Clinical Guidelines in Primary Care Testbank/Study Guide

Chapter 1 Cardiovascular Disorders

MULTIPLE CHOICE

1.The nurse is aware that the muscle layer of the heart, which is responsible for the hearts contraction, is the:

a.	endocardium.
b.	pericardium.
c.	mediastinum.
d.	myocardium.

ANS: D

The myocardium is the specialized muscle layer that allows the heart to contract.

2.The nurse clarifies that the master pacemaker of the heart is the:

a.	left ventricle.
b.	atrioventricular (AV) node.
c.	sinoatrial (SA) node.
d.	bundle of His.

ANS: C

The SA node is the master pacemaker of the heart.

3.The nurse is aware that the symptoms of an impending myocardial infarction (MI) differ in women because acute chest pain is not present. Women are frequently misdiagnosed as having:

a.	hepatitis A.
b.	indigestion.
c.	urinary infection.
d.	menopausal complications.

ANS: B

Indigestion, gallbladder attack, anxiety attack, and depression are frequent misdiagnoses for women having an MI.

4.The nurse identifies the LUBB sound of the LUBB/DUBB of the cardiac cycle as the sound of the:

a.	AV valves closing.
b.	closure of the semilunar valves.
c.	contraction of the papillary muscles.
d.	contraction of the ventricles.

ANS: A

The LUBB is the first sound of a low pitch heard when the AV valves close.

5.A patient is admitted from the emergency department. The emergency department physician notes the patient has a diagnosis of heart failure with a New York Heart Association (NYHA) classification of IV. This indicates the patients condition as:

a.	moderate heart failure.
b.	severe heart failure.
c.	congestive heart failure.
d.	negligible heart failure.

ANS: B

Class IV: Severe; patient unable to perform any physical activity without discomfort. Angina or symptoms of cardiac inefficiency may develop at rest.

6.The nurse assesses that the home health patient has no signs or symptoms of heart failure, but does have a history of rheumatic fever and has been recently diagnosed with diabetes mellitus. The nurse is aware that using the American College of Cardiology and the American Heart Association (ACC/AHA) staging, this patient would be a:

a.	stage A.
b.	stage B.
c.	stage C.
d.	stage D.

ANS: A

The ACC/AHA staging describes stage A as a person without symptoms of heart failure, but with primary conditions associated with the development of the disease.

7.The nurse caring for a patient recovering from a myocardial infarct who is on remote telemetry recognizes the need for added instruction when the patient says:

a.	I can ambulate in the hallway with this gadget on.
b.	I always take off the telemetry device when I shower.
c.	My EKG is being watched by one of the nurses in CCU on the home unit.
d.	I am able to sleep just fine with this device on.

ANS: B

Remote telemetry allows the patient to be on a separate unit, but be monitored in a central location. The patients can be ambulatory and can sleep with the monitor on. They should *not* remove the monitor to shower.

8.The nurse assesses pitting edema that can be depressed approximately inch and refills in 15 seconds. The nurse would document this assessment as:

a.	+1 edema.
b.	+2 edema.
c.	+3 edema.
d.	+4 edema.

ANS: B

A +2 edema can be documented if the skin can be depressed inch and respond within 15 seconds.

9.What do dark or cold spots on a thallium scan indicate?

a.	Tissue with adequate blood supply
b.	Dilated vessels
c.	Areas of neoplastic growth
d.	Tissue that has inadequate perfusion

ANS: D

Thallium scans show adequate perfused areas by the collection of thallium. Dark spots or cold spots indicate tissues that have inadequate perfusion.

10.The nurse recognizes the echocardiogram report that shows an ejection factor of 42% as an indication of:

a.	normal heart action.
b.	mild heart failure.
c.	moderate heart failure.

d.	severe heart failure.

ANS: C

An ejection factor (cardiac output) of 42% indicates moderate heart failure.

11.The nurse takes into consideration that age-related changes can affect the peripheral circulation because of:

a.	sclerosed blood vessels.
b.	hypotension.
c.	inactivity.
d.	poor nutrition.

ANS: A

Aging causes sclerotic changes in the blood vessels that lead to decreased elasticity and narrowing of the vessel lumen.

