1. The nurse is assigned to four clients who were diagnosed with gastric ulcers. Which client should be the nurse's priority when monitoring for GI bleeding?

A. The 40-year-old client who is positive for Helicobacter pylori (H. pylori)
B. The 45-year-old client who drinks 4 ounces of alcohol a day
C. The 70-year-old client who takes daily baby aspirin of8| mg
D. The 30-year-old pregnant client taking acetaminophen pm

ANSWER: C

A. The presence of H. pylori has not been proven to predispose to GI bleeding.
B. Although alcohol is associated with gastric mucosal injury, its causative role in bleeding is unclear.
C. It is most important for the nurse to monitor the 70-year-old client who is taking aspirin. The client has two risk factors for GI bleeding: age and taking aspirin.
D. Pregnancy and acetaminophen usage do not predispose to GI bleeding.

2. The nurse is assessing the client who is 24 hours post—GI hemorrhage. The findings include BUN of 40 mg/dL and serum creatinine of 0.8 mg/dL. Which action should be taken by the nurse?

A. Immediately call the health care provider to report these results.
B. Monitor urine output, as this may be a sign of kidney failure.
C. Document the findings and continue to monitor the client.
D. Encourage the client to limit his or her dietary protein intake.

ANSWER: C

A. No treatment is required; it is unnecessary to call the HCP.
B. If acute kidney failure is present, both the BUN and creatinine would be elevated.
C. The findings should be documented. The BUN can be elevated after a significant GI hemorrhage from the breakdown of blood proteins. The protein breakdown releases nitrogen that is then converted to urea.
D. Limiting protein intake in the presence of healthy kidneys is unnecessary.

3. The experienced nurse is instructing the new nurse. The experienced nurse explains that the definitive diagnosis of PUD involves which test?

A. A urea breath test
B. Upper GI endoscopy with biopsy
C. Barium contrast studies
D. The string test

ANSWER: B

A. A urea breath test only tests for the presence of Helicobacter pylori (H. pylori).
B. The gastric mucosa can be visualized with an endoscope. A biopsy is possible to differentiate PUD from gastric cancer and to obtain tissue specimens to identify H. pylori. These are used to make a definitive diagnosis of PUD.
C. Barium studies do not provide an opportunity for biopsy and H. pylori testing.
D. A urea breath test and a string test only test for the presence of H . pylori.

4. The client with a history of a duodenal ulcer is hospitalized with upper abdominal discomfort and projectile vomiting that has a foul odor. The nurse immediately notifies the HCP, concluding that the client may have developed which complication?

A. Gastric perforation
B. Gastrointestinal hemorrhage
C. Gastric outlet obstruction
D. Helicobacter pylori infection

ANSWER: C

A. Symptoms of perforation include severe abdominal pain; vomiting usually does not occur.
B. The client with GI hemorrhage would have bright red or coffee-ground-colored emesis.
C. Symptoms of gastric outlet obstruction include abdominal pain and projectile vomiting when the stomach fills enough to stimulate afferent nerve fibers relaying information to the vomiting center in the brain. The emesis may have a foul odor or contain food particles if the contents have been dormant in the stomach for a prolonged time period.
D. Infection with H. pylori is not a complication of PUD; rather, it is a major cause of peptic ulcers.

5. The nurse is completing the client's hospital admission history. Which statement should prompt the nurse to further question the client about symptoms associated with GERD?

A. "I have been experiencing headaches immediately after eating."
B. "Lately, I wake up at night with a burning feeling in my chest."
C. "I have been waking up at night sweating and wet all over."
D. "Immediately after eating I feel sleepy and want to go to bed."

ANSWER: B

A. Headaches are a symptom not related to GERD.
B. Heartburn, which is described as a burning, tight sensation in the lower sternum, is the most common symptom of GERD. It will often wake the client from sleep.
C. Night sweats are a symptom not related to GERD.

D. Postprandial sleepiness is a symptom not related to GERD.

6 . The nurse is preparing to care for the client diagnosed with hepatitis A. Which interventions should the nurse plan to include?

A. Teach the client to limit use of alcohol and drugs containing acetaminophen.
B. Provide a high-protein, high-carbohydrate diet with three large meals per day.
C. Wear gloves, mask, and gown when providing the client's personal cares.
D. Provide rest periods, alternating this with moderate activity during the day.

ANSWER: D

A. Clients with viral hepatitis should avoid all alcohol and all medications containing acetaminophen, not just limit their use.
B. Clients should eat small, frequent meals with a high-carbohydrate, moderate-fat, and moderate- protein content.
C. It is not necessary to wear a mask when caring for an individual with hepatitis A. A gown and gloves should be worn when in contact with blood and body fluids.
D. Rest is an essential intervention to decrease the liver's metabolic demands and increase its blood supply. Rest should be alternated with periods of activity to prevent complications and to restore health.

7. The home health nurse is perforating a follow-up visit for the client diagnosed with chronic hepatitis B. The client is being treated with interferon alpha-2b. Which client comment requires further assessment by the nurse?

A. "My clothes are tight; I gained 2 pounds this month."
B. "Whenever I just bump into anything, I get a bruise."
C. "I've been staying home and avoiding large crowds."
D. "I get tired easily, so I just take my time with things."

ANSWER: B

A. Anorexia is commonly seen with hepatitis B- A weight gain of 2 lb in one month would typically not be a cause for concern.
B. Bruising can indicate thrombocytopenia, which is an adverse effect of treatment. Thrombocytopenia can also occur from liver dysfunction.
C. Avoiding large crowds is appropriate; the client will be at increased risk for infection while taking interferon alpha-2b.
D. Fatigue is commonly associated with chronic hepatitis B.

8. The nurse is caring for the client to manage and decrease the sensation of nausea. Which nonpharma-cological intervention should the nurse recommend?

A. Sipping tea made from gingerroot
B. Changing positions more rapidly
C. Decreasing intake of solid food
D. Playing stimulating classical music

ANSWER: A

A. Ginger has demonstrated antiemetic properties as well as analgesic and sedative effects on GI motility.
B. Avoidance of sudden changes in position and decreasing activity are recommended to control nausea.
C. All food should be stopped when nausea is present to prevent stomach stretching and stimulation of the afferent nerve fibers.
D. A quiet, calm environment, rather than one that is stimulating, is recommended to decrease nausea.

9. The nurse is caring for the client who had a vertical banded gastroplasty. The nurse teaches that nausea can occur after this surgery from which situation?

A. The stomach pouch becomes overfilled.
B. The lower half of the stomach becomes spastic.
C. The duodenum incision becomes inflamed.
D. The dumping syndrome from a high-protein meal.

ANSWER: A

A. A small pouch (15—20 mL capacity) is constructed in the upper part of the stomach during vertical banded gastroplasty. Overfilling of this pouch stimulates afferent nerve fibers, which relay information to the chemoreceptor trigger zone in the brain, causing nausea.
B. The function of the lower half of the stomach is not affected with a vertical banded gastroplasty.
C. The duodenum is not incised during a vertical banded gastroplasty.
D. Dumping syndrome is more likely to occur from a meal high in simple carbohydrates, not protein.

10. The nurse is discharging the client after Billroth H surgery (gastrojejunostomy). To assist the client to control dumping syndrome, which information should the nurse include in the client's discharge instructions?

A. Drink plenty of fluids with all your meals.
B. Eat a high-carbohydrate, low-protein diet
C. Wait to eat at least 5 hours between meals.

D. Lie down for 20 to 30 minutes after meals.

ANSWER: D

A. Drinking fluids at mealtime increases the size of the food bolus that enters the stomach.
B. Carbohydrates are more rapidly digested than fats and proteins and would cause the food bolus to pass quickly into the intestine, increasing the likelihood that dumping syndrome would occur. Meals high in carbohydrates result in postprandial hypoglycemia, which is considered a variant of dumping syndrome.
C. Small, frequent meals are recommended to decrease dumping syndrome.
D. Lying down after meals slows the passage of the food bolus into the intestine and helps to control dumping syndrome.

11. After Billroth ii surgery (gastroJejunostomy), the client experiences weakness, diaphoresis, anxiety, and palpitations 2 hours after a high-carbohydrate meal. The nurse should interpret that these symptoms indicate the development of which problem?

