A patient's 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.

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 nurse's 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.

16. A patient's 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.

17. When performing the corneal light reflex assessment, the nurse notes that the light is reflected at 2 o'clock 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.

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.

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.

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 individual's 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.

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.

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.

d.

Ask the patient to focus on a distant object. Then ask the patient to follow the penlight to approximately
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.

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.

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.

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.

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.

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 child's 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.

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 child's 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.

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 patient's 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.

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.

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 can't 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.

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.

35. A 68-year-old woman is in the eye clinic for a checkup. She tells the nurse that she has been having trouble reading the paper, sewing, and even seeing the faces of her grandchildren. On examination, the nurse notes that she has some loss of central vision but her peripheral vision is normal. These findings suggest that she may have:

- a. Macular degeneration.
- b. Vision that is normal for someone her age.
- c. The beginning stages of cataract formation.
- d. Increased intraocular pressure or glaucoma.

ANS: A

Macular degeneration is the most common cause of blindness. It is characterized by the loss of central vision. Cataracts would show lens opacity. Chronic open-angle glaucoma, the most common type of glaucoma, involves a gradual loss of peripheral vision. These findings are not consistent with vision that is considered normal at any age.

36. A patient comes into the emergency department after an accident at work. A machine blew dust into his eyes, and he was not wearing safety glasses. The nurse examines his corneas by shining a light from the side across the cornea. What findings would suggest that he has suffered a corneal abrasion?

- a. Smooth and clear corneas
- b. Opacity of the lens behind the cornea
- c. Bleeding from the areas across the cornea
- d. Shattered look to the light rays reflecting off the cornea

ANS: D

A corneal abrasion causes irregular ridges in reflected light, which produce a shattered appearance to light rays. No opacities should be observed in the cornea. The other responses are not correct.

37. An ophthalmic examination reveals papilledema. The nurse is aware that this finding indicates:

- a. Retinal detachment.
- b. Diabetic retinopathy.
- c. Acute-angle glaucoma.
- d. Increased intracranial pressure.

ANS: D

Papilledema, or choked disk, is a serious sign of increased intracranial pressure, which is caused by a space-occupying mass such as a brain tumor or hematoma. This pressure causes venous stasis in the globe, showing redness, congestion, and elevation of the optic disc, blurred margins, hemorrhages, and absent venous pulsations. Papilledema is not associated with the conditions in the other responses.

38. During a physical education class, a student is hit in the eye with the end of a baseball bat. When examined in the emergency department, the nurse notices the presence of blood in the anterior chamber of the eye. This finding indicates the presence of:

- a. Hypopyon.
- b. Hyphema.
- c. Corneal abrasion.
- d. Pterygium.

ANS: B

Hyphema is the term for blood in the anterior chamber and is a serious result of blunt trauma (a fist or a baseball) or spontaneous hemorrhage and may indicate scleral rupture or major intraocular trauma.

39. During an assessment, the nurse notices that an older adult patient has tears rolling down his face from his left eye. Closer examination shows that the lower lid is loose and rolling outward. The patient complains of his eye feeling dry and itchy. Which action by the nurse is *correct*?

- a. Assessing the eye for a possible foreign body
- b. Documenting the finding as ptosis
- c. Assessing for other signs of ectropion
- d. Contacting the prescriber; these are signs of basal cell carcinoma

ANS: C

The condition described is known as *ectropion*, and it occurs in older adults and is attributable to atrophy of the elastic and fibrous tissues. The lower lid does not approximate to the eyeball, and, as a result, the puncta cannot effectively siphon tears; excessive tearing results. Ptosis is a drooping of the upper eyelid. These signs do not suggest the presence of a foreign body in the eye or basal cell carcinoma.

MULTIPLE RESPONSE

1. During an examination, a patient states that she was diagnosed with open-angle glaucoma 2 years ago. The nurse assesses for characteristics of open-angle glaucoma. Which of these are characteristics of open-angle glaucoma? *Select all that apply.*

- a. Patient may experience sensitivity to light, nausea, and halos around lights.
- b. Patient experiences tunnel vision in the late stages.
- c. Immediate treatment is needed.
- d. Vision loss begins with peripheral vision.
- e. Open-angle glaucoma causes sudden attacks of increased pressure that cause blurred vision.
- f. Virtually no symptoms are exhibited.

ANS: B, D, F

Open-angle glaucoma is the most common type of glaucoma; virtually no symptoms are exhibited. Vision loss begins with the peripheral vision, which often goes unnoticed because individuals learn to compensate intuitively by turning their heads. The other characteristics are those of closed-angle glaucoma.

Chapter 7 Ear Disorders

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 patient's 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*.

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 son's eustachian tube is shorter and wider than yours because of his age, which allows for infections to develop more easily.

ANS: D

The infant's eustachian tube is relatively shorter and wider than the adult's 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.

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 can't 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 person's 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 may 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 patient's 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.

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 o'clock 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 child's 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 school's 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 (swimmer's 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.

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 8 Nose, Sinus, Mouth, and Throat Disorders

MULTIPLE CHOICE

1. The primary purpose of the ciliated mucous membrane in the nose is to:

- a. Warm the inhaled air.
- b. Filter out dust and bacteria.
- c. Filter coarse particles from inhaled air.
- d. Facilitate the movement of air through the nares.

ANS: B

The nasal hairs filter the coarsest matter from inhaled air, whereas the mucous blanket filters out dust and bacteria. The rich blood supply of the nasal mucosa warms the inhaled air.

2. The projections in the nasal cavity that increase the surface area are called the:

- a. Meatus.
- b. Septum.
- c. Turbinates.
- d. Kiesselbach plexus.

ANS: C

The lateral walls of each nasal cavity contain three parallel bony projections: the superior, middle, and inferior turbinates. These increase the surface area, making more blood vessels and mucous membrane available to warm, humidify, and filter the inhaled air.

3. The nurse is reviewing the development of the newborn infant. Regarding the sinuses, which statement is *true* in relation to a newborn infant?

- a. Sphenoid sinuses are full size at birth.
- b. Maxillary sinuses reach full size after puberty.
- c. Frontal sinuses are fairly well developed at birth.
- d. Maxillary and ethmoid sinuses are the only sinuses present at birth.

ANS: D

Only the maxillary and ethmoid sinuses are present at birth. The sphenoid sinuses are minute at birth and develop after puberty. The frontal sinuses are absent at birth, are fairly well developed at age 7 to 8 years, and reach full size after puberty.

4. The tissue that connects the tongue to the floor of the mouth is the:

- a. Uvula.
- b. Palate.
- c. Papillae.
- d. Frenulum.

ANS: D

The frenulum is a midline fold of tissue that connects the tongue to the floor of the mouth. The uvula is the free projection hanging down from the middle of the soft palate. The palate is the arching roof of the mouth. Papillae are the rough, bumpy elevations on the tongue's dorsal surface.

5. The salivary gland that is the largest and located in the cheek in front of the ear is the

_____ gland.

- a. Parotid
- b. Stensens
- c. Sublingual
- d. Submandibular

ANS: A

The mouth contains three pairs of salivary glands. The largest, the parotid gland, lies within the cheeks in front of the ear extending from the zygomatic arch down to the angle of the jaw. The Stensens duct (not gland) drains the parotid gland onto the buccal mucosa opposite the second molar. The sublingual gland is located within the floor of the mouth under the tongue. The submandibular gland lies beneath the mandible at the angle of the jaw.

6. In assessing the tonsils of a 30 year old, the nurse notices that they are involuted, granular in appearance, and appear to have deep crypts. What is correct response to these findings?

- a. Refer the patient to a throat specialist.
- b. No response is needed; this appearance is normal for the tonsils.
- c. Continue with the assessment, looking for any other abnormal findings.
- d. Obtain a throat culture on the patient for possible streptococcal (strep) infection.

ANS: B

The tonsils are the same color as the surrounding mucous membrane, although they look more granular and their surface shows deep crypts. Tonsillar tissue enlarges during childhood until puberty and then involutes.

7. The nurse is obtaining a health history on a 3-month-old infant. During the interview, the mother states, I think she is getting her first tooth because she has started drooling a lot. The nurses best response would be:

- a. You're right, drooling is usually a sign of the first tooth.
- b. It would be unusual for a 3 month old to be getting her first tooth.
- c. This could be the sign of a problem with the salivary glands.
- d. She is just starting to salivate and hasn't learned to swallow the saliva.

ANS: D

In the infant, salivation starts at 3 months. The baby will drool for a few months before learning to swallow the saliva. This drooling does not herald the eruption of the first tooth, although many parents think it does.

8. The nurse is assessing an 80-year-old patient. Which of these findings would be expected for this patient?

- a. Hypertrophy of the gums
- b. Increased production of saliva
- c. Decreased ability to identify odors
- d. Finer and less prominent nasal hair

ANS: C

The sense of smell may be reduced because of a decrease in the number of olfactory nerve fibers. Nasal hairs grow coarser and stiffer with aging. The gums may recede with aging, not hypertrophy, and saliva production decreases.

9. The nurse is performing an oral assessment on a 40-year-old Black patient and notices the presence of a 1 cm, nontender, grayish-white lesion on the left buccal mucosa. Which one of these statements is *true*? This lesion is:

- a. Leukoedema and is common in dark-pigmented persons.
- b. The result of hyperpigmentation and is normal.
- c. Torus palatinus and would normally be found only in smokers.
- d. Indicative of cancer and should be immediately tested.

ANS: A

Leukoedema, a grayish-white benign lesion occurring on the buccal mucosa, is most often observed in Blacks.

10. While obtaining a health history, a patient tells the nurse that he has frequent nosebleeds and asks the best way to get them to stop. What would be the nurses best response?

- a. While sitting up, place a cold compress over your nose.
- b. Sit up with your head tilted forward and pinch your nose.
- c. Just allow the bleeding to stop on its own, but dont blow your nose.
- d. Lie on your back with your head tilted back and pinch your nose.

ANS: B

With a nosebleed, the person should sit up with the head tilted forward and pinch the nose between the thumb and forefinger for 5 to 15 minutes.

11. A 92-year-old patient has had a stroke. The right side of his face is drooping. The nurse might also suspect which of these assessment findings?

- a. Epistaxis
- b. Rhinorrhea
- c. Dysphagia
- d. Xerostomia

ANS: C

Dysphagia is difficulty with swallowing and may occur with a variety of disorders, including stroke and other neurologic diseases. Rhinorrhea is a runny nose, epistaxis is a bloody nose, and xerostomia is a dry mouth.

12. While obtaining a health history from the mother of a 1-year-old child, the nurse notices that the baby has had a bottle in his mouth the entire time. The mother states, It makes a great pacifier. The best response by the nurse would be:

- a. You're right. Bottles make very good pacifiers.
- b. Using a bottle as a pacifier is better for the teeth than thumb-sucking.
- c. Its okay to use a bottle as long as it contains milk and not juice.
- d. Prolonged use of a bottle can increase the risk for tooth decay and ear infections.

ANS: D

Prolonged bottle use during the day or when going to sleep places the infant at risk for tooth decay and middle ear infections.

13. A 72-year-old patient has a history of hypertension and chronic lung disease. An important question for the nurse to include in the health history would be:

- a. Do you use a fluoride supplement?
- b. Have you had tonsillitis in the last year?
- c. At what age did you get your first tooth?
- d. Have you noticed any dryness in your mouth?

ANS: D

Xerostomia (dry mouth) is a side effect of many drugs taken by older people, including antidepressants, anticholinergics, antispasmodics, antihypertensives, antipsychotics, and

bronchodilators.

14. The nurse is using an otoscope to assess the nasal cavity. Which of these techniques is *correct*?

- a. Inserting the speculum at least 3 cm into the vestibule
- b. Avoiding touching the nasal septum with the speculum
- c. Gently displacing the nose to the side that is being examined
- d. Keeping the speculum tip medial to avoid touching the floor of the nares

ANS: B

The correct technique for using an otoscope is to insert the apparatus into the nasal vestibule, avoiding pressure on the sensitive nasal septum. The tip of the nose should be lifted up before inserting the speculum.

15. The nurse is performing an assessment on a 21-year-old patient and notices that his nasal mucosa appears pale, gray, and swollen. What would be the most appropriate question to ask the patient?

- a. Are you aware of having any allergies?
- b. Do you have an elevated temperature?
- c. Have you had any symptoms of a cold?
- d. Have you been having frequent nosebleeds?

ANS: A

With chronic allergies, the mucosa looks swollen, boggy, pale, and gray. Elevated body temperature, colds, and nosebleeds do not cause these mucosal changes.

16. The nurse is palpating the sinus areas. If the findings are normal, then the patient should report which sensation?

- a. No sensation
- b. Firm pressure
- c. Pain during palpation
- d. Pain sensation behind eyes

ANS: B

The person should feel firm pressure but no pain. Sinus areas are tender to palpation in persons with chronic allergies or an acute infection (sinusitis).

17. During an oral assessment of a 30-year-old Black patient, the nurse notices bluish lips and a dark line along the gingival margin. What action would the nurse perform in response to this finding?

- a. Check the patient's hemoglobin for anemia.
- b. Assess for other signs of insufficient oxygen supply.
- c. Proceed with the assessment, knowing that this appearance is a normal finding.
- d. Ask if he has been exposed to an excessive amount of carbon monoxide.

ANS: C

Some Blacks may have bluish lips and a dark line on the gingival margin; this appearance is a normal finding.

18. During an assessment of a 20-year-old patient with a 3-day history of nausea and vomiting, the nurse notices dry mucosa and deep vertical fissures in the tongue. These findings are reflective of:

- a. Dehydration.
- b. Irritation by gastric juices.

- c. A normal oral assessment.
- d. Side effects from nausea medication.

ANS: A

Dry mouth occurs with dehydration or fever. The tongue has deep vertical fissures.

19. A 32-year-old woman is at the clinic for little white bumps in my mouth. During the assessment, the nurse notes that she has a 0.5 cm white, nontender papule under her tongue and one on the mucosa of her right cheek. What would the nurse tell the patient?

- a. These spots indicate an infection such as strep throat.
- b. These bumps could be indicative of a serious lesion, so I will refer you to a specialist.
- c. This condition is called leukoplakia and can be caused by chronic irritation such as with smoking.
- d. These bumps are Fordyce granules, which are sebaceous cysts and are not a serious condition.

ANS: D

Fordyce granules are small, isolated white or yellow papules on the mucosa of the cheek, tongue, and lips. These little sebaceous cysts are painless and are not significant. Chalky, white raised patches would indicate leukoplakia. In strep throat, the examiner would see tonsils that are bright red, swollen, and may have exudates or white spots.

20. A 10 year old is at the clinic for a sore throat that has lasted 6 days. Which of these findings would be consistent with an acute infection?

- a. Tonsils 1+/1-4+ and pink; the same color as the oral mucosa
- b. Tonsils 2+/1-4+ with small plugs of white debris
- c. Tonsils 3+/1-4+ with large white spots
- d. Tonsils 3+/1-4+ with pale coloring

ANS: C

With an acute infection, tonsils are bright red and swollen and may have exudate or large white spots. Tonsils are enlarged to 2+, 3+, or 4+ with an acute infection.

21. Immediately after birth, the nurse is unable to suction the nares of a newborn. An attempt is made to pass a catheter through both nasal cavities with no success. What should the nurse do next?

- a. Attempt to suction again with a bulb syringe.
- b. Wait a few minutes, and try again once the infant stops crying.
- c. Recognize that this situation requires immediate intervention.
- d. Contact the physician to schedule an appointment for the infant at his or her next hospital visit.

ANS: C

Determining the patency of the nares in the immediate newborn period is essential because most newborns are obligate nose breathers. Nares blocked with amniotic fluid are gently suctioned with a bulb syringe. If obstruction is suspected, then a small lumen (5 to 10 Fr) catheter is passed down each naris to confirm patency. The inability to pass a catheter through the nasal cavity indicates choanal atresia, which requires immediate intervention.

22. The nurse notices that the mother of a 2-year-old boy brings him into the clinic quite frequently for various injuries and suspects there may be some child abuse involved. During an inspection of his mouth, the nurse should look for:

- a. Swollen, red tonsils.
- b. Ulcerations on the hard palate.
- c. Bruising on the buccal mucosa or gums.

d. Small yellow papules along the hard palate.

ANS: C

The nurse should notice any bruising or laceration on the buccal mucosa or gums of an infant or young child. Trauma may indicate child abuse from a forced feeding of a bottle or spoon.

23. The nurse is assessing a 3 year old for drainage from the nose. On assessment, a purulent drainage that has a very foul odor is noted from the left naris and no drainage is observed from the right naris. The child is afebrile with no other symptoms. What should the nurse do next?

- a. Refer to the physician for an antibiotic order.
- b. Have the mother bring the child back in 1 week.
- c. Perform an otoscopic examination of the left nares.
- d. Tell the mother that this drainage is normal for a child of this age.

ANS: C

Children are prone to put an object up the nose, producing unilateral purulent drainage with a foul odor. Because some risk for aspiration exists, removal should be prompt.

24. During an assessment of a 26 year old at the clinic for a spot on my lip I think is cancer, the nurse notices a group of clear vesicles with an erythematous base around them located at the lipskin

border. The patient mentions that she just returned from Hawaii. What would be the most appropriate response by the nurse?

- a. Tell the patient she needs to see a skin specialist.
- b. Discuss the benefits of having a biopsy performed on any unusual lesion.
- c.

Tell the patient that these vesicles are indicative of herpes simplex I or cold sores and that they will heal

4 to 10 days.

- d. Tell the patient that these vesicles are most likely the result of a riboflavin deficiency and discuss nutrition

ANS: C

Cold sores are groups of clear vesicles with a surrounding erythematous base. These evolve into pustules or crusts and heal in 4 to 10 days. The most likely site is the lip-skin junction. Infection often recurs in the same site. Recurrent herpes infections may be precipitated by sunlight, fever, colds, or allergy.

25. While performing an assessment of the mouth, the nurse notices that the patient has a 1-cm ulceration that is crusted with an elevated border and located on the outer third of the lower lip. What other information would be most important for the nurse to assess?

- a. Nutritional status
- b. When the patient first noticed the lesion
- c. Whether the patient has had a recent cold
- d. Whether the patient has had any recent exposure to sick animals

ANS: B

With carcinoma, the initial lesion is round and indurated, but then it becomes crusted and ulcerated with an elevated border. Most cancers occur between the outer and middle thirds of the lip. Any lesion that is still unhealed after 2 weeks should be referred.

26. A pregnant woman states that she is concerned about her gums because she has noticed they are swollen and have started bleeding. What would be an appropriate response by the nurse?

- a. Your condition is probably due to a vitamin C deficiency.
- b. I'm not sure what causes swollen and bleeding gums, but let me know if it's not better in a few weeks.
- c. You need to make an appointment with your dentist as soon as possible to have this checked.
- d.

Swollen and bleeding gums can be caused by the change in hormonal balance in your system during pregnancy.

ANS: D

Gum margins are red and swollen and easily bleed with gingivitis. A changing hormonal balance may cause this condition to occur in pregnancy and puberty.

27. A 40-year-old patient who has just finished chemotherapy for breast cancer tells the nurse that she is concerned about her mouth. During the assessment the nurse finds areas of buccal mucosa that are raw and red with some bleeding, as well as other areas that have a white, cheesy coating. The nurse recognizes that this abnormality is:

- a. Aphthous ulcers.
- b. Candidiasis.
- c. Leukoplakia.
- d. Koplik spots.

ANS: B

Candidiasis is a white, cheesy, curdlike patch on the buccal mucosa and tongue. It scrapes off, leaving a raw, red surface that easily bleeds. It also occurs after the use of antibiotics or corticosteroids and in persons who are immunosuppressed.

28. The nurse is assessing a patient in the hospital who has received numerous antibiotics and notices that his tongue appears to be black and hairy. In response to his concern, what would the nurse say?

- a. We will need to get a biopsy to determine the cause.
- b. This is an overgrowth of hair and will go away in a few days.
- c. Black, hairy tongue is a fungal infection caused by all the antibiotics you have received.
- d. This is probably caused by the same bacteria you had in your lungs.

ANS: C

A black, hairy tongue is not really hair but the elongation of filiform papillae and painless overgrowth of mycelial threads of fungus infection on the tongue. It occurs after the use of antibiotics, which inhibit normal bacteria and allow a proliferation of fungus.

29. The nurse is assessing a patient with a history of intravenous drug abuse. In assessing his mouth, the nurse notices a dark red confluent macule on the hard palate. This could be an early sign of:

- a. Acquired immunodeficiency syndrome (AIDS).
- b. Measles.
- c. Leukemia.
- d. Carcinoma.

ANS: A

Oral Kaposi sarcoma is a bruise-like, dark red or violet, confluent macule that usually occurs on the hard palate. It may appear on the soft palate or gingival margin. Oral lesions may be among the earliest lesions to develop with AIDS.

30. A mother brings her 4-month-old infant to the clinic with concerns regarding a small pad in the middle of the upper lip that has been there since 1 month of age. The infant has no health problems. On physical examination, the nurse notices a 0.5-cm, fleshy, elevated area in the middle of the upper lip. No evidence of inflammation or drainage is observed. What would the nurse tell this mother?

- a. This area of irritation is caused from teething and is nothing to worry about.
- b. This finding is abnormal and should be evaluated by another health care provider.
- c. This area of irritation is the result of chronic drooling and should resolve within the next month or two.
- d.

This elevated area is a sucking tubercle caused from the friction of breastfeeding or bottle-feeding and is normal.

ANS: D

A normal finding in infants is the sucking tubercle, a small pad in the middle of the upper lip from the friction of breastfeeding or bottle-feeding. This condition is not caused by irritation, teething, or excessive drooling, and evaluation by another health care provider is not warranted.

31. A mother is concerned because her 18-month-old toddler has 12 teeth. She is wondering if this is normal for a child of this age. The nurses best response would be:

- a. How many teeth did you have at this age?
- b. All 20 deciduous teeth are expected to erupt by age 4 years.
- c. This is a normal number of teeth for an 18 month old.
- d. Normally, by age 2 years, 16 deciduous teeth are expected.

ANS: C

The guidelines for the number of teeth for children younger than 2 years old are as follows: the child's age in months minus the number 6 should be equal to the expected number of deciduous teeth. Normally, all 20 teeth are in by 2 years old. In this instance, the child is 18 months old, minus 6, equals 12 deciduous teeth expected.

32. When examining the mouth of an older patient, the nurse recognizes which finding is due to the aging process?

- a. Teeth appearing shorter
- b. Tongue that looks smoother in appearance
- c. Buccal mucosa that is beefy red in appearance
- d. Small, painless lump on the dorsum of the tongue

ANS: B

In the aging adult, the tongue looks smoother because of papillary atrophy. The teeth are slightly yellowed and appear longer because of the recession of gingival margins.

33. When examining the nares of a 45-year-old patient who has complaints of rhinorrhea, itching of the nose and eyes, and sneezing, the nurse notices the following: pale turbinates, swelling of the turbinates, and clear rhinorrhea. Which of these conditions is most likely the cause?

- a. Nasal polyps
- b. Acute sinusitis
- c. Allergic rhinitis
- d. Acute rhinitis

ANS: C

Rhinorrhea, itching of the nose and eyes, and sneezing are present with allergic rhinitis. On physical examination, serous edema is noted, and the turbinates usually appear pale with a smooth, glistening surface.

34. When assessing the tongue of an adult, the nurse knows that an abnormal finding would be:

- a. Smooth glossy dorsal surface.
- b. Thin white coating over the tongue.
- c. Raised papillae on the dorsal surface.
- d. Visible venous patterns on the ventral surface.

