

# NR 602 FINAL EXAM QUESTIONS BANK (129 Q&A) / NR602 EXAM QUESTIONS BANK (129 Q&A):RATED A 2022 |CHAMBERLAIN

# 2023

UPDATE

- The following are **risk factors for hypertension in children and teens** (choose all that apply): **being obese. being exposed to second-hand smoke.**
- In evaluating a **9-year-old child with a healthy BMI during a well visit**, a comprehensive cardiovascular evaluation should be conducted by the following methods (choose all that apply):  
**Obtain fasting lipid profile. / Assess diet and physical activity.**
- At what age is it **appropriate to recommend dietary changes** to parents if overweight or obesity is a concern?  
**12 months old**
- The following are **risk factors for type 2 diabetes mellitus** in children and teens (choose all that apply): **hyperinsulinemia: abnormal weight-to-height ratio.: Native American ancestry.**
- Screening children with a known risk factor for type 2 diabetes mellitus is recommended at age 10 or at onset of puberty, and **should be repeated how often?**  
**every year.**
- Prediabetes** in children is defined as (choose all that apply):  
**impaired fasting glucose (glucose level  $\geq 100$  mg/dL or 6.2 mmol/L) but  $\leq 125$  mg/dL or 7 mmol/L). impaired glucose tolerance (2-hour postprandial  $\geq 140$ -199 mg/dL or 7.8 mmol/L-11 mmol/L).**
- Risk factors for dyslipidemia** in children include (choose all that apply): **family history of lipid abnormalities. family history of type 2 diabetes mellitus.**
- Screening cholesterol** levels in children with one or more risk factors begins **at what age?** .2 years
- An **acceptable level of total cholesterol** (mg/dL) in children and teens is:  
**<170 mg/dL or 9.4 mmol/L.**
- low birth weight**, and **poor infant growth** are risk factors for type 2 diabetes **True**
- Prediabetes** in children is defined as **impaired fasting glucose** (glucose level  $\geq 100$  mg/dL or 5.6 mmol/L but

≤125 mg/dL or 7 mmol/L) or impaired glucose tolerance (2-hour postprandial ≥140-199 mg/dL or 7.8 mmol/L-11 mmol/L) or an A1C of 5.7% to 6.4%.

True

11. Screening for type 2 diabetes begins at age 10 or at onset of puberty and continues every 2 years until adulthood; at that point, the adult guidelines should be followed.
12. The AAP screening guidelines for total cholesterol levels in children and adolescents aged 2 to 19 years old are as follows: Acceptable level is < 170 mg/dL (<9.4 mmol/L), borderline is 170-199 mg/dL (9.4 mmol/L-11 mmol/L), and high is >200 mg/dL (≥11.1 mmol/L)
13. Children should be screened for family history of cardiovascular disease (CVD) beginning at age 3 and should be periodically updated annually or as required by risk factors during non-urgent health visits.
14. For at-risk children, fasting lipid levels should be tested after 2 years of age (but no later than 10 years of age) and should be retested in 3-5 years if the values fall within the reference range.
15. Body mass index (BMI) should be measured beginning at age 2.