A. Steatorrhea
B. Duodenal reflux
C. Hypervolemic fluid overload
D. Postprandial hypoglycemia

ANSWER: D

A. Although steatorrhea may occur after gastric resection, the symptoms of steatorrhea include fatty stools with a foul odor, not these symptoms.
B. The symptoms of duodenal reflux are abdominal pain and vomiting, not these symptoms. Duodenal reflux is not associated with food intake.
C. Symptoms of fluid overload would include increased BP, edema, and weight gain, not these symptoms.
D. When eating large amounts of carbohydrates at a meal, the rapid glucose absorption from the chime results in hyperglycemia. This elevated glucose stimulates insulin production, which then causes an abrupt lowering of the blood glucose level. Hypoglycemic symptoms of weakness, diaphoresis, anxiety, and palpitations occur.

12. The nurse is caring for the postoperative client who underwent an open Roux-cn-Y gastric bypass. The charge nurse should intervene if which observation is made?

A. The nursing care plan for postoperative day one indicates restricting fluids to 30—60 mL per hour of clear liquids.
B. The nurse is instructing the licensed practical nurse (LPN) to remove the client’s urinary catheter 24 hours after surgery.

C. The client is wearing a bilevel positive airway pressure (BiPAP) mask when sleeping during the day.
D. A bottle of saline and 60-mL catheter-tip syringe are on the bedside table for nasogastrie (NG) tube irrigation.

ANSWER: D

A. For the first 2448 hours postoperatively, the client sips small amounts of clear liquids to avoid nausea, vomiting, and distention and stress on the suture line.
B. If used, urinary catheters should be removed within 24 hours after surgery to prevent UTIs and to encourage mobility. The nurse may delegate this task to an LPN.
C. The BiPAP mask is used to keep the airway open and should be worn whenever the client is sleeping.
D. A bottle of saline and a large-sized syringe may indicate that the client's NG tube has been or will be irrigated. Manipulating or irrigating an NG tube with too much solution can lead to disruption of the anastomosis in gastric surgeries. If an NG tube is present the surgeon should be consulted before irrigating the tube.

13. The nurse is performing an initial postoperative assessment on the client following upper GI surgery. The client has an NG tube to low intermittent suction. To best assess the client for the presence of bowel sounds, which intervention should the nurse implement?

A. Start auscultating to the left of the umbilicus.
B. Turn off the NG suction before auscultation.
C. Use the bell of the stethoscope for auscultation.
D. Empty the drainage canister before auscultation.

ANSWER: B

A. When the client has hypoactive bowel sounds, which would be expected in a postsurgical client, the nurse should begin listening over the ileocecal valve in the right lower abdominal quadrant rather than to the left of the umbilicus. The ileocecal valve normally is a very active area.
B. When listening for bowel sounds on the client who has an NG tube to suction, the nurse should turn off the suction during auscultation to prevent mistaking the suction sound for bowel sounds.
C. The diaphragm of the stethoscope should be utilized for bowel sounds. The bell of the stethoscope should be utilized for abdominal vascular sounds, such as bruits.
D. There is no reason to empty the canister before auscultation.

14. The experienced nurse is teaching the new nurse about surgery to repair a hiatal hernia. The experienced nurse is most likely to state that the surgery is becoming more common to prevent which emergency complication?

A. Severe dysphagia
B. Esophageal edema
C. Hernia strangulation
D. Aspiration

ANSWER: C

A. Although dysphagia is a complication of hiatal hemia, it is not an emergency condition.
B. Esophageal edema is not a complication of hiatal hernia.
C. A hiatal hernia can become strangulated (Circulation of blood to the hernia is cut off by constriction). Strangulation can occur with any type of hernia.
D. Although aspiration is a complication of hiatal hernia, it is not an emergency condition.

15. While performing a home visit, the nurse observes that the client's head of the bed is raised on 6-in. blocks. The nurse should question the client for a history of which conditions? Select all that apply.

A. Hiatal hemia
B. Dumping syndrome
C. Crohn's disease
D. Gastroesophageal reflux disease
E. Gastritis

ANSWER: A, D

A. Clients with a hiatal hernia are encouraged to sleep with the HOB elevated on 4- to 6-in. blocks to reduce intraabdominal pressure and to foster esophageal emptying.
B. Dumping syndrome occurs after surgery when the stomach no longer has control over the amount of chime that enters the small intestine. Clients are encouraged to lie flat after a meal.
C. Crohn's disease is an inflammatory disease of the bowel. Positioning interventions do not decrease symptoms.
D. Clients with GERD are encouraged to sleep with the HOB elevated on 4— to 6-in. blocks to reduce intraabdominal pressure and to foster esophageal emptying.
E. Gastritis is inflammation of the gastric mucosa. Positioning interventions do not decrease symptoms.

16 . The nurse is caring for the client with a Zenker's diverticulum. Which problem should be the nurse's priority?

A. Pain related to heartburn from gastric reflux.
B. Aspiration related to regurgitation of food accumulated in the diverticula.
C. Constipation related to anatomical changes of the sigmoid colon.
D. Altered nutrition, less than body requirements related to dysphagia.

ANSWER: B

A. The client may have difficulty with heartburn, but this does not take priority over aspiration.
B. Zenker's diverticulum is an outpouching of the esophagus near the hypopharyngeal sphincter. Food can become trapped in the diverticula and cause aspiration.
C. Constipation is not a concern With Zenker's diverticulum.
D. The client may have weight loss, but this does not take priority over aspiration.

17. During a clinic visit the client provides all of the following health history information. Which client statement should be most concerning to the nurse because it could describe a symptom of esophageal cancer?

A. "I have been having a lot of indigestion lately."
B. "When I eat meat, it seems to get stuck halfway down."
C. "I have been waking up at night lately with chest pain."
D. "I gained weight, even though I have not changed my diet."

ANSWER: B

A. Indigestion is not a symptom of esophageal cancer
B. Progressive dysphagia is the most common symptom associated with esophageal cancer, and it is initially experienced when eating meat- It is often described as a feeling that food is not passing.
C. Chest pain is not a symptom of esophageal cancer.
D. Weight loss rather than gain is a symptom of esophageal cancer.

18. Following an esophagectomy with colon interposition (esophagoenterostomy) for esophageal cancer, the client is beginning to eat oral foods. The nurse monitors for aspiration because the client no longer has which structure?

A. A stomach
B. A pyloric sphincter
C. A pharynx
D. A lower esophageal sphincter

ANSWER: D

A. All or part of the stomach will remain intact following an esophagoenterostomy.
B. The pyloric sphincter will remain intact following an esophagoenterostomy.
C. The pharynx will remain intact following an esophagoenterostomy.
D. An esophagectomy for cancer involves removal of the lower esophageal sphincter, which normally functions to keep food from refluxing back into the esophagus. The absence of the lower esophageal sphincter places the client at risk for aspiration.

19. During a health promotion seminar for senior citizens, a participant asks the nurse to discuss symptoms of gastric cancer. Which statement should be the basis for the nurse's response?

A. Cancers that do not penetrate the gastric muscular layer are asymptomatic in the majority of clients.
B. Pain from early gastric cancer lesions cannot be reduced by over-the-counter (OTC) histamine receptor antagonists.
C. Unexplained weight gain and increased body mass index (BMI) are early symptoms of gastric cancer.
D. Anemia is uncommon in gastric cancer, but if it occurs, it is likely due to the effects of aging.

ANSWER: A

A. Eighty percent of clients with early gastric cancer do not have symptoms.
B. Pain caused by gastric cancer can be alleviated by OTC histamine receptor antagonists.
C. Weight loss and anemia are common symptoms, not weight gain and increased BMI.
D. Anemia occurs from malabsorption and nutritional deficiencies, not the effects of aging.

20. The client had Billroth II surgery 24 hours ago. The client's son approaches the nurse in the hallway and asks for information regarding his father's condition. The wife is listed as the designated contact person. Which nurse response is best?

A. "What has the surgeon told you about your father's condition?"
B. "Let's both go into your father's room and ask him how he feels."
C. "Let's go to a more private place to discuss your father's condition."
D. "Let's review your father's medical record information together."

ANSWER: B

A. Discussing client information in a hospital hall- way is inappropriate; individuals passing by could overhear confidential client information.

