

50 item Integumentary Exam

Source: Saunders Q&A NCLEX Review 3rd edition

1. A nurse is caring for a burn client who has sustained thoracic burns and smoke inhalation and is at risk for impaired gas exchange. The nurse avoids which action in caring for this client?
 - a. repositioning the client from side to side every 2 hours
 - b. maintaining the client in a supine position with the head of the bed elevated**
 - c. suctioning the airway as needed
 - d. providing humidified oxygen as prescribed

Aggressive pulmonary measures are used to prevent respiratory complications in the client who has impaired gas exchange as a result of a burn injury. These include turning and repositioning, positioning for comfort, using humidified oxygen, providing incentive spirometry, and suctioning the client on an as needed basis. The nurse would avoid maintaining the client in one position. This will ultimately lead to atelectasis and possible pneumonia.

2. A client sustains a burn injury to the entire right arm, entire right leg, and anterior thorax. According to the rule of nine's the nurse determines that what body percent was injured?

Answer: _____ 45% _____

According to the Rule of Nine's, the right arm is equal to 9% and the left arm is equal to 9%. The right leg is equal to 18% and the left leg is equal to 18%. The anterior thorax is equal to 18% and the posterior thorax is equal to 18%. The head is equal to 9% and the perineum is 1%. If the anterior thorax (18%), entire right leg (18%), and entire right arm (9%) were burned, according to the Rule of Nine's, this would equal 45%.

3. A nurse assesses a burn injury and determines that the client sustained a full-thickness fourth-degree burn if which of the following is noted at the site of injury?
 - a. a wet shiny weeping wound surface
 - b. a dry wound surface
 - c. charring at the wound site**
 - d. blisters

In a full-thickness fourth-degree burn injury, charring is visible. Extremity movement is limited and wound sensation is absent. Blisters and a wet shiny

weeping surface would be noted in a partial-thickness second-degree burn injury. A dry wound surface would be noted in a full-thickness third-degree burn injury.

4. A client is brought to the emergency room following a burn injury. In assessment the nurse notes that the client's eyebrow and nasal hairs are singed. The nurse would identify this type of burn as:
 - a. **thermal**
 - b. electrical
 - c. radiation
 - d. chemical

Exposure to or contact with flames, hot liquids, or hot objects causes thermal burns. Thermal burns are those sustained in residential fires, explosive accidents, scald injuries, or ignition of clothing or liquids. If the nurse notes facial burns or singed eyebrow or nasal hairs, the victim likely experienced the burn in an enclosed smoke filled space such as in a residential fire. Electrical burns are caused by heat that is generated by the electrical energy as it passes through the body. Radiation burns are caused by exposure to a radioactive source. Chemical burns are caused by tissue contact with strong acids, alkalis, or organic compounds.

5. A nurse assesses the carbon monoxide level of a client following a burn injury and notes that the level is 8%. Based on this level, which finding would the nurse expect to note during the assessment of the client?
 - a. tachycardia
 - b. tachypnea
 - c. coma
 - d. **impaired visual acuity**

Clinical manifestations of carbon monoxide poisoning are related to the levels of carbon monoxide saturation. A level between 5 to 10% would cause impaired visual acuity; 11 to 20% flushing and headache; 21 to 30% nausea and impaired dexterity; 31 to 40% vomiting, dizziness, and syncope; 41 to 50% tachypnea and tachycardia; and greater than 50% coma and death.

6. A nurse assesses the client's burn injury and determines that the client sustained a partial-thickness superficial burn. Based on this determination, which finding did the nurse note?
 - a. **a wet, shiny, weeping wound**
 - b. a dry wound surface

- c. charring at the wound site
- d. absence of wound sensation

A partial-thickness superficial burn appears wet, shiny, and weeping, or may contain blisters. The wound blanches with pressure, is painful, and very sensitive to touch or air currents. Charring would occur in a deep full-thickness burn. Decreased or absence of wound sensation would occur in full-thickness or deep full-thickness burns.

7. A nurse assesses the client's burn injury and determines that the client sustained a partial-thickness deep burn. Based on this determination, which finding did the nurse note?
- a. a wet, shiny, weeping wound surface
 - b. a dry wound surface**
 - c. charring at the wound site
 - d. total absence of wound sensation

A partial-thickness deep burn appears dry and may be red or white in appearance. No blanching occurs and thrombosed vessels may be visible. Decreased wound sensation will be present. Blisters and a wet shiny weeping surface occur in partial-thickness superficial burns. Charring would occur in deep full-thickness burns. Total absence of wound sensation would occur in deep full-thickness burns.

