**1 . The nurse is preparing to conduct a women's wellness seminar. What information should the nurse plan to include about risk factors for development of breast cancer? Select all that apply.**

A. The risk increases for women who have fibrocystic breast disease.
B. The risk increases if the onset of menarche occurs at a young age.
C. Women who have breastfed their infants are at an increased risk.
D. Risk is increased in postmenopausal women with a BMI below 20.
E. Women whose sisters have had breast cancer are at increased risk.

**ANSWER: B. E**

A. Fibrocystic breast disease is not related to breast cancer development, but fibrocystic changes can make it more difficult to feel early cancerous lumps during breast examination.
B. Early menarche and/or late menopause increase the risk of developing breast cancer.
C. Childless women, not those who have breastfed, are at increased risk. It is thought that pregnancy and lactation interrupt ovulation and alter the hormonal environment, reducing breast cancer risk.
D. Postmenopausal women who are obese, not those with a lower BMI, are at increased risk.
E. Women with first-degree relatives, such as a mother or sister, who had breast cancer are at risk.

**2. The nurse overheats the client talking with her husband about her new diagnosis of stage 1 breast cancer. Which statement by the client indicates that she does not fully understood the diagnosis?**

A. "I won't be here to see our daughter graduate this spring."
B. "I understand that I will need some type of chemotherapy."
C. "I will be starting radiation therapy on my breast soon."
D. "The cancer was in an early stage, and it was contained."

**ANSWER: A**

A. Ninety percent of women with localized tumors (stage 1 and 2) can be expected to achieve long-term disease-free survival. This statement indicates she did not understand the diagnosis of stage 1 breast cancer.
B. Both chemotherapy and radiation are recommended for stage 1 and 2 breast cancer.
C. Both chemotherapy and radiation are recommended for stage I and 2 breast cancer.
D. Stage 1 cancer means that it was contained in the area where the first abnormal cells began to develop.

**3. The client with newly diagnosed breast cancer asks the nurse to explain the advantages of a sentinel lymph node biopsy (SLNB). Which explanation should the nurse state to the client?**

A. “This biopsy will improve the chances that all of the tumor will be removed.”
B. “This biopsy can reduce the number of lymph nodes that must be removed.”
C. “This biopsy makes breast reconstruction easier to perform.”
D. “This biopsy, if performed, will make hormonal therapy unnecessary.”

**ANSWER: B**

A. The SLNB will not improve the ability of the surgeon to remove all of the tumor.
B. An SLNB uses a radioactive substance or dye to help to identify axillary lymph node involvement before axillary dissection has occurred. If the sentinel node is identified and is found to be negative for tumor cells. then further axillary lymph node dissection is unnecessary. Thus the lymph drainage of the involved arm can be preserved.
C. The SLNB will not make breast reconstruction easier to perform.
D. The use of hormonal therapy for breast cancer treatment is detennined by the receptor status of the tumor, not by the SLNB results.

**4. The HCP recommends tamoxifen for the female client because she is at high risk for developing breast cancer. The client asks the nurse to explain how this drug will help avoid developing breast cancer. Which information about tamoxifen should be the basis for the nurse’s response?**

A. Tamoxifen is an anti-inflammatory drug that reduces the body’s response to the tumor.
B. Tamoxifen is a chemotherapy agent that has minimal side effects if taken prophylactically.
C. Tamoxifen will protect against the development of other cancers such as endometrial cancer.
D. Tamoxifen will block estrogen receptors on tumor cells and thus cause the tumor to regress.

**ANSWER: D**

A. Tamoxifen does not have anti-inflammatory properties.
B. Tamoxifen is a hormonal rather than a chemotherapeutic agent.
C. A major side effect of tamoxifen is that it increases the risk of developing endometrial cancer.
D. Tamoxifen (Soltamox) blocks estrogen receptors on tumor cells, and thus the cell growth declines and the tumor regresses.

**5. The nurse is planning care for the client who had a TRAM (transrectus abdominis myocutaneous) flap breast reconstruction. Which actions should the nurse include?**

A. Initiate passive ROM to the affected side immediately after surgery and q4h.
B. Assess capillary refill, color, and temperature of the flap hourly for 24 hours.
C. Maintain a pressure dressing on the reconstructed breast for the first 48 hours.
D. Keep the affected arm below the level of the reconstructed breast for 48 hours-

**ANSWER: B**

A. Upper-extremity exercise and ROM are restricted to reduce strain on the incision site.
B. To monitor for viability and adequacy of blood supply to the TRAM flap, the flap must be assessed hourly for the first 24 hours.
C. Pressure over the flap is avoided until healing is complete.
D. The affected arm should be elevated to promote venous return.

**6. The client tells the nurse that she has been having breast pain and has had several diagnostic procedures that all have been negative. Which suggestions should the nurse include when the client asks for advice on controling this breast pain? Select al that apply.**

A. Place a towel wet with primrose oil on the breasts.
B. Go without a bra for at least 4 hours every day.
C. Reduce the amount of caffeine in the diet.
D. Supplement the diet with B complex vitamins.
E. Apply hot packs to the breasts for 20 minutes.

**ANSWER: C, D, E**

A. There is no evidence that placing a towel wet with primrose oil over the breasts will reduce pain. Taking evening primrose oil orally may help, but its use is controversial.
B. The women should be taught to wear a support bra, not to go Without a bra.
C. Reducing caffeine has been shown by some to reduce breast pain.
D. B complex vitamins have been shown by some to reduce breast pain.
E. Applying hot packs to the breasts for 20 minutes has been shown by some to reduce breast pain.

