

Kevin's Review - 85 NCLEX Practice Questions

1. You are preparing a child for IV conscious sedation before the repair of a facial laceration. What information should you report immediately to the physician?

- A. The child suddenly pulls out the IV
- B. The parent is not sure regarding the child's tetanus immunization status
- C. The parent wants information about the IV conscious sedation
- D. The parent's refusal of the administration of the IV sedation

Correct Answer: D. The parent's refusal of the administration of the IV sedation.

The refusal of the parents is an absolute contraindication; therefore the physician must be notified. But the autonomy of parents is very obviously different from the autonomy of patients to make decisions for themselves. While adult patients are generally thought to have an absolute right to refuse medical treatment for themselves, we don't usually think that parents can refuse all medical treatment for their children.

- **Option A:** The RN can reestablish the IV access. Parents' views might, at least in some circumstances, influence whether or not treatment would be in a child's best interests. Nurses and doctors are able to administer fluid directly into the veins using IV therapy. IV therapy is a relatively simple process that can be performed by nurses, but there are serious complications associated with it.
- **Option B:** Tetanus status can be addressed later. Tetanus immunization is part of the DTaP (diphtheria, tetanus, and acellular pertussis) vaccinations. Kids usually get: a series of four doses of DTaP vaccine before 2 years of age. another dose at 4–6 years of age.
- **Option C:** The RN can provide information about conscious sedation. Identifying teachable moments in clinical practice is an effective way to increase workplace learning with all nurses playing a role, not just nurse educators.

2. Prior to administering chlorpromazine (Thorazine) to an agitated client, the nurse should:

- A. Assess skin color and sclera
- B. Assess the radial pulse
- C. Take the client's blood pressure
- D. Ask the client to void

Correct Answer: C. Take the client's blood pressure

Because chlorpromazine (Thorazine) can cause a significant hypotensive effect (and possible client injury), the nurse must assess the client's blood pressure (lying, sitting, and standing) before administering this drug. When administered as intramuscular or intravenous injections, it may cause hypotension and headache. Prolonged use of chlorpromazine may cause corneal deposits and lens opacity. It may prolong the QT interval.

- **Option A:** If the client had taken the drug previously, the nurse would also need to assess the skin color and sclera for signs of jaundice, a possible drug side effect; however, based on the information given here, there is no evidence that the client has received chlorpromazine before.

- **Option B:** The hepatic P450 enzyme CYP2D6 metabolizes the drug, and its half-life is approximately 30 hours. It gets excreted from the body via urine and in bile. Studies have shown the correlation between chlorpromazine's therapeutic level and the improvement of the psychiatric symptoms. Researchers have noted that the patients receiving chronic treatment with chlorpromazine have lower plasma levels as compared to the patients acutely treated on an oral dose of chlorpromazine.
- **Option D:** Although the drug can cause urine retention, asking the client to avoid will not alter this anticholinergic effect. Chlorpromazine is a low-potency antipsychotic that mainly causes non-neurologic side effects. It is highly lipid-soluble and stored in body fats, thus very slow to be removed from the body. Being a low-potency typical antipsychotic, it primarily causes dry mouth, dizziness, urine retention, blurred vision, and constipation by blocking the muscarinic receptors. There is a risk of angle-closure glaucoma in the elderly. It also causes sedation due to the blockade of histamine H1 receptors.

3. The initial nursing intervention for the significant-others during shock phase of a grief reaction should be focused on:

- A. Presenting the full reality of the loss of the individuals.
- B. Directing the individual's activities at this time.
- C. Staying with the individuals involved.
- D. Mobilizing the individual's support system.

Correct Answer: C. Staying with the individuals involved.

This provides support until the individual's coping mechanisms and personal support systems can be immobilized. Assess the patient's ability to make decisions. Grief may limit a person's cognitive ability that is needed in decision-making and problem-solving. Know the availability of support systems for the patient. If the patient's main support is the object of perceived loss, the patient may need help in naming other sources of support.

- **Option A:** Review and point out strengths and progress to date. Reviewing a patient's progress is very helpful and provides perspective in the whole process. Communicate therapeutically with patient and family members and allow them to verbalize feelings. Sharing feelings with a healthcare provider may help the patient find significance in the experience of loss.
- **Option B:** Encourage significant others to manage their own self-care needs for rest, sleep, nutrition, leisure activities, and time away from the patient. Alteration in normal activities is evident during this time of stress. Care should be taken to treat these symptoms so that emotional reconstitution is not complicated by illness.
- **Option D:** Initiate a process that provides additional support and resources. The patient and family may benefit from spiritual support resources. Support the patient and significant others share mutual fears, concerns, plans, and hopes for each other. Keeping secrets won't do any help during this time. These times of stress can be used as an opportunity for growth and family development.

4. A 56-year-old patient, recently diagnosed with end-stage renal disease, is preparing for their first peritoneal dialysis session in a clinic. The patient has a history of diabetes and hypertension, and has been experiencing increasing fatigue and fluid retention. Upon arrival, the nurse notes that the patient appears anxious about the procedure. The patient's vital signs are stable, with a

blood pressure of 150/90 mmHg, pulse 78 bpm, and respiratory rate 16 breaths per minute. The nurse reviews the physician's orders, which indicate the type and volume of dialysate to be used. The peritoneal dialysis catheter had been placed a week earlier, and there's no sign of infection at the site. The patient is settled in a comfortable position in the dialysis room, which is equipped with all necessary emergency equipment. Considering this scenario, which of the following actions should the nurse prioritize?

- A. Assess for a bruit and a thrill.
- B. Warm the dialysate solution.
- C. Position the client on the left side.
- D. Insert a Foley catheter
- E. Assess the patient's understanding of the peritoneal dialysis procedure.
- F. Address the patient's anxiety and provide emotional support.

Correct Answer: B. Warm the dialysate solution.

Cold dialysate increases discomfort. The solution should be warmed to body temperature in a warmer or heating pad; don't use a microwave oven.

- **Option A:** Assessing for bruit and thrill can be done to check for the patency of the fistula.
- **Option C:** The client may resume a position that will be comfortable for him.
- **Option D:** A Foley catheter is unnecessary during peritoneal dialysis.

5. Kris with a history of chronic infection of the urinary system complains of urinary frequency and burning sensation. To figure out whether the current problem is of renal origin, the nurse should assess whether the client has discomfort or pain in the:

- A. Urinary meatus
- B. Pain in the labium
- C. Suprapubic area
- D. Right or left costovertebral angle

Correct Answer: D. Right or left costovertebral angle

Discomfort or pain is a problem that originates in the kidney. It is felt at the costovertebral angle on the affected side. Flank or costovertebral angle (CVA) tenderness is most commonly unilateral over the involved kidney, although bilateral discomfort may be present. Discomfort varies from absent to severe. This finding is usually not subtle and may be elicited with mild or moderately firm palpation.

- **Option A:** Pain or discomfort in the urinary meatus can also be indicative of urethritis or acute urinary tract infection. In both men and women, common causes of urethral pain include sexually transmitted diseases (STDs) such as chlamydia, local irritation from soaps or spermicides, and urinary tract infections (UTIs). In men, prostatitis isn't an uncommon cause, whereas in women, vaginal dryness due to menopause can be an issue.

- **Option B:** Pain in the labium can be due to a swollen labia or vulva. Chronic yeast infections and bacterial infections can both cause pain that ranges from mild discomfort and itching to severe burning or throbbing. Viral and bacterial infections, such as bacterial vaginosis and the herpes simplex virus, can also cause vulvar pain or discomfort.
- **Option C:** Suprapubic pain has a wide variety of causes, and can include pyelonephritis, perinephric abscess, and nephrolithiasis. Gynecological causes are common with suprapubic pain. Suprapubic pain happens in the lower abdomen near where the hips and many important organs, such as the intestines, bladder, and genitals, are located. Suprapubic pain can have a wide variety of causes, so the doctor may need to do tests of vital functions before diagnosing the underlying cause.

6. Which of the following statements is true when educating clients about penicillin therapy?

- A. The client must take the medication at evenly spaced intervals.
- B. The client may save leftover medication for a future illness.
- C. If signs of an allergic reaction, continue the medication and notify the physician.
- D. Clients taking oral contraceptives must be cautioned to use an alternate form of birth control while being treated with penicillin.

Correct Answer: D. Clients taking oral contraceptives must be cautioned to use an alternate form of birth control while being treated with penicillin.

Penicillin will reduce the effectiveness of birth control pills. Numerous antibiotics have been implicated in causing oral contraceptive failure by means of interfering with the enterohepatic recirculation of ethinylestradiol. The two groups of antibiotics most commonly involved in contraceptive failures are tetracyclines and penicillins, namely ampicillin.

- **Option A:** The safety of penicillin and penicillin derivatives when administered either intramuscularly, intravenously, or orally for extended periods of time (beyond the usual duration of use) can be extrapolated from multiple published studies. A review of the medical literature reveals studies in which such drugs have been used therapeutically for extended treatment durations. This includes studies of the treatment of recurrent acute otitis media, endocarditis, salmonella infections, prophylaxis of at-risk populations (asplenic children, young children with sickle cell disease, patients with prior rheumatic fever), and the long term treatment of certain types of Lyme disease.
- **Option B:** 159 patients were treated with 200,000 units orally BID, 143 were treated with 200,000 units orally BID-TID, and 9 patients were treated with an unspecified dose. In these studies, the safety and tolerability of the regimen is summarized by such descriptions as the treatment was “generally well tolerated.” There were no reports in any of these studies of adverse events including serious adverse events or adverse events requiring treatment.
- **Option C:** Although there are no specific studies that directly assess the safety of these antibiotics when given over an extended period of time, there is a significant amount of information that supports the safety of such therapy. Despite very wide usage for many years, no reports were found in the literature which described specific adverse events related to long term use of penicillin or amoxicillin.

7. A client with hypothyroidism frequently complains of feeling cold. The nurse should tell the client that she will be more comfortable if she:

- A. Uses an electric blanket at night
- B. Dresses in extra layers of clothing
- C. Applies a heating pad to her feet
- D. Takes a hot bath morning and evening

Correct Answer: B. Dresses in extra layers of clothing

- Option B: Cold intolerance is a symptom of hypothyroidism. Dressing in layers and using extra covering will help decrease the feeling of being cold that is experienced by the client.
- Options A and C: Decreased sensation and decreased alertness are common in the client with hypothyroidism; therefore, the use of electric blankets and heating pads can result in burns.
- Option D: The client with hypothyroidism has dry skin, and a hot bath morning and evening would make her condition worse.

8. A nurse is administering an IV bolus of cimetidine (Tagamet). Which of the following should the nurse monitor closely follow the administration?

- A. Respiratory rate
- B. Skin turgor
- C. Blood pressure
- D. Temperature

Correct Answer: C. Blood pressure

Rapid intravenous administration of Cimetidine causes hypotension due to arterial vasodilation. It is recommended to be injected slowly over a period of not less than 5 minutes.

- **Options A, B, & D:** These are not related to this medication.

9. A male client with type 1 diabetes is scheduled to receive 30 U of 70/30 insulin. There is no 70/30 insulin available. As a substitution, the nurse may give the client:

- A. 9 U regular insulin and 21 U neutral protamine Hagedorn (NPH).
- B. 21 U regular insulin and 9 U NPH.
- C. 10 U regular insulin and 20 U NPH.
- D. 20 U regular insulin and 10 U NPH.

Correct Answer: A. 9 U regular insulin and 21 U neutral protamine Hagedorn (NPH).

A 70/30 insulin preparation is 70% NPH and 30% regular insulin. Therefore, a correct substitution requires mixing 21 U of NPH and 9 U of regular insulin.

- **Option B:** Using this dosage would be incorrect and may produce no effect on the client's blood sugar level.
- **Option C:** This is an incorrect insulin dose. Incorrect administration can result in transient and serious hypoglycemia and hyperglycemia, wide glycemic excursions, and diabetic ketoacidosis.

- **Option D:** This is an incorrect dosage for the prescribed insulin. Glycemic control is poorer in those who lacked confidence in their ability to choose correct doses.

11. Nurse Maureen has assisted a physician with the insertion of a chest tube. The nurse monitors the client and notes fluctuation of the fluid level in the water seal chamber after the tube is inserted. Based on this assessment, which action would be appropriate?

- A. Inform the physician.
- B. Continue to monitor the client.
- C. Reinforce the occlusive dressing.
- D. Encourage the client to deep breathe.

Correct Answer: B. Continue to monitor the client.

The presence of fluctuation of the fluid level in the water seal chamber indicates a patent drainage system. With normal breathing, the water level rises with inspiration and falls with expiration. Fluctuation stops if the tube is obstructed, if a dependent loop exists, if the suction is not working properly, or if the lung has re-expanded.

- **Option A:** Monitor water-seal chamber “tidaling.” Note whether the change is transient or permanent. The water-seal chamber serves as an intrapleural manometer (gauges intrapleural pressure); therefore, fluctuation (tidaling) reflects pressure differences between inspiration and expiration.
- **Option C:** If the catheter is dislodged from the chest, cover insertion site immediately with petrolatum dressing and apply firm pressure. Notify the physician at once. Pneumothorax may recur, requiring prompt intervention to prevent fatal pulmonary and circulatory impairment.
- **Option D:** Assist the patient with splinting painful areas when coughing, deep breathing. Supporting chest and abdominal muscles makes coughing more effective and less traumatic.

12. The client on Haldol has pill rolling tremors and muscle rigidity. He is likely manifesting:

- A. Tardive dyskinesia
- B. Pseudoparkinsonism
- C. Akinesia
- D. Dystonia

Correct Answer: B. Pseudoparkinsonism

Pseudoparkinsonism is a side effect of antipsychotic drugs characterized by mask-like faces, pill-rolling tremors, muscle rigidity. Patients with this disorder have apraxic slowness, paratonic rigidity, frontal gait disorder, and elements of akinesia that, taken together, may be mistaken for true parkinsonism. Pseudoparkinsonism appears to be common and is most often due to Alzheimer’s disease or vascular dementia.

- **Option A:** Tardive dyskinesia is manifested by lip-smacking, wormlike movement of the tongue. Tardive dyskinesia (TD) is a syndrome that includes a group of iatrogenic movement disorders

caused due to a blockade of dopamine receptors. The movement disorders include akathisia, dystonia, buccolingual stereotypy, myoclonus, chorea, tics, and other abnormal involuntary movements which are commonly caused by the long-term use of typical antipsychotics.

- **Option C:** Akinesia is characterized by a feeling of weakness and muscle fatigue. The term akinesia refers to the inability to perform a clinically perceivable movement. It can present as a delayed response, freezing mid-action, or even total abolition of movement. Akinesia occurs when movement is not perceived either because the amplitude of the movement is small or because the time taken to initiate the reaction is significantly increased.
- **Option D:** Dystonia is manifested by torticollis and rolling back of the eyes. Dystonia is defined by involuntary maintained contraction of agonist and antagonist muscles yielding abnormal posturing, twisting, and repetitive movements or tremulous and can be initiated or worsened by attempted movement.

13. A client with Congestive heart failure is about to take a dose of furosemide (Lasix). Which of the following potassium levels, if noted in the client's record, should be reported before giving the due medication?

- A. 5.1 mEq/L.
- B. 4.9 mEq/L.
- C. 3.9 mEq/L.
- D. 3.3 mEq/L.

Correct Answer: D. 3.3 mEq/L.

The normal potassium level is 3.5 to 5.5 mEq/L. Low potassium levels can be dangerous, especially for people with CHF. Low potassium can cause fatal heart arrhythmias. An abnormal serum K⁺ level is associated with an increased risk of ventricular arrhythmia and sudden cardiac death (SCD) and these patients are generally prescribed furosemide and potassium chloride (KCl).

