

100 Item MEDICAL SURGICAL Nursing Examination Correct answers and rationales

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Question Pool

MEDICAL SURGICAL NURSING

DISCLAIMER : Care has been taken to verify that all answers and rationale below are accurate. Please comment up if you noticed any errors or contradictions to maintain accuracy and precision of the answers as not to mislead the readers.

-Budek

DEGREE OF QUESTION DIFFICULTY

4 – Very hard question, 25% Chance of answering correctly

3 – Hard question, 50% Chance of answering correctly

2 – Moderately hard question, 75% of answering correctly

1 – Easy question, 99% will answer the question correctly

SITUATION : Dervid, A registered nurse, witnessed an old woman hit by a motorcycle while crossing a train railway. The old woman fell at the railway. Dervid Rushed at the scene.

1. As a registered nurse, Dervid knew that the first thing that he will do at the scene is [3]

A. Stay with the person, Encourage her to remain still and Immobilize the leg while While waiting for the ambulance.

B. Leave the person for a few moments to call for help.

C. Reduce the fracture manually.

D. Move the person to a safer place.

* The old woman is in the middle of a train railway. It is very unsafe to immobilize here legs and remain still at the middle of a railway considering that a train might come anytime while waiting for an ambulance. Safety is the utmost importance at this point. If letter D is not among the choices and the situation is a little less dangerous, the answer will be A. Remember that in all cases of emergencies, removing the victim from the scene to a much safer place is a priority.

2. Dervid suspects a hip fracture when he noticed that the old woman's leg is [4]

A. Lengthened, Abducted and Internally Rotated.

B. Shortened, Abducted and Externally Rotated.

C. Shortened, Adducted and Internally Rotated.

D. Shortened, Adducted and Externally Rotated.

* **SADDER** should be your keyword. A hip fracture will produce a **SHORTENED, ADDUCTED AND EXTERNALLY ROTATED** extremity. Treatment will evolve in casting the leg and putting it in a **EXTENSION, NEUTRALLY POSITIONED** and **SLIGHT INTERNAL ROTATION**. In Hip prosthesis, The nurse should maintain the client's leg in **FLEXION, EXTERNAL ROTATION** and **ABDUCTION** to prevent the dislocation of the prosthesis from the acetabulum. Take note of the difference because I mistakenly answered the **LATTER** in casting a hip fracture thinking that it is similar to a leg positioning in hip dislocation. Just imagine a patient with a cast that has his leg in **ABDUCTION, EXTERNAL ROTATION AND FLEXION**. It will cause flexion contractures.

3. The old woman complains of pain. John noticed that the knee is reddened, warm to touch and swollen. John interprets that this signs and symptoms are likely related to [2]

- A. Infection
- C. Thrombophlebitis
- B. Inflammation**
- D. Degenerative disease

* After a trauma, Inflammation will start almost instantly. Infection occurse 24-48 hours after bone fracture and not immediately. Thrombophlebitis occurs within 4 to 7 days of hospitalization after prolonged immobilization. There is no evidence that the client has a degenerative disease and degenerative diseases will manifest in variety of ways and not after a trauma.

4. The old woman told John that she has osteoporosis; Dervid knew that all of the following factors would contribute to osteoporosis except [4]

- A. Hypothyroidism**
- B. End stage renal disease
- C. Cushing's Disease
- D. Taking Furosemide and Phenytoin.

* B,C,D all contributes to bone demineralization except **HYPOTHYROIDISM**. Hyperthyroidism will contribute to bone demineralization as well as Hyperparathyroidism due to the increase in PTH, It will cause the movement of calcium from the bone to the blood causing **HYPERCALCEMIA**. ESRD will cause increase in **PHOPHSATE** due to its poor excretion. The amount of phosphate is inversely proportional to the amount of calcium. Cushing disease promotes bone demineralization as well as medications like diuretics and anti convulsants.

5. Martha, The old woman was now Immobilized and brought to the emergency room. The X-ray shows a fractured femur and pelvis. The ER Nurse would carefully monitor Martha for which of the following sign and symptoms? [3]

- A. Tachycardia and Hypotension**
- B. Fever and Bradycardia

- C. Bradycardia and Hypertension
- D. Fever and Hypertension

* hemorrhage results in severing of the vascular supply of the bone of the femur and the pelvis due to the fracture leading to bleeding causing the s/s of tachycardia and hypotension.

SITUATION: Mr. D. Rojas, An obese 35 year old MS Professor of OLFU Lagro is admitted due to pain in his weight bearing joint. The diagnosis was Osteoarthritis.

6. As a nurse, you instructed Mr. Rojas how to use a cane. Mr. Rojas has a weakness on his right leg due to self immobilization and guarding. You plan to teach Mr. Rojas to hold the cane [4]

- A. On his left hand, because his right side is weak.
- B. On his left hand, because of reciprocal motion.**
- C. On his right hand, to support the right leg.
- D. On his right hand, because only his right leg is weak.

* Reciprocal motion is a very important aspect of rehabilitation. Mr. Rojas has a weakness on his right leg. If a human moves his right leg, the left arm will accompany the movement of the right leg. That is what you call **RECIPROCAL MOTION** which is innate, natural and required to maintain balance. Mr. Rojas has weakness in his **RIGHT LEG**. If we put the cane on his right arm, The client will then be left **UNSUPPORTED** when he use his stronger leg [**LEFT LEG**] and stand with his weaker leg [**RIGHT LEG**] due to the fact that the opposite arm must accompany the movement of the opposite leg [**RIGHT ARM**]. In a more easier term, Always put the cane on the opposite of the weaker side. A is not correct because the client is **NOT** hemiplegic and will never be correct to reason out why the cane must always be at the opposite of the weaker side, it will always be due to reciprocal motion.

7. You also told Mr. Rojas to hold the cane [4]

- A. 1 Inches in front of the foot.
- B. 3 Inches at the lateral side of the foot.
- c. 6 Inches at the lateral side of the foot.**
- D. 12 Inches at the lateral side of the foot.

* Remove option A, the client will kick off the cane if it was in the front of the foot. Remove option D because that is too far and will cause the cane to poorly support the client because the side, not the tip, is touching the ground. At 3 inches, imagine how short it is and will cause a very poor supporting base. The correct answer is anywhere from 6 to 10 inches for both crutches and cane.

8. Mr. Rojas was discharged and 6 months later, he came back to the emergency room of the hospital because he suffered a mild stroke. The right side of the brain was affected. At the rehabilitative phase of your nursing care, you observe Mr. Rojas use a cane and you intervene if you see him [4]

- A. Moves the cane when the right leg is moved.**
- B. Leans on the cane when the right leg swings through.
- C. keeps the cane 6 Inches out to the side of the right foot.
- D. Holds the cane on the right side.

* If the right side of the brain is affected, weakness will always be CONTRALATERAL and therefore, Mr. Rojas will have weakness on his left side. Earlier I told you that cane is held on the opposite side of the weaker side, which in this situation, will be on the RIGHT. Imagine if the client moves his RIGHT LEG together with the RIGHT CANE, it already violated the LAW OF RECIPROCAL MOTION. Moving the right leg will require Mr. Rojas to move his left arm and not the cane, which is on his right.