B. Going into the client's room together allows the client to determine if he wants to disclose information and how much information he wants to disclose.
C. Even if in a private location, the nurse should not share confidential client information with anyone unless the client has specifically given permission.
D. The nurse should not review the medical record of the client with a family member without permission. Some facilities require the client to complete a form requesting permission to review his or her own medical records.

21. The nurse is admitting the client with gastric cancer to an oncology unit for treatment. Which assessment finding should prompt the nurse to review the medical record to determine whether the cancer may have metastasized to the peritoneal cavity?

A. The client is reporting nausea.
B. Grey Turner's sign is present.
C. The client reports a rapid weight loss.
D. Ascites is evident in the abdomen.

ANSWER: D

A. Nausea is a sign of gastric outlet obstruction or impending hemorrhage.
B. Grey Turner's sign is a symptom of pancreatitis, not metastasis.
C. Weight loss is an initial sign associated with cancer.
D. The presence of ascites indicates seeding of the tumor in the peritoneal cavity.

22. The nurse is reviewing the health history of the client hospitalized with nonalcoholic fatty liver disease (NAFLD). Which finding should the nurse associate with this disease process?

A. 70 years old at diagnosis
B. Body mass index of35
C. History of recent antibiotic use
D. Living in a colder climate

ANSWER: B

A. Adults in their forties are most at risk for NAFLD, not someone 70 years of age.
B. The client's BMI is 35; a BMI of greater than 30 indicates obesity. The risk for developing NAFLD is directly related to body weight and is a major complication of obesity.
C. Antibiotic use has no influence on NAFLD development.
D. Climate has no influence on NAFLD development.

(1 238)23. **ANSWER: D**

A. Antibiotics and acid-reducing medications are expected with the treatment of PUD, but propranolol (Inderal) would not be expected. Although these medications may cue the nurse to further explore a history of PUD, this is not the most likely conclusion.
B. There is no indication that the client has abdominal pain, and there isn't an analgesic on the medication list.
C. There is no indication that the client has an infectious condition necessitating airborne precautions.
D. All medications listed are used to treat liver cirrhosis and its complications of portal hypertension and hepatic encephalopathy. The antibiotic rifaximin (Xifaxan) and the laxative lactulose (Cephulac) are used for treating hepatic encephalopathy. Thus, assessing the client's neurological status and measuring abdominal girth are most important.

(1 239)24. **ANSWER: B**

A. The client's temperature will not be affected.
B. Elevated serum ammonia levels may cause neurological changes, such as confusion.
C. The client's urine specific gravity will not be affected.
D. Oral fluid intake should be encouraged if tolerated by the client.

(1240)25. **ANSWER: A**

A. The nurse should prepare to monitor the client's blood sugar level. The client with cirrhosis may develop insulin resistance. Impaired glucose tolerance is common with cirrhosis, and about 20% to 40% of clients also have diabetes. Hypoglycemia may occur during fasting because of decreased hepatic glycogen reserves and decreased gluconeogenesis.
B. The client with cirrhosis would not be NPO but should receive a high-protein diet unless hepatic encephalopathy is present.
C. Antibiotics are not part of the treatment plan of cirrhosis because it is not caused by microorganisms.
D. The client with cirrhosis requires rest; thus, ambulation should not be encouraged every 4 hours.

(1241)26 . **ANSWER: D**, **B, C, A**

D. The client with Crohn's disease who received an initial dose of certolizumab (Cimzia) and is having generalized rashes should be attended to first. Generalized rash indicates an allergic reaction. This could develop into an anaphylactic reaction.

B. The client with a peptic ulcer who now has severe vomiting should be attended to second. Vomiting in PUD may indicate a complication such as mechanical obstruction from scarring.

C. The client who had a colonoscopy and is having diarrheal stools should be attended to third. Diarrhea may have been the indication for the client's colonoscopy or a side effect of the bowel prep.

A. The client with ascites who is having mild dyspnea with activity can be attended to last. The dyspnea is usually due to the enlarged abdomen.

27. The client with cirrhosis is scheduled for a transjugular intrahepatic portosystemic shunt (TIPS) placement. The nurse realizes the client does not understand the procedure when the client makes which statement?

A. "I hope the abdominal incision heals fast after this procedure so I can return home."
B. "My risk of bleeding from my esophagus again should be decreased after this procedure."
C. "The shunt they are placing could become occluded in the future; I hope it doesn't happen."
D. "This procedure should keep me from getting so much fluid buildup in my abdomen."

ANSWER: A

A. This statement indicates the client does not understand the procedure. There is no need for an abdominal incision. The TIPS is placed through the jugular vein and threaded down to the hepatic vein.
B. The TIPS procedure will decrease pressure in the portal vein and thus decrease the risk of bleeding from esophageal varices.
C. There is a risk that the stent that is placed will become occluded.
D. The shunt will decrease ascites formation.

28. The nurse is caring for the client diagnosed with cirrhosis. After completing discharge education, the nurse recognizes the need for further teaching when the client makes which statement?

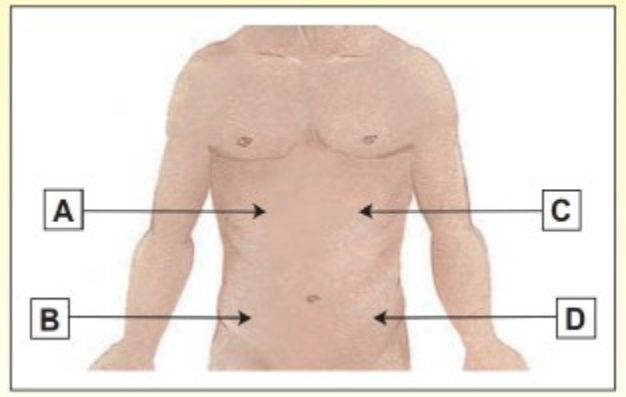
A. "My cirrhosis was caused from too much alcohol; I plan to stop drinking."
B. "I need to rest more; I plan on only going to work on a part-time basis."
C. "Propranolol has been ordered to decrease my blood pressure."
D. "Furosemide will help to reduce the amount of abdominal fluid."

ANSWER: C

A. Alcohol intake is a major cause of cirrhosis and must be eliminated from the client's diet.
B. Rest may enable the liver to restore itself and should be encouraged.
C. Although propranolol (Inderal) does decrease BP, it is not ordered for this purpose in treating cirrhosis. Prophylactic treatment with a nonselective beta blocker like propranolol has been shown to reduce the risk of bleeding from esophageal varices and to reduce bleeding-related deaths.

D. Furosemide (Lasix) is used in combination with potassium-sparing diuretics to decrease ascites.

29. The client preparing for a liver transplantation asks the nurse, "Where will my new liver be located?" Using an illustration, the nurse should identify which area as the location of the client's liver transplant?



A. A
B. B
C. C
D. D

ANSWER: A

A. The liver transplantation procedure involves total removal of the diseased liver and replacement with a healthy liver in the same anatomical location in the upper right quadrant of the abdomen (line A).
B. Line B is the lower right quadrant, which would be too low for liver placement.
C. Line C is the upper left quadrant, which would be on the wrong side of the body.
D. Line D is the lower left quadrant, which would be on the wrong side of the body and too low.

30. The client is admitted with upper right-side abdominal pain. The nurse is concerned that the client may have liver cancer when which serum laboratory test results are elevated?

A. Creatinine and BUN
B. α-fetoprotein (AFP)
C. Phosphorus levels
D. CA-125 levels

ANSWER: B

A. Elevated serum creatinine and BUN are associated with renal problems.

B. Serum a-fetoprotein is a major serum protein synthesized by fetal liver cells, by yolk track cells, and in small amounts by the fetal GI system. Reappearance of AFP in adults signals pathological problems. In 50% to 75% of clients with liver cancer, serum AF P levels are elevated.
C. Elevated serum phosphorus is associated with renal and many other diseases and is not specific to liver cancer.
D. CA-125 is a tumor marker for ovarian cancer.

