M_COCNPQ (200+ Questions) - Quiz Questions with Answers

1.

Which of the following is the *MOST* important to determine when conducting a preoperative assessment of patient scheduled for an ostomy?

state of mind

ability to do self-care

family and community support

economic status

Explanation:

While all of these are important aspects to evaluate, the patient's ability to do self-care is primary because this can help determine the type of procedure that is best for the patient as well as the extent and type of postoperative care and education that may be needed. If the patient is not able to manage self-care, then the presence and abilities of caregivers must be evaluated as well. Low economic status may affect the patient's ability to purchase needed supplies and to manage care.

2.

The button gastrostomy tube may be especially recommended for

elderly patients.

bedridden patients.

ambulatory patients.

patients with dementia.

Explanation:

The button gastrostomy tube, which is secured by a balloon or traction device, lies flat against the abdomen, and is often recommended for patients who are confused and pull on tubes, such as patients with dementia, especially if they have already pulled out a gastrostomy tube, because it is more difficult to grasp and pull out. The button gastrostomy tube is also often recommended for younger ambulatory patients who are concerned about the external appearance of the tube and want to wear fashionable clothing.

3.

In which type of urinary diversion is the appendix used as the conduit for catheterization?

Kock pouch

Miami pouch

Indiana pouch

Mitrofanoff procedure

Explanation:

In the Mitrofanoff procedure, the appendix is used as the conduit for catheterization. The stoma is typically placed at or near the navel or in the RLQ if the appendix is too short to reach the

navel area. The appendix is used to connect the bladder (which is sometimes augmented with a section of intestine) to the stoma. The conduit is tunneled in such a way that it creates a flap valve to retain urine when the bladder is full.

4.

How long after creation of an Indiana pouch should the patient usually begin to practice self-catheterization?

3 to 4 days

1 to 2 weeks

2 to 3 weeks

4 to 5 weeks

Explanation:

After creation of an Indian pouch, the patient should usually begin to practice self-catheterization within 2 to 3 weeks. Initially, the Malecot catheter is left in place but capped in case the patient encounters problems with catheterization. The pouch is small and requires catheterization every 2 hours during the first week and then the duration is increased to every 3 hours for the next two weeks and then to every 4 hours during the fourth week. The Malecot catheter is removed when the patient is adept at catheterization.

5.

The primary problem associated with the orthoptic urinary diversion (neobladder) is

hypercontinence.

incontinence.

lack of sensation.

hypocontinence.

Explanation:

The primary problem associated with the orthoptic urinary diversion (neobladder) is hypercontinence, inability to urinate or urination resulting in a residual of greater than 150 mL of urine. Hypercontinence is more common in females than males and requires that the patient carry out clean intermittent catheterization, so this possibility must be considered when the choice of urinary diversion is determined. A patient that lacks the ability to do clean intermittent catheterization or doesn't want to do so is not a good candidate.

6.

Which of the following foods are likely to cause the most odor in stool from a fecal ostomy?

beans and broccoli

garlic and onions

fish and eggs

cheese and peanut butter

Explanation:

Fish and eggs are the foods that are most likely to cause the most odor from a fecal ostomy. Garlic, onion, and asparagus also can cause a distinctive odor in the urine. Other foods that

cause increased odor in the stool include cruciferous vegetables, such as cabbage, Brussels sprouts, broccoli, and beans, which also increase gas production, and this can exacerbate the problem. Patients should be advised to add one food at a time to determine which foods affect them the most.

7.

Which of the following drugs may be recommended as an adjunctive therapy to decrease output of an enterocutaneous fistula?

somatostatin

octreotide

simethicone

loratadine

Explanation:

Somatostatin (a growth hormone inhibiting hormone) may be recommended as an adjunctive therapy to decrease output of an enterocutaneous fistula. Octreotide, an analog of somatostatin, is effective but is generally not recommended because of increased adverse effects, including villous atrophy. However, somatostatin has a half-life of only 1 to 2 minutes compared to octreotide's 1 to 2 hours, so somatostatin must be given by continuous IV infusion.

8.

If a patient has an orthoptic urinary diversion (neobladder), early maintenance includes

urinating when feeling the urge.

scheduled voiding every 2 to 3 hours during waking hours.

scheduled voiding very 3 to 4 hours during waking hours.

scheduled voiding every 4 to 6 hours during waking hours.

Explanation:

If a patient has an orthoptic urinary diversion (neobladder), early maintenance includes scheduled voiding every 2 to 3 hours and clean catheterization if necessary, so this entails more time and effort than an Indiana pouch, and the patient must be aware of this commitment and motivated to maintain this schedule. Initially, the volume the bladder will hold only 150 mL but over time the capacity should increase to 300 to 500 mL.

9.

Duodenostomy and jejunostomy are

common procedures for cancer.

increasing in popularity.

reserved for bariatric patients.

reserved for catastrophic events.

Explanation:

Duodenostomy and jejunostomy are reserved for catastrophic events. Patient management with these procedures is more difficult than when a section of the ileum is used because the patient will experience electrolyte imbalances and high output because little absorption takes

place, resulting in increased risk of malnutrition without intervention. The output often contains partially undigested food and has a strong foul odor.

10.

Which of the following foods are stoma obstructive?

pineapple

cheese

cauliflower

cucumbers

Explanation:

Foods that are stoma obstructive are those that are high in fiber or pass through the digestive system and are poorly digested. These foods include pineapple, apple peels, tomato skins, whole kernel corn, dried fruits, nuts, popcorn, seeds, raw cabbage, coconuts, celery, mushrooms, bamboo shoots, whole grains, and oranges. Patients should be advised to peel fruits and vegetables and to thoroughly chew any foods high in fiber and to drink ample fluids.

11.

If a patient with an ostomy plans to travel extensively, the nurse should advise the patient to

avoid third world countries.

contact medical facilities in advance.

carry adequate ostomy supplies for the duration.

refuse x-ray airport screenings.

Explanation:

If a patient with an ostomy plans to travel extensively, the nurse should advise the patient to carry adequate ostomy supplies for the duration because, in many parts of the world, supplies may not be readily available, or the types that are available may be different from those that the patient usually uses. The patient can be screened by x-ray at airports, but the presence of an appliance will often trigger a personal screening, so the patient should carry a UOAA travel card that includes information about the ostomy.

12.

With an orthoptic urinary diversion (neobladder), when voiding the patient should

strain to empty bladder.

use Credé massage to empty the bladder.

blow bubbles to relax sphincters.

pour warn water over the genitals to encourage urination.

Explanation:

With an orthoptic urinary diversion (neobladder), when voiding the patient should use Credé massage to empty the bladder. The neobladder is essentially flaccid because it lacks the musculature that allows the normal bladder to contract. Only the urethral sphincter controls the

flow of urine, but residual urine and mucus may stay in the bladder, so applying firm massage to the abdomen and pressing downwards may help to empty the bladder.

13.

What is the procedure of choice for a patient with severe intractable ulcerative colitis whose rectum remains relatively free of the disease and the anal sphincter is intact?

total colectomy with ileostomy

continent ileostomy

ileal pouch-anal anastomosis

intestinal transplant

Explanation:

The procedure of choice for a patient with severe intractable ulcerative colitis is IPAA if the rectum is relatively free of disease and the anal sphincter is intact. If the rectum is severely diseased, complete excision of the colon, rectum, and anus is recommended, as disease will recur. Usually after the diseased colon is removed, extraintestinal manifestations of the disease subside. Surgery is indicated when the patient continues to deteriorate and does not respond to conservative treatment.

14.

The primary goal in the plan of treatment for a patient with a vesicocutaneous fistula is

determining the appropriate appliances.

teaching the patient self-care.

monitoring daily output.

preventing moisture-associated skin damage.

Explanation:

The primary goal in the plan of treatment for a patient with a vesicocutaneous fistula is preventing moisture-associated skin damage because the fistula leaks urine constantly. The fistula, with a tract from the bladder to the skin's surface, may exit in various places, such as the abdomen or perineal area, so management depends partly on location and the ability to apply an appropriate pouching system. The use of skin barriers to protect the skin is essential.

15.

Maturation of the stoma refers to

eversion of the bowel segment so that the mucosa is exposed.

healing of the mucosa so that it remains intact.

selection of the most appropriate site for placement.

interior healing of anastomoses.

Explanation:

Maturation of the stoma refers to the eversion of the bowel segment so that the mucosa is exposed. If this eversion is not carried out by the surgeon (such as with a stoma flush with the skin), the mucosa will eventually mature, but this involves serositis and an inflammatory

response that results in edema of the stoma and eventual eversion. However, this process can take up to 6 weeks, so surgeons typically evert the mucosa during the surgical procedure when they form the stoma.

16.

In the postoperative period with a loop stoma, the proximal limb can be identified because it

is flush with the skin.

is marked with brown sutures.

protrudes above the skin.

is marked with red sutures.

Explanation:

In the postoperative period with a loop stoma, the proximal limb can be identified because it protrudes above the skin and is marked with blue sutures (Vicryl). The distal limb, on the other hand, is flush with the skin and is marked with brown sutures. (catgut). During surgery, a rod is placed under the loop to prevent stomal retraction and is left in place for the first 2 to 7 days.

17.

With which procedure is the stoma typically placed on the left side?

abdominal perineal resection

proctocolectomy

ileal conduit anal pouch (IPAA)

low anterior resection

Explanation:

Most stomas are placed on the right side. However, with the abdominal perineal resection, the stoma is typically placed on the left side. With the Hartmann's procedure, the stoma may be placed on either the right or left side. With a cystectomy, if there is an ileal conduit, the stoma is on the right, if there is a colonic conduit, the stoma is on the left.

18.

Which of the following postoperative skills should the patient with a new ostomy master first?

peristomal skin care

changing the appliance

managing odor

emptying the pouch

Explanation:

The postoperative skills that the patient with a new ostomy should master first is emptying the pouch because this often needs to be done multiple times a day, so the patient cannot always wait for assistance. Many patients are discharged from the hospital before they have mastered all aspects of ostomy care, and education is often continued with home health nurses, especially if patients are older and may need more time to master the various skills needed.

19.

During preoperative education to prepare a patient for managing a stoma, the nurse should begin by asking

what the patient already knows about stoma management.

if there are any barriers to care that the nurse should be aware of.

what learning style the patient prefers.

what the patient is most concerned or fearful about.

Explanation:

While all of these issues are important during preoperative education to prepare a patient for managing a stoma, the nurse should begin by asking what the patient already knows because there can be huge differences in patients' health literacy or knowledge about different procedures. Some patients educate themselves well before surgery and others know virtually nothing. This information can help the nurse to develop and pace education to fit the patient's needs.

20.

