Chapter 02: Assessing the Integumentary System

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which is a primary function of the integumentary system?
1) First line of the body's defense
2) Increases body temperature
3) Synthesizes vitamin E
4) Absorbs ultraviolet rays

____ 2. The nurse is providing care to a newborn. Which is a normal assessment finding that often occurs within the first 2 to 3 days of life for this patient?
1) Decreased elasticity
2) Physiologic jaundice
3) Pronounced body odor
4) Hyperpigmentation of the skin

____ 3. The nurse is assessing a school-age patient with a skin disorder. Which disorder is most likely to occur during childhood?
1) Acne
2) Psoriasis
3) Varicella
4) Rosacea

____ 4. The nurse is assessing the skin color for a dark-skinned patient. Which location is most appropriate for the nurse to use for this assessment?
1) Sclera
2) Oral mucosa
3) Soles of the feet
4) Abdominal region

____ 5. The nurse is providing care to an African American patient. Which is a common skin assessment finding for a patient of this ethnicity?
1) Keloids
2) Age spots
3) Increased risk for sunburn
4) Decreased facial hair

____ 6. The nurse is conducting a skin assessment for a patient who has a mole. Which question is most appropriate during this assessment?
1) "Do you have any allergies?"
2) "When did you first notice this?"
3) "Have you noticed any rashes?"
4) "Do you often have a runny nose?"

____ 7. The nurse is assessing a patient with a skin condition. Which condition is the most common during the fall?
1) Eczema
2) Tinea
3) Urticaria
4) Impetigo

____ 8. The nurse is assessing an adolescent client who is experiencing increased perspiration. Which location will the nurse assess to determine apocrine gland functioning?
1) Legs
2) Underarms
3) Chest
4) All of the above

____ 9. The nurse is providing care to a patient who is prescribed valproic acid for the treatment of a seizure disorder. Which will the nurse assess for during the skin examination?
1) Alopecia
2) Pruritic rash
3) Toxic epidermal necrolysis
4) Stevens-Johnson syndrome

____ 10. The nurse is providing care to a patient who presents with a fever. Which is the most appropriate action by the nurse during the assessment process?
1) Assess for confusion
2) Assess vital signs
3) Assess for lethargy
4) Assess for irritability

____ 11. The nurse is assessing a patient's skin and notes jaundice, a yellow discoloration of skin. Which conclusion by the nurse is most appropriate based on this assessment finding?
1) Impaired cardiovascular circulation
2) Diminished oxygen concentration
3) Liver impairment
4) Renal impairment

____ 12. The nurse assessing a patient who is experiencing renal failure. Which change to the integumentary system does the nurse anticipate for this patient?
1) Jaundice
2) Thinning hair
3) Uremic frost
4) Thickened nails

____ 13. A student nurses asks the nursing instructor why an infant's skin appears reddened. Which response by the nursing instructor is most appropriate?
1) "The infant's skin color is caused by an excessive breakdown of erythrocytes."
2) "The infant's skin color is caused by increased lipid levels."
3) "The infant's skin color is caused by diminished peripheral circulation."
4) "The infant's skin color is caused by lower amounts of subcutaneous tissue."

____ 14. The nurse is assessing an adolescent patient who presents with acne. When teaching the patient why this occurs, which reason will the nurse provide?
1) Increased lipid levels
2) Increased sebum production
3) Increased cardiac output
4) Increased hemoglobin production

____ 15. The nurse notes that a pregnant patient is experiencing chloasma on the face. For which reason does the change occur during pregnancy?
1) Increased estrogen levels
2) Increased hemoglobin production

3) Decreased testosterone production
4) Fluid retention

____ 16. The nurse is assessing the skin of several patients at the community clinic. Which patient is at the greatest risk for developing skin cancer?
1) 38-year-old, red-haired female of Irish descent
2) 42-year-old African American male
3) 50-year-old female of Mediterranean descent
4) 52-year-old Hispanic male

____ 17. The nurse is assessing the skin of an adult patient and notes a wound. The patient states, "I just can't seem to get this sore to heal." Which is the priority assessment question by the nurse?
1) "How often are you cleaning it?"
2) "Do your clothes rub against the wound?"
3) "Do you have a history of diabetes?"
4) "Do you have any allergies?"