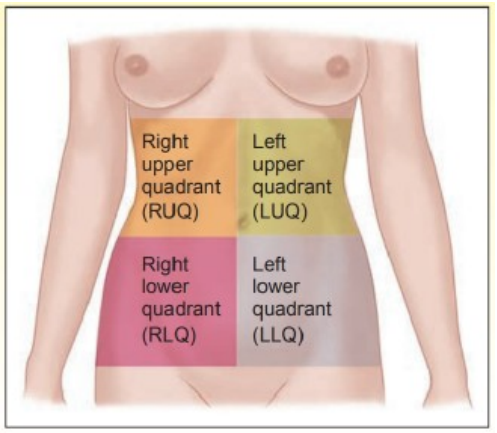
31. The client tells the nurse about being diagnosed with a 2-cm cancerous tumor in the liver. The client wants to know about the treatment. Which statement should be the basis for the nurse's response?

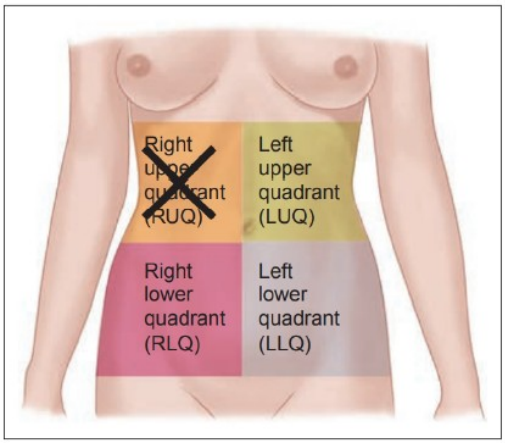
A. The use of chemotherapy is the first-line treatment for liver cancer.
B. Liver transplantation is not an option for clients with liver cancer.
C. Radiofrequency ablation can be successful in treating tumors of this size.
D. A tumor of this size can only be removed through an open surgical approach.

ANSWER: C

A. Chemotherapy is only used for clients who are not likely to benefit from other therapies.
B. Liver transplantation is used when the tumor is large or localized.
C. Radiofrequency ablation is a treatment technique that uses high—frequency alternating electrical current to heat tissue cells and destroy them. It can be successfully used to treat tumors less than 5 cm in size because these tumors tend to be slow growing and encapsulated.
D. Surgical resection of the tumor is used when the tumor is large or localized.

32. The client is scheduled for a percutaneous liver biopsy. Place an X in the quadrant where the nurse should tell the client that the needle will be inserted.





The right upper quadrant is the site used for a percutaneous liver biopsy. The liver is located under the right diaphragm and extends just below the right costal margin. The client will be asked to sustain exhalation during the biopsy to reduce the possibility ofa pneumothorax.

33. The RN is caring for the client following a liver biopsy with the assistance of the student nurse. The RN evaluates that the student understands the postprocedure care when making which observation of the student nurse?

A. Takes the client's vital signs every hour
B. Walks the client 1 hour postprocedure
C. Positions the client onto the right side
D. Has the client cough and deep-breathe hourly

ANSWER: C

A. After a liver biopsy VS should be assessed every 15 minutes times two, every 30 minutes times four, and then every hour times four to monitor for shock, peritonitis, and pneumothorax.
B. The client should be kept flat in bed for 12 to 14 hours following the procedure to prevent the risk of bleeding.
C. Positioning the client on the right side after a liver biopsy splints the puncture site to prevent and decrease bleeding.
D. The client should be cautioned to avoid coughing, which could precipitate bleeding.

34. The nurse is taking a hospital admission history for the 40-year—old client. The nurse is concerned about possible acute pancreatitis when the client makes which statement?

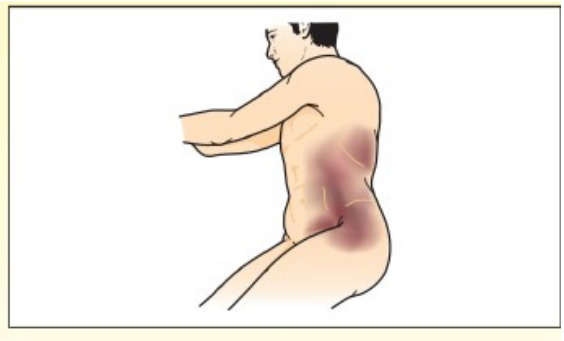
A. "I have sudden-onset intense pain in my upper left abdomen that goes to my back."
B. "I had persistent lower abdominal pain that now shifted to the lower right quadrant."

C. “My stools are loose and bloody, and I have cramping abdominal pain with spasms.”
D. “I have this mild pain in my upper abdomen, but I have been vomiting forcefully a lot.”

ANSWER: A

A. The predominant symptom of acute pancreatitis is severe, deep or piercing, continuous or steady abdominal pain in the upper left quadrant. The pain may radiate to the back because of the retroperitoneal location of the pancreas. Middle-aged individuals are at increased risk for developing acute pancreatitis.
B. Abdominal pain located mainly in the right lower quadrant may be a symptom of appendicitis (not pancreatitis). Appendicitis is more common in younger adults.
C. Bloody diarrhea and colicky abdominal pain are symptoms of IBD, also more common in young adults.
D. Upper abdominal pain and projectile vomiting are symptoms of gastric outlet obstruction or another GI disorder and not pancreatitis.

35. While performing an assessment of the client with acute pancreatitis, the nurse notes the skin appearance illustrated. What should be the nurse’s interpretation of this finding?



A. Portal hypertension has developed from the acute pancreatitis.
B. Seepage of blood-stained exudates from the pancreas has occurred.
C. Pancreatitis resulted in stomach bleeding, and the blood is now in the interstitial tissue.
D. Increased vascular pressure from pancreatic inflammation caused an intestinal obstruction.

ANSWER: B

A. Portal hypertension is related to cirrhosis, not pancreatitis.

B. The bluish flank discoloration (Grey Turner's Sign) indicates blood-stained exudates have seeped from the pancreas due to the severity of the disease process.
C. Pancreatitis will not cause stomach bleeding.
D. Pancreatitis will not cause intestinal obstruction.

36 . The nurse is caring for the newly admitted client with acute necrotizing pancreatitis. Which interventions, if prescribed, should the nurse implement? Select all that apply.

A. NS 1000 mL IV over 1 hour, then IV fluids at 250 mL/hour
B. Initiate nasojejunal enteral feedings with a low- fat formula
C. Imipenem-eilastatin 500 mg IV every 6 hours
D. Up to chair for meals and ambulate four times daily
E. Position left side-lying with head of bed elevated 30 degrees
F. Insert a urinary catheter; monitor urine output every 2 hours

ANSWER: A, B, C, F

A. Giving an IV bolus followed by fluids at 250 mL/hour should be implemented. A large amount of fluids is lost due to third spacing into the retroperitoneum and intraabdominal area. Fluids are needed to prevent hypovolemia and maintain hemodynamic stability.
B. Nasojejunal enteral feedings with a low-fat formula should be initiated to decrease the secretion of secretin, meet calorie needs, and maintain a positive nitrogen balance.
C. Antibiotics, usually medications of the imipenem class such as imipenem-cilastatin (Prirnaxin), are used when pancreatitis is complicated by infected pancreatic necrosis. They have greater potency and a broader antimicrobial spectrum than other betalactam antibiotics.
D. The client should be maintained on bedrest to decrease the metabolic rate and therefore reduce pancreatic secretions.
E. Discomfort frequently improves with the client in the supine position rather than side-lying.
F. A urinary catheter should be inserted to closely monitor urine output for circulating fluid volume status and to monitor for complications.

37. The client recovering from acute pancreatitis who has been NPO asks the nurse, "When can I start eating again?" Which response by the nurse is most accurate?

A. "As soon as you start to feel hungry you can begin eating."
B. "When I hear that your bowel sounds are active and you are passing flatus."
C. "When your pain is controlled and your serum lipase level has decreased."
D. "You will be NPO for at least more 2 weeks; oral intake stimulates the pancreas."

ANSWER: C

A. Regaining appetite is a positive sign, but it must be accompanied by a decrease in pain before the client is allowed to take food orally.
B. Intestinal peristalsis may be slowed due to inflammation associated with acute pancreatitis., but the return of bowel sounds and flatus is not used to determine when to begin oral intake.
C. This response is correct. Once pain is controlled and the serum enzyme levels begin to decrease, the client can begin oral intake. These are signs that the pancreas is healing.
D. There is no specific time limit for being NPO.