12.The nurse assessing a cardiac monitor notes that the cardiac complexes each have a P wave followed by a QRS and a T. The rate is 120. The nurse recognizes this arrhythmia as:

a.	sinus bradycardia.
b.	atrial fibrillation.
c.	sinus tachycardia.
d.	ventricular tachycardia.

ANS: C

Sinus tachycardia has a P wave followed by the QRS and the T. All the components of the complex are present and in the correct order, but the rate is over 100 beats a minute.

13.After an influenza-like illness, the patient complains of chills and small petechiae in his mouth and his legs. A heart murmur is detectable. These are characteristic signs of:

a.	congestive heart failure.
b.	heart block.
c.	aortic stenosis.
d.	infective endocarditis.

ANS: D

Collection of subjective data includes noting patient complaints of influenza-like symptoms with recurrent fever, undue fatigue, chest pain, and chills. Objective data may reveal the significant

signs of petechiae in the conjunctiva and mouth. Both subjective data and objective data are indicative of infective endocarditis.

14.The nurse notes a run of three ventricular contractions (PVC) that are not preceded by a P wave. This particular arrhythmia can progress into:

a.	atrial fibrillation and possible emboli.
b.	sinus tachycardia and syncope.
c.	ventricular tachycardia and death.
d.	sinus bradycardia and fatigue.

ANS: C

PVCs are capable of progressing into ventricular tachycardia and death.

15.The nurse reminds the patient who is on Coumadin for the treatment of atrial fibrillation that the ideal is to maintain the international normalized ratio (INR) at between:

a.	1 and 2.
b.	2 and 3.
c.	3 and 4.
d.	4 and 5.

ANS: B

The desired INR for the monitoring of anticoagulant therapy is between 2 and 3.

16.What should a person with unstable angina avoid?

a.	Walking outside
b.	Eating red meat
c.	Swimming in warm pool
d.	Shoveling snow

ANS: D

The person with angina should avoid exposure to cold, heavy exercise, eating heavy meals, and emotional stress.

17.The elderly patient with angina pectoris says she is unsure how she should take nitroglycerin when she has an attack. The nurses most helpful response would be:

a.	Continue to take nitroglycerin sublingually at 5-minute intervals until the pain is relieved.
b.	If the pain is not relieved after three doses of nitroglycerin at 5-minute intervals, call your physician and come to the hospital.

c. When nitroglycerin is not relieving the pain, lie down and rest.

d. Use oxygen at home to relieve pain when nitroglycerin is not successful.

ANS: B

Administer prescribed nitroglycerin. Repeat every 5 minutes, three times. If pain is unrelieved, notify the physician. Nitroglycerin administered sublingually usually relieves angina symptoms but does not relieve the pain from an MI. Administering nitroglycerin more than three times will probably not relieve the pain.

18.The patient has been hospitalized for hypertensive episodes three times in the last months. While preparing the discharge teaching plan, the nurse assesses that he does not comply with his medication regimen. The nurses immediate course of action would be to:

a. reteach him about his medications.

b. have a serious talk with him and his family about compliance.

c. arrange for home visits after discharge.

d. collect more information to identify his reasons for noncompliance.

ANS: D

Nursing interventions include measures to prevent disease progression and complications. Reteaching about medication will not identify the cause of noncompliance.

19.What is the major cause of cardiac valve disease?

a. Rheumatic fever

b. Long history of malnutrition

c. Drug abuse

d. Obesity

ANS: A

Rheumatic fever, a streptococcal infection, is the major cause of cardiac valve disease.

20.The patient has a total cholesterol of 190 with a high-density lipid (HDL) of 110 and a low-density lipid (LDL) of 80. The nurses reaction is one of:

a. satisfaction. This is good cholesterol control.

b. determination. This is evidence that more instruction is necessary.

c. inquiry. This needs to clarified as to the cause of noncompliance with the drug protocol.

d. regret. This shows very poor cholesterol control.

ANS: A

Total cholesterol of less than 200 is desirable. The higher the number of HDLs the better. A high number of LDLs puts the patient at risk for heart disease.