- **Option A:** Furosemide, a short-acting diuretic is commonly recommended as an essential drug in patients with heart failure and fluid retention. A recent study has shown that furosemide administration increases mortality in heart failure rat models. The commonly used drugs, furosemide, and KCl in the treatment of various diseases render the differential expression of proteins in the LV tissue, which is involved in the cardiac conductivity.
- **Option B:** The risk of hypokalemia increases with the use of a high dose of furosemide, decreased oral intake of potassium in patients with hyperaldosteronism states (liver abnormalities or licorice ingestion), or concomitant use of corticosteroid, ACTH, and laxatives.
- **Option C:** Careful monitoring of the patient's clinical condition, daily weight, fluids intake, and urine output, electrolytes, i.e., potassium and magnesium, kidney function monitoring with serum creatinine and serum blood urea nitrogen level is vital to monitor the response to furosemide. If indicated as diuresis with furosemide, replete electrolytes lead to electrolyte depletion and adjust the dose or even hold off on furosemide if laboratory work shows signs of kidney dysfunction.

14. Etiologies associated with hypocalcemia may include all of the following except:

- A. Renal failure

- B. Inadequate intake calcium
- C. Metastatic bone lesions
- D. Vitamin D deficiency

Correct Answer: C. Metastatic bone lesions

Metastatic bone lesions are associated with hypercalcemia due to accelerated bone metabolism and release of calcium into the serum. Although more common in adults than pediatric patients, the next important etiology to consider is malignancy. Renal carcinomas, leukemias, lymphomas, and rhabdomyosarcoma can be associated with elevated calcium levels mediated by the action of PTH-related peptides. Renal failure, inadequate calcium intake, and vitamin D deficiency may cause hypocalcemia.

- **Option A:** CKD leads to impaired phosphate excretion which drives PTH secretion and can cause secondary hyperparathyroidism. However, due to impaired Vitamin D metabolism and high phosphorus level, the serum calcium remains low despite the high PTH.
- **Option B:** Serum calcium is normally bound to proteins in the blood most prominently albumin and therefore low albumin states can give a falsely low total serum calcium level. Ionized calcium level is usually normal in these states and thus a correction of adding 0.8 mg/dL to serum calcium level is usually recommended for every 1gm drop in serum albumin below normal (4 gm/dL)
- **Option D:** Absolute or relative Vitamin D deficiency includes lack of active metabolite of vitamin D due to inadequate sun exposure or liver disease or kidney disease. Also, included in this category are familial causes of vitamin D resistance.

15. The nurse understands that electroconvulsive therapy is primarily used in psychiatric care for the treatment of:

- A. Anxiety disorders
- B. Depression
- C. Mania
- D. Schizophrenia

Correct Answer: B. Depression

Electroconvulsive therapy (ECT) can provide relief for patients with severe depression who have not been able to feel better with other treatments. In some severe cases where rapid response is necessary or medications cannot be used safely, ECT can even be a first-line intervention. ECT consists of a series of sessions, typically three times a week, for two to four weeks. ECT is indicated in patients with treatment-resistant depression or severe major depression that impairs activities of daily living. The definition of treatment-resistant depression is depression that is unresponsive to multiple antidepressant medication trials.

- **Option A:** Suicidal ideation is rapidly relieved by ECT, and complete resolution was seen in 38% of patients after one week, 61% of patients after two weeks and in 81% of patients with the completion of ECT. ECT is also recommended for patients that have exhibited a favorable response to ECT previously. ECT is a relatively safe and low-risk procedure that is helpful in the treatment of depression, suicidality, severe psychosis, food refusal secondary to depression, and catatonia.
- **Option C:** There are also suggestions for ECT as a treatment for suicidality, severe psychosis, food refusal secondary to depression, and catatonia. Bipolar depressive and manic patients can also receive treatment with ECT. ECT may have a safer profile than antidepressants or

antipsychotics in debilitated, elderly, pregnant, and breastfeeding patients.

- **Option D:** In a patient under intravenous sedation or general anesthesia, electroconvulsive therapy (ECT) uses an electric current to create a generalized cerebral seizure. Although it is primarily utilized to treat patients with severe depression, patients with schizophrenia, schizoaffective disorder, catatonia, neuroleptic malignant syndrome, and bipolar disorder may also benefit.

16. 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.

17. A client is admitted with needle tracks on his arm, stuporous and with pinpoint pupil will likely be managed with:

- A. naltrexone (Revia)
- B. naloxone hydrochloride (Narcan)
- C. disulfiram (Antabuse)
- D. methadone (Dolophine)

Correct Answer: B. naloxone hydrochloride (Narcan)

Narcan is a narcotic antagonist used to manage the CNS depression due to overdose with heroin. Naloxone is indicated for the treatment of opioid toxicity, specifically to reverse respiratory depression from opioid use. It is useful in accidental or intentional overdose and acute or chronic toxicity. Common opioid overdoses treated with naloxone include heroin, fentanyl, carfentanil, hydrocodone, oxycodone, methadone, and others.

- **Option A:** This is an opiate receptor blocker used to relieve the craving for heroin. Naltrexone is an opioid antagonist used to treat alcohol use disorder and opioid dependence. Naltrexone is a mu-opioid antagonist. It is FDA-approved for alcohol abuse and opioid dependence treatment. Off-label use includes treatment of cholestatic pruritus in adults. Researchers are studying its use

in patients with stimulant addiction, particularly for patients with polydrug dependence on opioids, heroin, and amphetamine.

- **Option C:** Disulfiram is used as a deterrent in the use of alcohol. Disulfiram is one of three drugs approved by the FDA for the treatment of alcohol dependence. It is a second-line option (acamprosate and naltrexone are first-line treatments) in patients with sufficient physician supervision. Disulfiram is safe and efficient in supervised short-term and long-term treatment of individuals dependent on alcohol but who are motivated to discontinue alcohol use.
- **Option D:** Methadone is used as a substitute in the withdrawal from heroin. Methadone and buprenorphine are FDA approved to treat opioid use disorder as part of federally regulated opioid treatment programs. Methadone prescriptions are for detoxification and maintenance therapy. Methadone is a useful agent for opioid withdrawal symptoms such as tachycardia, diaphoresis, nausea, vomiting, diarrhea, etc.

18. A laboring client has external electronic fetal monitoring in place. Which of the following assessment data can be determined by examining the fetal heart rate strip produced by the external electronic fetal monitor?

- A. Gender of the fetus
- B. Fetal position
- C. Labor progress
- D. Oxygenation

Correct Answer: D. Oxygenation

Oxygenation of the fetus may be indirectly assessed through fetal monitoring by closely examining the fetal heart rate strip. Accelerations in the fetal heart rate strip indicate good oxygenation, while decelerations in the fetal heart rate sometimes indicate poor fetal oxygenation.

- **Option A:** In the second and third trimesters of pregnancy, ultrasound imaging scans the genital anatomy of the fetus to identify its gender. In the early studies conducted on the use of ultrasound results for identifying the fetal gender, a male fetus was demonstrated by the presence of a scrotum and a penis, and a female fetus by the absence of these organs.
- **Option B:** Ultrasonography is noninvasive and has been found to be more accurate for assessing position of the fetal head, during labor. Recent studies by Sherer et al., Chou et al., Dupuis et al., and Zahalka et al. have shown that ultrasound scanning is a quick and efficient way of increasing the accuracy of the assessment of fetal head position during the second stage of labor.
- **Option C:** Recently, intrapartum transperineal ultrasound for the assessment of fetal head descent has been introduced to assess labor progress in the first stage of labor in a more objective and non-invasive way.

19. A nurse is assigned to the pediatric rheumatology clinic and is assessing a child who has just been diagnosed with juvenile idiopathic arthritis. Which of the following statements about the disease is most accurate?

- A. The child has a poor chance of recovery without joint deformity.
- B. Most children progress to adult rheumatoid arthritis.

- C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.
- D. Physical activity should be minimized.

Correct Answer: C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.

Nonsteroidal anti-inflammatory drugs are important first-line treatment for juvenile idiopathic arthritis (formerly known as juvenile rheumatoid arthritis). NSAIDs require 3-4 weeks for the therapeutic anti-inflammatory effects to be realized. Nonsteroidal anti-inflammatory drugs (NSAIDs) are the mainstay of initial symptomatic treatment for all subtypes. The NSAID use in JIA has decreased over time with modern aggressive treatment, including methotrexate and biologics.

- **Option A:** Half of the children with the disorder recover without joint deformity. The prognosis of JIA has changed dramatically in recent years thanks to the availability of novel drugs, which can inhibit the biological mechanisms responsible for persistent inflammation selectively. Prompt and accurate diagnosis and treatment are essential to prevent permanent joint damage and preserve joint functionality.
- **Option B:** About a third will continue with symptoms into adulthood. A recent study on 168 patients showed the remission of medication in 48.8% of cases, the remission on medication (or minimal disease activity) in 49.9% of cases, and only 1.3% of subjects were no-responders. No association was found between the state and duration of remission and age of patients, clinical features, disease course, or laboratory findings.
- **Option D:** Physical activity is an integral part of therapy. Assist parents and child to develop plans and goals for daily ADL and include interventions formed by a physical and occupational therapist. Promotes independence and compliance in self-care.

20. Nurse Helen is assigned to care for a client with anorexia nervosa. Initially, which nursing intervention is most appropriate for this client?

- A. Providing one-on-one supervision during meals and for one (1) hour afterward.
- B. Letting the client eat with other clients to create a normal mealtime atmosphere.
- C. Trying to persuade the client to eat and thus restore nutritional balance.
- D. Giving the client as much time to eat as desired.

Correct Answer: A. Providing one-on-one supervision during meals and for one (1) hour afterward.

Because the client with anorexia nervosa may discard food or induce vomiting in the bathroom, the nurse should provide one-on-one supervision during meals and for 1 hour afterward. Provide one-to-one supervision and have a patient with bulimia remain in the day room area with no bathroom privileges for a specified period (1 hr) following eating, if contracting is unsuccessful. Prevents vomiting during and after eating. The patient may desire food and use a binge-purge syndrome to maintain weight. Note: The patient may purge for the first time in response to the establishment of a weight gain program.

- **Option B:** This wouldn't be therapeutic because other clients may urge the client to eat and give attention for not eating. Supervise the patient during mealtimes and for a specified period after meals (usually one hour). It prevents vomiting during or after eating.
- **Option C:** This would reinforce control issues, which are central to this client's underlying psychological problem. Establish a minimum weight goal and daily nutritional requirements. Malnutrition is a mood-altering condition, leading to depression and agitation and affecting cognitive

function and decision making. Improved nutritional status enhances thinking ability, allowing initiation of psychological work.

- **Option D:** Instead of giving the client unlimited time to eat, the nurse should set limits and let the client know what is expected. Make a selective menu available, and allow the patient to control choices as much as possible. Patient who gains confidence in himself and feels in control of the environment is more likely to eat preferred foods. Be alert to choices of low-calorie foods and beverages; hoarding food; disposing of food in various places, such as pockets or wastebaskets. Patients will try to avoid taking in what is viewed as excessive calories and may go to great lengths to avoid eating.

21. Tiffany is diagnosed with increased intracranial pressure (ICP); which of the following if stated by her parents would indicate a need for Nurse Charlie to reexplain the purpose for elevating the head of the bed at a 10 to 20-degree angle?

- A. Help alleviate headache
- B. Increase intrathoracic pressure
- C. Maintain neutral position
- D. Reduce intra-abdominal pressure.

Correct Answer: B. Increase intrathoracic pressure

Head elevation decreases, not increases, intrathoracic pressure. In most patients with intracranial hypertension, head and trunk elevation up to 30 degrees is useful in helping to decrease ICP, providing that a safe CPP of at least 70 mmHg or even 80 mmHg is maintained.

- **Option A:** Elevating the head of the bed in a child with increased ICP helps to alleviate headache which may contribute to increased ICP. Therapeutic positioning of the head (different degrees of head-of-bed elevation (HBE)) has been proposed as a low-cost and simple way of preventing secondary brain injury in these people.
- **Option C:** The position of the backrest of the bed is a simple and cheap intervention. This is important as most brain injury happens in low- and middle-income countries with relatively undeveloped health systems and few resources to deal with brain injury.
- **Option D:** Elevated intra-abdominal pressure (IAP) occurs in many clinical settings, including sepsis, severe acute pancreatitis, acute decompensated heart failure, hepatorenal syndrome, resuscitation with large volume, mechanical ventilation with high intrathoracic pressure, major burns, and acidosis.

22. A female patient is being discharged after cataract surgery. After providing medication teaching, the nurse asks the patient to repeat the instructions. The nurse is performing which professional role?

- A. Manager
- B. Educator
- C. Caregiver
- D. Patient advocate

Correct Answer: B. Educator

When teaching a patient about medications before discharge, the nurse is acting as an educator. They provide educational leadership to patients and care providers to enhance specialized patient care within established healthcare settings. Assists patients and caregivers with educational needs, problem resolution, and health management across the continuum of care.

- **Option A:** The nurse acts as a manager when performing such activities as scheduling and making patient care assignments. Great nurse managers are able to work in coordination with other departments. They must also possess the ability to oversee an array of practice functions including staff supervision, clinical tasks, and appointments. It is also part of their jobs to liaise with pathology labs, suppliers, and other health facilities.
- **Option C:** The nurse performs the caregiving role when providing direct care, including bathing patients and administering medications and prescribed treatments. Healthcare should address a patient's cultural, spiritual and mental needs. Increasing diversity in a growing patient population requires nurses to demonstrate cultural awareness and sensitivity. Patients may have specific needs and preferences due to their religion or gender, for example. Nurses need to be respectful of, and knowledgeable about, diverse backgrounds while remaining vigilant in providing quality care.
- **Option D:** The nurse acts as a patient advocate when making the patient's wishes known to the doctor. A nurse advocate is a nurse who works on behalf of patients to maintain quality of care and protect patients' rights. They intervene when there is a care concern, and following the proper channels, work to resolve any patient care issues. Realistically, every nurse is an advocate.

23. Which finding leads you to suspect acute glomerulonephritis in your 32 y.o. patient?

- A. Dysuria, frequency, and urgency
- B. Back pain, nausea, and vomiting
- C. Hypertension, oliguria, and fatigue
- D. Fever, chills, and right upper quadrant pain radiating to the back

Correct Answer: C. Hypertension, oliguria, and fatigue

Mild to moderate HTN may result from sodium or water retention and inappropriate renin release from the kidneys. Oliguria and fatigue also may be seen. Other signs are proteinuria and azotemia. The term "glomerulonephritis" encompasses a subset of renal diseases characterized by immune-mediated damage to the basement membrane, mesangium, or the capillary endothelium, leading to hematuria, proteinuria, and azotemia.

- **Option A:** As the glomerular filtration rate (GFR) is decreased, symptoms like edema and hypertension occur, majorly due to the subsequent salt and water retention caused by the activation of the renin-angiotensin-aldosterone system.
- **Option B:** Acute forms of glomerulonephritis can result from either a primary renal cause or a secondary illness that causes renal manifestations. Most forms of glomerulonephritis are considered progressive disorders, which without timely therapy progress to chronic glomerulonephritis (characterized by progressive glomerular damage and tubulointerstitial fibrosis leading to a reduced glomerular filtration rate).
- **Option D:** Etiological classification can be made on the basis of clinical presentation, which can range from severe proteinuria (>3.5 g/day) and edema qualifying for nephrotic syndrome, to a

nephritic syndrome where hematuria and hypertension are more prominent while proteinuria is less pronounced.

