1) A nurse is caring for a client with hyperparathyroidism and notes that the client's serum calcium level is 13 mg/dL. Which medication should the nurse prepare to administer as prescribed to the client?

1. Calcium chloride

2. Calcium gluconate

3. Calcitonin (Miacalcin)

4. Large doses of vitamin D   3. Calcitonin (Miacalcin)

Rationale:

The normal serum calcium level is 8.6 to 10.0 mg/dL. This client is experiencing hypercalcemia. Calcium gluconate and calcium chloride are medications used for the treatment of tetany, which occurs as a result of acute hypocalcemia. In hypercalcemia, large doses of vitamin D need to be avoided. Calcitonin, a thyroid hormone, decreases the plasma calcium level by inhibiting bone resorption and lowering the serum calcium concentration.

10.) The clinic nurse is performing an admission assessment on a client. The nurse notes that the client is taking azelaic acid (Azelex). Because of the medication prescription, the nurse would suspect that the client is being treated for:

1. Acne

2. Eczema

3. Hair loss

4. Herpes simplex   1. Acne

Rationale:

Azelaic acid is a topical medication used to treat mild to moderate acne. The acid appears to work by suppressing the growth of Propionibacterium acnes and decreasing the proliferation of keratinocytes. Options 2, 3, and 4 are incorrect.

100.) Saquinavir (Invirase) is prescribed for the client who is human immunodeficiency virus seropositive. The nurse reinforces medication instructions and tells the client to:

1. Avoid sun exposure.

2. Eat low-calorie foods.

3. Eat foods that are low in fat.

4. Take the medication on an empty stomach.   1. Avoid sun exposure.

Rationale:

Saquinavir (Invirase) is an antiretroviral (protease inhibitor) used with other antiretroviral medications to manage human immunodeficiency virus infection. Saquinavir is administered with meals and is best absorbed if the client consumes high-calorie, high-fat meals. Saquinavir can cause photosensitivity, and the nurse should instruct the client to avoid sun exposure.

101.) Ketoconazole is prescribed for a client with a diagnosis of candidiasis. Select the interventions that the nurse includes when administering this medication. Select all that apply.

1. Restrict fluid intake.

2. Instruct the client to avoid alcohol.

3. Monitor hepatic and liver function studies.

4. Administer the medication with an antacid.

5. Instruct the client to avoid exposure to the sun.

6. Administer the medication on an empty stomach.   2. Instruct the client to avoid alcohol.

3. Monitor hepatic and liver function studies.

5. Instruct the client to avoid exposure to the sun.

Rationale:

Ketoconazole is an antifungal medication. It is administered with food (not on an empty stomach) and antacids are avoided for 2 hours after taking the medication to ensure absorption. The medication is hepatotoxic and the nurse monitors liver function studies. The client is instructed to avoid exposure to the sun because the medication increases photosensitivity. The client is also instructed to avoid alcohol. There is no reason for the client to restrict fluid intake. In fact, this could be harmful to the client.

102.) A client with human immunodeficiency virus is taking nevirapine (Viramune). The nurse should monitor for which adverse effects of the medication? Select all that apply.

1. Rash

2. Hepatotoxicity

3. Hyperglycemia

4. Peripheral neuropathy

5. Reduced bone mineral density   1. Rash

2. Hepatotoxicity

Rationale:

Nevirapine (Viramune) is a non-nucleoside reverse transcriptase inhibitors (NRTI) that is used to treat HIV infection. It is used in combination with other antiretroviral medications to treat HIV. Adverse effects include rash, Stevens-Johnson syndrome, hepatitis, and increased transaminase levels. Hyperglycemia, peripheral neuropathy, and reduced bone density are not adverse effects of this medication.

103.) A nurse is caring for a hospitalized client who has been taking clozapine (Clozaril) for the treatment of a schizophrenic disorder. Which laboratory study prescribed for the client will the nurse specifically review to monitor for an adverse effect associated with the use of this medication?