21.A patient, age 72, was admitted to the medical unit with a diagnosis of angina pectoris. Characteristic signs and symptoms of angina pectoris include:

a.	substernal pain that radiates down the left arm.
b.	epigastric pain that radiates to the jaw.
c.	indigestion, nausea, and eructation.
d.	fatigue, shortness of breath, and dyspnea.

ANS: A

The pain often radiates down the left inner arm to the little finger and also upward to the shoulder and jaw.

22.A patient admitted to the emergency room with a possible myocardial infarction (MI) has reports back from the laboratory. Which laboratory report is specific for myocardial damage?

a.	CK-MB
b.	Elevated white count
c.	Elevated sedimentation rate
d.	Low level of sodium

ANS: A

The CK-MB is elevated when there is infarcted myocardial muscle. The elevated white count, low sodium, and ESR are nonspecific.

23.The patient, age 26, is hospitalized with cardiomyopathy. While obtaining a nursing history from her, the nurse recognizes that the increased incidence of cardiomyopathy in young

adults who have minimal risk factors for cardiovascular disease is related to which factor(s)?

a.	Cocaine use
b.	Viral infections
c.	Vitamin B_1 deficiencies
d.	Pregnancy

ANS: A

Cardiomyopathy caused by cocaine abuse is seen more frequently than ever before. Cocaine also causes high circulating levels of catecholamines, which may further damage myocardial cells, leading to ischemic or dilated cardiomyopathy. The cardiomyopathy produced is difficult to treat. Interventions deal mainly with the HF that ensues.

24.The patient has become very dyspneic, respirations are 32, and the pulse is 100. The patient is coughing up frothy red sputum. What should be the initial nursing intervention?

a.	Lay the patient flat to reduce hypotension and the symptoms of cardiogenic shock.
b.	Place patient in side-lying position to reduce the symptoms of atrial fibrillation.
c.	Place patient upright with legs in dependent position to reduce the symptoms of pulmonary edema.
d.	Lay the patient flat and elevate the feet to increase venous return in cardiogenic shock.

ANS: C

Signs and symptoms of pulmonary edema are restlessness; vague uneasiness; agitation; disorientation; diaphoresis; severe dyspnea; tachypnea; tachycardia; pallor or cyanosis; cough producing large quantities of blood-tinged, frothy sputum; audible wheezing and crackles; and cold extremities. The legs in a dependent position will decrease venous return and ease the pulmonary edema.

25.The nurse caring for a patient recovering from a myocardial infarction (MI) teaches which method to avoid the Valsalva maneuver during a bowel movement?

a.	Mouth breathing
b.	Pursing the lips and whistling
c.	Taking a deep breath and holding it
d.	Breathing rapidly through the nose

ANS: A

Mouth breathing will lessen the severity of straining and will decrease the effect of the Valsalva maneuver on intrathoracic pressure.

26.The nurse reminds the patient that the National Heart, Lung, and Blood Institute recommends a lipid study every _____ years.

a.	2
b.	3
c.	4
d.	5

ANS: D

The National Heart, Lung, and Blood Institute recommend a lipid study every 5 years for all Americans, but especially for the older adult.

27.During a health interview by the home health nurse, which patient complaint suggests left-sided heart failure?

a. I have to sleep in my recliner and I have this hacking cough.

b. I have no appetite and I have lost 3 lb in the last week.

c. I have to urinate every 2 hours, even during the night.

d. I go barefoot most of the time because my feet are so hot.

ANS: A

Left ventricular failure; the first is signs and symptoms of decreased cardiac output. The second is pulmonary congestion. Signs and symptoms of this condition include dyspnea, orthopnea, pulmonary crackles, hemoptysis, and cough.

28.The home health nurse caring for a patient with infective endocarditis overhears the patient making a dental appointment for an extraction next month. Which question is most important for the nurse to ask?

a. Do you have a toothache?

b. Have you contacted your physician about your dental appointment?

c. Is your dentist board certified?

d. Do you think you should wait that long for your tooth extraction?

ANS: B

Patients with endocarditis are put on a protocol of prophylactic antibiotics for any invasive procedure. The dentist and physician should be contacted before the extraction.