**7. A 21-year-old client starts crying during a clinic visit and says to the nurse, "I found a lump in my breast last night; I'm scared I might have cancer!" Which fact should the nurse consider when formulating a response to the client?**

A. Young women at this age are at increased risk of breast cancer development.

B. A nondiscrete possible mass or thickening has a high index of suspicion for breast cancer.
C. Benign fibroadenomas are the most frequent cause of breast masses in women under 25 years.
D. Close personal contact required in dormitory living can cause infectious breast disorders-

**ANSWER: C**

A. Breast cancer is diagnosed most commonly in women older than 50 years.
B. A nondiscrete possible mass or thickening has a lower (not higher) index of suspicion for breast cancer.
C. Fibroadenomas are the most common benign breast neoplasm and most often occur in women younger than 25 years.
D. Mastitis is a bacterial infection of the breast tissue and is not contagious, and therefore it would not be spread by dormitory living.

**8. The client tells the nurse that she is considering breast reduction but wants to know if she could breastfeed in the future after this procedure. Which response by the nurse is correct?**

A. "Breast reduction will not affect whether or not you choose to breastfeed."
B. "Breastfeeding is possible if the nipples are left connected to breast tissue."
C. "The amount of breast tissue removed will make breastfeeding impossible."
D. "Changes in the nipple structure from surgery will prevent milk production."

**ANSWER: B**

A. Breast reduction has the potential to negatively affect lactation (breastfeeding) if large amounts of breast tissue are removed.
B. Lactation can usually be accomplished if the nipples are left connected to breast tissue.
C. The amount of breast tissue removed will determine whether or not lactation is possible.
D. The nipple structure is not changed with breast reduction; however, some surgeries may necessitate relocation of the nipple.

**9. The nurse is discharging the client after an elective abortion by suction curettage. Which statement should the nurse include in the client's discharge instructions?**

A. Sexual intercourse can be resumed once vaginal discharge has stopped.
B. Perform a vaginal douche with clean tap water twice daily for 48 hours.
C. Notify the HCP immediately if the vaginal discharge develops a foul odor.
D. Increase fluid intake, rest, and make plans to return to work in 1 week.

**ANSWER: C**

A. Sexual intercourse should not resume until the client is reexamined in about 2 weeks.
B. Vaginal douching is not recommended.
C. Foul-smelling vaginal discharge is a sign of vaginal infection and/or retained tissue and should be reported as soon as it is noted by the client.
D. There is no evidence to support the need to wait a week before returning to work. Many women resume their usual activities the same day as the abortion.

**10. A 15-year-old client's mother asks the nurse why the I-ICP prescribed oral contraceptives (OCPs) for treating her daughter's dysmenorrhea. Before responding to the mother, which fact about oral contraceptives should the nurse consider?**

A. OCPs inhibit uterine inflammation, which indirectly causes the dysmenorrhea.
B. OCPs increase blood flow to the uterus during menstruation, thereby reducing pain.
C. OCPs inhibit the progesterone production that causes uterine contractions and pain.
D. OCPs suppress ovulation and thus prostaglandin production, which causes pain.

**ANSWER: D**

A. OCPs do not inhibit inflammation.
B. OCPs do not increase uterine blood flow; the amount of menstrual discharge may decrease with OCP usage as a result of decreased endometrial stimulation.
C. OCPs do inhibit progesterone production, but it is not progesterone that stimulates uterine contractions and pain; rather, it is prostaglandins.
D. OCPs block ovulation by preventing the release of follicle stimulating hormone from the pituitary. The absence of ovulation decreases the sequential stimulation ofthe endometrium by estrogen and progesterone. This results in a decrease in the prostaglandin production by the endometrium and thus a decrease in pain.

**11 . A 17-year-old female receives treatment for primary amenorrhea caused by hyperthyroidism. Which finding during a clinic visit should indicate to the nurse that treatment for amenorrhea was effective?**

A. Weight increased by 10 pounds
B. Denies having menstrual cramps
C. States just started having her menses
D. No longer has a fine hand tremor

**ANSWER: C**

A. An increased weight may help with initiating a menstrual cycle if the cause is a body fat composition of less than 10%, but this does not indicate that the woman has started her menstrual cycle.
B. If the client is not menstruating (amenorrhea), she will not have menstrual cramps.
C. Hyperthyroidism and a body fat composition of less than 10% can be contributing factors to amenorrhea (absence of menses). The start of a menstrual cycle indicates that treatment of the underlying cause of amenorrhea is effective.
D. The absence of a fine hand tremor may indicate treatment is effective for the hyperthyroidism. It does not indicate that the primary amenorrhea is resolved.

**12. The nurse is completing a health assessment of the female client with menorrhagia of unknown origin. Which serum laboratory result should the nurse carefully review?**

A. Calcium level
B. Blood urea nitrogen
C. Hemoglobin level
D. White blood cell count

**ANSWER: C**

A. Calcium should not be affected by menorrhagia.
B. BUN should not be affected by menorrhagia.
C. Persistent heavy bleeding can result in anemia, which would be reflected in the client's Hgb level.
D. WBCs should not be affected by menorrhagia.

**13. The nurse is caring for the 30-year-old female client. Which concems stated by the client should alert the nurse to the possibility of endometriosis? Select all that apply.**

A. Vaginal dryness
B. Premenstrual tension headache
C. Pain during her menstrual period
D. Inability to conceive
E. Dyspareunia

**ANSWER: C, D, E**

A. Vaginal dryness is not a symptom of endometriosis.
B. Premenstrual tension headache is not a symptom of endometriosis.
C. Endometriosis is the presence of normal endometrial tissue in sites outside the endometrial cavity. The tissue responds to hormonal influence, and therefore during menstruation the tissue bleeds. This bleeding causes inflammation and pain at the time of menstruation.

D. Women with endometriosis are at increased risk for infertility, although the exact reason is unknown.
E. Depending on the location of the endometrial tissue, clients may experience pain with intercourse.

