

Kevin's Review - 35 NCLEX Practice Questions

1. The charge nurse on the cardiac unit is planning assignments for the day. Which of the following is the most appropriate assignment for the float nurse that has been reassigned from labor and delivery?

- A. A one-week postoperative coronary bypass patient, who is being evaluated for placement of a pacemaker prior to discharge.
- B. A suspected myocardial infarction patient on telemetry, just admitted from the Emergency Department and scheduled for an angiogram.
- C. A patient with unstable angina being closely monitored for pain and medication titration.
- D. A postoperative valve replacement patient who was recently admitted to the unit because all surgical beds were filled.

Correct Answer: A. A one-week postoperative coronary bypass patient, who is being evaluated for placement of a pacemaker prior to discharge.

The charge nurse planning assignments must consider the skills of the staff and the needs of the patients. The labor and delivery nurse who is not experienced with the needs of cardiac patients should be assigned to those with the least acute needs. The patient who is one-week post-operative and nearing discharge is likely to require routine care.

- **Option B:** A new patient admitted with suspected MI and scheduled for angiography would require continuous assessment as well as coordination of care that is best carried out by experienced staff. Nurse-patient assignments are typically allocated based on estimated direct patient care requirements with little consideration for other activities that must be completed throughout a shift. In an effort to improve upon previous assignment methodologies, new measures and metrics were considered in this study to reduce and balance demands placed on nurses through the assignment of required activities.
- **Option C:** The unstable patient requires staff that can immediately identify symptoms and respond appropriately. In most hospitals, a unit charge nurse is responsible for the shift assignment of patients to nurses based on experience and past practices. The nurse-patient assignment process is also often a manual process in which the charge nurse must sort through multiple decision criteria in a limited amount of time.
- **Option D:** A postoperative patient also requires close monitoring and cardiac experience. Balancing workload among nurses on a hospital unit is important for the satisfaction and safety of nurses and patients. To balance nurse workloads, direct patient care activities, indirect patient care activities, and non-patient care activities that occur throughout a shift must be considered.

2. A female adult patient is taking a progestin-only oral contraceptive or mini pill. Progestin use may increase the patient's risk for:

- A. Endometriosis
- B. Female hypogonadism
- C. Premenstrual syndrome
- D. Tubal or ectopic pregnancy

Correct Answer: D. Tubal or ectopic pregnancy

Women taking the mini pill have a higher incidence of tubal and ectopic pregnancies, possibly because progestin slows ovum transport through the fallopian tubes.

- **Option A:** Progestins are widely regarded as effective treatments for the symptoms of endometriosis despite not all being indicated for the treatment of the disease. It is not yet fully understood how progestins relieve the symptoms of endometriosis, but they probably work by suppressing the growth of endometrial implants in some way, causing them to gradually waste away.
- **Option B:** Hypogonadism is a condition in which the male testes or the female ovaries produce little or no sex hormones. Treatment may involve estrogen and progesterone pills or skin patches, GnRH injections, or HCG injections.
- **Option C:** Premenstrual syndrome is defined as the recurrence of psychological and physical symptoms in the luteal phase, which remit in the follicular phase of the menstrual cycle. The rationale for the use of progesterone and progestogens in the management of premenstrual syndrome is based on the unsubstantiated premise that progesterone deficiency is the cause.

3. A client with catatonic schizophrenia is mute, can't perform activities of daily living, and stares out the window for hours. What is the nurse's first priority?

- A. Assist the client with feeding
- B. Assist the client with showering
- C. Reassure the client about safety
- D. Encourage socialization with peers

Correct Answer: A. Assist the client with feeding

According to Maslow's hierarchy of needs, the need for food is among the most important. The initial management includes supportive measures such as IV fluids and even nasogastric tubes given that patients with catatonia are susceptible to malnutrition, dehydration, pneumonia, etc. The key is early identification of catatonia in a patient with schizophrenia and initiation of treatment.

- **Option B:** Catatonia again is a complex combination of psychomotor abnormalities and mood and thought processes. There are at least forty different signs and symptoms that have been associated with catatonia. The Diagnostic and Statistical Manual V has criteria for catatonia with specifiers, including that for schizophrenia.
- **Option C:** Features of catatonia had been described since the 1800s with prominent physicians such as Kahlbaum and even Kraepelin, who defined catatonia within the larger definition of dementia praecox.[2] There are several theories behind the same as catatonia can be part of a larger psychiatric or neurological illness. Kahlbaum has ultimately been credited with the understanding that symptoms such as stupor and catalepsy were part of a larger syndrome of psychomotor abnormalities, which he termed as "catatonia." This can be a part of a larger schizophrenic illness or even a bipolar affective illness or medical illness.
- **Option D:** Other needs, in order of decreasing importance, include hygiene, safety, and a sense of belonging. The epidemiology of catatonic schizophrenia can be multivariate. It is said that about 10% of patients in psychiatric inpatient services have catatonic features.[7] On the one hand, the older school of psychiatry associated schizophrenia with catatonia, while newer epidemiological studies show that 20% of patients with catatonia have schizophrenia, and about 45% have symptoms of mood disorders and medical illness.

4. When administering amphotericin B, which of the following must be used?

- A. A brown bag to protect the infusion from the light
- B. A diluent of 5% dextrose with no preservatives
- C. A diluent of normal saline with alcohol
- D. A micron filter of above 1 micron

Correct Answer: B. A diluent of 5% dextrose with no preservatives

Amphotericin B must be mixed with a solution with no preservatives. Amphotericin B is amphoteric (can act as both an acid and a base) and virtually water-insoluble. It is not absorbable via oral or intramuscular administration.

- **Option A:** The solution is sensitive to light but does not require the infusion to be covered. Amphotericin B acts by binding to ergosterol in the cell membrane of most fungi. After binding with ergosterol, it causes the formation of ion channels leading to loss of protons and monovalent cations, which results in depolarization and concentration-dependent cell killing.
- **Option C:** Amphotericin B, which is more commonly administered in a liposomal formulation and exhibits increased tolerability and a reduced toxicity profile. These lipid formulations permit a higher daily dose, provide better delivery to organs within the reticuloendothelial system such as the lungs, liver, and spleen, have similar efficacy when compared to conventional amphotericin B, and are less nephrotoxic.
- **Option D:** A micron filter should not be used; if unavoidable, it must be less than 1 μ . Additionally, amphotericin B also produces oxidative damage to the cells with the formation of free radicals and subsequently increased membrane permeability. Additionally, amphotericin B has a stimulatory effect on phagocytic cells, which assists in fungal infection clearance.