1. Platelet count

2. Cholesterol level

3. White blood cell count

4. Blood urea nitrogen level 3. White blood cell count

Rationale:

Hematological reactions can occur in the client taking clozapine and include agranulocytosis and mild leukopenia. The white blood cell count should be checked before initiating treatment and should be monitored closely during the use of this medication. The client should also be monitored for signs indicating agranulocytosis, which may include sore throat, malaise, and fever. Options 1, 2, and 4 are unrelated to this medication.

104.) Disulfiram (Antabuse) is prescribed for a client who is seen in the psychiatric health care clinic. The nurse is collecting data on the client and is providing instructions regarding the use of this medication. Which is most important for the nurse to determine before administration of this medication?

1. A history of hyperthyroidism

2. A history of diabetes insipidus

3. When the last full meal was consumed

4. When the last alcoholic drink was consumed 4. When the last alcoholic drink was consumed

Rationale:

Disulfiram is used as an adjunct treatment for selected clients with chronic alcoholism who want

to remain in a state of enforced sobriety. Clients must abstain from alcohol intake for at least 12 hours before the initial dose of the medication is administered. The most important data are to determine when the last alcoholic drink was consumed. The medication is used with caution in clients with diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, nephritis, and hepatic disease. It is also contraindicated in severe heart disease, psychosis, or hypersensitivity related to the medication.

105.) A nurse is collecting data from a client and the client's spouse reports that the client is taking donepezil hydrochloride (Aricept). Which disorder would the nurse suspect that this client may have based on the use of this medication?

1. Dementia

2. Schizophrenia

3. Seizure disorder

4. Obsessive-compulsive disorder 1. Dementia

Rationale:

Donepezil hydrochloride is a cholinergic agent used in the treatment of mild to moderate dementia of the Alzheimer type. It enhances cholinergic functions by increasing the concentration of acetylcholine. It slows the progression of Alzheimer's disease. Options 2, 3, and 4 are incorrect.

106.) Fluoxetine (Prozac) is prescribed for the client. The nurse reinforces instructions to the client regarding the administration of the medication. Which statement by the client indicates an understanding about administration of the medication?

1. "I should take the medication with my evening meal."

2. "I should take the medication at noon with an antacid."

3. "I should take the medication in the morning when I first arise."

4. "I should take the medication right before bedtime with a snack." 3. "I should take the medication in the morning when I first arise."

Rationale:

Fluoxetine hydrochloride is administered in the early morning without consideration to meals.

Eliminate options 1, 2, and 4 because they are comparable or alike and indicate taking the medication with an antacid or food.

107.) A client receiving a tricyclic antidepressant arrives at the mental health clinic. Which

observation indicates that the client is correctly following the medication plan?

1. Reports not going to work for this past week

2. Complains of not being able to "do anything" anymore

3. Arrives at the clinic neat and appropriate in appearance

4. Reports sleeping 12 hours per night and 3 to 4 hours during the day 3. Arrives at the clinic neat and appropriate in appearance

Rationale:

Depressed individuals will sleep for long periods, are not able to go to work, and feel as if they cannot "do anything." Once they have had some therapeutic effect from their medication, they will report resolution of many of these complaints as well as demonstrate an improvement in their appearance.

108.) A nurse is performing a follow-up teaching session with a client discharged 1 month ago who is taking fluoxetine (Prozac). What information would be important for the nurse to gather regarding the adverse effects related to the medication?

1. Cardiovascular symptoms

2. Gastrointestinal dysfunctions

3. Problems with mouth dryness

4. Problems with excessive sweating 2. Gastrointestinal dysfunctions

Rationale:

The most common adverse effects related to fluoxetine include central nervous system (CNS) and gastrointestinal (GI) system dysfunction. This medication affects the GI system by causing nausea and vomiting, cramping, and diarrhea. Options 1, 3, and 4 are not adverse effects of this medication.

109.) A client taking buspirone (BuSpar) for 1 month returns to the clinic for a follow-up visit. Which of the following would indicate medication effectiveness?

1. No rapid heartbeats or anxiety

2. No paranoid thought processes

3. No thought broadcasting or delusions

4. No reports of alcohol withdrawal symptoms 1. No rapid heartbeats or anxiety

Rationale:

Buspirone hydrochloride is not recommended for the treatment of drug or alcohol withdrawal, paranoid thought disorders, or schizophrenia (thought broadcasting or delusions). Buspirone hydrochloride is most often indicated for the treatment of anxiety and aggression.