Using the PLISSIT model for assessing sexuality, which of the following should the nurse do FIRST when speaking to the patient about sexual issues associated with an ostomy?

provide limited information about sexual function

provide suggestions for dealing with erectile dysfunction

ask permission to discuss sexual function

suggest intensive therapy

Explanation:

Because patients may be embarrassed and uncomfortable discussing sexual functioning (especially with someone of the opposite gender), the PLISSIT model begins with asking the patient's permission to discuss sexual function. If the patient agrees, then the nurse can go to the next steps:

- *P: Ask permission.*
- *LI: Provide limited information about sexual function.*
- *SS: Provide specific suggestions for dealing with sexual dysfunction.*
- *IT: Refer to a specialist in sex therapy for intensive therapy.*

If the patient declines, the nurse should tell the patient they can discuss it later if he changes his mind and ask if there is someone else with whom the patient would feel more comfortable discussing the issue.

21.

The majority of stomal complications can be attributed to

surgical errors.

underlying health problems.

inability of patient to manage care.

improper siting of stoma.

Explanation:

The majority of stomal complications can be attributed to improper siting of stoma, such as in an area with creases or folds or where the patient is not able to completely see the stoma. About half of ostomy patients are still not seen by ostomy nurses preoperatively, and many do not have the site marked before surgery, and the stoma is placed without adequate consideration of issues that may arise.

22.

When marking a stoma site, the nurse should first examine the patient

fully clothed and sitting.

fully clothed and supine.

sitting with abdomen exposed.

supine with abdomen exposed.

Explanation:

When marking a stoma site, the nurse should first examine the patient fully clothed and sitting to determine the type of clothing the patient wears, any belts or appliances, and the sitting posture. The nurse should ask if the patient must wear any specific type of uniform, clothing, or equipment (carpenter's belt, gun holster) as part of work. The nurse should ask the patient to stand, sit, bend over, and carry out different movements while clothed as well as with the abdomen exposed.

23.

The primary goals of stoma site markings are to avoid placing the stoma in a crease and to place the stoma

so that it can be easily camouflaged with clothing.

opposite of the patient's handedness.

where it will be visible to the patient.

as close to midline as possible.

Explanation:

The primary goals of stoma site markings are to avoid placing the stoma in a crease and to place the stoma where it will be visible to the patient, so the nurse must collaborate closely with the patient when marking the site. The stoma should be placed so that the patient can be as independent as possible in caring for the stoma, including emptying the pouch, irrigating if indicated, and changing the appliances.

24.

A patient with regional enteritis (Crohn's disease) usually has localized pain in the

RUQ.

RLQ.

LUQ.

LLQ.

Explanation:

With regional enteritis, pain is most commonly localized in the right lower quadrant. Borborygmus and increased peristalsis result in hyperactive bowel sounds noted on auscultation. Patients complain of abdominal tenderness on palpation. The most common symptom is intermittent pain, occurring with diarrhea but unrelieved by defecation. Pain usually occurs after eating because this stimulates peristalsis. If the terminal ileum is involved, pain may occur in the periumbilical area. Patients often begin to limit food intake to control pain, but this can result in malnutrition and anemia.

25.

If, in the immediate postoperative period, a patient who underwent emergency surgery for traumatic injury and has a mucous fistula and a fecal stoma has fecal discharge from the mucous fistula, this probably indicates

perforation of the bowel that was undetected.

the anastomoses failed.

the nurse has mistaken the stoma for the mucous fistula.

residual stool that was in the bowel.

Explanation:

If, in the immediate postoperative period, a patient who underwent emergency surgery for traumatic injury and has a mucous fistula and a fecal stoma has fecal discharge from the mucous fistula, this probably indicates residual stool that was in the bowel. With emergency surgery, there may be no time for bowel prep prior to the surgery. The residual stool washes out of the mucous fistula along with the mucus that is still produced.

26.

After a colostomy, which of the following foods should generally be avoided?

nuts, seeds

apples, oranges

broccoli, cauliflower

grapes, bananas

Explanation:

While individual sensitivity to foods varies, in general patients should avoid foods high in cellulose or hemicellulose, such as nuts and seeds, because they retain fluid and stimulate peristalsis and may also cause obstruction. Some foods should be eaten in moderation, including fruits such as prunes, grapes, and bananas. Cruciferous vegetables, such as broccoli and cauliflower, may increase gas and odor. Patients should be advised to keep a food diary to help to determine which foods are most irritating to them.

27.

Patients undergoing ostomy surgery are especially at risk for which electrolyte imbalances?

hypernatremia and hyperkalemia

hypercalcemia and hyperphosphatemia

hypocalcemia and hypophosphatemia

hyponatremia and hypokalemia

Explanation:

The primary electrolyte regulating fluid balance is sodium, which works in conjunction with potassium, so excess fluid loss, common in ostomy patients, can result in hyponatremia and hypokalemia. Symptoms of hyponatremia include irritability, lethargy, and alterations in consciousness; cerebral edema with seizures and coma; and dyspnea leading to respiratory failure. Symptoms of hypokalemia include lethargy and weakness, hypotension, nausea and vomiting, paresthesia, muscle cramps with hyporeflexia, dysrhythmias with ECG abnormalities such as premature ventricular contractions and flattened T waves.

28.

When marking the abdomen for placement of a stoma (excluding colostomy), the ideal site is in which muscle?

rectus abdominis

transversus abdominus

external oblique

internal oblique

Explanation:

Ideally, the stoma should be placed in the rectus abdominis muscle, which stretches from the rib cage to the pelvis. In most cases (excluding colostomy), the best placement is in the RLQ about 2 inches (10 cm) below the waist so the person's belt and bending motions do not interfere with the stoma; however, this placement may not always be possible. The stoma should not be placed in folds or scar tissue and should be easily accessible by the patient.

29.

A patient who is concerned about the copious amount of postoperative drainage from an ileostomy should be advised that

the amount of drainage may vary widely from one day to another.

the amount of drainage will decrease over time.

the amount of drainage may increase when the patient resumes a normal diet.

the amount of drainage will remain about the same.

Explanation:

In the immediate postoperative period, drainage from an ileostomy may be up to about 1800 mL/day. Initially, the drainage may be thick and greenish but it then becomes watery with constant drainage because the small intestine usually reabsorbs little fluid; however, as time passes, the small bowel begins to compensate for the lack of the colon and absorbs more fluid, decreasing the output to about 500 to 800 mL/day and thickening the stool.

30.

What is the correct response if, in the initial period after surgery for a colostomy, the stoma appears dull and blue-tinged?

observe for further changes

notify the physician

no response needed, as this is normal finding

provide patient with nasal oxygen

Explanation:

While the stoma may be edematous in the initial postoperative period, it should appear red to pink, shiny, and moist, indicating adequate oxygenation and healthy tissue. If the stoma appears dull and cyanotic (blue to purple to brown/black if the tissue becomes necrotic), the physician should be notified immediately because reoperation to increase blood flow to the tissue may be indicated. The stoma should be assessed for circulatory impairment on a regular schedule after surgery.

31.

A defunctionalized bladder remaining after urinary diversion is especially at risk for

pyocystis.

rupture.

prolapse.

fistula formation.

Explanation:

While a cystectomy is usually performed as part of urinary diversion procedures, in some cases, the bladder is left in place. Because the mucous lining of the bladder still secretes, discharge can build up in the defunctionalized bladder. Usually, these secretions are expelled periodically, but if blockage occurs, the secretions continue to collect in the bladder and may become infected, resulting in pyocystis. Treatment of pyocystis usually includes drainage and antibiotics.

32.

Which of the following patients is a candidate for a convex skin barrier?

a patient whose stoma protrudes 2 cm

a patient whose stoma is in the RLQ

a patient whose stoma protrudes 4 cm

a patient with a very soft pendulous abdomen

Explanation:

Convex skin barriers help to create a tight seal around stomas that are flush or retracted, but they are also appropriate to use with a patient with a very soft pendulous abdomen or where folds in the skin interfere with the appliance. Appliances are available with shallow, moderate, and deep convexity, but a barrier ring, with adhesive on both sides, can be placed around the stoma to create convexity as well if only flat skin barrier wafers are available.

33.

Which of the following is *MOST* likely to promote cooperation in a 25-year-old woman who required an ileostomy but refuses to look at the stoma or participate in care postoperatively?

refer patient to a psychologist

ask family to intervene

arrange visit with a recovered ostomate

advise patient of the importance of self-care

Explanation:

A visit from a recovered ostomate who is functioning well can provide invaluable support. Refusing to look at the stoma or participate in care after surgery is very common as patients grapple with the alteration in body image and anxiety about their role in family and society, their sexuality, and their ability to resume their normal activities. Family members should be encouraged to learn about ostomy care and to provide support as well, but they may also be very stressed and unsure. Referral to a psychologist may be indicated if the patient cannot overcome her anxiety and fears.

34.

Stomal retraction postoperatively increases risk of

infection.

small bowel obstruction.

stomal stenosis.

stomal fistula.

Explanation:

Stomal retraction, usually caused by increased tension on the intestine or stoma, is associated with increased risk of stenosis, especially if the retraction results from ischemia. Mild stomal retraction is managed with convex skin barriers, but if the retraction is severe, local repair and creation of a new stoma are indicated. If stenosis is present, then the scar tissue may need to be excised because attempting to dilate the stenotic area may increase the stenosis.

35.

A patient who develops stomal prolapse has a significant risk of developing

stomal stenosis.

stomal varices.

wound infection.

parastomal hernia.

Explanation:

About half of the patients who develop a significant stomal prolapse also develop a parastomal hernia. Obese patients and those with COPD are at increased risk of developing stomal prolapse, but is may also occur with inadequate surgical construction or creation of a stoma outside of the rectus abdominis. Prolapse may be fixed or a sliding stoma prolapse, which is more likely to develop incarceration. The prolapsed portion may be repaired with resection and surgical stapling.

36.

After cleansing the PEG tube, what is the next step in rotating the tube?

pull the tube gently away from the abdomen 1 to 2 cm

gently insert the tube into the abdomen 1 to 2 cm

turn the tube 180° in one direction and then 180° in the other

turn the tube 360°

Explanation:

When rotating the PEG tube, an important step in preventing adherence and promoting healing of the tract, the tube should be gently inserted 1 to 2 cm so that the internal stabilizing device is pushed away from the tissue so that rotation does not cause trauma. Then, the tube is slowly turned 360°. Next, the tube is gently pulled back out until the interior stabilizing device is in correct position and the external stabilizing device secured.

37.

Which of the following complies with the American Medical Association guidelines for informed consent?

a patient with an inflammatory bowel disease is provided a list of treatment options

a patient with regional enteritis is told that her only option is a standard ileostomy

a preoperative patient is advised she has nothing to worry about as ostomy surgery poses little risk

information about a patient's condition is withheld to prevent causing her anxiety

Explanation:

The patient with inflammatory bowel disease is provided a list of possible treatment options, as required by the guidelines for informed consent. Surgical repair for regional enteritis is done in different ways, so providing one option limits the patient's right to choose. Telling a patient she has nothing to worry about is a platitude and may be wrong. Patients have a legal right to information about their conditions, even if it may cause anxiety. Patients cannot make informed consent without adequate and accurate information.

38.