**14. The HCP prescribed mifepristone for the 35-year-old female to treat a leiomyoma. Before the client begins the medication, which information is most important for the nurse to obtain?**

A. Baseline blood pressure
B. Liver enzyme test results
C. Pregnancy test results
D. Baseline height and weight

**ANSWER: C**

A. Mifepristone does not cause changes in BP.
B. Mifepristone does not cause changes in liver enzymes.
C. The pregnancy test results should be known because mifepristone is also used in conjunction with other medications for termination of early intrauterine pregnancy.
D. Although weight can influence the dose, this information is not the most important. Mifepristone does not cause changes in weight.

**15. A female client has an abdominal hysterectomy to remove a uterine fibroid. Which action should the nurse include when caring for the client postoperatively?**

A. Monitor the perineal pad for bleeding.
B. Administer hormone replacement therapy.
C. Maintain bedrest for the first 48 hours.
D. Start a regular diet 6 hours postsurgery.

**ANSWER: A**

A. Monitoring the perineal pad will alert the nurse to any increase in vaginal bleeding. Infection and hemorrhage are the major risks following a hysterectomy.
B. HRT is needed only if the ovaries have been removed (oophorectomy).
C. The client should be encouraged to ambulate in the early postoperative period, rather than remain on bedrest. Development of DVT is a concern after abdominal hysterectomy.
D. Peristalsis is typically suppressed after abdominal hysterectomy, and the client will be on restricted oral intake until physical signs indicate the return of peristalsis.

**16. The 21-year-old who has been diagnosed with polycystic ovary syndrome (PCOS) asks about changes she could make to help control her disease. Which statement is the nurse's best response?**

A. "Take ibuprofen to reduce your pain."
B. "Avoid oral contraceptives for birth control."
C. "Avoid having more than one sexual partner."
D. "Keep your BMI within the acceptable range."

**ANSWER: D**

A. Although an anti-inflammatory medication such as ibuprofen (Advil) may help reduce pelvic pain, this is not a lifestyle change.
B. Oral contraceptives are useful in regulating the menstrual cycle for clients with PCOS and are utilized (not avoided) to treat this syndrome.
C. Maintaining a monogamous sexual relationship will not impact PCOS.
D. Obesity exacerbates insulin resistance and hyperinsulinemia associated with PCOS.

**17. The nurse is reviewing content prepared by the student nurse, who is planning a presentation on risk reduction for developing ovarian cancer. Which statement should the nurse delete from the student's prepared content?**

A. "Bear children if physically and psychologically able."
B. "Decrease the amount of saturated fat in your diet."
C. "Avoid taking oral contraceptives for birth control."
D. "Breastfeed instead of bottle feed if you give birth."

**ANSWER: C**

A. Nulliparity increases the risk of developing ovarian cancer.
B. A high-fat diet increases the risk of developing ovarian cancer.
C. The nurse should delete the statement about avoiding oral contraceptives. Using oral contraceptives is associated with a lower ovarian cancer risk if they are used for more than 5 years.
D. Breastfeeding reduces the risk of developing ovarian cancer.

**18. The HCP writes orders for the client who is 24 hours postvulvectomy. Which order should the nurse question?**

A. Cleanse perineal wound with warm saline daily.
B. Maintain high Fowler's position for 24 hours.
C. Begin low-residue diet when tolerating oral intake.
D. Apply antiembolic stockings; remove 20 minutes bid.

**ANSWER: B**

A. The perineal wound is cleansed with saline, or the client is given sitz baths for cleansing to promote healing and prevent infection.
B. A high Fowler's position places pressure on the perineal area and will increase discomfort. The client should be placed in a low Fowler's position to decrease tension on the suture line and promote comfort.
C. A low-residue diet prevents strainng at stool and wound contamination.
D. Antiembolic stockings increase venous return to decrease the risk of DVT and to assist in the development of collateral pathways for lymph drainage.

**19. The client asks the nurse how a woman can recognize when she is ovulating. Which should be the nurse's response?**

A. "The mucus produced by the cervix during ovulati on becomes abundant and stretchy."
B. "The body temperature drops and stays low for the remainder of the menstrual cycle."
C. "Do an over-the-counter urine test; with ovulation luteinizing hormone is negative."
D. "You may notice a decrease in your desire for sexual activity when you are ovulating."

**ANSWER: A**

A. At the time of ovulation, the mucus produced by the cervix becomes more abundant and stretchy. It looks and feels like egg whites. The ability of the mucus to be stretched indicates the time of maximum fertility.
B. At the time of ovulation, the basal body temperature drops slightly and then, under the influence of progesterone, increases and stays elevated until 2 to 4 days before menstruation starts.
C. Home measurement of luteinizing hormone (LI-I) is possible with dipstick urine tests. A positive test (not negative) for LH indicates ovulation. LH causes the egg to be released from the ovary.
D. At the time of ovulation, most females note an increase (not decrease) in libido.

**20. The otherwise healthy client who is menopausal tells. the nurse that she has been experiencing vaginal itching and burning and increased vaginal infections over the last 2 years. Which statement is the nurse's best response?**

A. "The frequent vaginal infections could be a precursor to vulvar cancer."
B. "You could have a contact allergy that is causing your vaginal itching."
C. "The vagina becomes more acidic after menopause, causing your symptoms."
D. "The vaginal pH increases during menopause, predisposing you to these symptoms."

**ANSWER: D**

A. Vaginal infections do not predispose a female to vulvar cancer.
B. Although vaginal itching may be related to a contact allergy, it is not the best response.
C. Acidic secretions would have a low pH value; the pH increases during menopause.
D. Decreased estrogen in menopausal women causes thinning of the vaginal mucosa and an increase in pH of vaginal secretions. As a result, the vagina is easily traumatized and more susceptible to infection.

**21 . A 54-year-old client who is postmenopausal reports increasing episodes of urinary leakage. Which lifestyle practice is most important for the nurse to discuss with the client?**

A. Eliminate the consumption of caffeine.
B. Establish an hourly voiding schedule.
C. Decrease the intake of water and other fluids.
D. Strengthen pelvic muscles with Kegel exercises.