____ 18. The nurse is assessing a patient who is experiencing a pruritic rash. Which is a cause of this assessment finding?
1) Allergic reactions to environmental exposure
2) Medications
3) Renal failure
4) All of the above

____ 19. A bull's-eye rash may be indicative of which problem?
1) Herpes zoster
2) Lyme disease
3) Lupus
4) Tinea corporis

____ 20. Which is the best location for the nurse to assess cyanosis for a dark-skinned patient with congestive heart failure?
1) Nail beds
2) Palms
3) Buccal mucosa
4) Conjunctiva

____ 21. Which normal skin variation might be noted when assessing an older adult patient's skin?
1) Increased moisture
2) Decreased turgor
3) Increased temperature
4) Decreased texture

____ 22. When inspecting the nails for clubbing, which is the normal angle of attachment?
1) 45 degrees
2) 90 degrees
3) 160 degrees
4) 180 degrees

____ 23. The nurse is assessing a patient who presents with a lesion. When distinguishing between a primary lesion and a secondary lesion, which rationale is correct?
1) A secondary lesion results from a change in a primary lesion.
2) A secondary lesion results from injury to the skin.

3) A secondary lesion differs in configuration.
4) A secondary lesion contains exudate.

____ 24. The nurse is assessing a patient who presents with a bruised ankle caused by an injury. When documenting this finding, which term is most appropriate for the nurse to use?
1) Petechiae
2) Ecchymosis
3) Purpura
4) Venous star

____ 25. The nurse is assessing the skin of a patient who believes that a new lesion may be melanoma. Which finding would support this patient's concern?
1) Collagen formation
2) Border irregularity or notching
3) Avascularity of the lesion
4) Depth of the color change

____ 26. Which primary skin lesion presents as a temporary elevation of the skin?
1) Macule
2) Keloid
3) Papule
4) Wheal

____ 27. Which secondary skin lesion is a linear break in the skin with well-defined borders that may extend into the dermis?
1) Fissure
2) Erosion
3) Excoriation
4) Keloid

____ 28. Which is a primary skin lesion that is considered a raised macule?
1) Patch
2) Papule
3) Wheal
4) Nodule

____ 29. Which vascular lesion is red and blanches with palpation?
1) Venous star
2) Capillary angioma
3) Spider angioma
4) Port-wine stain

____ 30. During a skin assessment, the nurse notes an extravasation of blood into the skin layers that was caused by an injury. Which is most appropriate when documenting this finding?
1) Ecchymosis
2) Petechiae
3) Purpura
4) Telangiectasia

____ 31. Which primary lesion is a flat area of color change, less than 1 cm in size, that is often referred to as a freckle?
1) Macule
2) Patch

3) Papule
4) Plaque

____ 32. Which is a palpable, serous fluid–filled primary skin lesion that is less than 1 cm in size?
1) Cyst
2) Vesicle
3) Bulla
4) Pustule

____ 33. Which term will the nurse use when documenting bluish spider veins found during a skin assessment?
1) Capillary hemangioma
2) Spider angioma
3) Telangiectasia
4) Venous star

____ 34. The nurse notes a pus-filled primary skin lesion. Which term will the nurse use when documenting this finding?
1) Cyst
2) Vesicle
3) Bulla
4) Pustule

____ 35. Which term is used to describe scar tissue caused by excessive collagen formation?
1) Fissure
2) Erosion
3) Excoriation
4) Keloid

____ 36. The nurse is assessing a patient who presents with a pressure ulcer. There is full-thickness loss involving subcutaneous tissue. When documenting this finding, which stage will the nurse use?
1) Stage I
2) Stage II
3) Stage III
4) Stage IV

____ 37. Which pressure ulcer presents as a full-thickness loss with extensive involvement of supporting structures?
1) Stage I
2) Stage II
3) Stage III
4) Stage IV

Chapter 02: Assessing the Integumentary System
Answer Section

MULTIPLE CHOICE

1. ANS: 1
   Chapter number and title: 2, Assessing the Integumentary System
   Chapter learning objective: N/A
   Chapter page reference: 29
   Integrated Processes: Nursing Process: Planning
   Client Need: Health Promotion and Maintenance
   Cognitive level: Comprehension [Understanding]
   Concept: Skin Integrity
   Difficulty: Medium

	Feedback
1	One of the primary functions of the integumentary system is that it is the body's first line of defense.
2	The integumentary system maintains body temperature. It does not specifically increase it.
3	The integumentary system synthesizes vitamin D, not E.
4	The integumentary system protects against ultraviolet radiation.