5. What information is correct about stomach cancer?

- A. Stomach pain is often a late symptom.
- B. Surgery is often a successful treatment.
- C. Chemotherapy and radiation are often successful treatments.
- D. The patient can survive for an extended time with TPN.

Correct Answer: A. Stomach pain is often a late symptom.

Stomach pain is often a late sign of stomach cancer; outcomes are particularly poor when cancer reaches that point. In the United States, most patients have symptoms of an advanced stage at the time of presentation. The most common presenting symptoms for gastric cancers are non-specific weight loss, persistent abdominal pain, dysphagia, hematemesis, anorexia, nausea, early satiety, and dyspepsia.

- **Option B:** Surgery has minimal positive effects. Patients with localized, resectable gastric cancer have the best chance of long-term survival with surgery alone. The main goal of surgery is complete resection with adequate margins (more than 4 cm), and only 50% of patients will obtain R0.
- **Option C:** Chemotherapy and radiation have minimal positive effects. Neoadjuvant chemotherapy has been shown to downstage primary tumors and regional lymph nodes to attempt higher long-term curative resections. Neoadjuvant therapy should be offered to patients at high risk of developing distant metastases (bulky T3/T4, perigastric nodes, linitis plastica, or positive peritoneal cytology), sparing unnecessary surgery in case an emerging metastasis appears.

- **Option D:** TPN may enhance the growth of cancer. Total parenteral nutrition is known to be effective in cases of malnutrition in patients who do not have cancer. However, TPN has not been shown to positively affect the nutritional status in patients with cancer. This is due in part to the metabolic changes associated with cancer.

6. The adaptations of a client with complete heart block would most likely include:

- A. Nausea and vertigo
- B. Flushing and slurred speech
- C. Cephalalgia and blurred vision
- D. Syncope and slow ventricular rate

Correct Answer: D. Syncope and slow ventricular rate

In complete atrioventricular block, the ventricles take over the pacemaker function in the heart but at a much slower rate than that of the SA node. As a result, there is decreased cerebral circulation, causing syncope. Patients with third-degree blocks can have varying clinical presentations. Rarely, patients are asymptomatic. Usually, they may present with generalized fatigue, tiredness, chest pain, shortness of breath, presyncope, or syncope. They may have significant hemodynamic instability and can be obtunded.

- **Option A:** The physical exam is usually remarkable for bradycardia. JVP examination often demonstrates cannon A-waves owing to the simultaneous contraction of the atria and ventricles. Thus a very large pressure wave is felt up against the vein.
- **Option B:** Especially with heart rates below 40/min, patients might also present with features consistent with decompensated heart failure, respiratory distress, and hypoperfusion such as diaphoresis, tachypnea, altered mental status, retraction, cool skin, and decreased capillary refill.
- **Option C:** Patients with complete AV-block accompanying an acute myocardial infarction often have ischemic symptoms of chest pain or dyspnea. The past medical history will often include the presence of cardiovascular disease and/or its risk factors, including diabetes mellitus, hypertension, dyslipidemia, and smoking, etc.

7. While caring for a client, the nurse notes a pulsating mass in the client's periumbilical area. Which of the following assessments is appropriate for the nurse to perform?

- A. Measure the length of the mass.
- B. Auscultate the mass.
- C. Percuss the mass.
- D. Palpate the mass.

Correct Answer: B. Auscultate the mass.

Auscultate the mass. Auscultation of the abdomen and finding a bruit will confirm the presence of an abdominal aneurysm and will form the basis of information given to the provider. Occasionally, an overlying mass (pancreas or stomach) may be mistaken for an AAA. An abdominal bruit is nonspecific for an unruptured aneurysm, but the presence of an abdominal bruit or the lateral propagation of the

aortic pulse wave can offer subtle clues and maybe more frequently found than a pulsatile mass.

- **Option A:** In one study, 38% of AAA cases were detected on the basis of physical examination findings, whereas 62% were detected incidentally on radiologic studies obtained for other reasons. Femoral/popliteal pulses and pedal (dorsalis pedis or posterior tibial) pulses should be palpated to determine if an associated aneurysm (femoral/popliteal) or occlusive disease exists. Flank ecchymosis (Grey Turner sign) represents retroperitoneal hemorrhage.
- **Option C:** Do not percuss the abdominal mass. The presence of a pulsatile abdominal mass is virtually diagnostic of an AAA but is found in fewer than 50% of cases. It is more likely to be noted with a ruptured aneurysm.
- **Option D:** The mass should not be palpated because of the risk of rupture. Most clinically significant AAAs are palpable upon routine physical examination; however, the sensitivity of palpation depends on the experience of the examiner, the size of the aneurysm, and the size of the patient.

8. A nurse is describing the process of fetal circulation to a client during a prenatal visit. The nurse accurately tells the client that fetal circulation consists of:

- A. Two umbilical veins and one umbilical artery.
- B. Two umbilical arteries and one umbilical vein.
- C. Arteries carrying oxygenated blood to the fetus.
- D. Veins carrying deoxygenated blood to the fetus.

Correct Answer: B. Two umbilical arteries and one umbilical vein.

Blood pumped by the embryo's heart leaves the embryo through two umbilical arteries. Once oxygenated, the blood then is returned by one umbilical vein. Arteries carry deoxygenated blood and waste products from the fetus, and veins carry oxygenated blood and provide oxygen and nutrients to the fetus.

- **Option A:** The fetal circulation system is distinctly different from adult circulation. This intricate system allows the fetus to receive oxygenated blood and nutrients from the placenta. It comprises the blood vessels in the placenta and the umbilical cord, which contains two umbilical arteries and one umbilical vein.
- **Option C:** Oxygenated blood from the mother in the placenta flows through the umbilical vein and into the inferior vena cava (IVC), bypassing the liver via the ductus venosus. From the IVC, oxygenated blood travels to the right atrium of the heart. There is greater pressure in the right atrium compared to the left atrium in fetal circulation; therefore most of the blood is shunted from the right atrium to the left atrium through an opening called the foramen ovale. Once in the left atrium, blood travels through the left ventricle into the aorta and the systemic circulation.
- **Option D:** The deoxygenated blood travels back to the placenta via the umbilical arteries to be oxygenated by the mother. Additionally, some oxygenated blood in the right atrium can also enter the right ventricle and then the pulmonary artery. Because there is high resistance to blood flow in the lungs, the blood is shunted from the pulmonary artery into the aorta via the ductus arteriosus, hence bypassing the lungs. Blood then enters the systemic circulation, and the deoxygenated blood is recycled back to the mother via the umbilical arteries.

9. A patient with Addison's disease asks a nurse for nutrition and diet advice. Which of the following diet modifications is not recommended?

