Submission Details

Submission Date: 1/31/2014

Submission Time: 1:28 AM

Points Awarded: 101

Points Missed: 1

Number of Attempts Allowed: Unlimited

Not Scored: 0

Percentage: 99%

Maternity A

1.ID: 310993981

Which action should the nurse implement when preparing to measure the fundal height of a pregnant client?

- (selected) Have the client empty her bladder. Correct
- Request the client lie on her left side.
- Perform Leopold's maneuvers first.
- Give the client some cold juice to drink.

To accurately measure the fundal height, the bladder must be empty (A) to avoid elevation of the uterus. Fundal height is not measured with the client lying on her side (B). Leopold's maneuvers are performed to assess fetal position and the expected location of the point of maximal impulse (PMI) for fetal heart rate (C). Cold juice (D) does not affect the fundal height measurement, but may be given to arouse the fetus if the fetus appears to be sleeping during a non-stress test.

Awarded 1.0 points out of 1.0 possible points.

2.ID: 311028927

The nurse identifies crepitus when examining the chest of a newborn who was delivered vaginally. Which further assessment should the nurse perform?

Elicit a positive scarf sign on the affected side.

Observe for an asymmetrical Moro (startle) reflex. Correct

Watch for swelling of fingers on the affected side.

Note paralysis of affected extremity and muscles.

The most common neonatal birth trauma due to a vaginal delivery is fracture of the clavicle. Although an infant may be asymptomatic, a fractured clavicle should be suspected if an infant has limited use of the affected arm, malposition of the arm, an asymmetric Moro reflex (B), crepitus over the clavicle, focal swelling or tenderness, or cries when the arm is moved. Eliciting (A) (extending arm across the chest toward the opposite shoulder) is contraindicated if a fractured clavicle is present. (C and D) on the affected side require follow-up, but are not indicative of a fractured clavicle.

Awarded 1.0 points out of 1.0 possible points.

3.ID: 310955049

One hour after giving birth to an 8-pound infant, a client's lochia rubra has increased from small to large and her fundus is boggy despite massage. The client's pulse is 84 beats/minute and blood pressure is 156/96. The healthcare provider prescribes Methergine 0.2 mg IM × 1. What action should the nurse take immediately?

Give the medication as prescribed and monitor for efficacy.

Encourage the client to breastfeed rather than bottle feed.

Have the client empty her bladder and massage the fundus.

( ) Call the healthcare provider to question the prescription. Correct

Methergine is contraindicated for clients with elevated blood pressure, so the nurse should contact the healthcare provider and question the prescription (D). (A) compromises patient safety. While (B) releases endogenous oxytocin, and (C) promotes uterine contraction, questioning the administration of Methergine is a higher priority because it concerns medication safety.

Awarded 1.0 points out of 1.0 possible points.

4.ID: 311013689

The nurse is preparing to give an enema to a laboring client. Which client requires the most caution when carrying out this procedure?

A gravida 6, para 5 who is 38 years of age and in early labor.

A 37-week primigravida who presents at 100% effacement, 3 cm cervical dilatation, and a -1 station.

A gravida 2, para 1 who is at 1 cm cervical dilatation and a 0 station admitted for induction of labor

due to post dates.

A 40-week primigravida who is at 6 cm cervical dilatation and the presenting part is not engaged.

Correct

When the presenting part is ballottable (D), it is floating out of the pelvis. In such a situation, the cord can descend before the fetus causing a prolapsed cord, which is an emergency situation. (A, B, and C) do not present problems with administration of an enema.

Awarded 1.0 points out of 1.0 possible points.

5.ID: 310945203

In evaluating the respiratory effort of a one-hour-old infant using the Silverman-Anderson Index, the nurse determines the infant has synchronized chest and abdominal movement, just visible lower chest retractions, just visible xiphoid retractions, minimal and transient nasal flaring, and an expiratory grunt heard only on auscultation. What Silverman-Anderson score should the nurse assign to this infant? (Enter numeral value only.)

4 Correct

Awarded 1.0 out of 1.0 possible points.

6.ID: 310951930

A client at 32-weeks gestation comes to the prenatal clinic with complaints of pedal edema, dyspnea, fatigue, and a moist cough. Which question is most important for the nurse to ask this client?

