Silvestri: Saunders Comprehensive Review for the NCLEX-RN® Examination, 6th Edition

Adult Health

Test Bank

MULTIPLE CHOICE

1. The nurse reviews the health record of a client with melasma. The nurse would anticipate that this client will exhibit:
   1. Skin that is uniformly dark in color
   2. Very pale skin with little pigmentation
   3. Patches of skin that have loss of pigmentation
   4. Blotchy brown macules across the cheeks and forehead

   ANS: 4

   Rationale: Melasma is a condition caused by hormonal influences on melanin production and is noted by the appearance of blotchy brown macules across the cheeks and forehead. "Skin that is uniformly dark in color" describes vitiligo. "Very pale skin with little pigmentation" and "patches of skin that have loss of pigmentation" refer to normal variations in skin color.

   Test-Taking Strategy: To answer this question correctly, you must be familiar with the various terms used when discussing skin structures and functions. "Skin that is uniformly dark in color" describes vitiligo. "Very pale skin with little pigmentation" and "patches of skin that have loss of pigmentation" refer to normal variations in skin color. Review the description of melasma if you had difficulty with this question.

   PTS: 1
   DIF: Level of Cognitive Ability: Understanding
   REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Integumentary
   MSC: Integrated Process: Nursing Process—Assessment

2. The client with cellulitis of the lower leg has had cultures done on the affected area. The nurse reviewing the results of the culture report interprets that which of the following organisms is not part of the normal flora of the skin?
   1. *Escherichia coli*
   2. *Candida albicans*
   3. *Staphylococcus aureus*
   4. *Staphylococcus epidermidis*

   ANS: 1

Rationale: *E. coli* is normally found in the intestines and is a common source of infection of wounds and the urinary system. *C. albicans*, *S. aureus*, and *S. epidermis* are part of the normal flora of the skin.

Test-Taking Strategy: To answer this question correctly, you must be familiar with the normal microorganisms that inhabit the skin. Note that the question asks for the organism that is not part of normal flora. Remember that *E. coli* is normally found in the intestines. Review basic skin structures if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Assessment

3. The client complains of chronic pruritus. Which of the following diagnoses would the nurse expect to support this client's complaint?
   1. Anemia
   2. Renal failure
   3. Hypothyroidism
   4. Diabetes mellitus

   ANS: 2

   Rationale: Clients with renal failure often have pruritus, or itchy skin. This is because of impaired clearance of waste products by the kidneys. The client who is markedly anemic is likely to have pale skin. Hypothyroidism may lead to complaints of dry skin. Clients with diabetes mellitus are at risk for skin infections and skin breakdown.

   Test-Taking Strategy: Focus on the subject, chronic pruritus. Remember that clients with renal failure often experience this problem. If this question was difficult, review the common causes of pruritus.

   PTS: 1
   DIF: Level of Cognitive Ability: Understanding
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Integumentary
   MSC: Integrated Process: Nursing Process—Assessment

4. A client being seen in an ambulatory clinic for an unrelated complaint has a butterfly rash noted across the nose. The nurse interprets that this finding is consistent with early manifestations of which of the following disorders?
   1. Hyperthyroidism
   2. Pernicious anemia

3. Cardiopulmonary disorders
4. Systemic lupus erythematosus (SLE)

ANS: 4

Rationale: An early sign of SLE is the appearance of a butterfly rash across the nose. Hyperthyroidism often leads to moist skin and increased perspiration. Pernicious anemia is exhibited by pale skin. Severe cardiopulmonary disorders may lead to clubbing of the fingers.

Test-Taking Strategy: To answer this question accurately, you must be familiar with the impact of systemic conditions on the skin. Remember that SLE causes a characteristic butterfly rash. If this question was difficult, review the disorders identified in the options and the associated skin conditions that occur in each disorder.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Assessment

5. The nurse notes that the older adult client has a number of bright, ruby-colored, round lesions scattered on the trunk and thighs. The nurse correctly interprets the finding as alterations in blood vessels of the skin and defines them as:
   1. Purpura
   2. Venous star
   3. Cherry angioma
   4. Spider angioma

ANS: 3

Rationale: A cherry angioma occurs with increasing age and has no clinical significance. It is noted by the appearance of small, bright, ruby-colored round lesions on the trunk and/or extremities. Purpura results from hemorrhage into the skin. A venous star results from increased pressure in veins, usually in the lower legs, and has an irregularly shaped bluish center with radiating branches. Spider angiomas have a bright red center, with legs that radiate outward. These are commonly seen in those with liver disease or vitamin B deficiency, although they can occur occasionally without underlying pathology.