38. The 40-year-old client is recovering from an exacerbation of chronic pancreatitis. As the client prepares for discharge, the client makes several statements to the nurse. Which statement should be concerning because it could inhibit the client's ability to accomplish the developmental tasks of middle adulthood?

A. "I'm planning on continuing to be active in the local town service club."
B. "I enjoy my job; I should be able to return to work in about 3 to 4 weeks."
C. "I've missed friends and look forward to having a glass of wine with them."
D. "My spouse has been very supportive during my lengthy hospitalization."

ANSWER: C

A. Volunteer activities meet the developmental task of middle adulthood of generativity.
B. Planning to return to work meets the developmental task of middle adulthood of generativity.
C. Consuming alcohol will cause continued progression of the pancreatic disease and could eventually result in the inability to work or to participate in community service. This statement should be concerning to the nurse.
D. This statement indicates that the client has the support of another.

39. The client diagnosed with chronic pancreatitis is concerned about pain control. The nurse explains that the initial plan for chronic pancreatic pain control involves the administration of which of the following?

A. Opioid analgesics, such as morphine sulfate
B. Nonsteroidal anti-inflammatory drugs (NSAIDS)
C. Pancreatic enzymes with H2 blocker medications
D. Injection of medication directly into the nerves

ANSWER: C

A. Opioid analgesics may be prescribed if pancreatic enzymes do not relieve pain.

B. NSAIDS, such as ibuprofen, may be used to treat chronic pancreatic pain, but they are not the initial treatment and are usually not sufficient to control the pain.
C. The initial pain control measures include exogenous pancreatic enzymes because pancreatic stimulation by food is thought to cause pain. Pancreatic enzymes are coupled with H2 blockers, which block the action of histamine on parietal cells in the stomach . H2 blockers are used because gastric acid destroys the lipase needed to break down fats.
D. A nerve block relieves pain in about 50 percent of people who undergo the procedure, but this is not the initial measure for pain control.

40. The nurse is preparing to care for the client immediately after a Whipple procedure. The nurse should plan to include which action?

A. Monitor the blood glucose levels
B. Administer enteral feedings
C. Irrigate the NG tube with 30 mL of saline
D. Assist with bowel elimination within 8 hours of surgery

ANSWER: A

A. The Whipple procedure induces insulin-dependent diabetes because the proximal pancreas is resected. Thus, the blood glucose levels should be monitored closely starting immediately after surgery.
B. Parenteral (not enteral) feedings are the method of choice for providing nutrition immediately after surgery.
C. The NG tube is strategically placed during surgery and should not be irrigated without a surgeon's order. With an order, gentle irrigation with 10 to 20 mL of NS is appropriate.
D. Since this surgery reshapes the GI tract, the client will not have peristalsis and bowel movements for several days.

41. While reviewing the client's medical records, the nurse notes the diagnosis of biliary colic. Considering this diagnosis, which additional sign will the nurse most likely find in the client's medical record?

A. Bloody diarrhea
B. Heartbum and regurgitation
C. Abdominal distention
D. Severe abdominal pain

ANSWER: D

A. Diarrhea is not related to biliary colic.
B. Heartburn and regurgitation are not related to biliary colic.
C. Abdominal distention is not related to biliary colic.

D. Biliary colic is the term used for the severe pain that is caused by a gallstone lodged in the cystic or common bile duct and/or traveling through the ducts. The presence of the stone causes the duct to spasm, causing severe abdominal pain.

42. The nurse is caring for the client with acute cholecystitis. The nurse anticipates that conservative treatment will include which component?

A. Providing a low-texture bland diet
B. Giving anticholinergic medications
C. Positioning so the head of the bed is flat
D. Administering laxatives to clear the bowel

ANSWER: B

A. The client should be NPO rather than be given a bland diet to decrease gallbladder stimulation.
B. The nurse should anticipate giving anticholinergic medications to decrease secretions and counteract smooth muscle spasms.
C. The client should be positioned with the head of the bed elevated (not flat) to decrease the pressure of the abdominal contents on the diaphragm and to improve ventilation.
D. Laxatives would increase GI stimulation unnecessarily.

43. The nurse has been assigned to care for four clients. Which client should the nurse plan to assess first?

A. The 50-year-old client who has chronic pancreatitis and is reporting a pain level of 6 out of 10 on a numerical scale
B. The 47-year-old client with esophageal varices who has influenza and has been coughing for the last 30 minutes
C. The 60-year-old client who had an open cholecystectomy 15 hours ago and has been stable through the night
D. The 54-year-old client with cirrhosis and jaundice who is reporting having itching all over the body

ANSWER: B

A. The client with a pain rating of 6 out of 10 on a numerical scale needs attention, but the pain is not a life-threatening concern.
B. Bleeding esophageal varices are the most life-threatening complication of cirrhosis. Coughing can precipitate a bleeding episode. The nurse should assess this client first.
C. The client who is postcholecystectomy is reported as being stable and could be assessed last.
D. The client reporting itching needs attention, but the itching is not a life-threatening concern.

44. The nurse is caring for the client who is 6 hours post—open cholecystectomy. The client's T—tube drainage bag is empty, and the nurse notes slight jaundice of the sclera. Which action by the nurse is most important?

A. Reposition the client to promote T-tube drainage
B. Telephone the surgeon to report these findings
C. Ask a nursing assistant to obtain a blood pressure
D. Record the findings and continue to monitor the client

ANSWER: B

A. Repositioning the client might promote bile flow into the T—tube if the client were lying on the tube. However, the jaundice indicates that the problem is internal.
B. The T-tube is placed in the common bile duct to ensure patency of the duct. Lack of bile draining into the T—tube and jaundiced sclera are signs of an obstruction to the bile flow. This is most important to report to the surgeon.
C. The client's BP would not be affected by this situation.
D. Recording the findings and continuing to monitor the client are inappropriate because the client is experiencing signs of a complication.

45. The client has diarrhea that has been cultured positive for Clostridium difiicile (C. diif). In order to prevent the spread of infection, the nurse should perform which intervention?

A. Wear an isolation gown, gloves, and mask when providing care.
B. Perform vigorous hand hygiene using only soap and water.
C. Place the client in a private room with negative pressure airflow.
D. Instruct visitors to use the alcohol-based hand wash for self-protection.

ANSWER: B

A. The nurse does not need to wear a mask when caring for the client; the bacterium is transmitted through direct contact.
B. Hand washing with soap and water is per; formed instead of using alcohol—based hand cleaners; alcohol-based cleaners lack sporicidal activity. Even vigorous scrubbing with soap and water does not kill all of the spores.
C. The client should be in a private room but does not need a flow pressure room. flow pressure rooms are used with airborne diseases.
D. The spores of C. diff can survive on inanimate objects such as tables and bedrails. For selfprotection, visitors should be instructed to wash vigorously with soap and water and not to use the alcohol-based hand wash.

46 . The client of Chinese ethnicity has diarrhea and refuses to drink the prescribed oral hydration solution, insisting on having chicken broth instead. Which statement about clients of Chinese ethnicity should be the basis for the nurse's intervention in this situation?

A. They consider chicken a food with yang qualities.
B. They believe extra protein is needed to treat diarrhea.
C. They believe high-sodium foods are needed to treat diarrhea.
D. They mistrust modern medicine and eat broth to treat disease.

ANSWER: A

A. Loose stools are a yin symptom, which should be treated with foods that have yang qualities, one of which is chicken.
B. There is no belief in the Chinese culture related to consuming high-protein foods.
C. There is no belief in the Chinese culture related to consuming high-sodium foods.
D. The Chinese do not mistrust modern medicine but may combine Western medicine and Chinese herbal medicines to treat disease.

47. The nurse is taking a hospital admission history of the client- The nurse considers that the cheat may have IBS when the client makes which statement?

A. "I am having a lot of bloody diarrhea."
B. "I have been vomiting for 2 days."
C. "I have lost 10 pounds in the last month."
D. "I have noticed mucus in my stools."

ANSWER: D

A. Clients with IBS may have diarrhea, but it is not bloody.
B. Vomiting is not a symptom of IBS.
C. Clients with IBS do not have unintentional weight loss.
D. Mucus in the stools is a sign of IBS.