24. A client who is admitted with an above-the-knee amputation tells the nurse that his foot hurts and itches. Which response by the nurse indicates an understanding of phantom limb pain?

- A. "The pain will go away in a few days."
- B. "The pain is due to peripheral nervous system interruptions. I will get you some pain medication."
- C. "The pain is psychological because your foot is no longer there."
- D. "The pain and itching are due to the infection you had before the surgery."

Correct Answer: B. "The pain is due to peripheral nervous system interruptions. I will get you some pain medication."

Pain-related to phantom limb syndrome is due to a peripheral nervous system interruption. A recent study estimated that there were about 1.6 million people with limb loss in the USA in 2005 and this number was projected to increase by more than double to 3.6 million by the year 2050. Vascular problems, trauma, cancer, and congenital limb deficiency are among the common causes of limb loss.

- **Option A:** Phantom limb pain can last several months or indefinitely. The phantom pain and sensation may have its onset immediately or years after the amputation. There are reports of two peak periods of onset, the first within a month and the second a year after amputation. The prevalence is reported to decrease over time after amputation.
- **Option C:** The explanation of phantom limb pain is not psychologically related. PLP was once thought to be primarily a psychiatric illness. With the accumulation of evidence from research over the past decades, the paradigm has shifted more towards changes at several levels of the neural axis, especially the cortex. Peripheral mechanisms and central neural mechanisms are among the hypotheses that have gained consensus as proposed mechanisms over the recent years.
- **Option D:** Pain and itching are not symptoms of an infection due to surgery. During amputation, peripheral nerves are severed. This results in massive tissue and neuronal injury-causing disruption of the normal pattern of afferent nerve input to the spinal cord. This is followed by a process called deafferentation and the proximal portion of the severed nerve sprouts to form neuromas. There is an increased accumulation of molecules enhancing the expression of sodium channels in these neuromas that results in hyper-excitability and spontaneous discharges. This abnormal peripheral activity is thought to be a potential source of stump pain, including phantom pain.

25. A nurse performs an assessment on a client who is 4 hours PP. The nurse notes that the client has cool, clammy skin and is restless and excessively thirsty. The nurse prepares immediately to:

- A. Assess for hypovolemia and notify the health care provider.
- B. Begin hourly pad counts and reassure the client.
- C. Begin fundal massage and start oxygen by mask.
- D. Elevate the head of the bed and assess vital signs.

Correct Answer: A. Assess for hypovolemia and notify the health care provider.

Symptoms of hypovolemia include cool, clammy, pale skin, sensations of anxiety or impending doom, restlessness, and thirst. When these symptoms are present, the nurse should further assess for hypovolemia and notify the health care provider. Patients with hypovolemic shock have severe hypovolemia with decreased peripheral perfusion. If left untreated, these patients can develop ischemic injury of vital organs, leading to multi-system organ failure.

- **Option B:** The first factor to be considered is whether the hypovolemic shock has resulted from hemorrhage or fluid losses, as this will dictate treatment. When etiology of hypovolemic shock has been determined, replacement of blood or fluid loss should be carried out as soon as possible to minimize tissue ischemia.
- **Option C:** Medical management with uterotonic and pharmacologic agents is typically the first step if uterine atony is identified. While oxytocin is given routinely by most institutions at the time of delivery (see prevention), additional uterotonic medications may be given with bimanual massage in an initial response to hemorrhage. Uterotonic agents include oxytocin, ergot alkaloids, and prostaglandins.
- **Option D:** Initial evaluation of the patient should include a rapid assessment of the patient's status and risk factors. In postpartum women, signs or symptoms of blood loss such as tachycardia and hypotension may be masked, so if these signs are present, there should be a concern for considerable blood volume loss (greater than 25% of total blood volume). Continuous assessment of vital signs and on-going estimation of total blood loss is an important factor in ensuring safe care of the patient with PPH.

26. During the previous few months, a 56-year-old woman felt brief twinges of chest pain while working in her garden and has had frequent episodes of indigestion. She comes to the hospital after experiencing severe anterior chest pain while raking leaves. Her evaluation confirms a diagnosis of stable angina pectoris. After stabilization and treatment, the client is discharged from the hospital. At her follow-up appointment, she is discouraged because she is experiencing pain with increasing frequency. She states that she is visiting an invalid friend twice a week and now cannot walk up the second flight of steps to the friend's apartment without pain. Which of the following measures that the nurse could suggest would most likely help the client deal with this problem?

- A. Visit her friend earlier in the day.
- B. Rest for at least an hour before climbing the stairs.
- C. Take a nitroglycerin tablet before climbing the stairs.
- D. Lie down once she reaches the friend's apartment.

Correct Answer: C. Take a nitroglycerin tablet before climbing the stairs.

Nitroglycerin may be used prophylactically before stressful physical activities such as stair climbing to help the client remain pain-free. Nitrates relax vascular smooth muscle leading to dilation of veins primarily; this decreases cardiac preload and, in turn, decreases myocardial oxygen demand providing relief in anginal symptoms.

- **Option A:** Visiting her friend early in the day would have no impact on decreasing pain episodes. An average of 150 minutes of moderate-intensity exercise per week or 75 minutes of high-intensity exercise per week has been shown to decrease overall cardiac risk factors and, in turn, decrease

the risk of coronary heart disease.

- **Option B:** Resting before or after an activity is not as likely to help prevent an activity-related pain episode. The 2017 AHA/ACC guidelines define hypertension as systolic blood pressure ≥ 130 mmHg or diastolic pressure ≥ 80 mmHg. Goal blood pressure will be unique to each patient; however, it is important to keep in mind that for each 20/10 mmHg increase in systolic/diastolic blood pressure, evidence has supported a two-fold increased risk of coronary heart and stroke-related mortality.
- **Option D:** Treatment for stable angina is geared toward reducing risk factors for presumed underlying coronary heart disease. An interdisciplinary approach would likely benefit individuals with multiple comorbidities; nutrition, diabetic educator, addiction counselor, physical and occupational therapy.

27. When assessing a patient for signs of fluid overload, the nurse would expect to observe:

- A. Bounding pulse
- B. Flat neck veins
- C. Poor skin turgor
- D. Vesicular

Correct Answer: A. Bounding pulse

Bounding pulse is a sign of fluid overload as more volume in the vessels causes a stronger sensation against the blood vessel walls. Assess for bounding peripheral pulses and S3. These assessment findings are signs of fluid overload.

- **Option B:** Flat neck veins and vesicular breath sounds are normal findings. Check for distended neck veins and ascites. Monitor abdominal girth to follow any ascites accurately. Distended neck veins are caused by elevated CVP. Ascites occur when fluid accumulates in extravascular spaces.
- **Option C:** Poor skin turgor is consistent with dehydration. Note for the presence of edema by palpating over the tibia, ankles, feet, and sacrum. Edema occurs when fluid accumulates in the extravascular spaces. Dependent areas more readily exhibit signs of edema formation.
- **Option D:** Assess for crackles in the lungs, changes in respiratory pattern, shortness of breath, and orthopnea. These signs are caused by an accumulation of fluid in the lungs.

28. The nurse is preparing a discharge teaching plan for the male client who had umbilical hernia repair. What should the nurse include in the plan?

- A. Irrigating the drain
- B. Avoiding coughing
- C. Maintaining bed rest
- D. Restricting pain medication

Correct Answer: B. Avoiding coughing.

Coughing is avoided following umbilical hernia repair to prevent disruption of tissue integrity, which can occur because of the location of this surgical procedure. Splint the stomach by placing a pillow over the

abdomen with firm pressure before coughing or movement to help reduce the pain.

- **Option A:** A drain is not used in this surgical procedure, although the client may be instructed in simple dressing changes. Do not soak in a bathtub until the stitches or staples are removed. A small amount of drainage from the incision is normal.
- **Option C:** Bed rest is not required following this surgical procedure. The client may slowly increase his activity. He should get up and walk every hour or so to prevent blood clot formation. After recovery, the client may return to work within 2 or 3 days. There should be no lifting anything above 10 lbs, climbing, or any strenuous activities for 4 to 6 weeks.
- **Option D:** The client should take analgesics as needed and as prescribed to control pain. Most non-opioid analgesics are classified as non-steroidal anti-inflammatory drugs (NSAIDs). They are used to treat mild pain and inflammation or combined with narcotics. Narcotics or opioids are used for severe pain.

29. Which of the following types of angina is most closely related with an impending MI?

- A. Angina decubitus
- B. Chronic stable angina
- C. Nocturnal angina
- D. Unstable angina

Correct Answer: D. Unstable angina

Unstable angina progressively increases in frequency, intensity, and duration and is related to an increased risk of MI within 3 to 18 months. Evidence shows that patients with new-onset ST-segment elevation (more than 1 mm) have a 12-month rate of an MI or death of about 11%, compared to only 7% for patients who only have isolated inversion of the T wave. Unstable angina results when the blood flow is impeded to the myocardium. Most commonly, this block can be from intraluminal plaque formation, intraluminal thrombosis, vasospasm, and elevated blood pressure.

- **Option A:** Angina decubitus is a variant of angina pectoris that occurs at night while the patient is recumbent. Some have suggested that it is induced by an increase in myocardial oxygen demand caused by expansion of the blood volume with increased venous return during recumbency.
- **Option B:** The most important complication of stable angina is the possibility of progression to acute coronary syndrome. Risk factor modification and medical optimization should be utilized to decrease risk. These individuals require routine monitoring and attentive primary care providers.
- **Option C:** Several authors have noted increases and irregularity of heart rate, respiration, and arterial pressure occurring in nearly all instances of D-sleep (sleep associated with dreaming). Shifts in the blood pressure might be dangerous to a cardiac patient, and as early as 1921, it had been suggested that sudden death during sleep of patients with heart disease was probably caused by blood pressure changes associated with dreaming.

30. You are a nurse on a pediatric unit, and are assigned to care for Tommy, an 8-year-old boy with a severe bacterial lung infection. Tommy has been receiving intravenous antibiotics for the past 10 days. During the morning assessment, Tommy mentions that he has been having frequent watery stools since the previous evening. You recall that antibiotic-associated diarrhea, particularly

caused by Clostridium difficile, is a common problem in hospitalized patients. Keeping Tommy's comfort and the safety of other patients in mind, you need to decide the appropriate initial action to manage this new symptom.

- A. Place the client on contact precaution.
- B. Instruct the client about correct handwashing.
- C. Obtain stool specimens for culture.
- D. Notify the physician about the loose stools.
- E. Administer antidiarrheal medication as a standing order.
- F. Educate the family about the importance of notifying the healthcare team regarding changes in bowel habits.

Correct Answer: A. Place the client on contact precaution.

Given the scenario, the first action should be to implement contact precautions to prevent the potential spread of a Clostridium difficile infection (or other infectious causes of diarrhea) to other vulnerable patients on the unit. It's crucial to follow infection control practices while the exact cause of diarrhea is being determined. In summary, in a clinical setting, ensuring the safety of all patients by preventing the spread of infection is paramount. Therefore, placing Tommy on contact precaution is the most appropriate initial action to take in response to his new symptom of frequent watery stools following a prolonged antibiotic treatment.

- **Option B:** While important, this action does not address the immediate need to prevent potential transmission of an infectious agent.
- **Option C:** This action is necessary to identify the causative agent of the diarrhea, but it does not take precedence over preventing the potential spread of infection.
- **Option D:** While it is important to notify the physician, the first action should be to prevent the potential spread of infection to other patients or staff on the unit.
- **Option E:** Administration of antidiarrheal medication without a specific order and before identifying the cause of diarrhea could potentially worsen the condition, especially if Clostridium difficile is the culprit.
- **Option F:** Although education is important, the priority should be to prevent potential transmission of an infectious agent to other patients.

31. You have a patient with achalasia (incomplete muscle relaxation of the GI tract, especially sphincter muscles). Which medications do you anticipate to administer?

- A. isosorbide dinitrate (Isordil)
- B. digoxin (Lanoxin)
- C. captopril (Capoten)
- D. propranolol (Inderal)

Correct Answer: A. isosorbide dinitrate (Isordil)

Achalasia is characterized by incomplete relaxation of the LES, dilation of the lower esophagus, and a lack of esophageal peristalsis. Because nitrates relax the lower esophageal sphincter, expect to give

Isordil orally or sublingually. Isosorbide is a nitrate that exerts its pharmacologic effect by releasing nitric oxide (NO), an endothelium-derived relaxing factor (EDRF). NO is endogenously produced in the endothelium to dilate the blood vessels.

- **Option B:** Digoxin is a medication used in the management and treatment of heart failure and certain arrhythmias and abortion. It is in the cardiac glycoside class of drugs. It is used for rate control in atrial fibrillation or atrial flutter when conventional therapies have not achieved goal heart rate. Digoxin should not be administered in cases of pre-excitation caused by accessory pathways as digoxin induces AV blockade and may trigger ventricular tachyarrhythmias.
- **Option C:** The benefits of captopril in hypertension and heart failure result primarily from suppressing the renin-angiotensin-aldosterone system (RAAS). As an angiotensin-converting enzyme (ACE) inhibitor, it inhibits ACE, which converts angiotensin I to angiotensin II. Angiotensin II binds to AT1 receptors on smooth muscles to produce vasoconstriction of precapillary arterioles and postcapillary venules, inhibits the reuptake of norepinephrine, and release of catecholamines from the adrenal medulla, which all increases blood pressure.
- **Option D:** Propranolol can be used to ameliorate the sympathetic response in angina, tachyarrhythmias, prevention of acute ischemic attacks, migraine prophylaxis, and restless leg syndrome. Propranolol can be used in almost all cases if the desired result is to slow contractility and decrease a patient's heart rate.

32. When critiquing a qualitative study, which of the following questions are helpful in determining the study's auditability? Select all that apply.

- A. Has adequate time been allowed to understand the phenomenon fully?
- B. Can the reader follow the researcher's thinking?
- C. Are the results meaningful to individuals not involved in the research?
- D. Does the researcher document the research process?

Correct Answer: B, C

Auditability assists the reader to judge the appropriateness of the interview questions posed. Auditability is established by the reader being able to follow the steps of the research from the research questions, to the data collection, to the data, and then to the findings (categories, themes, model).

- **Option A:** This question will critique the significance of a research project. "The purpose of a research critique is to determine whether the findings are usable for you" (Brink & Wood, 2001, p. 57).
- **Option B:** This question will critique the auditability of a research project. Understand the purpose and problem, while determining if the design and methodology are consistent with the purpose.
- **Option C:** Auditability assists the reader to judge the adequacy of the coding system used. By the steps for interpretation and synthesis and data examples provided, the reader should be able to follow the researcher's thinking.
- **Option D:** This question will critique the auditability of a research project. Understand the purpose and problem, while determining if the design and methodology are consistent with the purpose.

33. Which of the following conditions is common in pregnant women in the 2nd trimester of pregnancy?

- A. Mastitis
- B. Metabolic alkalosis
- C. Physiologic anemia
- D. Respiratory acidosis

Correct Answer: C. Physiologic anemia.

Hemoglobin and hematocrit levels decrease during pregnancy as the increase in plasma volume exceeds the increase in red blood cell production.

- **Option A:** Mastitis, which mainly affects breastfeeding women, causes redness, swelling, and pain in one or both breasts. Mastitis is an inflammation of breast tissue that sometimes involves an infection. The inflammation results in breast pain, swelling, warmth, and redness. You might also have fever and chills.
- **Option B:** Metabolic alkalosis is uncommon in pregnancy and is most often the result of severe vomiting. If this is present at the time of delivery, transient metabolic derangement in the fetus can occur, potentially requiring additional organ support.
- **Option D:** Progesterone levels are increased during pregnancy. Progesterone causes stimulation of the respiratory center, which can lead to respiratory alkalosis. Chronic respiratory alkalosis is a common finding in pregnant women.