- A. A diet high in grains
- B. A diet with adequate caloric intake
- C. A high protein diet
- D. A restricted sodium diet

Correct Answer: D. A restricted sodium diet

A patient with Addison's disease requires normal dietary sodium to prevent excess fluid loss. Patients should eat an unrestricted diet. Those with primary adrenal insufficiency (Addison disease) should have ample access to salt because of the salt-wasting that occurs if their condition is untreated. Infants with primary adrenal insufficiency often need 2-4 g of sodium chloride per day.

- **Option A:** A well-balanced diet is the best way to keep the body healthy and to regulate sugar levels. Doctors recommend balancing protein, healthy fats, and high-quality, nutrient-dense carbohydrates.
- **Option B:** High-calorie comfort food reduces symptoms of neuroglycopenia in Addison patients, suggesting that Addison's disease is associated with a deficit in cerebral energy supply that can partly be alleviated by intake of palatable food.
- **Option C:** Healthy fats and high-quality proteins slow the blood sugar rollercoaster and promote stable blood sugar levels throughout the day.

10. Emmanuel, a 52-year-old jazz pianist, presents to the rheumatology clinic with a severely swollen and tender right wrist, which he reports has affected his ability to play the piano. The attending rheumatologist is considering various diagnostic modalities. Given Emmanuel's presentation, symptoms, and the need to make a definitive diagnosis, what would be the primary purpose of recommending joint aspiration for this patient?

- A. To obtain synovial fluid to confirm the diagnosis of gout through crystal identification.
- B. To draw out excess fluid, thereby relieving pain and inflammation in the joint.
- C. To inspect and evaluate the extent of joint damage and deterioration directly.
- D. To gauge how the joint is responding to medication therapy by analyzing synovial markers.

Correct Answer: A. To obtain synovial fluid to confirm the diagnosis of gout through crystal identification.

The definitive diagnosis of gout is made by identifying monosodium urate (MSU) crystals in the synovial fluid of the affected joint. Joint aspiration allows for the extraction of this fluid, which can then be analyzed under a microscope to detect these crystals.

- **Option B:** While removing the synovial fluid can indeed reduce pressure and provide some relief from pain and inflammation, this is not the primary reason for joint aspiration in the context of suspected gout. The main goal is diagnostic—to confirm the presence of MSU crystals.
- **Option C:** Joint aspiration doesn't provide direct visualization of the joint structures. It is primarily used to obtain synovial fluid for analysis. Other imaging modalities, like X-rays or MRIs, would be

more appropriate for assessing structural joint damage.

- **Option D:** While synovial fluid can be analyzed for various markers and cells, the primary reason for aspiration in the context of suspected gout is to identify the presence of MSU crystals for diagnostic confirmation. Monitoring the response to therapy would be based on clinical symptomatology, uric acid levels, and, in some cases, imaging.

11. A client with iron deficiency anemia is scheduled for discharge. Which instruction about prescribed ferrous gluconate therapy should the nurse include in the teaching plan?

- A. "Take the medication with an antacid."
- B. "Take the medication with a glass of milk."
- C. "Take the medication with cereal."
- D. "Take the medication on an empty stomach."

Correct Answer: D. "Take the medication on an empty stomach."

Preferably, ferrous gluconate should be taken on an empty stomach. For best absorption, the recommendation is to take iron at least 30 minutes before a meal or 2 hours before taking other medications. Oral iron replacement therapy is the most cost-effective and readily available for the general public as ferrous sulfate (20% elemental iron), ferrous gluconate (12% elemental iron), and ferrous fumarate (33% elemental iron).

- **Option A:** If the patient cannot tolerate the gastrointestinal side effects, they may take it with small amounts of food. Avoid taking it with milk, calcium, and antacids, high fiber foods, or caffeine. Lab Work consistent with iron deficiency includes low serum iron levels, low transferrin saturation, and a high total iron-binding capacity (TIBC). For patients receiving oral iron, patients will need to return to the office for repeat bloodwork to monitor tolerability to the medication and will need to be on supplementation for months.
- **Option B:** Some studies have suggested taking iron with orange juice or with vitamin C supplementation to help improve absorption. The most common side effects are gastrointestinal, such as nausea/vomiting, constipation or diarrhea, flatulence, metallic taste, staining of the teeth, or epigastric distress.
- **Option C:** Ferrous gluconate should not be taken with antacids, milk, or whole-grain cereals because these foods reduce iron absorption. Patients can decrease the adverse effects by taking iron supplements on an adjusted regimen (i.e., three times a week instead of daily), or taking it with food, although this may de

12. The doctor has prescribed Exelon (rivastigmine) for the client with Alzheimer's disease. Which side effect is most often associated with this drug?

- A. Urinary incontinence
- B. Headaches
- C. Confusion
- D. Nausea

Correct Answer: D. Nausea

Nausea and gastrointestinal upset are very common in clients taking acetylcholinesterase inhibitors such as Exelon. Other side effects include liver toxicity, dizziness, unsteadiness, and clumsiness. The main adverse effects associated with the use of rivastigmine are gastrointestinal. The primary symptoms are nausea and vomiting. These acute effects primarily occur during the initial dose-escalation phase of therapy upward dose titration of the drug to achieve a therapeutic dose. These events can be minimized by using a slow titration schedule and taking the medication with food if prescribing an oral formulation.

- **Option A:** Toxicity to the drug, while rare, should be carefully monitored. Common manifestations of toxicity include the presence of severe gastrointestinal reactions, allergic cutaneous reactions, as well as central nervous system effects. Classic manifestations of a patient in crisis can be remembered by the mnemonic DUMBELS – diarrhea, urination, miosis, bradycardia, excitability, lacrimation, salivation/excessive sweating prior to treatment.
- **Option B:** The client might already be experiencing urinary incontinence or headaches, but they are not necessarily associated. Patients that are experiencing a cholinergic crisis should have atropine followed by pralidoxime to reverse the anticholinergic effects of rivastigmine. While the usual treatment of the crisis involves giving atropine before pralidoxime, a case study done in 2009 showed a successful reversal of cholinergic crisis with just pralidoxime without atropine pretreatment.
- **Option C:** The client with Alzheimer's disease is already confused. With its approval by the FDA, rivastigmine is indicated to treat mild to moderate dementia of the Alzheimer's type. Its indications also include the treatment of mild to moderate dementia that is associated with Parkinson's disease.

13. Mrs. Bagapayo who had abdominal surgery 3 days earlier complains of sharp, throbbing abdominal pain that ranks 8 on a scale of 1 (no pain) to 10 (worst pain). Which intervention should the nurse implement first?