48. The nurse is preparing to administer amitriptyline 10 mg orally to the client diagnosed with IBS. The client asks, "Why am I receiving this? I don't feel depressed." Which response by the nurse is best?

A. "The medication is working. People with chronic diseases typically also suffer from depression."
B. "People with IBS have difficulty returning to sleep after walking to the bathroom. It will help you get adequate rest."
C. "The anticholinergic side effects of the drug will help to prevent bowel irritability and constipation."
D. "Tricyclic antidepressants reduce abdominal pain by affecting the communication system from the bowel to the brain."

ANSWER: D

A. Not all clients with chronic diseases suffer from depression. The response does not address the primary reason for the use of a TCA such as amitriptyline (Elavil) in IBS.
B. A common response to TCAs is sedation; how- ever, this medication is not given for this reason.
C. TCAs do have anticholinergic side effects and can cause (not prevent) constipation. Clients with IBS can have constipation or diarrhea.
D. Evidence supports that TCAs can reduce abdominal pain, and this benefit is unrelated to whether or not the client is being treated for depression.

49. The HCP writes the following admission orders for the client with possible appendicitis. Which order should the nurse question?

A. Place on NPO (nothing per mouth) status.
B. No analgesics until diagnosis is confirmed.
C. Apply heat to abdomen to decrease pain.
D. Start IV lactated Ringer's at 125 ml / hr.

ANSWER: C

A. Clients are kept NPO in case surgery is needed.
B. Analgesic medications are usually withheld untila definitive diagnosis is established to avoid masking critical symptom changes.
C. The nurse should question applying heat to the abdomen when appendicitis is suspected. Heat is contraindicated because it increases circulation, which, in turn, could cause the appendix to rupture.
D. Isotonic IV fluids are initiated to replace lost body fluid and prevent dehydration.

50. The nurse is reviewing the history and physical of a teenager admitted to a hospital with a diagnosis of ulcerative colitis. Based on this diagnosis, which information should the nurse expect to see on this client's medical record?

A. Heartburn and regurgitation
B. Abdominal pain and bloody diarrhea
C. Weight gain and elevated blood glucose
D. Abdominal distention and hypoactive bowel sounds

ANSWER: B

A. Heartburn and regurgitation are not symptoms of ulcerative colitis.
B. The nurse should expect to read about the primary symptoms of ulcerative colitis, which are bloody diarrhea and abdominal pain.
C. Weight loss, not weight gain, often occurs in severe cases of ulcerative colitis.

D. Bowel sounds are often hyperactive rather than hypoactive in ulcerative colitis.

51. The 25-year-old client, hospitalized with an exacerbation of distal ulcerative colitis, is prescribed mesalamine rectally via enema. The client states that an enema is disgusting and wants to know why the medication cannot be given orally. Which is the best response by the nurse?

A. "It can be given orally; I'll contact the doctor and see if the change can be made."
B. "Rectal administration delivers the mesalamine directly to the affected area."
C. "Oral administration is not possible for treating your ulcerative colitis exacerbation."
D. "It can be given orally; I'll make the change, and we'll tell the doctor in the morning."

ANSWER: B

A. If the client still desires a change in medication route after the rationale for rectal administration is explained, the HCP should be consulted.
B. This is the nurse's best response because it explains the purpose for administration via enema. This route delivers mesalamine (Asacol) directly to the affected area, thus maximizing effectiveness and minimizing side effects.
C. Oral administration is possible, but rectal administration is preferred in distal colitis.
D. Nurses cannot order medications or change medication routes without specific approval by the HCP, who is licensed to prescribe medications.

52. The client is 6 days post—total proctocolectomy with ileostomy creation for ulcerative colitis. The client's ileostomy is draining large amounts of liquid stool, and the client has dizziness with ambulation. Which parameters should the nurse assess immediately? Select all that apply.

A. Pulse rate for the last 24 hours
B. Urine output for the last 24 hours
C. Weight over the last 3 days
D. Ability to move the lower extremities
E. Temperature readings for the last 24 hours

ANSWER: A, B, C, E

A. The nurse should assess for increasing pulse rate over time because it is a sign of dehydration; large amounts of ileostomy output can result in dehydration, and the dizziness with ambulation could be from dehydration.
B. The nurse should assess for decreasing urine output because it is a sign of dehydration; large amounts of ileostomy output can result in dehydration, and the dizziness with ambulation could be from dehydration.

C. The nurse should assess for decreasing weight because it is a sign of dehydration; large amounts of ileostomy output can result in dehydration, and the dizziness with ambulation could be from dehydration.
D. The ability to move the lower extremities is not related to dehydration.
E. The nurse should assess the temperature readings because a low-grade temperature is a sign of dehydration; large amounts of ileostomy output can result in dehydration, and the dizziness with ambulation could be from dehydration.

53. The RN overhears the LPN talking with the client who is being prepared for a total colectomy with the creation of an ileoanal reservoir for ulcerative colitis. Which statement made by the LPN should the RN clarify to decrease the client's anxiety?

A. "This surgery will prevent you from developing colon cancer."
B. "After this surgery you will no longer have ulcerative colitis."
C. "After surgery you may not have solid food for several days."
D. "You'll have a permanent ileostomy after having this surgery."

ANSWER: D

A. The client will not be at risk for colon cancer because with a total colectomy the entire colon is removed.
B. Since this surgery removes the total colon, the ulcerative colitis will be cured.
C. The client will be unable to eat until peristalsis returns, and then it may take several days before solid foods are tolerated.
D. The client will initially have an ileostomy; after the reservoir has healed, the ileostomy will be closed. Knowing that the ileostomy will be temporary is important information for the client to decrease anxiety.

54. The client with Crohn's disease has undergone a barium enema that showed strictures in the ileum. Based on this finding, the nurse should monitor the client closely for signs of which complication?

A. Peritonitis
B. Obstruction
C. Malabsorption
D. Fluid imbalance

ANSWER: B

A. Peritonitis would not be an expected consequence of a bowel stricture.
B. The nurse should monitor for signs of a bowel obstruction. Bowel strictures are a common complication of Crohn's disease and can result in an acute bowel obstruction.
C. Malabsorption would not be an expected consequence of a bowel stricture.
D. Fluid balance would be affected once total obstruction develops.

55. The nurse completes discharge teaching for the client after a small bowel resection for Crohn's disease. The nurse detemiines that more education is needed when overbearing which statement made by the client to the client's spouse?

A. "I'm so glad I'll never need surgery again for Crohn's disease."
B. "I'll need to get a new scale so I can continue to monitor my weight."
C. "I'll likely need to be on hydrocortisone if an exacerbation occurs."
D. "I will probably have to take vitamin supplements all of my life."

ANSWER: A

A. The nurse should determine that the client needs additional education with this statement. Crohn's disease can occur throughout the GI tract. Surgery in one area of the GI tract will not prevent the disease from recurring in another area. This recurrence can result in the need for further surgery.
B. Clients with Crohn's disease will always need to monitor their weight.
C. Most likely, the client will need some type of glucocorticoid medication such as hydrocortisone to treat a future exacerbation.
D. Clients will need vitamins to maintain adequate nutrient levels, since inflamed areas of the GI tract do not absorb nutrients well.

56 . The 20-year—old female is being admitted to the hospital with exacerbation of Crohn's disease. The client is alert and oriented and has been taking azathioprine for disease control. Into which room should the charge nurse place the client?

A. Private room across from the nurse's station
B. Room with a female who has Crohn's disease
C. Private room that has a private attached bathroom
D. Room with an elderly female who is on bedrest

ANSWER: C

A. The client is alert and oriented; there is no need to be near the nurse's station.
B. The client is at an increased risk for infection and should have a private room rather rooming with another female with Crohn's disease.
C. The client should be in a private room with a private bathroom due to an increased risk for infection with azathioprine (Imuran). Azathioprine suppresses cell-mediated immune responses and may cause bone marrow suppression. It is also a biohazard medication.
D. The client is at an increased risk for infection and should have a private room rather rooming with another female.

57. The client is prescribed infliximab 5 mg/kg every 8 weeks for treatment of Crohn's disease. The client weighs 116 lb. How many milligrams (mg) should the nurse administer?