11.) The health care provider has prescribed silver sulfadiazine (Silvadene) for the client with a partial-thickness burn, which has cultured positive for gram-negative bacteria. The nurse is reinforcing information to the client about the medication. Which statement made by the client indicates a lack of understanding about the treatments?

1. "The medication is an antibacterial."

2. "The medication will help heal the burn."

3. "The medication will permanently stain my skin."

4. "The medication should be applied directly to the wound." 3. "The medication will permanently stain my skin."

Rationale:

Silver sulfadiazine (Silvadene) is an antibacterial that has a broad spectrum of activity against gram-negative bacteria, gram-positive bacteria, and yeast. It is applied directly to the wound to assist in healing. It does not stain the skin.

110.) A client taking lithium carbonate (Lithobid) reports vomiting, abdominal pain, diarrhea, blurred vision, tinnitus, and tremors. The lithium level is checked as a part of the routine follow-up and the level is 3.0 mEq/L. The nurse knows that this level is:

1. Toxic

2. Normal

3. Slightly above normal

4. Excessively below normal 1. Toxic

Rationale:

The therapeutic serum level of lithium is 0.6 to 1.2 mEq/L. A level of 3 mEq/L indicates toxicity.

111.) A client arrives at the health care clinic and tells the nurse that he has been doubling his daily dosage of bupropion hydrochloride (Wellbutrin) to help him get better faster. The nurse understands that the client is now at risk for which of the following?

1. Insomnia

2. Weight gain

3. Seizure activity

4. Orthostatic hypotension 3. Seizure activity

Rationale:

Bupropion does not cause significant orthostatic blood pressure changes. Seizure activity is common in dosages greater than 450 mg daily. Bupropion frequently causes a drop in body weight. Insomnia is a side effect, but seizure activity causes a greater client risk.

112.) A hospitalized client is started on phenelzine sulfate (Nardil) for the treatment of depression. The nurse instructs the client to avoid consuming which foods while taking this medication? Select all that apply.

1. Figs

2. Yogurt

3. Crackers

4. Aged cheese

5 Tossed salad

6. Oatmeal cookies 1. Figs

2. Yogurt

4. Aged cheese

Rationale:

Phenelzine sulfate (Nardil) is a monoamine oxidase inhibitor(MAOI). The client should avoid taking in foods that are high in tyramine. Use of these foods could trigger a potentially fatal hypertensive crisis. Some foods to avoid include yogurt, aged cheeses, smoked or processed meats, red wines, and fruits such as avocados, raisins, and figs.

113.) A nurse is reinforcing discharge instructions to a client receiving sulfisoxazole. Which of the following would be included in the plan of care for instructions?

1. Maintain a high fluid intake.

2. Discontinue the medication when feeling better.

3. If the urine turns dark brown, call the health care provider immediately.

4. Decrease the dosage when symptoms are improving to prevent an allergic response. 1.

Maintain a high fluid intake.

Rationale:

Each dose of sulfisoxazole should be administered with a full glass of water, and the client should maintain a high fluid intake. The medication is more soluble in alkaline urine. The client should not be instructed to taper or discontinue the dose. Some forms of sulfisoxazole cause the urine to turn dark brown or red. This does not indicate the need to notify the health care provider.

114.) A postoperative client requests medication for flatulence (gas pains). Which medication from the following PRN list should the nurse administer to this client?

1. Ondansetron (Zofran)

2. Simethicone (Mylicon)

3. Acetaminophen (Tylenol)

4. Magnesium hydroxide (milk of magnesia, MOM)   2. Simethicone (Mylicon)

Rationale:

Simethicone is an antiflatulent used in the relief of pain caused by excessive gas in the gastrointestinal tract. Ondansetron is used to treat postoperative nausea and vomiting. Acetaminophen is a nonopioid analgesic. Magnesium hydroxide is an antacid and laxative.