8. On assessment of a child, the nurse notes the presence of white patches on the child's tongue and determines that they may be indicative of candidiasis (thrush). The nurse understands that the white patches of candidiasis (thrush):
- a. adhere to the tongue even when scraped with tongue blade**
 - b. cause the tongue to bleed continuously around the patch
 - c. produce a red circle in the center of the white lesion
 - d. will occur only in the tongue

Candidiasis, a fungal infection, adheres firmly to the tongue and/or mucous membranes of the mouth and throat. Bleeding may occur after the trauma of trying to remove the patches. A red circle on the skin may be associated with other disorders such as Lyme disease but is not seen in candidiasis. Candidiasis can occur on the oral mucous membranes as well as on the tongue.

9. On assessment, a nurse notes a flat brown circular nevi on the skin of a client that measures less than one centimeter. The client asks, "Is this cancer?" The nurse makes which response to the client?

- a. **"These are likely to be benign moles."**
- b. "These require immediate attention because they are probably cancer."
- c. "These indicate malignancy."
- d. "These are probably verrucae."

A flat brown circular nevi is a description of a classic benign mole. Therefore option 1 is correct. If the color changes or varies, if the size is greater than 1 cm, or if the mole was raised or itchy, it should be considered suspicious. The description in the question indicates that the lesions are nevi (moles) and thus are not verrucae (warts).

10. A nurse is performing a skin assessment on a client. The nurse understands that moles with variegated color, irregular borders, and/or an irregular surface should be considered:

- a. **suspicious**
- b. normal
- c. common
- d. benign

The data identified in the question suggest the possibility of malignant melanoma; therefore, moles with these characteristics should be considered suspicious. Options b, c, and d are incorrect.

11. A client is diagnosed with herpes zoster (shingles). Which pharmacological therapy would the nurse expect to be prescribed to treat this disorder?

- a. tetracycline hydrochloride (achromycin)
- b. erythromycin base (e-mycin)
- c. **acyclovir (zovirax)**
- d. indomethacin (indocin)

The goals of treatment for herpes zoster are to relieve pain, to prevent infection and scarring, and to reduce the possibility of postherpetic neuralgia. Oral analgesics are prescribed to reduce the incidence of persistent pain. The lesions may also be injected with corticosteroids. Acyclovir, if started early, may reduce the severity of herpes zoster. Options a and b identify antibiotics that are not normally prescribed for this condition. Option d is a nonsteroidal antiinflammatory medication.

12. A nurse reviews the record of a client diagnosed with pemphigus and notes that the physician has documented the presence of Nikolsky's

sign. Based on this documentation, which of the following would the nurse expect to note?

- a. client complains of discomfort behind the knee on forced dorsiflexion of the foot
- b. a spasm of the facial muscles elicited by tapping the facial nerve in the region of the parotid gland
- c. carpal spasm elicited by compressing the upper arm
- d. the epidermis of the client's skin can be rubbed off by slight friction or injury**

A hallmark sign of pemphigus is Nikolsky's sign, which occurs when the epidermis can be rubbed off by slight friction or injury. Other characteristics of pemphigus include flaccid bullae that rupture easily and emit a foul smelling drainage, leaving crusted, denuded skin. The lesions are common on the face, back, chest, groin and umbilicus. Even slight pressure on an intact blister may cause spread to adjacent skin. Trousseau's sign is a sign for tetany in which carpal spasm can be elicited by compressing the upper arm and causing ischemia to the nerves distally. Chvostek's sign seen in tetany is a spasm of the facial muscles elicited by tapping the facial nerve in the region of the parotid gland. Homans' sign, a sign of thrombosis in the leg, is discomfort behind the knee on forced dorsiflexion of the foot.

13. A hospitalized client is diagnosed with scabies. Which of the following would a nurse expect to note on inspection of the client's skin?

- a. the appearance of vesicles or pustules
- b. the presence of white patches scattered about the trunk
- c. multiple straight or wavy threadlike lines beneath the skin**
- d. patchy hair loss and round, red macules with scales

Scabies can be identified by the presence of multiple straight or wavy threadlike lines beneath the skin. The skin lesions are caused by a female mite, which burrows beneath the skin and lays its eggs. Options a, b, and d are not characteristics of scabies.