- Which symptom did you experience first?
- Are you eating large amounts of salty foods?
- Have you visited a foreign country recently?
- Do you have a history of rheumatic fever? Correct

Clients with a history of rheumatic fever (D) may develop mitral valve prolapse, which increases the risk for cardiac decompensation due to the increased blood volume that occurs during pregnancy, so obtaining information about this client's health history is a priority. (A) is not important. Salty foods (B) sometimes cause edema, but this client is experiencing additional cardiac symptoms. (C) assesses for possible exposure to microorganisms, but these symptoms are more indicative of a cardiovascular etiology.

Awarded 1.0 points out of 1.0 possible points.

7.ID: 310974981

The nurse is assessing a client who is having a non-stress test (NST) at 41-weeks gestation. The nurse determines that the client is not having contractions, the fetal heart rate (FHR) baseline is 144 bpm, and no FHR accelerations are occurring. What action should the nurse take?

- Check the client for urinary bladder distention.

Notify the healthcare provider of the nonreactive results.

Have the mother stimulate the fetus to move.

Ask the client if she has felt any fetal movement. Correct

The client should be asked if she has felt the fetus move (D). An NST is used to determine fetal well-being, and is often implemented when postmaturity is suspected. A "reactive" NST occurs if the FHR accelerates 15 bpm for 15 seconds in response to the fetus' own movement, and is "nonreactive" if no FHR acceleration occurs in response to fetal movement. The client should empty her bladder before starting the test, but bladder distention does not impede fetal movement (A). The client should be quizzed about fetal movement before determining that the NST is nonreactive (B). If no movement has occurred in the last 20 to 30 minutes, it is likely that the fetus is sleeping--providing the mother with orange juice often wakes the infant, and then the NST should be conducted again.

Awarded 1.0 points out of 1.0 possible points.

8.ID: 310955099

A client in active labor is admitted with preeclampsia. Which assessment finding is most significant in planning this client's care?

Patellar reflex 4+. Correct

Blood pressure 158/80.

Four-hour urine output 240 ml.

Respiration 12/minute.

A 4+ reflex in a client with pregnancy-induced hypertension (A) indicates hyperreflexia, which is an indication of an impending seizure. Although (B) is significant, some individuals have preeclampsia superimposed on chronic hypertension, and an elevated blood pressure alone is not as significant a finding as (A). (C and D) are important, but these findings are within normal range.

Awarded 1.0 points out of 1.0 possible points.

9.ID: 311008995

The nurse assesses a client admitted to the labor and delivery unit and obtains the following data: dark red vaginal bleeding, uterus slightly tense between contractions, BP 110/68, FHR 110 beats/minute, cervix 1 cm dilated and uneffaced. Based on these assessment findings, what intervention should the nurse implement?

- Insert an internal fetal monitor.
- Assess for cervical changes q1h.
- Monitor bleeding from IV sites. Correct
- Perform Leopold's maneuvers.

Monitoring bleeding from peripheral sites (C) is the priority intervention. This client is presenting with signs of placental abruption. Disseminated intravascular coagulation (DIC) is a complication of placental abruptio, characterized by abnormal bleeding. Invasive vaginal procedures (A and B) or (D) can increase the abruption and bleeding, so these interventions are contraindicated.

Awarded 1.0 points out of 1.0 possible points.

10.ID: 310947644

A client at 32-weeks gestation is diagnosed with preeclampsia. Which assessment finding is most indicative of an impending convulsion?

- 3+ deep tendon reflexes and hyperclonus. Correct
- Periorbital edema, flashing lights, and aura.

Epigastric pain in the third trimester.

Recent decreased urinary output.

Three plus deep tendon reflexes and hyperclonus (A) are indicative of an impending convulsion and requires immediate attention. Epigastric pain (C) in the third trimester is indicative of HELLP Syndrome leading to impaired hepatic functioning. (B and D) are pathological changes that occur with preeclampsia.

Awarded 1.0 points out of 1.0 possible points.

11.ID: 311013637

Immediately after birth a newborn infant is suctioned, dried, and placed under a radiant warmer. The infant has spontaneous respirations and the nurse assesses an apical heart rate of 80 beats/minute and respirations of 20 breaths/minute. What action should the nurse perform next?

Initiate positive pressure ventilation. Correct

Intervene after the one minute Apgar is assessed.

Initiate CPR on the infant.