115.) A client received 20 units of NPH insulin subcutaneously at 8:00 AM. The nurse should check the client for a potential hypoglycemic reaction at what time?

1. 5:00 PM

2. 10:00 AM

3. 11:00 AM

4. 11:00 PM   1. 5:00 PM

Rationale:

NPH is intermediate-acting insulin. Its onset of action is 1 to 2½ hours, it peaks in 4 to 12 hours, and its duration of action is 24 hours. Hypoglycemic reactions most likely occur during peak time.

116.) A nurse administers a dose of scopolamine (Transderm-Scop) to a postoperative client. The nurse tells the client to expect which of the following side effects of this medication?

1. Dry mouth

2. Diaphoresis

3. Excessive urination

4. Pupillary constriction 1. Dry mouth

Rationale:

Scopolamine is an anticholinergic medication for the prevention of nausea and vomiting that causes the frequent side effects of dry mouth, urinary retention, decreased sweating, and dilation of the pupils. The other options describe the opposite effects of cholinergic-blocking agents and therefore are incorrect.

117.) A nurse has given the client taking ethambutol (Myambutol) information about the medication. The nurse determines that the client understands the instructions if the client immediately reports:

1. Impaired sense of hearing

2. Distressing gastrointestinal side effects

3. Orange-red discoloration of body secretions

4. Difficulty discriminating the color red from green 4. Difficulty discriminating the color red from green

Rationale:

Ethambutol causes optic neuritis, which decreases visual acuity and the ability to discriminate between the colors red and green. This poses a potential safety hazard when driving a motor vehicle. The client is taught to report this symptom immediately. The client is also taught to take the medication with food if gastrointestinal upset occurs. Impaired hearing results from antitubercular therapy with streptomycin. Orange-red discoloration of secretions occurs with rifampin (Rifadin).

118.) A nurse is caring for an older client with a diagnosis of myasthenia gravis and has reinforced self-care instructions. Which statement by the client indicates that further teaching is necessary?

1. "I rest each afternoon after my walk."

2. "I cough and deep breathe many times during the day."

3. "If I get abdominal cramps and diarrhea, I should call my doctor."

4. "I can change the time of my medication on the mornings that I feel strong." 4. "I can change the time of my medication on the mornings that I feel strong."

Rationale:

The client with myasthenia gravis should be taught that timing of anticholinesterase medication is critical. It is important to instruct the client to administer the medication on time to maintain a chemical balance at the neuromuscular junction. If not given on time, the client may become too weak to swallow. Options 1, 2, and 3 include the necessary information that the client needs to understand to maintain health with this neurological degenerative disease.

119.) A client with diabetes mellitus who has been controlled with daily insulin has been placed on atenolol (Tenormin) for the control of angina pectoris. Because of the effects of atenolol, the nurse determines that which of the following is the most reliable indicator of hypoglycemia?

1. Sweating

2. Tachycardia

3. Nervousness

4. Low blood glucose level   4. Low blood glucose level

Rationale:

β-Adrenergic blocking agents, such as atenolol, inhibit the appearance of signs and symptoms of acute hypoglycemia, which would include nervousness, increased heart rate, and sweating. Therefore, the client receiving this medication should adhere to the therapeutic regimen and monitor blood glucose levels carefully. Option 4 is the most reliable indicator of hypoglycemia.

12.) A nurse is caring for a client who is receiving an intravenous (IV) infusion of an antineoplastic medication. During the infusion, the client complains of pain at the insertion site. During an inspection of the site, the nurse notes redness and swelling and that the rate of infusion of the medication has slowed. The nurse should take which appropriate action?

1. Notify the registered nurse.

2. Administer pain medication to reduce the discomfort.

3. Apply ice and maintain the infusion rate, as prescribed.

4. Elevate the extremity of the IV site, and slow the infusion.   1. Notify the registered nurse.

Rationale:

When antineoplastic medications (Chemotheraputic Agents) are administered via IV, great care must be taken to prevent the medication from escaping into the tissues surrounding the injection site, because pain, tissue damage, and necrosis can result. The nurse monitors for signs of extravasation, such as redness or swelling at the insertion site and a decreased infusion rate. If extravasation occurs, the registered nurse needs to be notified; he or she will then contact the health care provider.