SITUATION: Alfred, a 40 year old construction worker developed cough, night sweats and fever. He was brought to the nursing unit for diagnostic studies. He told the nurse he did not receive a BCG vaccine during childhood

9. The nurse performs a Mantoux Test. The nurse knows that Mantoux Test is also known as [1]

- A. PPD**
- B. PDP
- C. PDD
- D. DPP

* PPD stands for purified protein derivative. It is used to check for TB exposure. All clients who had BCG need not perform this test because they will always be + .

10. The nurse would inject the solution in what route? [1]

- A. IM
- B. IV
- C. ID**
- D. SC

* A Wheal is created intradermally and then it is marked and timed. reading will be done within 2 to 3 days.

11. The nurse notes that a positive result for Alfred is [2]

- A. 5 mm wheal
- B. 5 mm Induration
- C. 10 mm Wheal
- D. 10 mm Induration**

* 10 mm Induration [redness] is considered positive for individuals with competitive immune response. Wheals are not measured, they will not anymore enlarge. A 5 mm induration is considered positive for patients with AIDS or immunocompromised.

12. The nurse told Alfred to come back after [2]

- A. a week
- B. 48 hours**
- C. 1 day
- D. 4 days

* Clients are asked to come back within 2 to 3 days for the reading.

13. Mang Alfred returns after the Mantoux Test. The test result read POSITIVE. What should be the nurse's next action? [3]

- A. Call the Physician**
- B. Notify the radiology dept. for CXR evaluation
- C. Isolate the patient
- D. Order for a sputum exam

* The nurse has no authority order the radiology department for a chest x ray evaluation nor order for a sputum exam. The client need not be isolated because Mantoux test do not determine the activeness of the disease.

14. Why is Mantoux test not routinely done in the Philippines? [2]

- A. It requires a highly skilled nurse to perform a Mantoux test
- B. The sputum culture is the gold standard of PTB Diagnosis and it will definitively determine the extent of the cavitory lesions
- C. Chest X Ray Can diagnose the specific microorganism responsible for the lesions
- D. Almost all Filipinos will test positive for Mantoux Test**

* almost all filipinos tests positive for mantoux test due to the fact that BCG are required and TB exposure in the country is fullminant. All individuals vaccinated with BCG will test POSITIVE for mantoux test all their lives.

15. Mang Alfred is now a new TB patient with an active disease. What is his category according to the DOH? [1]

- A. I**
- B. II
- C. III
- D. IV

* Category I patients are those with a newly diagnosed TB whose sputum culture are positive. II are for those who have relapses while III are those with negative sputum culture but positive chest x ray, or PTB Minimal.

16. How long is the duration of the maintenance phase of his treatment? [2]

- A. 2 months
- B. 3 months
- C. 4 months**
- D. 5 months

* Clients in category I will have 2 months INTENSIVE and 4 months maintenance treatment.

17. Which of the following drugs is UNLIKELY given to Mang Alfred during the maintenance phase? [3]

- A. Rifampicin
- B. Isoniazid
- C. Ethambutol**
- D. Pyridoxine

* Drugs given in the maintenance phase includes Rifampicin and Isoniazid. Ethambutol is given on the intensive phase along with rifampicin and isoniazid. Pyridoxine is given during Isoniazid treatment to prevent peripheral neuritis in contrast in treatment of parkinson's with levodopa, Pyridoxine or VB6 is restricted.

18. According to the DOH, the most hazardous period for development of clinical disease is during the first [4]

- A. 6-12 months after**
- B. 3-6 months after
- C. 1-2 months after
- D. 2-4 weeks after

* According to the department of health, the most hazardous period for development of clinical disease is during the first 6 to 12 months.

19. This is the name of the program of the DOH to control TB in the country [2]

- A. DOTS
- B. National Tuberculosis Control Program**
- C. Short Coursed Chemotherapy
- D. Expanded Program for Immunization

* National tuberculosis control program is the name of the program of the DOH to control and eradicate TB in the country. DOTS refers to the STRATEGY used by the department in treating TB patients. EPI is not a program for TB control although BCG is one of the vaccine given in this program.

20. Susceptibility for the disease [TB] is increased markedly in those with the following condition except [3]

A. 23 Year old athlete with diabetes insipidus

- B. 23 Year old athlete taking long term Decadron therapy and anabolic steroids
- C. 23 Year old athlete taking illegal drugs and abusing substances
- D. Undernourished and Underweight individual who undergone gastrectomy

* Nutrition, Long term immunosuppression and drug abuse are all factors that affects the resistance of an individual in acquiring communicable diseases. Other factors includes extremes of ages, poor environmental sanitation, poverty and poor living conditions. Diabetes insipidus does not, in anyway alter a persons immune response.

21. Direct sputum examination and Chest X ray of TB symptomatic is in what level of prevention? [1]

- A. Primary
- B. Secondary**
- C. Tertiary
- D. Quarterly

* National board exam loves asking about level of prevention. Mastery with the primary, secondary and tertiary levels of prevention is a must. All diagnostic, case finding and treatment belongs to the secondary level of prevention.

SITUATION: Michiel, A male patient diagnosed with colon cancer was newly put in colostomy.

22. Michiel shows the BEST adaptation with the new colostomy if he shows which of the following? [2]

- A. Look at the ostomy site
- B. Participate with the nurse in his daily ostomy care**
- C. Ask for leaflets and contact numbers of ostomy support groups
- D. Talk about his ostomy openly to the nurse and friends

* Actual participation conveys positive acceptance and adjustment to the altered body image. Although looking at the ostomy site also conveys acceptance and adjustment, Participating with the nurse to his daily ostomy care is the BEST adaptation a client can make during the first few days after colostomy creation.

23. The nurse plans to teach Michiel about colostomy irrigation. As the nurse prepares the materials needed, which of the following item indicates that the nurse needs further instruction? [3]

- A. Plain NSS / Normal Saline**
- B. K-Y Jelly
- C. Tap water
- D. Irrigation sleeve

* The colon is not sterile, nor the stomach. Tap water is used in enema irrigation and not

NSS. Although some clients would prefer a distilled, mineral or filtered water, NSS is not always necessary. KY Jelly is used as the lubricant for the irrigation tube and is inserted 3-4 inches into the colostomy pointing towards the RIGHT. Irrigation sleeve is use to direct the flow of the irrigated solution out of the stomach and into the bedpan or toilet.

24. The nurse should insert the colostomy tube for irrigation at approximately [3]

- A. 1-2 inches
- B. 3-4 inches**
- C. 6-8 inches
- D. 12-18 inches

* Remember 3-4 inches. They are both used in the rectal tube and colostomy irrigation tube insertion. 1 to 2 inches is too short and may spill out the irrigant out of the stoma. Starting from 6 inches, it would be too long already and may perforate the bowel.