   PTS: 1 CON: Skin Integrity
2. ANS: 2
   Chapter number and title: 2, Assessing the Integumentary System
   Chapter learning objective: N/A
   Chapter page reference: 29
   Integrated Processes: Nursing Process: Assessment
   Client Need: Health Promotion and Maintenance
   Cognitive level: Comprehension [Understanding]
   Concept: Assessment, Skin Integrity
   Difficulty: Easy

	Feedback
1	Decreased elasticity can be a normal assessment finding for the older adult patient.
2	Physiologic jaundice is often a normal finding when assessing a newborn during the first 2 to 3 days of life.
3	Pronounced body odor tends to occur during adolescence.
4	Hyperpigmentation of the skin often occurs during pregnancy.

   PTS: 1 CON: Assessment | Skin Integrity
3. ANS: 3
   Chapter number and title: 2, Assessing the Integumentary System
   Chapter learning objective: N/A
   Chapter page reference: 31
   Integrated Processes: Nursing Process: Assessment
   Client Need: Physiological Integrity: Physiological Adaptation
   Cognitive level: Knowledge [Remembering]
   Concept: Assessment, Skin Integrity
   Difficulty: Easy

	Feedback
1	Acne is a skin disorder that is most likely to occur during adolescence or early adulthood.
2	Psoriasis is a skin disorder that is most likely to occur during adolescence or early adulthood.
3	Varicella is a skin disorder that is most likely to occur in children.
4	Rosacea is a skin disorder that is most likely to occur during adulthood.

PTS: 1 CON: Assessment | Skin Integrity

4. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 32
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Comprehension [Understanding]
Concept: Assessment, Diversity
Difficulty: Easy

	Feedback
1	The sclera is typically used when assessing the skin of the Asian patient for jaundice.
2	When assessing the skin color for a dark-skinned patient, the nurse will use the oral mucosa.
3	The soles of the feet are inspected during a skin assessment, but this location is not used to assess skin color for a dark-skinned patient.
4	The abdominal region is inspected during a skin assessment, but this location is not used to assess skin color for a dark-skinned patient.

PTS: 1 CON: Assessment | Diversity

5. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 32
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Assessment, Diversity
Difficulty: Easy

	Feedback
1	African American patients have a higher incidence of keloids, pseudofolliculitis, and mongolian spots.
2	African American patients do not have a higher incidence of age spots.
3	Increased risk for sunburn is common for fair-skinned persons of Irish, German, or Polish descent.
4	Decreased facial hair often occurs for patients of Asian descent.

PTS: 1 CON: Assessment | Diversity

6. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A

Chapter page reference: 32
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Assessment, Skin Integrity
Difficulty: Easy

	Feedback
1	The nurse would ask about allergies if the patient presented with pruritis, not a mole.
2	An appropriate question for the nurse to ask a patient who presents with a mole is when the patient first noticed the mole and whether there have been any changes in the mole.
3	The nurse would ask about rashes if the patient presented with pruritis, not a mole.
4	The nurse would ask about a runny nose if the patient presented with pruritis, not a mole.

PTS: 1 CON: Assessment | Skin Integrity

7. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 34
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Knowledge [Remembering]
Concept: Assessment, Skin Integrity
Difficulty: Easy

	Feedback
1	Eczema is a skin condition that typically occurs during the winter.
2	Tinea is a skin condition that typically occurs during the summer months.
3	A skin condition that typically occurs during the fall is urticaria, or hives.
4	Impetigo is a skin condition that typically occurs during the summer months.

PTS: 1 CON: Assessment | Skin Integrity

8. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 30
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Moderate

	Feedback
1	Apocrine glands are not found on the legs.
2	Apocrine glands are limited to the genitalia, axillae, and areolae. Apocrine glands secrete pheromones.
3	Apocrine glands are not found on the chest.
4	Apocrine glands are not found on the legs or the chest.