- A. Assessing the client to rule out possible complications secondary to surgery.
- B. Checking the client's chart to determine when pain medication was last administered.
- C. Explaining to the client that the pain should not be this severe 3 days postoperatively.
- D. Obtaining an order for a stronger pain medication because the client's pain has increased.

Correct Answer: A. Assessing the client to rule out possible complications secondary to surgery.

The nurse's immediate action should be to assess the client in an attempt to exclude possible complications that may be causing the client's complaints. The health care provider ordered the pain medication for routine postoperative pain that is expected after abdominal surgery, not for such complications as hemorrhage, infection, or dehiscence. The nurse should never administer pain medication without assessing the client first.

- **Option B:** Checking the client's chart is appropriate after the nurse determines that the client is not experiencing complications from surgery. It is essential to assist patients to express as factually as possible (i.e., without the effect of mood, emotion, or anxiety) the effect of pain relief measures. Inconsistencies between behavior or appearance and what the patient says about pain relief (or lack of it) may be more a reflection of other methods the patient is using to cope with the pain rather than pain relief itself.
- **Option C:** Pain is subjective, and each person has his own level of pain tolerance. The nurse must always believe the client's complaint of pain. Nurses have the duty to ask their clients about their

pain and believe their reports of pain. Challenging or undermining their pain reports results in an unhealthy therapeutic relationship that may hinder pain management and deteriorate rapport.

- **Option D:** Obtaining an order for a strong medication may be appropriate after the nurse assesses the client and checks the chart to see whether the current analgesic is ineffective. The World Health Organization (WHO) in 1986 published guidelines in the logical usage of analgesics to treat cancer using a three-step ladder approach – also known as the analgesic ladder. The analgesic ladder focuses on aligning the proper analgesics with the intensity of pain.

14. The nurse is caring for a client with a T5 complete spinal cord injury. Upon assessment, the nurse notes flushed skin, diaphoresis above the T5, and a blood pressure of 162/96. The client reports a severe, pounding headache. Which of the following nursing interventions would be appropriate for this client? Select all that apply.

- A. Elevate the HOB to 90 degrees.
- B. Loosen constrictive clothing.
- C. Use a fan to reduce diaphoresis.
- D. Assess for bladder distention and bowel impaction.
- E. Administer antihypertensive medication.
- F. Place the client in a supine position with legs elevated.

Correct Answer: A, B, D, & E

The client has signs and symptoms of autonomic dysreflexia. The potentially life-threatening condition is caused by an uninhibited response from the sympathetic nervous system resulting from a lack of control over the autonomic nervous system.

- **Option A:** The nurse should immediately elevate the HOB to 90 degrees and place extremities dependently to decrease venous return to the heart and increase venous return from the brain. Elevate head of bed to 45-degree angle or place patient in sitting position. Lowers BP to prevent intracranial hemorrhage, seizures, or even death. Note: Placing tetraplegic in sitting position automatically lowers BP.
- **Option B:** Because tactile stimuli can trigger autonomic dysreflexia, any constrictive clothing should be loosened. Removing noxious stimulus usually terminates the episode and may prevent more serious autonomic dysreflexia (in the presence of sunburn, topical anesthetic should be applied). Removal of constrictive clothing and vascular support also promotes venous pooling to help lower BP.
- **Option C:** A fan shouldn't be used because cold drafts may trigger autonomic dysreflexia. Identify and monitor precipitating risk factors (bladder and bowel distention or manipulation; bladder spasms, stones, infection; skin/tissue pressure areas, prolonged sitting position; temperature extremes or drafts).
- **Option D:** The nurse should also assess for distended bladder and bowel impaction, which may trigger autonomic dysreflexia, and correct any problems. Eliminate causative stimulus as able such as bladder, bowel, skin pressure (including loosening tight leg bands or clothing, removing abdominal binder or elastic stockings); temperature extremes.
- **Option E:** Elevated blood pressure is the most life-threatening complication of autonomic dysreflexia because it can cause stroke, MI, or seizures. If removing the triggering event doesn't

reduce the client's blood pressure, IV antihypertensives should be administered. Monitor BP frequently (every 3–5 min) during acute autonomic dysreflexia and take action to eliminate stimulus. Continue to monitor BP at intervals after symptoms subside.

- **Option F:** Early detection and immediate intervention is essential to prevent serious consequences and complications. Note: Average systolic BP in a tetraplegic patient is 120, therefore readings of 140+ may be considered high.

15. Nurse Nikki knows that laboratory results supports the diagnosis of systemic lupus erythematosus (SLE) is:

- A. Elevated serum complement level
- B. Thrombocytosis, elevated sedimentation rate
- C. Pancytopenia, elevated antinuclear antibody (ANA) titer
- D. Leukocytosis, elevated blood urea nitrogen (BUN) and creatinine levels

Correct Answer: C. Pancytopenia, elevated antinuclear antibody (ANA) titer

Laboratory findings for clients with SLE usually show pancytopenia, elevated ANA titer, and decreased serum complement levels.

- **Option A:** Decreased levels of serum complement is usually associated with SLE. The cause of complement activation in SLE is the formation of immune complexes, which in turn activate complement, predominantly by means of the classical pathway.
- **Option B:** Thrombocytopenia is one of the components of pancytopenia. It is a condition in which the platelet count is decreased.
- **Option D:** Clients may have elevated BUN and creatinine levels from nephritis, but the increase does not indicate SLE. The part of the kidney most frequently troubled by SLE is part of the nephron called the glomerulus, a tuft of capillaries that functions to filter substances from the blood. For this reason, the type of kidney inflammation most commonly experienced in lupus is glomerulonephritis.

16. The ABCD method offers one way to assess skin lesions for possible skin cancer. What does the A stand for?

- A. Assessment
- B. Arcus
- C. Actinic
- D. Asymmetry

Correct Answer: D. Asymmetry

- **Option D:** When following the ABCD method for assessing skin lesions, the A stands for "asymmetry," the B for "border irregularity," the C for "color variation," and the D for "diameter."

17. Michael, 42 y.o. The man is admitted to the med-surg floor with a diagnosis of acute pancreatitis. His BP is 136/76, pulse 96, Resps 22, and temp 101. His

past history includes hyperlipidemia and alcohol abuse. The doctor prescribes an NG tube. Before inserting the tube, you explain the purpose to the patient. Which of the following is the most accurate explanation?

- A. "It empties the stomach of fluids and gas."
- B. "It prevents spasms at the sphincter of Oddi."
- C. "It prevents air from forming in the small intestine and large intestine."
- D. "It removes bile from the gallbladder."

Correct Answer: A. "It empties the stomach of fluids and gas."

An NG tube is inserted into the patient's stomach to drain fluid and gas. Nasogastric tubes are part of the standard of care in treating intestinal obstruction and can also be used to provide nutritional support. They are most common in surgical patients but are useful in any patient population where gastric decompression or nutritional support is necessary.