_____ mg (Record your answer rounded to a whole number.)

ANSWER: 264

First, the client's weight should be converted to kg. Formula:
Weight in lb ÷ 2.2 kg = kg wt. 116 ÷ 2.2 = 52.7
Next, multiply the weight in kg by 5; 52.7 × 5 = 263.6 or 264
The nurse should administer 264 mg infliximab (Remicade).

58. The nurse is completing a home visit with the client who had a partial resection of the ileum for Crohn's disease 4 weeks previously. The nurse should collect additional information when the client makes which statement?

A. "My stools float and seem to have fat in them."
B. "I have gained 5 pounds since I left the hospital."
C. "I am still avoiding milk and milk products."
D. "I am having only two formed stools per day."

ANSWER: A

A. The nurse should collect additional information when the client states having stools that float and have fat in them. Bile salts are absorbed in the terminal ileum. Disease in this area or resection of the ileum can result in poor fat absorption and loss of fat in the stool. The presence of bile salts leads to diarrhea.
B. Weight gain is a positive sign after small bowel resection for Crohn's disease.
C. Many clients with Crohn's disease develop lactose intolerance and therefore should avoid milk products.
D. Formed stools are a positive sign after small bowel resection for Crohn's disease.

59. The nurse is admitting the client for a colonoscopy. Which information, if found in the client's medical record, should the nurse consider as the primary reason for this client's colonoscopy?

A. Chronic constipation
B. Urostomy placed 3 years ago

C. History of colon polyps
D. Hemoglobin 10 g/dL

ANSWER: C

A. Although a colonoscopy may be performed to evaluate chronic constipation, this is less likely than evaluation of colon polyps.
B. A urostomy is used for urinary diversion following bladder cancer; it does not affect the colon.
C. Colonoscopy is used in screening and diagnosing colon cancer and for surveillance in persons with prior history of colon cancer or polyps. This is likely the primary reason for a colonoscopy with this client.
D. An Hgb of 10 g/dL is slightly low. This could be a reason for a colonoscopy, especially if there is a pattern of low Hgb levels and the stool guaiac test is positive. However, this is less likely the primary reason than evaluation of colon polyps.

60. The nurse assesses the client previously diagnosed as having an inguinal hernia. The nurse considers that the client's hernia may be strangulated when which assessment findings are noted? Select all that apply.

A. Abdominal distention
B. Dyspnea with exertion
C. Severe abdominal pain
D. No stool for the past week
E. Hyperactive bowel sounds

ANSWER: A, C, D

A. Abdominal distention occurs because the bowel is obstructed when the hernia is strangulated.
B. Dyspnea with exertion is not associated with strangulation of an inguinal hernia.
C. Lack of blood supply from strangulation causes severe abdominal pain.
D. A bowel obstruction prevents the passage of stool.
E. Bowel sounds with strangulation and bowel obstruction would be hypoactive or absent, not hyperactive.

61. The nurse is reviewing the health history of the client receiving treatment for hemorrhoids. Which information, related to the development of hemorrhoids, should the nurse expect to find in the client's medical history? Select all that apply.

A. Body mass index of 18
B. Chronic constipation
C. Nulliparous female
D. Works as a salesperson

E. Taking iron supplements

ANSWER: B. E

A. Clients who are thin (BMI = 18) would have a decreased risk of hemorrhoid development. Obesity is a risk factor for hemorrhoid development.
B. Prolonged constipation is a risk factor for development of hemorrhoids.
C. Since pregnancy is a common cause of constipation, nulliparous women would have a decreased risk of hemorrhoid development.
D. Sedentary rather than active occupations have an increased risk of hemorrhoid development.
E. Iron supplements can lead to constipation and straining, which can precipitate hemorrhoid development.

62. The client is being admitted to a postsurgical unit following anorectal surgery. The nurse reviews the following postoperative orders from the surgeon. Which order should the nurse question?

A. Give morphine sulfate per IV bolus before the first defecation.
B. Have the client take a site bath after each defecation.
C. Begin high-fiber diet as soon as client can tolerate oral intake.
D. Position supine with the head of the bed elevated to 30 degrees.

ANSWER: D

A. Pain medication is recommended before the first defecation to avoid straining.
B. A sitz bath is encouraged for rectal cleansing after defecation.
C. A high-fiber diet prevents constipation.
D. After anorectal surgery, the client should be positioned in a side-lying (not supine) position to decrease rectal edema and client discomfort.

63. The nurse is caring for the client with diverticulitis. The nurse should plan to instruct the client to avoid which food during an episode of diverticulitis?

A. White bread
B. Ripe banana
C. Cooked oatmeal
D. Iceberg lettuce

ANSWER: C

A. White bread is a recommended food for fiber- restricted diets. It contains less than 1 g fiber per ounce.
B. Ripe bananas, canned soft fruits, and most well-cooked vegetables without seeds or skins are recommended for fiber-restricted diets.

C. Cooked oatmeal contains 4 g of fiber per serving. Foods high in fiber should be avoided during an episode of diverticulitis, and foods should be restricted to low fiber or clear liquids. Once diverticulitis is resolved, the client should return to a high—fiber diet.
D. Iceberg lettuce contains less than 1 g of fiber.

64. The client is admitted to a hospital for medical management of acute diverticulitis. The nurse should anticipate that this client's treatment plan will include which component? Select all that apply.

A. NPO (nothing per month) status
B. Frequent ambulation
C. Prescribed antibiotics
D. Antiemetic medication
E. Deep breathing every 2 hours

ANSWER: A. C

A. The nurse should plan for the client to be NPO. Medical management for diverticulitis includes resting the bowel. NPO status will help to achieve this.
B. Ambulation is not encouraged; resting the body promotes bowel rest.
C. Broad-spectrum antibiotics effective against known enteric pathogens are used in treating every stage of diverticulitis.
D. Nausea is not a concern with diverticulitis.
E. The client did not have surgery; there is no need for deep breathing every 2 hours.

65. The nurse is caring for the client with acute diverticulitis. Which finding should most prompt the nurse to consider that the client has developed an intestinal perforation?

A. White blood cells (W BCs) elevated
B. Temperature of 101°F (383°C)
C. Bowel sounds are absent
D. Reports intense abdominal pain

ANSWER: C

A. Elevated WBCs are a symptom of acute diverticulitis.
B. Increased temperature is a symptom of acute diverticulitis.
C. Clients with intestinal perforation develop paralytic ileus. Bowel sounds would be absent.
D. Abdominal pain is a symptom of acute diverticulitis that may worsen with intestinal perforation, but the most significant finding would be absent bowel sounds.

66 . After examining the client's laboratory results, the nurse thinks that the client's colon cancer may have metastasized to the liver. Which laboratory findings lead the nurse to this conclusion?

Serum Lab Test	Client Value	Normal Values
BUN	30	5–25 mg
Creatinine	2.0	0.5–1.5 mg/dL
Na	133	135–145 mEq/L
K	4.5	3.5–5.3 mEq/L
Cl	92	95–105 mEq/L
CO_2	23	22–30 mEq/L
Hgb/Hct	10/32%	13.5–17g/dL, 40%–54%
WBC	12,000	4500–10,000/mm^3
Neutrophils	85%	50%–70%
Albumin	2.5	3.5–5.0 g/dL
Alkaline phosphatase (ALP)	500	42–136 unit/L
AST	76	8–38 unit/L
Calcium	3.0	4.5–5.5 mEq/L
Phosphorus	3.5	1.7–2.6 mg/dL

A. AST and ALP
B. BUN and creatinine
C. Albumin and calcium
D. WBCs and neutrophils

ANSWER: A

A. ALP is an enzyme produced in the bone and liver, and AST is an enzyme produced in the heart and liver. Both are elevated when liver cancer is present.
B. Elevated BUN and Cr could indicate kidney involvement.
C. Decreased albumin and calcium could be related to the kidney or to poor nutrition.
D. Elevated WBCs and neutrophils would indicate an acute inflammatory/infectious process.

67. The nurse is caring for the client who has a temporary colostomy following surgery for colon cancer. The nurse assesses that the client's colostomy bag is empty and that there has been no stool since surgery 24 hours ago. What should the nurse do?

A. Call the surgeon immediately.
B. Place the client left side-lying.
C. Document these findings.
D. Give a laxative medication.