ANS: A

The dorsal surface of the tongue is normally roughened from papillae. A thin white coating may be present. The ventral surface may show veins. Smooth, glossy areas may indicate atrophic glossitis

35. The nurse is performing an assessment. Which of these findings would cause the greatest concern?

- a. Painful vesicle inside the cheek for 2 days
- b. Presence of moist, nontender Stensen's ducts
- c. Stippled gingival margins that snugly adhere to the teeth
- d. Ulceration on the side of the tongue with rolled edges

ANS: D

Ulceration on the side or base of the tongue or under the tongue raises the suspicion of cancer and must be investigated. The risk of early metastasis is present because of rich lymphatic drainage. The vesicle may be an aphthous ulcer, which is painful but not dangerous. The other responses are normal findings.

36. A patient has been diagnosed with strep throat. The nurse is aware that without treatment, which complication may occur?

- a. Rubella
- b. Leukoplakia
- c. Rheumatic fever
- d. Scarlet fever

ANS: C

Untreated strep throat may lead to rheumatic fever. When performing a health history, the patient should be asked whether his or her sore throat has been documented as streptococcal.

37. During a checkup, a 22-year-old woman tells the nurse that she uses an over-the-counter nasal spray because of her allergies. She also states that it does not work as well as it used to when she first started using it. The best response by the nurse would be:

- a. You should never use over-the-counter nasal sprays because of the risk of addiction.
- b. You should try switching to another brand of medication to prevent this problem.
- c. Continuing to use this spray is important to keep your allergies under control.
- d. Using these nasal medications irritates the lining of the nose and may cause rebound swelling.

ANS: D

The misuse of over-the-counter nasal medications irritates the mucosa, causing rebound swelling, which is a common problem.

38. During an oral examination of a 4-year-old Native-American child, the nurse notices that her uvula is partially split. Which of these statements is accurate?

- a. This condition is a cleft palate and is common in Native Americans.

- b. A bifid uvula may occur in some Native-American groups.
- c. This condition is due to an injury and should be reported to the authorities.
- d. A bifid uvula is palatinus, which frequently occurs in Native Americans.

ANS: B

Bifid uvula, a condition in which the uvula is split either completely or partially, occurs in some Native-American groups.

39. A patient comes into the clinic complaining of facial pain, fever, and malaise. On examination, the nurse notes swollen turbinates and purulent discharge from the nose. The patient also complains of a dull, throbbing pain in his cheeks and teeth on the right side and pain when the nurse palpates the areas. The nurse recognizes that this patient has:

- a. Posterior epistaxis.
- b. Frontal sinusitis.
- c. Maxillary sinusitis.
- d. Nasal polyps.

ANS: C

Signs of maxillary sinusitis include facial pain after upper respiratory infection, red swollen nasal mucosa, swollen turbinates, and purulent discharge. The person also has fever, chills, and malaise. With maxillary sinusitis, dull throbbing pain occurs in the cheeks and teeth on the same side, and pain with palpation is present. With frontal sinusitis, pain is above the supraorbital ridge.

40. 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 patient's 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.

MULTIPLE RESPONSE

1. The nurse is teaching a health class to high-school boys. When discussing the topic of using smokeless tobacco (SLT), which of these statements are accurate? *Select all that apply.*

- a. One pinch of SLT in the mouth for 30 minutes delivers the equivalent of one cigarette.
- b. Using SLT has been associated with a greater risk of oral cancer than smoking.
- c. Pain is an early sign of oral cancer.
- d. Pain is rarely an early sign of oral cancer.
- e. Tooth decay is another risk of SLT because of the use of sugar as a sweetener.
- f. SLT is considered a healthy alternative to smoking.

ANS: B, D, E

One pinch of SLT in the mouth for 30 minutes delivers the equivalent of three cigarettes. Pain is rarely an early sign of oral cancer. Many brands of SLT are sweetened with sugars, which promotes tooth decay. SLT is not considered a healthy alternative to smoking, and the use of SLT has been associated with a greater risk of oral cancer than smoking.

2. During an assessment, a patient mentions that I just can't smell like I used to. I can barely smell the roses in my garden. Why is that? For which possible causes of changes in the sense of smell

will the nurse assess? *Select all that apply.*

- a. Chronic alcohol use
- b. Cigarette smoking
- c. Frequent episodes of strep throat
- d. Chronic allergies
- e. Aging
- f. Herpes simplex virus I

ANS: B, D, E

Sen

The sense of smell diminishes with cigarette smoking, chronic allergies, and aging. Chronic alcohol use, a history of strep throat, and herpes simplex virus I are not associated with changes in the sense of smell.

Chapter 9 Respiratory Disorders

MULTIPLE CHOICE

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

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

ANS: A

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

2. When performing a respiratory assessment on a patient, the nurse notices a costal angle of approximately 90 degrees. This characteristic is:

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

ANS: C

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

3. When assessing a patient's lungs, the nurse recalls that the left lung:

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

ANS: A

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

4. Which statement about the apices of the lungs is *true*? The apices of the lungs:

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

ANS: B

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

5. During an examination of the anterior thorax, the nurse is aware that the trachea bifurcates anteriorly at the:

- a. Costal angle.
- b. Sternal angle.
- c. Xiphoid process.
- d. Suprasternal notch.

ANS: B

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

6. During an assessment, the nurse knows that expected assessment findings in the normal adult lung include the presence of:

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

ANS: C

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

7. The primary muscles of respiration include the:

- a. Diaphragm and intercostals.
- b. Sternomastoids and scaleni.
- c. Trapezii and rectus abdominis.
- d. External obliques and pectoralis major.

ANS: A

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

8. A 65-year-old patient with a history of heart failure comes to the clinic with complaints of being awakened from sleep with shortness of breath. Which action by the nurse is most appropriate?

- a. Obtaining a detailed health history of the patient's allergies and a history of asthma

- b. Telling the patient to sleep on his or her right side to facilitate ease of respirations
- c. Assessing for other signs and symptoms of paroxysmal nocturnal dyspnea
- d.

Assuring the patient that paroxysmal nocturnal dyspnea is normal and will probably resolve within the week

ANS: C

The patient is experiencing paroxysmal nocturnal dyspnea being awakened from sleep with shortness of breath and the need to be upright to achieve comfort.

9. When assessing tactile fremitus, the nurse recalls that it is normal to feel tactile fremitus most intensely over which location?

- a. Between the scapulae
- b. Third intercostal space, MCL
- c. Fifth intercostal space, midaxillary line (MAL)
- d. Over the lower lobes, posterior side

ANS: A

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

10. The nurse is reviewing the technique of palpating for tactile fremitus with a new graduate. Which statement by the graduate nurse reflects a *correct* understanding of tactile fremitus?

Tactile fremitus:

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

ANS: C

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

11. During percussion, the nurse knows that a dull percussion note elicited over a lung lobe most likely results from:

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

ANS: D

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

12. The nurse is observing the auscultation technique of another nurse. The correct method to use when progressing from one auscultatory site on the thorax to another is _____ comparison.

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

ANS: A

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

13. When auscultating the lungs of an adult patient, the nurse notes that low-pitched, soft breath sounds are heard over the posterior lower lobes, with inspiration being longer than expiration.

The nurse interprets that these sounds are:

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

ANS: C

Vesicular breath sounds are low-pitched, soft sounds with inspiration being longer than expiration. These breath sounds are expected over the peripheral lung fields where air flows through smaller bronchioles and alveoli.

14. The nurse is auscultating the chest in an adult. Which technique is *correct*?

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

ANS: C

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

15. The nurse is percussing over the lungs of a patient with pneumonia. The nurse knows that percussion over an area of atelectasis in the lungs will reveal:

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

ANS: A

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

16. During auscultation of the lungs, the nurse expects decreased breath sounds to be heard in which situation?

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

ANS: A

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

17. The nurse knows that a normal finding when assessing the respiratory system of an older adult is:

- a. Increased thoracic expansion.
- b. Decreased mobility of the thorax.
- c. Decreased anteroposterior diameter.

d. Bronchovesicular breath sounds throughout the lungs.

ANS: B

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

18. A mother brings her 3-month-old infant to the clinic for evaluation of a cold. She tells the nurse that he has had a runny nose for a week. When performing the physical assessment, the nurse notes that the child has nasal flaring and sternal and intercostal retractions. The nurses next action should be to:

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

ANS: B

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

19. When assessing the respiratory system of a 4-year-old child, which of these findings would the nurse expect?

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

ANS: C

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

20. When inspecting the anterior chest of an adult, the nurse should include which assessment?

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

ANS: D

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

21. The nurse knows that auscultation of fine crackles would most likely be noticed in:

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

ANS: C

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

22. During an assessment of an adult, the nurse has noted unequal chest expansion and recognizes that this occurs in which situation?

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

ANS: B

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

23. During auscultation of the lungs of an adult patient, the nurse notices the presence of bronchophony. The nurse should assess for signs of which condition?

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

ANS: C

Pathologic conditions that increase lung density, such as pulmonary consolidation, will enhance the transmission of voice sounds, such as

24. The nurse is reviewing the characteristics of breath sounds. Which statement about bronchovesicular breath sounds is *true*? Bronchovesicular breath sounds are:

- a. Musical in quality.
- b. Usually caused by a pathologic disease.
- c. Expected near the major airways.
- d. Similar to bronchial sounds except shorter in duration.

ANS: C

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

25. The nurse is listening to the breath sounds of a patient with severe asthma. Air passing through narrowed bronchioles would produce which of these adventitious sounds?

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

ANS: A

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

emphysema.

26. A patient has a long history of chronic obstructive pulmonary disease (COPD). During the assessment, the nurse will most likely observe which of these?

- a. Unequal chest expansion
- b. Increased tactile fremitus
- c. Atrophied neck and trapezius muscles
- d. Anteroposterior-to-transverse diameter ratio of 1:1

ANS: D

An anteroposterior-to-transverse diameter ratio of 1:1 or *barrel chest* is observed in individuals with COPD because of hyperinflation of the lungs. The ribs are more horizontal, and the chest appears as if held in continuous inspiration. Neck muscles are hypertrophied from aiding in forced respiration. Chest expansion may be decreased but symmetric. Decreased tactile fremitus occurs from decreased transmission of vibrations.

27. A teenage patient comes to the emergency department with complaints of an inability to breathe and a sharp pain in the left side of his chest. The assessment findings include cyanosis, tachypnea, tracheal deviation to the right, decreased tactile fremitus on the left, hyperresonance on the left, and decreased breath sounds on the left. The nurse interprets that these assessment findings are consistent with:

- a. Bronchitis.
- b. Pneumothorax.
- c. Acute pneumonia.
- d. Asthmatic attack.

ANS: B

With a pneumothorax, free air in the pleural space causes partial or complete lung collapse. If the pneumothorax is large, then tachypnea and cyanosis are evident. Unequal chest expansion, decreased or absent tactile fremitus, tracheal deviation to the unaffected side, decreased chest expansion, hyperresonant percussion tones, and decreased or absent breath sounds are found with the presence of pneumothorax.

28. An adult patient with a history of allergies comes to the clinic complaining of wheezing and difficulty in breathing when working in his yard. The assessment findings include tachypnea, the use of accessory neck muscles, prolonged expiration, intercostal retractions, decreased breath sounds, and expiratory wheezes. The nurse interprets that these assessment findings are consistent with:

- a. Asthma.
- b. Atelectasis.
- c. Lobar pneumonia.
- d. Heart failure.

ANS: A

Asthma is allergic hypersensitivity to certain inhaled particles that produces inflammation and a reaction of bronchospasm, which increases airway resistance, especially during expiration. An increased respiratory rate, the use of accessory muscles, a retraction of the intercostal muscles, prolonged expiration, decreased breath sounds, and expiratory wheezing are all characteristics of asthma.

29. The nurse is assessing the lungs of an older adult. Which of these changes are normal in the respiratory system of the older adult?

- a. Severe dyspnea is experienced on exertion, resulting from changes in the lungs.
- b. Respiratory muscle strength increases to compensate for a decreased vital capacity.
- c. Decrease in small airway closure occurs, leading to problems with atelectasis.
- d. Lungs are less elastic and distensible, which decreases their ability to collapse and recoil.

ANS: D

In the aging adult, the lungs are less elastic and distensible, which decreases their ability to collapse and recoil. Vital capacity is decreased, and a loss of intra-alveolar septa occurs, causing less surface area for gas exchange. The lung bases become less ventilated, and the older person is at risk for dyspnea with exertion beyond his or her usual workload.

30. A woman in her 26th week of pregnancy states that she is not really short of breath but feels that she is aware of her breathing and the need to breathe. What is the nurses best reply?

- a. The diaphragm becomes fixed during pregnancy, making it difficult to take in a deep breath.
- b.

The increase in estrogen levels during pregnancy often causes a decrease in the diameter of the rib cage and makes it difficult to breathe.

c.

What you are experiencing is normal. Some women may interpret this as shortness of breath, but it is a normal finding and nothing is wrong.

d.

This increased awareness of the need to breathe is normal as the fetus grows because of the increased

oxygen demand on the mothers body, which results in an increased respiratory rate.

ANS: C

During pregnancy, the woman may develop an increased awareness of the need to breathe. Some women may interpret this as dyspnea, although structurally nothing is wrong. Increases in estrogen relax the chest cage ligaments, causing an increase in the transverse diameter. Although the growing fetus increases the oxygen demand on the mothers body, this increased demand is easily met by the increasing tidal volume (deeper breathing). Little change occurs in the respiratory rate.

31. A 35-year-old recent immigrant is being seen in the clinic for complaints of a cough that is associated with rust-colored sputum, low-grade afternoon fevers, and night sweats for the past 2 months. The nurses preliminary analysis, based on this history, is that this patient may be suffering from:

- a. Bronchitis.
- b. Pneumonia.
- c. Tuberculosis.
- d. Pulmonary edema.

ANS: C

Sputum is not diagnostic alone, but some conditions have characteristic sputum production.

Tuberculosis often produces rust-colored sputum in addition to other symptoms of night sweats and low-grade afternoon fevers.

32. A 70-year-old patient is being seen in the clinic for severe exacerbation of his heart failure.

Which of these findings is the nurse most likely to observe in this patient?

- a. Shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, and ankle edema
- b. Rasping cough, thick mucoid sputum, wheezing, and bronchitis

- c. Productive cough, dyspnea, weight loss, anorexia, and tuberculosis
- d. Fever, dry nonproductive cough, and diminished breath sounds

ANS: A

A person with heart failure often exhibits increased respiratory rate, shortness of breath on exertion, orthopnea, paroxysmal nocturnal dyspnea, nocturia, ankle edema, and pallor in lightskinned

individuals. A patient with rasping cough, thick mucoid sputum, and wheezing may have bronchitis. Productive cough, dyspnea, weight loss, and dyspnea indicate tuberculosis; fever, dry nonproductive cough, and diminished breath sounds may indicate *Pneumocystis jiroveci*.

33. A patient comes to the clinic complaining of a cough that is worse at night but not as bad during the day. The nurse recognizes that this cough may indicate:

- a. Pneumonia.
- b. Postnasal drip or sinusitis.
- c. Exposure to irritants at work.
- d. Chronic bronchial irritation from smoking.

ANS: B

A cough that primarily occurs at night may indicate postnasal drip or sinusitis. Exposure to irritants at work causes an afternoon or evening cough. Smokers experience early morning coughing. Coughing associated with acute illnesses such as pneumonia is continuous throughout the day.

34. During a morning assessment, the nurse notices that the patients sputum is frothy and pink. Which condition could this finding indicate?

- a. Croup
- b. Tuberculosis
- c. Viral infection
- d. Pulmonary edema

ANS: D

Sputum, alone, is not diagnostic, but some conditions have characteristic sputum production.

Pink, frothy sputum indicates pulmonary edema or it may be a side effect of sympathomimetic medications. Croup is associated with *abarking* cough, not sputum production. Tuberculosis may produce rust-colored sputum. Viral infections may produce white or clear mucoid sputum.

35. During auscultation of breath sounds, the nurse should correctly use the stethoscope in which of the following ways?

- a. Listening to at least one full respiration in each location
- b. Listening as the patient inhales and then going to the next site during exhalation
- c. Instructing the patient to breathe in and out rapidly while listening to the breath sounds
- d. If the patient is modest, listening to sounds over his or her clothing or hospital gown

ANS: A

During auscultation of breath sounds with a stethoscope, listening to one full respiration in each location is important. During the examination, the nurse should monitor the breathing and offer times for the person to breathe normally to prevent possible dizziness.

36. A patient has been admitted to the emergency department with a possible medical diagnosis of pulmonary embolism. The nurse expects to see which assessment findings related to this condition?

- a. Absent or decreased breath sounds

- b. Productive cough with thin, frothy sputum
- c. Chest pain that is worse on deep inspiration and dyspnea
- d. Diffuse infiltrates with areas of dullness upon percussion

ANS: C

Findings for pulmonary embolism include chest pain that is worse on deep inspiration, dyspnea, apprehension, anxiety, restlessness, partial arterial pressure of oxygen (PaO₂) less than 80 mm Hg, diaphoresis, hypotension, crackles, and wheezes.

37. During palpation of the anterior chest wall, the nurse notices a coarse, crackling sensation over the skin surface. On the basis of these findings, the nurse suspects:

- a. Tactile fremitus.
- b. Crepitus.
- c. Friction rub.
- d. Adventitious sounds.

ANS: B

Crepitus is a coarse, crackling sensation palpable over the skin surface. It occurs in subcutaneous emphysema when air escapes from the lung and enters the subcutaneous tissue, such as after open thoracic injury or surgery.

38. The nurse is auscultating the lungs of a patient who had been sleeping and notices short, popping, crackling sounds that stop after a few breaths. The nurse recognizes that these breath sounds are:

- a. Atelectatic crackles that do not have a pathologic cause.
- b. Fine crackles and may be a sign of pneumonia.
- c. Vesicular breath sounds.
- d. Fine wheezes.

ANS: A

One type of adventitious sound, atelectatic crackles, does not have a pathologic cause. They are short, popping, crackling sounds that sound similar to fine crackles but do not last beyond a few breaths. When sections of alveoli are not fully aerated (as in people who are asleep or in older adults), they deflate slightly and accumulate secretions. Crackles are heard when these sections are expanded by a few deep breaths. Atelectatic crackles are heard only in the periphery, usually in dependent portions of the lungs, and disappear after the first few breaths or after a cough.

39. A patient has been admitted to the emergency department for a suspected drug overdose. His respirations are shallow, with an irregular pattern, with a rate of 12 respirations per minute. The nurse interprets this respiration pattern as which of the following?

- a. Bradypnea
- b. Cheyne-Stokes respirations
- c. Hypoventilation
- d. Chronic obstructive breathing

ANS: C

Hypoventilation is characterized by an irregular, shallow pattern, and can be caused by an overdose of narcotics or anesthetics. Bradypnea is slow breathing, with a rate less than 10 respirations per minute.

40. A patient with pleuritis has been admitted to the hospital and complains of pain with breathing. What other key assessment finding would the nurse expect to find upon auscultation?

- a. Stridor

- b. Friction rub
- c. Crackles
- d. Wheezing

ANS: B

A patient with pleuritis will exhibit a pleural friction rub upon auscultation. This sound is made when the pleurae become inflamed and rub together during respiration. The sound is superficial, coarse, and low-pitched, as if two pieces of leather are being rubbed together. Stridor is associated with croup, acute epiglottitis in children, and foreign body inhalation. Crackles are associated with pneumonia, heart failure, chronic bronchitis, and other diseases. Wheezes are associated with diffuse airway obstruction caused by acute asthma or chronic emphysema.

MULTIPLE RESPONSE

1. 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 10 Cardiovascular Disorders

MULTIPLE CHOICE

MULTIPLE RESPONSE

1. 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 10 Cardiovascular Disorders

MULTIPLE CHOICE

1. The sac that surrounds and protects the heart is called the:

- a. Pericardium.
- b. Myocardium.
- c. Endocardium.
- d. Pleural space.

ANS: A

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

2. The direction of blood flow through the heart is best described by which of these?

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

ANS: B

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

3. The nurse is reviewing the anatomy and physiologic functioning of the heart. Which statement best describes what is meant by *atrial kick*?

- a. The atria contract during systole and attempt to push against closed valves.
- b. Contraction of the atria at the beginning of diastole can be felt as a palpitation.

- c. Atrial kick is the pressure exerted against the atria as the ventricles contract during systole.
- d. The atria contract toward the end of diastole and push the remaining blood into the ventricles.

ANS: D

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

4. When listening to heart sounds, the nurse knows the valve closures that can be heard best at the base of the heart are:
- a. Mitral and tricuspid.
 - b. Tricuspid and aortic.
 - c. Aortic and pulmonic.
 - d. Mitral and pulmonic.

ANS: C

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

5. Which of these statements describes the closure of the valves in a normal cardiac cycle?
- a. The aortic valve closes slightly before the tricuspid valve.
 - b. The pulmonic valve closes slightly before the aortic valve.
 - c. The tricuspid valve closes slightly later than the mitral valve.
 - d. Both the tricuspid and pulmonic valves close at the same time.

ANS: C

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

6. The component of the conduction system referred to as *the pacemaker of the heart* is the:
- a. Atrioventricular (AV) node.
 - b. Sinoatrial (SA) node.
 - c. Bundle of His.
 - d. Bundle branches.

ANS: B

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

7. The electrical stimulus of the cardiac cycle follows which sequence?

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

ANS: D

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

8. The findings from an assessment of a 70-year-old patient with swelling in his ankles include jugular venous pulsations 5 cm above the sternal angle when the head of his bed is elevated 45 degrees. The nurse knows that this finding indicates:

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

ANS: D

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

9. When assessing a newborn infant who is 5 minutes old, the nurse knows which of these statements to be *true*?

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

ANS: C

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

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

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

This decline in blood pressure means a decrease in circulating blood volume, which is dangerous for the fetus.

ANS: A

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

11. In assessing a 70-year-old man, the nurse finds the following: blood pressure 140/100 mm Hg; heart rate 104 beats per minute and slightly irregular; and the split S2 heart sound. Which of these findings can be explained by expected hemodynamic changes related to age?

- a. Increase in resting heart rate

- b. Increase in systolic blood pressure
- c. Decrease in diastolic blood pressure
- d. Increase in diastolic blood pressure

ANS: B

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

12. A 45-year-old man is in the clinic for a routine physical examination. During the recording of his health history, the patient states that he has been having difficulty sleeping. Ill be sleeping great, and then I wake up and feel like I cant get my breath. The nurses best response to this would be:

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

ANS: C

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

13. In assessing a patients major risk factors for heart disease, which would the nurse want to include when taking a history?

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

ANS: C

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

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

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

ANS: D

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

15. In assessing the carotid arteries of an older patient with cardiovascular disease, the nurse would:

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

ANS: B

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

Palpating only one carotid artery at a time will avoid compromising arterial blood to the brain.

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

16. During an assessment of a 68-year-old man with a recent onset of right-sided weakness, the nurse hears a blowing, swishing sound with the bell of the stethoscope over the left carotid artery. This finding would indicate:

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

ANS: B

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

17. During an inspection of the precordium of an adult patient, the nurse notices the chest moving in a forceful manner along the sternal border. This finding most likely suggests a(n):

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

ANS: D

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

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

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

ANS: D

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

19. The nurse is examining a patient who has possible cardiac enlargement. Which statement about percussion of the heart is *true*?

- a. Percussion is a useful tool for outlining the heart's borders.

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

ANS: C

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

20. The nurse is preparing to auscultate for heart sounds. Which technique is *correct*?

- a. Listening to the sounds at the aortic, tricuspid, pulmonic, and mitral areas
- b.

Listening by inching the stethoscope in a rough Z pattern, from the base of the heart across and down, th

over to the apex

- c. Listening to the sounds only at the site where the apical pulse is felt to be the strongest
- d. Listening for all possible sounds at a time at each specified area

ANS: B

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

21. While counting the apical pulse on a 16-year-old patient, the nurse notices an irregular rhythm. His rate speeds up on inspiration and slows on expiration. What would be the nurses response?