Assess the infant's blood glucose level.

The nurse should immediately begin positive pressure ventilation (A) because this infant's vital signs are not within the normal range, and oxygen deprivation leads to cardiac depression in infants. (The normal newborn pulse is 100 to 160 beats/minute and respirations are 40 to 60 breaths/minute.) Waiting until the infant is 1 minute old to intervene may worsen the infant's condition. According to neonatal resuscitation guidelines, CPR is not begun until the heart rate is 60 or below or between 60 and 80 and not increasing after 20 to 30 seconds of PPV. (D) can be checked after treating the respiratory rate.

Awarded 1.0 points out of 1.0 possible points.

12.ID: 311013687

A pregnant woman comes to the prenatal clinic for an initial visit. In reviewing her childbearing history, the client indicates that she has delivered premature twins, one full-term baby, and has had no abortions. Which GTPAL should the nurse document in this client's record?

- 3-1-2-0-3.
- 4-1-2-0-3.
- 2-1-2-1-2.
- 3-1-1-0-3. Correct

(D) describes the correct GTPAL. The client has been pregnant 3 times including the current pregnancy (G-3). She had one full-term infant (T-1). She also had a preterm (P-1) twin pregnancy (a multifetal gestation is considered one birth when calculating parity). There were no abortions (A-0), so this client has a total of 3 living children. (A, B, and C) are inaccurate.

Awarded 1.0 points out of 1.0 possible points.

13.ID: 310949422

The healthcare provider prescribes terbutaline (Brethine) for a client in preterm labor. Before initiating this prescription, it is most important for the nurse to assess the client for which condition?

- Gestational diabetes. Correct
- Elevated blood pressure.
- Urinary tract infection.

Swelling in lower extremities.

The nurse should evaluate the client for gestational diabetes (A) because terbutaline (Brethine) increases blood glucose levels. (B) could be related to the client being in preterm labor, however, terbutaline (Brethine) can cause a decrease in blood pressure. (C) can cause uterine irritability, which can result in preterm labor that should be treated by first resolving the infection rather than by administering a tocolytic agent such as terbutaline (Brethine). (D) is a common pregnancy complaint.

Awarded 1.0 points out of 1.0 possible points.

14.ID: 310945764

A 4-week-old premature infant has been receiving epoetin alfa (Epogen) for the last three weeks. Which assessment finding indicates to the nurse that the drug is effective?

Slowly increasing urinary output over the last week.

Respiratory rate changes from the 40s to the 60s.

Changes in apical heart rate from the 180s to the 140s. Correct

Change in indirect bilirubin from 12 mg/dl to 8 mg/dl.

Epogen, given to prevent or treat anemia, stimulates erythropoietin production, resulting in an increase in RBCs. Since the body has not had to compensate for anemia with an increased heart rate, changes in heart rate from high to normal (C) is one indicator that Epogen is effective. (A) is not related to Epogen administration. Respiratory rate should decrease rather than increase (B) with Epogen administration. (D) is usually related to resolution of hyperbilirubinemia, treated with phototherapy or increased oral intake in the infant.

Awarded 1.0 points out of 1.0 possible points.

15.ID: 310985673

The nurse is providing discharge teaching for a client who is 24 hours postpartum. The nurse explains to the client that her vaginal discharge will change from red to pink and then to white. The client asks, "What if I start having red bleeding after it changes?" What should the nurse instruct the client to do?

Reduce activity level and notify the healthcare provider. Correct

Go to bed and assume a knee-chest position.

Massage the uterus and go to the emergency room.

Do not worry as this is a normal occurrence.

Lochia should progress in stages from rubra (red) to serosa (pinkish) to alba (whitish), and not return to red. The return to rubra usually indicates subinvolution or infection. If such a sign occurs, the mother should notify the clinic/healthcare provider and reduce her activity to conserve energy (A). Going to bed, or resting might be helpful, but (B) is not indicated. (C) would be an over-reaction and the uterus might not be palpable at that time. This is not a normal occurrence (D).

Awarded 1.0 points out of 1.0 possible points.

16.ID: 310945726

A couple has been trying to conceive for nine months without success. Which information obtained from the clients is most likely to have an impact on the couple's ability to conceive a child?

Exercise regimen of both partners includes running four miles each morning.

History of having sexual intercourse 2 to 3 times per week.