ANSWER: C

A. The absence of stool is an expected finding; there is no need to call the surgeon.
B. A left side-lying position will not produce stool if peristalsis has not yet returned.
C. The nurse should document the findings; the absence of stool is expected 24 hours postsurgery.
D. A laxative is unnecessary.

68. At a follow-up clinic visit, the client who had a sigmoid colectomy for colon cancer is instructed to take 325 mg of aspirin per day. The nurse explains to the client that the aspirin will have which effect?

A. Help decrease the surgical pain
B. Help heal the surgical incision
C. Prevent the return of colon cancer
D. Prevent metastasis of the cancer

ANSWER: C

A. Although aspirin may relieve some pain, it has a low analgesic effect to relieve postoperative pain.
B. Aspirin will not promote healing.
C. Aspirin (Ecotrin) 325 mg taken daily has been shown to decrease the risk of recurrence of colon cancer.
D. Aspirin will not prevent metastasis of the cancer.

69. The client is scheduled for an abdominal-perineal resection for cancer of the rectum. Which components should the nurse include in the client's preoperative education? Select all that apply.

A. The enterostomal nurse will be visiting the client prior to surgery.
B. After surgery rectal suppositories will be given to prevent straining and stress.
C. The bowel will be cleansed before surgery with a laxative, enema, or whole-gut lavage.
D. Oral or intravenous (IV) antibiotics will be prescribed to be given preoperatively.

E. A member of the surgical team will discuss the risk of postoperative sexual dysfunction.

ANSWER: A, C, D, E

A. An abdominal-perineal resection removes the sigmoid colon, rectum, and anus. As a result the client will have a permanent colostomy. The enterustumal nurse will identify and mark an appropriate stoma location after considering the client's skinfolds, clothing preferences, and the level of the colostomy.
B. After an abdominal-perineal resection the client needs to avoid rectal temperatures, suppositories, or other rectal procedures. These interventions may damage the anal suture line, cause bleeding, or impair healing.
C. The bowel is cleansed preoperatively to reduce the risk of peritoneal contamination by bowel contents during surgery.
D. Antibiotics are prescribed to be given preoperatively to reduce the risk of peritoneal con- tamination by bowel contents during surgery.
E. Postoperatively the client with an abdominal- perineal resection is at risk for sexual dysfunction and urinary incontinence as a result of nerve damage. This needs to be discussed with the client prior to surgery by the surgeon or a member of the surgical team.

70. The nurse is caring for the surgical client during the first 24 hours after an abdominal-perineal resection. Which action should be priority?

A. Provide a diet that is low in residue
B. Check the colostomy bag for stool amount
C. Assess the perineal dressing for drainage
D. Encourage the client to see the colostomy site

ANSWER: C

A. After bowel surgery, a temporary ileus is expected; thus, the client would be NPO (nothing per month) initially.
B. There would not be stool coming from the colostomy until bowel peristalsis returns.
C. The perineal incision must be examined frequently to assess for drainage and the need for dressing changes.
D. The client's physiological needs in the early postoperative period take precedence over the integration of the body image change into the client's self—concept.

71. During a home visit, the client's spouse reports that since her husband's placement of a colostomy 3 months ago, he has lost interest in golf. She also says he cries often for no reason, sleeps for only a few hours at night, and reports fatigue. The wife asks the nurse for advice. Which statement should be the basis for the nurse's response?

A. One in four clients develops depression after ostomy surgery.
B. Athletic activities like golf are not possible after ostomy surgery.
C. After 3 months the client should have accepted his new body image.
D. The smell and location make it difficult to sleep well with an ostomy.

ANSWER: A

A. The client is exhibiting signs of depression. At least 25% of clients develop clinically significant depression following colostomy. Poor adjustment to a stoma correlates to development. of depression.
B. Only sports where direct trauma to the stoma is likely should be avoided; golf is acceptable.
C. The adjustment period for ostomy clients is unique for each individual.
D. Altered sleep is associated more with depression than with the ostomy placement. Smell can be controlled by emptying prior to retiring.

72. The client with a newly created colostomy is concerned about having satisfying sexual relations. What should the nurse recommend?

A. Participate in sexual activity only in a darkened room.
B. Utilize self-gratification for the majority of sexual needs.
C. Empty and clean the ostomy bag just before sexual activity.
D. Utilize only the female superior position for sexual activity.

ANSWER: C

A. Participating in sexual activity only in a darkened room may be a way of coping with body image concerns, but it is not necessary.
B. Self-gratification, if it involves emotional distancing, can be destructive to the client's sexual relationship.
C. Emptying the pouch before sexual activity is recommended to decrease the concern of pouch breakage or leakage; cleaning it will reduce odor.
D. Various positions should be explored during sexual activity with the goal of minimizing stress and pressure on the pouch.

73. The nurse is preparing to admit the hospitalized client diagnosed with peritonitis. Which collaborative interventions should the nurse anticipate? Select all that apply.

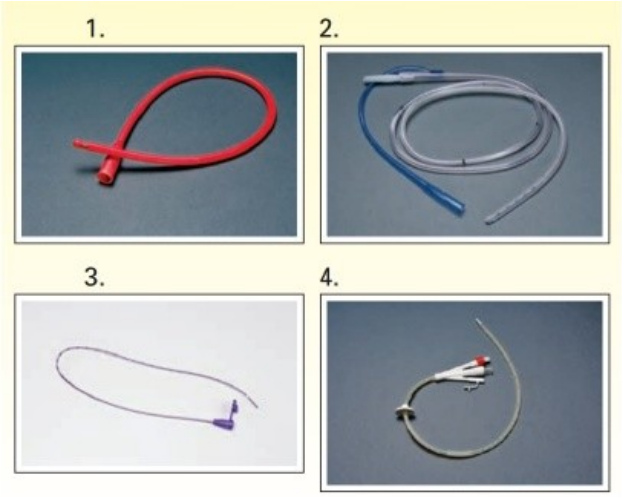
A. Intravenous (1W fluids
B. Oral or IV antibiotics
C. NPO (nothing per mouth) status
D. Analgesic medications

E. Positioning in a supine position
F. Nasogastric tube (NGT) to suction

ANSWER: A, C, D, F

A. IV fluids are given to replace fluids shifting in the peritoneum and bowel from the inflammatory process.
B. Appropriate antibiotics are given, but these would only be by the IV route because the client should be NPO.
C. NPO status will rest the bowel.
D. Analgesics are utilized for pain control.
E. The client can assume any position that promotes comfort; a supine position is not required.
F. NG suction decompresses the stomach and intestine and rests the GI tract.

74. The client is admitted with a bowel obstruction. The nurse is directed by the HCP to insert an NG tube for decompression and connect it to low continuous suction. Which tube should the nurse obtain for insertion?



ANSWER: B

A. The red tube is a single—lumen tube and comes in varying lengths that can be used for NG suction, postpyloric feedings, or urinary catheterizations. Single-lumen tubes should not be used with continuous suction.
B. The nurse should obtain a double-lumen NG tube with an air vent for continuous suction. The pigtail (air vent) helps to keep the tube away from the stomach wall so that it is not damaged.
C. This is a single-lumen feeding tube. It should not be used for GI suctioning.
D. This is a gastrostomy tube. It is commonly inserted endoscopically into the stomach; it is unnecessary to have this invasive procedure for gastric decompression.

75. The client is hospitalized with a large bowel obstruction resulting in massive abdominal distention. Which assessment findings should be most concerning to the nurse?

A. Urine specific gravity value of 1.020
B. High-pitched and tinkling bowel sounds
C. Decreased lung sounds in both lung bases
D. Client describes abdominal pain as colicky

ANSWER: C

A. A specific gravity value of 1.020 is normal. The nurse would expect to see an increase in specific gravity due to sequestering of fluids in the abdomen.
B. High-pitched bowel sounds are expected with a bowel obstruction.
C. Decreased lung sounds are the most concerning finding because it can be life-threatening. Massive distention can impair function of the diaphragm, which in turn leads to atelectasis and compromised respiratory function.
D. Pain that is colicky in nature is a usual manifestation of the obstruction- If the pain is deep and cramping or continuous, the bowel may be ischemic or possibly perforated.