Which procedure is MOST often indicated for a patient with diverticulitis, perforated diverticulum, and peritonitis?

end colostomy (temporary) and Hartmann's pouch

loop colostomy (temporary)

loop ileostomy (temporary)

colectomy

Explanation:

The procedure usually performed for a patient with diverticulitis, perforated diverticulum, and peritonitis is the end colostomy (temporary) and Hartmann's pouch. The affected parts of the colon (often the sigmoid and part of the descending colon) are removed surgically, but anastomosis must be delayed until the infection clears, so a Hartmann pouch with the intact rectum is left in place so that the colostomy can be removed at a later time and reanastomosis completed.

39.

What advice should a woman with ulcerative colitis receive if she wants to have children and is considering having an ileal pouch-anal anastomosis (IPAA)?

the IPAA will not interfere with fertility or pregnancy

the woman should try to get pregnant prior to the IPAA

the woman should have the IPAA before trying to get pregnant

the woman cannot carry a child after having the IPAA.

Explanation:

While women have successfully carried pregnancies after IPAA, the ileoanal pouch has been associated with about a 50% drop in fertility, so the woman should be advised to try to get pregnant and complete childbearing prior to having the IPAA. There is not yet consensus about the best method of delivery, although there seems to be increased risk with vaginal delivery, especially if tearing of the anal sphincter occurs. Most women are advised to have cesarean deliveries.

40.

When applying a drainage appliance for an ileostomy or colostomy, how much clearance should be allowed around the stoma?

10 mm

8 mm

5 mm

3 mm

Explanation:

When applying a drainage appliance for an ileostomy or colostomy, about 3 mm clearance should be allowed around the stoma. Exposed skin may become macerated, so a skin barrier should be applied under to the exposed skin. The appliance should fit snugly about the stoma

but not so tightly that it could cause trauma. The size of the stoma may vary from time to time, so this must be considered when fitting an appliance.

41.

Which is the MOST appropriate action to take with a patient who has undergone emergency ileostomy for Crohn's disease and severe hemorrhage but is refusing transfusions for religious reasons?

provide the patient with facts about the disease, treatments, and prognosis

ask family members to intervene

remind the patient that he may die without treatment

refer to a psychologist

Explanation:

Patients have a right to refuse treatment for religious or other personal reasons, so the most appropriate action is to simply provide the patient with factual information about the blood loss and prognosis in a neutral manner, without trying to coerce or frighten the patient. In some cases, patients may change their minds when presented with information, but the nurse should remain supportive regardless of the patient's decision. Asking the family to intervene is not appropriate, and refusal of treatment alone does not suggest the need for referral to a psychologist.

42.

When irrigating a Koch pouch to improve drainage postoperatively, how much maximum fluid should be instilled at one time?

≤1000 mL

≤500 mL

≤100 mL

≤40 mL

Explanation:

The Koch pouch may need to be irrigated postoperatively to promote drainage because of the accumulation of mucus. Also, once the patient begins to eat, drainage may slow, requiring irrigation. Up to 1000 mL of total of solution (usually tap water) may be needed to flush the pouch but only 30 to 40 mL of fluid should be instilled at one time as the capacity of the pouch is small. The instilled fluid should be drained completely before doing another instillation and the patient observed carefully for abdominal discomfort.

43.

A patient with a high-output enterocutaneous fistula of the proximal ileum with 96 cm of small intestine remaining before the fistula would initially receive nutrition by which method?

oral only

enteral feeding

total parenteral nutrition

combination of oral and enteral

Explanation:

A patient with a small amount of small intestine (less than 100 cm) before the fistula and high-output fistula usually is kept NPO initially because eating stimulates increased loss of fluids, resulting in increased electrolyte imbalance, and protein, leading to increased malnutrition. Enteral feeding (TPN) is commonly used for fistula affecting the duodenum, distal ileum, or colon. Patients able to maintain adequate oral intake should eat a diet high in calorie and sodium but low in fiber, which may cause fistula blockage.

44.

Which of the following is the surveillance method of choice for adolescents with familial adenomatous polyposis?

barium enema

CT scan

MRI

colonoscopy

Explanation:

Colonoscopy is the surveillance method of choice for FAP, with routine surveillance usually beginning between 10 and 15 years, depending on the severity of the disease. Genetic testing is available to identify the type of FAP, as the rate of colorectal cancer varies somewhat. The most common genetic mutation is of the APC gene (chromosome 5q21), which carries a 75% risk of cancer by age 20 and 90% risk by age 30. Patients with high risk of colorectal cancer may be advised to have a prophylactic colectomy.

45.

Which of the following procedures may result in inadequate absorption of birth control pills?

transverse colostomy

ileostomy

urostomy

descending colostomy

Explanation:

Women of childbearing age with an ileostomy should be advised that absorption of birth control pills may be impaired because the medication is generally absorbed in the small intestine. Thus, they may want to consider other options such as an IUD or diaphragm for birth control, but they should discuss use of these devices with health care professionals if part of the vaginal wall or the rectum has been removed. Women with urostomy, transverse, descending, or sigmoid colostomies generally should be able to take birth control pills without concerns about absorption.

46.

A male patient who is to have his bladder and prostate removed and is concerned about sexual functioning should be advised that

he will be able to ejaculate and experience orgasm.

he may have erectile dysfunction and will experience dry orgasm.

he should experience no increased sexual problems.

he should have no problem with erection but will experience dry orgasm.

Explanation:

When discussing sexual issues, the patient should be provided complete and honest information. Following removal of the prostate and bladder, the male patient often experiences erectile dysfunction and will not be able to ejaculate but can achieve a dry orgasm. Interventions to help the patient achieve an erection will vary depending on whether he has partial or complete nerve damage or other problems, such as anxiety, that are preventing erection.

47.

What is the *BEST* explanation for a patient who complains that the gas filter on her ostomy appliance does not appear to work after she goes swimming?

contact with water inactivates the gas filter

the gas filter must be thoroughly dried after the patient goes swimming

contact with water should not be the cause of the problem

the water pressure may have damaged the filter

Explanation:

Gas (flatus) filters are inactivated if they come in contact with water, so the patient wearing the appliance in the bath or while swimming should apply a waterproof cover (usually supplied by the manufacturer) or cover with a strip of waterproof tape. Filters contain carbon to neutralize odors and must control for sulfurous and complex organic odors, so patients may need to experiment to determine which type of filter is most effective for them.

48.

Which of the following is an initial appropriate intervention for a patient with a descending colostomy that expels softly formed stools but has persistent pancaking?

provide a daily laxative

change the appliance immediately after passing any stool

increase fiber in the diet

apply foam blocks to the inside of the pouch

Explanation:

While dietary modifications are sometimes indicated to help control pancaking, the patient's stool is soft and formed already, so the best initial intervention is to apply foam blocks or other bridging device to the inside of the pouch to prevent the two sides of the appliance from adhering. Other solutions include applying oil to the inside of the appliance or special lubricating gels. Some people remove the flatus filters, but this may result in ballooning.

49.

A male ostomate with a very hairy abdomen should be advised to

use a chemical depilatory agent to remove hair.

use an electric razor to remove hair once weekly.

use a safety razor to remove hair with each appliance change.

use extra sealant before applying an appliance.

Explanation:

Hair can interfere with appliance adherence, even with the use of sealants, so the best method is to shave with an electric razor. Depilatories should be avoided as they may irritate the skin, and small nicks may occur with a safety razor. Inflammation of the hair follicles (folliculitis) may occur in those with abdominal hair because of irritation from application and removal of appliances or from too frequent shaving, so shaving should be done no more frequently than once a week.

50.

The most common cause of dermatitis in the peristomal area is

too frequent changing of appliances.

too infrequent changing of appliances.

allergic response to appliance.

incorrect sizing.

Explanation:

While some people have allergic responses to the sealant or appliance, the most common cause of dermatitis in the peristomal area is incorrect sizing that leaves too much skin exposed around the stoma, increasing the risk of leakage under the appliance as well as irritation of the exposed skin. Patients should be advised to measure their stomas with each appliance change for at least 6 to 8 weeks after surgery until the stoma size stabilizes and then periodically. The stoma opening should not be more than 3 mm larger than the stoma size.

51.

The most important factor in controlling the expelling of gas from a colostomy is

diet modification.

medication control.

lifestyle modification.

maintaining adequate fluid balance.

Explanation:

The most important factor in controlling the expelling of gas from a colostomy is diet modification, and this can include modifying both the types of foods in the diet as well as the manner of eating and drinking. Patients should chew food slowly and completely and avoid talking while eating. They may also benefit from small frequent meals rather than 3 large meals daily. Patients should avoid drinking fluids through straws and avoid carbonated drinks. Reducing fiber and avoiding cruciferous vegetables, nonabsorbable sugars, and resistant starches may also help.

52.

Which of the following factors is the greatest barrier to self-care?

age

hearing deficit

economic instability

cognitive impairment

Explanation:

While all of these may pose a challenge, cognitive impairment poses the greatest barrier to self-care because instruction may need to be repeated many times and steps to managing an ostomy broken down into simple steps. Picture guides, or in some cases written guides, may also be helpful, depending on the patient's degree of cognitive impairment. If cognitive impairment is profound, such as with advanced Alzheimer disease, then self-care may not be a realistic goal.

53.

What is the *MOST* likely cause when a patient with an ileoanal pouch develops a sudden increase in the frequency of stools as well as bloody diarrhea, fever, and fecal incontinence?

peritonitis

pouchitis

anastomotic leak

fistula formation

Explanation:

Increased frequency of stools, bloody diarrhea, fever, and fecal incontinence are signs of pouchitis, nonspecific inflammation of the pouch. Although the cause is not known, pouchitis may indicate undiagnosed regional enteritis (Crohn disease) in some patients, although it is more common in patients with ulcerative colitis. Pouchitis is most common in the first 2 years after surgery. Pouchitis usually responds rapidly to metronidazole, and this helps to differentiate the condition from others that may cause similar symptoms.

54.

Which of the following *MOST* indicates that a premature infant with necrotizing enterocolitis has suffered a perforation of the intestine and requires surgical intervention?

pneumoperitoneum

increased white blood cell count

hypoglycemia

feeding intolerance

Explanation:

Pneumoperitoneum is the primary predictor that perforation or necrosis of the bowel has occurred, resulting in the need for surgical intervention. Necrotizing enterocolitis (NEC) is the most common gastrointestinal emergency in premature neonates. Seventy-five percent of neonates who develop NEC are less than 37 weeks' gestation and weigh less than 2000 grams. NEC is an acute necrosis in 1 or multiple bowel segments anywhere from the stomach to the rectum. Inflammation occurs, and often bacterial invasion, and perforation. Initial treatment is NG decompression, IV fluids, and antibiotics.

55.

How much time should elapse after placement of a percutaneous endoscopic gastrostomy (PEG) tube before the tube is secured to the abdomen?

24 hours

until fully healed

1 to 2 weeks

3 to 4 days

Explanation:

The PEG tube should not be secured to the abdomen until the PEG is fully healed because tension caused by taping the tube against the abdomen may cause the tract to change shape and direction. The tract should be straight to facilitate insertion and removal of catheters. A solid skin barrier with the tube fed through an anchored baby nipple is an inexpensive stabilizer that keeps the tube in correct position. Position and length of tube should be carefully documented.