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

ANS: C

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

22. When listening to heart sounds, the nurse knows that the S1:

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

ANS: C

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

23. During the cardiac auscultation, the nurse hears a sound immediately occurring after the S2 at the second left intercostal space. To further assess this sound, what should the nurse do?

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

ANS: D

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

24. Which of these findings would the nurse expect to notice during a cardiac assessment on a 4-year-old child?

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

ANS: C

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

25. While auscultating heart sounds on a 7-year-old child for a routine physical examination, the nurse hears an S3, a soft murmur at the left midsternal border, and a venous hum when the child is standing. What would be a correct interpretation of these findings?

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

ANS: B

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

26. During the precordial assessment on an patient who is 8 months pregnant, the nurse palpates the apical impulse at the fourth left intercostal space lateral to the midclavicular line. This finding would indicate:

- a. Right ventricular hypertrophy.
- b. Increased volume and size of the heart as a result of pregnancy.
- c. Displacement of the heart from elevation of the diaphragm.
- d. Increased blood flow through the internal mammary artery.

ANS: C

Palpation of the apical impulse is higher and more lateral, compared with the normal position, because the enlarging uterus elevates the diaphragm and displaces the heart up and to the left and rotates it on its long axis.

27. In assessing for an S4 heart sound with a stethoscope, the nurse would listen with the:

- a. Bell of the stethoscope at the base with the patient leaning forward.
- b. Bell of the stethoscope at the apex with the patient in the left lateral position.
- c. Diaphragm of the stethoscope in the aortic area with the patient sitting.
- d. Diaphragm of the stethoscope in the pulmonic area with the patient supine.

ANS: B

The S4 is a ventricular filling sound that occurs when the atria contract late in diastole and is heard immediately before the S1. The S4 is a very soft sound with a very low pitch. The nurse needs a good bell and must listen for this sound. An S4 is heard best at the apex, with the person in the left lateral position.

28. A 70-year-old patient with a history of hypertension has a blood pressure of 180/100 mm Hg and a heart rate of 90 beats per minute. The nurse hears an extra heart sound at the apex immediately before the S1. The sound is heard only with the bell of the stethoscope while the patient is in the left lateral position. With these findings and the patient's history, the nurse knows that this extra heart sound is most likely a(n):

- a. Split S1.
- b. Atrial gallop.
- c. Diastolic murmur.
- d. Summation sound.

ANS: B

A pathologic S4 is termed an *atrial gallop* or an *S4 gallop*. It occurs with decreased compliance of the ventricle and with systolic overload (afterload), including outflow obstruction to the ventricle (aortic stenosis) and systemic hypertension. A left-sided S4 occurs with these conditions and is heard best at the apex with the patient in the left lateral position.

29. The nurse is performing a cardiac assessment on a 65-year-old patient 3 days after her myocardial infarction (MI). Heart sounds are normal when she is supine, but when she is sitting and leaning forward, the nurse hears a high-pitched, scratchy sound with the diaphragm of the stethoscope at the apex. It disappears on inspiration. The nurse suspects:

- a. Increased cardiac output.
- b. Another MI.
- c. Inflammation of the precordium.
- d. Ventricular hypertrophy resulting from muscle damage.

ANS: C

Inflammation of the precordium gives rise to a friction rub. The sound is high pitched and scratchy, similar to sandpaper being rubbed. A friction rub is best heard with the diaphragm of the stethoscope, with the person sitting up and leaning forward, and with the breath held in expiration. A friction rub can be heard any place on the precordium. Usually, however, the sound is best heard at the apex and left lower sternal border, which are places where the pericardium comes in close contact with the chest wall.

30. The mother of a 10-month-old infant tells the nurse that she has noticed that her son becomes blue when he is crying and that the frequency of this is increasing. He is also not crawling yet. During the examination the nurse palpates a thrill at the left lower sternal border and auscultates a loud systolic murmur in the same area. What would be the most likely cause of these findings?

- a. Tetralogy of Fallot
- b. Atrial septal defect
- c. Patent ductus arteriosus

d. Ventricular septal defect

ANS: A

The cause of these findings is tetralogy of Fallot. Its *subjective* findings include: (1) severe cyanosis, not in the first months of life but developing as the infant grows, and right ventricle outflow (i.e., pulmonic) stenosis that gets worse; (2) cyanosis with crying and exertion at first and then at rest; and (3) slowed development. Its *objective* findings include: (1) thrill palpable at the left lower sternal border; (2) the S1 is normal, the S2 has a loud A2, and the P2 is diminished or absent; and (3) the murmur is systolic, loud, and crescendo-decrescendo.

31. A 30-year-old woman with a history of mitral valve problems states that she has been very tired. She has started waking up at night and feels like her heart is pounding. During the assessment, the nurse palpates a thrill and lift at the fifth left intercostal space midclavicular line. In the same area, the nurse also auscultates a blowing, swishing sound right after the S1. These findings would be most consistent with:

- a. Heart failure.
- b. Aortic stenosis.
- c. Pulmonary edema.
- d. Mitral regurgitation.

ANS: D

These findings are consistent with mitral regurgitation. Its *subjective* findings include fatigue, palpitation, and orthopnea, and its *objective* findings are: (1) a thrill in systole at the apex; (2) a lift at the apex; (3) the apical impulse displaced down and to the left; (4) the S1 is diminished, the S2 is accentuated, and the S3 at the apex is often present; and (5) a pansystolic murmur that is often loud, blowing, best heard at the apex, and radiating well to the left axilla.

32. During a cardiac assessment on a 38-year-old patient in the hospital for chest pain, the nurse finds the following: jugular vein pulsations 4 cm above the sternal angle when the patient is elevated at 45 degrees, blood pressure 98/60 mm Hg, heart rate 130 beats per minute, ankle edema, difficulty breathing when supine, and an S3 on auscultation. Which of these conditions best explains the cause of these findings?

- a. Fluid overload
- b. Atrial septal defect
- c. MI
- d. Heart failure

ANS: D

Heart failure causes decreased cardiac output when the heart fails as a pump and the circulation becomes backed up and congested. Signs and symptoms include dyspnea, orthopnea, paroxysmal nocturnal dyspnea, decreased blood pressure, dependent and pitting edema; anxiety; confusion; jugular vein distention; and fatigue. The S3 is associated with heart failure and is always abnormal after 35 years of age. The S3 may be the earliest sign of heart failure.

33. The nurse knows that normal splitting of the S2 is associated with:

- a. Expiration.
- b. Inspiration.
- c. Exercise state.
- d. Low resting heart rate.

ANS: B

Normal or physiologic splitting of the S2 is associated with inspiration because of the increased

blood return to the right side of the heart, delaying closure of the pulmonic valve.

34. During a cardiovascular assessment, the nurse knows that a *thrill* is:

- a. Vibration that is palpable.
- b. Palpated in the right epigastric area.
- c. Associated with ventricular hypertrophy.
- d. Murmur auscultated at the third intercostal space.

ANS: A

A *thrill* is a palpable vibration that signifies turbulent blood flow and accompanies loud murmurs. The absence of a thrill does not rule out the presence of a murmur.

35. During a cardiovascular assessment, the nurse knows that an S4 heart sound is:

- a. Heard at the onset of atrial diastole.
- b. Usually a normal finding in the older adult.
- c. Heard at the end of ventricular diastole.
- d. Heard best over the second left intercostal space with the individual sitting upright.

ANS: C

An S4 heart sound is heard at the end of diastole when the atria contract (atrial systole) and when the ventricles are resistant to filling. The S4 occurs just before the S1.

36. During an assessment, the nurse notes that the patient's apical impulse is laterally displaced and is palpable over a wide area. This finding indicates:

- a. Systemic hypertension.
- b. Pulmonic hypertension.
- c. Pressure overload, as in aortic stenosis.
- d. Volume overload, as in *heart failure*.

ANS: D

With volume overload, as in heart failure and cardiomyopathy, cardiac enlargement laterally displaces the apical impulse and is palpable over a wider area when left ventricular hypertrophy and dilation are present.

37. When the nurse is auscultating the carotid artery for bruits, which of these statements reflects the correct technique?

- a. While listening with the bell of the stethoscope, the patient is asked to take a deep breath and hold it.
- b.

While auscultating one side with the bell of the stethoscope, the carotid artery is palpated on the other side to check pulsations.

- c.

While lightly applying the bell of the stethoscope over the carotid artery and listening, the patient is asked to take a breath, exhale, and briefly hold it.

- d.

While firmly placing the bell of the stethoscope over the carotid artery and listening, the patient is asked to take a breath, exhale, and briefly hold it.

ANS: C

The correct technique for auscultating the carotid artery for bruits involves the nurse lightly applying the bell of the stethoscope over the carotid artery at three levels. While listening, the nurse asks the patient to take a breath, exhale, and briefly hold it. Holding the breath on inhalation will also tense the levator scapulae muscles, which makes it hard to hear the carotid arteries.

Examining only one carotid artery at a time will avoid compromising arterial blood flow to the brain. Pressure over the carotid sinus, which may lead to decreased heart rate, decreased blood pressure, and cerebral ischemia with syncope, should be avoided.

38. The nurse is preparing for a class on risk factors for hypertension and reviews recent statistics. Which racial group has the highest prevalence of hypertension in the world?

- a. Blacks
- b. Whites
- c. American Indians
- d. Hispanics

ANS: A

According to the American Heart Association, the prevalence of hypertension is higher among Blacks than in other racial groups.

39. The nurse is assessing a patient with possible cardiomyopathy and assesses the hepatojugular reflux. If heart failure is present, then the nurse should recognize which finding while pushing on the right upper quadrant of the patient's abdomen, just below the rib cage?

- a. The jugular veins will rise for a few seconds and then recede back to the previous level if the heart is properly working.
- b. The jugular veins will remain elevated as long as pressure on the abdomen is maintained.
- c. An impulse will be visible at the fourth or fifth intercostal space at or inside the midclavicular line.
- d. The jugular veins will not be detected during this maneuver.

ANS: B .When performing hepatojugular reflux, the jugular veins will rise for a few seconds and then recede back to the previous level if the heart is able to pump the additional volume created by the pushing. However, with heart failure, the jugular veins remain elevated as long as pressure on the abdomen is maintained.

40. The nurse is assessing the apical pulse of a 3-month-old infant and finds that the heart rate is 135 beats per minute. The nurse interprets this result as:

- a. Normal for this age.
- b. Lower than expected.
- c. Higher than expected, probably as a result of crying.
- d. Higher than expected, reflecting persistent tachycardia.

ANS: A. The heart rate may range from 100 to 180 beats per minute immediately after birth and then stabilize to an average of 120 to 140 beats per minute. Infants normally have wide fluctuations with activity, from 170 beats per minute or more with crying or being active to 70 to 90 beats per minute with sleeping. Persistent tachycardia is greater than 200 beats per minute in newborns or greater than 150 beats per minute in infants.

MULTIPLE RESPONSE

1. The nurse is presenting a class on risk factors for cardiovascular disease. Which of these are considered modifiable risk factors for MI? *Select all that apply.*

- a. Ethnicity
- b. Abnormal lipids
- c. Smoking
- d. Gender

- e. Hypertension
- f. Diabetes
- g. Family history

ANS: B, C, E, F

Nine modifiable risk factors for MI, as identified by a recent study, include abnormal lipids, smoking, hypertension, diabetes, abdominal obesity, psychosocial factors, consumption of fruits and vegetables, alcohol use, and regular physical activity.

SHORT ANSWER

1. The nurse is assessing a patient's pulses and notices a difference between the patient's apical pulse and radial pulse. The apical pulse was 118 beats per minute, and the radial pulse was 105 beats per minute. What is the pulse deficit?

ANS: 13

The nurse should count a serial measurement (one after the other) of the apical pulse and then the

radial pulse. Normally, every beat heard at the apex should perfuse to the periphery and be palpable. The two counts should be identical. If they are different, then the nurse should subtract the radial rate from the apical pulse and record the remainder as the pulse deficit.

Chapter 11 Gastrointestinal Disorders

MULTIPLE CHOICE

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

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

ANS: A

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

2. Which structure is located in the left lower quadrant of the abdomen?

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

ANS: D

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

3. A patient is having difficulty swallowing medications and food. The nurse would document that this patient has:

- a. Aphasia.
- b. Dysphasia.
- c. Dysphagia.
- d. Anorexia.

ANS: C

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

4. The nurse suspects that a patient has a distended bladder. How should the nurse assess for this condition?

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

ANS: D

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

5. The nurse is aware that one change that may occur in the gastrointestinal system of an aging adult is:

- a. Increased salivation.
- b. Increased liver size.
- c. Increased esophageal emptying.
- d. Decreased gastric acid secretion.

ANS: D

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

6. A 22-year-old man comes to the clinic for an examination after falling off his motorcycle and landing on his left side on the handle bars. The nurse suspects that he may have injured his spleen. Which of these statements is *true* regarding assessment of the spleen in this situation?

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

ANS: D

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

7. A patient's abdomen is bulging and stretched in appearance. The nurse should describe this finding as:

- a. Obese.
- b. Herniated.
- c. Scaphoid.
- d. Protuberant.

ANS: D

A protuberant abdomen is rounded, bulging, and stretched (see Figure 21-7). A scaphoid abdomen caves inward.

8. The nurse is describing a scaphoid abdomen. To the horizontal plane, a scaphoid contour of the abdomen depicts a _____ profile.

- a. Flat
- b. Convex
- c. Bulging
- d. Concave

ANS: D

Contour describes the profile of the abdomen from the rib margin to the pubic bone; a scaphoid contour is one that is concave from a horizontal plane (see Figure 21-7).

9. While examining a patient, the nurse observes abdominal pulsations between the xiphoid

process and umbilicus. The nurse would suspect that these are:

- a. Pulsations of the renal arteries.
- b. Pulsations of the inferior vena cava.
- c. Normal abdominal aortic pulsations.
- d. Increased peristalsis from a bowel obstruction.

ANS: C

Normally, the pulsations from the aorta are observed beneath the skin in the epigastric area, particularly in thin persons who have good muscle wall relaxation.

10. A patient has hypoactive bowel sounds. The nurse knows that a potential cause of hypoactive bowel sounds is:

- a. Diarrhea.
- b. Peritonitis.
- c. Laxative use.
- d. Gastroenteritis.

ANS: B

Diminished or absent bowel sounds signal decreased motility from inflammation as exhibited with peritonitis, with paralytic ileus after abdominal surgery, or with late bowel obstruction.

11. The nurse is watching a new graduate nurse perform auscultation of a patient's abdomen. Which statement by the new graduate shows a *correct* understanding of the reason auscultation precedes percussion and palpation of the abdomen?

- a. We need to determine the areas of tenderness before using percussion and palpation.
- b. Auscultation prevents distortion of bowel sounds that might occur after percussion and palpation.
- c.

Auscultation allows the patient more time to relax and therefore be more comfortable with the physical examination.

d.

Auscultation prevents distortion of vascular sounds, such as bruits and hums, that might occur after percussion and palpation.

ANS: B

Auscultation is performed first (after inspection) because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

12. The nurse is listening to bowel sounds. Which of these statements is *true* of bowel sounds? Bowel sounds:

- a. Are usually loud, high-pitched, rushing, and tinkling sounds.
- b. Are usually high-pitched, gurgling, and irregular sounds.
- c. Sound like two pieces of leather being rubbed together.
- d. Originate from the movement of air and fluid through the large intestine.

ANS: B

Bowel sounds are high-pitched, gurgling, and cascading sounds that irregularly occur from 5 to 30 times per minute. They originate from the movement of air and fluid through the small intestine.

13. The physician comments that a patient has abdominal borborygmi. The nurse knows that this

term refers to:

- a. Loud continual hum.
- b. Peritoneal friction rub.
- c. Hypoactive bowel sounds.
- d. Hyperactive bowel sounds.

ANS: D

Borborygmi is the term used for hyperperistalsis when the person actually feels his or her stomach growling.

14. During an abdominal assessment, the nurse would consider which of these findings as normal?

- a. Presence of a bruit in the femoral area
- b. Tympanic percussion note in the umbilical region
- c. Palpable spleen between the ninth and eleventh ribs in the left midaxillary line
- d. Dull percussion note in the left upper quadrant at the midclavicular line

ANS: B

Tympany should predominate in all four quadrants of the abdomen because air in the intestines rises to the surface when the person is supine. Vascular bruits are not usually present. Normally, the spleen is not palpable. Dullness would not be found in the area of lung resonance (left upper quadrant at the midclavicular line).

15. The nurse is assessing the abdomen of a pregnant woman who is complaining of having acid indigestion all the time. The nurse knows that esophageal reflux during pregnancy can cause:

- a. Diarrhea.
- b. Pyrosis.
- c. Dysphagia.
- d. Constipation.

ANS: B

Pyrosis, or heartburn, is caused by esophageal reflux during pregnancy. The other options are not correct.

16. The nurse is performing percussion during an abdominal assessment. Percussion notes heard during the abdominal assessment may include:

- a. Flatness, resonance, and dullness.
- b. Resonance, dullness, and tympany.
- c. Tympany, hyperresonance, and dullness.
- d. Resonance, hyperresonance, and flatness.

ANS: C

Percussion notes normally heard during the abdominal assessment may include tympany, which should predominate because air in the intestines rises to the surface when the person is supine; hyperresonance, which may be present with gaseous distention; and dullness, which may be found over a distended bladder, adipose tissue, fluid, or a mass.

17. An older patient has been diagnosed with pernicious anemia. The nurse knows that this condition could be related to:

- a. Increased gastric acid secretion.
- b. Decreased gastric acid secretion.
- c. Delayed gastrointestinal emptying time.
- d. Increased gastrointestinal emptying time.

ANS: B

Gastric acid secretion decreases with aging and may cause pernicious anemia (because it interferes with vitamin B12 absorption), iron-deficiency anemia, and malabsorption of calcium.

18. A patient is complaining of a sharp pain along the costovertebral angles. The nurse is aware that this symptom is most often indicative of:

- a. Ovary infection.
- b. Liver enlargement.
- c. Kidney inflammation.
- d. Spleen enlargement.

ANS: C

Sharp pain along the costovertebral angles occurs with inflammation of the kidney or paranephric area. The other options are not correct.

19. A nurse notices that a patient has ascites, which indicates the presence of:

- a. Fluid.
- b. Feces.
- c. Flatus.
- d. Fibroid tumors.

ANS: A

Ascites is free fluid in the peritoneal cavity and occurs with heart failure, portal hypertension, cirrhosis, hepatitis, pancreatitis, and cancer.

20. The nurse knows that during an abdominal assessment, deep palpation is used to determine:

- a. Bowel motility.
- b. Enlarged organs.
- c. Superficial tenderness.
- d. Overall impression of skin surface and superficial musculature.

ANS: B

With deep palpation, the nurse should notice the location, size, consistency, and mobility of any palpable organs and the presence of any abnormal enlargement, tenderness, or masses.

21. The nurse notices that a patient has had a black, tarry stool and recalls that a possible cause would be:

- a. Gallbladder disease.
- b. Overuse of laxatives.
- c. Gastrointestinal bleeding.
- d. Localized bleeding around the anus.

ANS: C

Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding. Red blood in stools occurs with localized bleeding around the anus.

22. During an abdominal assessment, the nurse elicits tenderness on light palpation in the right lower quadrant. The nurse interprets that this finding could indicate a disorder of which of these structures?

- a. Spleen
- b. Sigmoid
- c. Appendix
- d. Gallbladder

ANS: C

The appendix is located in the right lower quadrant. When the iliopsoas muscle is inflamed, which occurs with an inflamed or perforated appendix, pain is felt in the right lower quadrant.

23. The nurse is assessing the abdomen of an older adult. Which statement regarding the older adult and abdominal assessment is *true*?

- a. Abdominal tone is increased.
- b. Abdominal musculature is thinner.
- c. Abdominal rigidity with an acute abdominal condition is more common.
- d. The older adult with an acute abdominal condition complains more about pain than the younger person.

ANS: B

In the older adult, the abdominal musculature is thinner and has less tone than that of the younger adult, and abdominal rigidity with an acute abdominal condition is less common in the aging person. The older adult with an acute abdominal condition often complains less about pain than the younger person.

24. During an assessment of a newborn infant, the nurse recalls that pyloric stenosis would be exhibited by:

- a. Projectile vomiting.
- b. Hypoactive bowel activity.
- c. Palpable olive-sized mass in the right lower quadrant.
- d. Pronounced peristaltic waves crossing from right to left.

ANS: A

Significant peristalsis, together with projectile vomiting, in the newborn suggests pyloric stenosis. After feeding, pronounced peristaltic waves cross from *left to right*, leading to projectile vomiting. One can also palpate an olive-sized mass in the right *upper* quadrant.

25. The nurse is reviewing the assessment of an aortic aneurysm. Which of these statements is *true* regarding an aortic aneurysm?

- a. A bruit is absent.
- b. Femoral pulses are increased.
- c. A pulsating mass is usually present.
- d. Most are located below the umbilicus.

ANS: C

Most aortic aneurysms are palpable during routine examination and feel like a pulsating mass. A bruit will be audible, and femoral pulses are present but decreased. Such aneurysms are located in the upper abdomen just to the left of midline.

26. During an abdominal assessment, the nurse is unable to hear bowel sounds in a patient's abdomen. Before reporting this finding as *silent bowel sounds*, the nurse should listen for at least:

- a. 1 minute.
- b. 5 minutes.
- c. 10 minutes.
- d. 2 minutes in each quadrant.

ANS: B

Absent bowel sounds are rare. The nurse must listen for 5 minutes before deciding that bowel sounds are completely absent.

27. A patient is suspected of having inflammation of the gallbladder, or cholecystitis. The nurse

should conduct which of these techniques to assess for this condition?

- a. Obturator test
- b. Test for Murphy sign
- c. Assess for rebound tenderness
- d. Iliopsoas muscle test

ANS: B

Normally, palpating the liver causes no pain. In a person with inflammation of the gallbladder, or cholecystitis, pain occurs as the descending liver pushes the inflamed gallbladder onto the examining hand during inspiration (Murphy test). The person feels sharp pain and abruptly stops midway during inspiration.

28. Just before going home, a new mother asks the nurse about the infant's umbilical cord. Which of these statements is *incorrect*?

- a. It should fall off in 10 to 14 days.
- b. It will soften before it falls off.
- c. It contains two veins and one artery.
- d. Skin will cover the area within 1 week.

ANS: A

At birth, the umbilical cord is white and contains two umbilical arteries and one vein inside the Wharton jelly. The umbilical stump dries within a week, hardens, and falls off in 10 to 14 days. Skin will cover the area in 3 to 4 weeks.

29. Which of these percussion findings would the nurse expect to find in a patient with a large amount of ascites?

- a. Dullness across the abdomen
- b. Flatness in the right upper quadrant
- c. Hyperresonance in the left upper quadrant
- d. Tympany in the right and left lower quadrants

ANS: A

A large amount of ascitic fluid produces a dull sound to percussion.

30. A 40-year-old man states that his physician told him that he has a hernia. He asks the nurse to explain what a hernia is. Which response by the nurse is appropriate?

- a. No need to worry. Most men your age develop hernias.
- b. A hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.
- c. A hernia is the result of prenatal growth abnormalities that are just now causing problems.
- d. I'll have to have your physician explain this to you.

ANS: B

The nurse should explain that a hernia is a protrusion of the abdominal viscera through an abnormal opening in the muscle wall.

31. A 45-year-old man is in the clinic for a physical examination. During the abdominal assessment, the nurse percusses the abdomen and notices an area of dullness above the right costal margin of approximately 11 cm. The nurse should:

- a. Document the presence of hepatomegaly.
- b. Ask additional health history questions regarding his alcohol intake.
- c. Describe this dullness as indicative of an enlarged liver, and refer him to a physician.
- d. Consider this finding as normal, and proceed with the examination.

ANS: D

A liver span of 10.5 cm is the mean for males and 7 cm for females. Men and taller individuals are at the upper end of this range. Women and shorter individuals are at the lower end of this range. A liver span of 11 cm is within normal limits for this individual.