PTS: 1 CON: Assessment

9. ANS: 1

Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 34
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies
Cognitive level: Application [Applying]
Concept: Assessment, Skin Integrity
Difficulty: Medium

	Feedback
1	A patient who is prescribed valproic acid may experience alopecia, or a loss of hair.
2	A pruritic rash is not associated with valproic acid.
3	Toxic epidermal necrolysis is not associated with valproic acid.
4	Stevens-Johnson syndrome is not associated with valproic acid.

PTS: 1 CON: Assessment | Skin Integrity

10. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 36
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Assessment
Difficulty: Medium

	Feedback
1	For a patient who has a change in energy level, the nurse assesses for confusion and irritability.
2	When a patient presents with a fever, the nurse should measure vital signs and the patient's height and weight.
3	For a patient who presents with weight changes, the nurse assesses for lethargy and irritability.
4	For a patient who presents with weight changes, the nurse assesses for lethargy and irritability.

PTS: 1 CON: Assessment

11. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 57
Integrated Processes: Nursing Process: Evaluation
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Assessment
Difficulty: Medium

	Feedback
1	Cyanosis, or a bluish discoloration of the skin, often occurs with impaired cardiovascular circulation and diminished oxygen concentration.
2	Cyanosis, or a bluish discoloration of the skin, often occurs with impaired cardiovascular circulation and diminished oxygen concentration.

3	When bile excretion is impaired so that it builds up, jaundice, a yellow discoloration, results.
4	Renal impairment can cause dry, itchy skin and edema.

PTS: 1 CON: Assessment

12. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 36
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Analysis [Analyzing]
Concept: Assessment, Urinary Elimination
Difficulty: Difficult

	Feedback
1	Jaundice is a manifestation associated with liver disease.
2	Thinning hair can be a natural occurrence of aging.
3	When renal function is altered and filtration decreases, toxins and fluids build up in the body. The toxins often include pigmented metabolites, which alter the skin coloring. For example, an increased concentration of urea may lead to a residue of urea on the skin, which is called uremic frost.
4	Thickened nails may occur due to poor circulation.

PTS: 1 CON: Assessment | Urinary Elimination

13. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 29
Integrated Processes: Nursing Process: Implementation
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Skin Integrity
Difficulty: Easy

	Feedback
1	The skin color is not caused by the excessive breakdown of erythrocytes, increased lipid levels, or diminished circulation.
2	The skin color is not caused by the excessive breakdown of erythrocytes, increased lipid levels, or diminished circulation.
3	The skin color is not caused by the excessive breakdown of erythrocytes, increased lipid levels, or diminished circulation.
4	Newborns often appear pinker/redder because of the lack of subcutaneous tissue.

PTS: 1 CON: Skin Integrity

14. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 30
Integrated Processes: Nursing Process: Implementation
Client Need: Health Promotion and Maintenance

Cognitive level: Knowledge [Remembering]
Concept: Skin Integrity
Difficulty: Easy

	Feedback
1	Acne is not caused by increased levels of lipids, increased cardiac output, or increased hemoglobin production.
2	The sebaceous glands increase sebum production and the skin becomes oilier, leading to the onset of acne.
3	Acne is not caused by increased levels of lipids, increased cardiac output, or increased hemoglobin production.
4	Acne is not caused by increased levels of lipids, increased cardiac output, or increased hemoglobin production.

PTS: 1 CON: Skin Integrity

15. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 30
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Pregnancy
Difficulty: Easy

	Feedback
1	Hormonal changes result in hyperpigmentation during pregnancy. The pigmentary changes occur on the face, resulting in chloasma; on the abdominal midline (the linea alba becomes the linea nigra); and on the nipples, areolae, axillae, and vulva.
2	These changes do not occur because of increased hemoglobin production, decreased testosterone, or fluid retention.
3	These changes do not occur because of increased hemoglobin production, decreased testosterone, or fluid retention.
4	These changes do not occur because of increased hemoglobin production, decreased testosterone, or fluid retention.