The woman's menstrual period occurs every 35 days.

They use lubricants with each sexual encounter to decrease friction. Correct

The use of lubricants (D) has the potential to affect fertility because some lubricants interfere with sperm motility. While excessive heat can affect sperm production, bicycling, rather than running (A) is more likely to concentrate heat in the groin area. While having intercourse too frequently has been implicated

as a cause for decreased numbers of sperm, 2 to 3 times per week (B) is not considered excessive. (C) should not affect fertility.

Awarded 1.0 points out of 1.0 possible points.

17.ID: 310974967

A pregnant client tells the nurse that the first day of her last menstrual period was August 2, 2006. Based on Nägele's rule, what is the estimated date of delivery?

- April 25, 2007.
- May 9, 2007. Correct
- May 29, 2007.
- June 2, 2007.

Since this woman's first day of her last normal menstrual period occurred on August 2, 2006, the estimated date of delivery is May 9, 2007 (B). Nägele's rule is used to calculate the expected date of delivery, and is obtained by subtracting 3 months and adding 7 days beginning from the first day of the last normal menstrual period. (A, C, and D) are incorrect calculations.

Awarded 1.0 points out of 1.0 possible points.

18.ID: 310985611

A client with no prenatal care arrives at the labor unit screaming, "The baby is coming!" The nurse performs a vaginal examination that reveals the cervix is 3 centimeters dilated and 75% effaced. What additional information is most important for the nurse to obtain?

- Gravidity and parity.
- Time and amount of last oral intake.

Date of last normal menstrual period. Correct

Frequency and intensity of contractions.

Evaluating the gestation of the pregnancy (C) takes priority. If the fetus is preterm and the fetal heart pattern is reassuring, the healthcare provider may attempt to prolong the pregnancy and administer corticosteroids to mature the lungs of the fetus. (A, B, and D) are all important to evaluate and incorporate into the plan of care, but establishing gestation takes priority.

Awarded 1.0 points out of 1.0 possible points.

19.ID: 311008973

The nurse is preparing a client with a term pregnancy who is in active labor for an amniotomy. What equipment should the nurse have available at the client's bedside? (Select all that apply.)

- [ ] Litmus paper.
- [ ] Fetal scalp electrode.
- [x] A sterile glove. Correct
- [x] An amniotic hook. Correct
- [ ] Sterile vaginal speculum.
- [x] A Doppler. Correct

A single sterile glove (C), an amniotic hook (D), and Doppler (F) to check fetal heart tones are the necessary equipment for performing an amniotomy. Litmus paper (A) is used to assess for the presence of amniotic fluid. A fetal scalp probe (B) is used to assess fetal heart rates but is not indicated with the information provided. A sterile vaginal speculum (E) is used to visualize the cervix and is not indicated with the information provided.

Awarded 1.0 points out of 1.0 possible points.

20.ID: 311002969

The nurse should explain to a 30-year-old gravid client that alpha fetoprotein testing is recommended for which purpose?

- ○ Detect cardiovascular disorders.
- ◉ Screen for neural tube defects. Correct
- ○ Monitor the placental functioning.
- ○ Assess for maternal pre-eclampsia.

Alpha-fetoprotein (AFP) is a screening test used in pregnancy. Elevated AFP may indicate an increased rish of neural tube defects (B) such as anencephaly and spinal bifida. AFP does not apply in (A, C, or D).

Awarded 1.0 points out of 1.0 possible points.

21.ID: 310969495

A woman who gave birth 48 hours ago is bottle-feeding her infant. During assessment, the nurse determines that both breasts are swollen, warm, and tender upon palpation. What action should the nurse take?

- ◉ Apply cold compresses to both breasts for comfort. Correct
- ○ Instruct the client run warm water on her breasts.

Wear a loose-fitting bra to prevent nipple irritation.

Express small amounts of milk to relieve pressure.

The client is experiencing engorgement even though she is bottle-feeding her infant, and cold compresses (A) may help reduce discomfort. Lactation begins about the third day after delivery, so the mother should avoid any breast stimulation, such as (B or D), which further stimulates milk production. To aid in suppressing lactation, a well-fitting bra, not (C), should be worn to support and bind the breasts.

Awarded 1.0 points out of 1.0 possible points.