32. When palpating the abdomen of a 20-year-old patient, the nurse notices the presence of tenderness in the left upper quadrant with deep palpation. Which of these structures is most likely to be involved?

- a. Spleen
- b. Sigmoid colon
- c. Appendix
- d. Gallbladder

ANS: A

The spleen is located in the left upper quadrant of the abdomen. The gallbladder is in the right upper quadrant, the sigmoid colon is in the left lower quadrant, and the appendix is in the right lower quadrant.

33. The nurse is reviewing statistics for lactose intolerance. In the United States, the incidence of lactose intolerance is higher in adults of which ethnic group?

- a. Blacks
- b. Hispanics
- c. Whites
- d. Asians

ANS: A

A recent study found estimates of lactose-intolerance prevalence as follows: 19.5% for Blacks, 10% for Hispanics, and 7.72% for Whites.

34. The nurse is assessing a patient for possible peptic ulcer disease. Which condition or history often causes this problem?

- a. Hypertension
- b. Streptococcal infections
- c. Recurrent constipation with frequent laxative use
- d. Frequent use of nonsteroidal antiinflammatory drugs

ANS: D

Peptic ulcer disease occurs with the frequent use of nonsteroidal antiinflammatory drugs, alcohol use, smoking, and *Helicobacter pylori* infection.

35. During reporting, the student nurse hears that a patient has *hepatomegaly* and recognizes that this term refers to:

- a. Enlarged liver.
- b. Enlarged spleen.
- c. Distended bowel.
- d. Excessive diarrhea.

ANS: A

The term *hepatomegaly* refers to an enlarged liver. The term *splenomegaly* refers to an enlarged spleen. The other responses are not correct.

36. During an assessment, the nurse notices that a patient's umbilicus is enlarged and everted. It is positioned midline with no change in skin color. The nurse recognizes that the patient may have which condition?

- a. Intra-abdominal bleeding

- b. Constipation
- c. Umbilical hernia
- d. Abdominal tumor

ANS: C

The umbilicus is normally midline and inverted with no signs of discoloration. With an umbilical hernia, the mass is enlarged and everted. The other responses are incorrect.

37. During an abdominal assessment, the nurse tests for a fluid wave. A positive fluid wave test occurs with:

- a. Splenomegaly.
- b. Distended bladder.
- c. Constipation.
- d. Ascites.

ANS: D

If ascites (fluid in the abdomen) is present, then the examiner will feel a fluid wave when assessing the abdomen. A fluid wave is not present with splenomegaly, a distended bladder, or constipation.

38. The nurse is preparing to examine a patient who has been complaining of right lower quadrant pain. Which technique is *correct* during the assessment?

The nurse should:

- a. Examine the tender area first.
- b. Examine the tender area last.
- c. Avoid palpating the tender area.
- d. Palpate the tender area first, and then auscultate for bowel sounds.

ANS: B

The nurse should save the examination of any identified tender areas until last. This method avoids pain and the resulting muscle rigidity that would obscure deep palpation later in the examination. Auscultation is performed before percussion and palpation because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

39. During a health history, the patient tells the nurse, I have pain all the time in my stomach. Its worse 2 hours after I eat, but it gets better if I eat again! Based on these symptoms, the nurse suspects that the patient has which condition?

- a. Appendicitis
- b. Gastric ulcer
- c. Duodenal ulcer
- d. Cholecystitis

ANS: C

Pain associated with duodenal ulcers occurs 2 to 3 hours after a meal; it may be relieved by more food. Chronic pain associated with gastric ulcers usually occurs on an empty stomach. Severe, acute pain would occur with appendicitis and cholecystitis.

MULTIPLE RESPONSE

1. The nurse suspects that a patient has appendicitis. Which of these procedures are appropriate for use when assessing for appendicitis or a perforated appendix? *Select all that apply.*

- a. Test for the Murphy sign
- b. Test for the Blumberg sign
- c. Test for shifting dullness

- d. Perform the iliopsoas muscle test
- e. Test for fluid wave

ANS: B, D

Testing for the Blumberg sign (rebound tenderness) and performing the iliopsoas muscle test should be used when assessing for appendicitis. The Murphy sign is used when assessing for an inflamed gallbladder or cholecystitis. Testing for a fluid wave and shifting dullness is performed when assessing for ascites.

Chapter 12 Male Genitourinary Disorders

MULTIPLE CHOICE

1. The external male genital structures include the:

- a. Testis.
- b. Scrotum.
- c. Epididymis.

40. The nurse is assessing the apical pulse of a 3-month-old infant and finds that the heart rate is 135 beats per minute. The nurse interprets this result as:

- a. Normal for this age.
- b. Lower than expected.
- c. Higher than expected, probably as a result of crying.
- d. Higher than expected, reflecting persistent tachycardia.

ANS: A. The heart rate may range from 100 to 180 beats per minute immediately after birth and then stabilize to an average of 120 to 140 beats per minute. Infants normally have wide fluctuations with activity, from 170 beats per minute or more with crying or being active to 70 to 90 beats per minute with sleeping. Persistent tachycardia is greater than 200 beats per minute in newborns or greater than 150 beats per minute in infants.

MULTIPLE RESPONSE

1. The nurse is presenting a class on risk factors for cardiovascular disease. Which of these are considered modifiable risk factors for MI? *Select all that apply.*

- a. Ethnicity
- b. Abnormal lipids
- c. Smoking
- d. Gender
- e. Hypertension
- f. Diabetes
- g. Family history

ANS: B, C, E, F

Nine modifiable risk factors for MI, as identified by a recent study, include abnormal lipids, smoking, hypertension, diabetes, abdominal obesity, psychosocial factors, consumption of fruits and vegetables, alcohol use, and regular physical activity.

SHORT ANSWER

1. The nurse is assessing a patient's pulses and notices a difference between the patient's apical pulse and radial pulse. The apical pulse was 118 beats per minute, and the radial pulse was 105 beats per minute. What is the pulse deficit?

ANS: 13

The nurse should count a serial measurement (one after the other) of the apical pulse and then the radial pulse. Normally, every beat heard at the apex should perfuse to the periphery and be palpable. The two counts should be identical. If they are different, then the nurse should subtract the radial rate from the apical pulse and record the remainder as the pulse deficit.

Chapter 11 Gastrointestinal Disorders

MULTIPLE CHOICE

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

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

ANS: A

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

2. Which structure is located in the left lower quadrant of the abdomen?

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

ANS: D

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

3. A patient is having difficulty swallowing medications and food. The nurse would document that this patient has:

- a. Aphasia.
- b. Dysphasia.
- c. Dysphagia.
- d. Anorexia.

ANS: C

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

4. The nurse suspects that a patient has a distended bladder. How should the nurse assess for this condition?

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

ANS: D

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

5. The nurse is aware that one change that may occur in the gastrointestinal system of an aging adult is:

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

d. Decreased gastric acid secretion.

ANS: D

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

6. A 22-year-old man comes to the clinic for an examination after falling off his motorcycle and landing on his left side on the handle bars. The nurse suspects that he may have injured his spleen. Which of these statements is *true* regarding assessment of the spleen in this situation?

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

ANS: D

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

7. A patient's abdomen is bulging and stretched in appearance. The nurse should describe this finding as:

- a. Obese.
- b. Herniated.
- c. Scaphoid.
- d. Protuberant.

ANS: D

A protuberant abdomen is rounded, bulging, and stretched (see Figure 21-7). A scaphoid abdomen caves inward.

8. The nurse is describing a scaphoid abdomen. To the horizontal plane, a scaphoid contour of the abdomen depicts a _____ profile.

- a. Flat
- b. Convex
- c. Bulging
- d. Concave

ANS: D

Contour describes the profile of the abdomen from the rib margin to the pubic bone; a scaphoid contour is one that is concave from a horizontal plane (see Figure 21-7).

9. While examining a patient, the nurse observes abdominal pulsations between the xiphoid process and umbilicus. The nurse would suspect that these are:

- a. Pulsations of the renal arteries.
- b. Pulsations of the inferior vena cava.
- c. Normal abdominal aortic pulsations.
- d. Increased peristalsis from a bowel obstruction.

ANS: C

Normally, the pulsations from the aorta are observed beneath the skin in the epigastric area, particularly in thin persons who have good muscle wall relaxation.

10. A patient has hypoactive bowel sounds. The nurse knows that a potential cause of hypoactive bowel sounds is:

- a. Diarrhea.
- b. Peritonitis.

- c. Laxative use.
- d. Gastroenteritis.

ANS: B

Diminished or absent bowel sounds signal decreased motility from inflammation as exhibited with peritonitis, with paralytic ileus after abdominal surgery, or with late bowel obstruction.

11. The nurse is watching a new graduate nurse perform auscultation of a patient's abdomen. Which statement by the new graduate shows a *correct* understanding of the reason auscultation precedes percussion and palpation of the abdomen?

- a. We need to determine the areas of tenderness before using percussion and palpation.
- b. Auscultation prevents distortion of bowel sounds that might occur after percussion and palpation.

c.

Auscultation allows the patient more time to relax and therefore be more comfortable with the physical examination.

d.

Auscultation prevents distortion of vascular sounds, such as bruits and hums, that might occur after percussion and palpation.

ANS: B

Auscultation is performed first (after inspection) because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

12. The nurse is listening to bowel sounds. Which of these statements is *true* of bowel sounds? Bowel sounds:

- a. Are usually loud, high-pitched, rushing, and tinkling sounds.
- b. Are usually high-pitched, gurgling, and irregular sounds.
- c. Sound like two pieces of leather being rubbed together.
- d. Originate from the movement of air and fluid through the large intestine.

ANS: B

Bowel sounds are high-pitched, gurgling, and cascading sounds that irregularly occur from 5 to 30 times per minute. They originate from the movement of air and fluid through the small intestine.

13. The physician comments that a patient has abdominal borborygmi. The nurse knows that this term refers to:

- a. Loud continual hum.
- b. Peritoneal friction rub.
- c. Hypoactive bowel sounds.
- d. Hyperactive bowel sounds.

ANS: D

Borborygmi is the term used for hyperperistalsis when the person actually feels his or her stomach growling.

14. During an abdominal assessment, the nurse would consider which of these findings as normal?

- a. Presence of a bruit in the femoral area
- b. Tympanic percussion note in the umbilical region

- c. Palpable spleen between the ninth and eleventh ribs in the left midaxillary line
- d. Dull percussion note in the left upper quadrant at the midclavicular line

ANS: B

Tympany should predominate in all four quadrants of the abdomen because air in the intestines rises to the surface when the person is supine. Vascular bruits are not usually present. Normally, the spleen is not palpable. Dullness would not be found in the area of lung resonance (left upper quadrant at the midclavicular line).

15. The nurse is assessing the abdomen of a pregnant woman who is complaining of having acid indigestion all the time. The nurse knows that esophageal reflux during pregnancy can cause:

- a. Diarrhea.
- b. Pyrosis.
- c. Dysphagia.
- d. Constipation.

ANS: B

Pyrosis, or heartburn, is caused by esophageal reflux during pregnancy. The other options are not correct.

16. The nurse is performing percussion during an abdominal assessment. Percussion notes heard during the abdominal assessment may include:

- a. Flatness, resonance, and dullness.
- b. Resonance, dullness, and tympany.
- c. Tympany, hyperresonance, and dullness.
- d. Resonance, hyperresonance, and flatness.

ANS: C

Percussion notes normally heard during the abdominal assessment may include tympany, which should predominate because air in the intestines rises to the surface when the person is supine; hyperresonance, which may be present with gaseous distention; and dullness, which may be found over a distended bladder, adipose tissue, fluid, or a mass.

17. An older patient has been diagnosed with pernicious anemia. The nurse knows that this condition could be related to:

- a. Increased gastric acid secretion.
- b. Decreased gastric acid secretion.
- c. Delayed gastrointestinal emptying time.
- d. Increased gastrointestinal emptying time.

ANS: B

Gastric acid secretion decreases with aging and may cause pernicious anemia (because it interferes with vitamin B12 absorption), iron-deficiency anemia, and malabsorption of calcium.

18. A patient is complaining of a sharp pain along the costovertebral angles. The nurse is aware that this symptom is most often indicative of:

- a. Ovary infection.
- b. Liver enlargement.
- c. Kidney inflammation.
- d. Spleen enlargement.

ANS: C

Sharp pain along the costovertebral angles occurs with inflammation of the kidney or paranephric area. The other options are not correct.

19. A nurse notices that a patient has ascites, which indicates the presence of:

- a. Fluid.
- b. Feces.
- c. Flatus.
- d. Fibroid tumors.

ANS: A

Ascites is free fluid in the peritoneal cavity and occurs with heart failure, portal hypertension, cirrhosis, hepatitis, pancreatitis, and cancer.

20. The nurse knows that during an abdominal assessment, deep palpation is used to determine:

- a. Bowel motility.
- b. Enlarged organs.
- c. Superficial tenderness.
- d. Overall impression of skin surface and superficial musculature.

ANS: B

With deep palpation, the nurse should notice the location, size, consistency, and mobility of any palpable organs and the presence of any abnormal enlargement, tenderness, or masses.

21. The nurse notices that a patient has had a black, tarry stool and recalls that a possible cause would be:

- a. Gallbladder disease.
- b. Overuse of laxatives.
- c. Gastrointestinal bleeding.
- d. Localized bleeding around the anus.

ANS: C

Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding. Red blood in stools occurs with localized bleeding around the anus.

22. During an abdominal assessment, the nurse elicits tenderness on light palpation in the right lower quadrant. The nurse interprets that this finding could indicate a disorder of which of these structures?

- a. Spleen
- b. Sigmoid
- c. Appendix
- d. Gallbladder

ANS: C

The appendix is located in the right lower quadrant. When the iliopsoas muscle is inflamed, which occurs with an inflamed or perforated appendix, pain is felt in the right lower quadrant.

23. The nurse is assessing the abdomen of an older adult. Which statement regarding the older adult and abdominal assessment is *true*?

- a. Abdominal tone is increased.
- b. Abdominal musculature is thinner.
- c. Abdominal rigidity with an acute abdominal condition is more common.
- d. The older adult with an acute abdominal condition complains more about pain than the younger person.

ANS: B

In the older adult, the abdominal musculature is thinner and has less tone than that of the younger adult, and abdominal rigidity with an acute abdominal condition is less common in the aging

person. The older adult with an acute abdominal condition often complains less about pain than the younger person.

24. During an assessment of a newborn infant, the nurse recalls that pyloric stenosis would be exhibited by:

- a. Projectile vomiting.
- b. Hypoactive bowel activity.
- c. Palpable olive-sized mass in the right lower quadrant.
- d. Pronounced peristaltic waves crossing from right to left.

ANS: A

Significant peristalsis, together with projectile vomiting, in the newborn suggests pyloric stenosis. After feeding, pronounced peristaltic waves cross from *left to right*, leading to projectile vomiting. One can also palpate an olive-sized mass in the right *upper* quadrant.

25. The nurse is reviewing the assessment of an aortic aneurysm. Which of these statements is *true* regarding an aortic aneurysm?

- a. A bruit is absent.
- b. Femoral pulses are increased.
- c. A pulsating mass is usually present.
- d. Most are located below the umbilicus.

ANS: C

Most aortic aneurysms are palpable during routine examination and feel like a pulsating mass. A bruit will be audible, and femoral pulses are present but decreased. Such aneurysms are located in the upper abdomen just to the left of midline.

26. During an abdominal assessment, the nurse is unable to hear bowel sounds in a patient's abdomen. Before reporting this finding as *silent bowel sounds*, the nurse should listen for at least:

- a. 1 minute.
- b. 5 minutes.
- c. 10 minutes.
- d. 2 minutes in each quadrant.

ANS: B

Absent bowel sounds are rare. The nurse must listen for 5 minutes before deciding that bowel sounds are completely absent.

27. A patient is suspected of having inflammation of the gallbladder, or cholecystitis. The nurse should conduct which of these techniques to assess for this condition?

- a. Obturator test
- b. Test for Murphy sign
- c. Assess for rebound tenderness
- d. Iliopsoas muscle test

ANS: B

Normally, palpating the liver causes no pain. In a person with inflammation of the gallbladder, or cholecystitis, pain occurs as the descending liver pushes the inflamed gallbladder onto the examining hand during inspiration (Murphy test). The person feels sharp pain and abruptly stops midway during inspiration.

28. Just before going home, a new mother asks the nurse about the infant's umbilical cord. Which of these statements is *incorrect*?

- a. It should fall off in 10 to 14 days.
- b. It will soften before it falls off.
- c. It contains two veins and one artery.
- d. Skin will cover the area within 1 week.

ANS: A

At birth, the umbilical cord is white and contains two umbilical arteries and one vein inside the Wharton jelly. The umbilical stump dries within a week, hardens, and falls off in 10 to 14 days. Skin will cover the area in 3 to 4 weeks.

29. Which of these percussion findings would the nurse expect to find in a patient with a large amount of ascites?

- a. Dullness across the abdomen
- b. Flatness in the right upper quadrant
- c. Hyperresonance in the left upper quadrant
- d. Tympany in the right and left lower quadrants

ANS: A

A large amount of ascitic fluid produces a dull sound to percussion.

30. A 40-year-old man states that his physician told him that he has a hernia. He asks the nurse to explain what a hernia is. Which response by the nurse is appropriate?

- a. No need to worry. Most men your age develop hernias.
- b. A hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.
- c. A hernia is the result of prenatal growth abnormalities that are just now causing problems.
- d. Ill have to have your physician explain this to you.

ANS: B

The nurse should explain that a hernia is a protrusion of the abdominal viscera through an abnormal opening in the muscle wall.

31. A 45-year-old man is in the clinic for a physical examination. During the abdominal assessment, the nurse percusses the abdomen and notices an area of dullness above the right costal margin of approximately 11 cm. The nurse should:

- a. Document the presence of hepatomegaly.
- b. Ask additional health history questions regarding his alcohol intake.
- c. Describe this dullness as indicative of an enlarged liver, and refer him to a physician.
- d. Consider this finding as normal, and proceed with the examination.

ANS: D

A liver span of 10.5 cm is the mean for males and 7 cm for females. Men and taller individuals are at the upper end of this range. Women and shorter individuals are at the lower end of this range. A liver span of 11 cm is within normal limits for this individual.

32. When palpating the abdomen of a 20-year-old patient, the nurse notices the presence of tenderness in the left upper quadrant with deep palpation. Which of these structures is most likely to be involved?

- a. Spleen
- b. Sigmoid colon
- c. Appendix
- d. Gallbladder

ANS: A

The spleen is located in the left upper quadrant of the abdomen. The gallbladder is in the right

upper quadrant, the sigmoid colon is in the left lower quadrant, and the appendix is in the right lower quadrant.

33. The nurse is reviewing statistics for lactose intolerance. In the United States, the incidence of lactose intolerance is higher in adults of which ethnic group?

- a. Blacks
- b. Hispanics
- c. Whites
- d. Asians

ANS: A

A recent study found estimates of lactose-intolerance prevalence as follows: 19.5% for Blacks, 10% for Hispanics, and 7.72% for Whites.

34. The nurse is assessing a patient for possible peptic ulcer disease. Which condition or history often causes this problem?

- a. Hypertension
- b. Streptococcal infections
- c. Recurrent constipation with frequent laxative use
- d. Frequent use of nonsteroidal antiinflammatory drugs

ANS: D

Peptic ulcer disease occurs with the frequent use of nonsteroidal antiinflammatory drugs, alcohol use, smoking, and *Helicobacter pylori* infection.

35. During reporting, the student nurse hears that a patient has *hepatomegaly* and recognizes that this term refers to:

- a. Enlarged liver.
- b. Enlarged spleen.
- c. Distended bowel.
- d. Excessive diarrhea.

ANS: A

The term *hepatomegaly* refers to an enlarged liver. The term *splenomegaly* refers to an enlarged spleen. The other responses are not correct.

36. During an assessment, the nurse notices that a patient's umbilicus is enlarged and everted. It is positioned midline with no change in skin color. The nurse recognizes that the patient may have which condition?

- a. Intra-abdominal bleeding
- b. Constipation
- c. Umbilical hernia
- d. Abdominal tumor

ANS: C

The umbilicus is normally midline and inverted with no signs of discoloration. With an umbilical hernia, the mass is enlarged and everted. The other responses are incorrect.

37. During an abdominal assessment, the nurse tests for a fluid wave. A positive fluid wave test occurs with:

- a. Splenomegaly.
- b. Distended bladder.
- c. Constipation.
- d. Ascites.

ANS: D

If ascites (fluid in the abdomen) is present, then the examiner will feel a fluid wave when assessing the abdomen. A fluid wave is not present with splenomegaly, a distended bladder, or constipation.

38. The nurse is preparing to examine a patient who has been complaining of right lower quadrant pain. Which technique is *correct* during the assessment?

The nurse should:

- a. Examine the tender area first.
- b. Examine the tender area last.
- c. Avoid palpating the tender area.
- d. Palpate the tender area first, and then auscultate for bowel sounds.

ANS: B

The nurse should save the examination of any identified tender areas until last. This method avoids pain and the resulting muscle rigidity that would obscure deep palpation later in the examination. Auscultation is performed before percussion and palpation because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

39. During a health history, the patient tells the nurse, I have pain all the time in my stomach. Its worse 2 hours after I eat, but it gets better if I eat again! Based on these symptoms, the nurse suspects that the patient has which condition?

- a. Appendicitis
- b. Gastric ulcer
- c. Duodenal ulcer
- d. Cholecystitis

ANS: C

Pain associated with duodenal ulcers occurs 2 to 3 hours after a meal; it may be relieved by more food. Chronic pain associated with gastric ulcers usually occurs on an empty stomach. Severe, acute pain would occur with appendicitis and cholecystitis.

MULTIPLE RESPONSE

1. The nurse suspects that a patient has appendicitis. Which of these procedures are appropriate for use when assessing for appendicitis or a perforated appendix? *Select all that apply.*

- a. Test for the Murphy sign
- b. Test for the Blumberg sign
- c. Test for shifting dullness
- d. Perform the iliopsoas muscle test
- e. Test for fluid wave

ANS: B, D

Testing for the Blumberg sign (rebound tenderness) and performing the iliopsoas muscle test should be used when assessing for appendicitis. The Murphy sign is used when assessing for an inflamed gallbladder or cholecystitis. Testing for a fluid wave and shifting dullness is performed when assessing for ascites.

Chapter 12 Male Genitourinary Disorders

MULTIPLE CHOICE

1. The external male genital structures include the:

- a. Testis.
- b. Scrotum.

c. Epididymis.

The nurse should save the examination of any identified tender areas until last. This method avoids pain and the resulting muscle rigidity that would obscure deep palpation later in the examination. Auscultation is performed before percussion and palpation because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

39. During a health history, the patient tells the nurse, I have pain all the time in my stomach. Its worse 2 hours after I eat, but it gets better if I eat again! Based on these symptoms, the nurse suspects that the patient has which condition?

- a. Appendicitis
- b. Gastric ulcer
- c. Duodenal ulcer
- d. Cholecystitis

ANS: C

Pain associated with duodenal ulcers occurs 2 to 3 hours after a meal; it may be relieved by more food. Chronic pain associated with gastric ulcers usually occurs on an empty stomach. Severe, acute pain would occur with appendicitis and cholecystitis.

MULTIPLE RESPONSE

1. The nurse suspects that a patient has appendicitis. Which of these procedures are appropriate for use when assessing for appendicitis or a perforated appendix? *Select all that apply.*

- a. Test for the Murphy sign
- b. Test for the Blumberg sign
- c. Test for shifting dullness
- d. Perform the iliopsoas muscle test
- e. Test for fluid wave

ANS: B, D

Testing for the Blumberg sign (rebound tenderness) and performing the iliopsoas muscle test should be used when assessing for appendicitis. The Murphy sign is used when assessing for an inflamed gallbladder or cholecystitis. Testing for a fluid wave and shifting dullness is performed when assessing for ascites.