Test-Taking Strategy: To answer this question accurately, you must be familiar with the various alterations in vascularity that can occur in the skin. Note the relationship of the words “ruby” in the question and “cherry” in the correct option. If you had difficulty with this question, review the various skin alterations identified in each of the options.

PTS: 1

DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Assessment

6. The client has been diagnosed with paronychia. The nurse understands that this is a disorder of the:
   1. Nails
   2. Hair follicles
   3. Pilosebaceous glands
   4. Epithelial layer of skin

   ANS: 1

   Rationale: Paronychia is a fungal infection that is most often caused by *Candida albicans*. This results in inflammation of the nail fold, with separation of the fold from the nail plate. The area is generally tender to touch, with purulent drainage. Disorders of the hair follicles include folliculitis, furuncles, and carbuncles. Disorders of the pilosebaceous glands include acne vulgaris and seborrheic dermatitis. There are a variety of disorders involving the epithelial skin.

   Test-Taking Strategy: To answer this question accurately, you must be familiar with a variety of skin disorders and their causes. Remember that paronychia is a nail disorder. If this question was difficult, review the characteristics of paronychia.

   PTS: 1
   DIF: Level of Cognitive Ability: Understanding
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Integumentary
   MSC: Integrated Process: Nursing Process—Assessment

7. The client is diagnosed with a full-thickness burn. The nurse understands that which of the following structural areas of the skin is involved?
   1. Epidermis only
   2. Epidermis and deeper dermis
   3. Epidermis and upper layer of dermis
   4. Epidermis, entire dermis, and epithelial portion of subcutaneous fat

   ANS: 4

   Rationale: A full-thickness burn involves the epidermis, entire dermis, and epithelial portion of subcutaneous fat layer. “Epidermis only” describes a superficial burn. “Epidermis and deeper dermis” describes a partial-thickness burn, and “epidermis, entire

dermis, and epithelial portion of subcutaneous fat" describes a deep partial-thickness burn.

Test-Taking Strategy: To answer this question accurately, you must be familiar with the classification of burn depth and the associated skin structures affected. Noting the words "full-thickness" will direct you to "epidermis, entire dermis, and epithelial portion of subcutaneous fat." If this question was difficult, review the types of burn injuries.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Assessment

8. A client who suffered carbon monoxide poisoning from working on an automobile in a closed garage has a carbon monoxide level of 15%. The nurse would anticipate observing which sign or symptom?
   1. Coma
   2. Flushing
   3. Dizziness
   4. Tachycardia

   ANS: 2

   Rationale: The signs and symptoms worsen as the carbon monoxide level rises in the bloodstream. Impaired visual acuity occurs at 5% to 10%, whereas flushing and headache are seen at 11% to 20%. Nausea and impaired dexterity appear at levels of 21% to 30%, and a 31% to 40% level is accompanied by vomiting, dizziness, and syncope. Levels of 41% to 50% cause tachypnea and tachycardia, and those higher than 50% result in coma and death.

   Test-Taking Strategy: Knowledge of the various manifestations of carbon monoxide poisoning is needed to answer this question. Remember that flushing is noted at levels of 11% to 20%. If you had difficulty with this question, review the manifestations associated with carbon monoxide poisoning.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Integumentary
   MSC: Integrated Process: Nursing Process—Assessment

9. A client is admitted to the hospital with cellulitis of the lower leg. The nurse would anticipate which of the following therapies to be prescribed?

1. Intermittent heat lamp treatments
2. Alternating hot and cold compresses
3. Warm compresses to the affected area
4. Cold compresses to the affected area

ANS: 3

Rationale: Warm compresses may be used to decrease the discomfort, erythema, and edema that accompany cellulitis. Definitive treatment includes antibiotic therapy after appropriate cultures have been done. Other supportive measures are also used to manage such symptoms as fatigue, fever, chills, headache, or myalgia. Heat lamps are not used because of the risk of burns, and moist heat is most useful in treating this disorder.