PTS: 1 CON: Pregnancy

16. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 32
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Cellular Regulation, Diversity
Difficulty: Medium

	Feedback
1	Fair-skinned persons of Irish, German, or Polish descent have an increased risk for skin cancer with prolonged sun exposure.
2	African Americans have a higher incidence of keloids, pseudofolliculitis, and mongolian spots.

3	Patients of Mediterranean descent and of Hispanic descent do not have an increased risk for skin cancer.
4	Patients of Mediterranean descent and of Hispanic descent do not have an increased risk for skin cancer.

PTS: 1 CON: Cellular Regulation | Diversity

17. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 33
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Analysis [Analyzing]
Concept: Assessment, Skin Integrity, Metabolism
Difficulty: Medium

	Feedback
1	Although it is important to determine how often the patient is caring for the wound, this is not the priority.
2	Although it is important to determine whether anything is consistently rubbing against the wound, this is not the priority.
3	A nonhealing wound or chronic irritation is often associated with an underlying disease, such as diabetes. The most common types of nonhealing wounds or chronic skin ulcerations are caused by vascular disease or pressure.
4	Although it is important to determine whether the patient has any allergies, this is not the priority.

PTS: 1 CON: Assessment | Skin Integrity | Metabolism

18. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 33
Integrated Processes: Nursing Process: Evaluation
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Skin Integrity
Difficulty: Easy

	Feedback
1	Pruritus can be caused by environmental exposure including heat, fiberglass, pets, plants, and insects.
2	Medications—especially opiates, amphetamines, quinidine, aspirin, B vitamins, and niacinamide—may cause itching as an adverse effect.
3	Several systemic diseases, such as renal disease, diabetes, Graves disease, liver disease with obstructive jaundice, Hodgkin disease, lymphoma, polycythemia vera, human immunodeficiency virus (HIV), and psychiatric disorders, may cause pruritus.
4	Allergies, some medications, and renal failure are all known to cause pruritic rashes.

PTS: 1 CON: Skin Integrity

19. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System

Chapter learning objective: N/A
Chapter page reference: 69
Integrated Processes: Nursing Process: Evaluation
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Knowledge [Understanding]
Concept: Skin Integrity, Infection
Difficulty: Easy

	Feedback
1	Herpes zoster causes a vesicular rash.
2	Lyme disease from a deer tick may cause bull's-eye rash.
3	Lupus causes a butterfly rash.
4	Tinea corporis causes a ring-shaped rash.

PTS: 1 CON: Skin Integrity | Infection

20. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 32
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Assessment, Diversity
Difficulty: Moderate

	Feedback
1	It may be difficult to assess cyanosis for a dark-skinned patient on the nail beds, palms, and conjunctiva.
2	It may be difficult to assess cyanosis for a dark-skinned patient on the nail beds, palms, and conjunctiva.
3	When assessing for color changes in dark-skinned patients, check oral mucous membranes.
4	It may be difficult to assess cyanosis for a dark-skinned patient on the nail beds, palms, and conjunctiva.

PTS: 1 CON: Assessment | Diversity

21. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 30
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Application [Applying]
Concept: Assessment, Skin Integrity
Difficulty: Medium

	Feedback
1	Increased moisture would be considered abnormal.
2	Decreased turgor or tenting may be caused by dehydration or normal aging.
3	Increased temperature would be considered abnormal.
4	Decreased texture would be considered abnormal.

PTS: 1 CON: Assessment | Skin Integrity

22. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 52
Integrated Processes: Nursing Process: Assessment
Client Need: Health Promotion and Maintenance
Cognitive level: Knowledge [Remembering]
Concept: Oxygenation, Perfusion
Difficulty: Easy

	Feedback
1	An angle of attachment of 45 degrees is not considered normal.
2	An angle of attachment of 90 degrees is not considered normal.
3	The normal angle of attachment is 160 degrees.
4	Chronic cardiopulmonary disease with hypoxia can result in clubbing with an angle of nail attachment 180 degrees or greater.

PTS: 1 CON: Oxygenation | Perfusion

23. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 67
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Knowledge [Remembering]
Concept: Skin Integrity
Difficulty: Easy

	Feedback
1	A primary lesion is an initial alteration in the skin. A secondary lesion arises from a change in a primary lesion.
2	An injury to the skin is a primary lesion.
3	A secondary lesion arises from a change in a primary lesion. It may or may not differ in configuration.
4	A secondary lesion arises from a change in a primary lesion. It may or may not contain exudate.