56.

What is the *BEST* solution for an ileostomy patient who had routinely taken enteric-coated and timed-release medications prior to surgery?

continue to take medications as before

crush the medications and mix with liquid

request a change in prescription to different medications

seek the advice of a pharmacist regarding each medication

Explanation:

While enteric-coated and timed-release medications may not be properly absorbed if left intact because the part of the bowel that normally absorbs the medication is missing, some medications may be inactivated by stomach acids, so each medication should be discussed with a pharmacist to determine if crushing the medication and mixing it with liquids is

acceptable. In some cases, different medications or different doses may be necessary, and the pharmacist is best able to discuss alternatives.

57.

Prior to surgery to create an orthotopic neobladder, the patient should be advised to

practice general strengthening exercises.

avoid heavy lifting.

increase fluid intake.

practice pelvic floor exercises.

Explanation:

Both before and after surgery for creation of an orthotopic neobladder, male and female patients should be advised to practice pelvic floor (Kegel) exercises to strengthen the sphincter muscles. Patients should do exercises sitting, standing, and lying supine at least twice daily and should try to complete at least 40 cycles of contracting and holding and 40 of quick contractions. After surgery, patients should increase exercises in positions in which they have the most leakage, such as when lying supine at night.

58.

Early obstruction of a colostomy stoma after surgery is *MOST* often caused by

edema of the bowel.

adhesions.

recurrent disease.

parastomal hernia.

Explanation:

Early obstruction of a colostomy stoma after surgery is most often caused by edema of the bowel or technical problems with the surgery. Once the patient starts to eat, obstruction may also occur with a bolus of food, so foods should be introduced slowly to the diet. Obstruction related to adhesions, recurrent disease (especially Crohn's disease), and parastomal hernia are usually late obstructions, and do not occur in the immediate postoperative period.

59.

Patients with which type of ostomy are *MOST* likely to benefit from routine ostomy irrigations to control fecal output?

ileostomy

ascending colostomy

descending colostomy

transverse colostomy

Explanation:

Irrigations to control fecal output are generally used only for descending or sigmoid colostomies, as fecal output is too high in ascending or transverse colostomies. Irrigations are

generally not advised for ileostomies. Frequency of irrigation varies, but every other day is the most common schedule. It may take about 6 weeks of routine irrigation before the bowel is regulated, so patients should be advised that the procedure requires some initial patience.

60.

What intervention is advised for a patient to relieve cramping following a colostomy irrigation?

gently massaging the abdomen

walking

taking an antacid

drinking warm liquid

Explanation:

Cramping is usually relieved by gently massaging the abdomen. Some patients also find that deep breathing and relaxing also helps as the cramping may be exacerbated by tension. While walking might also relieve cramping, if the fluid has not been completely expelled already, getting up in the middle of the irrigation procedure to move around can prove messy. Cramping may result from excess fluid instillation or too-rapid instillation.

61.

Patients with familial adenomatous polyposis (FAP) should be monitored routinely for which extracolonic cancer?

lung

thyroid

ovarian

pancreas

Explanation:

Patients with FAP have increased risk of extracolonic cancers, especially of the thyroid, so they should be monitored routinely. Additionally, other extracolonic manifestations of FAP include osteomas, epidermoid cysts, desmoid tumors, adrenal and duodenal adenomas, hepatoblastoma, abnormal dentition, and congenital hypertrophy of the retinal pigment epithelium (CHRPE). The most common cause of death in untreated FAP is colorectal cancer, but even those who have colectomy/IPAA are at risk for eventual development of duodenal adenoma.

62.

A porridge (oatmeal) enema test can be used to

evaluate sphincter function and potential for fecal continence.

facilitate bowel training after reanastomosis.

evaluate peristaltic action in the distal portion of the bowel.

evaluate stoma strictures.

Explanation:

The porridge (oatmeal) enema test is a simple method to evaluate sphincter function before stoma closure. The enema can be instilled into the distal stoma or the rectum. The oatmeal (or in some cases instant mashed potatoes) is thickened to the consistency of a normal soft stool. The patients are evaluated for fecal leakage lying down, sitting, standing, and after normal activities, including walking around, for 30 minutes. Those who can retain the enema for 30 minutes are generally good candidates for fecal continence after reanastomosis.

63.

In order to avoid an ostomy in an infant with bladder exstrophy, surgical repair of the bladder should be done within

24 hours.

72 hours.

1 week.

2 weeks.

Explanation:

Treatment for bladder exstrophy:

First stage:

- *Primary closure of bladder: No ostomy necessary if done within 72 hours of birth. Procedures include ureteral stents and suprapubic urinary drainage.*
- *Bilateral iliac ostomies: Necessary after 72 hours because pelvic ring is not malleable.*
- *Epispadias repair: May be done in first or second stage.*

Second stage:

- *Epispadias repair: Usually done between 6 and 12 months.*

Final stage:

- *Bladder neck reconstruction and reimplantation of ureters.*

- *Permanent urinary diversion: Required by 10% to 15%.*

64.

The ureteral stents in place after a urostomy are usually left in place for

24 hours.

5 to 14 days.

48 to 72 hours.

3 to 4 weeks.

Explanation:

Ureteral stents are usually removed after 5 to 14 days, although they may be left in for several weeks. Each protruding stent should be drained separately and clearly labeled. Stents have multiple holes along the length of the tube to promote drainage. It is important to ensure that the stents are not dislodged or blocked. If pain, purulent discharge, or fever occurs, an x-ray may be taken to determine position of the stent. Patient must be advised NOT to remove the stent.

65.

How would a patient be positioned for an endoanal ultrasound?

prone

supine with legs in stirrups

left side-lying

right side-lying

Explanation:

Endoanal ultrasound is used to diagnose perianal fistulas and abscesses and to assess sphincter damage related to fecal incontinence and for staging and follow-up of malignant infiltrations of sphincters with anal neoplasms. Procedure:

- *With the patient lying on the left side, a narrow, wand-like endoscopic probe with a transducer and a lubricated rigid plastic cone covering the end is inserted into the anal canal and pictures are viewed on a computer screen. The cone has a uniform diameter to prevent anatomical distortion.*
- *Patients may feel vibration during procedure.*

66.

Considering placement of a permanent colostomy, the anatomical position that is MOST likely to result in semi-soft, mushy stool is

ascending colon.

transverse colon.

descending.

sigmoid.

Explanation:

A permanent colostomy in the descending colon is most likely to result in semi-soft, mushy stool. A colostomy in the ascending colon results in liquid stool as little absorption has taken

place as liquid stool enters the colon from the small intestine. A transverse colostomy results in semi-liquid, somewhat mushy stool. Because the sigmoid colostomy is directly above the rectum, most excess fluid has been absorbed by the proximal colon, so stool tends to be more solid.

67.

Which of the following conditions is usually a contraindication for IPAA?

colon cancer

regional enteritis (Crohn's disease)

familial adenomatous polyposis (FAP)

ulcerative colitis

Explanation:

Regional enteritis (Crohn's disease) is usually a contraindication for IPAA because the failure rate with Crohn's disease is up to 60%. IPAA is primarily indicated for those with ulcerative colitis, indeterminate ulcerative colitis, or familial adenomatous polyposis. IPAA is used less frequently with colon cancer but may be indicated if the margins are clear and the cancer has not spread into the surrounding tissues. IPAA may be done at any age but patients older than 55 years may have more problems with incontinence.

68.

Which test is indicated to evaluate a possible anastomotic leak from an IPAA?

CT scan

defecating pouchogram

MRI

radiograph

Explanation:

The pelvic MRI is recommended to evaluate for a possible anastomotic leak from an IPAA. If a leak occurs, the patient may develop pelvic sepsis, most commonly in the early postoperative period. Symptoms may include poorly functioning pouch and pain. Symptoms are similar to those of pouchitis, so an MRI can differentiate. Anastomotic leak may require antibiotic therapy alone or surgical repair as well if a collection of fluid is found on MRI.

69.

When assessing factors that affect readiness to learn, a patient's cultural background and personal goals relate to which of the following?

physical factors

mental/emotional status

experience

knowledge/education

Explanation:

Experience with learning can vary widely and is affected by ability to cope with changes, personal goals, motivation to learn, and cultural background. People may have widely divergent

ideas about what constitutes illness and/or treatment. Lack of English skills may make learning difficult and prevent people from asking questions. The patients' and families' readiness to learn should be assessed because if they are not ready, instruction is of little value. Often readiness is indicated when the patients/families ask questions or show an interest in procedures.

70.

What is the appropriate intervention for an ostomate who is receiving chemotherapy and develops a small sore and increased bleeding of the stoma?

cauterize sore with silver nitrate

flush stoma area with antibiotic solution

apply topical corticosteroid to stoma

do gentle routine care

Explanation:

Ostomates undergoing chemotherapy often exhibit increased swelling and bleeding of the stoma as well as mouth and stoma sores. No specific treatment is indicated, as the sores will generally heal when chemotherapy stops. The stoma should be gently cleansed to decrease the chance of bleeding and pressure applied if bleeding occurs. The size of the appliance opening may need to be increased because of swelling. Some patients develop constipation because of dehydration related to nausea and vomiting, while others develop persistent diarrhea.

71.

What dressing strategy is usually used for low-output fistulas?

skin barrier and absorptive dressings

alginate and secondary dressings

solid skin barrier and ostomy appliance

gauze dressing only.

Explanation:

Low-output fistulas (less than 150 mL per 24 hours) may need only skin barriers and easily changed absorbent dressings. If drainage cannot be contained with an absorbent dressing, then ostomy appliances with solid skin barriers and pouches are indicated. The barrier should extend at least 1.5 inches around the perimeter of the fistula. The barrier must adhere to even skin to avoid drainage getting under the barrier, so the opening may need to be enlarged. Pouching systems with barriers that can be cut to fit usually work best. Very large wounds (more than 4 inches) may require a custom pouching system.

72.

The most common cause of spontaneous enterocutaneous fistula is

Crohn's disease.

diverticulosis.

ulcerative colitis.

colon cancer.

Explanation:

The most common cause of spontaneous enterocutaneous fistula is Crohn's disease. Most fistulae occur postoperatively but 20% to 30% occur spontaneously. Ulcerative colitis (UC) may also occasionally result in spontaneous fistula, but UC is more commonly associated with postoperative fistula. Diverticulosis rarely results in fistula except postoperatively. Other causes of spontaneous fistula include cancer, radiation, and intra-abdominal sepsis.

73.

If a patient with a J-PEG (jejunostomy) tube develops vomiting, abdominal distention, and increasing abdominal pain, the nurse should suspect

perforation.

blockage.

migration.

breakage.

Explanation:

These symptoms are indications of J-PEG migration, which is unique to J-PEG tubes. If the J-tube migrates proximally, the patient may experience vomiting and increased risk of aspiration while if the J-tube migrates distally, the patient may experience vomiting, abdominal distention, and increasing abdominal pain. If tube migration is suspected, then fluid should be aspirated and tested for pH using a colorimetric pH strip. The tube should be marked carefully, checked frequently, and secured to prevent migration.