34. A patient in her 14th week of pregnancy has presented with abdominal cramping and vaginal bleeding for the past 8 hours. She has passed several clots. What is the primary nursing diagnosis for this patient?

- A. Knowledge deficit
- B. Fluid volume deficit
- C. Anticipatory grieving
- D. Pain

Correct Answer: B. Fluid volume deficit

If bleeding and clots are excessive, this patient may become hypovolemic. Pad count should be instituted. Blood volume expands during pregnancy, and a considerable portion of the weight of a pregnant woman is retained water.

- **Option A:** Knowledge deficit is an appropriate nursing diagnosis because the woman might not have any knowledge on how to manage her symptoms. However, this is not a priority diagnosis.
- **Option C:** Anticipatory grieving is the name given to the tumultuous set of feelings and reactions that occur when someone is expecting the death of a loved one.
- **Option D:** Pain may be felt due to abdominal cramping accompanied by bleeding. This is not a cause of alarm since true labor pain includes strong and regular contractions and lower back pain.

35. A nurse is preparing the client's morning NPH insulin dose and notices a clumpy precipitate inside the insulin vial. The nurse should:

- A. Draw up and administer the dose.

- B. Shake the vial in an attempt to disperse the clumps.
- C. Draw the dose from a new vial.
- D. Warm the bottle under running water to dissolve the clump.

Correct Answer: C. Draw the dose from a new vial.

The nurse should always inspect the vial of insulin before use for solution changes that may signify a loss of potency. NPH insulin is normally uniformly cloudy. Clumping, frosting, and precipitates are signs of insulin damage. In this situation, because potency is questionable, it is safer to discard the vial and draw up the dose from a new vial.

- **Option A:** Crystalline NPH insulin administration is subcutaneous. Administration is not intramuscular or intravenous. NPH insulin is available in a two-phase solution, which means that apart from NPH, it has a solvent or a rapid-acting insulin solution. It comes in the form of a subcutaneous suspension or suspension pen-injector.
- **Option B:** The abdominal subcutaneous injection causes quicker absorption as compared to arms or thighs. The most significant advantage of NPH is that it can be included in premixed formulation with regular insulin. NPH in premixed formulations does not affect the potency and time-action profile of regular insulin. Exercise, massage, and local heat application increase NPH insulin absorption.
- **Option D:** NPH insulin has a somewhat higher risk of hypoglycemia. Inadequate resuspension is thought to contribute to the high day to day variability in the pharmacodynamic and pharmacokinetic profile of NPH insulin, leading to hypoglycemia. Patients can adequately resuspend NPH by rotating the vial several times until it's uniformly cloudy.

36. A client admitted to the hospital with a subarachnoid hemorrhage has complaints of severe headache, nuchal rigidity, and projectile vomiting. The nurse knows lumbar puncture (LP) would be contraindicated in this client in which of the following circumstances?

- A. Vomiting continues.
- B. Intracranial pressure (ICP) is increased.
- C. The client needs mechanical ventilation.
- D. Blood is anticipated in the cerebrospinal fluid (CSF).

Correct Answer: B. Intracranial pressure (ICP) is increased.

Sudden removal of CSF results in pressures lower in the lumbar area than the brain and favors herniation of the brain; therefore, LP is contraindicated with increased ICP. A head computed tomogram (CT) should be obtained before performing a lumbar puncture if there is a concern for increased intracranial pressure. Signs and symptoms of possible increased intracranial pressure include altered mental status, focal neurological deficits, new-onset seizure, papilledema, immunocompromised state, malignancy, history of focal CNS disease (stroke, focal infection, tumor), concern for mass CNS lesion and age greater than 60 years old.

- **Option A:** Vomiting may be caused by reasons other than increased ICP; therefore, LP isn't strictly contraindicated. Contraindications to performing a lumbar puncture include skin infection near or at the site of lumbar puncture needle insertion, central nervous system (CNS) lesion or spinal mass leading to increased intracranial pressure, platelet count less than 20,000 mm³ (ideally the platelet count should be greater than 50,000 mm³), use of unfiltered heparin or low-molecular-weight

heparin in the past 24 hours, coagulopathies (i.e., hemophilia, von Willebrand disease) and vertebral trauma.

- **Option C:** An LP may be performed on clients needing mechanical ventilation. Lumbar puncture (LP), also referred to as “spinal tap,” is a commonly performed procedure that involves obtaining and sampling cerebrospinal fluid from the spinal cord.
- **Option D:** Blood in the CSF is diagnostic for subarachnoid hemorrhage and was obtained before signs and symptoms of ICP. It is the gold standard diagnostic procedure in the diagnosis of meningitis, subarachnoid hemorrhage, and certain neurological disorders. It is also used in the measurement of intracranial pressure and administration of medications or diagnostic agents.

37. The LPN/LVN, under your supervision, is providing nursing care for a patient with GBS. What observation would you instruct the LPN/LVN to report immediately?

- A. Complaints of numbness and tingling.
- B. Facial weakness and difficulty speaking.
- C. Rapid heart rate of 102 beats per minute.
- D. Shallow respirations and decreased breath sounds.

Correct Answer: D. Shallow respirations and decreased breath sounds

The priority interventions for the patient with GBS are aimed at maintaining adequate respiratory function. These patients are at risk for respiratory failure, which is urgent. Upon presentation, 40% of patients have a respiratory or oropharyngeal weakness. Ventilatory failure with required respiratory support occurs in up to one-third of patients at some time during the course of their disease.

- **Option A:** These findings should be reported to the nurse but it is not an urgent matter. The typical patient with Guillain-Barré syndrome (GBS), which in most cases will manifest as acute inflammatory demyelinating polyradiculoneuropathy (AIDP), presents 2-4 weeks following a relatively benign respiratory or gastrointestinal illness with complaints of finger dysesthesias and proximal muscle weakness of the lower extremities.
- **Option B:** Facial weakness and difficulty of speaking are common signs of GBS and must be reported, but it is not a priority. The classic clinical picture of weakness is ascending and symmetrical in nature. The lower limbs are usually involved before the upper limbs. Proximal muscles may be involved earlier than the more distal ones. Trunk, bulbar, and respiratory muscles can be affected as well.
- **Option C:** A rapid heart rate is important and should be reported to the nurse, but it is not life-threatening. Autonomic nervous system involvement with dysfunction in the sympathetic and parasympathetic systems can be observed in patients with GBS.

38. Nurse Thompson is conducting a teaching session for a group of new nursing hires in the hematology department. To ensure their understanding of the bone marrow’s role in hematopoiesis, she asks them the following question: “Several statements here relate to red bone marrow’s characteristics. Identify which statement is NOT true.”

- A. Red marrow is the only site of blood formation in adults.

- B. Adults have more red marrow than children.
- C. In adults, it is found in the cancellous bone spaces found in flat bones.
- D. In children, it is located in the medullary cavity of the long bones.

Correct Answer: B. Adults have more red marrow than children.

Children's bones have proportionately more red bone marrow than adults. As a person ages, red marrow is mostly replaced by yellow marrow, which is mainly fat.

- **Option A:** Red bone marrow consists of a delicate, highly vascular fibrous tissue containing blood-forming cells called hematopoietic stem cells.
- **Option C:** In adults, red bone marrow is primarily found in the flat bones, such as the pelvic girdle and the sternum.
- **Option D:** In children, it is found in the medullary cavity of the long bones, such as the femur.

39. Nurse Maria plans to administer dexamethasone cream to a female client who has dermatitis over the anterior chest. How should the nurse apply this topical agent?

- A. With a circular motion, to enhance absorption.
- B. With an upward motion, to increase blood supply to the affected area.
- C. In long, even, outward, and downward strokes in the direction of hair growth.
- D. In long, even, outward, and upward strokes in the direction opposite hair growth.

Correct Answer: C. In long, even, outward, and downward strokes in the direction of hair growth

When applying a topical agent, the nurse should begin at the midline and use long, even, outward, and downward strokes in the direction of hair growth. This application pattern reduces the risk of follicle irritation and skin inflammation.

- **Option A:** This type of application may contaminate the areas which are clean and irritate the skin.
- **Option B:** An upward motion does not increase blood supply to the affected area; the goal is to reduce irritation of the skin and follicles.
- **Option D:** The strokes should be downward in the direction of hair growth.

40. Nurse Oliver checks for residual before administering a bolus tube feeding to a client with a nasogastric tube and obtains a residual amount of 150 mL. What is the appropriate action for the nurse to take?

- A. Hold the feeding
- B. Reinstill the amount and continue with administering the feeding
- C. Elevate the client's head at least 45 degrees and administer the feeding
- D. Discard the residual amount and proceed with administering the feeding

Correct Answer: A. Hold the feeding

Unless specifically indicated, residual amounts more than 100 mL require holding the feeding. Gastric residual refers to the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding. Nurses withdraw this fluid via the feeding tube by pulling back on the plunger of a large (usually 60 mL) syringe at intervals typically ranging from four to eight hours.

- **Option B:** When interpreting GRV, clinicians must keep in mind that the stomach has a reservoir function and that the stomach fluid is a mixture of both the infused EN formula and normal gastric secretions.
- **Option C:** Patients at risk for delayed gastric emptying include those with gastroparesis, poorly controlled diabetes mellitus, gastric outlet obstruction, ileus, recent surgery, trauma, or sepsis, and those using a large amount of narcotic pain medication. Efforts to prevent aspiration of gastric contents are important in these patients.
- **Option D:** The feeding is not discarded unless its contents are abnormal in color or characteristics. In a review article, "Measurement of Gastric Residual Volume: State of the Science," published in 2000 in MEDSURG Nursing, Edwards and Metheny reported that the literature contained a variety of recommendations for what is considered a high GRV, ranging from 100 to 500 mL.

41. A parent brings a toddler, age 19 months, to the clinic for a regular check-up. When palpating the toddler's fontanels, what should the nurse expect to find?

- A. Open anterior and fontanel and closed posterior fontanel
- B. Closed anterior and posterior fontanels
- C. Closed anterior fontanel and open posterior fontanel
- D. Open anterior and posterior fontanels

Correct Answer: B. Closed anterior and posterior fontanels

By age 18 months, the anterior and posterior fontanels should be closed. The diamond-shaped anterior fontanel normally closes between ages 9 and 18 months. The triangular posterior fontanel normally closes between ages 2 and 3 months. Fontanelles, often referred to as "soft spots," are one of the most prominent anatomical features of the newborn's skull. Fontanelle morphology may vary between infants, but characteristically they are flat and firm.

- **Option A:** The most common conditions associated with a large anterior fontanelle or a delay in its closure are as listed: Down syndrome, achondroplasia, congenital hypothyroidism, rickets, and elevated intracranial pressures. Infants of African descent statically have larger fontanelles that range from 1.4 to 4.7 cm, and in terms of sex, the fontanelles of male infants will close sooner compared to female infants.
- **Option C:** Often, the delayed closure of the posterior fontanelle is associated with hydrocephalus or congenital hypothyroidism. Unlike the anterior fontanelle, the posterior fontanelle is triangular and completely closes within about six to eight weeks after birth. On average, the posterior fontanelle is 0.5 cm in Caucasian infants and 0.7 cm in infants of African descent.
- **Option D:** An elevated thyroid-stimulating hormone level on a newborn screening usually detects congenital hypothyroidism, but an abnormally large anterior fontanel in conjunction with an open posterior fontanel can be an early sign of the disorder. Myxedema and growth deficiency are later signs.

42. A client is receiving nutrition via parenteral nutrition (PN). A nurse assesses the client for complications of the therapy and assesses the client for which of the following signs of hyperglycemia?

- A. High-grade fever, chills, and decreased urination.
- B. Fatigue, increased sweating, and heat intolerance.
- C. Coarse dry hair, weakness, and fatigue.
- D. Thirst, blurred vision, and diuresis.

Correct Answer: D. Thirst, blurred vision, and diuresis.

Signs of hyperglycemia include excessive thirst, fatigue, restlessness, blurred vision, confusion, weakness, Kussmaul's respirations, diuresis, and coma when hyperglycemia is severe. Hyperglycaemia is found in up to 50% of PN patients. Important predictors are insulin resistance or diabetes mellitus, severity of the underlying illness, concomitant steroid therapy, and the amount of glucose provided.

- **Option A:** High-grade fever, chills, and decreased urination are signs of infection. The risk of infectious complications is increased due to venous access for PN. The likelihood of hyperglycemia-induced complications may depend on concomitant diseases, duration of PN, and life expectancy.
- **Option B:** Fatigue, increased sweating, and heat intolerance are signs of hyperthyroidism. Hyperthyroidism may manifest as weight loss despite an increased appetite, palpitation, nervousness, tremors, dyspnea, fatigability, diarrhea or increased GI motility, muscle weakness, heat intolerance, and diaphoresis.
- **Option C:** Coarse dry hair, weakness, and fatigue are signs of hypothyroidism. Inquire about dry skin, voice changes, hair loss, constipation, fatigue, muscle cramps, cold intolerance, sleep disturbances, menstrual cycle abnormalities, weight gain, and galactorrhea. Also obtain a complete medical, surgical, medication, and family history.

43. In a pediatric oncology unit, a 6-year-old child, Leo, is admitted with a diagnosis of Wilms tumor, stage II. Wilms tumor, also known as nephroblastoma, is a rare kidney cancer primarily found in children. The healthcare team is developing a comprehensive care plan to address Leo's medical needs and to provide education and support for his family. The staging of Wilms tumor is vital as it guides the treatment plan and provides insight into the prognosis. The interdisciplinary team discusses the implications of a stage II diagnosis during their care conference. With reference to Leo's stage II diagnosis of Wilms tumor, which of the following statements most accurately describes this stage?

- A. The tumor is less than 3 cm. in size and requires no chemotherapy.
- B. The tumor did not extend beyond the kidney and was completely resected.
- C. The tumor extended beyond the kidney but was completely resected.
- D. The tumor has spread into the abdominal cavity and cannot be resected.
- E. The tumor has metastasized to distant organs such as the lungs.

F. The tumor is confined to the kidney and is not amenable to surgical resection.

G. The tumor has invaded the renal capsule and surrounding structures but is still confined to the abdomen.

Correct Answer: C. The tumor extended beyond the kidney but was completely resected.

This statement is accurate for a stage II diagnosis of Wilms tumor. At this stage, the tumor may have extended beyond the kidney into surrounding structures or vessels but was still completely removed by surgery.

- **Option A:** This choice inaccurately describes the stage as there's no mention of tumor size relating to staging, and chemotherapy is often part of the treatment plan for Wilms tumor regardless of the stage.
- **Option B:** This statement is more representative of stage I where the tumor is confined to the kidney and completely removed by surgery.
- **Option D:** This statement is more representative of a stage III or IV diagnosis, where the tumor has spread to surrounding lymph nodes, the abdominal cavity, or other distant areas, and may not be completely resectable.
- **Option E:** This scenario is characteristic of stage IV Wilms tumor, where the cancer has spread to distant structures like the lungs, liver, bone, or brain.
- **Option F:** This choice does not accurately represent any of the stages of Wilms tumor as surgical resection is often a primary treatment modality.
- **Option G:** This choice may also describe a scenario within stage II; however, it does not explicitly state that the tumor was completely resected, which is a distinguishing feature of stage II when compared to stage III where there is residual non-hematogenous tumor.

44. School phobia is usually treated by:

A. Returning the child to the school immediately with family support.

B. Calmly explaining why attendance in school is necessary.

C. Allowing the child to enter the school before the other children.

D. Allowing the parent to accompany the child in the classroom.

Correct Answer: A. Returning the child to the school immediately with family support.