Test-Taking Strategy: Use knowledge of the disease process and concepts related to heat and cold therapy to answer this question. Eliminate "alternating hot and cold compresses" and "cold compresses to the affected area" first, because cold therapy would cause vasoconstriction rather than vasodilation. Choose correctly between "intermittent heat lamp treatments" and "warm compresses to the affected area," knowing that moist heat decreases the discomfort, erythema, and edema that accompanies cellulitis. If you had difficulty with this question, review the treatment associated with cellulitis.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Monahan, F., Sands, J., Marek, J., Neighbors, M., & Green, C. (2007). Phipps' medical-surgical nursing: health and illness perspectives (8th ed.). St. Louis: Mosby.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Planning

10. The nurse has instructed the client in the correct technique for breast self-examination (BSE). For a portion of the examination, the client will lie down. If the client were to examine the right breast, the nurse would tell the client to place a pillow:
    1. Under the left scapula
    2. Under the left shoulder
    3. Under the right shoulder
    4. Under the small of the back

ANS: 3

Rationale: The nurse would instruct the client to lie down and place a towel or pillow under the shoulder on the side of the breast to be examined. If the right breast is to be examined, the pillow would be placed under the right shoulder, and vice versa. Therefore "under the left scapula," "under the left shoulder," and "under the small of the back" are incorrect.

Test-Taking Strategy: Use the process of elimination, and visualize this procedure. This will direct you to "under the right shoulder." If you are unfamiliar with the procedure for performing BSE, review this important self-examination.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Teaching and Learning

11. The nurse would identify that which of the following foods should be increased in the diet to help decrease the risk of cancer development?
    1. Bacon
    2. Broccoli
    3. Bologna
    4. Broiled beef

ANS: 2

Rationale: Broccoli is a cruciferous vegetable, which is helpful in reducing the risk of cancer. Other cruciferous vegetables are cauliflower, Brussels sprouts, and cabbage. Red meat ("bacon") and meats with nitrites ("bologna" and "broiled beef") can increase the risk of developing cancer.

Test-Taking Strategy: Remember that options that are comparable or alike are not likely to be correct. With this in mind, note that each incorrect option lists a meat, whereas the correct choice is a cruciferous vegetable. Review dietary risk factors for cancer if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Nix, S. (2009). Williams' basic nutrition and diet therapy (13th ed.). St. Louis: Mosby.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Nursing Process—Implementation

12. The nurse would include which of the following in a list of the **most** helpful foods for the vegan client wishing to increase foods high in vitamin A?
    1. Peas
    2. Carrots
    3. Potatoes
    4. Green beans

ANS: 2

Rationale: Foods that are high in vitamin A include carrots, green leafy vegetables, and yellow vegetables. The other vegetables are high in vitamins but do not necessarily have the highest amount of vitamin A.

Test-Taking Strategy: Note the strategic words "most helpful." To answer this question accurately, you must be aware of the type of foods that are naturally high in vitamin A. Remember that carrots are high in vitamin A. If you had difficulty with this question, review foods that are in this vitamin group.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Peckenpaugh, N. (2010). Nutrition essentials and diet therapy (11th ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Nursing Process—Implementation

13. According to the American Cancer Society, fecal occult blood testing should be done annually after the age of _____ years.
    1. 30
    2. 40
    3. 50
    4. 60

    ANS: 3

    Rationale: Fecal occult blood testing for colorectal cancer should be done annually for both men and women after the age of 50 years. The other options are incorrect.

    Test-Taking Strategy: To answer this question correctly, you must be familiar with the recommendations for cancer screening published by the American Cancer Society. This would allow you to eliminate each of the incorrect options easily. Review these cancer prevention guidelines.

    PTS: 1
    DIF: Level of Cognitive Ability: Applying
    REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
    OBJ: Client Needs: Health Promotion and Maintenance
    TOP: Content Area: Adult Health/Oncology
    MSC: Integrated Process: Nursing Process—Implementation

14. A 27-year-old female client is undergoing evaluation of lumps in her breasts. In determining whether the client could have fibrocystic breast disorder, the nurse should ask the client whether the breast lumps seem to become more prominent or troublesome at which of the following times?
    1. After menses
    2. Before menses

3. During menses
4. At any time, regardless of the menstrual cycle

ANS: 2

Rationale: The nurse assesses the client with fibrocystic breast disorder for worsening of symptoms (breast lumps, painful breasts, and possible nipple discharge) before the onset of menses. This is associated with cyclical hormone changes. Therefore "after menses," "during menses," and "at any time, regardless of the menstrual cycle" are incorrect.