25. The maximum height of irrigation solution for colostomy is [3]

- A. 5 inches
- B. 12 inches**
- C. 18 inches**
- D. 24 inches

* If you will answer in the CGFNS and NCLEX, C will be the correct answer. According to BRUNNER AND SUDDARTHS and Saunders, The height of the colostomy irrigation bag should be hanging above the clients shoulder at around 18 inches. According to MOSBY, 12 inches should be the maximum height. According to Lippincotts, 18 inches is the maximum height. According the the board of examiners, 12 inches should be the maximum height and an 18 inches irrigant height would cause rapid flow of the irrigant towards the colostomy. Therefore, answer in the local board should only be at 12 inches.

26. Which of the following behavior of the client indicates the best initial step in learning to care for his colostomy? [1]

- A. Ask to defer colostomy care to another individual
- B. Promises he will begin to listen the next day
- C. Agrees to look at the colostomy**
- D. States that colostomy care is the function of the nurse while he is in the hospital

* The client made the best initial step in learning to care for his colostomy once he looks at the site. This is the start of the client's acceptance on his altered body image. A,B and D delays learning and shows the client's disintrest regarding colostomy care.

27. While irrigating the client's colostomy, Michiel suddenly complains of severe cramping. Initially, the nurse would [1]

- A. Stop the irrigation by clamping the tube**
- B. Slow down the irrigation

- C. Tell the client that cramping will subside and is normal
- D. Notify the physician

* Stopping the irrigation will also stop the cramping and pain. During the first few days of irrigation, The client will feel pain and cramping as soon as the irrigant touches the bowel. This will start to lessen once the client got accustomed to colostomy irrigation. Slowing down the irrigation will not stop the pain. Telling the client that it is normal and will subside eventually is not acceptable when a client experiences pain. Pain is all encompassing and always a priority over anything else in most situations. Notifying the physician will not be helpful and unnecessary.

28. The next day, the nurse will assess Michiel's stoma. The nurse noticed that a prolapsed stoma is evident if she sees which of the following? [1]

- A. A sunken and hidden stoma
- B. A dusky and bluish stoma
- C. A narrow and flattened stoma
- D. Protruding stoma with swollen appearance**

* A refers to a retracted stoma, B refers to a stoma that is getting a very poor blood supply. C is a description of stenosis of the stoma.

29. Michiel asked the nurse, what foods will help lessen the odor of his colostomy. The nurse best response would be [4]

- A. Eat eggs
- B. Eat cucumbers
- C. Eat beet greens and parsley**
- D. Eat broccoli and spinach

* Kinchay and Pechay helps lessen the odor of the colostomy. Spinach, broccoli, Cabbage, Cucumbers, Patola or bottle gourd also help lessen the odor BUT are gas formers. Eggs are not recommended because they are known to cause unpleasant odors in patients with colostomy.

30. The nurse will start to teach Michiel about the techniques for colostomy irrigation. Which of the following should be included in the nurse's teaching plan? [4]

- A. Use 500 ml to 1,000 ml NSS
- B. Suspend the irrigant 45 cm above the stoma**
- C. Insert the cone 4 cm in the stoma
- D. If cramping occurs, slow the irrigation

* 1 inches is equal to 2.54 cm. Convert the cm if you are not familiar. 45 cm is around 17 inches which is ideal for colostomy irrigation. Any value from 12 to 18 is accepted as the colostomy irrigant height. Tap water is used as an irrigant and is infused at room temperature. 4 cm is a little bit short for the ideal 3-4 inches. If cramping occurs STOP the irrigation and continue when it subsides.

31. The nurse knew that the normal color of Michiel's stoma should be [1]

A. Brick Red

B. Gray

C. Blue

D. Pale Pink

* The stoma should be RED in color. Pale pink are common with anemic or dehydrated patients who lost a lot of blood after an operation. Blue stoma indicated cyanosis or alteration in perfusion. Stomas are not expected to be Gray.

SITUATION: James, A 27 basketball player sustained inhalation burn that required him to have tracheostomy due to massive upper airway edema.

32. Wilma, His sister and a nurse is suctioning the tracheostomy tube of James. Which of the following, if made by Wilma indicates that she is committing an error? [2]

A. Hyperventilating James with 100% oxygen before and after suctioning

B. Instilling 3 to 5 ml normal saline to loosen up secretion

C. Applying suction during catheter withdrawal

D. Suction the client every hour

* This is unnecessary. Suctioning is done on PRN basis and not every hour. A,B and C are all correct processes of suctioning a tracheostomy.

33. What size of suction catheter would Wilma use for James, who is 6 feet 5 inches in height and weighing approximately 145 lbs? [2]

A. Fr. 5

B. Fr. 10

C. Fr. 12

D. Fr. 18

* The height is given and it looks like James is a very tall individual. The maximum height of suction tube is used. Fr 12-18 are used for adults while 6-8 are used in children.

34. Wilma is using a portable suction unit at home, What is the amount of suction required by James using this unit? [4]

A. 2-5 mmHg

B. 5-10 mmHg

C. 10-15 mmHg

D. 20-25 mmHg

* A is used in pediatric clients. B is for children and C is for adults. 20-25 mmHg is too much for a portable suction unit and is not recommended.

35. If a Wall unit is used, What should be the suctioning pressure required by James? [4]

- A. 50-95 mmHg
- B. 95-110 mmHg
- C. 100-120 mmHg**
- D. 155-175 mmHg

* A is used in pediatric clients. B is for children and C is for adults. 155-175 mmHg is too much for a wall suction unit and is not recommended.

36. Wilma was shocked to see that the Tracheostomy was dislodged. Both the inner and outer cannulas was removed and left hanging on James' neck. What are the 2 equipment's at James' bedside that could help Wilma deal with this situation? [3]

- A. New set of tracheostomy tubes and Oxygen tank
- B. Theophylline and Epinephrine
- C. Obturator and Kelly clamp**
- D. Sterile saline dressing

* In an emergency like this, The first thing the nurse should do is maintaining the airway patency. With the cannulas dislodged, The stoma will stenosed and narrows giving James an obstructed airway. The nurse would insert the Kelly clamp to open the stoma and lock the clamp in place to maintain it open while she uses an obturator as to prevent further stenosis of the stoma. An obturator is a part of the NGT package included by most manufacturers to guide the physician or nurses in inserting the outer cannula.

37. Which of the following method if used by Wilma will best assure that the tracheostomy ties are not too tightly placed? [2]

- A. Wilma places 2 fingers between the tie and neck**
- B. The tracheotomy can be pulled slightly away from the neck
- C. James' neck veins are not engorged
- D. Wilma measures the tie from the nose to the tip of the earlobe and to the xiphoid process.

* Wilma should place 2 fingers underneath the tie to ensure that it is not too tight nor too loose. Letter D is the measurement for NGT insertion and is unrelated to tracheostomy.