Exposure to a feared situation can help in overcoming anxiety. Behavior therapy is the most effective treatment for phobias is behavioral therapy. This includes systematic desensitization and flooding. In methodical desensitization, the patient is exposed to a list of stimuli ranging from the least to the most anxiety-provoking. With this method, patients are taught various techniques to deal with anxiety such as relaxation, breathing control, and cognitive approaches.

- **Option B:** This will not help in relieving the anxiety due to separation from a significant other. The cognitive-behavioral approach includes reinforcing the realization that the phobic stimulus is safe. As the patient masters these techniques, they are taught to use them in the face of anxiety-provoking stimuli and induce relaxation. As the patients become desensitized to each stimulus on the scale, they keep moving up until the most anxiety-provoking stimuli no longer elicit any fear or anxiety.
- **Option C:** Anxiety in school phobia is not due to being in school but due to separation from parents/caregivers so these interventions are not applicable. To be successful, behavioral therapy

requires that the patient be committed to the treatment, there are distinctly identified problems and objectives, and there are alternative strategies for dealing with the patient's feelings.

- **Option D:** This will not help the child overcome the fear. Other forms of treatment that may also be considered are virtual therapy in which a patient is exposed to or interacts with the phobic object or situation on the computer screen. This field of treatment is relatively new and requires more research. Other treatment modalities include hypnosis, supportive therapy, and family therapy. The goal of all 3 forms of therapy is to help the patient recognize that the feared stimulus is not dangerous and to provide emotional support.

45. A male client is admitted to a psychiatric facility by court order for evaluation for antisocial personality disorder. This client has a long history of initiating fights and abusing animals and recently was arrested for setting a neighbor's dog on fire. When evaluating this client for the potential for violence, nurse Perry should assess for which behavioral clues?

- A. A rigid posture, restlessness, and glaring
- B. Depression and physical withdrawal
- C. Silence and noncompliance
- D. Hypervigilance and talk of past violent acts

Correct Answer: A. A rigid posture, restlessness, and glaring

Behavioral clues that suggest the potential for violence include a rigid posture, restlessness, glaring, a change in usual behavior, clenched hands, overtly aggressive actions, physical withdrawal, noncompliance, overreaction, hostile threats, recent alcohol ingestion or drug use, talk of past violent acts, inability to express feelings, repetitive demands and complaints, argumentativeness, profanity, disorientation, inability to focus attention, hallucinations or delusions, paranoid ideas or suspicions, and somatic complaints.

- **Option B:** Before performing a comprehensive psychiatric assessment of the patient, a careful history and physical examination is necessary. "The DSM-5 diagnostic criteria for Antisocial Personality Disorder. A pervasive pattern of disregard for and violation of the rights of others, since age 15 years, as indicated by three (or more) of the following: failure to conform to social norms concerning lawful behaviors, such as performing acts that are grounds for arrest; deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit; Impulsivity or failure to plan; Irritability and aggressiveness, often with physical fights or assaults; reckless disregard for the safety of self or others; consistent irresponsibility, failure to sustain consistent work behavior, or honor monetary obligations; lack of remorse, being indifferent to or rationalizing having hurt, mistreated, or stolen from another person.
- **Option C:** Of those children with conduct disorder, 25% of girls and 40% of boys will meet the diagnostic criteria for antisocial personality disorder. Boys exhibit symptoms earlier than girls, who often only elicit these symptoms in puberty. Children who do not develop conduct disorder and progress to the age of 15 without antisocial behaviors will not develop ASPD.
- **Option D:** Antisocial personality disorder, although a chronic condition with a lifelong presentation, has had moderations shown with advancing ages, with the mean remitted age of 35 years old. Those with less baseline symptomatology showed better-remitted rates. Studies in the past revealed remission rates of 12 to 27% and 27 to 31% rates of improvement, but not remitted. Crime rates and severity reflect this relation as well, with peak crime statistics in late teens and higher severity of crimes at younger ages.

46. A nurse is instructing a client regarding intranasal vasopressin (Pitressin). The nurse tells the client which of the following is a side effect specific to the medication?

- A. Rhinitis
- B. Headache
- C. Flushing
- D. Nausea

Correct Answer: A. Rhinitis

High doses of vasopressin administered via intranasal route may cause rhinitis and nasal congestion.

- **Options B, C, & D:** These are the side effects of the medication administered intravenously.

47. A client tells the nurse, "I feel bad because my mother does not want me to return home after I leave the hospital." Which nursing response is therapeutic?

- A. "It's quite common for clients to feel that way after a lengthy hospitalization."
- B. "Why don't you talk to your mother? You may find out she doesn't feel that way."
- C. "Your mother seems like an understanding person. I'll help you approach her."
- D. "You feel that your mother does not want you to come back home?"

Correct Answer: D. "You feel that your mother does not want you to come back home?"

This is an example of the therapeutic communication technique of restatement. Restatement is the repeating of the main idea that the client has verbalized. This lets the client know whether or not an expressed statement has been understood and gives him or her the chance to continue or clarify if necessary.

- **Option A:** When the nurse tries to equate the intense and overwhelming feelings the client has expressed to "everybody" or to the nurse's own feelings, the nurse implies that the discomfort is temporary, mild, self-limiting, or not very important. The client is focused on his or her own worries and feelings' hearing the problems or feelings of others is not helpful.
- **Option B:** Requesting an explanation or asking the client to provide reasons for thoughts, feelings, behaviors or events is nontherapeutic. There is a difference between asking the client to describe what is occurring or has taken place and asking him to explain why. Usually, a "why" question is intimidating.
- **Option C:** Attempts to dispel the client's anxiety by implying that there is not sufficient reason for concern completely devalue the client's feelings. Vague reassurances without accompanying facts are meaningless to the client.

48. A tuberculosis intradermal skin test to detect tuberculosis infection is given to a high-risk adolescent. How long after the test is administered should the result be evaluated?

- A. Immediately
- B. Within 24 hours
- C. In 48 to 72 hours
- D. After 5 days

Correct Answer: C. In 48 to 72 hours

Tuberculin skin tests of delayed hypersensitivity. If the test results are positive, a reaction should appear in 48 to 72 hours. Two visits are required in this test. First visit to get the test administered, and the second visit to get the reading of the test after 48 to 72 hours of test placement.

- **Option A:** Immediately after the test is too soon to observe a reaction. The results of this test are interpreted by measuring the hypersensitivity reaction (delayed-type hypersensitivity) to tuberculin purified protein derivative, derived from *Mycobacterium tuberculosis*.
- **Option B:** Within 24 hours is too soon to observe a reaction. The peak of the induration reaction occurs after 24 hours of the test injection. Induration of the skin at the injection site occurs secondary to cell infiltration.
- **Option D:** Waiting more than 5 days to evaluate the test is too long because any reaction may no longer be visible. It takes about 6 to 8 weeks after exposure to the bacteria for the PPD test to be positive.

49. Which paradigm provides the basis for qualitative research? A. Empirical analytical research

- A. Empirical analytical research
- B. Constructivism
- C. Postpositivism
- D. Naturalistic research

Correct Answer: B. Constructivism

The paradigm that provides the basis for qualitative research is constructivism. Constructivism implies that reality is constructed through human interaction. Knowledge is a human product and is socially and culturally constructed. Individuals create meaning through their interactions with each other and with the environment in which they live.

- **Option A:** Empirical research is a type of research methodology that makes use of verifiable evidence in order to arrive at research outcomes. In other words, this type of research relies solely on evidence obtained through observation or scientific data collection methods.
- **Option C:** Postpositivism or postempiricism is a metatheoretical stance that critiques and amends positivism and has impacted theories and practices across philosophy, social sciences, and various models of scientific inquiry.
- **Option D:** Naturalistic observation is a nonexperimental, primarily qualitative research method in which organisms are studied in their natural settings. Behaviors or other phenomena of interest are observed and recorded by the researcher, whose presence might be either known or unknown to the subjects.

50. Nurse Brian is developing a plan of care for marrow suppression, the major dose-limiting adverse reaction to floxuridine (FUDR). How long after drug administration does bone marrow suppression become noticeable?

- A. 24 hours
- B. 2 to 4 days
- C. 7 to 14 days
- D. 21 to 28 days

Correct Answer: C. 7 to 14 days

- Bone marrow suppression becomes noticeable 7 to 14 days after floxuridine administration. Bone marrow recovery occurs in 21 to 28 days.

51. A nurse is caring for a client diagnosed with TB. Which assessment, if made by the nurse, would not be consistent with the usual clinical presentation of TB and may indicate the development of a concurrent problem?

- A. Non Productive or productive cough
- B. Anorexia and weight loss
- C. Chills and night sweats
- D. High-grade fever

Correct Answer: D. High-grade fever

The client with TB usually experiences cough (non-productive or productive), fatigue, anorexia, weight loss, dyspnea, hemoptysis, chest discomfort or pain, chills and sweats (which may occur at night), and a low-grade fever. Clients with TB typically have low-grade fevers, not higher than 102°F. A chronic cough, hemoptysis, weight loss, low-grade fever, and night sweats are some of the most common physical findings in pulmonary tuberculosis.

- **Option A:** In pulmonary tuberculosis, the most commonly reported symptom is a chronic cough. Cough most of the time is productive, sometimes mixed with blood. Physical examination depends on the organs involved. In the case of pulmonary TB, a patient can have crepitations, and bronchial breath sounds, especially over the upper lobes or affected area indicating cavity or consolidation.
- **Option B:** Constitutional symptoms like fever, weight loss, lymphadenopathy, and night sweats are commonly reported. Extrapulmonary tuberculosis can affect any organ and can have a varied presentation.
- **Option C:** A chronic cough, hemoptysis, weight loss, low-grade fever, and night sweats are some of the most common physical findings in pulmonary tuberculosis. Secondary tuberculosis differs in clinical presentation from the primary progressive disease

52. Mrs. Chua, a 78-year-old client, is admitted with the diagnosis of mild chronic heart failure. The nurse expects to hear when listening to client's lungs indicative of chronic heart failure would be:

- A. Stridor

- B. Crackles
- C. Wheezes
- D. Friction rubs

Correct Answer: B. Crackles

Left-sided heart failure causes fluid accumulation in the capillary network of the lung. Fluid eventually enters alveolar spaces and causes crackling sounds at the end of inspiration. Pulmonary edema may cause crackling sounds in the lungs. People with congestive heart failure (CHF) often have pulmonary edema. CHF occurs when the heart cannot pump blood effectively. This results in a backup of blood, which increases blood pressure and causes fluid to collect in the air sacs in the lungs.

- **Option A:** Stridor may result from lesions involving the central nervous system (CNS), the cardiovascular system, the gastrointestinal (GI) tract, or the respiratory tract. When air passes through a narrowed flexible airway in a child, the lateral pressure that holds the airway open can drop precipitously (the Bernoulli principle) and cause the tube to close. This process obstructs airflow and produces stridor.
- **Option C:** The most common causes of wheezing are asthma and chronic obstructive pulmonary disease (COPD), which both cause narrowing and spasms (bronchospasms) in the small airways of the lungs. However, any inflammation in the throat or larger airways can cause wheezing. Common causes include infection, an allergic reaction or a physical obstruction, such as a tumor or a foreign object that's been inhaled.
- **Option D:** A pericardial friction rub is pathognomonic for acute pericarditis; the rub has a scratching, grating sound similar to leather rubbing against leather. Serial examinations may be necessary for detection, as a friction rub may be transient from one hour to the next and is present in approximately 50% of cases.

53. While examining a client's leg, the nurse notes an open ulceration with visible granulation tissue in the wound. Until a wound specialist can be contacted, which type of dressings is most appropriate for the nurse in charge to apply?

- A. Dry sterile dressing
- B. Sterile petroleum gauze
- C. Moist, sterile saline gauze
- D. Povidone-iodine-soaked gauze

Correct Answer: C. Moist, sterile saline gauze

Moist, sterile saline dressings support wound healing and are cost-effective. If the wound is infected and there are a lot of sloughs, which cannot be mechanically debrided, then a chemical debridement can be done with collagenase-based products. The goal is to help the wound heal as soon as possible by using an appropriate dressing material to maintain the right amount of moisture. When the wound bed is dry, use a dressing to increase moisture and if too wet and the surrounding skin is macerated, use material that will absorb excess fluid and protect the surrounding healthy skin.

- **Option A:** Dry sterile dressings adhere to the wound and debride the tissue when removed. Tulle is a non-adherent dressing impregnated with paraffin. It aids healing but doesn't absorb exudate. It also requires a secondary dressing to hold it in place. It is ideal for burns as one can add topical antibiotics to the dressing. It is known to cause allergies, and this limits its wider use.

- **Option B:** Petroleum supports healing but is expensive. The semipermeable dressing allows for moisture to evaporate and also reduces pain. This dressing also acts as a barrier to prevent environmental contamination. The semipermeable dressing does not absorb moisture and requires regular inspection. It also requires a secondary dressing to hold the semipermeable dressing in place.
- **Option D:** Povidone-iodine can irritate epithelial cells, so it shouldn't be left on an open wound. Plastic film dressings are known to absorb exudate and can be used for wounds with a moderate amount of exudate. They should not be used on dry wounds. They often require a secondary dressing to hold the plastic in place.

54. The most serious adverse effect of tricyclic antidepressant (TCA) overdose is:

- A. Hyperpyrexia
- B. Cardiac arrhythmias
- C. Seizures
- D. Metabolic acidosis

Correct Answer: B. Cardiac arrhythmias.

Excessive ingestion of TCAs results in life-threatening wide QRS complex tachycardia. Tricyclic antidepressants act on approximately five different neurotransmitter pathways to achieve their effects. They block the reuptake of serotonin and norepinephrine in presynaptic terminals, which leads to increased concentration of these neurotransmitters in the synaptic cleft. The increased concentrations of norepinephrine and serotonin in the synapse likely contribute to its antidepressant effect.

- **Option A:** TCAs do not cause an elevation in body temperature. TCAs have varying degrees of receptor affinities, leading to several adverse effects. The most common adverse effects include constipation, dizziness, and xerostomia. Due to its blockade of cholinergic receptors, it can lead to blurred vision, constipation, xerostomia, confusion, urinary retention, and tachycardia.
- **Option C:** TCA overdose can induce seizures, but they are typically not life-threatening. There is evidence of TCAs increasing the risk of seizures in those with epilepsy, and use requires caution in this population.
- **Option D:** TCAs do not cause metabolic acidosis. Due to the blockade of alpha-1 adrenergic receptors, it can cause orthostatic hypotension and dizziness. TCA-induced histamine blockade (H1) may lead to sedation, increased appetite, weight gain, and confusion.

55. The nurse is observing several healthcare workers providing care. Which action by the healthcare worker indicates a need for further teaching?

- A. The nursing assistant wears gloves while giving the client a bath.
- B. The nurse wears goggles while drawing blood from the client.
- C. The doctor washes his hands before examining the client.
- D. The nurse wears gloves to take the client's vital signs.

Correct Answer: D. The nurse wears gloves to take the client's vital signs.

It is not necessary to wear gloves to take the vital signs of the client. If the client has an active infection with methicillin-resistant *Staphylococcus aureus*, gloves should be worn. Wash hands or perform hand hygiene before having contact with the patient. Also impart these duties to the patient and their significant others. Know the instances when to perform hand hygiene or “5 moments for hand hygiene”.