PTS: 1 CON: Skin Integrity

24. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 64
Integrated Processes: Communication and Documentation
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Communication
Difficulty: Moderate

	Feedback
1	Bruising that is caused by steroids, vasculitis, or systemic disease is referred to as petechiae or purpura.

2	Bruising that is caused by an injury is termed ecchymosis.
3	Bruising that is caused by steroids, vasculitis, or systemic disease is referred to as petechiae or purpura.
4	A venous star is the term used to describe varicose veins.

PTS: 1 CON: Skin Integrity | Communication

25. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 66
Integrated Processes: Nursing Process: Evaluation
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Cellular Regulation
Difficulty: Medium

	Feedback
1	Collagen formation is not indicative of melanoma.
2	Border irregularity or notching is a finding that suggests a lesion is melanoma. Variegated-colored lesions may also signal melanoma.
3	Avascularity of the lesion is not indicative of melanoma.
4	The depth of color change is not indicative of melanoma.

PTS: 1 CON: Cellular Regulation

26. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 60
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Skin Integrity
Difficulty: Moderate

	Feedback
1	A macule is a flat, nonpalpable primary skin lesion.
2	A keloid is a secondary skin lesion. It is raised and irregular and is caused by excessive collagen formation.
3	A papule is a primary palpable, raised but superficial skin lesion, such as a raised mole or wart.
4	A wheal, or hive, is a temporary raised, superficial primary skin lesion.

PTS: 1 CON: Skin Integrity

27. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 63
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Analysis [Analyzing]
Concept: Skin Integrity

Difficulty: Moderate

	Feedback
1	A fissure is a secondary skin lesion consisting of a linear break in the skin with well-defined borders that may extend into the dermis.
2	An erosion is a secondary skin lesion that involves loss of superficial epidermis.
3	An excoriation is an abrasion or other loss that does not extend beyond the superficial epidermis.
4	A keloid is a secondary skin lesion. It is raised and irregular and is caused by excessive collagen formation.

PTS: 1 CON: Skin Integrity

28. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 59
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Comprehension [Understanding]
Concept: Skin Integrity
Difficulty: Easy

	Feedback
1	A patch is a flat macule that is greater than 1 cm in size.
2	A papule is a raised macule that is less than 1 cm in size.
3	A wheal, or hive, is a temporary raised, superficial primary skin lesion.
4	A nodule is a primary skin lesion that is palpable and solid with depth into the dermis.

PTS: 1 CON: Skin Integrity

29. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 64
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Perfusion, Skin Integrity
Difficulty: Moderate

	Feedback
1	A venous star is a vascular lesion that is blue in color and does not blanch.
2	A capillary angioma is an irregularly shaped macular patch that is red in color.
3	A spider angioma is a vascular lesion that is red in color and blanches. It appears like a spider, with a central body and fine, radiating legs.
4	A port-wine stain is a vascular lesion that is red in color and does not blanch. It is seen with dilation of dermal capillaries.

PTS: 1 CON: Perfusion | Skin Integrity

30. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 64

Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Perfusion
Difficulty: Moderate

	Feedback
1	An ecchymosis is an extravasation of blood into the layers of the skin that is caused by injury.
2	Petechiae is an extravasation of blood into the skin that is caused by steroids, vasculitis, and systemic disease.
3	Purpura is an extravasation of blood into the skin that is caused by steroids, vasculitis, and systemic disease.
4	Telangiectasia is red in color and is seen with dilation of capillaries.

PTS: 1 CON: Skin Integrity | Perfusion

31. ANS: 1
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 59
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Understanding [Comprehension]
Concept: Assessment, Skin Integrity
Difficulty: Moderate

	Feedback
1	A macule is a nonpalpable, flat skin lesion that is less than 1 cm in size. One example is a freckle.
2	A patch is a nonpalpable, flat skin lesion that is greater than 1 cm in size. One example is a mongolian spot.
3	A papule is a palpable, raised, but superficial skin lesion that is less than 1 cm in size. One example is a wart.
4	A plaque is a palpable, raised, but superficial skin lesion that is greater than 1 cm in size. One example is psoriasis.