74.

Following formation of an orthotopic neobladder, how frequently should patients generally schedule urination in the first week after the catheter is removed?

every 2 hours during the daytime and every 3 hours at night

every 3 hours during the daytime and every 4 hours at night

every 4 hours during the daytime and every 5 hours at night

every 5 hours during the daytime and every 6 hours at night

Explanation:

After the catheter is removed following creation of a neobladder, the patient begins scheduled urination in the sitting position, usually every 2 hours during the day and every 3 hours at night. Some incontinence is normal, especially during the night. The time between scheduled urination usually increases by about 1 hour per week up until 5 weeks, when patients should be able to go 6 hours between urinations, but this may vary with individuals. Patients should be advised to not exceed 6 hours between urinations, even at night.

75.

If urine does not flow freely or at all during routine catheterization of a continent urinary diversion, the patient should

remove the catheter.

insert the catheter a few centimeters further into the pouch.

irrigate the catheter.

stand and walk around before removing catheter.

Explanation:

If urine does not flow freely or at all, this usually indicates that the catheter is blocked by mucus. While removing the catheter and flushing it may solve the immediate problem, there may be more mucus in the pouch, so the best solution is to irrigate. Irrigation is usually done with 60 mL of normal saline, which is instilled and drained, repeating this procedure until the fluid runs clear of mucus and drains freely.

76.

Which is the best solution for a patient who complains of skin irritation and odor from the mucous fistula that formed when she had an emergency ileostomy?

change the gauze dressings more frequently

use a skin barrier and deodorizing stoma bag or cap

apply odor eliminator drops (such as M9) to the gauze dressing

apply gauze dressing and cover with waterproof tape to contain odor

Explanation:

Because this patient has both skin irritation and odor, the best solution is to apply a skin barrier, such as a wafer, and a deodorizing stoma bag or stoma cap, depending on the amount of drainage. The mucous fistula continues to drain mucus that forms in the distal bowel, and this may be quite malodorous, especially in the initial postoperative period. In some cases, the discharge may be quite watery. The skin around the mucous fistula should be cleansed with water and dried thoroughly with each dressing change.

77.

If a PEG tube is dislodged and pulled out 3 days after placement, the tube must be

replaced endoscopically.

replaced with a button gastrostomy.

replaced through the tract with a balloon gastrostomy.

replaced endoscopically and resited.

Explanation:

If a PEG tube is pulled out in the first 7 to 10 days after placement, the tract is not yet mature enough for a replacement catheter to be inserted through the tract, so the PEG must be replaced endoscopically. The replacement should be carried out as soon as possible because the tract will begin to close within a few hours. Resiting of the tube should not be necessary unless there is extensive trauma for some reason.

78.

Compared with continent cutaneous urinary diversion, the orthotopic neobladder has significantly increased incidence of

urinary obstruction.

parastomal hernia.

urinary infection.

wound complications.

Explanation:

The neobladder has a higher rate of wound complications (34%) than does continent urinary diversion (19%) within 5 years of surgery but both types of procedures result in numerous complications. The neobladder has 3 times the incidence of urinary stones and fistulae, although there is little difference in the rates of urinary obstruction or infection, parastomal hernias, or stoma complications. Studies indicate that patients receiving continent urinary diversion or neobladder should have long-term monitoring for complications.

79.

Patients with bladder cancer that has invaded multiple areas of the bladder muscle are usually treated with

radiation alone.

segmental cystectomy.

radical cystectomy and urinary diversion.

chemotherapy alone.

Explanation:

The most common treatment for invasive bladder cancer is radical cystectomy and urinary diversion, although some patients may undergo radiation and chemotherapy in addition to or in place of surgery, depending on the stage and extent of the cancer. Urinary diversion includes urostomy, continent cutaneous urinary diversion with a pouch formed from part of the bowel and an external stoma that must be catheterized, and orthotopic neobladder, which allows urination through the urethra. Segmental cystectomy is generally restricted to those whose cancer is low grade and whose disease has affected only one area of the bladder.

80.

For a male patient doing clean intermittent catheterization, which type of tip is best if the patient has a urethral stricture?

straight

coudé

olive tipped

personal preference

Explanation:

The Coudé curved-tip intermittent-use catheter is often used for men with urethral strictures or enlarged prostates to facilitate catheterization as the tip of the catheter is quite small. The straight catheter is most commonly used by women and many men as well. The olive-tipped catheter has a guide strip and is useful for people who have difficulty with insertion. Men usually require at least a 12-inch catheter, but women and children may use a shorter and more compact catheter.

81.

The most likely consequence of an orthotopic neobladder created from an ileocecal resection is

vitamin B12 deficiency.

decreased storage capacity.

diarrhea.

increased frequency of stools and risk of steatorrhea.

Explanation:

Creating an orthotopic neobladder from an ileocecal resection may result in increased frequency of stools and risk of steatorrhea. These patients are also at increased risk of developing (oxalate) kidney stones and gallstones because of loss of bile acid. Ileal resection is associated with malabsorption of vitamins B12, D, E, and K with resections of more than 100 cm of bowel. Colonic/sigmoid resection may result in diarrhea because less fluid and sodium are absorbed and there is decreased storage capacity.

82.

When draining an ileostomy pouch into a toilet, what can the patient do to avoid splashing stool and water?

sit further away from the toilet

place sheets of toilet tissue on the water in the toilet bowl

partially open the pouch

put the end of the pouch into the water

Explanation:

When liquid or semi-liquid contacts another liquid, splashing almost always occurs, but placing sheets of toilet tissue in the water in the toilet bowl often provides enough of a barrier to keep the stool from splashing. Patients usually empty their pouches while sitting on the toilet, although some may prefer to sit on a chair facing the toilet, especially if they are obese or very large. They unroll the bottom of the pouch into the toilet but should avoid contact with the water.

83.

Which dressing choice is *MOST* practical for the stoma of a continent cutaneous fecal diversion?

barrier wafer and stoma appliance

no dressing is necessary

stoma cap

gauze pad

Explanation:

The stoma for a continent cutaneous fecal diversion is a small nipple valve, usually about one-half inch in diameter in the lower right quadrant of the abdomen. Unless a complication arises, the stoma should not leak stool. The most inexpensive and easiest dressing to use is a gauze square, which will absorb mucous drainage. Once the pouch is well healed and has reached its maximum size, most people are able to empty the pouch only 3 to 4 times daily.

84.

A fistula that drains yellow/orange fluid usually originates in the

stomach.

duodenum.

small intestine.

colon.

Explanation:

A fistula that drains yellow/orange fluid usually originates in the small intestine. External fistulae are often first detected when drainage from a wound increases. A fistula from the stomach may drain clear, watery fluid while bile staining may occur with a fistula involving the duodenum. Brown, fecal-appearing, and odorous drainage usually occurs with fistula of the large intestine. Because of digestive enzymes found in chyme, drainage may rapidly result in skin excoriation.

85.

What is the earliest that reversal of a colostomy or ileostomy can usually be safely performed?

1 month

2 months

6 months

8 months

Explanation:

Reversal of a colostomy or ileostomy should usually be done only after a minimum of 2 months because the bowel may remain edematous for that period of time, and any abnormality of the bowel increases the risk of postoperative complications. However, in many cases, reversal is done after a longer time period, such as 3 to 6 months. Reanastomosis is done by suturing or stapling the proximal and distal ends. With loop ostomies, reanastomosis may be completed without surgically opening the abdomen.

86.

What is the medication of choice for the treatment of mild ulcerative colitis?

mesalazine

sulfasalazine

budesonide

infliximab

Explanation:

The medication of choice for mild ulcerative colitis is mesalazine, or 5-aminosalicylate (5-ASA), with the most effective dosing at least 2 g daily. This drug is used more frequently than sulfasalazine, which has more side effects. Corticosteroids, such as budesonide, are used when disease does not respond adequately to the 5-ASA medication. Steroids are more commonly used for acute disease, but if the disease does not respond adequately or if patients cannot tolerate corticosteroids, immunosuppressive drugs, such as infliximab, may be considered.

87.

Patients with spina bifida are at high risk for which of the following?

intellectual disability

underweight

latex allergy

diabetes mellitus type 1

Explanation:

Patients with spina bifida are at high risk of latex allergy because they often must do clean intermittent catheterizations and may have multiple surgeries, all of which have the potential to expose the patient to latex, resulting in sensitization, which may progress to an anaphylactic reaction. Patients may exhibit few or only mild symptoms, such as itching, erythema, sneezing, and cough, when in contact with latex, and may not be aware that these are indications of latex allergy, so all spina bifida patients should be considered latex allergic.

88.

The type of drain that is flat in appearance and often placed in surgical wounds to drain fluid by gravity and capillary action is

simple drain.

sump drain.

closed drainage system.

Penrose drain.

Explanation:

The Penrose drain is a soft, flat rubber/latex tubes placed in surgical wounds to drain fluid by gravity and capillary action. Simple drains are latex or vinyl tubes of varying sizes and lengths inserted usually into a stab wound to provide drainage of serous material, blood, pus, or other discharge. Sump drains are double-lumen or tri-lumen tubes (with a third lumen for infusions). A large outflow lumen and small inflow lumen produces venting when air enters the inflow lumen and forces drainage into the large lumen. A closed drainage system uses low-pressure suction to provide continuous gravity drainage of wounds.

89.

A patient undergoing an abdominoperineal resection of the rectum (APER) should expect which of the following to be resected?

the rectum and the anal canal

the rectum

the rectum, part of the sigmoid colon, and the anal canal

the rectum, part of the sigmoid colon, the anal canal, and anal sphincters

Explanation:

A patient undergoing an abdominoperineal resection of the rectum (APER) should expect that the rectum, part of the sigmoid colon, the anal canal, and the anal sphincters will be removed, and a colostomy created, usually in the LLQ. This procedure is usually reserved for those with a tumor low in the rectum or for those with severe regional enteritis (Crohn's disease) that has not responded to more conservative medical therapy. Those with Crohn's disease treated with steroids may have delayed healing.

90.

What does it indicate if a patient with severe cognitive impairment underwent emergency formation of a colostomy and is receiving pain medication around the clock but has short periods of hyperventilation, cries out frequently, is lying rigidly with fists clenched, and is increasingly combative?

inadequate pain control

excess sedation from pain medication

side effects of pain medication

increasing dementia

Explanation:

The patient is exhibiting nonverbal indications of pain. The Pain Assessment in Advanced Dementia (PAINAD) scale is as follows:

- *Respirations: Rapid and labored breathing as pain increases, with short periods of hyperventilation or Cheyne-Stokes respirations.*
- *Vocalization: Negative in speech or speaking quietly and reluctantly, may moan or groan. As pain increases, may call out, moan or groan loudly, or cry.*
- *Facial expression: May appear sad or frightened, may frown or grimace, especially with activity.*
- *Body language: May be tense, fidgeting, or pacing, and as pain increases rigid, clenched fists, lying in fetal position, and/or increasingly combative.*
- *Consolability: Less distractible or consolable.*

91.