**ANSWER: D**

A. Caffeine can increase urinary frequency, but the loss of muscle tone contributes to urinary leakage.
B. A regular voiding schedule improves bladder control, but beginning with an hourly voiding schedule is unnecessary and inconvenient.
C. Decreasing intake of fluids can contribute to dehydration.
D. Kegel exercises improve urinary incontinence by strengthening the pelvic floor muscles that support the bladder.

**22. The client, who is postmenopausal, reports pain with sexual intercourse. Which effective treatments should the nurse review with the client? Select all that apply.**

A. Use estradiol vaginal tablets as prescribed by the HCP.
B. Have regular intercourse to enhance vaginal blood flow.
C. Soak in a bath with fragrant oil or bubble bath every day.
D. Use feminine cleansing cloths or a vaginal douche daily.
E. Insert a vaginal lubricant prior to having intercourse.

**ANSWER: A, B, E**

A. Estradiol vaginal tablets increase vaginal lubrication production and have been shown to be effective for vaginal dryness and pain with intercourse.
B. Increased blood flow to the vagina through regular intercourse effectively helps to prevent further tissue atrophy.
C. Fragrant bath oil or bubble bath will cause further drying of vaginal tissues.

D. Feminine cleansing cloths or douches will cause further drying of vaginal tissues.
E. Vaginal lubricants have been shown to be effective for vaginal dryness and pain with intercourse.

**23. The nurse is assessing a postmenopausal woman for evidence of heart disease- Which factor contributes to the client's increased risk for heart disease after menopause?**

A. A decreased level ofestrogen hormone
B. A psychological craving for high-fat food
C. An increased level of progesterone hormone
D. An intolerance to exercise and physical activity

**ANSWER: A**

A. Estrogen has a positive and protective effect on the function of the heart and blood vessels.
B. Menopause is not known to cause a specific food craving.
C. Progesterone, which decreases with menopause, is more linked to weight gain.
D. Continued exercise and activity in menopause positively affects a woman's health.

**24. The married couple tells the nurse they have been unsuccessful at achieving a pregnancy. What should be the nurse's initial question when they ask if they should begin testing for infertility?**

A. "Do either of you use tobacco products or drink alcohol?"
B. "What are your ages, and how long ago were you married?"
C. "Did either of you ever have an infection in your reproductive tract?"
D. "How long have you been having regular intercourse without contraception?"

**ANSWER: D**

A. Using tobacco products and drinking alcohol are risk factors for infertility, but this is not the initial question.
B. Advancing age is a risk factor for infertility, but this is not the initial question.
C. A reproductive tract infection is a risk factor for infertility, but this is not the initial question.
D. The definition of infertility is the inability to achieve a pregnancy after 1 year of regular intercourse without contraception. If the couple has not been attempting to achieve a pregnancy for that length of time, then there is no need for infertility testing. The other questions address risk factors for infertility, but those questions would be inconsequential if the criterion in option 4 were not met.

**25. The client asks the nurse if there is anything he could do to impregnate his wife because his sperm count is "only 40 million." In responding to the client, which factor should the nurse consider?**

A. The client's lifestyle must be examined to eliminate contact with any gonadotoxins.
B. With a low sperm count, it will not be possible to impregnate his wife through intercourse.
C. The client will need a prescription from the HCP for testosterone supplementation.
D. The client needs reassurance that this number is sufficient for fertilization through intercourse.

**ANSWER: D**

A. Gonadotoxins are chemicals, drugs, or other substances that have a toxic or suppressive effect on sperm production, motility, or morphology. It is premature to examine the client's lifestyle because the client's sperm count is adequate.
B. Although 40 million sperm/mL of semen is less than the normal of 60 to 100 million, the number is adequate for fertilization through intercourse.
C. There is no need to utilize testosterone supplements for this client.
D. The incidence of impregnation is lessened only when the sperm count decreases to less than 20 million/mL. The client should be reassured. The normal sperm count is 60 to 100 million sperm/mL of semen.

**26. The client, who had been prescribed sildenafil 2 weeks ago for erectile dysfunction, calls the clinic to report that nothing happens, despite taking sildenafil orally and waiting for his erection to develop. Which fact should the nurse consider before responding to the client?**

A. In clinical trials, the sildenafil was effective only 20% of the time.
B. Sildenafil is not effective if taken orally and should be taken rectally.
C. In the absence of sexual stimuli, sildenafil will not cause an erection.
D. Sildenafil is ineffective if taken with foods high in saturated fats.

**ANSWER: C**

A. In clinical trials, some improvement in erectile hardness and duration was reported by 70% of men taking sildenafil.
B. Sildenafil should be taken orally.
C. Sildenafil (Viagra) enhances the normal erectile response to sexual stimuli by promoting relaxation of arterial and trabecular smooth muscle. The resultant arterial dilation causes engorgement of sinusoidal spaces in the corpus cavernosum. In the absence of sexual stimuli, however, nothing will happen.
D. A fatty meal delays absorption, and, as a result, plasma levels peak in 2 hours instead of an hour; it does not cause sildenafil to be ineffective.

**27. The nurse teaches the client with erectile dysfunction about the use of alprostadil via subcutaneous penile injection. Which statement indicates the client needs further teaching?**

A. “I need to keep the needle sterile before I inject my penis.”
B. “The erection won’t last long after alprostadil is injected.”
C. “The injection will produce an erection within 30 minutes.”
D. “I should report if I am feeling dizzy after an injection.”

**ANSWER: B**

A. The client is correct in using sterile technique for the injection.
B. The nurse should correct the statement about an erection not lasting long. Alprostadil (Caverject) injection therapy has the potential of producing a prolonged erection.
C. Alprostadil will begin to produce the desired effect within 30 minutes.
D. Dizziness is a side effect of alprostadil and should be reported.