14. A client is seen in the health care clinic and the physician suspects herpes zoster. The nurse prepares the items needed to perform the diagnostic test to confirm this diagnosis. Which item will the nurse obtain?

- a. a biopsy kit
- b. a wood's light
- c. a culture swab and tube**
- d. a patch test kit

Herpes zoster is caused by a reactivation of the varicella zoster virus, the cause of the virus for chicken pox. With classic presentation of herpes zoster, the clinical examination is diagnostic. A viral culture of the lesion provides the definitive diagnosis. In a Wood's light examination, the skin is viewed under ultraviolet light to identify superficial infections of the skin. A patch test is a skin test that involves the administration of an allergen to the skin's surface to identify specific allergies. A biopsy will determine tissue type.

15. A nurse reviews the health care record of a client diagnosed with herpes zoster. Which finding would the nurse expect to note as characteristic of this disorder?
- a. a generalized red body rash that causes pruritus
 - b. small blue-white spots with a red base noted on the extremities
 - c. a fiery red edematous rash on the cheeks and neck
 - d. clustered and grouped skin vesicles**

The primary lesion of herpes zoster is a vesicle. The classic presentation is grouped vesicles on an erythematous base along a dermatome. Because they follow nerve pathways, the lesions do not cross the body's midline. Options a, b, and c are not characteristics of herpes zoster.

16. A client returns to the clinic for a follow-up treatment following a skin biopsy of a suspicious lesion performed 1 week ago. The biopsy report indicated that the lesion is a squamous cell carcinoma. The nurse plans care knowing that which of the following describes the characteristic of this type of a lesion?
- a. it is highly metastatic
 - b. it does not metastasize
 - c. it is characterized by local invasion**
 - d. it is encapsulated

Squamous cell carcinomas are malignant neoplasms of the epidermis. They are characterized by local invasion and the potential for metastasis. Melanomas are pigmented malignant lesions originating in the melanin-producing cells of the epidermis. Melanomas are highly metastatic, and a person's survival depends on early diagnosis and treatment. Basal cell carcinomas arise in the basal cell layer of the epidermis. Early malignant basal cell lesions often go unnoticed and although metastasis is rare, underlying tissue destruction can progress to include vital structures.

17. A nurse reviews the record of a client scheduled for removal of a skin lesion. The record indicates that the lesion is an irregularly shaped,

pigmented papule with a blue-toned color. The nurse determines that this description of the lesion is characteristic of:

- a. **melanoma**
- b. basal cell carcinoma
- c. squamous cell carcinoma
- d. actinic keratosis

A melanoma is an irregularly shaped pigmented papule or plaque with a red, white or blue toned color. Basal cell carcinoma appears as a pearly papule with a central crater and rolled waxy border. Squamous cell carcinoma is a firm nodular lesion topped with a crust or a central area of ulceration. Actinic keratosis, a premalignant lesion, appears as a small macule or papule with dry, rough, adherent yellow or brown scale.

18. A nurse is reviewing the nursing care plan for a client for whom a stage 4 decubiti ulcer has been documented. Which of the following would the nurse expect to note on assessment of the client?

- a. a reddened area that returns to a normal skin color after 15 to 20 minutes of pressure relief
- b. intact skin
- c. an area in which the top layer of skin is missing
- d. **a deep ulcer that extends into muscle and bone.**

A stage 4 pressure ulcer is a deep ulcer that extends into muscle and bone. It has a foul smell, and the eschar is brown or black. Purulent drainage is common. In a stage 1 ulcer, the skin is intact, but the area may appear pale when pressure is first removed. A stage 1 ulcer is also identified by a reddened area that returns to normal skin color after 15 to 20 minutes of pressure relief. A stage 2 ulcer is an area in which the top layer of skin is missing.

19. A nurse notes documentation of a stage 3 pressure ulcer in a client's record. Which of the following would the nurse expect to note on assessment of the client?