38. Wilma knew that James have an adequate respiratory condition if she notices that [1]

- A. James' respiratory rate is 18**
- B. James' Oxygen saturation is 91%
- C. There are frank blood suction from the tube
- D. There are moderate amount of tracheobronchial secretions

* an RR of 18 means that James is not tachypneic and has an adequate air exchange. Oxygen saturation should be more than 95%. Frank blood is not expected in the suction

tube. A slight tinged of blood in the tube is acceptable and expected. Amount of secretion are not in anyway related in assessing the respiratory condition of a person and so is the amount of blood in the tube.

39. Wilma knew that the maximum time when suctioning James is [1]

- A. 10 seconds**
- B. 20 seconds
- C. 30 seconds
- D. 45 seconds

* According to our reviewers and lecturers, 10 to 15 seconds is the maximum suction time. But according to almost all foreign books I read, it should only be 10 seconds at max. I prefer following Saunders, Mosby and Lippincott when they are all united.

SITUATION : Juan Miguel Lopez Zobel Ayala de Batumbakal was diagnosed with Acute Close Angle Glaucoma. He is being seen by Nurse Jet.

40. What specific manifestation would nurse Jet see in Acute close angle glaucoma that she would not see in an open angle glaucoma? [3]

- A. Loss of peripheral vision
- B. Irreversible vision loss
- C. There is an increase in IOP
- D. Pain**

* There is NO PAIN in open angle glaucoma. A,B,C are all present in both glaucomas including the low pressure glaucoma. Pain is absent because the increase in intra ocular pressure is not initiated abruptly. It is gradual and progressive and will lead to unnoticed loss of peripheral vision. Pain is present in acute close angle glaucoma because there is a sudden closure or narrowing of the canal of schlemm. Therefore if you will be ask what s/s is common in both, answer IRREVERSIBLE LOSS OF PERIPHERAL VISION.

41. Nurse jet knew that Acute close angle glaucoma is caused by [3]

- A. Sudden blockage of the anterior angle by the base of the iris**
- B. Obstruction in trabecular meshwork
- C. Gradual increase of IOP
- D. An abrupt rise in IOP from 8 to 15 mmHg

* Sudden blockage of the angle will cause s/s of acute angle closure glaucoma. B and C are all related to open angle glaucoma. D is insignificant, If the client bends or cough, IOP can increase from 8 to as much as 30 mmHg but then return again to normal.

42. Nurse jet performed a TONOMETRY test to Mr. Batumbakal. What does this test measures [1]

- A. It measures the peripheral vision remaining on the client

B. Measures the Intra Ocular Pressure

C. Measures the Client's Visual Acuity

D. Determines the Tone of the eye in response to the sudden increase in IOP.

* Tonometry measures the IOP. Normal range is 8 to 21 mmHg.

43. The Nurse notices that Mr. Batumbakal cannot anymore determine RED from BLUE. The nurse knew that which part of the eye is affected by this change? [3]

A. IRIS

B. PUPIL

c. RODS [RETINA]

D. CONES [RETINA]

* **CONES** Are responsible for **COLOR VISION** and **DAY VISION**, they are very sensitive to **RED LIGHT** that is why red lights are use to guide the elderly towards the bathroom when they wake up to urinate. Rods are responsible for night vision. They are sensitive to blue and green lights.

44. Nurse Jet knows that Aqueous Humor is produce where? [4]

A. In the sub arachnoid space of the meninges

B. In the Lateral ventricles

C. In the Choroids

D. In the Ciliary Body

* AH is produced in the **CILIARY BODY**. It is filtered by the trabecular meshwork into the canal of schlemm.

45. Nurse Jet knows that the normal IOP is [2]

A. 8-21 mmHg

B. 2-7 mmHg

c. 31-35 mmHg

D. 15-30 mmHg

46. Nurse Jet wants to measure Mr. Batumbakal's CN II Function. What test would Nurse Jet implement to measure CN II's Acuity? [1]

A. Slit lamp

B. Snellen's Chart

C. Wood's light

D. Gonioscopy

* CN II is the optic nerve. To assess its acuity, Snellen's chart is used. Slit lamp is the one you see in the usual Eye glasses shop where in, you need to look into its binocular-like holes and the optometrist is on the other side to magnify the structures of the eye to assess gross damage and structure. Woods light is a **BLUE LIGHT** used in dermatology.

It is use to mark lesions usually caused skin infection. Gonioscopy is the angle measurement of the eye.

47. The Doctor orders pilocarpine. Nurse jet knows that the action of this drug is to [4]

- A. Contract the Ciliary muscle**
- B. Relax the Ciliary muscle
- C. Dilate the pupils
- D. Decrease production of Aqueous Humor

* When the ciliary muscles contract, pupils constrict and the angle widens causing an increase AH outflow and decrease IOP. Relaxing the ciliary muscle will cause mydriasis or dilation, it is used as a pre op meds for cataract surgery and eye examination to better visualize the structures behind the iris. A and C are the same. Other drugs like betaxolol, Azetazolamide and epinephrine are the drugs used to decrease AH production.

48. The doctor orders timolol [timoptic]. Nurse jet knows that the action of this drug is [4]

- A. Reduce production of CSF
- B. Reduce production of Aqueous Humor**
- C. Constrict the pupil
- D. Relaxes the Ciliary muscle

* All the eye drops the ends in OLOL decreases AH production. They are BETA BLOCKERS. Watch out for the S/S of congestive heart failure, bradycardia, hypotension and arrythmias.

49. When caring for Mr. Batumbakal, Jet teaches the client to avoid [1]

- A. Watching large screen TVs
- B. Bending at the waist**
- C. Reading books
- D. Going out in the sun

* Bending at the waist increase IOP and should be avoided by patients with glaucoma. Treatment for glaucoma is usually for life. Patients are given laxatives to avoid straining at the stool. They should avoid all activities that will lead to sudden IOP increase like bending at the waist. Clients should bend at the knees.

50. Mr. Batumbakal has undergone eye angiography using an Intravenous dye and fluoroscopy. What activity is contraindicated immediately after procedure? [4]

- A. Reading newsprint**
- B. Lying down
- C. Watching TV
- D. Listening to the music

* The client had an eye angiography. Eye angiography requires the use MYDRIATICS pre-procedure. It is done by injecting an Intravenous dye and visualizes the flow of the dye through the fluoroscopy along the vessels of the eye. This is to assess macular degeneration or neovascularizations [proliferation of new vessels to compensate for continuous rupture and aneurysms of the existing vessels] Mydratics usually takes 6 hours to a day to wear off. If client uses a mydratic, his pupil will dilate making it UNABLE to focus on closer objects. Only A necessitates the constriction of the pupil to focus on a near object, which Mr. Batumbakal's eye cannot perform at this time.

51. If Mr. Batumbakal is receiving pilocarpine, what drug should always be available in any case systemic toxicity occurs? [2]

- A. **Atropine Sulfate**
- B. Pindolol [Visken]
- C. Naloxone Hydrochloride [Narcan]
- D. Mesoridazine Besylate [Serentil]

* Atropine sulfate is used to reverse the effects of systemic toxicity of pilocarpine. Narcan is the antidote for respiratory depression caused by narcotics like morphine and demerol. Serentil is an antipsychotic.