- **Option B:** An NGT does not prevent spasms at the sphincter of Oddi. The most common indication for placement of a nasogastric tube is to decompress the stomach in the setting of distal obstruction. Small bowel obstruction from adhesions or hernias, ileus, obstructing neoplasms, volvulus, intussusception, and many other causes may block the normal passage of bodily fluids such as salivary, gastric, hepatobiliary, and enteric secretions.
- **Option C:** Similarly, intractable nausea or emesis, whether caused by medications, intoxication, or other reasons, can be an indication for the placement of a nasogastric tube in order to prevent aspiration. Prophylactic placement of the NG tube in patients with abdominal surgery is not recommended. Patients who develop postoperative ileus tend to recover faster without the placement of an NG tube.
- **Option D:** Placement of an NGT does not remove bile from the gallbladder. NG tubes have been used for various reasons in patients with GI bleeding. In the past, NG lavage was thought to help control GI bleeding. However, recent studies have shown that this is not helpful. Another indication for placement of a nasogastric tube is in the setting of massive hematochezia.

18. At the Sunshine Pediatric Clinic, Nurse Alex is on duty and responsible for addressing phone consultations. Midway through the morning, the clinic's phone rings, and Alex answers it. On the other end is Mrs. Hamilton, a distressed mother whose 10-year-old child, Sophia, is currently undergoing chemotherapy treatment for leukemia. Mrs. Hamilton informs Nurse Alex that Sophia's younger sibling has just been diagnosed with chickenpox. Given Sophia's compromised immune status, Mrs. Hamilton is deeply concerned about her daughter's risk. Nurse Alex recalls the clinic's protocols and considers the appropriate measures to ensure Sophia's safety. Given the presented situation, which action should Nurse Alex anticipate taking next?

- A. Teach the parents regarding contact and airborne precaution.
- B. Administer varicella-zoster immune globulin to the client.
- C. Prepare the client for admission to a private room in the hospital.
- D. Educate the parent about the correct use of acyclovir (Zovirax).

- E. Instruct the parents to keep the sibling isolated from Sophia.
- F. Schedule an emergency appointment for Sophia at the clinic.

Correct Answer: B. Administer varicella-zoster immune globulin to the client.

Varicella-zoster immune globulin provides passive immunity to those who are at high risk and have been exposed to the virus. Given Sophia's immunocompromised state and her exposure risk, this is the most immediate and appropriate action.

- **Option A:** While educating the parents about precautions is important, it is not the most immediate action to be taken given Sophia's compromised immunity.
- **Option C:** While hospitalization might be a consideration depending on the clinical manifestations and the client's overall health, immediate passive immunization is a priority.
- **Option D:** Acyclovir can be used as a treatment for varicella in high-risk patients, but prior to the onset of the disease, passive immunization is preferred.
- **Option E:** While it is crucial to keep the infected sibling isolated, the immediate priority is to address Sophia's risk of contracting the disease given her compromised state.
- **Option F:** While evaluating Sophia might be necessary, the administration of varicella-zoster immune globulin is the priority in this scenario.

19. When caring for a client with total parenteral nutrition (TPN), what is the most important action on the part of the nurse?

- A. Record the number of stools per day.
- B. Maintain strict intake and output records.
- C. Sterile technique for dressing change at IV site.
- D. Monitor for cardiac arrhythmias.

Correct Answer: C. Sterile technique for dressing change at IV site.

Clients receiving TPN are very susceptible to infection. The concentrated glucose solutions are a good medium for bacterial growth. Strict sterile technique is crucial in preventing infection at IV infusion sites. Catheter-related sepsis rates have decreased since the introduction of guidelines that emphasize sterile techniques for catheter insertion and skin care around the insertion site. The increasing use of dedicated teams of physicians and nurses who specialize in various procedures including catheter insertion also has accounted for a decrease in catheter-related infection rates.

- **Option A:** Progress of patients with a TPN line should be followed on a flowchart. An interdisciplinary nutrition team, if available, should monitor patients. Weight, complete blood count, electrolytes, and blood urea nitrogen should be monitored often (eg, daily for inpatients). Plasma glucose should be monitored every 6 hours until patients and glucose levels become stable. Fluid intake and output should be monitored continuously. When patients become stable, blood tests can be done much less often.
- **Option B:** Volume overload (suggested by > 1 kg/day weight gain) may occur when patients have high daily energy requirements and thus require large fluid volumes.
- **Option D:** Forty-one percent of procedures resulted in atrial arrhythmias and 25% produced some degree of ventricular ectopy, 30% of these were ventricular couplets or greater. Ventricular ectopy was significantly more common in shorter patients and when the catheter was inserted from the right subclavian position (43% ventricular ectopy vs 10% at the other sites). Other variables such

as age, cardiac history, serum potassium, type of procedure, and catheter brand were not significant.

20. You're caring for a patient with a sigmoid colostomy. The stool from this colostomy is:

- A. Formed
- B. Semisolid
- C. Semiliquid
- D. Watery

Correct Answer: A. Formed

A colostomy in the sigmoid colon produces a solid, formed stool. This is the most common type. It is located in the bottom part of the large intestine. The sigmoid colon moves waste to the rectum. Sigmoid colostomies produce stool that is more solid and regular than other colostomies.

- **Option B:** The transverse colon crosses the top of the abdomen. Stool in this area is usually soft. This is because only a small portion of the colon has absorbed water from the indigestible material. This common type of colostomy has 3 versions.
- **Option C:** A double-barrel colostomy divides the colon into 2 ends that form separate stomas. Stool exits from 1 of the stomas. Mucus made by the colon exits from the other. This type of transverse colostomy is the least common. A loop colostomy creates a stoma through which stool exits. In this type, the colon stays connected to the rectum. As a result, people will sometimes pass stool or gas through the rectum.
- **Option D:** The ascending colon runs from the beginning of the large intestine to the right side of the abdomen. In this procedure, only part of the colon still works. As a result, little water is absorbed from the waste. This means the stool is usually liquid. This type of colostomy is rare. An ileostomy is more appropriate for this portion of the colon.

21. A client was brought to the emergency room with complaints of slurring of speech, vomiting, dry mucosa, and dry skin turgor. Lab tests showing serum sodium 125 mEq/L and serum blood glucose of 350 mg/dL. Nurse Sophie will anticipate the physician to initially order which of the following intravenous solutions?