Test-Taking Strategy: Note the strategic words "more prominent or troublesome." This implies that there is a predictable variation in symptoms. Use knowledge of the effects of hormonal variations to select the correct option. Review fibrocystic breast disorder if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Nursing Process—Assessment

15. The nurse is assigned to the care of a client scheduled for surgery for a right colon tumor. Which of the following is the **most** characteristic manifestation of cancer at this site?
    1. Frequent diarrhea
    2. Crampy gas pains
    3. Flat, ribbon-like stools
    4. Dull abdominal pain exacerbated by walking

ANS: 4

Rationale: Characteristic symptoms of right colon tumors include vague, dull, abdominal pain exacerbated by walking, and dark red- or mahogany-colored blood mixed in the stool. The symptoms described in the other options are associated with left colon tumors.

Test-Taking Strategy: Knowledge regarding the signs of right and left colon tumors is required to answer this question. Note, however, that "crampy gas pains" and "dull abdominal pain exacerbated by walking" describe different patterns of pain. This may suggest to you that one of the two is correct. If you are not familiar with the differences between right and left colon tumors, review this content.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Nursing Process—Assessment

16. A client has undergone abdominal perineal resection for a bowel tumor. The nurse interprets that the client's colostomy is beginning to function if which of the following signs is noted?
    1. Absent bowel sounds
    2. The passage of flatus
    3. Blood drainage from the colostomy
    4. The client's ability to tolerate food

    ANS: 2

    Rationale: Following abdominal perineal resection, a colostomy should begin to function within 72 hours after surgery, although it may take up to 5 days. The nurse should monitor for a return of peristalsis by listening for bowel sounds and checking for the passage of flatus. Absent bowel sounds indicate that peristalsis has not returned. The client would remain NPO until bowel sounds return and the colostomy is functioning. Bloody drainage is not expected from a colostomy.

    Test-Taking Strategy: Note the strategic words "beginning to function." These strategic words should assist in eliminating "absent bowel sounds." Knowledge of general postoperative measures will assist in eliminating "the client's ability to tolerate food." Focus on the subject of the question to make your final selection. Review postoperative care of a client following abdominal perineal resection if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Adult Health/Oncology
    MSC: Integrated Process: Nursing Process—Assessment

17. A nurse assessing a postoperative ureterostomy client will interpret that the stoma has normal characteristics if the stoma is:
    1. Dry
    2. Pale
    3. Dark-colored
    4. Red and moist

    ANS: 4

    Rationale: Following ureterostomy, the stoma should be red and moist. A dry stoma may indicate fluid volume deficit. A pale stoma may indicate an inadequate vascular

refined carbohydrates, fats, and meats. Other risk factors include a family history of the disease, rectal polyps, and active inflammatory disease of at least 10 years' duration.

Test-Taking Strategy: Eliminate "a high-fiber diet" because it helps prevent colon cancer and "maternal grandfather who had a history of heart disease" because a family history of heart disease is not related to bowel cancer. "A history of inflammatory bowel disease" is important because a history of any disorder that interrupts bowel wall integrity places the client at risk. Foods high in fats and carbohydrates are low in fiber and thus may place the client at increased risk. A minimal alcohol intake is not associated with cancer. Review the risk factors associated with colorectal cancer if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Health Promotion and Maintenance
TOP: Content Area: Adult Health/Oncology
MSC: Integrated Process: Nursing Process—Assessment

3. The nurse teaching a group of adults about cancer warning signs presents to the group a list of the seven possible warning signs of cancer that is used by the American Cancer Society. What should this list include? **Select all that apply.**
   1. Areas of alopecia
   2. Sores that do not heal
   3. Nagging cough or hoarseness
   4. Indigestion or difficulty swallowing
   5. Change in bowel or bladder habits
   6. Absence or decreased frequency of menses

   ANS: 2, 3, 4, 5

   Rationale: Each of the seven warning signs of cancer begins with a letter from the word "CAUTION." Areas of alopecia occur following cancer chemotherapy. Absence of menses is not one of the signs.