Chapter 12 Male Genitourinary Disorders

MULTIPLE CHOICE

1. The external male genital structures include the:

- a. Testis.
- b. Scrotum.
- c. Epididymis.
- d. Vas deferens.

ANS: B

The external male genital structures include the penis and scrotum. The testis, epididymis, and vas deferens are internal structures.

2. An accessory glandular structure for the male genital organs is the:

- a. Testis.

- b. Scrotum.
- c. Prostate.
- d. Vas deferens.

ANS: C

Glandular structures accessory to the male genital organs are the prostate, seminal vesicles, and bulbourethral glands.

3. Which of these statements is *true* regarding the penis?

- a. The urethral meatus is located on the ventral side of the penis.
- b. The prepuce is the fold of foreskin covering the shaft of the penis.
- c. The penis is made up of two cylindrical columns of erectile tissue.
- d. The corpus spongiosum expands into a cone of erectile tissue called the *glans*.

ANS: D

At the distal end of the shaft, the corpus spongiosum expands into a cone of erectile tissue, the glans. The penis is made up of three cylindrical columns of erectile tissue. The skin that covers the glans of the penis is the prepuce. The urethral meatus forms at the tip of the glans.

4. When performing a genital examination on a 25-year-old man, the nurse notices deeply pigmented, wrinkled scrotal skin with large sebaceous follicles. On the basis of this information, the nurse would:

- a. Squeeze the glans to check for the presence of discharge.
- b. Consider this finding as normal, and proceed with the examination.
- c. Assess the testicles for the presence of masses or painless lumps.
- d. Obtain a more detailed history, focusing on any scrotal abnormalities the patient has noticed.

ANS: B

After adolescence, the scrotal skin is deeply pigmented and has large sebaceous follicles and appears corrugated.

5. Which statement concerning the testes is *true*?

- a. The lymphatic vessels of the testes drain into the abdominal lymph nodes.
- b. The vas deferens is located along the inferior portion of each testis.
- c. The right testis is lower than the left because the right spermatic cord is longer.
- d. The cremaster muscle contracts in response to cold and draws the testicles closer to the body.

ANS: D

When it is cold, the cremaster muscle contracts, which raises the scrotal sac and brings the testes closer to the body to absorb heat necessary for sperm viability. The lymphatic vessels of the testes drain into the inguinal lymph nodes. The vas deferens is located along the upper portion of each testis. The left testis is lower than the right because the left spermatic cord is longer.

6. A male patient with possible fertility problems asks the nurse where sperm is produced. The nurse knows that sperm production occurs in the:

- a. Testes.
- b. Prostate.
- c. Epididymis.
- d. Vas deferens.

ANS: A

Sperm production occurs in the testes, not in the other structures listed.

7. A 62-year-old man states that his physician told him that he has an inguinal hernia. He asks the nurse to explain what a hernia is. The nurse should:

- a. Tell him not to worry and that most men his age develop hernias.
- b. Explain that a hernia is often the result of prenatal growth abnormalities.
- c. Refer him to his physician for additional consultation because the physician made the initial diagnosis.
- d. Explain that a hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.

ANS: D

A hernia is a loop of bowel protruding through a weak spot in the musculature. The other options are not correct responses to the patient's question.

8. The mother of a 10-year-old boy asks the nurse to discuss the recognition of puberty. The nurse should reply by saying:

- a. Puberty usually begins around 15 years of age.
- b. The first sign of puberty is an enlargement of the testes.
- c. The penis size does not increase until about 16 years of age.
- d. The development of pubic hair precedes testicular or penis enlargement.

ANS: B

Puberty begins sometime between age 9 for African Americans and age 10 for Caucasians and Hispanics. The first sign is an enlargement of the testes. Pubic hair appears next, and then penis size increases.

9. During an examination of an aging man, the nurse recognizes that normal changes to expect would be:

- a. Enlarged scrotal sac.
- b. Increased pubic hair.
- c. Decreased penis size.
- d. Increased rugae over the scrotum.

ANS: C

In the aging man, the amount of pubic hair decreases, the penis size decreases, and the rugae over the scrotal sac decreases. The scrotal sac does not enlarge.

10. An older man is concerned about his sexual performance. The nurse knows that in the absence of disease, a withdrawal from sexual activity later in life may be attributable to:

- a. Side effects of medications.
- b. Decreased libido with aging.
- c. Decreased sperm production.
- d. Decreased pleasure from sexual intercourse.

ANS: A

In the absence of disease, a withdrawal from sexual activity may be attributable to side effects of medications such as antihypertensives, antidepressants, sedatives, psychotropics, antispasmodics, tranquilizers or narcotics, and estrogens. The other options are not correct.

11. A 59-year-old patient has been diagnosed with prostatitis and is being seen at the clinic for complaints of burning and pain during urination. He is experiencing:

- a. Dysuria.
- b. Nocturia.
- c. Polyuria.
- d. Hematuria.

ANS: A

Dysuria (burning with urination) is common with acute cystitis, prostatitis, and urethritis. Nocturia is voiding during the night. Polyuria is voiding in excessive quantities. Hematuria is voiding with blood in the urine.

12. A 45-year-old mother of two children is seen at the clinic for complaints of losing my urine when I sneeze. The nurse documents that she is experiencing:

- a. Urinary frequency.
- b. Enuresis.
- c. Stress incontinence.
- d. Urge incontinence.

ANS: C

Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing that occurs as a result to weakness of the pelvic floor. Urinary frequency is urinating more times than usual (more than five to six times per day). Enuresis is involuntary passage of urine at night after age 5 to 6 years (bed wetting). Urge incontinence is involuntary urine loss from overactive detrusor muscle in the bladder. It contracts, causing an urgent need to void.

13. When the nurse is conducting sexual history from a male adolescent, which statement would be most appropriate to use at the beginning of the interview?

- a. Do you use condoms?
- b. You dont masturbate, do you?
- c. Have you had sex in the last 6 months?
- d. Often adolescents your age have questions about sexual activity.

ANS: D

The interview should begin with a permission statement, which conveys that it is normal and acceptable to think or feel a certain way. Sounding judgmental should be avoided.

14. Which of these statements is most appropriate when the nurse is obtaining a genitourinary history from an older man?

- a. Do you need to get up at night to urinate?
- b. Do you experience nocturnal emissions, or wet dreams?
- c. Do you know how to perform a testicular self-examination?
- d. Has anyone ever touched your genitals when you did not want them to?

ANS: A

The older male patient should be asked about the presence of nocturia. Awakening at night to urinate may be attributable to a diuretic medication, fluid retention from mild heart failure or varicose veins, or fluid ingestion 3 hours before bedtime, especially coffee and alcohol. The other questions are more appropriate for younger men.

15. When the nurse is performing a genital examination on a male patient, the patient has an erection. The nurses most appropriate action or response is to:

- a. Ask the patient if he would like someone else to examine him.
- b. Continue with the examination as though nothing has happened.
- c. Stop the examination, leave the room while stating that the examination will resume at a later time.
- d. Reassure the patient that this is a normal response and continue with the examination.

ANS: D

When the male patient has an erection, the nurse should reassure the patient that this is a normal physiologic response to touch and proceed with the rest of the examination. The other responses

are not correct and may be perceived as judgmental.

16. The nurse is examining the glans and knows which finding is normal for this area?

- a. The meatus may have a slight discharge when the glans is compressed.
- b. Hair is without pest inhabitants.
- c. The skin is wrinkled and without lesions.
- d. Smegma may be present under the foreskin of an uncircumcised male.

ANS: D

The glans looks smooth and without lesions and does not have hair. The meatus should not have any discharge when the glans is compressed. Some cheesy smegma may have collected under the foreskin of an uncircumcised male.

17. When performing a genitourinary assessment, the nurse notices that the urethral meatus is ventrally positioned. This finding is:

- a. Called hypospadias.
- b. A result of phimosis.
- c. Probably due to a stricture.
- d. Often associated with aging.

ANS: A

Normally, the urethral meatus is positioned just about centrally. Hypospadias is the ventral location of the urethral meatus. The position of the meatus does not change with aging. Phimosis is the inability to retract the foreskin. A stricture is a narrow opening of the meatus.

18. The nurse is performing a genital examination on a male patient and notices urethral drainage. When collecting urethral discharge for microscopic examination and culture, the nurse should:

- a. Ask the patient to urinate into a sterile cup.
- b. Ask the patient to obtain a specimen of semen.
- c. Insert a cotton-tipped applicator into the urethra.
- d. Compress the glans between the examiners thumb and forefinger, and collect any discharge.

ANS: D

If urethral discharge is noticed, then the examiner should collect a smear for microscopic examination and culture by compressing the glans anteroposteriorly between the thumb and forefinger. The other options are not correct actions.

19. When assessing the scrotum of a male patient, the nurse notices the presence of multiple firm, nontender, yellow 1-cm nodules. The nurse knows that these nodules are most likely:

- a. From urethritis.
- b. Sebaceous cysts.
- c. Subcutaneous plaques.
- d. From an inflammation of the epididymis.

ANS: B

Sebaceous cysts are commonly found on the scrotum. These yellowish 1-cm nodules are firm, nontender, and often multiple. The other options are not correct.

20. When performing a scrotal assessment, the nurse notices that the scrotal contents show a red glow with transillumination. On the basis of this finding the nurse would:

- a. Assess the patient for the presence of a hernia.
- b. Suspect the presence of serous fluid in the scrotum.
- c. Consider this finding normal, and proceed with the examination.

d. Refer the patient for evaluation of a mass in the scrotum.

ANS: B

Normal scrotal contents do not allow light to pass through the scrotum. However, serous fluid does transilluminate and shows as a red glow. Neither a mass nor a hernia would transilluminate.

21. When the nurse is performing a genital examination on a male patient, which action is *correct*?

- a. Auscultating for the presence of a bruit over the scrotum
- b. Palpating for the vertical chain of lymph nodes along the groin, inferior to the inguinal ligament
- c. Palpating the inguinal canal only if a bulge is present in the inguinal region during inspection
- d.

Having the patient shift his weight onto the left (unexamined) leg when palpating for a hernia on the right side

ANS: D

When palpating for the presence of a hernia on the right side, the male patient is asked to shift his weight onto the left (unexamined) leg. Auscultating for a bruit over the scrotum is not appropriate. When palpating for lymph nodes, the horizontal chain is palpated. The inguinal canal should be palpated whether a bulge is present or not.

22. The nurse is aware of which statement to be *true* regarding the incidence of testicular cancer?

- a. Testicular cancer is the most common cancer in men aged 30 to 50 years.
- b. The early symptoms of testicular cancer are pain and induration.
- c. Men with a history of cryptorchidism are at the greatest risk for the development of testicular cancer.
- d. The cure rate for testicular cancer is low.

ANS: C

Men with undescended testicles (cryptorchidism) are at the greatest risk for the development of testicular cancer. The overall incidence of testicular cancer is rare. Although testicular cancer has no early symptoms, when detected early and treated before metastasizing, the cure rate is almost 100%.

23. The nurse is describing how to perform a testicular self-examination to a patient. Which statement is *most appropriate*?

- a. A good time to examine your testicles is just before you take a shower.
- b. If you notice an enlarged testicle or a painless lump, call your health care provider.
- c. The testicle is egg shaped and movable. It feels firm and has a lumpy consistency.
- d. Perform a testicular examination at least once a week to detect the early stages of testicular cancer.

ANS: B

If the patient notices a firm painless lump, a hard area, or an overall enlarged testicle, then he should call his health care provider for further evaluation. The testicle normally feels rubbery with a smooth surface. A good time to examine the testicles is during the shower or bath, when one's hands are warm and soapy and the scrotum is warm. Testicular self-examination should be performed once a month.

24. A 2-month-old uncircumcised infant has been brought to the clinic for a well-baby checkup. How would the nurse proceed with the genital examination?

- a. Eliciting the cremasteric reflex is recommended.
- b. The glans is assessed for redness or lesions.
- c. Retracting the foreskin should be avoided until the infant is 3 months old.
- d. Any dirt or smegma that has collected under the foreskin should be noted.

ANS: C

If uncircumcised, then the foreskin is normally tight during the first 3 months and should not be retracted because of the risk of tearing the membrane attaching the foreskin to the shaft. The other options are not correct.

25. A 2-year-old boy has been diagnosed with physiologic cryptorchidism. Considering this diagnosis, during assessment the nurse will most likely observe:

- a. Testes that are hard and painful to palpation.
- b. Atrophic scrotum and a bilateral absence of the testis.
- c. Absence of the testis in the scrotum, but the testis can be milked down.
- d. Testes that migrate into the abdomen when the child squats or sits cross-legged.

ANS: C

Migratory testes (physiologic cryptorchidism) are common because of the strength of the cremasteric reflex and the small mass of the prepubertal testes. The affected side has a normally developed scrotum and the testis can be milked down. The other responses are not correct.

26. The nurse knows that a common assessment finding in a boy younger than 2 years old is:

- a. Inflamed and tender spermatic cord.
- b. Presence of a hernia in the scrotum.
- c. Penis that looks large in relation to the scrotum.
- d. Presence of a hydrocele, or fluid in the scrotum.

ANS: D

A common scrotal finding in boys younger than 2 years of age is a hydrocele, or fluid in the scrotum. The other options are not correct.

27. During an examination of an aging man, the nurse recognizes that normal changes to expect would be:

- a. Change in scrotal color.
- b. Decrease in the size of the penis.
- c. Enlargement of the testes and scrotum.
- d. Increase in the number of rugae over the scrotal sac.

ANS: B

When assessing the genitals of an older man, the nurse may notice thinner, graying pubic hair and a decrease in the size of the penis. The size of the testes may be decreased, they may feel less firm, and the scrotal sac is pendulous with less rugae. No change in scrotal color is observed.

28. When performing a genital assessment on a middle-aged man, the nurse notices multiple soft, moist, painless papules in the shape of cauliflower-like patches scattered across the shaft of the penis. These lesions are characteristic of:

- a. Carcinoma.
- b. Syphilitic chancres.
- c. Genital herpes.
- d. Genital warts.

ANS: D

The lesions of genital warts are soft, pointed, moist, fleshy, painless papules that may be single

or multiple in a cauliflower-like patch. They occur on the shaft of the penis, behind the corona, or around the anus, where they may grow into large grapelike clusters.

29. A 15-year-old boy is seen in the clinic for complaints of dull pain and pulling in the scrotal area. On examination, the nurse palpates a soft, irregular mass posterior to and above the testis on the left. This mass collapses when the patient is supine and refills when he is upright. This description is consistent with:

- a. Epididymitis.
- b. Spermatocele.
- c. Testicular torsion.
- d. Varicocele.

ANS: D

A varicocele consists of dilated, tortuous varicose veins in the spermatic cord caused by incompetent valves within the vein. Symptoms include dull pain or a constant pulling or dragging feeling, or the individual may be asymptomatic. When palpating the mass, the examiner will feel a soft, irregular mass posterior to and above the testis that collapses when the individual is supine and refills when the individual is upright.

30. When performing a genitourinary assessment on a 16-year-old male adolescent, the nurse notices a swelling in the scrotum that increases with increased intra-abdominal pressure and decreases when he is lying down. The patient complains of pain when straining. The nurse knows that this description is most consistent with a(n) _____ hernia.

- a. Femoral
- b. Incisional
- c. Direct inguinal
- d. Indirect inguinal

ANS: D

With indirect inguinal hernias, pain occurs with straining and a soft swelling increases with increased intra-abdominal pressure, which may decrease when the patient lies down. These findings do not describe the other hernias

31. When the nurse is performing a testicular examination on a 25-year-old man, which finding is considered normal?

- a. Nontender subcutaneous plaques
- b. Scrotal area that is dry, scaly, and nodular
- c. Testes that feel oval and movable and are slightly sensitive to compression
- d. Single, hard, circumscribed, movable mass, less than 1 cm under the surface of the testes

ANS: C

Testes normally feel oval, firm and rubbery, smooth, and bilaterally equal and are freely movable and slightly tender to moderate pressure. The scrotal skin should not be dry, scaly, or nodular or contain subcutaneous plaques. Any mass would be an abnormal finding.

32. The nurse is inspecting the scrotum and testes of a 43-year-old man. Which finding would require additional follow-up and evaluation?

- a. Skin on the scrotum is taut.
- b. Left testicle hangs lower than the right testicle.
- c. Scrotal skin has yellowish 1-cm nodules that are firm and nontender.
- d. Testes move closer to the body in response to cold temperatures.

ANS: A

Scrotal swelling may cause the skin to be taut and to display pitting edema. Normal scrotal skin is rugae, and asymmetry is normal with the left scrotal half usually lower than the right. The testes may move closer to the body in response to cold temperatures.

33. A 55-year-old man is experiencing severe pain of sudden onset in the scrotal area. It is somewhat relieved by elevation. On examination the nurse notices an enlarged, red scrotum that is very tender to palpation. Distinguishing the epididymis from the testis is difficult, and the scrotal skin is thick and edematous. This description is consistent with which of these?

- a. Varicocele
- b. Epididymitis
- c. Spermatocoele
- d. Testicular torsion

ANS: B

Epididymitis presents as severe pain of sudden onset in the scrotum that is somewhat relieved by elevation. On examination, the scrotum is enlarged, reddened, and exquisitely tender. The epididymis is enlarged and indurated and may be hard to distinguish from the testis. The overlying scrotal skin may be thick and edematous.

34. The nurse is performing a genitourinary assessment on a 50-year-old obese male laborer. On examination, the nurse notices a painless round swelling close to the pubis in the area of the internal inguinal ring that is easily reduced when the individual is supine. These findings are most consistent with a(n) _____ hernia.

- a. Scrotal
- b. Femoral
- c. Direct inguinal
- d. Indirect inguinal

ANS: C

Direct inguinal hernias occur most often in men over the age of 40 years. It is an acquired weakness brought on by heavy lifting, obesity, chronic cough, or ascites. The direct inguinal hernia is usually a painless, round swelling close to the pubis in the area of the internal inguinal ring that is easily reduced when the individual is supine.

35. The nurse is providing patient teaching about an erectile dysfunction drug. One of the drugs potential side effects is prolonged, painful erection of the penis without sexual stimulation, which is known as:

- a. Orchitis.
- b. Stricture.
- c. Phimosis.
- d. Priapism.

ANS: D

Priapism is prolonged, painful erection of the penis without sexual desire. Orchitis is inflammation of the testes. Stricture is a narrowing of the opening of the urethral meatus. Phimosis is the inability to retract the foreskin.

36. During an examination, the nurse notices that a male patient has a red, round, superficial ulcer with a yellowish serous discharge on his penis. On palpation, the nurse finds a nontender base that feels like a small button between the thumb and fingers. At this point the nurse suspects that this patient has:

- a. Genital warts.

- b. Herpes infection.
- c. Syphilitic chancre.
- d. Carcinoma lesion.

ANS: C

This lesion indicates syphilitic chancre, which begins within 2 to 4 weeks of infection.

37. During a health history, a patient tells the nurse that he has trouble in starting his urine stream. This problem is known as:

- a. Urgency.
- b. Dribbling.
- c. Frequency.
- d. Hesitancy.

ANS: D

Hesitancy is trouble in starting the urine stream. Urgency is the feeling that one cannot wait to urinate. Dribbling is the last of the urine before or after the main act of urination. Frequency is urinating more often than usual.

38. During a genital examination, the nurse notices that a male patient has clusters of small vesicles on the glans, surrounded by erythema. The nurse recognizes that these lesions are:

- a. Peyronie disease.
- b. Genital warts.
- c. Genital herpes.
- d. Syphilitic cancer.

ANS: C

Genital herpes, or herpes simplex virus 2 (HSV-2), infections are indicated with clusters of small vesicles with surrounding erythema, which are often painful and erupt on the glans or foreskin.

39. During a physical examination, the nurse finds that a male patient's foreskin is fixed and tight and will not retract over the glans. The nurse recognizes that this condition is:

- a. Phimosis.
- b. Epispadias.
- c. Urethral stricture.
- d. Peyronie disease.

ANS: A

With phimosis, the foreskin is nonretractable, forming a pointy tip of the penis with a tiny orifice at the end of the glans. The foreskin is advanced and so tight that it is impossible to retract over the glans. This condition may be congenital or acquired from adhesions related to infection. (See MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation)

MULTIPLE RESPONSE

1. A 55-year-old man is in the clinic for a yearly checkup. He is worried because his father died of prostate cancer. The nurse knows which tests should be performed at this time? *Select all that apply.*

- a. Blood test for prostate-specific antigen (PSA)
- b. Urinalysis
- c. Transrectal ultrasound
- d. Digital rectal examination (DRE)
- e. Prostate biopsy

ANS: A, D Prostate cancer is typically detected by testing the blood for PSA or by a DRE. It is

recommended that *both* PSA and DRE be offered to men annually, beginning at age 50 years. If the PSA is elevated, then further laboratory work or a transrectal ultrasound (TRUS) and biopsy may be recommended.

2. A 16-year-old boy is brought to the clinic for a problem that he refused to let his mother see. The nurse examines him, and finds that he has scrotal swelling on the left side. He had the mumps the previous week, and the nurse suspects that he has orchitis. Which of the following assessment findings support this diagnosis? *Select all that apply.*

- a. Swollen testis
- b. Mass that transilluminates
- c. Mass that does not transilluminate
- d. Scrotum that is nontender upon palpation
- e. Scrotum that is tender upon palpation
- f. Scrotal skin that is reddened

ANS: A, C, E, F

With orchitis, the testis is swollen, with a feeling of weight, and is tender or painful. The mass does not transilluminate, and the scrotal skin is reddened. Transillumination of a mass occurs with a hydrocele, not orchitis.

Chapter 13 Female Genitourinary and Breast Disorders

MULTIPLE CHOICE

1. During a health history, a 22-year old woman asks, Can I get that vaccine for human papilloma virus (HPV)? I have genital warts and I'd like them to go away! What is the nurse's best response?

- a. The HPV vaccine is for girls and women ages 9 to 26 years, so we can start that today.

MULTIPLE RESPONSE

1. A 55-year-old man is in the clinic for a yearly checkup. He is worried because his father died of prostate cancer. The nurse knows which tests should be performed at this time? *Select all that apply.*

- a. Blood test for prostate-specific antigen (PSA)
- b. Urinalysis
- c. Transrectal ultrasound
- d. Digital rectal examination (DRE)
- e. Prostate biopsy

ANS: A, D Prostate cancer is typically detected by testing the blood for PSA or by a DRE. It is recommended that *both* PSA and DRE be offered to men annually, beginning at age 50 years. If the PSA is elevated, then further laboratory work or a transrectal ultrasound (TRUS) and biopsy may be recommended.

2. A 16-year-old boy is brought to the clinic for a problem that he refused to let his mother see. The nurse examines him, and finds that he has scrotal swelling on the left side. He had the mumps the previous week, and the nurse suspects that he has orchitis. Which of the following assessment findings support this diagnosis? *Select all that apply.*

- a. Swollen testis
- b. Mass that transilluminates

- c. Mass that does not transilluminate
- d. Scrotum that is nontender upon palpation
- e. Scrotum that is tender upon palpation
- f. Scrotal skin that is reddened

ANS: A, C, E, F

With orchitis, the testis is swollen, with a feeling of weight, and is tender or painful. The mass does not transilluminate, and the scrotal skin is reddened. Transillumination of a mass occurs with a hydrocele, not orchitis.

Chapter 13 Female Genitourinary and Breast Disorders

MULTIPLE CHOICE

1. During a health history, a 22-year old woman asks, Can I get that vaccine for human papilloma virus (HPV)? I have genital warts and I'd like them to go away! What is the nurse's best response?