- A. 10% dextrose in water (D10W)
- B. 0.9% normal saline solution
- C. 5% dextrose in water (D5W)
- D. 0.45% normal saline solution

Correct Answer: B. 0.9% normal saline solution

The client is experiencing diabetic ketoacidosis. Initial priority in the treatment is to restore the extracellular fluid volume through the intravenous administration of 0.9% normal saline at 15-20 ml/kg/h. Immediate fluid resuscitation is vital to correct hypovolemia, restore tissue perfusion, and to clear ketones. Hydration improves glycemic control independent of insulin.

- **Options A and C:** Intravenous solutions containing dextrose will be given once serum glucose reaches 250 mg/dL. When the plasma glucose reaches 200-250 mg/dl, and if the patient still has an anion gap, then dextrose-containing fluids should be initiated, and the insulin infusion rate may need to be reduced.
- **Option D:** 0.45% normal saline will be given once serum sodium stabilizes. In patients who have high serum sodium levels, 0.45% NaCl infused at 4–14 ml/kg/hour or 250–500 mL/hr is appropriate, and for patients with hyponatremia, 0.9% NaCl at a similar rate is preferred.

22. Sally is a nurse working in an emergency department and receives a client after a radiological accident. Which task is the utmost priority for the nurse to do first?

- A. Decontaminate the client's clothing.
- B. Decontaminate the open wound on the client's thigh.
- C. Decontaminate the examination room the client is placed in.
- D. Save the client's vomitus for analysis by the radiation safety staff.

Correct Answer: B. Decontaminate the open wound on the client's thigh.

Decontaminating an open wound is the first priority for the client. This minimizes the absorption of radiation in the client's body. A radiological accident is an event that involves the release of potentially dangerous radioactive materials into the environment. This release is usually in the form of a cloud or "plume" and could affect the health and safety of anyone in its path.

- **Option A:** Getting radioactive material off the body as soon as possible can lower a worker's radiation dose from external contamination. Removing outer clothing and showering or, at a minimum, washing the face, hands, and any other exposed skin are essential decontamination steps.
- **Option C:** Decontamination of emergency response workers, their clothing, and any equipment, including PPE they may be using, is essential to limit radiation dose and prevent the spread of radioactive contamination outside of the response area.
- **Option D:** A prodromal period during which victims may experience loss of appetite, nausea, vomiting, fatigue, and diarrhea; after extremely high doses, additional symptoms such as fever, prostration (laying down), respiratory distress, and hyper-excitability can occur. In cases where the dose is not sufficient to cause rapid death, these symptoms usually disappear within 1-2 days.

23. While examining a 2-year-old child, Nurse Victoria sees that the anterior fontanel is open. She should:

- A. Notify the doctor
- B. Look for other signs of abuse
- C. Recognize this as a normal finding
- D. Ask about a family history of Tay-Sachs disease

Correct Answer: A. Notify the doctor

Because the anterior fontanel normally closes between ages 12 and 18 months, the nurse should notify the doctor promptly of this finding. The fontanel can enlarge in the first few months of life, and the median age of closure is 13.8 months. By three months of age, the anterior fontanel is closed in 1 percent of infants; by 12 months, it is closed in 38 percent; and by 24 months, it is closed in 96 percent.

- **Option B:** An open fontanel does not indicate abuse. Fontanel size is influenced by brain growth, dural attachments, suture development, and osteogenesis. The newborn's skull should be evaluated for shape, circumference, suture ridges, and size of anterior and posterior fontanel. Size is calculated by the average of the anteroposterior and transverse dimensions.
- **Option C:** The key feature of a normal anterior fontanel is variation. On the first day of an infant's life, the normal fontanel ranges from 0.6 cm to 3.6 cm, with a mean of 2.1 cm. The fontanel can enlarge in the first few months of life and the median age of closure is 13.8 months.
- **Option D:** An open fontanel is not associated with Tay-Sachs disease. Achondroplasia, congenital hypothyroidism, Down syndrome, rickets, and increased intracranial pressure are among the most common conditions associated with an open anterior fontanel.

24. The nurse is assessing a male client admitted with second-and third-degree burns on the face, arms, and chest. Which finding indicates a potential problem?

- A. Partial pressure of arterial oxygen (PaO₂) value of 80 mm Hg
- B. Urine output of 20 ml/hour
- C. White pulmonary secretions
- D. Rectal temperature of 100.6° F (38° C)

Correct Answer: B. Urine output of 20 ml/hour

A urine output of less than 40 ml/hour in a client with burns indicates a fluid volume deficit.

- **Option A:** This client's PaO₂ value falls within the normal range (80 to 100 mm Hg).
- **Option C:** White pulmonary secretions also are normal.
- **Option D:** The client's rectal temperature isn't significantly elevated and probably results from the fluid volume deficit.

25. Which observation in the newborn of a diabetic mother would require immediate nursing intervention?

- A. Crying
- B. Wakefulness
- C. Jitteriness
- D. Yawning

Correct Answer: C. Jitteriness

Jitteriness is a sign of seizure in the neonate. For infants presenting with clinical signs compatible with hypoglycemia, like apnoea, hypotonia, jitteriness, apathy, hypothermia, tremors and seizures, treatment must ensure that blood glucose levels remain above 0.45 g/L (2.5 mmol/L). An IV bolus dose

of glucose (150-200 mg/kg) should be administered urgently, followed by a constant rate infusion.

- **Option A:** It's normal for a baby to cry for 2–3 hours a day for the first 6 weeks. During the first 3 months of life, they cry more than at any other time. New parents often are low on sleep and getting used to life with their little one.
- **Option B:** Generally, newborns sleep a total of about 8 to 9 hours in the daytime and a total of about 8 hours at night. But because they have a small stomach, they must wake every few hours to eat. Most babies don't start sleeping through the night (6 to 8 hours) until at least 3 months of age. But this can vary a lot. Some babies don't sleep through the night until closer to 1 year.
- **Option D:** It is also common for newborns to hiccup, sneeze, yawn, spit up, burp, and gurgle. Sometimes newborns cry for no reason at all. If this happens, try comforting the baby by rocking, singing, talking softly, or wrapping him or her in a blanket.

26. The school nurse is asked which action will take to have the most impact on the incidence of infectious diseases in school. The correct response is:

- A. Grant written information about infection control to all parents.
- B. Ensure that students are immunized according to national guidelines.
- C. Make soap and water easily accessible in the classrooms.
- D. Educate students on how to cover their mouths when coughing.

Correct Answer: B. Ensure that students are immunized according to national guidelines.

The incidence of once-common infectious diseases like measles, chickenpox, and mumps has been most effectively reduced by immunization of all school-aged children. Infectious diseases that used to be common in children in the United States – including polio, diphtheria, pertussis (whooping cough), rubella (German measles), and chickenpox – are preventable with vaccines approved by the U.S. Food and Drug Administration (FDA).