   Test-Taking Strategy: To answer this question accurately, you must be familiar with the seven warning signs of cancer. Remembering the word "CAUTION" will assist in answering correctly. Because it is so important to teach the public about general early recognition of cancer, memorize these if you had difficulty with this question.

   PTS: 1
   DIF: Level of Cognitive Ability: Applying
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Health Promotion and Maintenance
   TOP: Content Area: Adult Health/Oncology
   MSC: Integrated Process: Teaching and Learning

4. A client is admitted to the hospital with a diagnosis of Addison's disease. The nurse would monitor for which of the following problems associated with this disease? **Select all that apply.**
   1. Edema
   2. Obesity
   3. Syncope
   4. Hirsutism
   5. Hypotension
   6. Muscle weakness

   ANS: 3, 5, 6

   Rationale: Common manifestations of Addison's disease include postural hypotension from fluid loss, syncope, muscle weakness, anorexia, nausea and vomiting, abdominal cramps, weight loss, depression, and irritability. "Syncope," "obesity," and "hirsutism" do not occur with this disease.

   Test-Taking Strategy: Knowledge regarding the clinical manifestations associated with Addison's disease is required to answer this question. Think about the pathophysiology associated with this disorder to answer correctly. If you had difficulty with this question, review this endocrine disorder.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Endocrine
   MSC: Integrated Process: Nursing Process—Assessment

5. The client has been diagnosed with Cushing's syndrome. The nurse would monitor this client for which of the following expected signs of this disorder? **Select all that apply.**
   1. Anorexia
   2. Weight loss
   3. Hypertension
   4. Dizziness
   5. Moon facies
   6. Truncal obesity

   ANS: 3, 5, 6

   Rationale: The client with Cushing's syndrome may exhibit a number of different manifestations. These could include moon facies, truncal obesity, and a "buffalo hump" fat pad. Other signs include hypokalemia, peripheral edema, hypertension, increased appetite, and weight gain. Dizziness is not part of the clinical picture for this disorder.

Test-Taking Strategy: To answer this question correctly, recall that Cushing's syndrome is a disorder characterized by excess cortisol. With this in mind, analyze each of the manifestations to see if they are compatible with this alteration. Review the clinical manifestations associated with Cushing's syndrome if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Endocrine
MSC: Integrated Process: Nursing Process—Assessment

6. The client with liver dysfunction has low serum levels of fibrinogen and a prolonged prothrombin time (PT). Based on these findings, which of the following actions are planned to promote client safety? **Select all that apply.**
   1. Monitor potassium levels.
   2. Monitor for symptoms of fluid retention.
   3. Provide the client with a soft toothbrush.
   4. Instruct the client to use an electric razor.
   5. Weigh client daily, and monitor trends.
   6. Monitor all secretions for frank or occult blood.

   ANS: 3, 4, 6

   Rationale: Fibrinogen is produced by the liver and is necessary for normal clotting. The client who has insufficient levels is at risk for bleeding. The prothrombin time is prolonged when one or more of the clotting factors (II, V, VII, or X) is deficient, so the client's risk for bleeding is also increased. "Provide the client with a soft toothbrush," "instruct the client to use an electric razor," and "monitor all secretions for frank or occult blood" are measures that provide for client safety and monitor for bleeding.

   Test-Taking Strategy: Specific knowledge of the substances produced by the liver is needed to answer this question, as well as knowledge of laboratory abnormalities found in liver dysfunction. Eliminate "monitor potassium levels," "monitor for symptoms of fluid retention," and "weigh client daily, and monitor trends" because these actions are directed toward fluid and electrolyte disturbances that can occur with liver dysfunction. Review this content area if you had difficulty with this question.

   PTS: 1
   DIF: Level of Cognitive Ability: Applying
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Safe and Effective Care Environment
   TOP: Content Area: Adult Health/Gastrointestinal
   MSC: Integrated Process: Nursing Process—Implementation

7. The nurse is doing volunteer work in a homeless shelter. The nurse monitors the individuals in the shelter for which of the following initial symptoms of tuberculosis (TB)? **Select all that apply.**
   1. Fatigue
   2. Lethargy
   3. Chest pain
   4. Low-grade fever
   5. Morning cough
   6. Labored breathing

   ANS: 1, 2, 4, 5

   Rationale: The symptoms of TB include a slight morning cough, fatigue, lethargy, and low-grade fever. The other symptoms listed are advanced (not initial) symptoms.