SITUATION : Wide knowledge about the human ear, its parts and its functions will help a nurse assess and analyze changes in the adult client's health.

52. Nurse Budek is doing a caloric testing to his patient, Aida, a 55 year old university professor who recently went into coma after being mauled by her disgruntled 3rd year nursing students whom she gave a failing mark. After instilling a warm water in the ear, Budek noticed a rotary nystagmus towards the irrigated ear. What does this mean? [2]

- A. Indicates a CN VIII Dysfunction
- B. Abnormal
- C. **Normal**
- D. Inconclusive

* Rotary nystagmus towards the ear [if warm] or away from it [if cool] is a normal response. It indicates that the CN VIII Vestibular branch is still intact.

53. Ear drops are prescribed to an infant, The most appropriate method to administer the ear drops is [2]

- A. Pull the pinna up and back and direct the solution towards the eardrum
- B. **Pull the pinna down and back and direct the solution onto the wall of the canal**
- C. Pull the pinna down and back and direct the solution towards the eardrum
- D. Pull the pinna up and back and direct the solution onto the wall of the canal

* Instillation for children under age 3 is CHILD : DOWN AND BACK. Directing the solution towards the eardrum might perforate or damage the infant's fragile tympanic membrane.

54. Nurse Budek is developing a plan of care for a patient with Menieres disease. What is the priority nursing intervention in the plan of care for this particular patient? [1]

- A. Air, Breathing, Circulation
- B. Love and Belongingness
- C. Food, Diet and Nutrition
- D. Safety**

* Although A is priority according to maslow, it is not specific in clients with menieres disease. The client has an attack of incapacitating vertigo and client is high risk for injury due to falls. The client will perceive the environment moving due to disruption of the vestibular system of the ear's normal function.

55. After mastoidectomy, Nurse Budek should be aware that the cranial nerve that is usually damage after this procedure is [3]

- A. CN I
- B. CN II
- C. CN VII**
- D. CN VI

* The facial nerve branches from the back of the ear and spread towards the mouth, cheeks, eyelids and almost all over the face. In mastoidectomy, Incision is made at the back of the ears to clear the mastoid air cells of the mastoid bone that is infected. Clients are at very high risk for CN VII injury because of this. Observation during the post op after mastoidectomy should revolve around assessing the client's CN VII integrity.

56. The physician orders the following for the client with Menieres disease. Which of the following should the nurse question? [1]

- A. Dipenhydramine [Benadryl]
- B. Atropine sulfate
- C. Out of bed activities and ambulation**
- D. Diazepam [Valium]

* Clients with acute attack of Menieres are required to have bed rest with side rails up to prevent injury. During periods of incapacitating vertigo, patient's eyes will have rotary nystagmus because of the perception that the environment is moving. Patients are also observed to hold the side rails so hard because they thought they are going to fall. Benadryl is used in menieres due to its anti histamine effects. B and D are used to allay clients anxiety and apprehension.

57. Nurse Budek is giving dietary instruction to a client with Menieres disease. Which statement if made by the client indicates that the teaching has been successful? [1]

- A. I will try to eat foods that are low in sodium and limit my fluid intake**

- B. I must drink atleast 3,000 ml of fluids per day
- C. I will try to follow a 50% carbohydrate, 30% fat and 20% protein diet
- D. I will not eat turnips, red meat and raddish

* Clients are advised to limite fluid and sodium intake as not to further cause accumulation of fluids in the endolymph. C is the diabetic diet. D are the foods not eaten when clients are about to have a guaiac test.

58. Peachy was rushed by his father, Steven into the hospital admission. Peachy is complaining of something buzzing into her ears. Nurse Budek assessed peachy and found out It was an insect. What should be the first thing that Nurse Budek should try to remove the insect out from peachy's ear? [3]

- A. Use a flashlight to coax the insect out of peachy's ear**
- B. Instill an antibiotic ear drops
- C. Irrigate the ear
- D. Pick out the insect using a sterile clean forceps

* Lights can coax the insect out of the child's ear. This is the first measure employed in removing a live insect from the childs ear. Insects are not removed ALIVE, therefore, C and D are both wrong. Antibiotics has no effects since the child do not have any infection. If the insect did not come out after coaxing it with light, 2nd measure employs instillation of diluted alcohol or a mineral oil to kill the insect which is then removed using letter D.

59. Following an ear surgery, which statement if heard by Nurse Budek from the patient indicates a correct understanding of the post operative instructions? [2]

- A. Activities are resumed within 5 days
- B. I will make sure that I will clean my hair and face to prevent infection
- C. I will use straw for drinking
- D. I should avoid air travel for a while**

* After ear surgery, Air travel is halted for a while. There is no need to restrict activities. The client is not allowed to shower for 7 days, Patient can clean himself using a sponge bath but avoids to shampoo or wet the face and hair. Straws are not used after ear surgery because sips increases pressure in the ear.

60. Nurse Budek will do a caloric testing to a client who sustained a blunt injury in the head. He instilled a cold water in the client's right ear and he noticed that nystagmus occurred towards the left ear. What does this finding indicates? [2]

- A. Indicating a Cranial Nerve VIII Dysfunction
- B. The test should be repeated again because the result is vague
- C. This is Grossly abnormal and should be reported to the neurosurgeon
- D. This indicates an intact and working vestibular branch of CN VIII**

* Refer to #52

61. A client with Cataract is about to undergo surgery. Nurse Budek is preparing plan of care. Which of the following nursing diagnosis is most appropriate to address the long term need of this type of patient? [1]

A. Anxiety R/T to the operation and its outcome

B. Sensory perceptual alteration R/T Lens extraction and replacement

C. Knowledge deficit R/T the pre operative and post operative self care

D. Body Image disturbance R/T the eye packing after surgery

* Patient do not have signs of anxiety, knowledge deficit or body image disturbance. The safest answer is B because before cataract surgery, client has a blurry vision that alters his sensory perception. After surgery client will be APHAKIC and again, will have an alteration in perception until the aphakic glass is available.

62. Nurse Budek is performing a WEBERS TEST. He placed the tuning fork in the patients forehead after tapping it onto his knee. The client states that the fork is louder in the LEFT EAR. Which of the following is a correct conclusion for nurse Budek to make? [4]

A. He might have a sensory hearing loss in the left ear

B. Conductive hearing loss is possible in the right ear

C. He might have a sensory hearing loss in the right hear, and/or a conductive hearing loss in the left ear.

D. He might have a conductive hearing loss in the right ear, and/or a sensory hearing loss in the left ear.

* Webers test assesses both air and bone conduction but is not decisive enough to judge which is which. When the tuning fork is tapped on the examiners knee, it is placed in the forehead or above the clients top lip. If the sound lateralizes towards the left ear, its either, the client has conductive hearing loss towards the left OR a sensory hearing loss in the right ear.

Why does conductive hearing produces a louder sound ?