- a. The HPV vaccine is for girls and women ages 9 to 26 years, so we can start that today.
- b. This vaccine is only for girls who have not yet started to become sexually active.
- c. Let's check with the physician to see if you are a candidate for this vaccine.
- d. The vaccine cannot protect you if you already have an HPV infection.

ANS: D

The HPV vaccine is appropriate for girls and women age 9 to 26 years and is administered to prevent cervical cancer by preventing HPV infections before girls become sexually active. However, it cannot protect the woman if an HPV infection is already present.

2. During an examination, the nurse observes a female patient's vestibule and expects to see the:

- a. Urethral meatus and vaginal orifice.
- b. Vaginal orifice and vestibular (Bartholin) glands.
- c. Urethral meatus and paraurethral (Skene) glands.
- d. Paraurethral (Skene) and vestibular (Bartholin) glands.

ANS: A

The labial structures encircle a boat-shaped space, or cleft, termed the *vestibule*. Within the vestibule are numerous openings. The urethral meatus and vaginal orifice are visible. The ducts of the paraurethral (Skene) glands and the vestibular (Bartholin) glands are present but not visible.

3. During a speculum inspection of the vagina, the nurse would expect to see what at the end of the vaginal canal?

- a. Cervix
- b. Uterus
- c. Ovaries
- d. Fallopian tubes

ANS: A

At the end of the canal, the uterine cervix projects into the vagina.

4. The uterus is usually positioned tilting forward and superior to the bladder. This position is known as:

- a. Anteverted and anteflexed.
- b. Retroverted and anteflexed.
- c. Retroverted and retroflexed.
- d. Superiorverted and anteflexed.

ANS: A

The uterus is freely movable, not fixed, and usually tilts forward and superior to the bladder (a position labeled *asanteverted and anteflexed*).

5. An 11-year-old girl is in the clinic for a sports physical examination. The nurse notices that she has begun to develop breasts, and during the conversation the girl reveals that she is worried about her development. The nurse should use which of these techniques to best assist the young girl in understanding the expected sequence for development? The nurse should:

- a. Use the Tanner scale on the five stages of sexual development.
- b. Describe her development and compare it with that of other girls her age.
- c. Use the Jacobsen table on expected development on the basis of height and weight data.
- d. Reassure her that her development is within normal limits and tell her not to worry about the next step.

ANS: A

The Tanner scale on the five stages of pubic hair development is helpful in teaching girls the expected sequence of sexual development. The other responses are not appropriate.

6. A woman who is 8 weeks pregnant is in the clinic for a checkup. The nurse reads on her chart that her cervix is softened and looks cyanotic. The nurse knows that the woman is exhibiting _____ sign and _____ sign.

- a. Tanner; Hegar
- b. Hegar; Goodell
- c. Chadwick; Hegar
- d. Goodell; Chadwick

ANS: D

Shortly after the first missed menstrual period, the female genitalia show signs of the growing fetus. The cervix softens (Goodell sign) at 4 to 6 weeks, and the vaginal mucosa and cervix look cyanotic (Chadwick sign) at 8 to 12 weeks. These changes occur because of increased vascularity and edema of the cervix and hypertrophy and hyperplasia of the cervical glands. Hegar sign occurs when the isthmus of the uterus softens at 6 to 8 weeks. Tanner sign is not a correct response.

7. Generally, the changes normally associated with menopause occur because the cells in the reproductive tract are:

- a. Aging.
- b. Becoming fibrous.
- c. Estrogen dependent.
- d. Able to respond to estrogen.

ANS: C

Because cells in the reproductive tract are estrogen dependent, decreased estrogen levels during menopause bring dramatic physical changes. The other options are not correct.

8. The nurse is reviewing the changes that occur with menopause. Which changes are associated with menopause?

- a. Uterine and ovarian atrophy, along with a thinning of the vaginal epithelium
- b. Ovarian atrophy, increased vaginal secretions, and increasing clitoral size
- c. Cervical hypertrophy, ovarian atrophy, and increased acidity of vaginal secretions
- d. Vaginal mucosa fragility, increased acidity of vaginal secretions, and uterine hypertrophy

ANS: A

The uterus shrinks because of its decreased myometrium. The ovaries atrophy to 1 to 2 cm and are not palpable after menopause. The sacral ligaments relax, and the pelvic musculature weakens; consequently, the uterus droops. The cervix shrinks and looks paler with a thick glistening epithelium. The vaginal epithelium atrophies, becoming thinner, drier, and itchy. The vaginal pH becomes more alkaline, and secretions are decreased, which results in a fragile mucosal surface that is at risk for vaginitis.

9. A 54-year-old woman who has just completed menopause is in the clinic today for a yearly physical examination. Which of these statements should the nurse include in patient education? A postmenopausal woman:

- a. Is not at any greater risk for heart disease than a younger woman.
- b. Should be aware that she is at increased risk for dyspareunia because of decreased vaginal secretions.

c.

Has only stopped menstruating; there really are no other significant changes with which she should be concerned.

d.

Is likely to have difficulty with sexual pleasure as a result of drastic changes in the female sexual response cycle.

ANS: B

Decreased vaginal secretions leave the vagina dry and at risk for irritation and pain with intercourse (dyspareunia). The other statements are incorrect.

10. A woman is in the clinic for an annual gynecologic examination. The nurse should plan to begin the interview with the:

- a. Menstrual history, because it is generally nonthreatening.
- b. Obstetric history, because it includes the most important information.
- c. Urinary system history, because problems may develop in this area as well.
- d. Sexual history, because discussing it first will build rapport.

ANS: A

Menstrual history is usually nonthreatening and therefore a good topic with which to begin the interview. Obstetric, urinary, and sexual histories are also part of the interview but not necessarily the best topics with which to start.

11. A patient has had three pregnancies and two live births. The nurse would record this information as grav ____, para ____, AB ____.

- a. 2; 2; 1
- b. 3; 2; 0
- c. 3; 2; 1
- d. 3; 3; 1

ANS: C

Gravida (grav) is the number of pregnancies. Para is the number of births. Abortions are interrupted pregnancies, including elective abortions and spontaneous miscarriages.

12. During the interview with a female patient, the nurse gathers data that indicate the patient is perimenopausal. Which of these statements made by this patient leads to this conclusion?

- a. I have noticed that my muscles ache at night when I go to bed.

- b. I will be very happy when I can stop worrying about having a period.
- c. I have been noticing that I sweat a lot more than I used to, especially at night.
- d. I have only been pregnant twice, but both times I had breast tenderness as my first symptom.

ANS: C

Hormone shifts occur during the perimenopausal period, and associated symptoms of menopause may occur, such as hot flashes, night sweats, numbness and tingling, headache, palpitations, drenching sweats, mood swings, vaginal dryness, and itching. The other responses are not correct.

13. A 50-year-old woman calls the clinic because she has noticed some changes in her body and breasts and wonders if these changes could be attributable to the hormone replacement therapy (HRT) she started 3 months earlier. The nurse should tell her:

- a. HRT is at such a low dose that side effects are very unusual.
- b. HRT has several side effects, including fluid retention, breast tenderness, and vaginal bleeding.
- c.

Vaginal bleeding with HRT is very unusual; I suggest you come into the clinic immediately to have this evaluated.

d.

It sounds as if your dose of estrogen is too high; I think you may need to decrease the amount you are taking and then call back in a week.

ANS: B

Side effects of HRT include fluid retention, breast pain, and vaginal bleeding. The other responses are not correct.

14. A 52-year-old patient states that when she sneezes or coughs she wets herself a little. She is very concerned that something may be wrong with her. The nurse suspects that the problem is:

- a. Dysuria.
- b. Stress incontinence.
- c. Hematuria.
- d. Urge incontinence.

ANS: B

Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing. Dysuria is pain or burning with urination. Hematuria is bleeding with urination. Urge incontinence is involuntary urine loss that occurs as a result of an overactive detrusor muscle in the bladder that contracts and causes an urgent need to void.

15. During the interview, a patient reveals that she has some vaginal discharge. She is worried that it may be a sexually transmitted infection. The nurses most appropriate response to this would be:

- a. Oh, don't worry. Some cyclic vaginal discharge is normal.
- b. Have you been engaging in unprotected sexual intercourse?
- c. I'd like some information about the discharge. What color is it?
- d. Have you had any urinary incontinence associated with the discharge?

ANS: C

Questions that help the patient reveal more information about her symptoms should be asked in a nonthreatening manner. Asking about the amount, color, and odor of the vaginal discharge

provides the opportunity for further assessment. Normal vaginal discharge is small, clear or cloudy, and always nonirritating.

16. A woman states that 2 weeks ago she had a urinary tract infection that was treated with an antibiotic. As a part of the interview, the nurse should ask, Have you noticed any:

- a. Changes in your urination patterns?
- b. Excessive vaginal bleeding?
- c. Unusual vaginal discharge or itching?
- d. Changes in your desire for intercourse?

ANS: C

Several medications may increase the risk of vaginitis. Broad-spectrum antibiotics alter the balance of normal flora, which may lead to the development of vaginitis. The other questions are not appropriate.

17. Which statement would be *most* appropriate when the nurse is introducing the topic of sexual relationships during an interview?

- a. Now, it is time to talk about your sexual history. When did you first have intercourse?
- b. Women often feel dissatisfied with their sexual relationships. Would it be okay to discuss this now?
- c.

Women often have questions about their sexual relationship and how it affects their health.

Do you have any questions?

d.

Most women your age have had more than one sexual partner. How many would you say you have had?

ANS: C

The nurse should begin with an open-ended question to assess individual needs. The nurse should include appropriate questions as a routine part of the health history, because doing so communicates that the nurse accepts the individual's sexual activity and believes it is important. The nurse's comfort with the discussion prompts the patient's interest and, possibly, relief that the topic has been introduced. The initial discussion establishes a database for comparison with any future sexual activities and provides an opportunity to screen sexual problems.

18. A 22-year-old woman has been considering using oral contraceptives. As a part of her health history, the nurse should ask:

- a. Do you have a history of heart murmurs?
- b. Will you be in a monogamous relationship?
- c. Have you carefully thought this choice through?
- d. If you smoke, how many cigarettes do you smoke per day?

ANS: D

Oral contraceptives, together with cigarette smoking, increase the risk for cardiovascular side effects. If cigarettes are used, then the nurse should assess the patient's smoking history. The other questions are not appropriate.

19. A married couple has come to the clinic seeking advice on pregnancy. They have been trying to conceive for 4 months and have not been successful. What should the nurse do first?

- a. Ascertain whether either of them has been using broad-spectrum antibiotics.
- b. Explain that couples are considered infertile after 1 year of unprotected intercourse.
- c.

Immediately refer the woman to an expert in pelvic inflammatory disease the most common cause of infertility.

d. Explain that couples are considered infertile after 3 months of engaging in unprotected intercourse and that they will need a referral to a fertility expert.

ANS: B

Infertility is considered after 1 year of engaging in unprotected sexual intercourse without conceiving. The other actions are not appropriate.

20. A nurse is assessing a patient's risk of contracting a sexually transmitted infection (STI). An appropriate question to ask would be:

- a. You know that it's important to use condoms for protection, right?
- b. Do you use a condom with each episode of sexual intercourse?
- c. Do you have a sexually transmitted infection?
- d. You are aware of the dangers of unprotected sex, aren't you?

ANS: B

In reviewing a patient's risk for STIs, the nurse should ask in a nonconfrontational manner whether condoms are being used during each episode of sexual intercourse. Asking a person whether he or she has an infection does not address the risk.

21. When the nurse is interviewing a preadolescent girl, which opening question would be least threatening?

- a. Do you have any questions about growing up?
- b. What has your mother told you about growing up?
- c. When did you notice that your body was changing?
- d. I remember being very scared when I got my period. How do you think you'll feel?

ANS: C

Open-ended questions such as, When did you ? rather than Do you ? should be asked. Open-ended questions are less threatening because they imply that the topic is normal and unexceptional.

22. When the nurse is discussing sexuality and sexual issues with an adolescent, a permission statement helps convey that it is normal to think or feel a certain way. Which statement is the best example of a permission statement?

- a. It is okay that you have become sexually active.
- b. Girls your age often have questions about sexual activity. Do you have any questions?
- c. If it is okay with you, I'd like to ask you some questions about your sexual history.
- d. Girls your age often engage in sexual activities. It is okay to tell me if you have had intercourse.

ANS: B

The examiner should start with a permission statement such as, Girls your age often experience. A permission statement conveys the idea that it is normal to think or feel a certain way, and implying that the topic is normal and unexceptional is important.

23. The nurse is preparing to interview a postmenopausal woman. Which of these statements is *true* as it applies to obtaining the health history of a postmenopausal woman?

- a. The nurse should ask a postmenopausal woman if she has ever had vaginal bleeding.
- b. Once a woman reaches menopause, the nurse does not need to ask any history questions.
- c. The nurse should screen for monthly breast tenderness.

d. Postmenopausal women are not at risk for contracting STIs; therefore, these questions can be omitted.

ANS: A

Postmenopausal bleeding warrants further workup and referral. The other statements are not true.

24. During the examination portion of a patient's visit, she will be in lithotomy position. Which statement reflects some things that the nurse can do to make this position more comfortable for her?

a. Ask her to place her hands and arms over her head.

b. Elevate her head and shoulders to maintain eye contact.

c.

Allow her to choose to have her feet in the stirrups or have them resting side by side on the edge of the table.

d.

Allow her to keep her buttocks approximately 6 inches from the edge of the table to prevent her from

feeling as if she will fall off.

ANS: B

The nurse should elevate her head and shoulders to maintain eye contact. The patient's arms should be placed at her sides or across the chest. Placing her hands and arms over her head only tightens the abdominal muscles. The feet should be placed into the stirrups, knees apart, and buttocks at the edge of the examining table. The stirrups are placed so that the legs are not abducted too far.

25. An 18-year-old patient is having her first pelvic examination. Which action by the nurse is appropriate?

a. Inviting her mother to be present during the examination

b. Avoiding the lithotomy position for this first time because it can be uncomfortable and embarrassing

c.

Raising the head of the examination table and giving her a mirror so that she can view the examination

d.

Fully draping her, leaving the drape between her legs elevated to avoid embarrassing her with eye contact

ANS: C

The techniques of the educational or mirror pelvic examination should be used. This is a routine examination with some modifications in attitude, position, and communication. First, the woman is considered an active participant, one who is interested in learning and in sharing decisions about her own health care. The woman props herself up on one elbow, or the head of the table is raised. Her other hand holds a mirror between her legs, above the examiner's hands. The young woman can see all that the examiner is doing and has a full view of her genitalia. The mirror works well for teaching normal anatomy and its relationship to sexual behavior. The examiner can ask her if she would like to have a family member, friend, or chaperone present for the examination. The drape should be pushed down between the patient's legs so that the nurse can see her face.

26. The nurse has just completed an inspection of a nulliparous woman's external genitalia. Which of these would be a description of a finding within normal limits?

- a. Redness of the labia majora
- b. Multiple nontender sebaceous cysts
- c. Discharge that is foul smelling and irritating
- d. Gaping and slightly shriveled labia majora

ANS: B

No lesions should be noted, except for the occasional sebaceous cysts, which are yellowish 1-cm nodules that are firm, nontender, and often multiple. The labia majora are dark pink, moist, and symmetric; redness indicates inflammation or lesions. Discharge that is foul smelling and irritating may indicate infection. In the nulliparous woman, the labia majora meet in the midline, are symmetric and plump.

27. The nurse is preparing for an internal genitalia examination of a woman. Which order of the examination is correct?

- a. Bimanual, speculum, and rectovaginal
- b. Speculum, rectovaginal, and bimanual
- c. Speculum, bimanual, and rectovaginal
- d. Rectovaginal, bimanual, and speculum

ANS: C

The correct sequence is speculum examination, then bimanual examination after removing the speculum, and then rectovaginal examination. The examiner should change gloves before performing the rectovaginal examination to avoid spreading any possible infection.

28. During an internal examination of a woman's genitalia, the nurse will use which technique for proper insertion of the speculum?

a.

The woman is instructed to bear down, the speculum blades are opened and applied in a swift, upward movement.

b.

The blades of the speculum are inserted on a horizontal plane, turning them to a 30-degree angle while continuing to insert them. The woman is asked to bear down after the speculum is inserted.

c.

The woman is instructed to bear down, the width of the blades are horizontally turned, and the speculum is inserted downward at a 45-degree angle toward the small of the woman's back.

d.

The blades are locked open by turning the thumbscrew. Once the blades are open, pressure is applied to the introitus and the blades are inserted downward at a 45-degree angle to bring the cervix into view.

ANS: C

The examiner should instruct the woman to bear down, turn the width of the blades horizontally, and insert the speculum at a 45-degree angle downward toward the small of the woman's back.

29. The nurse is examining a 35-year-old female patient. During the health history, the nurse notices that she has had two term pregnancies, and both babies were delivered vaginally. During the internal examination, the nurse observes that the cervical os is a horizontal slit with some healed lacerations and that the cervix has some nabothian cysts that are small, smooth, and

yellow. In addition, the nurse notices that the cervical surface is granular and red, especially around the os. Finally, the nurse notices the presence of stringy, opaque, odorless secretions. Which of these findings are abnormal?

- a. Nabothian cysts are present.
- b. The cervical os is a horizontal slit.
- c. The cervical surface is granular and red.
- d. Stringy and opaque secretions are present.

ANS: C

Normal findings: Nabothian cysts may be present on the cervix after childbirth. The cervical os is a horizontal, irregular slit in the parous woman. Secretions vary according to the day of the menstrual cycle, and may be clear and thin or thick, opaque, and stringy. The surface is normally smooth, but cervical eversion, or ectropion, may occur where the endocervical canal is *rolled out*. Abnormal finding: The cervical surface should not be reddened or granular, which may indicate a lesion.

30. A patient calls the clinic for instructions before having a Papanicolaou (Pap) smear. The most appropriate instructions from the nurse are:

- a. If you are menstruating, please use pads to avoid placing anything into the vagina.
- b. Avoid intercourse, inserting anything into the vagina, or douching within 24 hours of your appointment.
- c. If you suspect that you have a vaginal infection, please gather a sample of the discharge to bring with you
- d.

We would like you to use a mild saline douche before your examination. You may pick this up in our office.

ANS: B

When instructing a patient before Pap smear is obtained, the nurse should follow these guidelines: Do not obtain during the woman's menses or if a heavy infectious discharge is present. Instruct the woman not to douche, have intercourse, or put anything into the vagina within 24 hours before collecting the specimens. Any specimens will be obtained during the visit, not beforehand.

31. During an examination, which tests will the nurse collect to screen for cervical cancer?

- a. Endocervical specimen, cervical scrape, and vaginal pool
- b. Endocervical specimen, vaginal pool, and acetic acid wash
- c. Endocervical specimen, potassium hydroxide (KOH) preparation, and acetic acid wash
- d. Cervical scrape, acetic acid wash, saline mount (wet prep)

ANS: A

Laboratories may vary in method, but usually the test consists of three specimens: endocervical specimen, cervical scrape, and vaginal pool. The other tests (acetic acid wash, KOH preparation, and saline mount) are used to test for sexually transmitted infections.

32. When performing the bimanual examination, the nurse notices that the cervix feels smooth and firm, is round, and is fixed in place (does not move). When cervical palpation is performed, the patient complains of some pain. The nurse's interpretation of these results should be which of these?

- a. These findings are all within normal limits.

- b. Cervical consistency should be soft and velvety not firm.
- c. The cervix should move when palpated; an immobile cervix may indicate malignancy.
- d. Pain may occur during palpation of the cervix.

ANS: C

Normally, the cervix feels smooth and firm, similar to the consistency of the tip of the nose. It softens and feels velvety at 5 to 6 weeks of pregnancy (Goodell sign). The cervix should be evenly rounded. With a finger on either side, the examiner should be able to move the cervix gently from side to side, and doing so should produce no pain for the patient. Hardness of the cervix may occur with malignancy. Immobility may occur with malignancy, and pain may occur with inflammation or ectopic pregnancy.

33. The nurse is palpating a female patient's adnexa. The findings include a firm, smooth uterine wall; the ovaries are palpable and feel smooth and firm. The fallopian tube is firm and pulsating. The nurse's most appropriate course of action would be to:

- a. Tell the patient that her examination is normal.
- b. Give her an immediate referral to a gynecologist.
- c. Suggest that she return in a month for a recheck to verify the findings.
- d. Tell the patient that she may have an ovarian cyst that should be evaluated further.

ANS: B

Normally, the uterine wall feels firm and smooth, with the contour of the fundus rounded. Ovaries are not often palpable, but when they are, they normally feel smooth, firm, and almond shaped and are highly movable, sliding through the fingers. The fallopian tube is not normally palpable. No other mass or pulsation should be felt. Pulsation or palpable fallopian tube suggests ectopic pregnancy, which warrants immediate referral.

34. A 65-year-old woman is in the office for routine gynecologic care. She had a complete hysterectomy 3 months ago after cervical cancer was detected. Which statement does the nurse know to be *true* regarding this visit?

- a. Her cervical mucosa will be red and dry looking.
- b. She will not need to have a Pap smear performed.
- c.

The nurse can expect to find that her uterus will be somewhat enlarged and her ovaries small and hard.

d.

The nurse should plan to lubricate the instruments and the examining hand adequately to avoid a painful examination.

ANS: D

In the aging adult woman, natural lubrication is decreased; therefore, to avoid a painful examination, the nurse should take care to lubricate the instruments and the examining hand adequately. Menopause, with the resulting decrease in estrogen production, shows numerous physical changes. The cervix shrinks and looks pale and glistening. With the bimanual examination, the uterus feels smaller and firmer and the ovaries are not normally palpable. Women should continue cervical cancer screening up to age 65 years if they have an intact cervix and are in good health. Women who have had a total hysterectomy do not need cervical cancer screening if they have 3 consecutive negative Pap tests or 2 or more consecutive negative HIV and Pap tests within the last 10 years.

35. The nurse is preparing to examine the external genitalia of a school-age girl. Which position

would be most appropriate in this situation?

- a. In the parents lap
- b. In a frog-leg position on the examining table
- c. In the lithotomy position with the feet in stirrups
- d. Lying flat on the examining table with legs extended

ANS: B

For school-age children, placing them on the examining table in a frog-leg position is best. With toddlers and preschoolers, having the child on the parents lap in a frog-leg position is best.

36. When assessing a newborn infants genitalia, the nurse notices that the genitalia are somewhat engorged. The labia majora are swollen, the clitoris looks large, and the hymen is thick. The vaginal opening is difficult to visualize. The infants mother states that she is worried about the labia being swollen. The nurse should reply:

- a. This is a normal finding in newborns and should resolve within a few weeks.
- b. This finding could indicate an abnormality and may need to be evaluated by a physician.
- c. We will need to have estrogen levels evaluated to ensure that they are within normal limits.
- d. We will need to keep close watch over the next few days to see if the genitalia decrease in size.

ANS: A

It is normal for a newborns genitalia to be somewhat engorged. A sanguineous vaginal discharge or leukorrhea is normal during the first few weeks because of the maternal estrogen effect.

During the early weeks, the genital engorgement resolves, and the labia minora atrophy and remain small until puberty.

37. During a vaginal examination of a 38-year-old woman, the nurse notices that the vulva and vagina are erythematous and edematous with thick, white, curdlike discharge adhering to the vaginal walls. The woman reports intense pruritus and thick white discharge from her vagina. The nurse knows that these history and physical examination findings are most consistent with which condition?

- a. Candidiasis
- b. Trichomoniasis
- c. Atrophic vaginitis
- d. Bacterial vaginosis

ANS: A

The woman with candidiasis often reports intense pruritus and thick white discharge. The vulva and vagina are erythematous and edematous. The discharge is usually thick, white, and curdlike. Infection with trichomoniasis causes a profuse, watery, gray-green, and frothy discharge.