   Test-Taking Strategy: Note the strategic word "initial" in the question and think about the pathophysiology associated with this disorder. This should easily direct you to the correct options. If you are unfamiliar with the signs associated with TB, review this important disease process.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Respiratory
   MSC: Integrated Process: Nursing Process—Assessment

8. The nurse notes that the client's serum calcium level is 6.0 mg/dL. Which of the following assessment findings would be anticipated in this client? **Select all that apply.**
   1. Tetany
   2. Constipation
   3. Renal calculi
   4. Hypotension
   5. Prolonged QT interval
   6. Positive Chvostek's sign

   ANS: 1, 4, 5, 6

   Rationale: The normal serum calcium level is 8.6 to 10 mg/dL; thus, the client's results are reflective of hypocalcemia. A low serum calcium level could lead to severe ventricular dysrhythmias and prolonged QT and ST intervals on the electrocardiogram. Calcium is needed by the heart for contraction. When the serum calcium level is decreased, cardiac contractility is decreased and the client will experience hypotension. The most common manifestations of hypocalcemia are caused by overstimulation of the nerves and muscles; therefore, tetany and presence of Chvostek's sign would be expected.

Test-Taking Strategy: Begin to answer this question by recalling the normal serum calcium level in the body. Apply knowledge of the effects of low and high serum calcium levels on excitable tissues to assist you with answering this question. Knowing that the level is low helps you eliminate "constipation" and "renal calculi," which could result from hypercalcemia. Review the effect of calcium on myocardial and neuromuscular function if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Analyzing
REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Cardiovascular
MSC: Integrated Process: Nursing Process—Assessment

9. The nurse notes during assessment and history taking that the older client exhibits visual changes. Which of the following are normal age-related changes of the eye? **Select all that apply.**
   1. Ptosis
   2. Photophobia
   3. Corneal thickening
   4. Decreased visual acuity
   5. Decreased tolerance of glare
   6. Decreased peripheral vision

   ANS: 4, 5, 6

   Rationale: Normal age-related visual changes include decreases in visual acuity, peripheral vision, and tolerance of glare, and difficulty in adapting to dark and light. "Ptosis," "photophobia," and "corneal thickening" are not normal age-related changes.

   Test-Taking Strategy: Focus on the subject, age-related changes. This will direct you to "decreased visual acuity," "decreased tolerance of glare," and "decreased peripheral vision." If this question was difficult, review the age-related visual changes.

   PTS: 1
   DIF: Level of Cognitive Ability: Analyzing
   REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
   OBJ: Client Needs: Physiological Integrity
   TOP: Content Area: Adult Health/Eye
   MSC: Integrated Process: Nursing Process—Assessment

10. The nurse caring for a client admitted to the hospital with acute back pain understands that this problem can be most likely caused by which of the following? **Select all that apply.**
    1. Scoliosis
    2. Twisting of the spine

3. Hyperflexion of the spine
4. Sciatic nerve inflammation
5. Herniation of an intervertebral disk
6. Degeneration of the vertebral posterior facet joints

ANS: 2, 3, 5

Rationale: Acute back pain is sudden in onset and is usually precipitated by injury to the lower back, such as with hyperflexion, twisting, or disk herniation. Degenerative vertebral changes, sciatica, and scoliosis are more likely to cause chronic back pain, which can be more insidious in onset and may also be accompanied by degeneration of the intervertebral disk.

Test-Taking Strategy: The strategic words in the question are "most likely" and "acute back pain." Use knowledge of the vertebral spine structures and mechanisms of injury to make your selection. You could also choose correctly by recalling that the term "acute" is often associated with a problem that is sudden in onset. Review the causes of acute back pain if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Musculoskeletal
MSC: Integrated Process: Nursing Process—Assessment

11. The client who sustained a severe sprain of the ankle is told by the physician that the pain experienced is caused by muscle spasm and swelling in the area of the injury. Which of the following interventions should the nurse anticipate will be included in the client's plan of care? **Select all that apply.**
    1. Ice bags
    2. Elevation
    3. Heating pad
    4. Range-of-motion exercises
    5. Compression by an elastic bandage
    6. Maintaining the affected extremity in a dependent position

    ANS: 1, 2, 5

    Rationale: Reflex spasm of local muscles and swelling caused by rupture of local capillary beds can best be treated by remembering the acronym *RICE*, which stands for ***r***est, ***i***ce, ***c***ompression, and ***e***levation. Heat, a dependent position, and range-of-motion exercises are contraindicated because they would increase swelling.