- **Option A:** Wear personal protective equipment (PPE) properly. Wear gloves when providing direct care; perform hand hygiene after properly disposing of gloves. Initiate specific precautions for suspected agents as determined by CDC protocol.
- **Option B:** Use masks, goggles, face shields to protect the mucous membranes of your eyes, mouth, and nose during procedures and in direct-care activities (e.g., suctioning secretions) that may generate splashes or sprays of blood, body fluids, secretions, and excretions.
- **Option C:** The health care workers indicate knowledge of infection control by their actions. Friction and running water effectively remove microorganisms from hands. Washing between procedures reduces the risk of transmitting pathogens from one area of the body to another. Wash hands with antiseptic soap and water for at least 15 seconds followed by an alcohol-based hand rub. If hands were not in contact with anyone or anything in the room, use an alcohol-based hand rub and rub until dry. Plain soap is good at reducing bacterial counts but antimicrobial soap is better, and alcohol-based hand rubs are the best.

56. The most important pathophysiological factor contributing to the formation of esophageal varices is:

- A. Decreased prothrombin formation.
- B. Decreased albumin formation by the liver.
- C. Portal hypertension.
- D. Increased central venous pressure.

Correct Answer: C. Portal hypertension

As the liver cells become fatty and degenerate, they are no longer able to accommodate a large amount of blood necessary for homeostasis. The pressure in the liver increases and causes increased pressure in the venous system. As the portal pressure increases, fluid exudes into the abdominal cavity. This is called ascites.

- **Option A:** Esophageal varices are dilated submucosal distal esophageal veins connecting the portal and systemic circulations. They form due to portal hypertension, which commonly is a result of cirrhosis, resistance to portal blood flow, and increased portal venous blood inflow. Variceal rupture is the most common fatal complication of cirrhosis. The severity of liver disease correlates with the presence of varices and the risk of bleeding.
- **Option B:** Increased resistance to portal flow at the level of hepatic sinusoids is caused by intrahepatic vasoconstriction due to decreased nitric oxide production, and increased release of endothelin-1 (ET-1), angiotensinogen, and eicosanoids; sinusoidal remodeling disrupting blood flow and increased portal flow is caused by hyperdynamic circulation due to splanchnic arterial vasodilation through mediators such as nitric oxide, prostacyclin, and TNF.
- **Option D:** Portal hypertension causes portocaval anastomosis to develop to decompress portal circulation. Normal portal pressure is between 5-10 mmHg but in the presence of portal obstruction, the pressure may be as high as 15-20 mmHg. Since the portal venous system has no valves, resistance at any level between the splanchnic vessels and the right side of the heart results in retrograde flow and elevated pressure.

57. Mrs. Maria Johnson, a 62-year-old woman with a recent diagnosis of pharyngitis, has been admitted to your medical ward. Due to her diagnosis and potential to spread the infection, the infection control team has advised placing her under droplet precautions until further notice. During the shift, you overhear a conversation between a new graduate nurse and a seasoned nurse discussing the droplet precautions implemented for Mrs. Johnson. As their charge nurse, you decide to evaluate their understanding of droplet precautions to ensure the safety and well-being of both the patient and the healthcare team. You gather the two nurses and ask them to clarify their understanding of droplet precautions. Which of the following statements, if made by the new graduate nurse, indicates the best understanding of this type of isolation?

- A. The client can be placed in a room with another client with measles (rubeola).
- B. Must maintain a spatial distance of 3 feet.
- C. A special mask (N95) should be worn when working with the client.
- D. Gloves should be only worn when giving direct care.
- E. It's necessary to perform hand hygiene before and after patient contact.
- F. Droplet precautions are primarily aimed at protecting against airborne transmissions.

Correct Answer: B. Must maintain a spatial distance of 3 feet.

This statement reflects the CDC guidelines for droplet precautions, which recommend keeping a distance of at least 3 feet between the healthcare worker and the patient to avoid contact with infectious droplets.

- **Option A:** Patients on droplet precautions should ideally be placed in single-patient rooms. If this is not possible, they may share a room with others with the same infectious disease, but not with those who have diseases spread through different routes, like measles which requires airborne precautions.
- **Option C:** N95 respirators are not usually required for droplet precautions, but are for airborne precautions. A surgical mask is generally adequate for droplet precautions unless aerosol-generating procedures are being performed.
- **Option D:** While it's true gloves should be worn during direct patient care, this statement does not reflect a complete understanding of droplet precautions which also includes use of gowns, masks, and eye protection when indicated, alongside maintaining a spatial distance.
- **Option E:** While correct and crucial, this statement is a standard practice for all patient interactions, not specific to droplet precautions.
- **Option F:** Droplet precautions are aimed at preventing the spread of infections via large respiratory droplets, not airborne transmissions which involve smaller particles and require different precautions (airborne precautions).

58. When assessing a client for an abdominal aortic aneurysm, which area of the abdomen is most commonly palpated?

- A. Right upper quadrant
- B. Directly over the umbilicus

- C. Middle lower abdomen to the left of the midline
- D. Midline lower abdomen to the right of the midline

Correct Answer: C. Middle lower abdomen to the left of the midline

The aorta lies directly left of the umbilicus; therefore, any other region is inappropriate for palpation. The aortic pulse can be palpated just above and to the left of the umbilicus. The width of the aorta can then be measured by placing both hands palms down on the patient's abdomen, with one index finger on either side of the aorta. Each systole should move the fingers apart.

- **Option A:** The right upper quadrant is a little farther from the appropriate area to be palpated. Abdominal examination includes palpation of the aorta and estimation of the size of the aneurysm. AAAs are palpated in the upper abdomen; the aorta bifurcates into the iliac arteries just above the umbilicus.
- **Option B:** Palpating the umbilicus would yield inappropriate results. The examiner may palpate the periumbilical area for any defect, mass, or an umbilical hernia. The patient can be asked to cough or bear down to feel for any protruding mass.
- **Option D:** The aorta lies to the left, not the right, of the umbilicus. Left lower quadrant tenderness may be a presenting sign of diverticulitis in the elderly. A mass, if present may be due to a tumor of the colon, a left ovarian cyst, or ectopic pregnancy. In the elderly, constipation leading to impacted feces may also present with a mass palpated in the left lower quadrant.

59. A newborn who has an asymmetrical Moro reflex response should be further assessed for which of the following?

- A. Talipes equinovarus
- B. Fractured clavicle
- C. Congenital hypothyroidism
- D. Increased intracranial pressure

Correct Answer: B. Fractured clavicle

A fractured clavicle would prevent the normal Moro response of symmetrical sequential extension and abduction of the arms followed by flexion and adduction.

- **Option A:** In talipes equinovarus (clubfoot) the foot is turned medially, and in plantar flexion, with the heel elevated. The feet are not involved with the Moro reflex.
- **Option C:** Hypothyroidism has no effect on the primitive reflexes. Hypothyroidism means that the thyroid gland can't make enough thyroid hormones to keep the body running normally.
- **Option D:** The absence of the Moro reflex is the most significant single indicator of central nervous system status, but it is not a sign of increased intracranial pressure.

60. A male client has jugular distention. In what position should the nurse place the head of the bed to obtain the most accurate reading of jugular vein distention?

- A. High Fowler's
- B. Raised 10 degrees

- C. Raised 30 degrees
- D. Supine position

Correct Answer: C. Raised 30 degrees

Jugular venous pressure is measured with a centimeter ruler to obtain the vertical distance between the sternal angle and the point of highest pulsation with the head of the bed inclined between 15 to 30 degrees.

- **Option A:** In high Fowler's position, the veins would be barely discernible above the clavicle.
- **Option B:** Increased pressure can't be seen when the head of the bed is raised 10 degrees because the point that marks the pressure level is above the jaw (therefore, not visible).
- **Option D:** Supine position does not make the increased pressure level seen.

61. In which step of the nursing process would the nurse ask a patient if the medication she administered relieved his pain?

- A. Assessment
- B. Analysis
- C. Planning
- D. Evaluation

Correct Answer: D. Evaluation

In the evaluation step of the nursing process, the nurse must decide whether the patient has achieved the expected outcome that was identified in the planning phase. This final step of the nursing process is vital to a positive patient outcome. Whenever a healthcare provider intervenes or implements care, they must reassess or evaluate to ensure the desired outcome has been met. Reassessment may frequently be needed depending upon the overall patient's condition. The plan of care may be adapted based on new assessment data.

- **Option A:** Assessment is the first step and involves critical thinking skills and data collection; subjective and objective. Subjective data involves verbal statements from the patient or caregiver. Objective data is measurable, tangible data such as vital signs, intake and output, and height and weight.
- **Option B:** Analysis can be a part of diagnosing. The formulation of a nursing diagnosis by employing clinical judgment assists in the planning and implementation of patient care. The North American Nursing Diagnosis Association (NANDA) provides nurses with an up to date list of nursing diagnoses. A nursing diagnosis, according to NANDA, is defined as a clinical judgment about responses to actual or potential health problems on the part of the patient, family, or community.
- **Option C:** The planning stage is where goals and outcomes are formulated that directly impact patient care based on EDP guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum.

62. A female client who's at high risk for suicide needs close supervision. To best ensure the client's safety, Nurse Mary should:

- A. Check the client frequently at irregular intervals throughout the night.
- B. Assure the client that the nurse will hold in confidence anything the client says.
- C. Repeatedly discuss previous suicide attempts with the client.
- D. Disregard decreased communication by the client because this is common with suicidal clients.

Correct Answer: A. Check the client frequently at irregular intervals throughout the night

Checking the client frequently but at irregular intervals prevents the client from predicting when observation will take place and altering behavior in a misleading way at these times. Once the patient is deemed to be at risk for suicide, then intervention steps must be initiated right away. The individual must not be left alone. Enlist the help of a support person while at home. The suicidal individual must be treated in a safe and secure place. In addition, the place has to be monitored.

- **Option B:** This may encourage the client to try to manipulate the nurse or seek attention for having a secret suicide plan. Assessing the individual's judgment is critical. One should try and determine how the individual can handle stress. Does he or she have an impairment in decision making? Does the individual know that jumping in front of a train is dangerous? Reflect empathy and concern. Offer a hand to help. Provide the patient with confidence that he or she can overcome the issues.
- **Option C:** This may reinforce suicidal ideas. Help develop internal coping strategies (e.g., exercise, journaling, reading, developing a hobby). Utilize the help of healthcare professionals to follow up on therapy. Once the individual is safe as an inpatient or outpatient, a formal treatment plan should be established. The next step is to refer all patients deemed to be at higher risk for suicide to a mental health counselor as soon as possible. Every state has laws and procedures regarding this process which must be incorporated into the clinical practice when addressing individuals at high suicide risk.
- **Option D:** Decreased communication is a sign of withdrawal that may indicate the client has decided to commit suicide; the nurse shouldn't disregard it. In some cases, assessment of the mental status may provide a clue to the individual's potential for self-harm. Depressed patients will often tend to appear unclean and unkempt. The clothing may not be ironed or dirty. The risk of suicide is often high in people who appear very anxious or depressed. The patient may exhibit a flat affect or no emotions at all. Some depressed patients may develop hallucinations that may be telling him or her to kill themselves. The majority of these hallucinations are auditory.

63. There are times when Katherine evaluates her staff as she makes her daily rounds. Which of the following is not a benefit of conducting an informal appraisal?

- A. The staff member is observed in a natural setting.
- B. Incidental confrontation and collaboration are allowed.
- C. The evaluation is focused on objective data systematically.
- D. The evaluation may provide valid information for the compilation of a formal report.

Correct Answer: C. The evaluation is focused on objective data systematically.

Collecting objective data systems can not be achieved in an informal appraisal. It is focused on what actually happens in the natural work setting. Informal appraisals give an employee a more current, ongoing perspective on performance. It helps avoid delivering positive or negative surprises in a formal review, which is important for internal communication. The manager also has the ability to motivate better performance and stem problems quickly. A drawback of informal evaluations is that the manager doesn't plan for them as with a formal review.

- **Option A:** Informal appraisals occur when a manager provides significant feedback and direction to an employee outside of a formal review meeting. Consistent, informal feedback is important to build rapport with employees and to coach them in an ongoing manner.
- **Option B:** A contrast to immediate praise is immediate criticism or negative feedback. This approach is applied when you spot an employee making a mistake, making a poor decision, or simply underperforming. Similar to positive feedback, the immediacy of constructive criticism is important. You need to address the undesirable behavior right away so the employee knows the specifics of the incident at the moment.
- **Option D:** A positive version of informal appraisal feedback occurs when a manager notices an employee performing well, overcoming an obstacle, or achieving a goal, and offers praise. The point is to immediately reinforce the desired behavior or achievement so that the employee is compelled to perform in a similar or better way going forward.

64. The following clients are presented with signs and symptoms of heat-related illness. Which of them needs to be attended first?

- A. A relatively healthy homemaker who reports that the air conditioner has been broken for days and who manifest fatigue, hypotension, tachypnea, and profuse sweating.
- B. An elderly person who complains of dizziness and syncope after standing in the sun for several hours to view a parade.
- C. A homeless person who is a poor historian; has altered mental status, poor muscle coordination, and hot, dry ashen skin; and whose duration of heat exposure is unknown.
- D. A marathon runner who complains of severe leg cramps and nausea, and manifests weakness, pallor, diaphoresis, and tachycardia.

Correct Answer: C. A homeless person who is a poor historian; has altered mental status, poor muscle coordination, and hot, dry ashen skin; and whose duration of heat exposure is unknown.

The signs and symptoms manifested by the homeless person indicate that a heat stroke is happening, a medical emergency, which can lead to brain damage. Also, there must be clinical signs of central nervous system dysfunction that may include ataxia, delirium, or seizures, in the setting of exposure to hot weather or strenuous physical exertion. Patients who present with heat stroke typically have vital sign abnormalities to include an elevated core body temperature, sinus tachycardia, tachypnea, a widened pulse pressure, and a quarter of patients will be hypotensive.

- **Option A:** The homemaker is experiencing heat exhaustion, which can be managed by fluids and cooling measures. It is important to differentiate where the patient is on the heat illness continuum. The signs and symptoms of heat exhaustion may present similarly include cramping, fatigue, dizziness, nausea, vomiting, headache. If progression to end-organ damage occurs it then becomes heat injury.
- **Option B:** The elderly client is at risk for heat syncope and should be advised to rest in a cool area and avoid similar situations. Heat syncope is the temporary, self-limited dizziness, weakness, or

loss of consciousness during prolonged standing or positional changes in a hot environment, including physical activity. The thinking is that it is due to a combination of dehydration, pooling of blood in the venous system, decreased cardiac filling, and low blood pressure, which leads to decreased cerebral blood flow.

- **Option D:** The runner is experiencing heat cramps, which can be managed with fluid and rest. Heat cramps: include involuntary spasmodic contractions of large muscle groups as opposed to an isolated muscle spasm/cramp that can also occur during or after exertion. This condition is due to a relative deficiency of sodium, potassium, chloride, or magnesium. Other symptoms may include nausea, vomiting, fatigue, weakness, sweating, and tachycardia.

65. A client with schizophrenia tells the nurse he hears the voices of his dead parents. To help the client ignore the voices, the nurse should recommend that he:

- A. Sit in a quiet, dark room and concentrate on the voices.
- B. Listen to a personal stereo through headphones and sing along with the music.
- C. Call a friend and discuss the voices and his feelings about them.
- D. Engage in strenuous exercise.

Correct Answer: B. Listen to a personal stereo through headphones and sing along with the music.

Increasing the amount of auditory stimulation, such as by listening to music through headphones, may make it easier for the client to focus on external sounds and ignore internal sounds from auditory hallucinations. Work with the client to find which activities help reduce anxiety and distract the client from a hallucinatory material. Practice new skills with the client. If clients' stress triggers hallucinatory activity, they might be more motivated to find ways to remove themselves from a stressful environment or try distraction techniques.