Bacterial vaginosis causes a profuse discharge that has a foul, fishy, rotten odor. Atrophic vaginitis may have a mucoid discharge

38. A 22-year-old woman is being seen at the clinic for problems with vulvar pain, dysuria, and fever. On physical examination, the nurse notices clusters of small, shallow vesicles with surrounding erythema on the labia. Inguinal lymphadenopathy present is also present. The most likely cause of these lesions is:

- a. Pediculosis pubis.
- b. Contact dermatitis.
- c. HPV.
- d. Herpes simplex virus type 2.

ANS: D

Herpes simplex virus type 2 exhibits clusters of small, shallow vesicles with surrounding erythema that erupt on the genital areas. Inguinal lymphadenopathy is also present. The woman reports local pain, dysuria, and fever.

39. When performing an external genitalia examination of a 10-year-old girl, the nurse notices that no pubic hair has grown in and the mons and the labia are covered with fine vellus hair. These findings are consistent with stage _____ of sexual maturity, according to the Sexual Maturity Rating scale.

- a. 1
- b. 2
- c. 3
- d. 4

ANS: A

Sexual Maturity Rating stage 1 is the preadolescent stage. There is no pubic hair, and the mons and labia are covered with fine, vellus hair as on the abdomen

40. A 46-year-old woman is in the clinic for her annual gynecologic examination. She voices a concern about ovarian cancer because her mother and sister died of it. Which statement does the nurse know to be *correct* regarding ovarian cancer?

- a. Ovarian cancer rarely has any symptoms.
- b. The Pap smear detects the presence of ovarian cancer.
- c.

Women at high risk for ovarian cancer should have annual transvaginal ultrasonography for screening.

- d. Women over age 40 years should have a thorough pelvic examination every 3 years.

ANS: C

With ovarian cancer, the patient may have abdominal pain, pelvic pain, increased abdominal size, bloating, and nonspecific gastrointestinal symptoms; or she may be asymptomatic. The Pap smear does not detect the presence of ovarian cancer. Annual transvaginal ultrasonography may detect ovarian cancer at an earlier stage in women who are at high risk for developing it.

41. During a bimanual examination, the nurse detects a solid tumor on the ovary that is heavy and fixed, with a poorly defined mass. This finding is suggestive of:

- a. Ovarian cyst.
- b. Endometriosis.
- c. Ovarian cancer.
- d. Ectopic pregnancy.

ANS: C

Ovarian tumors that are solid, heavy, and fixed, with poorly defined mass are suggestive of malignancy. Benign masses may feel mobile and solid. An ovarian cyst may feel smooth, round, fluctuant, mobile, and nontender. With an ectopic pregnancy, the examiner may feel a palpable, tender pelvic mass that is solid, mobile, and unilateral. Endometriosis may have masses (in various locations in the pelvic area) that are small, firm, nodular, and tender to palpation, with enlarged ovaries.

42. A 25-year-old woman comes to the emergency department with a sudden fever of 38.3 C and abdominal pain. Upon examination, the nurse notices that she has rigid, boardlike lower abdominal musculature. When the nurse tries to perform a vaginal examination, the patient has severe pain when the uterus and cervix are moved. The nurse knows that these signs and

symptoms are suggestive of:

- a. Endometriosis.
- b. Uterine fibroids.
- c. Ectopic pregnancy.
- d. Pelvic inflammatory disease.

ANS: D

These signs and symptoms are suggestive of acute pelvic inflammatory disease, also known as *acute salpingitis*

43. During an external genitalia examination of a woman, the nurse notices several lesions around the vulva. The lesions are pink, moist, soft, and pointed papules. The patient states that she is not aware of any problems in that area. The nurse recognizes that these lesions may be:

- a. Syphilitic chancre.
- b. Herpes simplex virus type 2 (herpes genitalis).
- c. HPV or genital warts.
- d. Pediculosis pubis (crab lice).

ANS: C

HPV lesions are painless, warty growths that the woman may not notice. Lesions are pink or flesh colored, soft, pointed, moist, warty papules that occur in single or multiple cauliflower-like patches around the vulva, introitus, anus, vagina, or cervix. Herpetic lesions are painful clusters of small, shallow vesicles with surrounding erythema. Syphilitic chancres begin as a solitary silvery papule that erodes into a red, round or oval superficial ulcer with a yellowish discharge. Pediculosis pubis causes severe perineal itching and excoriations and erythematous areas

44. During an examination, the nurse would expect the cervical os of a woman who has never had children to appear:

- a. Stellate.
- b. Small and round.
- c. As a horizontal irregular slit.
- d. Everted.

ANS: B

The cervical os in a nulliparous woman is small and round. In the parous woman, it is a horizontal, irregular slit that also may show healed lacerations on the sides (see Figure 26-13).

45. A woman has just been diagnosed with HPV or genital warts. The nurse should counsel her to receive regular examinations because this virus makes her at a higher risk for _____ cancer.

- a. Uterine
- b. Cervical
- c. Ovarian
- d. Endometrial

ANS: B

HPV is the virus responsible for most cases of cervical cancer, not the other options.

46. During an internal examination, the nurse notices that the cervix bulges outside the introitus when the patient is asked to strain. The nurse will document this as:

- a. Uterine prolapse, graded first degree.
- b. Uterine prolapse, graded second degree.
- c. Uterine prolapse, graded third degree.
- d. A normal finding.

ANS: B

The cervix should not be found to bulge into the vagina. Uterine prolapse is graded as follows: first degree the cervix appears at the introitus with straining; second degree the cervix bulges outside the introitus with straining; and third degree the whole uterus protrudes, even without straining (essentially, the uterus is inside out).

47. A 35-year-old woman is at the clinic for a gynecologic examination. During the examination, she asks the nurse, How often do I need to have this Pap test done? Which reply by the nurse is *correct*?

- a. It depends. Do you smoke?
- b. A Pap test needs to be performed annually until you are 65 years of age.
- c. If you have two consecutive normal Pap tests, then you can wait 5 years between tests.
- d.

After age 30 years, if you have three consecutive normal Pap tests, then you may be screened every 2 to 3 years.

ANS: D

Cervical cancer screening with the Pap test continues annually until age 30 years. After age 21, regardless of sexual history or activity, women should be screened every 3 years until age 30, then every 5 years until age 65.

MULTIPLE RESPONSE

48. The nurse is palpating an ovarian mass during an internal examination of a 63-year-old woman. Which findings of the mass characteristics would suggest the presence of an ovarian cyst? *Select all that apply.*

- a. Heavy and solid
- b. Mobile and fluctuant
- c. Mobile and solid
- d. Fixed
- e. Smooth and round
- f. Poorly defined

ANS: B, E

An ovarian cyst (fluctuant ovarian mass) is usually asymptomatic and would feel like a smooth, round, fluctuant, mobile, nontender mass on the ovary. A mass that is heavy, solid, fixed, and poorly defined suggests malignancy. A benign mass may feel mobile and solid.

MULTIPLE CHOICE

49. Which of the following statements is *true* regarding the internal structures of the breast? The breast is made up of:

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

ANS: B

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

50. In performing a breast examination, the nurse knows that examining the upper outer quadrant of the breast is especially important. The reason for this is that the upper outer quadrant is:

- a. The largest quadrant of the breast.

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

ANS: B

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

51. If a patient reports a recent breast infection, then the nurse should expect to find _____ node enlargement.

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

ANS: B

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

52. A 9-year-old girl is in the clinic for a sport physical examination. After some initial shyness she finally asks, Am I normal? I dont seem to need a bra yet, but I have some friends who do. What if I never get breasts? The nurses best response would be:

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

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

ANS: D

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

53. A patient contacts the office and tells the nurse that she is worried about her 10-year-old daughter having breast cancer. She describes a unilateral enlargement of the right breast with associated tenderness. She is worried because the left breast is not enlarged. What would be the nurses best response? Tell the mother that:

- a. Breast development is usually fairly symmetric and that the daughter should be examined right away.

b.

She should bring in her daughter right away because breast cancer is fairly common in preadolescent girls.

c.

Although an examination of her daughter would rule out a problem, her breast development is most likely normal.

d.

It is unusual for breasts that are first developing to feel tender because they havent developed much fibrous tissue.

ANS: C

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

54. A 14-year-old girl is anxious about not having reached menarche. When taking the health history, the nurse should ascertain which of the following? The age that:

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

ANS: A

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

55. A woman is in the family planning clinic seeking birth control information. She states that her breasts change all month long and that she is worried that this is unusual. What is the nurse's best response? The nurse should tell her that:

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

ANS: C

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

9. A woman has just learned that she is pregnant. What are some things the nurse should teach her about her breasts?

- a. She can expect her areolae to become larger and darker in color.
- b. Breasts may begin secreting milk after the fourth month of pregnancy.
- c. She should inspect her breasts for visible veins and immediately report these.
- d. During pregnancy, breast changes are fairly uncommon; most of the changes occur after the birth.

ANS: A

The areolae become larger and grow a darker brown as pregnancy progresses, and the tubercles become more prominent. (The brown color fades after lactation, but the areolae never return to

their original color). A venous pattern is an expected finding and prominent over the skin surface and does not need to be reported. After the fourth month of pregnancy, colostrum, a thick, yellow fluid (precursor to milk), may be expressed from the breasts.

56. The nurse is teaching a pregnant woman about breast milk. Which statement by the nurse is *correct*?

- a. Your breast milk is immediately present after the delivery of your baby.
- b. Breast milk is rich in protein and sugars (lactose) but has very little fat.
- c. The colostrum, which is present right after birth, does not contain the same nutrients as breast milk.
- d.

You may notice a thick, yellow fluid expressed from your breasts as early as the fourth month of pregnancy.

ANS: D

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

57. A 65-year-old patient remarks that she just cannot believe that her breasts sag so much. She states it must be from a lack of exercise. What explanation should the nurse offer her? After menopause:

- a. Only women with large breasts experience sagging.
- b. Sagging is usually due to decreased muscle mass within the breast.
- c. A diet that is high in protein will help maintain muscle mass, which keeps the breasts from sagging.
- d.

The glandular and fat tissue atrophies, causing breast size and elasticity to diminish, resulting in breasts that sag.

ANS: D

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

58. In examining a 70-year-old male patient, the nurse notices that he has bilateral gynecomastia. Which of the following describes the nurse's best course of action?

- a. Recommend that he make an appointment with his physician for a mammogram.
- b. Ignore it. Benign breast enlargement in men is not unusual.
- c.

Explain that this condition may be the result of hormonal changes, and recommend that he see his physician.

d.

Explain that gynecomastia in men is usually associated with prostate enlargement and recommend that he be thoroughly screened.

ANS: C

Gynecomastia may reappear in the aging man and may be attributable to a testosterone

deficiency.

59. During an examination of a 7-year-old girl, the nurse notices that the girl is showing breast budding. What should the nurse do next?

- a. Ask the young girl if her periods have started.
- b. Assess the girls weight and body mass index (BMI).
- c. Ask the girls mother at what age she started to develop breasts.
- d. Nothing; breast budding is a normal finding.

ANS: B

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

60. The nurse is reviewing statistics regarding breast cancer. Which woman, aged 40 years in the United States, has the highest risk for developing breast cancer?

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

ANS: A

The incidence of breast cancer varies within different cultural groups. White women have a higher incidence of breast cancer than black women starting at age 45 years; but black women have a higher incidence before age 45 years. Asian, Hispanic, and American Indian women have a lower risk for development of breast cancer

61. The nurse is preparing for a class in early detection of breast cancer. Which statement is *true* with regard to breast cancer in black women in the United States?

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

ANS: C

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

62. During a breast health interview, a patient states that she has noticed pain in her left breast. The nurses most appropriate response to this would be:

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

ANS: B

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

63. During a health history interview, a female patient states that she has noticed a few drops of

clear discharge from her right nipple. What should the nurse do next?

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

ANS: C

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

64. During a physical examination, a 45-year-old woman states that she has had a crusty, itchy rash on her breast for approximately 2 weeks. In trying to find the cause of the rash, which question would be important for the nurse to ask?

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

ANS: C

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

65. A patient is newly diagnosed with benign breast disease. The nurse recognizes which statement about benign breast disease to be *true*? The presence of benign breast disease:

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

ANS: A

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

66. During an annual physical examination, a 43-year-old patient states that she does not perform monthly breast self-examinations (BSEs). She tells the nurse that she believes that mammograms do a much better job than I ever could to find a lump. The nurse should explain to her that:

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

ANS: A

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

67. During an interview, a patient reveals that she is pregnant. She states that she is not sure whether she will breastfeed her baby and asks for some information about this. Which of these statements by the nurse is *accurate*?

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

ANS: B

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

68. The nurse is reviewing risk factors for breast cancer. Which of these women have risk factors that place them at a higher risk for breast cancer?

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

ANS: D

Risk factors for breast cancer include having a first-degree relative with breast cancer (mother, sister, or daughter) and being older than 50 years of age.

69. During an examination of a woman, the nurse notices that her left breast is slightly larger than her right breast. Which of these statements is *true* about this finding?

- a. Breasts should always be symmetric.
- b. Asymmetry of breast size and shape is probably due to breastfeeding and is nothing to worry about.
- c. Asymmetry is not unusual, but the nurse should verify that this change is not new.
- d.

Asymmetry of breast size and shape is very unusual and means she may have an inflammation or growth.

ANS: C

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

Chapter 14 Endocrine Disorders

MULTIPLE CHOICE

1. The nurse explains that the negative feedback system controls hormone release by communication between:

- a. the pituitary and the target organ.
- b. the thymus and the blood stream.
- a. Breasts should always be symmetric.
- b. Asymmetry of breast size and shape is probably due to breastfeeding and is nothing to worry about.
- c. Asymmetry is not unusual, but the nurse should verify that this change is not new.
- d.

Asymmetry of breast size and shape is very unusual and means she may have an inflammation or

growth.

ANS: C

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

Chapter 14 Endocrine Disorders

MULTIPLE CHOICE

1.The nurse explains that the negative feedback system controls hormone release by communication between:

- a. the pituitary and the target organ.
- b. the thymus and the blood stream.
- c. lymphatic system and the target organ.
- d. central nervous system and the blood stream.

ANS: A

The amount of hormone released is controlled by a negative feedback system. When the level of the particular hormone is appropriate, the target organ signals the pituitary to stop the stimulation of the target organ.

2.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.

3.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 (HgbA_{1c})
- 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.

4.To which diet should a patient with Cushing syndrome adhere?

- a. Less sodium
- b. More calories
- c. Less potassium
- d. More carbohydrates

ANS: A

5. 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.

6. 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.

7. 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.

8. 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. adrenocorticotrophic hormone (ACTH)

ANS: A

Diabetes insipidus is a transient or permanent metabolic disorder of the posterior pituitary in which ADH is deficient.

9. What is an appropriate nursing diagnosis for a patient who has recently been diagnosed with acromegaly?

- a. Ineffective coping
- b. Activity intolerance
- c. Risk for trauma

d. Chronic low self-esteem

ANS: C

Nursing interventions are mainly supportive. The presence of muscle weakness, joint pain, or stiffness warrants assessment of the ability to perform activities of daily living (ADLs).

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. The human insulin whose onset of action occurs within ____ minutes is lispro (Humalog).

- a. 30
- b. 60
- c. 15
- d. 45

ANS: C

Humalog begins to take effect in less than half the time of regular, fast-acting insulin. The new formula can be injected 15 minutes before a meal.

17. 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.

18. What do the Chvostek sign and the Trousseau sign indicate?

- a. Low levels of serum calcium
- b. High levels of blood sugar
- c. Low levels of serum sodium
- d. High levels of serum aldosterone

ANS: A

Low levels of blood calcium may cause the Chvostek sign and Trousseau sign.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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 carbohydrates such as orange juice or longer acting foods such as milk, crackers, and cheese are beneficial.

24. A patient has come to the clinic because of enlarged hands and feet, amenorrhea, and increased hair growth. These symptoms most likely indicate problems with the:

- a. pituitary gland.
- b. adrenal glands.

- c. thyroid gland.
- d. pancreas.

ANS: A

The pituitary gland may produce an overabundance of growth hormone. This overproduction of hormones may cause changes throughout the patient's body, including enlargement of the pituitary gland and hands and feet. Female patients may develop a deepened voice, increased facial hair growth, and amenorrhea.

25. 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 diabetic's feet.

26. 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.

27. 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

28. 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

29. 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.

30. A patient with a history of Graves disease is admitted to the unit with shortness of breath. The nurse notes the patient's 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. The nurse cautions the patient who is being instructed on self-medication with insulin to be aware that there are 25-, 30-, 50-, and 100-unit syringes. How is the 100-unit syringe marked?

- a. 1-unit increments
- b. 2-unit increments
- c. 4-unit increments
- d. 5-unit increments

ANS: B

The 100-unit syringe is marked in 2-unit increments while the smaller syringes are marked in 1-unit increments.

MULTIPLE RESPONSE

36. Which of the following are signs and symptoms of hypoglycemia? (Select all that apply.)

- a. Irritability
- b. Dry mouth
- c. Tremors
- d. Diaphoresis
- e. Fruity breath
- f. Deep respirations

ANS: A, C, D

Hypoglycemic reaction: rapid shallow respirations, irritability, tremors, excessive perspiration, and possibly loss of consciousness.

37. What are the three major life-threatening complications postoperatively of a thyroidectomy? (Select all that apply.)

- a. Hemorrhaging
- b. Seizures
- c. Tetany
- d. Hypoglycemia
- e. Thyroid crisis (storm)
- f. SIADH

ANS: A, C, E

The nurse must be alert for signs of internal or external bleeding. In addition to hemorrhage, two significant postoperative complications exist after thyroidectomy. The first is tetany. The second is thyroid crisis. Manipulation of the thyroid during surgery may cause the release of large amounts of thyroid hormones into the blood stream, creating a thyroid crisis (storm).

38. 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.

39. What should the nurse include in provisions for the postoperative care of the patient who had a thyroidectomy? (Select all that apply.)

- a. Assessing ability to speak by asking him or her to recite name and address every hour
- b. Maintaining anatomic position of the head when moving a patient
- c. Assisting a patient to hyperextend the head to assess for muscle damage
- d. Doing voice check every 2 hours
- e. Turning, coughing every hour
- f. Checking for bleeding at the sides and the back of the head

ANS: B, D, F

The nurse should hold the head in an anatomic position when moving the patient to prevent tension on the suture line, do a voice check every 2 to 4 hours by asking the patient to say ah; the patient is not turned nor is coughing recommended immediately after a thyroidectomy.

40. The nurse would instruct a patient with hyperthyroidism (Graves disease) to select which of the following nutritious foods because of the increased metabolism related to the disease. (Select all that apply.)

- a. Coffee with cream
- b. Lean meat
- c. White bread
- d. Leafy green vegetables
- e. Supplemental vitamin D

ANS: B, D, E

Nutritious food sources, such as food high in protein (e.g., lean meat), sources of vitamin B (e.g., leafy green vegetables), and vitamin D supplements are helpful to meet the metabolic needs of the patient with hyperthyroidism.

41. The nurse would instruct a patient who is hypocalcemic from hypoparathyroidism about a diet that should include (select all that apply):

- a. High phosphorus foods
- b. Canned fish with the bones
- c. Cucumbers
- d. Tofu
- e. Bananas
- f. Vitamin D supplements

ANS: B, C, D, F

The hypocalcemic patient should eat a high-calcium, low-phosphorus diet that includes canned fish, cucumbers, tofu, and vitamin D supplements as an aid to the absorption of the calcium.

COMPLETION

42. 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.

43. 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.

44.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.

45.A condition with a deficiency in growth hormone is called _____.

ANS:

hypopituitary dwarfism

A condition with a deficiency in growth hormone is called hypopituitary dwarfism. Most cases are idiopathic, but a small number can be attributed to an autosomal-recessive trait. In some cases there is also a lack of adrenocorticotrophic hormone (ACTH), TSH, and the gonadotropins.

46._____is the term that describes a condition of normal thyroid function.

ANS:

Euthyroid

Euthyroid is the term that describes a condition of normal thyroid function.

47.When the nurse inflates the sphygmomanometer cuff exceeding the systolic blood pressure and observes a carpal spasm, this is a(n) _____.

ANS:

Trousseau sign

Trousseau sign is a carpal spasm brought on by pressure of a cuff. This is an indicator for hypocalcemia and hypomagnesemia.

OTHER

48.Arrange the steps of the negative feedback system in the control of blood glucose in chronologic order. (Separate letters by a comma and space as follows: A, B, C, D):

- a. Elevation of blood glucose
- b. Decrease in blood glucose
- c. Beta cells repressed
- d. Beta cells of pancreas stimulated to excrete insulin
- e. Intake of nutrients

ANS:

E, A, D, B, C

After the intake of food the blood glucose increases, which stimulates the beta cells of the pancreas to excrete insulin. Insulin decreases the blood glucose and the negative feedback system represses the beta cells of the pancreas.

49.Arrange the steps of drawing up a short-acting and a long-acting insulin in the same syringe. (Separate letters by a comma and space as follows: A, B, C, D)

- a. Draw up amount of shorter-acting insulin

- b. Check insulin dose with a second licensed nurse
- c. Inject the desired amount of air into the long-acting insulin
- d. Clean rubber stopper of both vials with alcohol
- e. Draw up desired amount of longer-acting insulin
- f. Inject the desired amount of air into the short-acting insulin

ANS:

D, C, F, A, E, B

When drawing up two different types of insulin, the two vials are prepared by cleansing the tops, air is injected in the longer-acting insulin, air is injected into the short-acting insulin, and the required dose is drawn up. Set the vial of short-acting insulin out of reach to prevent accidental reuse. Holding the plunger securely, insert the needle in the long-acting insulin and withdraw the dose very carefully. Check the dose with a licensed nurse before administering.

Chapter 15 Musculoskeletal Disorders

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.

When drawing up two different types of insulin, the two vials are prepared by cleansing the tops, air is injected in the longer-acting insulin, air is injected into the short-acting insulin, and the required dose is drawn up. Set the vial of short-acting insulin out of reach to prevent accidental reuse. Holding the plunger securely, insert the needle in the long-acting insulin and withdraw the dose very carefully. Check the dose with a licensed nurse before administering.

Chapter 15 Musculoskeletal Disorders

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 the framework of the body. The other options are not correct.

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, one's 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 shoulders it doesn't 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 scapula's 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 patient's 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 patient's 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.

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.

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.

34. During a neonatal examination, the nurse notices that the newborn infant has six toes. This

finding is documented as:

- a. Unidactyly.
- b. Syndactyly.
- c. Polydactyly.
- d. Multidactyly.

ANS: C

Polydactyly is the presence of extra fingers or toes. *Syndactyly* is webbing between adjacent fingers or toes. The other terms are not correct.

35. A mother brings her newborn baby boy in for a checkup; she tells the nurse that he does not seem to be moving his right arm as much as his left and that he seems to have pain when she lifts him up under the arms. The nurse suspects a fractured clavicle and would observe for:

- a. Negative Allis test.
- b. Positive Ortolani sign.
- c. Limited range of motion during the Moro reflex.
- d. Limited range of motion during Lasgue test.

ANS: C

For a fractured clavicle, the nurse should observe for limited arm range of motion and unilateral response to the Moro reflex. The other tests are not appropriate for this type of fracture.

36. A 40-year-old man has come into the clinic with complaints of extreme pain in his toes. The nurse notices that his toes are slightly swollen, reddened, and warm to the touch. His complaints would suggest:

- a. Osteoporosis.
- b. Acute gout.
- c. Ankylosing spondylitis.
- d. Degenerative joint disease.

ANS: B Clinical findings for acute gout consist of redness, swelling, heat, and extreme pain like a continuous throbbing. Gout is a metabolic disorder of disturbed purine metabolism, associated with elevated serum uric acid.