Conductive hearing loss is a type of hearing loss where in, the ossicles hypertrophies, as in OTOSCLEROSIS. The stape is permanently attached to the oval window and it would not bulge causing a permanent LOUD conduction of sound using the bone because the stapes is already attached permanently into the inner ear. In a normal stape, It will not touch the oval window unless a sound is transmitted. [refer to the ear anatomy and physiology]

63. Aling myrna has Menieres disease. What typical dietary prescription would nurse Budek expect the doctor to prescribe? [2]

A. A low sodium , high fluid intake

B. A high calorie, high protein dietary intake

C. low fat, low sodium and high calorie intake

D. low sodium and restricted fluid intake

* Refer to # 57

SITUATION : [From DEC 1991 NLE] A 45 year old male construction worker was admitted to a tertiary hospital for incessant vomiting. Assessment disclosed: weak rapid pulse, acute weight loss of .5kg, furrows in his tongue, slow flattening of the skin was noted when the nurse released her pinch.

Temperature: 35.8 C , BUN Creatinine ratio : 10 : 1, He also complains for postural hypotension. There was no infection.

64. Which of the following is the appropriate nursing diagnosis? [1]

- A. Fluid volume deficit R/T furrow tongue
- B. Fluid volume deficit R/T uncontrolled vomiting**
- C. Dehydration R/T subnormal body temperature
- D. Dehydration R/T incessant vomiting

65. Approximately how much fluid is lost in acute weight loss of .5kg? [1]

- A. 50 ml
- B. 750 ml
- C. 500 ml**
- D. 75 ml

* 1L = 1kg

66. Postural Hypotension is [1]

- A. A drop in systolic pressure less than 10 mmHg when patient changes position from lying to sitting.
- B. A drop in systolic pressure greater than 10 mmHg when patient changes position from lying to sitting**
- C. A drop in diastolic pressure less than 10 mmHg when patient changes position from lying to sitting
- D. A drop in diastolic pressure greater than 10 mmHg when patient changes position from lying to sitting

* Postural hypotension is exhibited by a drop of systolic BP when client changes position from lying to sitting or standing.

67. Which of the following measures will not help correct the patient's condition [1]

- A. Offer large amount of oral fluid intake to replace fluid lost**
- B. Give enteral or parenteral fluid
- C. Frequent oral care
- D. Give small volumes of fluid at frequent interval

* The patient will not tolerate large amount of oral fluid due to incessant vomiting.

68. After nursing intervention, you will expect the patient to have [1]

1. Maintain body temperature at 36.5 C
2. Exhibit return of BP and Pulse to normal
3. Manifest normal skin turgor of skin and tongue
4. Drinks fluids as prescribed

- A. 1,3
- B. 2,4
- C. 1,3,4
- D. 2,3,4**

* Client need not maintain a temperature of 36.5 C. As long as the client will exhibit absence of fever or hypothermia, Nursing interventions are successfully carried out.

SITUATION: [From JUN 2005 NLE] A 65 year old woman was admitted for Parkinson's Disease. The charge nurse is going to make an initial assessment.

69. Which of the following is a characteristic of a patient with advanced Parkinson's disease? [1]

- A. Disturbed vision
- B. Forgetfulness
- C. Mask like facial expression**
- D. Muscle atrophy

* Parkinson's disease does not affect the cognitive ability of a person. It is a disorder due to the depletion of the neurotransmitter dopamine which is needed for inhibitory control of muscular contractions. Client will exhibit mask like facial expression, Cog wheel rigidity, Bradykinesia, Shuffling gait etc. Muscle atrophy does not occur in parkinson's disease nor visual disturbances.

70. The onset of Parkinson's disease is between 50-60 years old. This disorder is caused by [1]

- A. Injurious chemical substances
- B. Hereditary factors
- C. Death of brain cells due to old age
- D. Impairment of dopamine producing cells in the brain**

* Dopamine producing cells in the basal ganglia mysteriously deteriorates due to unknown cause.

71. The patient was prescribed with levodopa. What is the action of this drug? [1]

- A. Increase dopamine availability**

- B. Activates dopaminergic receptors in the basal ganglia
- C. Decrease acetylcholine availability
- D. Release dopamine and other catecholamine from neurological storage sites

* Levodopa is an altered form of dopamine. It is metabolized by the body and then converted into dopamine for brain's use thus increasing dopamine availability. Dopamine is not given directly because of its inability to cross the BBB.

72. You are discussing with the dietician what food to avoid with patients taking levodopa? [3]

- A. Vitamin C rich food
- B. Vitamin E rich food
- C. Thiamine rich food
- D. Vitamin B6 rich food**

* Vitamin b6 or pyridoxine is avoided in patients taking levodopa because levodopa increases vitamin b6 availability leading to toxicity.

73. One day, the patient complained of difficulty in walking. Your response would be [2]

- A. You will need a cane for support**
- B. Walk erect with eyes on horizon
- C. I'll get you a wheelchair
- D. Don't force yourself to walk

* Telling the client to walk erect neglects the clients complain of difficulty walking. Wheelchair is as much as possible not used to still enhance the client's motor function using a cane. Telling the client not to force himself walk is non therapeutic. The client wants to talk and we should help her walk using devices such as cane to provide support and prevent injuries.

SITUATION: [From JUN 2005 NLE] Mr. Dela Isla, a client with early Dementia exhibits thought process disturbances.

74. The nurse will assess a loss of ability in which of the following areas? [2]

- A. Balance**
- B. Judgment**
- C. Speech**
- D. Endurance

* Perhaps this question from the JUN 2005 NLE is finding what should the nurse NOT assess because A,B and C are all affected by dementia except ENDURANCE, which is normally lost as a person ages. There will be alteration in balance because coordination and spatial ability gradually deteriorates. Judgement is also impaired as the client exhibits poor memory and concentration. Speech is severely altered. Client develops aphasia, agnosia and in at end, will lose all the ability to speak without any manifestation of motor

problem.

75. Mr. Dela Isla said he cannot comprehend what the nurse was saying. He suffers from:
[1]

- A. Insomnia
- B. Aphraxia
- C. Agnosia
- D. Aphasia**

* This question was RECYCLED during the last 2006 NLE. Aphasia is the INABILITY to speak or understand. Aphraxia is the inability to carry out purposeful tasks. Agnosia is the inability to recognize familiar objects. Insomnia is the inability to fall asleep.

76. The nurse is aware that in communicating with an elderly client, the nurse will [1]

- A. Lean and shout at the ear of the client
- B. Open mouth wide while talking to the client
- C. Use a low-pitched voice
- D. Use a medium-pitched voice**

* Talk as normally as possible. The client has dementia and is not deaf, although hearing might be impaired progressively as the client ages, the nurse should not alter his voice, shout or over enunciate the words. Client will perceive this things as belittling and disrespectful.

77. As the nurse talks to the daughter of Mr. Dela Isla, which of the following statement of the daughter will require the nurse to give further teaching? [1]

- A. I know the hallucinations are parts of the disease
- B. I told her she is wrong and I explained to her what is right**
- C. I help her do some tasks he cannot do for himself
- D. Ill turn off the TV when we go to another room

* Hallucinations and delusions are part of DEMENTIA and is termed as ORGANIC PSYCHOSES. The daughter needs further teaching when she try to bargain, explain, disprove or advice a client with dementia. the client has an impaired judgement, concentration, thinking, reasoning and memory and has inability to learn that is why institutional care for clients with dementia is always required. The disease is progressive and is not preventable.