29.The home health nurse warns the patient who is taking warfarin (Coumadin) for anticoagulant therapy for thrombophlebitis to stop taking the herbal remedy of ginkgo because ginkgo can:

a. cause severe episodes of diarrhea.

b. cause a severe skin eruption if taken with Coumadin.

c. increase the action of the Coumadin.

d. cause the Coumadin to be less effective.

ANS: C

Herbal remedies such as ginkgo, garlic, angelica, and red clover can increase (potentiate) the action of the Coumadin.

30.What is the difference between primary and secondary hypertension?

a. Secondary hypertension is caused by another disorder like renal disease.

b. Secondary hypertension is related to hereditary factors.

c. Secondary hypertension cannot be treated effectively.

d. Secondary hypertension is no real threat to health.

ANS: A

Secondary hypertension is a consistently elevated blood pressure that is caused by another disorder, such as renal disease, diabetes, or Cushing syndrome.

31.The nurse is treating a patient who has had a pacemaker inserted for the correction of atrial fibrillation. Which diagnostic test is no longer available to the patient because of the implanted device?

a.	MRI
b.	CT scan
c.	Thallium scan
d.	PET

ANS: A

Because of the large magnets in the MRI cabinet, the pacemaker may be reset to a fixed mode and interfere with the functioning of the pacemaker.

32.Which assessment would lead the nurse to examine the leg closely for evidence of a stasis ulcer?

a.	Cool dry lower limb
b.	Edematous, red scaly skin on medial surface of the leg
c.	Lack of hair and shiny appearance of the lower leg
d.	Lack of a pedal pulse

ANS: B

Suggestion of a stasis ulcer in the making is an edematous, dry scaly area on the medial surface of the lower leg that has a darker pigmentation (rubor). Cool hairless limbs with absent or weak pedal pulses are indicative of arterial insufficiency.

33.What is the patient goal of the walking exercise program designed for the rehabilitation of a post-MI patient?

a.	Walk 2 miles in less than 60 minutes after 12 weeks.
b.	Jog mile in less than 30 minutes after 12 weeks.
c.	Fast walk 1 mile in less than 20 minutes after 12 weeks.
d.	Walk 1 mile in 15 minutes without dyspnea after 12 weeks.

ANS: A

The goal of the 12-week walking program is that the patient can walk 2 miles in less than 60 minutes.

34.The postsurgical patient has a painful and swollen right calf that appears to be larger than the calf of the left leg. What is the nurse assessing for when she flexes the patients right leg and dorsiflexes the foot?

a.	Pain, which would be a positive Homans sign
b.	Muscular spasm, which would be a sign of hypocalcemia
c.	Rigidity, which would be a sign of ankylosis
d.	Crepitus, which would be a sign of a joint disorder

ANS: A

A positive Homans sign for deep vein thrombosis (DVT) is a report of pain when the affected leg is flexed and the foot is dorsiflexed.

35.How should the nurse advise a patient with an international normalized ratio (INR) of 5.8?

a.	Make arrangements to go to the emergency room immediately
b.	Increase fluid intake to 2000 mL/day
c.	Stop taking the anticoagulant and notify health care provider
d.	Add more leafy green vegetables to patient diet

ANS: C

The INR that is desired should be maintained between 2 and 3. A reading of 5.8 puts the patient at risk for hemorrhage. The patient should stop taking the anticoagulant and contact the physician for further instruction.

36.The nurse making a teaching plan for a patient with Buerger disease (thromboangiitis obliterans) will focus on the need for:

a.	reduction of alcohol intake.
b.	avoiding cold remedies.
c.	cessation of smoking.
d.	weight reduction.

ANS: C

The hazards of cigarette smoking and its relationship to Buerger disease are the primary focus of patient teaching. None of the palliative treatments are effective if the patient does not stop smoking. Nowhere are the cause and effect of smoking so dramatically seen as with Buerger disease.

37.Which statement would lead the nurse to offer more instruction about taking warfarin (Coumadin)?

a.	I eat a banana every morning with breakfast.

b.	I try to eat more green leafy vegetables, especially broccoli, spinach, and kale.
c.	I try to eat a well-balanced, low-fat diet.
d.	I dont drink alcohol or caffeine.