**28. The client, with known benign prostatic hyperplasia (BPH), telephones the clinic nurse with concerns of increased urinary frequency and urgency after having a cold that started a few days ago- Which question should the nurse immediately ask the client?**

A. “Have you been drinking large amounts of water?”
B. “Have you been exercising more than usual?”
C. “Have you been taking any over-the-countcr cold remedies?”
D. “Have you increased the amount of dairy products in your diet?”

**ANSWER: C**

A. Clients with BPH should maintain fluid intake at normal levels to prevent dehydration. Drinking large amounts of water, however, could lead to bladder distention, which would result in abdominal discomfort.
B. Increased exercise will not alter BPH symptoms.
C. Compounds found in common cough and cold remedies, such as pseudoephedrine and phenylephrine, are alpha-adrenergic agonists that cause smooth muscle contraction. Since the bladder is a smooth muscle, these medications may increase symptoms of urinary urgency and frequency.
D. Increased amounts of alcohol and caffeine can increase BPH symptoms, but dairy products should not affect BPH symptoms.

**29. The client, admitted to a surgical unit following a TURF, has a C81 running. The nurse assesses the client’s urine and finds dark red urine containing several small clots. Which intervention should the nurse implement?**

A. Increase the flow of the bladder irrigation fluid.
B. Immediately stop the bladder irrigation flow.
C. Irrigate the urinary catheter manually.

D. Deflate the balloon on the urinary catheter.

**ANSWER: A**

A. If the urine is dark red, the flow rate of the CBI should be increased. The purpose of the CBI is to remove clots from the bladder and to ensure drainage of urine through the urinary catheter. The flow rate of the CBI fluid should be set so that the outflow remains free from clots and remains light red to pink.
B. Stopping the CBI would increase the risk that the urinary catheter would become blocked and the flow of urine interrupted.
C. There is no need to manually irrigate a catheter If a C81 is flowing, unless the urinary catheter becomes obstructed.
D. Deflating the urinary catheter balloon would be contraindicated because this could result in dislodging the catheter.

**30. The nurse is eating for the client following a TURF. At the end of an 8-hour shift, the nurse determines that the client received 3050 mL of CBI fluid and that 4030 mL of output was emptied from the urinary drainage bag. How many milliliters (mL) should the nurse document for the client's actual urine output for the 8 hours?**

**_____ mL (Record your answer as a whole number.)**

**ANSWER: 980**

Subtract the amount of CBI solution from the total amount of fluid emptied from the urinary drainage device: 4030 mL — 3050 mL = 980 mL.

**31 . The nurse is caring for the client who is 24 hours post-TURP and is having painful bladder spasms. Which intervention should the nurse plan to implement?**

A. Give the prn prescribed morphine sulfate intravenously.
B. Give the prn prescribed belladonna and opium suppository.
C. Assist the client out of bed to ambulate in the hallway.
D. Apply warm and then a cold cloth to the client's abdomen-

**ANSWER: B**

A. Opioid medications will decrease the pain sensations but will not decrease the muscle spasms.
B. The belladonna and opium suppository will inhibit smooth muscle contraction and decrease bladder spasms; thus, it will also reduce pain.
C. Ambulation will not decrease the discomfort.
D. Heat, rather than cold, is the recommended nonphannacological treatment for bladder spasms.

**32. The nurse is obtaining a hospital admission history for the client. Which statement should prompt the nurse to consider that the client has chronic prostatitis?**

A. “I am having difficulty sustaining an erection.”
B. “I have pain with ejaculation during intercourse.”
C. “I have been feeling pressure around my rectum.”
D. “I don’t think I am totally emptying my bladder.”

**ANSWER: B**

A. Chronic prostatitis does not cause erectile dysfunction.
B. Both chronic bacterial prostatitis and chronic prostatitis/pelvic pain syndrome manifest with ejaculatory pain.
C. Chronic prostatitis does not cause rectal pain.
D. Obstructive bladder symptoms, such as incomplete bladder emptying, are uncommon unless the client also has BPH.

**33. The nurse is reviewing hospital admission orders for the client diagnosed with acute prostatitis- Which prescription should the nurse verify with the HCP?**

A. Give trimethoprim/sulfamethoxazole 1 gram IV q6h.
B. Administer ibuprofen 600 mg orally q6h pm.
C. Increase fluid intake to 3 L daily; have client void often.
D. Insert an indwelling urinary drainage catheter now.

**ANSWER: D**

A. Trimethoprim/sulfamethoxazole (Bactrim) is a common antibiotic used to treat acute prostatitis.
B. Analgesics, such as ibuprofen (Motrin), should be used for pain control, and rest should be encouraged.
C. Increasing fluid intake and voiding often help decrease irritation when emptying the bladder.
D. Passage of a urinary catheter through an inflamed urethra is contraindicated in acute prostatitis. If urinary retention is a concern, a suprapubic catheter should be placed.

**34. The female nurse is sitting across a table from the Latino male she has been educating about testicular self-examination. When the client successfully verbalizes the process, the nurse excitedly praises the client, leans over the table, and makes the “OK” sign with her thumb and forefinger. The client angrily gets up and abruptly leaves the room. What likely caused the client’s abrupt departure?**

A. Discomfort discussing private body areas with the female nurse.
B. The nurse invaded the client’s personal space inappropriately.
C. The client may have interpreted the “OK” gesture as obscene.

D. The client may have felt that the teaching had been completed.

**ANSWER: C**

A. Since the client had participated in the discussion up to the point of the nurse's actions, he obviously was not uncomfortable with the discussion.
B. A Latino is usually not uncomfortable with close personal space; some Latinos perceive Anglos as distant because they prefer more personal space during a conversation.
C. In much of Latin America, the North American "OK" sign (i.e., pinched thumb and forefinger) may be considered obscene.
D. Anger and an abrupt departure are usually not behaviors displayed by the client when teaching is completed.