22.ID: 310946626

During labor, the nurse determines that a full-term client is demonstrating late decelerations. In which sequence should the nurse implement these nursing actions? (Arrange in order.)

Correct

Reposition the client.

Provide oxygen via face mask.

Increase IV fluid.

Call the healthcare provider.

To stabilize the fetus, intrauterine resuscitation is the first priority, and to enhance fetal blood supply, the laboring client should be repositioned (1) to displace the gravid uterus and improve fetal perfusion. Secondly, to optimize oxygenation of the circulatory blood volume, oxygen via face mask (2) should be applied to the mother. Next, the IV fluids should be increased (3) to expand the maternal circulating blood volume. Then, the primary healthcare provider should be notified (4) for additional interventions to resolve the fetal stress.

Awarded 1.0 points out of 1.0 possible points.

23.ID: 311008979

A vaginally delivered infant of an HIV positive mother is admitted to the newborn nursery. What intervention should the nurse perform first?

Bathe the infant with an antimicrobial soap. Correct

Measure the head and chest circumference.

Obtain the infant's footprints.

Administer vitamin K (AquaMEPHYTON).

To reduce direct contact with the human immuno-virus in blood and body fluids on the newborn's skin, a bath (A) with an antimicrobial soap should be administered first. (B, C, and D) should be implemented after the neonate's skin is cleansed of blood and body fluids.

Awarded 1.0 points out of 1.0 possible points.

24.ID: 310949408

At 14-weeks gestation, a client arrives at the Emergency Center complaining of a dull pain in the right lower quadrant of her abdomen. The nurse obtains a blood sample and initiates an IV. Thirty minutes after admission, the client reports feeling a sharp abdominal pain and a shoulder pain. Assessment findings include diaphoresis, a heart rate of 120 beats/minute, and a blood pressure of 86/48. Which action should the nurse implement next?

Check the hematocrit results.

Administer pain medication.

Increase the rate of IV fluids. Correct

Monitor client for contractions.

The client is demonstrating symptoms of blood loss, probably the result of an ectopic pregnancy, which occurs at approximately 14-weeks gestation when embryonic growth expands the fallopian tube causing its rupture, and can result in hemorrage and hypovolemic shock. Increasing the IV infusion rate (C) provides intravascular fluid to maintain blood pressure. (A, B, and D) can be implemented after fluid replacement is increased.

Awarded 1.0 points out of 1.0 possible points.

25.ID: 311008991

Client teaching is an important part of the maternity nurse's role. Which factor has the greatest influence on successful teaching of the gravid client?

- (•) The client's readiness to learn. Correct
- ( ) The client's educational background.
- ( ) The order in which the information is presented.
- ( ) The extent to which the pregnancy was planned.

When teaching any client, readiness to learn (A) is the most important criterion. For example, the client with severe morning sickness in the first trimester may not be "ready to learn" about labor and delivery, but is probably very "ready to learn" about ways to relieve morning sickness. (B and C) are factors that may influence learning, but they are not as influential as (A). Even if a pregnancy is planned and very desirable (D), the client must be ready to learn the content presented.

Awarded 1.0 points out of 1.0 possible points.

26.ID: 310949464

A 38-week primigravida who works as a secretary and sits at a computer 8 hours each day tells the nurse that her feet have begun to swell. Which instruction would be most effective in preventing pooling of blood in the lower extremities?

- ( ) Wear support stockings.
- ( ) Reduce salt in her diet.
- (•) Move about every hour. Correct

- [ ] Avoid constrictive clothing.

Pooling of blood in the lower extremities results from the enlarged uterus exerting pressure on the pelvic veins. Moving about every hour (C) will straighten out the pelvic veins and increase venous return. (A) increase venous return from varicose veins in the lower extremities, but are little help with swelling. (B) might be helpful with generalized edema (which could be an indication of PIH) but is not specific for edematous lower extremities. (D) does not specifically address venous return in this particular case.

Awarded 1.0 points out of 1.0 possible points.

27.ID: 310945766

During a prenatal visit, the nurse discusses with a client the effects of smoking on the fetus. When compared with nonsmokers, mothers who smoke during pregnancy tend to produce infants who have

- [ ] lower Apgar scores.
- [x] lower birth weights. Correct
- [ ] respiratory distress.
- [ ] a higher rate of congenital anomalies.