How often are urostomy appliances usually emptied?

2 times daily

3 to 4 times daily

4 to 6 times daily

8 to 10 times daily

Explanation:

Urostomy appliances are usually emptied 4 to 6 times daily, when the pouch is about one-third to one-half full. Allowing the appliance to fill more increases the risk of leakage. Urine should flow continually, but patients can usually establish a routine schedule of emptying the appliance if they maintain a fairly regular schedule of meals and fluid intake. Any change in the usual pattern of urinary output may indicate complications, such as a urinary tract infection or inadequate fluid intake.

92.

Which of the following is a common complication after takedown of a loop ileostomy?

dehiscence

small bowel obstruction

hemorrhage

chronic pain

Explanation:

The 3 most common problems associated with takedown of a loop ileostomy are small bowel obstruction, wound infection, and abdominal sepsis. Small bowel obstruction may occur because of twisting of the small intestine or (more commonly) the development of adhesions. The obstruction is usually treated conservatively but may require surgical intervention. The chance of wound infection correlates with wound size, but antibiotic prophylaxis may help prevent. Abdominal sepsis results from anastomotic leak. Localized abscesses may be drained percutaneously but more extensive infection may require laparotomy.

93.

What is the primary cause of chronic or recurrent perianal irritation after IPAA?

poor hygiene

digestive acids and enzymes

improper food choices

medications

Explanation:

While good hygiene (washing and drying the anal area after each fecal evacuation) is very important, patients may still develop anal irritation because digestive acids and enzymes are present in the stool because of removal of the colon. If the patient evacuates 8 or more times daily, this increases skin contact with the acids and enzymes and poses a high risk for skin irritation. Patients should be advised to apply skin barrier cream or wipe routinely to protect the skin. Some people complain of itching, which may be relieved with hemorrhoid preparations or aloe vera gel.

94.

Malabsorption of bile salts may result in

decreased bowel frequency.

pouchitis.

increased bowel frequency.

obstruction.

Explanation:

Malabsorption of bile salts may result in increased bowel frequency because they liquefy feces. Bile salts are generally absorbed through the ileum, so malabsorption may occur with resection of the ileum or disease affecting the ileum, such as Crohn's disease. Treatment is usually bile acid sequestrants. For the first 3 months after IPAA, there is minimal intestinal absorptive adaptation, so it may be up to a year before the consistency of the stools is optimal.

95.

How much fluid should a patient with an ileostomy be advised to drink each day?

800 mL

1000 mL

1500 mL

2000 mL

Explanation:

A patient with an ileostomy should be advised to drink about 2000 mL (8 to 10 glasses) of fluid daily because the high output of semi-liquid stool from the colostomy increases the risk of dehydration. Electrolyte levels should be monitored closely and electrolytes replaced as needed. Patients may need to further increase intake when stool output increases. In some cases, patients may be advised to take loperamide to decrease stool output if it remains excessive.

96.

How frequently should a patient with an orthotopic neobladder and the ability to urinate well do a routine catheterization?

daily

weekly

monthly

when problems arise

Explanation:

It is common for residual urine to remain in the bladder after a patient with an orthotopic neobladder urinates; over time, this problem may increase until the neobladder begins to become distended. Therefore, patients should routinely do a clean intermittent catheterization at least one time each month after urinating to check residual volume. About half the women with a neobladder may experience some urinary retention requiring regular or periodic catheterization.

97.

The ideal protrusion of an ileostomy stoma is

none, the stoma should be flush.

0.5 cm

2 cm.

3 cm.

Explanation:

The ideal protrusion of an ileostomy stoma is about 2 cm (0.8 inches) because this allows for easy fitting and seal of an appliance. A stoma that is flush with the skin is difficult to fit with an appliance and is more likely to leak. If the stoma is too long, it may develop mechanical trauma from the appliance. Stomas are classified as flush (even with or slightly below the skin), moderately protruding (1 to 3 cm), or long (more than 3 cm).

98.

What is the BEST solution for a patient who has had his colon and rectum removed but complains of rectal pressure and the sensation of needing to defecate?

relaxation exercises

sitting on the toilet and bearing down as though defecating

biofeedback

analgesia

Explanation:

Sometimes after removal of the colon and rectum, patients experience symptoms of a phantom rectum, similar to the phantom limb experience of amputees. Patients sense rectal pressure and the need to defecate. Often the best solution is for patients to sit on the toilet and bear down as though defecating. These sensations are often most acute in the early months after surgery and usually subside with time. Relaxation exercises and biofeedback may provide relief to some patients.

99.

The *MOST* likely anomaly in a female neonate found to have an imperforate anus with no external opening or dimple on initial physical exam, a slightly distended abdomen, and passage of some

meconium at 24 hours is

low anomaly with rectourethral fistula.

intermediate anomaly with a perineal fistula.

high anomaly with rectovaginal fistula.

atypical anomaly.

Explanation:

Anorectal abnormalities, such as imperforate anus, result from abnormal development, and they are classified according to the rectum's relationship to puborectalis muscle. A high anomaly occurs when the rectum is positioned above the puborectalis muscle and the child lacks an internal sphincter. Most commonly, this defect is associated with a rectourethral fistula in a male child and a rectovaginal fistula in a female child. This fistula accounts for the passage of some meconium even without an external opening.

100.

What is the initial intervention for a dietary obstruction of an IPAA?

laxative

irrigation

liquids only for 24 hours

high-residue diet

Explanation:

A dietary obstruction in a patient with an IPAA usually resolves if the patient stops eating solid foods and drinks only liquids for 24 hours. Massaging the abdomen, taking a hot bath, and walking may help to relieve a blockage. If the blockage persists and the patient develops other symptoms or begins vomiting, then the patient should get medical help. A diet too high in fiber, such as one with many raw fruits or vegetables, may increase the risk of blockage. Fruits and vegetables should be peeled and cooked.

101.

Patients with an ileal pouch anal anastomosis (IPAA) and frequent loose stools should be advised to do which of the following after each stool?

wash the perianal area with soap and water after each stool

cleanse the perianal area with a moisturizing cleanser and apply a barrier ointment

apply an antifungal powder to the perianal area as a preventive measure

wipe the perianal area carefully and thoroughly and apply an incontinent pad

Explanation:

Patients with an IPAA and frequent loose stools should be advised to cleanse the perianal area with a moisturizing cleanser and apply a barrier ointment to protect the skin. Wiping frequently may cause irritation, and soap and water tend to be drying. An antifungal powder may be applied under a skin barrier if a patient shows signs of a fungal infection but it should not be used prophylactically.

102.

If a patient with an ileal pouch anal anastomosis (IPAA) has developed increased fever, watery stools, abdominal cramping, urgency, and fatigue, the nurse should suspect

dehiscence.

viral infection.

perforation.

pouchitis.

Explanation:

If a patient with an IPAA has developed increased fever, watery stools, abdominal cramping, urgency, and fatigue, the nurse should suspect pouchitis, which is the most common complication after the immediate postoperative period, occurring in up to 50% of patients with ulcerative colitis, and sometimes becoming chronic. Treatment is with antibiotics, typically beginning with metronidazole and switching to rifaximin or ciprofloxacin if ineffective. Probiotics may also be administered.

103.

The expected eventual daily bowel movements for a patient with an ileal pouch anal anastomosis (IPAA) is

1 to 2 per day.

2 to 4 per day.

4 to 8 per day.

8 to 12 per day.

Explanation:

The expected eventual daily bowel movements for a patient with an IPAA is 4 to 8 per day. BMs are more frequent in the early postoperative period, but as the patient learns to manage food and fluids, this should improve. The stools are always more frequent than regular stools because part of the bowel is missing and there is less absorption, so there is more liquid in the stool.

104.

Which of the following skin barriers is most appropriate to fill in uneven areas about the outer edge of an appliance?

paste

strip

powder

liquid spray

Explanation:

The skin barrier that is most appropriate to fill in uneven areas about the outer edge of an appliance is the strip barrier. Strip barriers may also be used about a stoma to improve a seal. Strip barriers need to be molded into the proper size and shape, so the patient needs some

degree of manual dexterity in order to use the product. Strip barriers may be used on irritated skin rather than paste, which contains alcohol.

105.

If a fistula orifice is located closely adjacent to a surgical incision, the barrier of the pouching system used to collect discharge should be

placed over the incision.

discontinued and replaced with absorbant dressings.

cut to expose the incision.

placed over a piece of non-adherent dressing covering the incision.

Explanation:

If the fistula orifice is located closely adjacent to a surgical incision, the barrier of the pouching system used to collect discharge should be placed directly over the incision in order to protect the incision from the discharge. If the incision is not yet completely healed or sutures or stapes are present, incision tape or Steri-strips should be placed on the incision for added protection before the barrier of the pouching system is applied.

106.

With a continent ileostomy (Kock pouch), initial indications of valve slippage usually include

increased abdominal cramping.

abdominal distention.

difficulty intubating.

fever and chills.

Explanation:

With a continent ileostomy (Kock pouch), initial indications of valve slippage usually include difficulty intubating or fecal and flatus incontinence per the valve. Valve slippage is most common during the first 3 months after surgery and is rare after the first year. Patients who gain weight are at increasing risk of developing valve slippage. If the patient is unable to intubate, then a bowel obstruction is present and requires endoscopic and/or surgical intervention.

107.

In the postoperative period after construction of a continent ileostomy (Kock pouch) with a Medina catheter in place, the patient complains of pressure beneath the pouch, and stool is leaking about the catheter, the nurse should suspect

infection if pouch.

bleeding internally.

migration of catheter.

blockage of catheter.

Explanation:

In the postoperative period after construction of a continent ileostomy (Kock pouch) with a Medina catheter in place, the patient complains of pressure beneath the pouch, and stool is leaking about the catheter, the nurse should suspect blockage of the catheter. The nurse should check the catheter and tubing to ensure they are not kinked and may need to irrigate the catheter with up to 30 mL water or NS. If the catheter cannot be irrigated, then it should be replaced to ensure drainage.

108.

With a continent ileostomy (Kock pouch), the ultimate goal for the number of intubations per day is

2 to 4.

4 to 6.

6 to 8.

8 to 10.

Explanation:

With a continent ileostomy (Kock pouch), the ultimate goal for the number of intubations per day is 2 t to 4. The Medina catheter is left in place for 2 to 3 weeks to prevent pressure building up on the healing pouch, and then the catheter is removed and intubations begin. Initially, intubation is carried out every 2 hours during waking hours, but over time the pouch will begin to expand to contain up to about 500 mL and the frequency of intubation gradually decreases.

109.

If a patient undergoes urinary diversion because of severe bladder dysfunction and incontinence, the patient's bladder should be removed to prevent

pyocystis.

pain.

increased risk of cancer.

prolapse.

Explanation:

If a patient undergoes urinary diversion because of severe bladder dysfunction and incontinence, the patient's bladder should be removed to prevent pyocystis. Pyocystis is an infection that occurs when secretions that normally occur in the bladder begin to accumulate because there is no flow of urine to wash them out. The secretions provide an ideal medium for bacteria to multiply, so the bladder becomes infected and fills with purulent material.