ANS: B

Avoid marked changes in eating habits, such as dramatically increasing foods high in vitamin K (e.g., broccoli, spinach, kale, greens). Limit alcohol intake to small amounts.

38.The nurse caring for a 92-year-old patient with pneumonia who is receiving IV carefully monitors the flow rate of the IV infusion because rapid infusion can cause:

a.	hypotension.
b.	thrombophlebitis.
c.	pulmonary emboli.
d.	heart failure.

ANS: D

Heart failure can result from rapid infusion of intravenous fluids in older adults.

39.The nurse making the schedule for the daily dose of furosemide (Lasix) would schedule the administration for which of the following times?

a.	Late in the afternoon
b.	At bedtime
c.	With any meal
d.	In the morning

ANS: D

Diuretics should be scheduled for morning administration to avoid causing the patient nocturia.

Chapter 2 Dermatologic Disorders

MULTIPLE CHOICE

1.What should the nurse do when administering a therapeutic bath to a patient who has severe pruritus?

a.	Use Burows solution to help promote healing
b.	Rub the skin briskly to decrease pruritus
c.	Limit bathing to 3 times a week
d.	Ensure that bath area is at least 85 degrees and dehumidified

ANS: A

Pruritus is responsible for most of the discomfort. Wet dressings and using Burows solution help promote the healing process. A cool environment with increased humidity decreases the pruritus. Give daily baths with an application to cleanse the skin.

2.A frail, older adult home health patient who had chickenpox as a child has been exposed to varicella (chickenpox) several days ago. What should the nurse do?

a.	Assess frequently for herpes zoster
b.	Be aware of the patients immunity to chickenpox
c.	Encourage the patient to have a pneumonia vaccine
d.	Arrange for the patient to receive gamma globulin

ANS: A

Herpes zoster is caused by the same virus that causes chickenpox (Herpes varicella). The greatest risk occurs to patients who have a lowered resistance to infection, such as those on chemotherapy, aging, or receiving large doses of prednisone, in whom the disease could be fatal because of the patients compromised immune system.

3.A patient has herpes zoster (shingles) and is being treated with acyclovir (Zovirax). What should the nurse do when administering this drug?

a.	Apply lightly, being careful not to completely cover the lesion
b.	After application, wrap in warm wet dressings
c.	Use gloves
d.	Rub medication into lesions

ANS: C

The topical application requires that the nurse uses gloves, completely covers the lesion gently, then leaves it open to the air.

4.A child has been sent to the school nurse with pruritus and honey-colored crusts on the lower lip and chin. The nurse believes these lesions most likely are:

a.	chickenpox.
b.	impetigo.
c.	shingles.
d.	herpes simplex type I.

ANS: B

Impetigo is seen at all ages, but is particularly common in children. The crust is honey-colored and easily removed and is associated with pruritus. The disease is highly contagious and spreads by contact.

5.A school nurse assesses a child who has an erythematous circular patch of vesicles on her scalp with alopecia and complains of pain and pruritus. Why would the nurse use a Woods lamp?

a.	To dry out the lesions
b.	To reduce the pruritus
c.	To kill the fungus
d.	To cause fluorescence of the infected hairs

ANS: D

Tinea capitis is commonly known as ringworm of the scalp. *Microsporum audouinii* is the major fungal pathogen. The use of the diagnostic Woods lamp causes the infected hairs to turn a brilliant blue green.

6.A patient, age 46, reports to his physicians office with urticaria with elevated lesions that are white in the center with a pale red border on hands and arms. He says, It itches like crazy. Which type of lesion would the nurse include in her documentation?

a.	Macules
b.	Plaques
c.	Wheals
d.	Vesicles

ANS: C

Urticaria is the term applied to the presence of wheals or hives in an allergic reaction commonly caused by drugs, food, insect bites, inhalants, emotional stress, or exposure to heat or cold. The lesions are elevated with a white center and a pale red border.

7.The home health nurse assessing skin lesions uses the PQRST mnemonic as a guide. What does the S in this guide indicate?

a.	Severity of the symptoms
b.	Site of the lesions
c.	Symptomatology of the lesions
d.	Surface area of the lesions

ANS: A

The mnemonic PQRST stands for Provocative factors (causes), Quantity, Region of the body, Severity of the symptoms, Time (length of time the disorder has been present).