**35. The nurse is asked to complete health education on testicular cancer. To obtain the maximal impact, the nurse should plan to present this education to which group?**

A. Males who are between 15 and 34 years of age
B. Males over 30 years old who have never fathered a child
C. Males over 21 years old who have fathered at least one child
D. Males who are over the age of 50 years and sexually active

**ANSWER: A**

A. Testicular cancer is the most common type of cancer in young men between 15 and 34 years of age. Therefore, education should be directed at males within this age group.
B. Never fathering a child does not change the risk for testicular cancer development if the male is between 15 and 34 years of age.
C. Fathering a child does not change the risk for development of testicular cancer; all males in the high-risk age group should be educated.
D. Increasing age decreases the risk for testicular cancer.

**36. The nurse reviews the laboratory results exhibited of the client hospitalized with testicular cancer. Which conclusion by the nurse is most accurate?**

| Lab Serum | Client Value | Normal Values |
|---|---|---|
| BUN | 20 | 5–25 mg |
| Creatinine | 1.0 | 0.5–1.5 mg/dL |
| Na | 137 | 135–145 mEq/L |
| K | 3.4 | 3.5–5.3 mEq/L |
| Cl | 99 | 95–105 mEq/L |
| $CO_2$ | 24 | 22–30 mEq/L |
| Glucose | 148 | 70–110 mg/dL |
| Hgb/Hct | 10%/33% | 13.5–17 g/dL, 40%–54% |
| WBC | 9000 | 4500–10,000/ microL or $mm^3$ |
| Neutrophils | 65% | 50%–70% |
| AST | 200 | 8–38 unit/L |
| ALT | 150 | 10–35 units/L |

A. The client may have developed an infection.
B. The client's nutrient intake has been inadequate-
C. The client should be checked for type 2 DM.
D. The client's disease may have metastasized.

**ANSWER: D**

A. The WBCS are WNL; there is no indication of a developing infection.
B. There is no information in the stem about nutritional intake and the serum albumin or prealbumin is not reported in the laboratory results to make a judgment about Whether the client's nutrient intake is inadequate.
C. The elevated glucose level is likely related to the body's physiological response to stress.
D. The decreased Hgb indicates anemia, and the liver enzymes are elevated (AST, ALT). These changes occur when testicular cancer has metastasized.

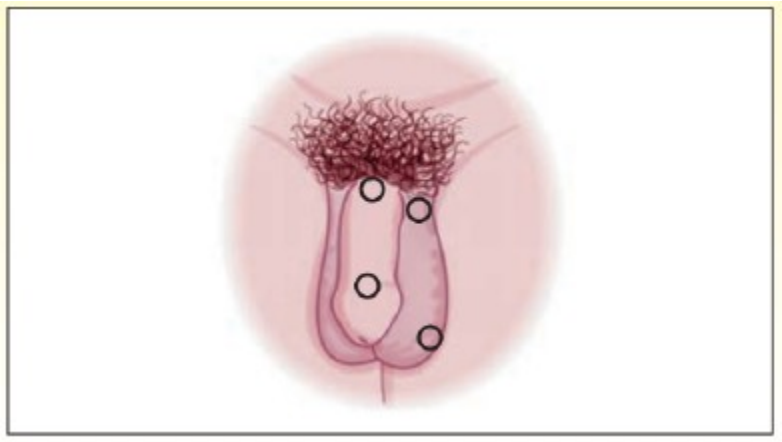
**37. The client is informed that he will require a right orchiectomy as part of his treatment of testicular cancer. The client asks the nurse if he will be infertile after this procedure. Which response by the nurse is best?**

A. “You need to plan ahead; this procedure will make you infertile.”
B. “Has your surgeon discussed cryopreservation of your sperm?”
C. “With the removal of only one testicle, your fertility will not be affected.”
D. “I can’t answer this; no one really knows whether fertility will be affected.”

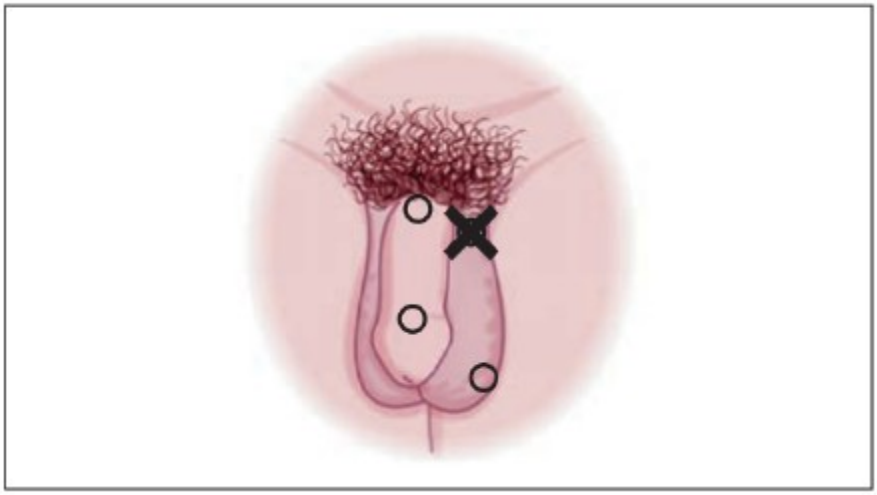
**ANSWER: B**

A. The client’s fertility can be affected to valying degrees, so it is inappropriate to say the client will be infertile.
B. The impact of treatment for testicular cancer on fertility varies. The involvement of chemotherapy, lymph node removal, and/or radiation in the treatment plan may all impact the client’s ability to procreate. Clients should be encouraged to consider cryopreservation of sperm in a sperm bank before beginning testicular cancer treatment.
C. The client’s fertility can be affected to varying degrees, so it is inappropriate to say the client will not be infertile.
D. Telling the client that the question can’t be answered dismisses the client’s concern and is not the best response. It may block further communication with the nurse about the client’s concerns.