- **Option A:** It would make it harder for the client to ignore the hallucinations. Stay with clients when they are starting to hallucinate, and direct them to tell the "voices they hear" to go away. Repeat often in a matter-of-fact manner. The client can sometimes learn to push voices aside when given repeated instructions, especially within the framework of a trusting relationship.
- **Option C:** Talking about the voices would encourage the client to focus on them. Keep to simple, basic, reality-based topics of conversation. Help the client focus on one idea at a time. Client' thinking might be confused and disorganized; this intervention helps the client focus and comprehend reality-based issues.
- **Option D:** This is incorrect because exercise alone wouldn't provide enough auditory stimulation to drown out the voices. Accept the fact that the voices are real to the client, but explain that you do not hear the voices. Refer to the voices as "your voices" or "voices that you hear". Validating that your reality does not include voices can help the client cast "doubt" on the validity of their voices.

66. Which of the following adverse effects is associated with levothyroxine (Synthroid) therapy?

- A. Hypotension
- B. Bradycardia

C. Tachycardia

D. Constipation

Correct Answer: C. Tachycardia

Levothyroxine, especially in higher doses, can induce hyperthyroid-like symptoms including tachycardia. Adverse effects (frequency undefined) include: angina pectoris, tachycardia, palpitations, arrhythmias, myocardial infarction, dyspnea, anxiety, fatigue, headache, heat intolerance, insomnia, irritability, diaphoresis, skin rash, alopecia, goiter, weight loss, menstrual irregularities, abdominal cramps, diarrhea, emesis, reduced fertility, and decreased bone mineral density (a result of TSH suppression).

- **Option A:** Hypotension would be a side effect of bradycardia. Thyroid hormone therapy decreases aortic stiffness, promoting decreased blood pressure in about 50 percent of these patients. Antihypertensive treatment further improves aortic elasticity and can decrease blood pressure among patients with hypertension and hypothyroidism whose blood pressure does not drop as thyroid function is normalized.
- **Option B:** An agent that increases the basal metabolic rate would not be expected to induce a slow heart rate. In a hypothyroid state, diastolic blood pressure increases, pulse pressure narrows, and renin levels decrease. This results in diastolic hypertension that is often sodium sensitive. Erythropoietin secretion is increased by T3, which can explain the normochromic, normocytic anemia often found in hypothyroidism. Thyroid hormones also regulate pacemaker-related genes through transcription as well as the beta-adrenergic system in cardiomyocytes. As a result of these mechanisms, heart rate increases in the presence of thyroid hormones and decreases in hypothyroidism.
- **Option D:** Constipation is a symptom of hypothyroid disease. The thyroid gland can have a significant impact on the gastrointestinal system. A common misconception is that diet causes chronic digestive trouble and weight changes, but this may be an oversimplification. Thyroid conditions and their resultant symptoms are often complex and require ongoing treatment by an endocrinologist.

67. Which nursing intervention would be a priority during the care of a 2-month-old after surgery?

- A. Minimize stimuli for the infant.
- B. Restrain all extremities.
- C. Encourage stroking of the infant.
- D. Demonstrate to the mother how she can assist with her infant's care.

Correct Answer: C. Encourage stroking of the infant.

Tactile stimulation is imperative for an infant's normal emotional development. After the trauma of surgery, sensory deprivation can cause failure to thrive. Most babies with FTT do not have a specific underlying disease or medical condition to account for their growth failure. This is referred to as Non-organic FTT. Up to 80% of all children with FTT have Non-organic type FTT. Non-organic FTT most commonly occurs when there is inadequate food intake or there is a lack of environmental stimuli.

- **Option A:** Provide sensory stimulation. Attempt to cuddle the child and talk to him or her in a warm, soothing tone and allow for play activities appropriate for the child's age. Feed the child slowly and carefully in a quiet environment; during feeding, the child might be closely snuggled and gently rocked; it may be necessary to feed the child every 2 to 3 hours initially.

- **Option B:** Do not restrain the child. Burp the child frequently during and at the end of each feeding, and then place him or her on the side with the head slightly elevated or held in a chest-to-chest position.
- **Option D:** If a family caregiver is present, encourage him or her to become involved in the child's feedings. While caring for the child, point out to the caregiver the child's development and responsiveness, noting and praising any positive parenting behaviors the caregiver displays.

68. A client taking the MAOI phenelzine (Nardil) tells the nurse that he routinely takes all of the medications listed below. Which medication would cause the nurse to express concern and therefore initiate further teaching?

- A. Acetaminophen (Tylenol)
- B. Diphenhydramine (Benadryl)
- C. Furosemide (Lasix)
- D. Isosorbide dinitrate (Isordil)

Correct Answer: B. Diphenhydramine (Benadryl)

Over-the-counter medications used for allergies and cold symptoms are contraindicated because they will increase the sympathomimetic effects of MAOIs, possibly causing a hypertensive crisis. In general, SSRIs, SNRIs, TCAs, bupropion, mirtazapine, St. John's Wort and sympathomimetic amines, including stimulants, are contraindicated with MAOIs. Tramadol, meperidine, dextromethorphan, and methadone are contraindicated in patients on MAOIs as they are at high risk for causing serotonin syndrome.

- **Option A:** Acetaminophen (APAP) is considered a non-opioid analgesic and antipyretic agent used to treat pain and fever. Clinicians can use it for their patients as a single agent for mild to moderate pain and in combination with an opioid analgesic for severe pain. Acetaminophen, also called N-acetyl para-aminophenol or paracetamol, is one of the most widely used over-the-counter analgesic and antipyretic agents. Although its exact mechanism of action remains unclear, it is historically categorized along with NSAIDs because it inhibits the cyclooxygenase (COX) pathways.
- **Option C:** The Food and Drug Administration (FDA) has approved the use of furosemide in the treatment of conditions with volume overload and edema secondary to congestive heart failure exacerbation, liver failure, or renal failure including the nephrotic syndrome. Furosemide inhibits tubular reabsorption of sodium and chloride in the proximal and distal tubules, as well as in the thick ascending loop of Henle by inhibiting sodium-chloride cotransport system resulting in excessive excretion of water along with sodium, chloride, magnesium, and calcium.
- **Option D:** Isosorbide is a nitrate that exerts its pharmacologic effect by releasing nitric oxide (NO), an endothelium-derived relaxing factor (EDRF). NO is endogenously produced in the endothelium to dilate the blood vessels. It is for the prevention or treatment of angina pectoris resulting from coronary artery disease; however, it is not recommended for use once the anginal episode has started because the onset of action is not sufficiently rapid enough to abort an acute anginal event. In the latter case, glyceryl trinitrate is preferable.

69. When assessing a patient for electrolyte balance, the nurse is aware that etiologies for hyponatremia include:

- A. Water gain
- B. Diuretic therapy

- C. Diaphoresis
- D. All of the following

Correct Answer: D. All of the following

Water gain, diuretic therapy, and diaphoresis are etiologies of hyponatremia. The etiology of hyponatremia can be classified based upon the volume status of the extracellular fluid. Sodium is the major solute of extracellular fluid (ECF). Based upon the volume of ECF, a patient can be classified into hypovolemic, euvolemic, or hypervolemic.

- **Option A:** Physiological stimuli that cause vasopressin release in adjunct with increased fluid intake can cause hyponatremia. Hypothyroidism and adrenal insufficiency may contribute to an increased release of vasopressin. Physiological stimuli for vasopressin release include loss of intravascular volume (hypovolemic hyponatremia) and the loss of effective intravascular volume (hypervolemic hyponatremia).
- **Option B:** Many drugs cause hyponatremia and the most common include: vasopressin analogs such as desmopressin and oxytocin; medications that stimulate vasopressin release or potentiate the effects of vasopressin such as selective serotonin-reuptake inhibitors and other antidepressants morphine and other opioids; and medications that impair urinary dilution such as thiazide diuretics.
- **Option C:** Water excretion is tightly regulated by antidiuretic hormone (ADH), synthesized in the hypothalamus, and stored in the posterior pituitary gland. Changes in tonicity lead to either enhancement or suppression of ADH secretion. Increased ADH secretion causes reabsorption of water in the kidney, and suppression causes the opposite effect.

70. She plans on assigning competent people to fill the roles designed in the hierarchy. Which process refers to this?

- A. Staffing
- B. Scheduling
- C. Recruitment
- D. Induction

Correct Answer: A. Staffing

Staffing is a management function involving putting the best people to accomplish tasks and activities to attain the goals of the organization. Staffing is the function by which managers build an organization through the recruitment, selection, development, of individuals as capable employees.

- **Option B:** The scheduling function consists of organizing activities in a specific system imposing some rules to respect. More generally, solving a scheduling problem can be reduced to the organization and the synchronization of a set of activities (jobs or tasks) by exploiting the available capacities (resources).
- **Option C:** Recruitment is the process of attracting, evaluating, and hiring employees for an organization. The recruitment process includes four steps: job analysis, sourcing, screening and selection, and onboarding.
- **Option D:** Induction means the introduction of a new employee to the job and the organization. It is the process of receiving and welcoming an employee when he first joins a company and giving him the basic information he needs to settle down quickly and happily and start work.

71. What laboratory finding is the primary diagnostic indicator for pancreatitis?

- A. Elevated blood urea nitrogen (BUN)
- B. Elevated serum lipase
- C. Elevated aspartate aminotransferase (AST)
- D. Increased lactate dehydrogenase (LD)

Correct Answer: B. Elevated serum lipase

Elevation of serum lipase is the most reliable indicator of pancreatitis because this enzyme is produced solely by the pancreas. Serum lipase typically increases 3–6 hours after the onset of acute pancreatitis and usually peaks at 24 hours. Unlike amylase, there is significant reabsorption of lipase in the renal tubules so the serum concentrations remain elevated for 8–14 days.

- **Option A:** A client's BUN is typically elevated in relation to renal dysfunction. A BUN test is done to see how well the kidneys are working. If the kidneys are not able to remove urea from the blood normally, the BUN level rises. Heart failure, dehydration, or a diet high in protein can also make the BUN level higher. Liver disease or damage can lower the BUN level.
- **Option C:** A client's AST is typically elevated in relation to liver dysfunction. The elevated AST-to-ALT ratio in alcoholic liver disease results in part from the depletion of vitamin B6 (pyridoxine) in chronic alcoholics. ALT and AST both use pyridoxine as a coenzyme, but the synthesis of ALT is more strongly inhibited by pyridoxine deficiency than is the synthesis of AST.
- **Option D:** A client's LD is typically elevated in relation to damaged cardiac muscle. Usually, LDH isoenzyme levels increase 24–72 hours following myocardial infarction and reach a peak concentration in 3–4 days. Glycogen phosphorylase BB is released into circulation 2–4 h after onset of cardiac ischemia and returns to baseline levels 1–2 days after acute myocardial infarction, making it an early marker.

72. The following are interventions to make the fundus contract postpartally, except:

- A. Make the baby suck the breast regularly.
- B. Apply ice cap on fundus.
- C. Massage the fundus vigorously for 15 minutes until contracted.
- D. Give oxytocin as ordered.

Correct Answer: C. Massage the fundus vigorously for 15 minutes until contracted.

Massaging the fundus of the uterus should not be vigorous and should only be done until the uterus feels firm and contracted. If the massage is vigorous and prolonged, the uterus will relax due to overstimulation.

- **Option A:** If the woman breastfeeds, the hormone oxytocin is released, which causes the uterus to contract.
- **Option B:** Cooling the uterus by placing an icepack on the lower abdomen is one of the standard non-pharmacological prophylactic strategies to prevent PPH in Japan; the reasoning is that cold compresses may help to contract the myometrium and decrease blood loss. Cold therapy causes blood vessels within the smooth muscles to constrict, which subsequently decreases blood flow. Furthermore, blood vessels in the skin are affected by cold, resulting in somatovisceral reflex and

subsequent vasoconstriction of relevant internal organs

- **Option D:** Prophylactic administration of oxytocin (Pitocin) reduces rates of postpartum hemorrhage by 40 percent; this reduction also occurs if oxytocin is given after placental delivery. Oxytocin is the drug of choice for preventing postpartum hemorrhage because it is at least as effective as ergot alkaloids or prostaglandins and has fewer side effects. Misoprostol (Cytotec) has a role in the prevention of postpartum hemorrhage; this agent has more side effects but is inexpensive, heat- and light-stable, and requires no syringes.

73. A patient on the cardiac telemetry unit unexpectedly goes into ventricular fibrillation. The advanced cardiac life support team prepares to defibrillate. Which of the following choices indicates the correct placement of the conductive gel pads?

- A. The left clavicle and right lower sternum.
- B. Right of midline below the bottom rib and the left shoulder.
- C. The upper and lower halves of the sternum.
- D. The right side of the sternum just below the clavicle and left of the precordium.

Correct Answer: D. The right side of the sternum just below the clavicle and left of the precordium.

One gel pad should be placed to the right of the sternum, just below the clavicle and the other just left of the precordium, as indicated by the anatomic location of the heart. To defibrillate, the paddles are placed over the pads. According to the ILCOR guidelines, the sternal paddle should be placed 'just to the right of the upper sternal border below the clavicle' and the apical paddle 'to the left of the nipple with the centre of the electrode in the mid-axillary line'.

- **Option A:** During the gel pad placement study it was noticed that about 50% of doctors placed the rectangular apical paddle vertically upwards, pointing towards the left armpit. The other 50% placed it in a horizontal position across the chest. The present ILCOR guidelines do not specify which orientation should be used for defibrillation. It was hypothesized that, with the paddle method for defibrillation, it would be more difficult to get good skin contact across the curved chest wall with the horizontal orientation, and in a small study this proved to be the case.
- **Option B:** In theory, a paddle position that is too superomedial means that less current will traverse the myocardium. When 60 N (the median force used by defibrillator operators in clinical practice) is applied to both paddles, the resulting TTI is 5% greater with the horizontal orientation. Thus, if paddles are used, it is recommended to use a vertical orientation. It is expected that their flexibility will allow better electrode/skin contact across the curved chest wall; however, in the absence of any evidence to the contrary, it is advised to use vertical orientation for this method as well.
- **Option C:** Most healthcare workers are not achieving optimal TTI during defibrillation. There is now good evidence that the use of a coupling agent, chest hair removal, placement of the apical paddle in a vertical orientation lateral to the nipple in the mid-axillary line, and application of at least 80 N of force are all measures that help minimize the TTI.

74. You are the charge nurse on the pediatric unit when a pediatrician calls wanting to admit a child with rubeola (measles). Which of these factors is of most concern in determining whether to admit the child to your unit?

- A. No negative-airflow rooms are available on the unit
- B. The infection control nurse liaison is not on the unit today
- C. There are several children receiving chemotherapy on the unit
- D. The unit is not staffed with the usual number of RNs

Correct Answer: A. No negative-airflow rooms are available on the unit

Because clients with rubeola require the implementation of airborne precautions, which include placement in a negative airflow room, this child cannot be admitted to the pediatric unit. An airborne isolation room is also known as a negative pressure room. This negative pressure room is usually a single-occupancy patient-care room frequently used to isolated individuals with confirmed or suspected airborne infections. The other circumstances may require actions such as staff reassignments but would not prevent the admission of a client with rubeola.

- **Option B:** The absence of the infection control nurse liaison should not prevent the admission of the child with rubeola. Before transferring a patient with an airborne infection, one must always communicate with the relevant department first. The earlier the airborne prevention methods are adopted, the lower the risk of transmission to other patients and healthcare staff.
- **Option C:** The clients receiving therapy can be transferred to a different location far from the isolation room. The door to the room of the isolation area must be kept closed to maintain negative pressure even if the client is not in the room. The windows in the room should remain closed at all times; opening the window may cause the reversal of airflow, which counters the benefits of a negative pressure room.
- **Option D:** Only healthcare providers immunized to the organism in question should enter a room where airborne precautions are in place for varicella or measles. A respirator is not necessary for immunized individuals but is required for non-immunized workers who provide care.