- a. a deep ulcer that extends into muscle and bone
- b. **a deep ulcer that extends into the dermis and the subcutaneous tissue**
- c. an area in which the top layer of skin is missing
- d. a reddened area that returns to normal skin color after 15 to 20 minutes of pressure relief

A stage 3 ulcer is a deep ulcer that extends into the dermis and the subcutaneous tissue. White, gray, or yellow eschar usually is present at the bottom of the ulcer, and the ulcer crater may have a lip or edge. Purulent drainage is common. A stage 4 ulcer is a deep ulcer that extends into muscle

and bone. A stage 2 ulcer is an area in which the top layer of skin is missing. A stage 1 ulcer is a reddened area that returns to normal skin color after 15 to 20 minutes of pressure relief.

20. A client is in the health care clinic for complaints of pruritus. Following diagnostic studies, it has been determined that there is not a pathophysiological process causing the pruritus. The nurse prepares instructions for the client to assist in reducing the problem and tells the client to:
- a. use a dehumidifier in the home
 - b. ensure that the temperature in the home is high, especially during the winter months
 - c. use a cool-mist vaporizer, especially during the winter months**
 - d. avoid use of skin moisturizers following a bath

Itching can be a symptom of systemic disease, such as severe liver or renal disease. It can also follow medication hypersensitivity or blood reactions, and it may occur in the older client as a result of dry skin. Heat and low humidity also induce pruritus. During the winter months, using a moisturizer and increasing room humidity with a cool-mist vaporizer are advantageous to alleviate the problem.

21. A client is seen in the health care clinic because of complaints of lesions on the elbows and the knees. The lesions are red raised papules, and large plaques covered by silvery scales are also noticed on the elbows and the knees. Psoriasis is diagnosed and the nurse provides information about treatment to the client. The nurse determines that the client needs additional information if the client states that which of the following is a component of the treatment plan?
- a. tar baths
 - b. ultraviolet light treatments
 - c. topical lubricants
 - d. systemic corticosteroids**

Systemic corticosteroids are not normally used to treat psoriasis. Even though systemic corticosteroids will quickly stop an exacerbation, after withdrawal of the corticosteroids, a rebound effect occurs. This steroid rebound will cause an immediate exacerbation or will convert the plaque or exfoliative type of psoriasis to pustular. Options a, b, and c are appropriate treatments for psoriasis.

22. A client is seen in the health care clinic and a biopsy is performed on a skin lesion that the physician suspects malignant melanoma. The

nurse prepares a plan of care for the client based on which characteristics of this type of skin cancer?

- a. **it is an aggressive cancer that requires aggressive therapy to control its rapid spread**
- b. it is a slow-growing cancer and seldom metastasizes
- c. it can grow so large that an entire area, such as the nose, the lip, or the ear must be removed and reconstructed if it occurs on the face
- d. it is the most common form of skin cancer

Malignant melanoma, commonly called melanoma, is cancer of the melanocyte cells of the skin. It is an aggressive cancer that requires aggressive therapy to control its spread. Basal cell carcinoma, also known as basal cell epithelioma, is the most common form of skin cancer. It is a slow-growing cancer and seldom metastasizes, but it can grow so large that the entire area of the nose, the lip, or the ear must be removed and reconstructed.

23. A nurse is caring for a client brought to the emergency room following a burn injury that occurred in the basement of the home. Which initial finding would indicate the presence of inhalation injury?
- a. expectoration of sputum tinged with blood
 - b. **the presence of singed nasal hair**
 - c. absent breath sounds in the lower lobes bilaterally
 - d. tachycardia

Inhalation injuries are most common when a fire occurs in a closed space. The findings are facial burns, singed nasal hairs, and sputum tinged with carbon. Additionally, auscultation of wheezing and rales suggests an inhalation injury. Tachycardia is not a specific manifestation of a burn inhalation injury.

24. A nurse is caring for a client who arrives at the emergency room with the emergency medical services team following a severe burn injury from an explosion. Once the initial assessment has been performed by the physician and life-threatening dysfunctions have been addressed, the nurse reviews the physician's orders anticipating that which pain medication will be prescribed?
- a. **intravenous (IV) morphine sulfate**
 - b. aspirin with oxycodone (percodan) via nasogastric tube
 - c. acetaminophen (tylenol) with codeine sulfate
 - d. morphine sulfate by the subcutaneous route

Once the initial assessment has been made and life-threatening dysfunctions have been addressed, pain medication can be administered. Narcotics

administered IV are the initial medications of choice because absorption from the musculature is erratic at this time, and an ileus can be present in the burn client. The initial medication of choice is morphine sulfate, although other medications such as methadone, codeine, or hydromorphone may be used also. Narcotics are given by the IV route until fluid resuscitation is complete and gastric motility is restored.