**38. The client, preparing to have a vasectomy, asks the nurse where the vasectomy incision will be made. Place an X within the circle on the illustration where the nurse should show the client the location of the vasectomy incision.**



**ANSWER:**



The nurse should identify that the incision for the vasectomy will be made in the upper portion of the scrotum to expose the vas deferens. The vas deferens is then severed, and the severed ends are occluded with ligatures or by electrocautery. An incision in the upper or lower aspect of the penis or lower aspect of the scrotum would not expose the vas deferens.

**39. The nurse is obtaining a health history on the client with a possible left-sided varicocele. Which question is most important?**

A. "Did your father have any testicular problems?"
B. "Does the left scrotum feel different from the right?"
C. "Do you have children or plan to have children?"
D. "Do you have any discomfort in your groin?"

**ANSWER: C**

A. Varicoceles are not inherited.
B. A varicocele does occur most frequently on the left side due to retrograde blood flow from the renal vein; however, a varicocele rarely produces symptoms.
C. Asking about children is important because the most common cause of male infertility is a varicocele. Approximately 15% to 20% of the healthy, fertile male population is estimated to have varicoceles. However, 40% of infertile men may have them.
D. A varicocele rarely produces any symptoms. It is usually diagnosed during physical examinations related to infertility. If symptoms do occur, pain and groin tenderness are the most common symptoms.

**40. The nurse is providing information to the client diagnosed with genital herpes- Which is the priority information that the nurse should provide to the client?**

A. Genital herpes simplex virus-2 (HSV-Z) is more common in women than in men.
B. A herpes simplex virus-l (HSV—l) genital infection can occur with oral-genital contact-
C. After a diagnosis of HSV—2, there are likely to be two to three outbreaks during the first year.
D. Transmission of genital herpes can occur from a partner who does not have a visible sore.

**ANSWER: D**

A. Information about females being infected more than males is important, and the client should be informed of this, but this is not the priority.
B. Information about the mode of transmission is important, and the client should be informed of this, but this is not the priority.
C. Typically in the first year after the diagnosis, the client will have four to five outbreaks, not two to three.
D. The priority information to tell the client is that transmission can occur from a partner who does not have a visible sore.

**41 . The female client has been diagnosed with genital warts. Which assessment findings should the nurse associate with genital warts?**

A. Painful vesicles on the labia, perineum, or anus
B. Painful ulcerations of the vagina, labia, or perineum
C. Painless, cauliflower-appearing lesions near the vaginal opening or anus
D. Painless chancre or ulceration on the labia or perineum

**ANSWER: C**

A. Painful vesicles on the labia, perineum, or anus describe the lesions of genital herpes (herpes simplex virus 2).
B. Painful ulcerations of the vagina, labia, or perineum describe the lesions of genital herpes (herpes simplex virus 2).
C. In females, genital warts appear as painless lesions near the vaginal opening, anus, vagina, or cervix. The lesions are textured, cauliflower appearing, and remain unchanged over time.
D. A chancre is associated with syphilis, not genital warts.

**42. The client with waits in the labial area is being seen in the clinic. The client is tearful and states to the nurse, "I'm so embarrassed that I let this happen to me." Which response by the nurse is appropriate?**

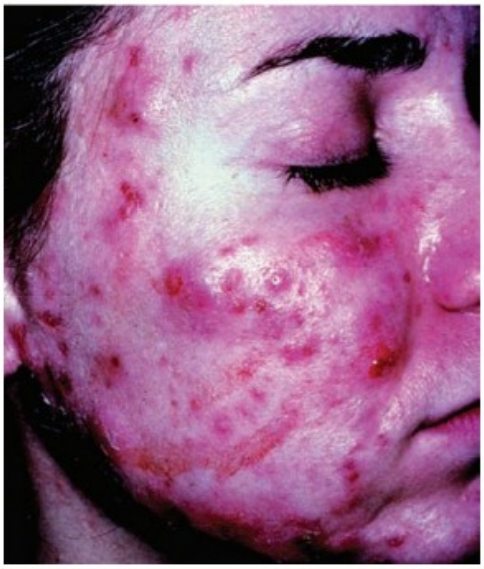
A. "You don't need to be embarrassed. We see clients with warts a lot of the time."
B. "There's no need for tears; this is treatable, and we will take good care of you."
C. "I see you are upset. Having labial warts is quite common. Let's talk more about it."
D. "Don't be too upset. You didn't do anything wrong. It just happens a let these days."

**ANSWER: C**

A. This response dismisses the client's feelings of embarrassment over an STI.
B. This response dismisses the client's feelings and promotes client dependency. It does not allow for further exploration of feelings.
C. This response is appropriate because it acknowledges the client's feelings. It provides brief information and then time for the client to express thoughts regarding the situation.
D. This response dismisses the client's feelings.

**43. After assessing the client, the nurse initiates the process for reporting the client's STI to the state health agency. Which client has the STI that the nurse is reporting?**

1.



2.



3.



4.



**ANSWER: B**

A. This illustrates acne vulgaris, which is not an STI.
B. This illustrates herpes. While herpes simplex may not necessarily be state reportable, it is an STI. By state law, the incidence of some STIs must be reported to the state.
C. This illustrates a contact dermatitis; in this client it was caused by nail polish.
D. This illustrates candidiasis or thrush. This is not reportable.

**44. The office nurse is caring for the client diagnosed with chlamydia and syphilis. Based on this diagnosis, which medication order would require the nurse's immediate review with the prescribing HCP?**

A. Doxycycline
B. Azithromycin
C. Metronidazole
D. Penicillin G

**ANSWER: C**

A. Doxycycline (Vibramycin), a tetracycline antibiotic, is an appropriate drug for treating chlamydia.

B. Azithromycin (Zithromax), a semisynthetic macrolide antibiotic, is an appropriate drug for treating chlamydia.
C. Metronidazole (F lagyl) is an anti-infective against anaerobic organisms, an amoebicide, and an antiprotozoal agent. It is not indicated for either chlamydia or syphilis. Flagyl is used to treat bacterial vaginosis and trichomoniasis. Collaboration with the HCP is necessary to discuss and clarify the order.
D. Penicillin G (Bicillin) is an appropriate drug for treating syphilis.