75. A client with human immunodeficiency syndrome has gastrointestinal symptoms, including diarrhea. The nurse should teach the client to avoid:

- A. Processed meat
- B. Pasteurized milk
- C. Raw fruits and vegetables
- D. Calcium-rich foods

Correct Answer: C. Raw fruits and vegetables

- Option C: The client with HIV should adhere to a low-bacteria diet by avoiding raw fruits and vegetables.
- Options A, B, and D: These can be eaten by a patient with HIV.

76. Ricardo, an outpatient in a psychiatric facility is diagnosed with dysthymic disorder. Which of the following statements about dysthymic disorder is true?

- A. It involves a mood range from moderate depression to hypomania.
- B. It involves a single manic depression.
- C. It's a form of depression that occurs in the fall and winter.

D. It's a mood disorder similar to major depression but of mild to moderate severity.

Correct Answer: D. It's a mood disorder similar to major depression but of mild to moderate severity

Dysthymic disorder is a mood disorder similar to major depression but it remains mild to moderate in severity. Persistent depressive disorder is a newly coined term in the DSM-5 to capture what was originally known as dysthymia and chronic major depression. This disorder has been poorly understood, and its classification has evolved due to the complicated and ever-evolving nature of the nosology of depressive disorders. It was not until the DSM-III that dysthymic disorder was defined as a mild chronic depression lasting longer than 2 years.

- **Option A:** Cyclothymic disorder is a mood disorder characterized by a mood range from moderate depression to hypomania. Cyclothymia is a primary mood disorder that is, by definition, characterized by episodes that do not meet the criteria for hypomania or major depression. It is currently classified under the umbrella of bipolar mood disorders. It is a chronic disease that must be present for at least two years in order to be diagnosable in adults and over 1 year in children and adolescents.
- **Option B:** Bipolar I disorder is characterized by a single manic episode with no past major depressive episodes. Bipolar 1 disorder has been frequently associated with serious medical and psychiatric comorbidity, early mortality, high levels of functional disability and compromised quality of life. The necessary feature of bipolar 1 disorder involves the occurrence of at least one-lifetime manic episode, although depressive episodes are common.
- **Option C:** Seasonal Affective Disorder is a form of depression occurring in the fall and winter. Unlike people with classic depression, who typically eat less and sleep more, people with SAD eat more and sleep more, much like animals hibernating for the winter. Many patients with SAD do not realize that they have depression, because they are not necessarily depressed with regard to their mood. Nevertheless, they feel tired and less interested in things and have increased sleep and appetite, thus meeting the clinical depression criteria.

77. Which of the following would the nurse identify as a presumptive sign of pregnancy?

- A. Hegar sign
- B. Nausea and vomiting
- C. Skin pigmentation changes
- D. Positive serum pregnancy test

Correct Answer: B. Nausea and vomiting

Presumptive signs of pregnancy are subjective signs. Of the signs listed, only nausea and vomiting are presumptive signs.

- **Option A:** Hegar's sign is a non-sensitive indication of pregnancy in women — its absence does not exclude pregnancy. It pertains to the features of the cervix and the uterine isthmus. It is demonstrated as a softening in the consistency of the uterus, and the uterus and cervix seem to be two separate regions. It is a probable sign of pregnancy.
- **Option C:** The area around the nipples and the skin on the inner thighs, genitals, and neck might darken, possibly due to hormonal changes. The woman might notice a dark line from the navel to the pubic bone (linea nigra). Dark patches might develop on the face (chloasma). Avoid sun exposure, which can worsen chloasma. After childbirth, skin typically returns to its normal pigment

over a period of several months.

- **Option D:** A positive serum pregnancy test is considered a probable sign, which is strongly suggestive of pregnancy.

78. A 3-year-old had a hip spica cast applied 2 hours ago. In order to facilitate drying, the nurse should:

- A. Expose the cast to air and turn the child frequently.
- B. Use a heat lamp to reduce the drying time.
- C. Handle the cast with the abductor bar.
- D. Turn the child as little as possible.

Correct Answer: A. Expose the cast to air and turn the child frequently

The child should be turned every 2 hours, with the surface exposed to the air. Casts and splints hold the bones in place while they heal. They also reduce pain, swelling, and muscle spasm.

- **Option B:** Heat lamps may cause burns in the skin inside the cast. Inspect the skin around the cast. If the skin becomes red or raw around the cast, contact a doctor.
- **Option C:** Do not handle the cast until it is dry because it might still break. It takes about one hour for fiberglass, and two to three days for plaster to become hard enough to walk on. Some physicians will give a “cast shoe” to wear over a walking cast. The cast shoe will help protect the bottom of the cast.
- **Option D:** Turning the child would ensure equal drying of the cast at all sides. Keep the cast dry. If the cast becomes wet, it can hurt the child’s skin. Do not try to dry cast with something warm (i.e., a blow dryer) this may cause burns.

79. During a clinical rotation in a renowned research hospital, medical students are engaged in a study focusing on a patient with Common Variable Immunodeficiency (CVID), a disorder characterized by impaired antibody responses. The patient’s susceptibility to recurrent bacterial and viral infections underscores the quintessential role antibodies play in immune defense. The clinician leading the study elaborates on the molecular architecture of antibodies, their diverse isotypes, and how they mediate various effector functions to ward off pathogens. The case triggers a profound discussion on the biochemical and functional attributes of antibodies. With the clinical scenario of CVID in mind, which of the following statements is TRUE about antibody molecules?

- A. have a constant region that binds to antigens
- B. have a variable region that can activate complement or attach to macrophages
- C. are large glycolipids
- D. are called gamma globulins or immunoglobulins

Correct Answer: D. are called gamma globulins or immunoglobulins

Antibodies are indeed referred to as gamma globulins due to their position in protein electrophoresis, or

immunoglobulins, highlighting their role in the immune system.

- **Option A:** The constant region of an antibody molecule is involved in effector functions but does not bind to antigens. The antigen-binding site is located in the variable region of the antibody molecule.
- **Option B:** While it is true that antibodies can activate complement or interact with immune cells such as macrophages, these actions are mediated through the constant region, not the variable region which is primarily involved in antigen recognition.
- **Option C:** Antibodies are proteins, not glycolipids. They are composed of polypeptide chains and can have carbohydrate groups attached, making them glycoproteins.

80. A nurse is providing teaching regarding the prevention of Lyme disease to a group of teenagers going on a hike in a wooded area. Which of the following points should the nurse include in the session? Select all that apply.

- A. Tuck pant legs into socks.
- B. Wear closed shoes when hiking.
- C. Apply insect repellent containing DEET.
- D. Cover the ground with a blanket when sitting.
- E. Remove attached ticks by grasping with thumb and forefinger.
- F. Wear long sleeves and long pants in dark colors when in high-risk areas.

Correct Answer: A, B, C, & D.

Lyme disease or Lyme borreliosis is the most commonly transmitted tick-borne infection in the United States and among the most frequently diagnosed tick-borne infections worldwide.

- **Options A, B, and F:** Measures to prevent tick bites focus on covering the body as completely as possible. Long sleeves and pants tucked into the socks along with closed shoes will offer some protection. Light-colored clothing should be worn so that ticks would be easily visible.
- **Option C:** Spraying insect repellent containing DEET on the skin and clothing can also prevent ticks. Permethrin can be used to treat boots, clothing, and camping gear and remain protective through several washings.
- **Option D:** Hikers should not sit directly on the ground and should cover the ground with an item such as a blanket. Ticks live in grassy, brushy, or wooded areas, or even on animals. Spending time outside walking the dog, camping, gardening, or hunting could bring in close contact with ticks.
- **Option E:** Ticks should be removed with tweezers. Use clean, fine-tipped tweezers to grasp the tick as close to the skin's surface as possible. Pull upward with steady, even pressure. Don't twist or jerk the tick; this can cause the mouth parts to break off and remain in the skin. If this happens, remove the mouth parts with tweezers.

81. During a mother's class, the nurse who is teaching the participants on stress management is questioned about the use of alternative treatments, such as herbal therapy and therapeutic touch. She explains that the advantage of these methods would include all of the following except:

- A. They are congruent with many cultural belief systems.
- B. They encourage the consumer to take an active role in health management.
- C. They promote interrelationships within the mind-body-spirit.
- D. They usually work better than traditional medical practice.

Correct Answer: D. They usually work better than traditional medical practice.

Complementary alternative medicine treatments are often used as adjuncts to traditional medical treatment. Although an individual may choose a particular alternative treatment method, there is really no current scientific proof that these methods will work better than traditional medicine. Stress can be effectively managed by Yoga, meditation, mindfulness, healthy eating, exercise, acupressure, acupuncture, building relaxation rituals like massaging or drinking herbal teas such as rose, bamboo, chamomile, peppermint etc.

- **Option A:** Complementary therapies can be described as the health care techniques aimed at integrating physical, mental, and spiritual dimensions. The objective of complementary therapies differs from the allopathic care used in Western medicine, in which the cure of the disease is the result from direct interventions in injured organs. Different classifications have been proposed for complementary therapies. The National Center for Complementary and Alternative Medicine mainly categorizes them as biologically based therapies, mind-body interventions, and manipulative and body-based methods.
- **Option B:** Complementary therapies may help improve a patient's quality of life and the use of these therapies should be part of a further health care model established toward comprehensive care, offering therapeutic modalities that can strengthen the mind-body-spirit during a patients' treatment journey.
- **Option C:** Mind-body-based programs can also reduce stress and anxiety associated with the cancer experience. Data from breast cancer populations have suggested that mind-body based complementary therapies (eg, mindfulness, meditation, yoga, Tai Chi, Qigong, guided imagery, and affirmations) have the potential to influence the immune profile of breast cancer patients and survivors, along with decreasing stress levels by helping them in developing a greater sense of emotional balance and well-being.

82. Albert, who suffered severe burns 6 months ago, is expressing concern about the possible loss of job-performance abilities and physical disfigurement. Which intervention is the most appropriate for him?

- A. Referring the client for counseling and occupational therapy.
- B. Staying with the client as much as possible and building trust.
- C. Providing cutaneous stimulation and pharmacologic therapy.
- D. Providing distraction and guided imagery techniques.

Correct Answer: A. Referring the client for counseling and occupational therapy

Because it has been 6 months, the client needs professional help to get on with life and handle the limitations imposed by the current problems. Staying with the client, building trust, and providing methods of pain relief, such as cutaneous stimulation, medications, distraction, and guided imagery interventions, would have been more appropriate in earlier stages of postburn injury when physical pain was most severe and fewer psychological factors needed to be addressed.

- **Option B:** Explain to the patient what happened. Provide opportunities for questions and give honest answers. Compassionate statements reflecting the reality of the situation can help the patient and SO acknowledge that reality and begin to deal with what has happened.
- **Option C:** The burned patient may require around-the-clock medication and dose titration. IV method is often used initially to maximize drug effect. Concerns of patient addiction or doubts regarding the degree of pain experienced are not valid during the emergent/acute phase of care, but narcotics should be decreased as soon as feasible and alternative methods for pain relief initiated.
- **Option D:** Encourage use of stress management techniques: progressive relaxation, deep breathing, guided imagery, and visualization. Refocuses attention, promotes relaxation, and enhances the sense of control, which may reduce pharmacological dependency.

83. The sexual response cycle in which the sexual interest continues to build:

- A. Sexual Desire
- B. Sexual arousal
- C. Orgasm
- D. Resolution

Correct Answer: B. Sexual arousal

Sexual arousal or excitement refers to attaining and maintaining the physiologic requirements for sexual intercourse. The vagina continues to swell from increased blood flow, and the vaginal walls turn a dark purple. The woman's clitoris becomes highly sensitive (may even be painful to touch) and retracts under the clitoral hood to avoid direct stimulation from the penis. Breathing, heart rate and blood pressure continue to increase.

- **Option A:** Sexual desire refers to the ability, interest or willingness for sexual stimulation. Sexual desire is typically viewed as an interest in sexual objects or activities. More precisely, it is the subjective feeling of wanting to engage in sex. Sexual desire is sometimes, but not always, accompanied by genital arousal (such as penile erection in men and vaginal lubrication in women).
- **Option C:** Orgasm refers to the peak of the sexual response where the female has vaginal contractions for the female and ejaculatory contractions for the male. This phase is the climax of the sexual response cycle. It is the shortest of the phases and generally lasts only a few seconds.
- **Option D:** Resolution is the final phase of the sexual response in which the organs and the body systems gradually return to the unaroused state. This phase is marked by a general sense of well-being and, often, fatigue. Some women are capable of a rapid return to the orgasm phase with further sexual stimulation and may experience multiple orgasms. Men need recovery time after orgasm, called a refractory period, during which they cannot reach orgasm again. The duration of the refractory period varies among men and changes with age.

84. A nurse is assessing a client with an abdominal aortic aneurysm. Which of the following assessment findings by the nurse is probably unrelated to an aneurysm?

- A. Pulsatile abdominal mass.
- B. Hyperactive bowel sounds in that area.

- C. Systolic bruit over the area of the mass.
- D. Subjective sensation of “heart beating” in the abdomen.

Correct Answer: B. Hyperactive bowel sounds in that area

Not all clients with abdominal aortic aneurysms exhibit symptoms. Physical exam should also look for other associated aneurysms. The most common associated aneurysm is an iliac artery aneurysm. Peripheral aneurysms are also associated in approximately 5 % of patients, of which popliteal artery aneurysms are the most common.

- **Option A:** A pulsatile mass may be palpated in the middle and upper abdomen. Palpation of the abdomen usually reveals a non-tender, pulsatile abdominal mass. Enlarging aneurysms can cause symptoms of abdominal, flank, or back pain. Compression of adjacent viscera can cause gastrointestinal (GI) or renal manifestations.
- **Option C:** A systolic bruit may be auscultated over the mass. Hyperactive bowel sounds are not related specifically to an abdominal aortic aneurysm. Rupture of an abdominal aortic aneurysm is life-threatening. These patients may present in shock often with diffuse abdominal pain and distension. However, the presentation of patients with this type of ruptured aneurysm can vary from subtle to quite dramatic. Most patients with a ruptured abdominal aortic aneurysm die before hospital arrival.
- **Option D:** Those who do describe a feeling of the “heart beating” in the abdomen when supine or be able to feel the mass throbbing. On physical exam, the patient may have tenderness over the aneurysm or demonstrate signs of embolization. The aneurysm may rupture into adjacent viscera or vessels presenting with GI bleeding or congestive heart failure due to the aortocaval fistula.

85. On a clinic visit a client who has a relative with cancer, is asking about the warning signs that may relate to cancer. The nurse correctly identifies the warning signs of cancer by responding:

- A. “A lump located only in the breast area may suggest the presence of cancer.”
- B. “Sudden weight loss of unexplained etiology can be a warning sign of cancer.”
- C. “Presence of dry cough is one of the warning signs of cancer.”
- D. “If a sore healing took a month or more to heal, cancer should be suspected.”

Correct Answer: B. “Sudden weight loss of unexplained etiology can be a warning sign of cancer.”

- **Option B:** Unexplained sudden weight loss of 10 pounds or more is a warning signal of cancer. This is common among cancers of the esophagus, stomach, and pancreas.
- **Option A:** The presence of lump is not limited to the breast only; it can grow elsewhere which is why this option is wrong.
- **Option C:** Nagging cough not dry cough and hoarseness of voice is a sign of cancer.
- **Option D:** The sore in cancer does not heal.