8.What would the nurse stress to the 17-year-old girl who has been prescribed Accutane for her acne?

a.	Avoid alcoholic beverages
b.	Drink at least 1000 mL of fluid daily
c.	Use dependable birth control to avoid pregnancy
d.	Avoid exposure to the sun

ANS: C

Accutane has a destructive effect on fetal development. Dependable birth control is important to avoid a pregnancy.

9.A 30-year-old African American had surgery 6 months ago and the incision site is now raised, indurated, and shiny. This is most likely which type of tissue growth?

a.	Angioma
b.	Keloid
c.	Melanoma
d.	Nevus

ANS: B

Keloids, which originate in scars, are hard and shiny and are seen more often in African Americans than in whites.

10.A patient, age 37, sustained partial- and full-thickness burns to 26% of the body surface area. When would the greatest fluid loss resulting from the burns occur?

a.	Within 12 hours after burn trauma
b.	24 to 36 hours after burn trauma

c.	24 to 48 hours after burn trauma
d.	48 to 72 hours after burn trauma

ANS: A

In a burn injury, usually the greatest fluid loss occurs within the first 12 hours.

11.Most of the deaths from burn trauma in the emergent phase that require a referral to a burn center result from:

a.	infection.
b.	arrhythmias with cardiac arrest.
c.	hypovolemic shock and renal failure.
d.	adrenal failure.

ANS: C

Hypovolemic shock is frequently lethal in the emergent period of a severe burn because of the transfer of fluids into the interstitial tissue from the circulating volume.

12.The nurse takes into consideration that carbon monoxide intoxication secondary to smoke inhalation is often fatal because carbon monoxide:

a.	binds with hemoglobin in place of oxygen.
b.	interferes with oxygen intake.
c.	is a respiratory depressant.
d.	is a toxic agent.

ANS: A

Carbon monoxide poisoning is likely if the patient has been in an enclosed area. Carbon monoxide displaces oxygen by binding with hemoglobin.

13.A nurse arrives at an accident scene where the victim has just received an electrical burn. What is the nurses primary concern?

a.	The extent and depth of the burn
b.	The sites of entry and exit
c.	The likelihood of cardiac arrest
d.	Control of bleeding

ANS: C

Most electrical burns result in cardiac arrest, and the patient will require CPR or acute cardiac monitoring.

14.A patient, age 27, sustained thermal burns to 18% of her body surface area. After the first 72 hours, the nurse will have to observe for the most common cause of burn-related deaths, which is:

a.	shock.
b.	respiratory arrest.
c.	hemorrhage.
d.	infection.

ANS: D

Infection is the most common complication and cause of death after the first 72 hours.

15.Two weeks after a severe burn of over 20% of the body, the patient vomits bright red blood. Which condition is most likely?

a.	Curling ulcer
b.	Paralytic ileus
c.	Hypoglycemia perforation of the stomach by the NG tube
d.	Gastritis

ANS: A

Curling ulcer is a duodenal ulcer that develops 8 to 14 days after severe burns on the surface of the body. The first sign is usually vomiting of bright red blood.

16.When providing the open method of treatment for a patient who is 52 years old with burns to the lower extremities, what would a nurse include in the nursing plan?

a.	Change the dressing using good medical asepsis
b.	Provide an analgesic immediately after the dressing change
c.	Perform circulation checks every 2 to 4 hours
d.	Keep the room temperature at 85 F (29.4 C) to prevent chilling

ANS: D

Chilling may be controlled by keeping the room temperature at 85 F (29.4 C). Strict surgical protocol is observed and analgesia should be given before the treatment. Frequent circulation checks are not a high priority with the open method.

17.The nurse has staged a pressure ulcer that has a shallow crater with a dry pink wound bed as a:

a.	stage I
b.	stage II

c.	stage III
d.	stage IV

ANS: B

Stage II pressure ulcers have a shallow crater with a dry pink wound bed without slough.

18.What would the nurse dressing a necrotic pressure ulcer with a minimal exudate most likely use?

a.	Hydrocolloid dressing
b.	Alginate dressing
c.	Hydrofiber dressing
d.	Transparent film

ANS: A

Hydrocolloid dressings are useful in necrotic wounds with little exudate. Alginate and hydrofiber dressings are used for wounds with copious exudate. Transparent film is not absorbent.