- **Option A:** People are to be given information on the infectious disease hazards in their environment, the modes of transmission and appropriate control methods. This is best provided during induction and in ongoing training.
- **Option C:** Infectious disease can be spread via contaminated hands. Hand hygiene is one of the most important measures in preventing transmission of infection. Hands can become contaminated from touching contaminated surfaces or by being contaminated through coughing, sneezing, rubbing eyes etc. The infectious agent can then be passed on to others e.g. shaking hands and/or contaminating clean surfaces. Hand should be regularly washed with soap, running water and then dried.
- **Option D:** Respiratory hygiene is a set of routine practices to prevent potentially infectious secretions from the nose and mouth from contaminating others directly or indirectly via surfaces. Cough into a single use tissue or into the sleeve, never into the hands. Always turn to direct the cough away from others and away from surfaces or food sources.

27. Which of the following interventions is essential when instilling Cortisporin suspension, 2 gtt right ear?

- A. Verifying the proper client and route.
- B. Warming the solution to prevent dizziness.

- C. Holding an emesis basin under the client's ear.
- D. Positioning the client in the Semi-fowler's position.

Correct Answer: A. Verifying the proper client and route.

When giving medications, a nurse follows the five R's of medication administration. The right patient: check that you have the correct patient using two patient identifiers (e.g., name and date of birth). The right route: check that the route is appropriate for the patient's current condition.

- **Option B:** The drops may be warmed to prevent pain or dizziness, but this action is not essential. Internal ear structures are particularly sensitive to temperature extremes. Therefore, ear (otic) medications should always be administered at room temperature. Always use sterile ear drops in case the eardrum is ruptured.
- **Option C:** An emesis basin would be used for irrigation of the ear. Apply gentle pressure to the tragus several times. Pressure helps move medication toward the tympanic membrane. If ordered, a cotton ball may be placed loosely in the ear canal. Cotton balls help prevent the medication from escaping from the ear.
- **Option D:** Put the client in the lateral position to prevent the drops from draining out for 5 minutes, not Semi-fowler's position. Position patient with affected ear uppermost, on the unaffected side, if lying down, or tilt head to the side if sitting up. Proper positioning helps to stop the medication from escaping. Do not tilt the head if the patient has a cervical spine injury.

28. A female client has just been diagnosed with condylomata acuminata (genital warts). What information is appropriate to tell this client?

- A. This condition puts her at a higher risk for cervical cancer; therefore, she should have a Papanicolaou (Pap) smear annually.
- B. The most common treatment is metronidazole (Flagyl), which should eradicate the problem within 7 to 10 days.
- C. The potential for transmission to her sexual partner will be eliminated if condoms are used every time they have sexual intercourse.
- D. The human papillomavirus (HPV), which causes condylomata acuminata, can't be transmitted during oral sex.

Correct Answer: A. This condition puts her at a higher risk for cervical cancer; therefore, she should have a Papanicolaou (Pap) smear annually.

Women with condylomata acuminata are at risk for cancer of the cervix and vulva. Yearly Pap smears are very important for early detection. Cervical cancer screening guidance comes from the American Cancer Society guidelines and does not require modification with the presence or absence of genital warts. There are no indications for females younger than 21 to be screened for cervical cancer.

- **Option B:** Because condylomata acuminata is a virus, there is no permanent cure. Topical therapies, cryotherapy, and surgical excision are available treatment options for patients. A formal treatment algorithm does not exist, and treatment depends on lesion location, morphology, and patient preference.
- **Option C:** Because condylomata acuminata can occur on the vulva, a condom won't protect sexual partners. The patient should receive education on safe sex practice; this means using barrier protection, avoiding anal sex, and multiple partners. The patient should be encouraged to be tested for other sexually transmitted infections and maintain long-term follow-up.

- **Option D:** HPV can be transmitted to other parts of the body, such as the mouth, oropharynx, and larynx. While condyloma acuminata generally occur in the anogenital region, lesions may also be present in the oral cavity. Simultaneous lesions in the anogenital region suggest sexual transmission, but fomites may also be the source of condyloma acuminata present in the oral cavity.

29. Which of the following conditions is an equal decrease of extracellular fluid (ECF) solute and water volume?

- A. Hypotonic FVD
- B. Isotonic FVD
- C. Hypertonic FVD
- D. Isotonic FVE

Correct Answer: B. Isotonic FVD

Isotonic FVD involves an equal decrease in solute concentration and water volume. ISOTONIC FLUID VOLUME deficit is a proportionate loss of sodium and water. Characterized by decreased extracellular fluid, including decreased circulating blood volume, isotonic fluid volume deficit results in signs and symptoms of dehydration. Common causes include vomiting, diarrhea, and polyuria.

- **Option A:** Hypotonic dehydration occurs when sodium loss is greater than water loss, resulting in a decrease in serum osmolality. This causes a shift of water from the extracellular space into the intracellular space. The cells swell and cerebral edema may occur. Hyponatremia can be acute or chronic.
- **Option C:** Hypertonic dehydration occurs when water excretion from the body exceeds that of sodium excretion, resulting in increased sodium concentration in the extracellular fluid (hypernatremia). Blood osmolality is increased, causing water to shift from the intracellular to the extracellular space.
- **Option D:** The excess of both solutes and water, which is also termed isotonic volume excess. The additional fluid is retained in the extracellular compartment resulting in fluid accumulation in the interstitial spaces.

30. A client at 8 weeks' gestation calls complaining of slight nausea in the morning hours. Which of the following client interventions should the nurse question?

- A. Taking 1 teaspoon of bicarbonate of soda in an 8-ounce glass of water.
- B. Eating a few low-sodium crackers before getting out of bed.
- C. Avoiding the intake of liquids in the morning hours.
- D. Eating six small meals a day instead of three large meals.

Correct Answer: A. Taking 1 teaspoon of bicarbonate of soda in an 8-ounce glass of water.

Using bicarbonate would increase the amount of sodium ingested, which can cause complications.

- **Option B:** Eating low-sodium crackers would be appropriate. Foods high in starch — such as saltines, bread, and toast — help absorb gastric acid and settle a queasy stomach. The bland

nature of a cracker helps to satisfy hunger (excessive hunger can exacerbate nausea) without the strong smells or tastes that may increase nausea.

- **Option C:** Since liquids can increase nausea avoiding them in the morning hours when nausea is usually the strongest is appropriate.
- **Option D:** Eating six small meals a day would keep the stomach full, which often decreases nausea.

31. A client is receiving sulfasalazine (Azulfidine) for the treatment of ulcerative colitis. Which of the following assessment findings will concern the nurse most?