120.) A client is taking lansoprazole (Prevacid) for the chronic management of Zollinger-Ellison syndrome. The nurse advises the client to take which of the following products if needed for a headache?

1. Naprosyn (Aleve)

2. Ibuprofen (Advil)

3. Acetaminophen (Tylenol)

4. Acetylsalicylic acid (aspirin) 3. Acetaminophen (Tylenol)

Rationale:

Zollinger-Ellison syndrome is a hypersecretory condition of the stomach. The client should avoid taking medications that are irritating to the stomach lining. Irritants would include aspirin and nonsteroidal antiinflammatory drugs (ibuprofen). The client should be advised to take acetaminophen for headache.

Remember that options that are comparable or alike are not likely to be correct. With this in mind, eliminate options 1 and 2 first.

121.) A client who is taking hydrochlorothiazide (HydroDIURIL, HCTZ) has been started on triamterene (Dyrenium) as well. The client asks the nurse why both medications are required. The nurse formulates a response, based on the understanding that:

1. Both are weak potassium-losing diuretics.

2. The combination of these medications prevents renal toxicity.

3. Hydrochlorothiazide is an expensive medication, so using a combination of diuretics is cost-effective.

4. Triamterene is a potassium-sparing diuretic, whereas hydrochlorothiazide is a potassium-losing diuretic. 4. Triamterene is a potassium-sparing diuretic, whereas hydrochlorothiazide is a potassium-losing diuretic.

Rationale:

Potassium-sparing diuretics include amiloride (Midamor), spironolactone (Aldactone), and triamterene (Dyrenium). They are weak diuretics that are used in combination with potassium-losing diuretics. This combination is useful when medication and dietary supplement of potassium is not appropriate. The use of two different diuretics does not prevent renal toxicity. Hydrochlorothiazide is an effective and inexpensive generic form of the thiazide classification of diuretics.

**It is especially helpful to remember that hydrochlorothiazide is a potassium-losing diuretic and

triamterene is a potassium-sparing diuretic**

122.) A client who has begun taking fosinopril (Monopril) is very distressed, telling the nurse that he cannot taste food normally since beginning the medication 2 weeks ago. The nurse provides the best support to the client by:

1. Telling the client not to take the medication with food

2. Suggesting that the client taper the dose until taste returns to normal

3. Informing the client that impaired taste is expected and generally disappears in 2 to 3 months

4. Requesting that the health care provider (HCP) change the prescription to another brand of angiotensin-converting enzyme (ACE) inhibitor   3. Informing the client that impaired taste is expected and generally disappears in 2 to 3 months

Rationale:

ACE inhibitors, such as fosinopril, cause temporary impairment of taste (dysgeusia). The nurse can tell the client that this effect usually disappears in 2 to 3 months, even with continued therapy, and provide nutritional counseling if appropriate to avoid weight loss. Options 1, 2, and 4 are inappropriate actions. Taking this medication with or without food does not affect absorption and action. The dosage should never be tapered without HCP approval and the medication should never be stopped abruptly.

123.) A nurse is planning to administer amlodipine (Norvasc) to a client. The nurse plans to check which of the following before giving the medication?

1. Respiratory rate

2. Blood pressure and heart rate

3. Heart rate and respiratory rate

4. Level of consciousness and blood pressure   2. Blood pressure and heart rate

Rationale:

Amlodipine is a calcium channel blocker. This medication decreases the rate and force of cardiac contraction. Before administering a calcium channel blocking agent, the nurse should check the blood pressure and heart rate, which could both decrease in response to the action of this medication. This action will help to prevent or identify early problems related to decreased cardiac contractility, heart rate, and conduction.

amlodipine is a calcium channel blocker, and this group of medications decreases the rate and force of cardiac contraction. This in turn lowers the pulse rate and blood pressure.

124.) A client with chronic renal failure is receiving ferrous sulfate (Feosol). The nurse monitors the client for which common side effect associated with this medication?