25. A nurse is assessing the operative site in a client who underwent a breast reconstruction. The nurse is inspecting the flap and the areola of the nipple and notes that the areola is a deep red color around the edge. The nurse takes which action first?
- a. document the findings
 - b. elevate the breast
 - c. encourage nipple massage
 - d. notify the physician**

Following breast reconstruction, the flap is inspected for color, temperature, and capillary refill. Assessment of the nipple areola is made, and dressings are designed so this area can be observed. An areola that is deep red, purple, dusky, or black around the edge is reported to the physician immediately because this may indicate a decreased blood supply to the area. The nurse would also document the findings once the physician is notified. Options b and c are incorrect actions.

26. A nurse performs a skin assessment on an assigned client and notes the presence of lesions that are red-tan scaly plaques. The nurse documents this findings as:
- a. seborrhea
 - b. xerosis
 - c. pruritus
 - d. actinic keratoses**

Actinic keratoses refers to lesions that are red-tan scaly plaques that increase over the years to become raised and roughened. They may have a silvery white scale adherent to the plaque. They occur on sun-exposed surfaces and are directly related to sun exposure. They are premalignant and may develop into squamous cell carcinoma. Dry skin is called xerosis. In this condition, the epidermis lacks moisture or sebum, and is often characterized by a pattern of fine lines, scaling, and itching. Causes include too frequent bathing, low humidity, and decreased production of sebum in aging skin. Seborrhea relates to any of several common skin conditions in which an overproduction of sebum results in excessive oiliness or dry scales. Pruritus refers to the symptom of itching, an uncomfortable sensation that leads to the urge to scratch the skin.

27. A community health nurse has provided fire safety instructions to a group of individuals who are part of a disaster response team. Which statement by a group member indicates a need for further instructions?
- a. "the victim may be rolled on the ground to extinguish the flames"
 - b. "a blanket or another cover can be used to smother the flames"
 - c. "flames should be doused with water"
 - d. "keep the victim in standing position so flames won't spread to other parts of the body"**

The victim should be placed or kept in a supine position because flames may otherwise spread to other parts of the body, causing more extensive injury. Flames can be extinguished by rolling the client on the ground, smothering the flames with a blanket or other cover, or dousing the flames with water.

28. A community health nurse is providing a teaching session to firefighters in a small community regarding care to a victim at the scene of a burn injury. The community health nurse instructs the firefighters that in the event of a tar burn the immediate action would be to:
- a. cool the injury with water**
 - b. remove all clothing immediately
 - c. remove the tar from the burn injury
 - d. leave any clothing that is saturated with tar in place

Scald, tar, or asphalt burns should be treated by immediate cooling with water, if available, or immediate removal of the saturated clothing. Clothing that is burned into the skin is not removed because increased tissue damage and bleeding may occur. No attempt is made to remove tar from the skin at the scene of the accident.

29. The client who sustained an inhalation injury arrives in the emergency department. On assessment of the client, the nurse notes that the client is very confused and combative. The nurse determines that the client is experiencing:
- a. anxiety
 - b. fear
 - c. hypoxia**
 - d. pain

After a burn injury, clients are normally alert. If a client becomes confused or combative, hypoxia may be the cause. Hypoxia occurs after inhalation injury and may occur after an electrical injury. Although the client may experience anxiety, fear, and pain, these would not be the cause of the client's confusion and combativeness.

30. The client is diagnosed with stage I of Lyme disease. The nurse assesses the client for the hallmark characteristic of this stage. Which assessment finding would the nurse expect to note?
- a. dizziness and headaches
 - b. enlarged and inflamed joints
 - c. arthralgias
 - d. skin rash**

The hallmark of stage I is the development of a skin rash within 2 to 30 days of infection, generally at the site of the tick bite. The rash develops into a concentric ring, giving it a 'bull's eye' appearance. The lesion enlarges up to 50 to 60 cm, and smaller lesions develop farther away from the original tick bite. In stage I, most infected persons also develop flulike symptoms that last 7 to 10 days, and these symptoms may recur later.