110.

How long after PEG is performed is the tract usually mature and healed enough for placement of a balloon gastrostomy (G-tube)?

2 to 4 weeks

4 to 7 days

1 to 2 months

3 to 4 months

Explanation:

The tract of a PEG usually matures and heals within 2 to 4 weeks. Once the tract has healed, the original PEG tube can generally be replaced with a balloon gastrostomy tube. Gastrostomy tubes with an internal balloon or mushroom tip, measured markings, and an external disk are easier to stabilize, but internal devices should be checked daily by gently pulling until resistance is felt. External stabilizing devices can be applied to the skin to hold the tube in place. The tube may also be taped to the abdomen or secured with a binder.

111.

The first indication of bladder cancer is typically

pyuria.

dysuria.

hematuria.

urinary retention.

Explanation:

The first indication of bladder cancer is typically hematuria, which occurs in 89% to 90% of patients. The rate of bladder cancer is three times higher in males than females and is associated with smoking, exposure to chemicals, and chronic use of an indwelling catheter. Bladder cancer develops in the mucosa but may spread to the submucosa, muscle, and other layers of tissue. Radical cystectomy is recommended for high grade invasive cancer.

112.

If, following pelvic radiation for uterine cancer, a patient develops bladder damage with persistent bleeding, pain, and incontinence, the most likely treatment is

anticholinergic/antimuscarinic.

indwelling catheter.

clean intermittent catheterization.

urinary diversion.

Explanation:

If, following pelvic radiation for uterine cancer, a patient develops bladder damage with persistent bleeding, pain, and incontinence, the most likely treatment is urinary diversion (usually ileal conduit diversion). Radiation may result in chronic irritation of the bladder lining, usually with onset of symptoms after several weeks of treatment. In most patients, the problems recede within the weeks after radiation stops, but the problem remains severe for some patients.

113.

What length of bowel is required to construct an ileal conduit with enterocutaneous stoma?

5 to 10 cm

10 to 12 cm

15 to 20 cm

30 to 40 cm

Explanation:

The length of bowel that is required to construct an ileal conduit with enterocutaneous stoma is 10 to 12 cm. The segment is usually obtained above the distal 12 to 15 cm of the ileum by the ileocecal valve because this part of the small intestine is essential for absorption of bile salt and vitamin B12. The chosen segment must have adequate blood supply and be free of disease or abnormalities.

114.

Which type of urinary diversion is most difficult for a patient with limited mobility and limited fine muscle dexterity to manage?

colon conduit

ileal conduit

Indiana pouch

orthotopic neobladder

Explanation:

The type of urinary diversion that is most difficult for a patient with limited mobility, and limited fine muscle dexterity is the orthotopic neobladder. Although the patient normally urinates through the urethra, the patient must be able to self-catheterize if the bladder does not empty adequately. If the bladder becomes full and distended and the patient cannot catheterize, this would constitute a urologic emergency as the bladder may rupture.

115.

Following surgery for construction of an ileal conduit, the nurse examines the stoma (end type) and expects to see

ureteral stents.

mucous drainage.

indwelling catheter.

stoma only.

Explanation:

Following surgery for construction of an ileal conduit, the nurse examines the stoma (end type) and expects to see ureteral stents. The ureterointestinal anastomoses is secured over ureteral stents in order to protect the anastomoses during the healing process. These stents are typically color-coded or the end cut so that right and left can be easily identified and are left in place for about 5 days although some surgeons may leave them for up to two weeks, depending on various factors.

116.

If, following the construction of an ileal conduit, a patient develops fatty diarrhea, this likely indicates

high fat diet.

vitamin B12 deficiency.

malabsorption of bile salts.

metabolic acidosis.

Explanation:

If, following construction of an ileal conduit, a patient develops fatty diarrhea, this likely indicates malabsorption of bile salts. Absorption of bile salts and vitamin B12 occurs in the distal ileum, which is proximal to the ileocecal valve. If part of this segment of small intestine is removed to form the urinary reservoir, then absorption of bile salts may be inadequate. Bile salts are necessary for the digestion and absorption of both fat and fat-soluble vitamins.

117.

If a patient has a complete ileostomy obstruction, how much NS should be instilled at a time for the irrigations?

30 to 50 mL

50 to 90 mL

90 to 120 mL

150 to 200 mL

Explanation:

If a patient has a complete ileostomy obstruction, 30 to 50 mL of NS should be instilled at a time for the irrigations. A digital disimpaction may be attempted first. For the irrigation, a lubricated 14 Fr or16 Fr catheter is gently inserted into the stoma until the obstruction is reached. Then, using a bulb syringe, the NS is slowly instilled, the catheter removed to allow drainage, and the procedure repeated as long as necessary until the blockage resolves (usually 1 to 2 hours).

118.

If a fistula orifice opens flush with the skin, the best containment method is

a flat pouching system.

absorbant dressings.

drainage catheter with absorbant dressings.

a convex pouching system.

Explanation:

If a fistula orifice opens flush with the skin, the best containment method is a convex pouching system because this may help the orifice to raise above the surrounding skin. When assessing the fistula, it's important to assess with the patient in different positions—standing, sitting, and lying down—because the appearance of the fistula may change, and the pouching system that is selected should correspond to the most challenging finding.

119.

The stoma site for an Indiana pouch is generally in the

right lower quadrant (RLQ).

right upper quadrant (RUQ).

left lower quadrant (LLQ).

left upper quadrant (LUQ).

Explanation:

The stoma site for an Indiana pouch is generally in the right lower quadrant (RLQ). However, the stoma placement should be sure to avoid the waist/belt line and should also take into consideration abdominal folds. If a patient has a very large abdomen with abdominal fold, then the stoma may need to be placed higher. The patient must be able to visualize the stoma and to catheterize it in order to manage self-care.

120.

Which type of catheter does the nurse expect to be in place to drain an Indiana pouch during the immediate postoperative period?

24 French straight catheter

24 French Malecot catheter

20 French Foley catheter

16 French Foley catheter

Explanation:

The type of catheter that the nurse expects to be in place to drain an Indiana pouch during the immediate postoperative period is the 24 French Malecot catheter. The large size facilitates drainage of mucus and irrigations to flush the mucus out of the pouch. The Malecot catheter has small mushroom-shaped wings that allow drainage and maintain the catheter in place, but the catheter can be easily removed by gently tugging as this collapses the wings.

121.

What percentage of patients with ulcerative colitis will eventually require total colectomy?

<10%

25%

50%

>80%

Explanation:

About 25% of patient with ulcerative colitis will eventually require total colectomy. Ulcerative colitis manifests with superficial inflammation of mucosa of colon and rectum, causing ulcerations in the areas where inflammation has destroyed cells. These ulcerations, ranging from pinpoint to extensive, may bleed and produce purulent material. The mucosa of the bowel becomes swollen, erythematous, and granular. Onset is usually between 15 and 30 years of age, and there is a genetic component. Ulcerative colitis may affect only the rectum (ulcerative proctitis), the entire colon (pancolitis), or only the left colon (limited or distal colitis).

122.

What dietary modification is indicated to manage the acute phase of chronic inflammatory bowel disease (IBD)?

low residue, low fat, high protein, and high calorie

low residue, low fat, low protein, and high calorie

low residue, low fat, and high protein, and low calorie

low residue, high fat, and high protein, and high calorie

Explanation:

During the acute phase of chronic inflammatory bowel disease, patients should be advised to stay on a low-residue, high-protein, low-fat, and high-calorie diet. This type of diet is digested primarily in the jejunum, allowing the bowel to rest. Patients should especially avoid foods that cause irritation, as this may be quite individual, and should be sure to drink at least 8 glasses a day because patients often become dehydrated. In severe case of IBD, patients may require parenteral nutrition.

123.

If a patient has developed peristomal candidiasis, the usual treatment is

oral antifungal medication.

antifungal ointment and powder barrier.

antifungal powder and skin barrier film.

vinegar solution cleanse and antifungal powder.

Explanation:

If a patient has developed peristomal candidiasis, the usual treatment is antifungal powder applied to the affected tissue and then a skin barrier film placed over the top so that the appliance can adhere to it. Candidiasis, which develops in moist areas, causes reddening of the tissue, maculopapular rash, and intense itching that can make wearing an appliance extremely uncomfortable. Some medications (antibiotics, corticosteroids, chemotherapy) increase the risk of developing candidiasis.

124.

A Hemovac drain can accommodate drainage up to about

100 mL/24 hr.

250 mL/24 hr.

350 mL/24 hr.

500 mL/24 hr.

Explanation:

A Hemovac drain can accommodate drainage up to about 500 mL in 24 hours. The Hemovac is a closed drainage system that utilizes suction to draw drainage from the wound. When emptying the Hemovac, the nurse should use aseptic technique, remover the plug, compress the two flat surfaces together while tilting the open port over a container. The Hemovac can also be attached to wall suction by connecting a graduated adaptor with wall suction tubing to the emptying port.

125.

Which of the following is an early stomal complication, often apparent within the first 24 hours?

mucocutaneous separation

stomal prolapse

stomal retraction

parastomal hernia

Explanation:

Mucocutaneous separation is an early stomal complication, often apparent within the first 24 hours. Mucocutaneous separation may be partial or complete and superficial or deep. A partial superficial separation may be treated by packing (as with any other wound), protecting, and allowing it to heal, but a complete or deep separation may result in retraction of the stoma and requires surgical repair.

126.

A pouching system is recommended for an enterocutaneous fistula with output greater than

50 mL/24 hr.

100 mL/24 hr.

250 mL/24 hr.

400 mL/24 hr.

Explanation:

A pouching system is recommended for an enterocutaneous fistula with output greater than 100 mL in 24 hours or with the need for dressing changes more frequently than every 4 hours. If the fistula requires frequent access, then a wound management system with a window or a two-piece pouching system should be used so that the pouch doesn't need to be removed each time. Absorbant dressings, even with skin barriers, pose an increased risk of skin breakdown.

127.

If a patient has very hairy peristomal skin, the pull of the hair and skin irritation when the appliance is removed put the patient at increased risk of

granulomas.

candidiasis.

folliculitis.

allergic dermatitis.

Explanation:

If a patient has very hairy peristomal skin, the pull of the hair and skin irritation when the appliance is removed put the patient at increased risk of folliculitis, infection of the hair follicles, often by Staphylococcus aureus, which is found in the skin's flora. Treatment may include a topical antibiotic powder. Excessive hair in the peristomal area should be clipped or trimmed or removed with an electric shaver (but not a straight razor) at least once a week.

128.

A common cause of stomal stenosis is

mucocutaneous separation.

malnutrition.

poor surgical technique.

infection.

Explanation:

When a mucocutaneous separation heals, the scar tissue increases the risk of stomal stenosis developing as a later complication (more than 30 days postoperatively). Stomal stenosis may also result from stomal necrosis and stomal retraction. Patients with stomal stenosis often exhibit ribbon-like stool and may have pain when stool is passed. Some will develop constipation because of the difficulty in passing stool.

129.