1. Diarrhea

2. Weakness

3. Headache

4. Constipation 4. Constipation

Rationale:

Feosol is an iron supplement used to treat anemia. Constipation is a frequent and uncomfortable side effect associated with the administration of oral iron supplements. Stool softeners are often prescribed to prevent constipation.

Focus on the name of the medication. Recalling that oral iron can cause constipation will easily direct you to the correct option.

125.) A nurse is preparing to administer digoxin (Lanoxin), 0.125 mg orally, to a client with heart failure. Which vital sign is most important for the nurse to check before administering the medication?

1. Heart rate

2. Temperature

3. Respirations

4. Blood pressure 1. Heart rate

Rationale:

Digoxin is a cardiac glycoside that is used to treat heart failure and acts by increasing the force of myocardial contraction. Because bradycardia may be a clinical sign of toxicity, the nurse counts the apical heart rate for 1 full minute before administering the medication. If the pulse rate is less than 60 beats/minute in an adult client, the nurse would withhold the medication and report the pulse rate to the registered nurse, who would then contact the health care provider.

126.) A nurse is caring for a client who has been prescribed furosemide (Lasix) and is monitoring for adverse effects associated with this medication. Which of the following should the nurse recognize as a potential adverse effect Select all that apply.

1. Nausea

2. Tinnitus

3. Hypotension

4. Hypokalemia

5. Photosensitivity

6. Increased urinary frequency 2. Tinnitus

3. Hypotension

4. Hypokalemia

Rationale:

Furosemide is a loop diuretic; therefore, an expected effect is increased urinary frequency. Nausea is a frequent side effect, not an adverse effect. Photosensitivity is an occasional side effect. Adverse effects include tinnitus (ototoxicity), hypotension, and hypokalemia and occur as a result of sudden volume depletion.

127.) The nurse provides medication instructions to an older hypertensive client who is taking 20 mg of lisinopril (Prinivil, Zestril) orally daily. The nurse evaluates the need for further teaching when the client states which of the following?

1. "I can skip a dose once a week."

2. "I need to change my position slowly."

3. "I take the pill after breakfast each day."

4. "If I get a bad headache, I should call my doctor immediately." 1. "I can skip a dose once a week."

Rationale:

Lisinopril is an antihypertensive angiotensin-converting enzyme (ACE) inhibitor. The usual dosage range is 20 to 40 mg per day. Adverse effects include headache, dizziness, fatigue, orthostatic hypotension, tachycardia, and angioedema. Specific client teaching points include taking one pill a day, not stopping the medication without consulting the health care provider (HCP), and monitoring for side effects and adverse reactions. The client should notify the HCP if side effects occur.

128.) A nurse is providing instructions to an adolescent who has a history of seizures and is taking an anticonvulsant medication. Which of the following statements indicates that the client understands the instructions?

1. "I will never be able to drive a car."

2. "My anticonvulsant medication will clear up my skin."

3. "I can't drink alcohol while I am taking my medication."

4. "If I forget my morning medication, I can take two pills at bedtime." 3. "I can't drink alcohol while I am taking my medication."

Rationale:

Alcohol will lower the seizure threshold and should be avoided. Adolescents can obtain a driver's license in most states when they have been seizure free for 1 year. Anticonvulsants cause acne and oily skin; therefore a dermatologist may need to be consulted. If an anticonvulsant medication is missed, the health care provider should be notified.

129.) Megestrol acetate (Megace), an antineoplastic medication, is prescribed for the client with metastatic endometrial carcinoma. The nurse reviews the client's history and contacts the registered nurse if which diagnosis is documented in the client's history?

1. Gout

2. Asthma

3. Thrombophlebitis

4. Myocardial infarction 3. Thrombophlebitis

Rationale:

Megestrol acetate (Megace) suppresses the release of luteinizing hormone from the anterior pituitary by inhibiting pituitary function and regressing tumor size. Megestrol is used with caution if the client has a history of thrombophlebitis.

megestrol acetate is a hormonal antagonist enzyme and that a side effect is thrombotic disorders

13.) The client with squamous cell carcinoma of the larynx is receiving bleomycin intravenously. The nurse caring for the client anticipates that which diagnostic study will be prescribed?