31. The emergency department nurse is performing an assessment on a client who has sustained circumferential burns of both legs. Which assessment would be the priority in caring for this client?
- a. assessing peripheral pulses**
 - b. assessing neurological status
 - c. assessing urine output
 - d. assessing blood pressure

The client who receives circumferential burns to the extremities is at risk for altered peripheral circulation. The priority assessment would be to check for peripheral pulses to ensure that adequate circulation is present. Although the urine output, neurological status, and BP would also be assessed, the priority with a circumferential burn is the assessment for the presence of peripheral pulses.

32. The nurse is reviewing the discharge instructions for a client who had skin biopsy. Which statement by the client indicates a need for further instructions?
- a. "I will watch for any drainage from the wound"
 - b. "I will return tomorrow to have the sutures removed"**
 - c. "I will use antibiotic ointment as prescribed"
 - d. "I will keep the dressing dry"

Sutures are usually removed 7 to 10 days after a skin biopsy. After a skin biopsy, the nurse instructs the client to keep the dressing dry and in place for a minimum of 8 hours. After the dressing is removed, the site is cleaned once a day with tap water or saline to remove any dry blood or crusts. The physician may prescribe an antibiotic ointment to minimize local bacterial

colonization. The nurse instructs the client to report any redness or excessive drainage at the site.

33. The nurse preparing to assist the physician to examine the client's skin with a Wood's light would do which of the following?
- a. obtain an informed consent
 - b. tell the client that the procedure is painless**
 - c. shave the skin site
 - d. prepare a local anesthetic

A Wood's light examination is a painless procedure. Examination of the skin under a Wood's light is always carried out in a darkened room. This is a noninvasive examination; therefore an informed consent is not required. A hand-held long wavelength ultraviolet light or Wood's light is used. The skin does not need to be shaved, and a local anesthetic is unnecessary. Areas of blue green or red fluorescence are associated with certain skin infections.

34. The nurse provides discharge instructions to a client following patch testing. Which instruction would the nurse provide to the client?
- a. return to the clinic in 2 weeks for the initial reading
 - b. reapply the patch if it comes off
 - c. continue all current activities
 - d. keep the test sites dry**

The nurse instructs the client to keep the test sites dry at all times. The nurse also discourages excessive physical activity that will result in sweating. If the client reapplies a loosened patch, this can interfere with accurate interpretation of the allergic reactions. The nurse should reinforce the necessity of removing loose or nonadherent test patches for reapplication at a later date. The initial reading is performed 2 days after application and the final reading is performed 2 to 5 days later.

35. A nurse is preparing a client for skin grafting and notes that the physician has documented that the client is scheduled for heterograft. The nurse understands that the heterograft used for the burn client is skin from:
- a. another species**
 - b. a cadaver
 - c. the burned client
 - d. a skin bank

Biological dressings are obtained from living or deceased humans (homograft or allograft) or animals (heterograft or xenograft). Heterograft is skin from another species. The most commonly used type of heterograft is pigskin, because of its relative compatibility with human skin. Homograft is skin from

another human, which is usually obtained from a cadaver and is provided through a skin bank.

36. Following assessment and diagnostic evaluation, it has been determined that the client has Stage II of Lyme disease. The nurse expects to note which assessment finding that is most indicative of this stage?
- a. erythematous rash
 - b. cardiac conduction defects**
 - c. arthralgias
 - d. enlargement of joints

Stage II of Lyme disease develops within 1 to 6 months in the majority of untreated individuals. The most serious problems include cardiac conduction defects and neurological disorders such as Bell's palsy and paralysis. These problems are not usually permanent. Arthralgias and joint enlargements are noted in stage III. A rash appears in stage I.

37. The clinic nurse reads the chart of a client that was seen by the physician and notes that the physician has documented that the client has Stage III of Lyme disease. Which clinical manifestation would the nurse expect to note in the client?
- a. a generalized skin rash
 - b. a cardiac dysrhythmia
 - c. complaints of joint pain**
 - d. paralysis in the extremity where the tick bite occurred

Stage III develops within a month to several months after initial infection. It is characterized by arthritic symptoms, such as arthralgias and enlarged or inflamed joints, which can persist for several years after the initial infection. Cardiac and neurological dysfunctions occur in stage II. A rash occurs in stage I. Paralysis of the extremity where the tick bite occurred is not a directly related characteristic of Lyme disease.