19.The nurse is caring for a 26-year-old male patient who was burned 72 hours ago. He has partial-thickness burns to 24% of his body surface area. He begins to excrete large amounts of urine. What should the nurse do?

a.	Increase the IV rate and monitor for burn shock
b.	Monitor for signs of seizure activity.
c.	Assess for signs of fluid overload
d.	Raise the foot of the bed and apply blankets

ANS: C

As the blood volume increases, the cardiac output increases to increase renal perfusion. The result includes diuresis. However, a great risk for the patient includes fluid overload because of the rapid movement of fluid back into the intravascular space.

20.A patient with severe eczema is starting a coal tar derivative treatment. What should the nurse include in the teaching plan for the patient relative to this treatment?

a.	Drink at least 1000 mL of fluid daily
b.	Avoid exposure to sunlight for 72 hours after use
c.	Bathe with an astringent soap
d.	Reduce intake of high calcium foods

ANS: B

Persons using coal tar derivatives should avoid exposure to sunlight for 72 hours after use. The product stains clothes and bathroom fixtures.

21.What should the nurse examine in assessing a patient for tinea corporis?

a.	Soles of the feet
b.	Scalp
c.	Armpits
d.	Abdomen

ANS: D

Tinea corporis is known as ringworm of the body. It occurs on parts of the body with little or no hair.

22.What is the initial intervention for relief of the pruritus of dermatitis venenata?

a.	Apply baking soda to lesions
b.	Wash area with copious amounts of water
c.	Apply cool compresses continuously
d.	Expose area to air

ANS: B

In dermatitis venenata (poison oak or ivy), the patient should wash the affected part immediately after contact with the offending allergen.

23.The nurse debriding a burn wound explains that the purpose of debridement is to:

a.	increase the effectiveness of the skin graft.
b.	prevent infection and promote healing.
c.	promote suppuration of the wound.
d.	promote movement in the affected area.

ANS: B

Debridement is the removal of damaged tissue and cellular debris from a wound or burn to prevent infection and to promote healing.

24.A patient has been admitted to the hospital with burns to the upper chest. The nurse notes singed nasal hairs. The nurse needs to assess this patient frequently for which condition?

a.	Decreased activity
b.	Bradycardia
c.	Respiratory complications

d.	Hypertension

ANS: C

Signs and symptoms of inhalation injury include singed nasal hairs. Breathing difficulties may take several hours to occur.

25.Which may indicate a malignant melanoma in a nevus on a patients arm?

a.	Even coloring of the mole
b.	Decrease in size of the mole
c.	Irregular border of the mole
d.	Symmetry of the mole

ANS: C

Any change in color, size, or texture and any bleeding or pruritus of a nevus deserves investigation. A malignant melanoma is a cancerous neoplasm in which pigment cells or melanocytes invade the epidermis, dermis, and sometimes the subcutaneous tissue.

26.A nurse can assess cyanosis in a dark-skinned patient by noting the color of the:

a.	conjunctiva.
b.	sclera.
c.	lips and mucous membranes.
d.	soles of the feet.

ANS: C

Assessment of color is more easily made in areas where the epidermis is thin, such as the lips and mucous membranes.

27.A patient developed a severe contact dermatitis of the hands, arms, and lower legs after spending an afternoon picking strawberries. The patient states that the itching is severe and cannot keep from scratching. Which instruction would be most helpful in managing the pruritus?

a.	Use cool, wet dressings and baths to promote vasoconstriction.
b.	Trim the fingernails short to prevent skin damage from scratching.
c.	Expose the areas to the sun to promote drying and healing of the lesions.
d.	Wear cotton gloves and cover all other affected areas with clothing to prevent environmental irritation.

ANS: A

Wet dressings and using Burows solution help promote the healing process. Cold compresses may be applied to decrease circulation to the area (vasoconstriction). Short nails prevent skin damage, but not pruritus.