    Test-Taking Strategy: Focus on the injury. Recalling the acronym *RICE* will direct you to the correct options. Review the interventions for a severe ankle sprain if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Musculoskeletal
MSC: Integrated Process: Nursing Process—Planning

12. The nurse collecting data related to the client's risk factors associated with osteoporosis would include which of the following? **Select all that apply.**
    1. Thin body build
    2. Smoking history
    3. Postmenopausal age
    4. Chronic corticosteroid use
    5. Family history of osteoporosis
    6. High intake of dairy products

    ANS: 1, 2, 3, 4, 5

    Rationale: A high intake of dairy products is not associated with osteoporosis, because dairy products are high in calcium. Other than low calcium intake, other risk factors for osteoporosis include a thin body frame, sedentary lifestyle, cigarette smoking, excessive alcohol intake, chronic illness, long-term use of corticosteroids, postmenopausal age, and a family history of osteoporosis.

    Test-Taking Strategy: Knowledge regarding the risk factors associated with osteoporosis is required to answer this question. Thinking about the pathophysiology associated with osteoporosis and recalling that a high intake of dairy products is not associated with osteoporosis will easily direct you to all choices except "high intake of dairy products." Review these risk factors if you had difficulty with this question.

    PTS: 1
    DIF: Level of Cognitive Ability: Analyzing
    REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.
    OBJ: Client Needs: Physiological Integrity
    TOP: Content Area: Adult Health/Musculoskeletal
    MSC: Integrated Process: Nursing Process—Assessment

13. The student nurse is assisting with an assessment of a client's level of consciousness using the Glasgow Coma Scale. The student understands that which of the following categories of client functioning are included in this assessment? **Select all that apply.**
    1. Eye opening
    2. Best verbal response
    3. Best motor response
    4. Pupil size and reaction
    5. Reflex response

ANS: 1, 2, 3

Rationale: Assessment of pupil size and reaction and reflex response are not part of the Glasgow Coma Scale. The three categories included are eye opening, best verbal response, and best motor response. Pupil assessment and reflex response is a necessary part of total assessment of the neurological status of a client but is not part of this particular scale. Many standardized neurological assessment forms include the pupillary response on the same page, but separate from the Glasgow Coma Scale data.

Test-Taking Strategy: To answer this question accurately, you must be familiar with the various components of the Glasgow Coma Scale. Remember that the three categories included are eye opening, best verbal response, and best motor response. Review this neurological assessment tool if you had difficulty with this question.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.
OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Neurological
MSC: Integrated Process: Nursing Process—Assessment

COMPLETION

1. An adult client trapped in a burning house has suffered burns to the back of the head, upper half of the posterior trunk, and the back of both arms. Using the rule of nines, what does the nurse determine the extent of the burn injury to be? **(Enter the answer in the space provided.)**
Answer: _____%

ANS: 22.5

Rationale: According to the rule of nines, the posterior side of the head equals 4.5%, the back of both arms equals 9%, and the upper half of the posterior trunk equals 9%, totaling 22.5%.

Test-Taking Strategy: Knowledge regarding the rule of nines is required to answer this question. The entire head equals 9%, each entire arm equals 9% (both arms 18%), the anterior or posterior torso each equals 18% (36% for the entire torso), each entire leg equals 18% (both legs equals 36%), and the perineum equals 1%. Remember that 9 (head), 18 (arms), 36 (thorax), 36 (legs), totals 99. If you had difficulty with this question, review the rule of nines.

PTS: 1
DIF: Level of Cognitive Ability: Understanding
REF: Black, J., & Hawks, J. (2009). Medical-surgical nursing: clinical management for positive outcomes (8th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity
TOP: Content Area: Adult Health/Integumentary
MSC: Integrated Process: Nursing Process—Assessment