38. A female client arrives at the health care clinic and tells the nurse that she was bitten by a tick and would like to be tested for Lyme disease. The client tells the nurse that she removed the tick and flushed it down the toilet. Which nursing action is appropriate?
- a. refer the client for a blood test immediately
 - b. inform the client that the tick is needed to perform the test
 - c. inform the client that she will need to return in 6 weeks to be tested because testing before this time is not reliable**
 - d. ask the client about the size and color of the tick

There is a blood test available to detect Lyme disease; however, it is not a reliable test if performed prior to 4 to 6 weeks following the tick bite. Options a, b, and d are inaccurate.

39. The client suspected of having Stage I of Lyme disease is seen in the health care clinic and is told that the Lyme disease test is positive. The client asks the nurse about the treatment for the disease. The nurse responds to the client, anticipating which of the following to be part of the treatment plan?
- a. no treatment unless symptoms develop
 - b. a 3-week course of oral antibiotic therapy**
 - c. treatment with intravenous penicillin G
 - d. ultraviolet light therapy

A 3-week course of oral antibiotics is recommended during stage I. Later stages of Lyme disease may require therapy with IV antibiotics, such as penicillin G. Ultraviolet light therapy is not a component of the treatment plan for Lyme disease.

40. The client with acquired immunodeficiency syndrome (AIDS) is suspected of having cutaneous Kaposi's sarcoma. The nurse prepares the client for which test that will confirm the presence of this type of sarcoma?
- a. sputum culture
 - b. liver biopsy
 - c. punch biopsy of the lesion**
 - d. white blood cell count

Kaposi's sarcoma lesions begin as red, dark blue, or purple macules on the lower legs that change into plaques. These large plaques ulcerate, or open, and drain. The lesions spread by metastasis through the upper body then to the face and oral mucosa. They can also move to the lymphatic system, lungs, and gastrointestinal tract. Late disease results in swelling and pain in the lower extremities, penis, scrotum, or face. Diagnosis is made by punch biopsy of cutaneous lesions and biopsy of pulmonary and gastrointestinal lesions.

41. The client who is newly admitted to the hospital for treatment of acute cellulitis of the lower left leg asks the nurse about the nature of the disorder. The nurse would respond that cellulitis is actually:
- a. a skin infection into the deep dermis and subcutaneous fat**
 - b. an acute superficial infection
 - c. an inflammation of the epidermis
 - d. an epidermal infection caused by Staphylococcus

Cellulitis is a skin infection into deeper dermis and subcutaneous fat that results in deep red erythema without sharp borders, and that spreads widely through tissue spaces. The skin is erythematous, edematous, tender, and sometimes nodular. Erysipelas is an acute superficial and rapidly spreading inflammation of the dermis and lymphatic tissue.

42. A nurse is preparing a plan of care for a client with a diagnosis of acute cellulitis of the lower leg. The nurse anticipates which measure will be prescribed to treat this condition?
- a. **warm moist compresses to the affected area**
 - b. cold compresses to the affected area
 - c. heat lamp treatments 4 times daily
 - d. alternating hot to cold compresses every 2 hours

Warm, moist compresses may be used to decrease the discomfort, erythema, and edema that accompany cellulitis. After tissue and blood cultures are obtained, antibiotic therapy will be initiated. The nurse should provide supportive care, as prescribed, to manage symptoms such as fatigue, fever, chills, headache, and myalgia.

43. A clinic nurse provides instructions to a client who will be taking isotretinoin (Accutane) for severe cystic acne. Which statement by the client indicates the need for further instructions?
- a. "I need to return to the clinic for a blood test to check my triglyceride level"
 - b. "The medication may cause my lips to burn"
 - c. "The medication may cause dryness and burning in my eyes"
 - d. **"I need to take vitamin A supplements to improve the effectiveness of this treatment"**

In severe cystic acne, isotretinoin is used to inhibit inflammation. Adverse effects include elevated triglycerides, skin dryness, eye discomfort such as dryness and burning, and cheilitis (lip inflammation). Close medical follow-up is required, and dry skin and cheilitis can be decreased by the use of emollients and lip balms. Vitamin A supplements are stopped during this treatment.