PTS: 1 CON: Assessment | Skin Integrity

32. ANS: 2
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 60
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Analysis [Analyzing]
Concept: Skin Integrity, Assessment
Difficulty: Moderate

	Feedback
1	A cyst is a tumor that is fluid filled and encapsulated.
2	A vesicle is a palpable, serous fluid–filled skin lesion that is less than 1 cm in size.
3	A bulla is a palpable, serous fluid–filled skin lesion that is greater than 1 cm in size.
4	A pustule is a palpable, pus-filled skin lesion.

PTS: 1 CON: Skin Integrity | Assessment

33. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 64
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Assessment, Perfusion, Communication
Difficulty: Moderate

	Feedback
1	A capillary hemangioma is an irregularly shaped macular patch that is red in color.
2	A spider angioma is a telangiectasia that is red in color. It looks like a spider with a central body and fine radiating legs.
3	Telangiectasia are very fine and irregular vessels that are red in color.
4	A venous star is irregularly shaped and linear and appears like a spider. It is blue in color.

PTS: 1 CON: Assessment | Perfusion | Communication

34. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 61
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Assessment, Communication
Difficulty: Moderate

	Feedback
1	A cyst is a tumor that is fluid filled and encapsulated.
2	A vesicle is a palpable, serous fluid–filled skin lesion that is less than 1 cm in size.
3	A bulla is a palpable, serous fluid–filled skin lesion that is greater than 1 cm in size.
4	A pustule is a palpable, pus-filled skin lesion.

PTS: 1 CON: Skin Integrity | Assessment | Communication

35. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 62
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Assessment, Communication
Difficulty: Moderate

	Feedback
1	A fissure is a secondary skin lesion consisting of a linear break in the skin with well-defined borders that may extend into the dermis.
2	An erosion is a secondary skin lesion that involves loss of superficial epidermis.

3	An excoriation is an abrasion or other loss that does not extend beyond the superficial epidermis.
4	A keloid is a secondary skin lesion. It is scar tissue that is raised and irregular and is caused by excessive collagen formation.

PTS: 1 CON: Skin Integrity | Assessment | Communication

36. ANS: 3
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 65
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Communication
Difficulty: Moderate

	Feedback
1	A stage I pressure ulcer is nonblanchable erythema of intact skin. This usually indicates a potential for ulceration.
2	A stage II pressure ulcer is a partial-thickness loss involving both the epidermis and the dermis. The ulcer is still superficial and appears as a blister, abrasion, or very shallow crater.
3	A stage III pressure ulcer is a full-thickness loss involving subcutaneous tissue. The ulcer may extend to, but not through, fascia. There may also be a deep crater that may undermine adjacent tissues.
4	A stage IV pressure ulcer is a full-thickness loss with extensive involvement of muscle, bone, or supporting structures. This deep ulcer may involve undermining and sinus tracts of adjacent tissues.

PTS: 1 CON: Skin Integrity | Communication

37. ANS: 4
Chapter number and title: 2, Assessing the Integumentary System
Chapter learning objective: N/A
Chapter page reference: 66
Integrated Processes: Nursing Process: Assessment
Client Need: Physiological Integrity: Physiological Adaptation
Cognitive level: Application [Applying]
Concept: Skin Integrity, Assessment
Difficulty: Moderate

	Feedback
1	A stage I pressure ulcer is nonblanchable erythema of intact skin. This usually indicates a potential for ulceration.
2	A stage II pressure ulcer is a partial-thickness loss involving both the epidermis and the dermis. The ulcer is still superficial and appears as a blister, abrasion, or very shallow crater.
3	A stage III pressure ulcer is a full-thickness loss involving subcutaneous tissue. The ulcer may extend to, but not through, fascia. There may also be a deep crater that may undermine adjacent tissues.
4	A stage IV pressure ulcer is a full-thickness loss with extensive involvement of muscle, bone, or supporting structures. This deep ulcer may involve undermining and sinus

	tracts of adjacent tissues.

PTS: 1 CON: Skin Integrity | Assessment