37. A young swimmer comes to the sports clinic complaining of a very sore shoulder. He was running at the pool, slipped on some wet concrete, and tried to catch himself with his outstretched hand. He landed on his outstretched hand and has not been able to move his shoulder since. The nurse suspects:

- a. Joint effusion.
- b. Tear of rotator cuff.
- c. Adhesive capsulitis.
- d. Dislocated shoulder.

ANS: D A dislocated shoulder occurs with trauma involving abduction, extension, and external rotation (e.g., falling on an outstretched arm or diving into a pool).

38. A 68-year-old woman has come in for an assessment of her rheumatoid arthritis, and the nurse notices raised, firm, nontender nodules at the olecranon bursa and along the ulna. These nodules are most commonly diagnosed as:

- a. Epicondylitis.
- b. Gouty arthritis.
- c. Olecranon bursitis.
- d. Subcutaneous nodules.

ANS: D Subcutaneous nodules are raised, firm, and nontender and occur with rheumatoid arthritis in the olecranon bursa and along the extensor surface of the ulna.

39. A woman who has had rheumatoid arthritis for years is starting to notice that her fingers are drifting to the side. The nurse knows that this condition is commonly referred to as:

- a. Radial drift.
- b. Ulnar deviation.
- c. Swan-neck deformity.
- d. Dupuytren contracture.

ANS: B Fingers drift to the ulnar side because of stretching of the articular capsule and muscle imbalance caused by chronic rheumatoid arthritis. A radial drift is not observed.

40. A patient who has had rheumatoid arthritis for years comes to the clinic to ask about changes in her fingers. The nurse will assess for signs of what problems?

- a. Heberden nodes
- b. Bouchard nodules
- c. Swan-neck deformities
- d. Dupuytren contractures

ANS: C

Changes in the fingers caused by chronic rheumatoid arthritis include swan-neck and boutonniere deformities. Heberden nodes and Bouchard nodules are associated with osteoarthritis. Dupuytren contractures of the digits occur because of chronic hyperplasia of the palmar fascia.

41. A patient's annual physical examination reveals a lateral curvature of the thoracic and lumbar segments of his spine; however, this curvature disappears with forward bending. The nurse knows that this abnormality of the spine is called:

- a. Structural scoliosis.
- b. Functional scoliosis.
- c. Herniated nucleus pulposus.
- d. Dislocated hip.

ANS: B

Functional scoliosis is flexible and apparent with standing but disappears with forward bending. Structural scoliosis is fixed; the curvature shows both when standing and when bending forward.

42. A 14-year-old boy who has been diagnosed with Osgood-Schlatter disease reports painful swelling just below the knee for the past 5 months. Which response by the nurse is appropriate?

- a. If these symptoms persist, you may need arthroscopic surgery.
- b. You are experiencing degeneration of your knee, which may not resolve.
- c.

Your disease is due to repeated stress on the patellar tendon. It is usually self-limited, and your symptoms should resolve with rest.

d.

Increasing your activity and performing knee-strengthening exercises will help decrease the inflammation and maintain mobility in the knee.

ANS: C Osgood-Schlatter disease is a painful swelling of the tibial tubercle just below the knee and most likely due to repeated stress on the patellar tendon. It is usually self-limited, occurring during rapid growth and most often in boys. The symptoms resolve with rest. The other responses are not appropriate.

43. When assessing muscle strength, the nurse observes that a patient has complete range of motion against gravity with full resistance. What grade of muscle strength should the nurse record using a 0- to 5-point scale?

- a. 2
- b. 3
- c. 4
- d. 5

ANS: D Complete range of motion against gravity is normal muscle strength and is recorded as grade 5 muscle strength. The other options are not correct.

44. The nurse is examining a 6-month-old infant and places the infants feet flat on the table and flexes his knees up. The nurse notes that the right knee is significantly lower than the left. Which of these statements is *true* of this finding?

- a. This finding is a positive Allis sign and suggests hip dislocation.
- b. The infant probably has a dislocated patella on the right knee.
- c. This finding is a negative Allis sign and normal for an infant of this age.
- d. The infant should return to the clinic in 2 weeks to see if his condition has changed.

ANS: A

Finding one knee significantly lower than the other is a positive Allis sign and suggests hip dislocation. Normally, the tops of the knees are at the same elevation. The other statements are not correct.

45. The nurse is assessing a 1-week-old infant and is testing his muscle strength. The nurse lifts the infant with hands under the axillae and notices that the infant starts to slip between the hands. The nurse should:

- a. Suspect a fractured clavicle.
- b. Suspect that the infant may have a deformity of the spine.
- c. Suspect that the infant may have weakness of the shoulder muscles.
- d. Conclude that this is a normal finding because the musculature of an infant at this age is undeveloped.

ANS: C An infant who starts to slip between the nurses hands shows weakness of the shoulder muscles. An infant with normal muscle strength wedges securely between the nurses hands. The other responses are not correct.

46. The nurse is examining a 2-month-old infant and notices asymmetry of the infants gluteal folds. The nurse should assess for other signs of what disorder?

- a. Fractured clavicle
- b. Down syndrome
- c. Spina bifida
- d. Hip dislocation

ANS: D Unequal gluteal folds may accompany hip dislocation after 2 to 3 months of age, but some asymmetry may occur in healthy children. Further assessment is needed. The other responses are not correct.

47. The nurse should use which test to check for large amounts of fluid around the patella?

- a. Ballotement
- b. Tinel sign
- c. Phalen test
- d. McMurray test

ANS: A. Ballottement of the patella is reliable when large amounts of fluid are present. The Tinel sign and the Phalen test are used to check for carpal tunnel syndrome. The McMurray test is used to test the knee for a torn meniscus.

48. A patient tells the nurse that, All my life I've been called knock knees. The nurse knows that another term for knock knees is:

- a. Genu varum.
- b. Genu valgum.
- c. Pes planus.
- d. Metatarsus adductus.

ANS: B. Genu valgum is also known as *knock knees* and is present when more than 2.5 cm is between the medial malleoli when the knees are together.

49. A patient with a problem with his toe. On examination, the nurse notices the presence of hard, painless nodules over the great toe; one has burst open with a chalky discharge. This finding is known as:

- a. Callus.
- b. Plantar wart.
- c. Bunion.
- d. Tophi.

ANS: D. Tophi are collections of monosodium urate crystals resulting from chronic gout in and around the joint that cause extreme swelling and joint deformity. They appear as hard, painless nodules (tophi) over the metatarsophalangeal joint of the first toe and they sometimes burst with a chalky

50. When performing a musculoskeletal assessment, the nurse knows that the correct approach for the examination should be:

- a. Proximal to distal.
- b. Distal to proximal.
- c. Posterior to anterior.
- d. Anterior to posterior.

ANS: A. The musculoskeletal assessment should be performed in an orderly approach, head to toe, proximal to distal, from the midline outward. The other options are not correct.

MULTIPLE RESPONSE

1. The nurse is assessing the joints of a woman who has stated, I have a long family history of arthritis, and my joints hurt. The nurse suspects that she has osteoarthritis. Which of these are symptoms of osteoarthritis? *Select all that apply.*

- a. Symmetric joint involvement
- b. Asymmetric joint involvement
- c. Pain with motion of affected joints
- d. Affected joints are swollen with hard, bony protuberances
- e. Affected joints may have heat, redness, and swelling

ANS: B, C, D. In osteoarthritis, asymmetric joint involvement commonly affects hands, knees, hips, and lumbar and cervical segments of the spine. Affected joints have stiffness, swelling with hard bony protuberances, pain with motion, and limitation of motion. The other options reflect the signs of rheumatoid arthritis.

Chapter 16 Neurological Disorders

MULTIPLE CHOICE

1. What are the two divisions of the nervous system?

- a. Somatic and the autonomic
- b. Cerebellum and the brainstem
- c. Medulla oblongata and the diencephalon
- d. Central and the peripheral

c. Bunion.

d. Tophi.

ANS: D Tophi are collections of monosodium urate crystals resulting from chronic gout in and around the joint that cause extreme swelling and joint deformity. They appear as hard, painless nodules (tophi) over the metatarsophalangeal joint of the first toe and they sometimes burst with a chalky

50. When performing a musculoskeletal assessment, the nurse knows that the correct approach for the examination should be:

- a. Proximal to distal.
- b. Distal to proximal.
- c. Posterior to anterior.
- d. Anterior to posterior.

ANS: A The musculoskeletal assessment should be performed in an orderly approach, head to toe, proximal to distal, from the midline outward. The other options are not correct.

MULTIPLE RESPONSE

1. The nurse is assessing the joints of a woman who has stated, I have a long family history of arthritis, and my joints hurt. The nurse suspects that she has osteoarthritis. Which of these are symptoms of osteoarthritis? *Select all that apply.*

- a. Symmetric joint involvement
- b. Asymmetric joint involvement
- c. Pain with motion of affected joints
- d. Affected joints are swollen with hard, bony protuberances
- e. Affected joints may have heat, redness, and swelling

ANS: B, C, D In osteoarthritis, asymmetric joint involvement commonly affects hands, knees, hips, and lumbar and cervical segments of the spine. Affected joints have stiffness, swelling with hard bony protuberances, pain with motion, and limitation of motion. The other options reflect the signs of rheumatoid arthritis.

Chapter 16 Neurological Disorders

MULTIPLE CHOICE

1. What are the two divisions of the nervous system?

- a. Somatic and the autonomic
- b. Cerebellum and the brainstem
- c. Medulla oblongata and the diencephalon
- d. Central and the peripheral

ANS: D The central and the peripheral are the two divisions of the nervous system. The autonomic and the somatic are the division of the peripheral nervous system.

2. What is the cranial nerve that supplies most of the organs in the thoracic and abdominal cavities and also carries motor fibers to glands that produce digestive juices and other secretions?

- a. Somatic motor nerve
- b. Visceral sensory nerve

- c. Abducens nerve
- d. Vagus nerve

ANS: D The vagus nerve extends from the throat, larynx, and organs in the thoracic and abdominal cavities. It is responsible for sensations and will accelerate peristalsis when stimulated.

3. The newly admitted patient to the emergency room 30 minutes ago after a fall off a ladder has gradually decreased in consciousness and has slowly reacting pupils, a widening pulse pressure, and verbal responses that are slow and unintelligible. What is the most appropriate position for the patient?

- a. Neck placed in a neutral position
- b. Head raised slightly with hips flexed
- c. Supine in gravity neutral position
- d. Turn on right side with head elevated

ANS: A

Place the neck in a neutral position (not flexed or extended) to promote venous drainage.

4. Which question is likely to elicit the most valid response from the patient who is being interviewed about a neurologic problem?

- a. Do you have any sensations of pins and needles in your feet?
- b. Does the pain radiate from your back into your legs?
- c. Can you describe the sensations you are having?
- d. Do you ever have any nausea or dizziness?

ANS: C

For patients with suspected neurologic conditions, the presence of many symptoms or subjective data may be significant. Offering leading questions is not beneficial and may allow the patient to give misinformation. Questions should be specific about symptoms.

5. What is the cardinal sign of increased intracranial pressure in a brain injured patient?

- a. Pupil changes
- b. Ipsilateral paralysis
- c. Vomiting
- d. Decrease in the level of consciousness

ANS: D

Collection of objective data includes a change in level of consciousness. A change in the level of consciousness is the earliest sign of increased intracranial pressure.

6. The nurse is aware that when assessing a patient by the FOUR score coma scale, the patient is assessed in four categories: eye response, brainstem reflexes, motor response, and respiration.

How are these results reported?

- a. As a sum of the scores of the four categories
- b. As part of the Glasgow coma scale
- c. As individual scores in each category
- d. As progressive scores during a 24-hour period

ANS: C

The FOUR score coma scale assesses the patient in four categories: eye response, brainstem reflexes, motor response, and respiration. The scores are reported as individual scores in each category. It is frequently done in conjunction with the Glasgow coma scale, not part of it.

7. As the result of a stroke, a patient has difficulty discerning the position of his body without

looking at it. In the nurses documentation, which would best describe the patients inability to assess spatial position of his body?

- a. Agnosia
- b. Proprioception
- c. Apraxia
- d. Sensation

ANS: B

Patients may experience a loss of proprioception with a stroke. This may include apraxia and agnosia (a total or partial loss of the ability to recognize familiar objects or people).

8.A patient, age 45, is to have a myelogram to confirm the presence of a herniated intervertebral disk. Which nursing action should be planned with respect to this diagnostic test?

- a. Obtain an allergy history before the test.
- b. Ambulate the patient when returned to the room after the test.
- c. Use heated blanket to keep patient warm after procedure.
- d. Keep NPO for 6 to 8 hours after the test.

ANS: A

Before the dye is injected, patients must be asked whether they have any allergies, specifically whether they have had any anaphylactic or hypotensive episodes from other dyes.

9.A patient has recently suffered a stroke with left-sided weakness and has problems with choking, especially when drinking thin liquids. What nursing interventions would be most helpful in assisting this patient to swallow safely?

- a. Use a straw
- b. Tuck chin when swallowing
- c. Take a sip of liquid with each bite
- d. Turn head to the left

ANS: B

The patient should sit at a 90-degree angle with the head up and chin slightly tucked.

10.What are surgical navigational systems?

- a. Computerized devices that guide the surgeon
- b. A set of detailed anatomic maps pinpointing specific areas of the brain
- c. A written set of progressive processes for the resection of small brain tumors
- d. The use of radioactive materials to pinpoint small tumors of the brain

ANS: A

Surgical navigational systems are computerized devices that guide the surgeon and make possible the resection of tumors that were once thought to be inoperable.

11.A family member of a patient who has just suffered a tonic-clonic seizure is concerned about the patients deep sleep. What is this behavior called?

- a. Convalescent period
- b. Neural recovery period
- c. Sombulant period
- d. Postictal period

ANS: D

Seizures are followed by a rest period of variable length, called a postictal period.

12.How would a nurse record the behavior when a patient with Alzheimer disease attempts to eat using a napkin rather than a fork?

- a. Apraxia
- b. Agnosia
- c. Aphasia
- d. Dysphagia

ANS: B

Agnosia is a total or partial loss of the ability to recognize familiar objects or people through sensory stimuli as a result of organic brain damage.

13. Which symptom is specific to migraine headaches?

- a. Tachycardia
- b. They become worse in the evening
- c. They involve the entire head
- d. They are preceded by an aura

ANS: D

Migraine headaches are unusual in that signs and symptoms occur before the acute attack.

14. The nurse assures an anxious family member of a 92-year-old patient who is demonstrating signs of dementia that many causes of dementia are reversible and preventable. What is one example?

- a. Hypotension
- b. Alzheimer disease
- c. Diabetes
- d. Parkinson disease

ANS: A

Some forms of dementia are reversible. Dementia caused by hypotension, anemia, drug toxicity, metabolic disturbance, and malnutrition can all be corrected to abolish the dementia.

15. What is the nurse assessing when asking the patient, Who is the president of the United States? during a level of consciousness assessment?

- a. Orientation
- b. Memory
- c. Calculation
- d. Fund of knowledge

ANS: D

Fund of knowledge is tested by questions such as Who is the president? or asking about current events.

16. What Glasgow Coma Scale rating would a patient receive who opens the eyes spontaneously, but has incomprehensible speech and obeys commands for movement?

- a. 8
- b. 10
- c. 11
- d. 12

ANS: D

The Glasgow coma scale was developed in 1974, and it consists of three parts of the neurologic assessment: eye opening, best motor response, and best verbal response. This patient gets a 4 for eye opening, a 2 for incomprehensible speech, and a 6 for moving on demand.

17. What is the nurse aware of when assessing a person with a craniocerebral injury?

- a. Most injuries of this type are irreversible

- b. Open injuries are always more serious than closed injuries
- c. Signs and symptoms may not occur until several days after the trauma
- d. Trauma to the frontal lobe is more significant than to any other area

ANS: C

If a patient who has been conscious for several days after head injury loses consciousness or develops neurologic signs and symptoms, a subdural hematoma should be suspected.

18. 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.

19. 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.

20. 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.

21. 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 side 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.

22. What does the nurse know about the stroke patient who has expressive aphasia?

- a. Has difficulty comprehending spoken and written communication
- b. Cannot make any vocal sounds
- c. Has total loss and comprehension of language
- d. Can understand the spoken word, but cannot speak

ANS: D

The patient with expressive aphasia has difficulty articulating words, but can understand the written and spoken word.

23. The nurse is aware that the drug t-PA (Activase), a tissue plasminogen activator, must be given in ____ hours of the onset of symptoms to have maximum benefit.

- a. 3 hours
- b. 4 hours
- c. 6 hours
- d. 8 hours

ANS: A

t-PA must be given within 3 hours of the onset of symptoms to be beneficial.

24. An 83-year-old patient has had a stroke. He is right-handed and has a history of hypertension and little strokes. He presents with right hemiplegia. To afford him the best visual field, the nurse should approach him:

- a. from the right side.
- b. from the left side.
- c. from the center.
- d. from either side.

ANS: B

Another perceptual problem is hemianopia, which is characterized by defective vision or blindness in half of the visual field. If the patient has hemianopia, which is common, the patient should be approached from the nonparalyzed side for care.

25. 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 patient's 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.

26. 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.

27. What is the basic problem that prompts most of the early signs of Alzheimer disease?

- a. Changes in mood
- b. Misplacing things
- c. Memory loss that disrupts daily life
- d. Problems with words in speaking

ANS: C

Memory loss that disrupts daily life is the basic problem that prompts most of the early signs of AD.

28. A patient is in which stage of Alzheimer disease when she demonstrates sundowning?

- a. Early stage
- b. Second stage
- c. Third stage
- d. Final stage

ANS: B

Sundowning is seen in the AD patient in the second stage of the disease.

29. Why are the drugs neostigmine (Prostigmin) and pyridostigmine (Mestinon) helpful to the person with myasthenia gravis?

- a. Improves speech
- b. Improves visual disturbances
- c. Reduces pain
- d. Promotes nerve impulse transmission

ANS: D

Prostigmine and Mestinon improve the nerve impulses and alleviate the symptoms.

30. 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.

31. What is the purpose of a drug holiday in the treatment of Parkinson disease?

- a. Change all drugs
- b. Allow the natural dopamine levels to rise
- c. Restart drugs at a lower dosage with favorable results
- d. Reduce the extrapyramidal symptoms

ANS: C

A drug holiday is a period of time when all drugs are withdrawn from the person with Parkinson disease. The drugs are then restarted at a lower dose with favorable results.

32. What is the first sign of Bells palsy?

- a. Inability to wrinkle forehead and pucker lips on affected side
- b. Sudden pain in nostril on affected side
- c. Excessive salivation on the affected side
- d. Excessive mucus running from nostril on affected side

ANS: A

Unilateral weakness of the facial muscles usually occurs, resulting in a flaccidity of the affected side of the face with inability to wrinkle the forehead, close the eyelid, pucker the lips, smile, frown, whistle, or retract the mouth on that side. The face appears asymmetric.

33. Following a myelogram the nurse should include in the postprocedure care assessment for:

- a. elevation of blood pressure.
- b. urine retention.
- c. sensation in lower extremities.
- d. slurred speech.

ANS: C

Postmyelogram care includes the assessment to ensure there is no leakage of CSF, sensation and strength of the lower extremities, or headache. To avoid a headache, the patient should be flat for a few hours.

34. Why is the patient with suspected Guillain-Barre Syndrome (GBS) hospitalized immediately?

- a. The infection needs to be treated with IV antibiotics to prevent paralysis
- b. The brain may swell quickly causing seizures
- c. The disease can rapidly progress into respiratory failure
- d. IV hydration is needed to prevent possible fatal hypotension

ANS: C

Hospitalization is necessary for GBS patients because the disease progresses very quickly and respiratory failure may occur.

MULTIPLE RESPONSE

35. Which foods should the person who suffers from migraine headaches avoid? (Select all that apply.)

- a. Yogurt
- b. Caffeine
- c. Beef
- d. Pears
- e. Marinated foods
- f. Milk

ANS: A, B, E

Some foods may cause or worsen headaches. Foods that may provoke headaches include vinegar, chocolate, yogurt, alcohol, fermented or marinated foods, ripened cheese, cured sandwich meat, caffeine, and pork.

36. What are the three signs of Cushing response? (Select all that apply.)

- a. Increased pulse rate
- b. Increased blood pressure
- c. Widened pulse pressure
- d. Bradycardia
- e. Increased systolic blood pressure

f. Uncontrolled thermoregulation

ANS: C, D, E

A widened pulse pressure, increased systolic blood pressure, and bradycardia are together called Cushing response. It is considered an important diagnostic sign of late-stage brain herniation.

37. Which of the following techniques are necessary for safely feeding a hemiplegic patient?

(Select all that apply.)

- a. Mixing liquids and solid foods together
- b. Taking the patient's dentures out to prevent choking
- c. Checking the affected side of mouth for food accumulation
- d. Offering small bites of food
- e. Elevating the patient to no more than 30 degrees
- f. Adding a thickening agent to liquids

ANS: C, D, F

Important nursing measures include avoiding foods that cause choking, checking the affected side of the mouth for accumulation of food and resultant poor hygiene, not mixing liquids and solid foods, and encouraging the patient to take small bites.

38. What is the reticular activating system (RAS) essential to? (Select all that apply.)

- a. Concentration
- b. Wakefulness
- c. Speech
- d. Attention
- e. Memory
- f. Introspection

ANS: A, B, D, F

The RAS, located on the brainstem, is essential to wakefulness, attention, concentration, and introspection.

39. What are the effects of normal aging on the nervous system? (Select all that apply.)

- a. Small vessel occlusion
- b. Loss of neurons
- c. Calcification of cerebrum
- d. Reduction of cerebral blood flow
- e. Lipofuscin
- f. Decrease in oxygen use

ANS: B, D, E, F

As the person ages, normal age-related changes occur such as loss of neurons, reduction of cerebral blood flow, appearance of lipofuscin, a decrease in oxygen use and brain metabolism, and a decline in velocity of nerve impulses.

COMPLETION

40. _____ is/are responsible for the transmission of impulses between synapses.

ANS:

Neurotransmitters

Neurotransmitters (acetylcholine, norepinephrine, dopamine, and serotonin) function to conduct transmission between the synapses.

41. A _____ is a diagnostic procedure used to identify lesions by observing the flow of radiopaque dye through the subarachnoid space.

ANS:

myelogram

Preparation for this procedure is the same as for lumbar puncture.

42. The nurse explains that the triad of signs of Parkinson disease is: _____, _____ and _____

ANS:

tremor, rigidity, bradykinesia

tremor, bradykinesia, rigidity

bradykinesia, tremor, rigidity

bradykinesia, rigidity, tremor

rigidity, bradykinesia, tremor

rigidity, tremor, bradykinesia

Tremor, rigidity, and bradykinesia are the triad that make up the signs of Parkinson disease.

43. Involuntary rhythmic movement of the eyes, with oscillations that may be horizontal, vertical, or mixed movements, is called _____

ANS:

nystagmus

Nystagmus is a rhythmic movement of the eyes, which may be horizontal, vertical, or mixed in directional movement. The eye movement cannot be controlled by the patient.

44. The waxy substance that covers the neuron fibers and increases the rate of transmission of impulses is the _____.

ANS:

myelin

Myelin is the waxy substance that covers the neuron fibers (axons and dendrites) and increases the rate of transmission of impulses.

OTHER

45. The nurse explains that the two divisions of the autonomic nervous system work to maintain homeostasis. Place in order the autonomic events. (Separate letters by a comma and space as follows: A, B, C, D)

a. Parasympathetic nervous system dominates

b. Extremely stressful or frightening event

c. Blood pressure, heart rate, and adrenaline output decrease

d. Sympathetic nervous system dominates

e. Heart rate and blood pressure rise, secretion of adrenaline

ANS:

B, D, E, A, C

In the event of a frightening event, the sympathetic nervous system dominates and increases the blood pressure, heart rate, and adrenaline output in the fight or flight mechanism. The body is calmed by the parasympathetic nervous system dominating and reducing the heart rate, blood pressure, and adrenaline output.