78. Which of the following is most important discharge teaching for Mr. Dela Isla [2]

- A. Emergency Numbers
- B. Drug Compliance**
- C. Relaxation technique
- D. Dietary prescription

* Drug compliance is the most important teaching for Mr. Dela Isla to prevent the symptoms of psychoses and to control behavioral symptoms.

SITUATION : Knowledge of the drug PROPANTHELINE BROMIDE [Probanthine] Is necessary in treatment of various disorders.

79. What is the action of this drug? [4]

- A. Increases glandular secretion for clients affected with cystic fibrosis
- B. Dissolve blockage of the urinary tract due to obstruction of cystine stones
- C. Reduces secretion of the glandular organ of the body**
- D. Stimulate peristalsis for treatment of constipation and obstruction

* Probanthine reduces glandular secretion of the different organs of the body. It is an anti-cholinergic / anti spasmodic drug and still, not approved by the FDA for treatment with various disorders. Probanthine exerts benefits for treatment of severe diaphoresis, Ulcers due to over secretion of HCl, Spasms, **PANCREATITIS** [Please take note] and other conditions of over secretion.

80. What should the nurse caution the client when using this medication [4]

- A. Avoid hazardous activities like driving, operating machineries etc.**
- B. Take the drug on empty stomach
- C. Take with a full glass of water in treatment of Ulcerative colitis
- D. I must take double dose if I missed the previous dose

* Like other anti cholinergics/ anti spasmodics, Probanthine causes dizziness, blurred vision and drowsiness. Patients are advised not to drive, operate heavy machineries etc. Probanthine should be taken with a full glass of water but is contraindicated with inflammatory bowel diseases like ulcerative colitis and chrons disease. Drug is taken with meals to prevent irritation of the gastric mucosa and client is advised not to take double dose in case the previous dose is missed.

81. Which of the following drugs are not compatible when taking Probanthine? [4]

- A. Caffeine
- B. NSAID
- C. Acetaminophen
- D. Alcohol**

* Probanthine on its own already cause severe dizziness and drowsiness. Addition of alcohol will further depress the CNS and might lead to potentiation of the side effects of probanthine. A,B,C are not contraindicated when taking probanthine EXCEPT when the disease entity itself do not permit intake of such drugs like in Pancreatitis, NSAID is not use. Pain is controlled using probanthine and meperidine [demerol] in cases of acute pancreatitis.

82. What should the nurse tell clients when taking Probanthine? [4]

- A. Avoid hot weathers to prevent heat strokes**
- B. Never swim on a chlorinated pool
- C. Make sure you limit your fluid intake to 1L a day
- D. Avoid cold weathers to prevent hypothermia

* Probanthine alters the ability of the body to secrete sweat. Telling the client to avoid hot weathers to prevent heat stroke is appropriate. Chlorinated pool is discouraged for patients undergoing skin radiation for skin cancer to prevent breakdown. Limiting fluid intake and avoiding cold weather are unnecessary teachings.

83. Which of the following disease would Probanthine exert the much needed action for control or treatment of the disorder? [4]

- A. Urinary retention
- B. Peptic Ulcer Disease**
- C. Ulcerative Colitis
- D. Glaucoma

* Probanthine is use in PUD to decrease gastric acid secretion. It is also used in Pancreatitis to rest the pancreas from over secretion of pancreatic enzyme and to prevent pain and spasm. Probanthine is contraindicated in clients with UC, Glaucoma. Since this is an anti spasmodic drug, Urinary retention will be a side effect.

SITUATION : [From DEC 2000 NLE] Mr. Franco, 70 years old, suddenly could not lift his spoons nor speak at breakfast. He was rushed to the hospital unconscious. His diagnosis was CVA.

84. Which of the following is the most important assessment during the acute stage of an unconscious patient like Mr. Franco? [1]

- A. Level of awareness and response to pain
- B. Papillary reflexes and response to sensory stimuli
- C. Coherence and sense of hearing
- D. Patency of airway and adequacy of respiration**

* Airway is always a priority in an unconscious client. Refer to maslows hierarchy of needs for prioritization. Although this is not absolute, knowledge with pathophysiology will best lead you to the correct option.

85. Considering Mr. Franco's conditions, which of the following is most important to include in preparing Franco's bedside equipment? [1]

- A. Hand bell and extra bed linen
- B. Sandbag and trochanter rolls
- C. Footboard and splint
- D. Suction machine and gloves**

* CVA patients has impaired swallowing ability and if not absent, depressed gag reflex. Client is at the highest risk for aspiration when eating or drinking that is why NGT is initiated early in the hospitalization. B prevent EXTERNAL ROTATION in hip or leg fracture. Footboards and splint prevents FOOTDROP seen in clients that has a severed peroneal nerve or prolonged immobilization usually due to fractures that eventually puts pressure on the peroneal nerve. A is not specific to clients with CVA.

86. What is the rationale for giving Mr. Franco frequent mouth care? [1]

- A. He will be thirsty considering that he is doesn't drink enough fluids
- B. To remove dried blood when tongue is bitten during a seizure
- C. The tactile stimulation during mouth care will hasten return to consciousness
- D. Mouth breathing is used by comatose patient and it'll cause oral mucosa drying and cracking.**

* Client will be on NGT once comatose, A is removed first. Client with CVA MAY have seizures, but it is RARE enough that it must require a frequent mouth care, B is eliminated next. Knowing that tactile stimulation is done by touching the patient and not by performing mouth care will lead you to letter D. Comatose patient uses the mouth to breathe predisposing himself to drying, cracking and infections.

87. One of the complications of prolonged bed rest is decubitus ulcer. Which of the following can best prevent its occurrence? [1]

- A. Massage reddened areas with lotion or oils
- B. Turn frequently every 2 hours**
- C. Use special water mattress
- D. Keep skin clean and dry

* Frequent turning and positioning is the single most important nursing intervention to prevent ulcer formation. Skins are massaged but once the areas are reddened already [CLASS I Ulcer], It is not anymore massaged as not to prevent further breakdown. Lotions and Oils are not use in clients skin because it will further enhance skin breakdown. Water mattress are used in BURN patients to limit the pressure on the skin by his own body weight. An alternating-inflatable air mattress is much more compatible in periodic distribution of pressure in clients with prolong immobility. Keeping skin clean and dry is important but not as important as frequent turning and positioning.

88. If Mr. Franco's Right side is weak, What should be the most accurate analysis by the nurse? [4]

- A. Expressive aphasia is prominent on clients with right sided weakness**
- B. The affected lobe in the patient is the Right lobe
- C. The client will have problems in judging distance and proprioception
- D. Clients orientation to time and space will be much affected

* If the client's right side is weak, the affected lobe is the LEFT LOBE which is where the broca's area is located. Client will exhibit expressive aphasia, careful and slow

movements and right sided weakness. Judging distance and proprioception is usually impaired in clients with RIGHT sided stroke. Telling that the clients orientation to time and space will be much affected is a blind shot analysis. This is seen on clients with severe and massive hemorrhagic stroke with recovery failure related to aneurysms producing long term and permanent coma. Mr. Franco right side is weak, not paralysed, meaning, some functions are still left intact.