1. Echocardiography

2. Electrocardiography

3. Cervical radiography

4. Pulmonary function studies 4. Pulmonary function studies

Rationale:

Bleomycin is an antineoplastic medication (Chemotheraputic Agents) that can cause interstitial pneumonitis, which can progress to pulmonary fibrosis. Pulmonary function studies along with

hematological, hepatic, and renal function tests need to be monitored. The nurse needs to monitor lung sounds for dyspnea and crackles, which indicate pulmonary toxicity. The medication needs to be discontinued immediately if pulmonary toxicity occurs. Options 1, 2, and 3 are unrelated to the specific use of this medication.

130.) The nurse is analyzing the laboratory results of a client with leukemia who has received a regimen of chemotherapy. Which laboratory value would the nurse specifically note as a result of the massive cell destruction that occurred from the chemotherapy?

1. Anemia

2. Decreased platelets

3. Increased uric acid level

4. Decreased leukocyte count   3. Increased uric acid level

Rationale:

Hyperuricemia is especially common following treatment for leukemias and lymphomas because chemotherapy results in a massive cell kill. Although options 1, 2, and 4 also may be noted, an increased uric acid level is related specifically to cell destruction.

131.) The nurse is reinforcing medication instructions to a client with breast cancer who is receiving cyclophosphamide (Neosar). The nurse tells the client to:

1. Take the medication with food.

2. Increase fluid intake to 2000 to 3000 mL daily.

3. Decrease sodium intake while taking the medication.

4. Increase potassium intake while taking the medication.   2. Increase fluid intake to 2000 to 3000 mL daily.

Rationale:

Hemorrhagic cystitis is a toxic effect that can occur with the use of cyclophosphamide. The client needs to be instructed to drink copious amounts of fluid during the administration of this medication. Clients also should monitor urine output for hematuria. The medication should be taken on an empty stomach, unless gastrointestinal (GI) upset occurs. Hyperkalemia can result from the use of the medication; therefore the client would not be told to increase potassium intake. The client would not be instructed to alter sodium intake.

132.) The client with non-Hodgkin's lymphoma is receiving daunorubicin (DaunoXome). Which of the following would indicate to the nurse that the client is experiencing a toxic effect related to the medication?

1. Fever

2. Diarrhea

3. Complaints of nausea and vomiting

4. Crackles on auscultation of the lungs 4. Crackles on auscultation of the lungs

Rationale:

Cardiotoxicity noted by abnormal electrocardiographic findings or cardiomyopathy manifested as congestive heart failure is a toxic effect of daunorubicin. Bone marrow depression is also a toxic effect. Nausea and vomiting are frequent side effects associated with the medication that begins a few hours after administration and lasts 24 to 48 hours. Fever is a frequent side effect, and diarrhea can occur occasionally. The other options, however, are not toxic effects.

keep in mind that the question is asking about a toxic effect and think: ABCs—airway, breathing, and circulation

133.) A nurse is monitoring a client receiving desmopressin acetate (DDAVP) for adverse effects to the medication. Which of the following indicates the presence of an adverse effect?

1. Insomnia

2. Drowsiness

3. Weight loss

4. Increased urination 2. Drowsiness

Rationale:

Water intoxication (overhydration) or hyponatremia is an adverse effect to desmopressin. Early signs include drowsiness, listlessness, and headache. Decreased urination, rapid weight gain, confusion, seizures, and coma also may occur in overhydration.

Recall that this medication is used to treat diabetes insipidus to eliminate weight loss and increased urination.

134.) A nurse reinforces instructions to a client who is taking levothyroxine (Synthroid). The nurse tells the client to take the medication:

1. With food

2. At lunchtime

3. On an empty stomach

4. At bedtime with a snack Rationale:

Oral doses of levothyroxine (Synthroid) should be taken on an empty stomach to enhance absorption. Dosing should be done in the morning before breakfast.

Note that options 1, 2, and 4 are comparable or alike in that these options address administering the medication with food.

135.) A nurse reinforces medication instructions to a client who is taking levothyroxine (Synthroid). The nurse instructs the client to notify the health care provider (HCP) if which of the following occurs?