- A. Drowsiness
- B. Decreased urine output
- C. Urine discoloration
- D. Vomiting

Correct Answer: B. Decreased urine output

Sulfasalazine is used to treat bowel inflammation, diarrhea (stool frequency), rectal bleeding, and abdominal pain in patients with ulcerative colitis. It is nephrotoxic, so a decrease in urine output is the most serious concern.

- **Options A, C, & D:** These are also side effects but are less serious.

32. Nurse Maureen knows that the non-antipsychotic medication used to treat some clients with schizoaffective disorder is:

- A. phenelzine (Nardil)
- B. clordiazepoxide (Librium)
- C. lithium carbonate (Lithane)
- D. imipramine (Tofranil)

Correct Answer: C. lithium carbonate (Lithane)

Lithium carbonate, an antimanic drug, is used to treat clients with cyclical schizoaffective disorder, a psychotic disorder once classified under schizophrenia that causes affective symptoms, including manic-like activity. Lithium helps control the affective component of this disorder. Lithium was the first mood stabilizer and is still the first-line treatment option, but is underutilized because it is an older drug. Lithium is a commonly prescribed drug for a manic episode in bipolar disorder as well as maintenance therapy of bipolar disorder in a patient with a history of a manic episode. The primary target symptoms of lithium are mania and unstable mood.

- **Option A:** Phenelzine is a monoamine oxidase inhibitor prescribed for clients who don't respond to other antidepressant drugs such as imipramine. Phenelzine is an FDA-approved drug for the management of depression in adults. Off label, the drug may be used for the management of treatment-resistant depression, panic disorder, and social anxiety disorder. Phenelzine is also specifically useful for young women who have depression and mood disorders. Research has not established the safety and efficacy for children or adolescents.

- **Option B:** Chlordiazepoxide, an antianxiety agent, generally is contraindicated in psychotic clients. Chlordiazepoxide is a long-acting benzodiazepine and is an FDA approved medication for adults with mild-moderate to severe anxiety disorder, preoperative apprehension and anxiety, and withdrawal symptoms of acute alcohol use disorder. It is also FDA approved for pediatric patients greater than six years old for anxiety.
- **Option D:** Imipramine, primarily considered an antidepressant agent, is also used to treat clients with agoraphobia and those undergoing cocaine detoxification. Imipramine is a tertiary amine tricyclic antidepressant. Tricyclic antidepressants (TCAs) had been approved by the Food and Drug Administration (FDA) as antidepressants in the 1950s. Although it is FDA approved for the treatment of depression, it is a second-line treatment notably in severe depression with melancholic and atypical features, due to its undesirable side effects and due to its toxicity in overdose.

33. A nurse prepares to administer an intramuscular injection to a 6-month-old infant. The nurse selects which site to administer the medication?

- A. Rectus femoris
- B. Dorsal gluteal
- C. Ventrogluteal
- D. Vastus lateralis

Correct Answer: D. Vastus lateralis

Intramuscular injection sites are selected based on the child's age and muscle development. The vastus lateralis is the only safe muscle group to use for intramuscular injection in a 6 month-old infant. Muscle has fewer pain-sensing nerves than subcutaneous tissue and is less sensitive to irritating and viscous medications, so pain is lessened.

- **Option A:** I.M. injections are administered in newborns to deliver medications deeply into the muscle without causing injury to the tiny patient. Skeletal muscle can accommodate larger volumes of medication than subcutaneous tissue, and absorption is faster because muscle tissue is highly vascular.
- **Option B:** Never give an IM injection in the buttocks. Using the vastus lateralis muscle avoids the risk of sciatic nerve damage from gluteal injection. Also, the vastus lateralis muscle has a larger muscle mass than the gluteal region and therefore has reduced risk of severe local reactions.
- **Option C:** The ventrogluteal site is unsafe for that age. Avoid subcutaneous and intramuscular injections when intravenous administration is a suitable alternative option. Make sure that infants do not move during the IM injection. This is very important.

34. Ben feels hatred each time he sees her father showing affection to her mother. According to Freud, this behavior is known as?

- A. Misomater
- B. Oedipus Complex
- C. Superiority Complex
- D. Electra Complex

Correct Answer: B. Oedipus complex

Oedipus complex is a Freudian concept that describes a child's sexual desire for the parent of the opposite sex and a sense of rivalry with the parent of the same sex. This desire is kept out of conscious awareness through repression, but Freud believed that it still had an influence over a child's behavior and played a role in development.

- **Option A:** Misomater is a term that describes a person's animosity toward his or her mother. Parent-offspring conflict describes the evolutionary conflict arising from differences in optimal fitness of parents and their offspring.
- **Option C:** Superiority complex is a psychological behavior that exists when a person overcompensates his or her feelings of inferiority. A superiority complex is a belief that one's abilities or accomplishments are somehow dramatically better than other people's. People with a superiority complex may be condescending, smug, or mean to other people who don't agree with them.
- **Option D:** Electra complex is used to describe a girl's attraction to their father and resentment or rivalry towards their mothers. The term Electra complex was introduced by Carl Jung to describe how this complex manifests in girls.

35. The client is admitted to the hospital with hypertensive crises. Diazoxide (Hyperstat) is ordered. During administration, the nurse should:

- A. Utilize an infusion pump
- B. Check the blood glucose level
- C. Place the client in Trendelenburg position
- D. Cover the solution with foil

Correct Answer: B. Check the blood glucose level

Hyperstat is given as an IV push for hypertensive crises, but it often causes hyperglycemia. The glucose level will drop rapidly when stopped. This medication is used to treat very low blood sugar (hypoglycemia). Certain conditions (such as tumor on the pancreas, cancer, leucine sensitivity) can cause the release of too much insulin. Insulin is a natural substance that lowers blood sugar. This drug works by preventing insulin release from the pancreas, helping to return the blood sugar to normal levels. Diazoxide is a thiazide drug, but has no diuretic ("water pill") effects like other thiazides.

- **Option A:** Diazoxide (Hyperstat) is given by IV push. Diazoxide is a potassium channel activator. Its mechanism of action revolves around enhancing cell membrane permeability to potassium ions. This action consequently elicits the relaxation of local smooth muscles. This switches off voltage-gated calcium ion channels which inhibits the generation of an action potential.
- **Option C:** The client should be placed in dorsal recumbent position, not a Trendelenburg position. Diazoxide is used to treat low blood sugar (hypoglycemia) caused by certain cancers or other conditions that can make the pancreas release too much insulin. This medicine is for use in adults and children as young as infants.
- **Option D:** This medication does not have to be covered with foil. Store at room temperature away from moisture, heat, and light. Diazoxide is only part of a treatment program that may also include diet. Follow the doctor's instructions very closely.