16. For children between 12 months and 2 years of age for whom overweight or obesity is a concern, the use of **REDUCED** fat milk would be appropriate.
17. Beginning at age **5** if BMI is  $\geq$  85th percentile, intensify dietary and activity changes to the parent.
18. Infection with **Corynebacterium diphtheriae** usually causes: **Pseudomembranous pharyngitis**
19. The **tetanus infection** is caused by **CLOSTRIDIUM TETANI**, an anaerobic, gram-positive, spore-forming rod. This organism is found in soil and is particularly potent in manure.
20. Sources of **lead that can contribute to plumbism** include select traditional remedies such as azarcon and greta. **True**
21. Patients with **plumbism present** with which kind of anemia? **Microcytic, hypochromic**
22. **Intervention for a child with a lead level** of 5 to 44 mcg/dL usually includes all of the following except: **Chelation therapy**
23. Ingested lead inactivates heme synthesis by inhibiting the insertion of iron into the protoporphyrin ring. This **leads to the development of what kind of anemia?**  
microcytic, hypochromic
24. **Basophilic** stippling is often noted on **red blood cell morphology in lead poisoning.**
25. **Lead is significantly** toxic to the **solid organs, bones, and nervous system**
26. **Long-term complications** of **LEAD** poisoning include behavior or attention problems, poor academic performance, hearing problems, kidney damage, reduced IQ, and slowed body growth.
27. Unless deleading procedures have been performed, however, most homes built before **1957** contain **lead-based paint.**
28. **A diet low in calcium**, iron, zinc, magnesium, and copper and high in fat, which is a typical diet for children living in **poverty**, enhances oral lead absorption
29. In older homes, the point of greatest risk is the **window** because their sills and the putty have high lead concentration. Because toddlers (age 2 to 3) are the ideal height to reach them and are often drawn to open ones, they are at greatest risk and summer is the riskiest season.  
**window**
30. Symptoms of elevated **LEAD** levels include abdominal pain and cramping, aggressive behavior, anemia, constipation, difficulty sleeping, headaches, irritability, loss of previous developmental skills in young children, low appetite and energy, and reduced sensations. Very high levels can result in vomiting, staggering walk, muscle weakness, seizures, or coma.
31. A measure of **5** mcg/dL is now used to identify children with elevated blood lead levels.
32. Most children with lead levels of 5-44 mcg/dL are treated with removal from the source, improved nutrition, and **IRON** therapy.
33. Those with lead levels of 45-50 mcg/dL are treated with a **CHELATION** agent such as succimer,

in addition to the previously listed interventions.

34. For children with lead levels of greater than 51 mcg/dL, hospital admission with expert evaluation is likely the most prudent course to avoid serious problems (including **ENCEPHALOPATHY**) associated with markedly elevated lead levels

35. Which of the following represents the best choice of clinical agents for a child who has had a history of **penicillin allergy who requires antimicrobial therapy**?

**Cefdinir**

36. The clinical presentation of UTI in children can be without the classic symptoms such as frequency, dysuria, or flank pain.

True

37. In younger children, UTI often manifests as IRRITABILITY, LETHARGY, and FEVER with no obvious focal infectious source.

38. Older children with UTI often present with ABDOMINAL pain, unexplained fever, or both; as children approach puberty, flank pain becomes more common

40. UTI should be considered in infants and young children 2 months to 2 years old with unexplained fever, particularly in boys younger than 6 months and girls younger than 2 years who have a temperature greater than or equal to 39°C (≥102.2°F).

41. A URINALYSIS should be obtained in a child with unexplained fever or symptoms that suggest a UTI; however, 20% from UTI cases return a false-negative result.

42. Any of the following findings are suggestive, although not diagnostic, of UTI: positive leukocyte esterase, positive nitrite, more than 5 white blood cells (WBCs) per high-power field in spun specimen, and bacteria present in unspun Gram-stained specimen.

43. An acceptable method because of the low rate of skin and fecal contamination is a urine specimen collection via bag or from the diaper.

False, unacceptable because of the high rate of contamination

44. a single documented UTI in a child must be taken seriously. If an infant or young child 2 months to 2 years old with suspected UTI is assessed as toxic, dehydrated, or unable to retain oral intake, HOSPITALIZATION is advised.

45. Oral amoxicillin, TMP-SMX, or a second- or third-generation CEPHALOSPORIN is recommended as options for initial therapy for UTI in children

46. The use of TMP-SMX has a small risk of treatment failure.

47. Current evidence-based practice recommendations for UTI in Children indicate a 7 to 14 day course of antibiotics because the outcomes are superior to a 1- to 3-day course in preventing spread of infection and subsequent renal scarring.

48. Although fluoroquinolone antibiotics have not been widely used in children, ciprofloxacin is approved by the

U.S. Food and Drug Administration (FDA) for use in pediatric patients for the treatment of UTI; this use is approved starting at age 1 years old.

49. Urinary tract imaging should be considered for all children with UTI, particularly if this occurs before toilet training.

true

50. The two mainstays for imaging for UTI in young children are RENAL BLADDER ULTRASONOGRAPHY (RBUS) and voiding cystourethrography (VCUG)

51. RBUS is an easily obtained, noninvasive test but can miss a small number of high-grade REFLUX cases

52. The benefits of RBUS (no radiation exposure, non-invasive, minimal discomfort for child and parents), however, outweigh the slight increase in specificity of VCUG