1. Fatigue

2. Tremors

3. Cold intolerance

4. Excessively dry skin 2. Tremors

Rationale:

Excessive doses of levothyroxine (Synthroid) can produce signs and symptoms of hyperthyroidism. These include tachycardia, chest pain, tremors, nervousness, insomnia, hyperthermia, heat intolerance, and sweating. The client should be instructed to notify the HCP if these occur. Options 1, 3, and 4 are signs of hypothyroidism.

136.) A nurse performs an admission assessment on a client who visits a health care clinic for the first time. The client tells the nurse that propylthiouracil (PTU) is taken daily. The nurse continues to collect data from the client, suspecting that the client has a history of:

1. Myxedema

2. Graves' disease

3. Addison's disease

4. Cushing's syndrome 2. Graves' disease

Rationale:

PTU inhibits thyroid hormone synthesis and is used to treat hyperthyroidism, or Graves' disease. Myxedema indicates hypothyroidism.

Cushing's syndrome and Addison's disease are disorders related to adrenal function.

137.) A nurse is reinforcing instructions for a client regarding intranasal desmopressin acetate (DDAVP). The nurse tells the client that which of the following is a side effect of the medication?

1. Headache

2. Vulval pain

3. Runny nose

4. Flushed skin 3. Runny nose

Rationale:

Desmopressin administered by the intranasal route can cause a runny or stuffy nose. Headache, vulval pain, and flushed skin are side effects if the medication is administered by the intravenous (IV) route.

138.) A daily dose of prednisone is prescribed for a client. A nurse reinforces instructions to the client regarding administration of the medication and instructs the client that the best time to take this medication is:

1. At noon

2. At bedtime

3. Early morning

4. Anytime, at the same time, each day 3. Early morning

Rationale:

Corticosteroids (glucocorticoids) should be administered before 9:00 AM. Administration at this time helps minimize adrenal insufficiency and mimics the burst of glucocorticoids released naturally by the adrenal glands each morning.

Note the suffix "-sone," and recall that medication names that end with these letters are corticosteroids.

139.) Prednisone is prescribed for a client with diabetes mellitus who is taking Humulin neutral protamine Hagedorn (NPH) insulin daily. Which of the following prescription changes does the nurse anticipate during therapy with the prednisone?

1. An additional dose of prednisone daily

2. A decreased amount of daily Humulin NPH insulin

3. An increased amount of daily Humulin NPH insulin

4. The addition of an oral hypoglycemic medication daily 3. An increased amount of daily Humulin NPH insulin

Rationale:

Glucocorticoids can elevate blood glucose levels. Clients with diabetes mellitus may need their dosages of insulin or oral hypoglycemic medications increased during glucocorticoid therapy. Therefore the other options are incorrect.

14.) The client with acute myelocytic leukemia is being treated with busulfan (Myleran). Which laboratory value would the nurse specifically monitor during treatment with this medication?

1. Clotting time

2. Uric acid level

3. Potassium level

4. Blood glucose level   2. Uric acid level

Rationale:

Busulfan (Myleran) can cause an increase in the uric acid level. Hyperuricemia can produce uric acid nephropathy, renal stones, and acute renal failure. Options 1, 3, and 4 are not specifically related to this medication.

140.) The client has a new prescription for metoclopramide (Reglan). On review of the chart, the nurse identifies that this medication can be safely administered with which condition?

1. Intestinal obstruction

2. Peptic ulcer with melena

3. Diverticulitis with perforation

4. Vomiting following cancer chemotherapy   4. Vomiting following cancer chemotherapy

Rationale:

Metoclopramide is a gastrointestinal (GI) stimulant and antiemetic. Because it is a GI stimulant, it is contraindicated with GI obstruction, hemorrhage, or perforation. It is used in the treatment of emesis after surgery, chemotherapy, and radiation.

141.) The nurse has reinforced instructions to a client who has been prescribed cholestyramine (Questran). Which statement by the client indicates a need for further instructions?

1. "I will continue taking vitamin supplements."

2. "This medication will help lower my cholesterol."

3. "This medication should only be taken with water."