28.What is the best instruction by the nurse regarding reducing the risk factors for melanoma?

a.	Avoid exposure to the sun and use protective measures when exposure occurs.
b.	Have all nevi removed.
c.	Watch for changes in moles, especially on the back.
d.	Use a sun lamp for tanning.

ANS: A

Encourage the patient to protect skin from the sun by wearing protective clothing, including a hat with 4-inch brim, applying sunscreen all over the body, and avoiding the midday sun from 10 am to 4 pm. Sun lamps are just as damaging as the sun.

29.Which patient instruction should the nurse include in the teaching plan relative to the management of systemic lupus erythematosus?

a.	Maintain a balance between rest and activity
b.	Increase activity to promote mobility
c.	Increase exposure to the sun to increase vitamin D absorption
d.	Increase sodium consumption

ANS: A

Balanced rest, activity, and diet will support medication management. Limited sunlight exposure is recommended to prevent photosensitivity. SLE often has kidney involvement, which would require reduction of sodium.

30.Which patient statement indicates that more teaching is needed regarding antibiotic therapy for the treatment of cellulitis?

a.	My skin is cleared up. I dont think I need the medication anymore.
b.	Cellulitis can come back at any time.
c.	If I had washed that scratch with soap and water, I probably would not have gotten cellulitis.
d.	Cellulitis is contagious.

ANS: A

The entire amount of antibiotic medication should be completed even if the symptoms have abated to ensure the eradication of the infectious agent.

31.What should a patient be assessed for upon the diagnosis of genital herpes?

a.	Hepatitis B
b.	Syphilis
c.	Human immunodeficiency virus (HIV).
d.	Cirrhosis

ANS: C

Persons with genital herpes should be assessed for HIV because the therapy for herpes is suppressive; persons with HIV are not candidates for suppressant therapy.

32.The school nurse recognizes the signs of scabies when a child presents with:

a.	small fluid filled blisters that sting when scratched.
b.	dry scaly patches in body creases that itch.
c.	wavy threadlike lines on the body and pruritus.
d.	cluster of papular lesions with pruritus.

ANS: C

Scabies is manifested by brown threadlike lines on the body, especially the hands, anus, and body folds. Pruritus is severe.

33.Melanocytes give rise to the pigment melanin, which is responsible for skin color. Where can the melanocytes be found?

a.	Dermis
b.	Superficial fascia
c.	Epidermis
d.	Loose connective tissue

ANS: C

A layer in the epidermis contains highly specialized cells called melanocytes.

MULTIPLE RESPONSE

34.Which of the following are major functions of the skin? (Select all that apply.)

a.	Excretion of wastes
b.	Protection
c.	Vitamin C synthesis
d.	Temperature regulation

e.	Prevention of dehydration

ANS: A, B, D, E

Functions of the skin include protection from the environment (pathogenic organisms, foreign substances, natural barrier against infection), temperature regulation, prevention of dehydration, excretion of waste products, and vitamin D synthesis.

35.During primary survey assessment of a burn patient, the nurse checks for which of the following as early signs of carbon monoxide poisoning? (Select all that apply.)

a.	Dizziness
b.	Urticaria
c.	Vomiting
d.	Headache
e.	Vertigo
f.	Unsteady gait

ANS: C, D, F

Early signs of carbon monoxide poisoning include headache, nausea, vomiting, and unsteady gait.

MULTIPLE CHOICE

1.A client is not able to successfully pass the whisper test. Which of the following would be indicated for this client?

1.	Head CT scan
2.	Audiometry
3.	MRI of the brain
4.	Electroencephalogram

ANS: 2

Failure to pass the whisper test would indicate the need for formal audiometry testing. The client would not need a head CT or MRI at this time. An electroencephalogram is not necessary.

2.A client is prescribed a medication that is ototoxic. The nurse realizes that this medication may cause:

1.	permanent or temporary vision loss.
2.	permanent or temporary hearing loss.
3.	nausea and vomiting.
4.	central nervous system (CNS) depression.

ANS: 2

Although many drugs cause nausea and vomiting and central nervous system (CNS) depression, ototoxic drugs cause hearing loss and the risks must be considered prior to suggesting these types of medications.

3.The nurse is trying to communicate with a hearing-impaired client. The best way to do this is to:

1.	write down all of the message.