When caring for a fistula, troughing is most indicated for

a fistula at one end of a vertical incision.

a fistula adjacent to an incision.

a fistula adjacent to a large open wound.

a fistula located within a large open wound.

Explanation:

When caring for a fistula, troughing is most indicated for a fistula located within a large open wound where pouching is difficult. Troughing involves covering the periwound skin with a skin barrier and ensuring the edges are sealed with barrier paste and then applying a transparent film dressing over the wound with an opening cut at the fistula orifice and then applying the pouching system over that opening.

130.

The most common cause of an enterocutaneous fistula is

radiation enteritis.

anastomotic breakdown.

trauma.

diverticulitis.

Explanation:

The most common cause (75%) of an enterocutaneous fistula (abnormal tract developing between any part of the large or small intestines and the skin) is anastomotic breakdown involving the intestines in the postoperative period. Factors that put patients at increased risk of an external enterocutaneous fistula include malnutrition, ulcerative colitis, Crohn's disease, cancer, and history of radiation therapy. An inadequate blood supply and improper surgical technique may also result in development of an enterocutaneous fistula.

131.

A patient with Medicare part B should expect that Medicare will cover what percentage of the cost of ostomy supplies?

20%

80%

100%

None

Explanation:

A patient with Medicare part B should expect that Medicare will cover 80% of the cost of ostomy supplies and will allow a three-month supply at one time. The patient is responsible for paying for the deductible and the remaining 20% although this may be covered by supplemental insurance. Medicaid coverage for ostomy supplies varies from state to state but is not federally required. Private insurances also vary in coverage for ostomy supplies, so patients should be advised to consult their carriers.

132.

The nurse is teaching a patient to care for a gastrostomy feeding tube and tells the patient that in order to prevent dumping syndrome, the patient should

administer refrigerated formula.

increase rate of instillation.

stay in semi-Fowler's position for one hour after feedings.

increase volume of water used to flush tube before and after feedings.

Explanation:

When teaching a patient to care for a gastrostomy feeding tube, the nurse should tell the patient that, in order to prevent dumping syndrome, the patient should stay in semi-Fowler's position for one hour after feedings as this slows transit time by decreasing the force of gravity. Additionally, formula should be instilled slowly and at room temperature. Small volumes of water should be used to flush the tubing before and after feedings because diluted formula has a faster transit time. Continuous drip also results in less incidence of dumping syndrome than bolus administration.

133.

The ideal placement for a stoma for an ileostomy is

RUQ about 2 inches lateral to midline.

RLQ about 2 inches below the waist.

LUQ about 2 inches lateral to midline.

LLQ about 2 inches below the waist.

Explanation:

The ideal placement for a stoma for an ileostomy is in the right lower quadrant, about 2 inches below the waist, although this may vary if there are folds or scar tissue that precludes this placement. The stoma should be conveniently placed, avoiding bony prominences, so that the patient can easily see the stoma and manage care independently, and so that an appliance can be easily applied. The site should be marked prior to surgery, usually by the surgeon or enterostomal therapist, and discussed with the patient.

134.

If the nurse notes that a patient's fistula has developed a pseudostoma, this means that the fistula

is healing properly.

is eroding.

requires surgical closure.

has signs of infection.

Explanation:

If the nurse notes that a patient's fistula has developed a pseudostoma, this means that the fistula requires surgical closure because it will no longer close on its own. A pseudostoma occurs when the anterior wall of the intestine adheres to the abdominal wall, and the mucosa of the fistula tract everts onto the surface, resulting in epithelialization of the tract, and creation of a permanent opening. If a pseudostoma is noted, then the physician must be notified.

135.

Before surgical closure, a type 1 fistula should be free of infection for at least

1 to 2 weeks.

3 to 4 weeks.

5 to 6 weeks

6 to 8 weeks.

Explanation:

Before surgical closure, a type 1 fistula should be free of infection for at least 6 to 8 weeks to ensure that the surgical repair will heal and the abdominal tissue is in optimal condition. For a type 2 fistula, surgical repair is usually delayed for up to 6 months to allow scar tissue to soften sufficiently so that the fistula tract can be isolated and removed. Even after surgical repairs, fistula recurrence is not uncommon.

136.

If there is crusting about the insertion site of a percutaneous endoscopic gastrostomy (PEG) tube, the recommended way to remove it is with a cotton swab moistened with

water.

hydrogen peroxide.

povidone-iodine.

isopropyl alcohol.

Explanation:

If there is crusting about the insertion site of a PEG tube, the recommended way to remove it is with a cotton swab moistened with water. Other antiseptics, such as hydrogen peroxide, povidone-iodine, and isopropyl alcohol may cause skin irritation and stinging, and hydrogen peroxide may contribute to the development of hypertrophic granulation. The patient should be taught to keep the site clean with mild soap and water, to dry the skin thoroughly, and to report any indications of skin irritation or drainage about the tube.

137.

Saddlebagging is indicated when a fistula

is located near a large wound.

is located at one end of a vertical wound.

is very large.

needs cushioning to protect the skin.

Explanation:

Saddlebagging is indicated when a fistula is very large and standard available pouches aren't adequate. Saddlebagging is a technique by which the bags of two cut-to-fit pouches are attached by overlapping one over the other to make one large pouch with a larger adhesive surface than usual. Saddlebagging is sometimes used when a fistula is located within a large open wound. This technique is useful for a high output fistula because the fistula can drain into both pouches.

138.

Which technique may be useful for a fistula at the lateral of a long horizontal wound?

troughing

bridging

saddlebagging

closed suction

Explanation:

The technique that may be useful for a fistula at the lateral of a long horizontal wound (or at the inferior aspect of a long vertical wound) is bridging. This technique involves filling the wound near the fistula with strips of pectin barrier or hydrocolloid wafer to build a bridge across the wound so that a pouching system can be attached to the skin on one side and the bridge on the other, making a tight seal.

139.

When using crusting over denuded skin to provide a surface for a pouching system, the first layer is

strip barrier.

wafer barrier.

polymer skin barrier spray.

skin barrier powder.

Explanation:

When using crusting over denuded skin to provide a surface for a pouching system, the first layer is skin barrier powder, which is applied and excess brushed off so that it adheres only to the denuded tissue. Then polymer skin barrier spray is applied and allowed to dry, forming a white crust. These steps are repeated 2 to 6 times to build up a firm secure base that covers and protects the denuded skin and allows the pouching system to adhere well.

140.

Hypergranulation tissue about a percutaneous enteral tube usually indicates

an infection is present.

the tube is poorly secured.

improper surgical technique.

allergic response.

Explanation:

Hypergranulation tissue about a percutaneous enteral tube usually indicates the tube was poorly secured and was causing trauma to the tissue as it slipped in and out. Other causes may include use of hydrogen peroxide about the tube and leakage of drainage that causes irritation to the tissues. If granulation tissue occurs, the tube should be stabilized. Treatment may include cauterization with silver nitrate, antimicrobial cream on a foam dressing, or a topical steroid.

141.

A nasogastric tube puts the patient especially at increased risk of

aspiration pneumonia.

gastric ulcer.

gastritis.

gastrointestinal hemorrhage.

Explanation:

A nasogastric tube puts the patient especially at risk of aspiration pneumonia because NG tubes have a high risk of dislodgement even though they are easier than other tubes to insert and less invasive. If patients require long-term tube feedings, then another option should be chosen, such as the PEG. With an NG tube, the tube should be checked before each feeding by aspirating stomach contents to ensure that it remains in the correct position.

142.

Following surgery for construction of an ileostomy because of ulcerative colitis, what psychosocial issues is likely to most impact the patient?

social isolation

loss of autonomy

altered body image

lack of social support

Explanation:

Following surgery for construction of an ileostomy because of ulcerative colitis, the psychosocial issue that is likely to have the most impact on the patient is an altered body image. The patient is likely to go through a grieving period, and it may take varying amounts of time for a person to come to terms with a new body normal and to accept the stoma as part of the person, especially since the feedback from others is quite negative.

143.

If a patient with Crohn's disease and no rectal involvement has an ileorectal anastomosis, the chance of eventually needing a proctectomy is about

10%.

25%.

50%.

75%.

Explanation:

If a patient with Crohn's disease and no rectal involvement has an ileorectal anastomosis, the chance of eventually needing a proctectomy is about 50%. Disease recurrence in the area is

common and results in surgical removal of the anus and rectum and creation of an end ileostomy. Because of frequency of this complication, some may choose to forego the ileorectal anastomosis.

144.

The *MOST* critical indication for total colectomy in a patient with ulcerative colitis is

hypocalcemia and anemia.

dehydration and electrolyte imbalance.

nonresponsive toxic megacolon.

erythema nodosum and uveitis.

Explanation:

With toxic megacolon, inflammation extends through the mucous lining of the intestines into the smooth muscle of the muscularis, which controls peristalsis. Because the intestinal ability to contract becomes impaired, the colon distends. Symptoms include weakness, fatigue, fever, pain, vomiting, and distention. Treatment includes insertion of a nasogastric tube for decompression, IV fluids, electrolyte replacement, corticosteroids, and antibiotics, but if the condition does not respond within 1 to 3 days, then total colectomy is usually performed.

145.

Following surgery for construction of a continent ileostomy (Kock pouch), which referral is most indicated to help the client manage at home and resume normal activities?

occupational therapist

nutritionist

physical therapist

recreational therapist

Explanation:

Following surgery for construction of a continent ileostomy (Kock pouch), the referral that is most indicated to help the client manage at home and resume normal activities is a nutritionist. The patient must learn what foods to avoid because they may plug the catheter (corn, popcorn, high fiber foods, mushrooms, nuts, foods with peels) and which cause gas (cruciferous foods) as well as which ones thin (grape juice, prune juice) or thicken the stool.

146.

After surgery for Crohn's disease, inflammation

never recurs.

rarely recurs.

recurs in about 10% to 15%.

recurs in almost all patients.

Explanation:

After surgery for regional enteritis, the inflammation almost always returns at some point. Within 5 years, almost 30% of patients have experienced recurrence, so medical management remains very important to try to control symptoms and control progression of the disease.

About 50% of patients with regional enteritis eventually need surgery of some type. One common procedure to relieve strictures in the small intestine is laparoscopic strictureplasty, which opens narrowed portions of the intestines. In some cases, a segment of the small bowel is removed, but others require ileostomy.

147.

Infants born with spina bifida should usually begin having intermittent clean catheterization

if their diapers are not routinely wet with urine.

as newborns.

when they are 1 to 2 months old.

if they completely stop passing urine.

Explanation:

Most children with spina bifida have normal function of the kidney and ureters, but the kidneys may become damaged because of urinary retention and abnormalities associated with the lower urinary tract; therefore, clean intermittent catheterization (CIC) should begin immediately after birth because, if bladder function is normal, urination is reflexive in the infant, but the child may have sphincter impairment or other abnormalities, so catheterization can help to determine whether the child has residual urine. The infant should have urodynamic studies done as soon as possible to determine whether CIC should be continued.

148.

The first goal in management of enterocutaneous fistula is

control fluid and electrolyte imbalance.