Smoking is associated with low-birth-weight infants (B). Mothers are encouraged not to smoke during pregnancy. To date, significant relationships have not been found between smoking and options (A, C, or D).

Awarded 1.0 points out of 1.0 possible points.

28.ID: 310944500

A woman who thinks she could be pregnant calls her neighbor, a nurse, to ask when she could use a home pregnancy test to diagnose pregnancy. Which response is best?

- [x] A home pregnancy test can be used right after your first missed period. Correct

These tests are most accurate after you have missed your second period.

Home pregnancy tests often give false positives and should not be trusted.

The test can provide accurate information when used right after ovulation.

Home urine tests are based on the chemical detection of human chorionic gonadotrophin, which begins to increase 6 to 8 days after conception, and is best detected at 2 weeks gestation or immediately after the first missed period (A). (B and D) provide inaccurate information. Although home tests are accurate, they have more false negatives than false positives (C), usually because they are used too early.

Awarded 1.0 points out of 1.0 possible points.

29.ID: 310969423

A 26-year-old, gravida 2, para 1 client is admitted to the hospital at 28-weeks gestation in preterm labor. She is given 3 doses of terbutaline sulfate (Brethine) 0.25 mg subcutaneously to stop her labor contractions. The nurse plans to monitor for which primary side effect of terbutaline sulfate?

Drowsiness and bradycardia.

Depressed reflexes and increased respirations.

Tachycardia and a feeling of nervousness. Correct

A flushed, warm feeling and a dry mouth.

Terbutaline sulfate (Brethine), a beta-sympathomimetic drug, stimulates beta-adrenergic receptors in the uterine muscle to stop contractions. The beta-adrenergic agonist properties of the drug may cause tachycardia, increased cardiac output, restlessness, headache, and a feeling of "nervousness" (C). Hypotension, hypertension, and/or drowsiness may occur, but tachycardia, not (A), is a primary side effect. (B and D) are side effects of magnesium sulfate.

Awarded 1.0 points out of 1.0 possible points.

30.ID: 311008955

A mother who is breastfeeding her baby receives instructions from the nurse. Which instruction is most effective to prevent nipple soreness?

- Wear a cotton bra.
- Increase nursing time gradually.
- Correctly place the infant on the breast. Correct
- Manually express a small amount of milk before nursing.

The most common cause of nipple soreness is incorrect positioning (C) of the infant on the breast, e.g., grasping too little of the areola or grasping only the nipple. (A) helps prevent chafing. (B) is important, but is not necessary for all women. (D) helps soften an engorged breast and encourages correct infant attachment, but is not the BEST answer.

Awarded 1.0 points out of 1.0 possible points.

31.ID: 310989315

A full term infant is transferred to the nursery from labor and delivery. Which information is most important for the nurse to receive when planning immediate care for the newborn?

- Length of labor and method of delivery. Incorrect
- Infant's condition at birth and treatment received. Correct
- Feeding method chosen by the parents.
- History of drugs given to the mother during labor.

Immediate care is most dependent on the infant's current status (i.e., Apgar scores at 1 and 5 minutes) and any treatment or resuscitation that was indicated. The transitional care nurse needs the information listed in the choices (A, C, and D), but the priority is (B).

Awarded 0.0 points out of 1.0 possible points.

32.ID: 310950750

In developing a teaching plan for expectant parents, the nurse plans to include information about when the parents can expect the infant's fontanels to close. The nurse bases the explanation on knowledge that for the normal newborn, the

- ○ anterior fontanel closes at 2 to 4 months and the posterior by the end of the first week.
- ○ anterior fontanel closes at 5 to 7 months and the posterior by the end of the second week.
- ○ anterior fontanel closes at 8 to 11 months and the posterior by the end of the first month.
- ● anterior fontanel closes at 12 to 18 months and the posterior by the end of the second month.

Correct

In the normal infant the anterior fontanel closes at 12 to 18 months of age and the posterior fontanel by the end of the second month (D). These growth and development milestones should be memorized to prepare for the NCLEX.

Awarded 1.0 points out of 1.0 possible points.

33.ID: 310959879

When assessing a client who is at 12-weeks gestation, the nurse recommends that she and her husband consider attending childbirth preparation classes. When is the best time for the couple to attend these classes?

- ○ At 16-weeks gestation.
- ○ At 20-weeks gestation.