SITUATION : [From JUN 1988 NLE] a 20 year old college student was rushed to the ER of PGH after he fainted during their ROTC drill. Complained of severe right iliac pain. Upon palpation of his abdomen, Ernie jerks even on slight pressure. Blood test was ordered. Diagnosis is acute appendicitis.

89. Which result of the lab test will be significant to the diagnosis? [1]

- A. RBC : 4.5 TO 5 Million / cu. mm.
- B. Hgb : 13 to 14 gm/dl.
- C. Platelets : 250,000 to 500,000 cu.mm.
- D. WBC : 12,000 to 13,000/cu.mm**

* WBC increases with inflammation and infection.

90. Stat appendectomy was indicated. Pre op care would include all of the following except? [1]

- A. Consent signed by the father
- B. Enema STAT**
- C. Skin prep of the area including the pubis
- D. Remove the jewelries

* Refer to ABDOMINAL ASSESSMENT : STORY TOWARDS MASTERY

91. Pre-anesthetic med of Demerol and atrophine sulfate were ordered to : [3]

- A. Allay anxiety and apprehension**
- B. Reduce pain
- C. Prevent vomiting
- D. Relax abdominal muscle

* Pain is not reduced in appendicits. Clients are not given pain medication as to assess whether the appendix ruptured. A sudden relief of pain indicates the the appendix has ruptured and client will have an emergency appendectomy and prevent peritonitis. Demerol and Atropine are used to allay client's anxiety pre operatively.

92. Common anesthesia for appendectomy is [3]

- A. Spinal**
- B. General
- C. Caudal

D. Hypnosis

* Spinal anesthesia is the most common method used in appendectomy. Using this method, Only the area affected is anesthetized preventing systemic side effects of anesthetics like dizziness, hypotension and RR depression.

93. Post op care for appendectomy include the following except [1]

- A. Early ambulation
- B. Diet as tolerated after fully conscious**
- C. Nasogastric tube connect to suction
- D. Deep breathing and leg exercise

* Client's peristalsis will return in 48 to 72 hours post-op therefore, Fluid and food are withheld until the bowel sounds returns. Remember that ALL PROCUDURES requiring GENERAL and SPINAL anesthesia above the nerves that supply the intestines will cause temporary paralysis of the bowel. Specially when the bowels are traumatized during the procedure, it may take longer for the intestinal peristalsis to resume.

94. Peritonitis may occur in ruptured appendix and may cause serious problems which are [2]

1. Hypovolemia, electrolyte imbalance
2. Elevated temperature, weakness and diaphoresis
3. Nausea and vomiting, rigidity of the abdominal wall
4. Pallor and eventually shock

- A. 1 and 2
- B. 2 and 3
- C. 1,2,3
- D. All of the above**

* Peritonitis will cause all of the above symptoms. The peritoneum has a natural tendency to GUARD and become RIGID as to limit the infective exudate exchange inside the abdominal cavity. Hypovolemia and F&E imbalance are caused by severe nausea and vomiting in patients with peritonitis because of acute pain. As inflammation and infection spreads, fever and chills will become more apparent causing elevation in temperature, weakness and sweating. If peritonitis is left untreated, Client will become severely hypotensive leading to shock and death.

95. If after surgery the patient's abdomen becomes distended and no bowel sounds appreciated, what would be the most suspected complication? [1]

- A. Intussusception
- B. Paralytic Ileus**
- C. Hemorrhage
- D. Ruptured colon

* Paralytic Ileus is a mechanical bowel obstruction where in, the patients intestine fails to regain its motility. It is usually caused by surgery and anesthesia. Intussusception, Appendicitis and Peritonitis also causes paralytic ileus.

96. NGT was connected to suction. In caring for the patient with NGT, the nurse must [2]

- A. **Irrigate the tube with saline as ordered**
- B. Use sterile technique in irrigating the tube
- C. advance the tube every hour to avoid kinks
- D. Offer some ice chips to wet lips

* NGT after appendectomy is used not to deliver nutrients but to decompress the GI tract because of the absence of peristalsis after appendectomy. The stomach and intestines are not sterile, Clean technique is sufficient during irrigation. NGT is placed and not anymore advanced as long as it already reach the stomach. Naso enteric tubes are the one that are advanced periodically until obstruction is reached in the intestine. The client still needs assessment and confirmation of the return of peristalsis before anything is given per ore. Irrigations are done to prevent obstruction in the tube.

97. When do you think the NGT tube be removed? [1]

- A. When patient requests for it
- B. Abdomen is soft and patient asks for water
- C. **Abdomen is soft and flatus has been expelled**
- D. B and C only

* When flatus is expelled, it means that peristalsis has returned and theres is no need for continuing the NGT.

Situation: Amanda is suffering from chronic arteriosclerosis Brain syndrome she fell while getting out of the bed one morning and was brought to the hospital, and she was diagnosed to have cerebrovascular thrombosis thus transferred to a nursing home.

98. What do you call a STROKE that manifests a bizarre behavior? [4]

- A. Inorganic Stroke
- B. Inorganic Psychoses
- C. Organic Stroke
- D. **Organic Psychoses**

* Organic psychoses is a broad and collective term used for psychoses and schizophrenia that has an organic cause. [Due to Creutzfeldt jakob disease, huntington, hydrocephalus, increase ICP, dementia, stroke etc.] Manifesting signs and symptoms like hallucination, delusions, illusion, ideas of reference etc. that is similar to schizophrenia and psychoses in absence of organic causes.

99. The main difference between chronic and organic brain syndrome is that the former [2]

- A. Occurs suddenly and reversible
- B. Is progressive and reversible
- C. tends to be progressive and irreversible**
- D. Occurs suddenly and irreversible

* Chronic brain syndrome tends to be progressive and irreversible. Organic brain syndrome is acute and irreversible or reversible depending on the causative factor.

100. Which behavior results from organic psychoses? [4]

- A. Memory deficit
- B. Disorientation**
- C. Impaired Judgement**
- D. Inappropriate affect**

* B, C and D are all behaviors that results from organic psychoses. The questions seems to ask EXCEPTION which is **A. MEMORY DEFICIT**. Organic psychoses is the same as the usual psychoses except that the causative factor of organic psychoses is evidently caused by a disease process of the brain or affecting the brain. Example are patients who suffer stroke suddenly experience hallucinations and delusions. Organic psychoses is simply a psychoses that has an IDENTIFIED CAUSE. Knowing this will lead you to understand that psychoses is manifested by B,C, and D but NOT MEMORY DEFICIT.

DISCLAIMER: Answers to the above questions are all accurate and correct and researched thoroughly with all my skills and capabilities . If you disagree with any answers form the above rationales, please comment up and we can work on it.