44. A client sustained full-thickness burns to both hands from scalding water. A sheet graft was surgically applied to the wounds. The nurse tells the client that this type of graft is indicated for which of the following primary purposes?
- a. better adherence to the wound bed
 - b. **better cosmetic result**
 - c. better donor site availability

- d. easier to care for initially

Sheet grafts are often used to graft burns in visible areas. Sheet grafts are done on cosmetically important areas, such as the face and hands, to avoid the meshed pattern that occurs with meshed grafts. Options a, c, and d are not the primary purposes of using sheet grafts.

45. A client sustained a major burn is beginning to take an oral diet again. The nurse plans to encourage the client to eat variety of which of the following types of foods to best help in continued wound healing and tissue repair?

- a. high carbohydrate and low protein
- b. high fat and low carbohydrate
- c. high protein and high fat
- d. high protein and high carbohydrate**

To promote adequate healing and to meet continued high metabolic needs, the client with a major burn should eat a diet that is high in calories, protein, and carbohydrate. This type of diet also keeps the client in positive nitrogen balance. There is no need to increase the amount of fat in the diet.

46. A client with a major burn is admitted to the emergency department. The nurse anticipates that which of the following routes will be ordered for analgesics for this client?

- a. intramuscular
- b. intravenous**
- c. oral
- d. subcutaneous

The client with a major burn should receive medications by the intravenous route whenever possible. Oral medications are not absorbed well because the mobility of the gastrointestinal tract slows with shock or paralytic ileus. The subcutaneous and intramuscular routes are avoided because absorption may be poor or erratic due to fluid shifts as a result of the burn injury.

47. A nurse is performing a skin assessment of a client who is immobile and notes the presence of partial thickness skin loss of the upper layer of the skin in the sacral area. The nurse documents these findings as a:

- a. stage 1 pressure ulcer
- b. stage 2 pressure ulcer**
- c. stage 3 pressure ulcer
- d. stage 4 pressure ulcer

In a stage 2 pressure ulcer, the skin is not intact. There is partial thickness skin loss of the epidermis or dermis. The ulcer is superficial and may be characterized as an abrasion, blister, or shallow crater. The skin is intact in stage 1. A deep crater-like appearance occurs in stage 3, and sinus tracts develop in stage 4.

48. A student nurse is instructed by the registered nurse to monitor a client who has dark skin for cyanosis. The registered nurse determines that the student needs instructions regarding physical assessment techniques for the dark-skinned client if the student states that the best area to assess for cyanosis was in the:

- a. nail beds
- b. lips
- c. sclera of the eye**
- d. tongue

Skin color is sometimes more difficult to assess in the dark-skinned client. If impaired gas exchange is suspected, the nurse would examine the lips, tongue, nail beds, conjunctivae (not sclera) of the eye, and palms of the hands and soles of the feet. In a client with cyanosis, the lips and tongue are gray, and the palms, soles, conjunctivae, and nail beds have a bluish tinge.

49. A client with severe psoriasis has a nursing diagnosis of Chronic Low Self-Esteem. The nurse uses which therapeutic strategy when working with this client?

- a. listening attentively**
- b. pretending not to notice affected skin areas
- c. keeping communications brief
- d. approaching the client in a formal manner

Clients with chronic skin disorders may have Chronic Low Self-Esteem because of the disorder itself and possible rejection by others. The nurse uses a quiet, unhurried manner, as well as appropriate visual contact, facial expression, and therapeutic touch to demonstrate acceptance of the client. Communications that are purposefully brief and formal may reinforce the feelings of rejection. These feelings may also be reinforced if the nurse obviously pretends not to notice the affected skin areas.

50. A nurse caring for a client who sustained a high-voltage electrical injury analyzes the client's test results. Which finding would the nurse interpret as increasing the client's risk of developing acute tubular necrosis?

- a. myoglobin in the urine**
- b. carbonaceous sputum
- c. hyperkalemia

d. cloudy cerebrospinal fluid

Myoglobin can be released from damaged muscles and precipitate out in the renal tubules, causing acute tubular necrosis. Carbonaceous sputum occurs as a result of inhalation of smoke, as during a fire; this finding would indicate an inhalation injury. Hyperkalemia commonly occurs after any cellular trauma or as a result of deteriorating renal function and cardiac dysrhythmias. Cloudy cerebrospinal fluid would indicate meningitis. Additionally, assessing cerebrospinal fluid would not routinely be performed in a burn injury.