**45. The nurse is teaching the client about metronidazole, which has been prescribed for treating trichomoniasis. Which client comment indicates the need for additional education?**

A. "I may have a bad metallic taste in my mouth."
B. "I'm glad I can still drink beer with these pills."
C. "My urine may look a little darker than usual."
D. "These pills may make me sick to my stomach."

**ANSWER: B**

A. Clients may experience a metallic taste while taking metronidazole.
B. Drinking alcohol while on metronidazole (Flagyl) is contraindicated. It can cause a disulfiram-like reaction with nausea, vomiting, abdominal cramps, headache, and flushing.
C. Metronidazole can turn urine dark. It is important to inform clients of this.
D. Nausea can occur when taking metronidazole. Taking it with food or milk may decrease GI irritation.

**46. The clinic nurse is reviewing the history of the client diagnosed with bacterial vaginosis (BV). Which identified disorder places the client at a higher risk of developing BV?**

A. Gastroesophageal reflux
B. Hypothyroidism
C. Cardiovascular disease
D. Diabetes mellitus

**ANSWER : D**

A. Gastroesophageal reflux disorder is not a risk factor for BV.
B. Hypothyroidism does affect the reproductive system. However, it does not specifically alter the pH of the vagina, which could increase the incidence of BV.
C. Cardiovascular disease is not a risk factor for BV.
D. Diabetes is a risk factor for a variety of vulvovaginal infections.

**47. The nurse is caring for the client who is angry about a new diagnosis of gonorrhea. The client informs the nurse, "I absolutely will not allow the release of this information to anyone." Which response by the nurse is most appropriate?**

A. "I see you are upset. Tell me more about what you mean by this statement."
B. "I'm sorry, but I'm required by law to report this to the Health Department."
C. "Are you worried that your spouse wouldn't want the information released?"
D. "I can see you are angry, but there is no reason for you to be upset with me."

**ANSWER: A**

A. Being diagnosed with an STI can cause emotional distress. This response acknowledges the client's reaction and provides the opportunity to clarify the statement's meaning.
B. Although gonorrhea is reportable, this response is a closed statement and does not allow the opportunity for the client to express feelings.
C. The nurse is making an assumption about the client's spouse.
D. Although this response does acknowledge the client's reaction, the last portion becomes judgmental and places the emphasis on the nurse's feelings.

**48. The 45-year-old diagnosed with HIV presents to the clinic requesting to receive herpes zoster vaccine live. Which statement by the nurse is accurate concerning administration of zoster vaccine live to this client?**

A. "Zoster vaccine live is an appropriate vaccine for someone at your age."
B. "Zoster vaccine live is a live virus that could be problematic for you."
C. "Zoster vaccine live is best administered in childhood to be effective."
D. "Zoster vaccine live will prevent you from contracting chicken pox."

**ANSWER: B**

A. Zoster vaccine live (Zostavax) is indicated for clients starting at age 55; the client is 45.
B. Since the client is immunocompromised from HIV infection, the live vaccine would be contraindicated.
C. Zostavax is not given to children.
D. Zostavax is used in the prevention of shingles, not chicken pox. Shingles occurs in individuals who already have had chicken pox. The virus associated with chicken pox lies dormant inside the nerve cell and can be reactivated later in life.

**49. The nurse is teaching the client and the family members about protection measures when the client, diagnosed with AIDS, returns home. Which instruction indicates that the nurse is unclear about the disease transmission?**

A. “Disinfect items in your home using a bleach solution of 1 part bleach to 10 parts water.“
B. “Place contaminated items, except sharps, in a plastic bag and then put them in the garbage.”
C. “Use separate dishes and wash them with hot, soapy water or place them in the dishwasher.”
D. “Wear gloves to clean body fluid spills with soap and water; then clean with bleach solution.”

**ANSWER: C**

A. This is the correct formula for mixing a bleach solution for disinfection.
B. Placing contaminated items in a plastic bag and then in the garbage is the correct method for disposing of contaminated articles. Sharps should first be placed in a rigid labeled container (such as a tin can), bleach solution added, the lid taped, and then placed in a bag for disposal in the garbage.
C. Because sharing eating utensils does not transmit HIV, it is unnecessary to separately wash dishes and silverware used by the client. The client is prone to opportunistic and other infections.
D. Cleaning with soap and water and then disinfecting with bleach solution is the correct method for cleaning body fluid spills.

**50. The nurse is planning care for the female client, who is newly diagnosed with herpes simplex virus type 2 (HSV-2, herpes genitalis). In which order should the nurse complete the planned actions? Place the nurse’s planned actions in order of priority.**

A. Teach abstinence from sexual intercourse during treatment and use of condoms.
B. Determine if the woman is pregnant.
C. Discuss the benefits of joining a support group such as HELP (Herpetics Engaged in Living Productively).
D. Administer an analgesic.
E. Administer the first dose of acyclovir.

**ANSWER: B, D, E, A, C**

**B**. Determine if the woman is pregnant. This is priority because medications can be terato -genie, presenting a substantial risk to the developing fetus.

**D**. Administer an analgesic. Measures are needed to promote comfort. Itching, pain, macules, and papules occur initially with HSV-2. The infection can progress to

vesicles and ulcers and can involve the labia, cervix, and vaginal and perianal areas.

**E**. Administer the first dose of acyclovir (Zovirax). An antiviral medication is needed to treat the infection.

**A**. Teach abstinence from sexual intercourse during treatment and use of condoms. The woman is unlikely to be receptive to teaching until some degree of comfort is achieved.

**C**. Discuss the benefits of joining a support group such as HELP (Herpetics Engaged in Living Productively). There is no cure for HSV-2 infection.