

Pediatric Nursing – A Case-Based Approach 1st Edition Tagher Knapp Test Bank

Chapter 1: Bronchiolitis

1. Which intervention is appropriate for the infant hospitalized with bronchiolitis?

- a. Position on the side with neck slightly flexed.
- b. Administer antibiotics as ordered.
- c. Restrict oral and parenteral fluids if tachypneic.
- d. Give cool, humidified oxygen.

ANS: D

Cool, humidified oxygen is given to relieve dyspnea, hypoxemia, and insensible fluid loss from tachypnea. The infant should be positioned with the head and chest elevated at a 30- to 40-degree angle and the neck slightly extended to maintain an open airway and decrease pressure on the diaphragm. The etiology of bronchiolitis is viral. Antibiotics are given only if there is a secondary bacterial infection. Tachypnea increases insensible fluid loss. If the infant is tachypneic, fluids are given parenterally to prevent dehydration.

2. An infant with bronchiolitis is hospitalized. The causative organism is respiratory syncytial virus (RSV). The nurse knows that a child infected with this virus requires what type of isolation?

- a. Reverse isolation
- b. Airborne isolation
- c. Contact Precautions
- d. Standard Precautions

ANS: C

RSV is transmitted through droplets. In addition to Standard Precautions and hand washing, Contact Precautions are required. Caregivers must use gloves and gowns when entering the room. Care is taken not to touch their own eyes or mucous membranes with a contaminated gloved hand. Children are placed in a private room or in a room with other children with RSV infections. Reverse isolation focuses on keeping bacteria away from the infant. With RSV, other children need to be protected from exposure to the virus. The virus is not airborne.

3. A child has a chronic cough and diffuse wheezing during the expiratory phase of respiration. This suggests what condition?

- a. Asthma
- b. Pneumonia
- c. Bronchiolitis
- d. Foreign body in trachea

ANS: A

Asthma may have these chronic signs and symptoms. Pneumonia appears with an acute onset, fever, and general malaise. Bronchiolitis is an acute condition caused by respiratory syncytial

virus. Foreign body in the trachea occurs with acute respiratory distress or failure and maybe stridor.

4. Which nursing diagnosis is most appropriate for an infant with acute bronchiolitis due to respiratory syncytial virus (RSV)?

- a. Activity Intolerance
- b. Decreased Cardiac Output
- c. Pain, Acute
- d. Tissue Perfusion, Ineffective (peripheral)

ANS: A

Rationale 1: Activity intolerance is a problem because of the imbalance between oxygen supply and demand. Cardiac output is not compromised during an acute phase of bronchiolitis. Pain is not usually associated with acute bronchiolitis. Tissue perfusion (peripheral) is not affected by this respiratory-disease process.

Rationale 2: Activity intolerance is a problem because of the imbalance between oxygen supply and demand. Cardiac output is not compromised during an acute phase of bronchiolitis. Pain is not usually associated with acute bronchiolitis. Tissue perfusion (peripheral) is not affected by this respiratory-disease process.

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Chapter 2: Asthma

1. The nurse is caring for a child hospitalized for status asthmaticus. Which assessment finding suggests that the child's condition is worsening?

- a. Hypoventilation
- b. Thirst
- c. Bradycardia
- d. Clubbing

ANS: A

The nurse would assess the child for signs of hypoxia, including restlessness, fatigue, irritability, and increased heart and respiratory rate. As the child tires from the increased work of breathing hypoventilation occurs leading to increased carbon dioxide levels. The nurse would be alert for signs of hypoxia. Thirst would reflect the child's hydration status. Bradycardia is not a sign of hypoxia; tachycardia is. Clubbing develops over a period of months in response to hypoxia. The presence of clubbing does not indicate the child's condition is worsening.

2. Which finding is expected when assessing a child hospitalized for asthma?

- a. Inspiratory stridor
- b. Harsh, barking cough
- c. Wheezing
- d. Rhinorrhea

ANS: C

Wheezing is a classic manifestation of asthma. Inspiratory stridor is a clinical manifestation of croup. A harsh, barking cough is characteristic of croup. Rhinorrhea is not associated with asthma.

3. A child has had cold symptoms for more than 2 weeks, a headache, nasal congestion with purulent nasal drainage, facial tenderness, and a cough that increases during sleep. The nurse recognizes these symptoms are characteristic of which respiratory condition?

- a. Allergic rhinitis
- b. Bronchitis
- c. Asthma
- d. Sinusitis

ANS: D

Sinusitis is characterized by signs and symptoms of a cold that do not improve after 14 days, a low-grade fever, nasal congestion and purulent nasal discharge, headache, tenderness, a feeling of fullness over the affected sinuses, halitosis, and a cough that increases when the child is lying down. The classic symptoms of allergic rhinitis are watery rhinorrhea, itchy nose, eyes, ears, and palate, and sneezing. Symptoms occur as long as the child is exposed to the allergen. Bronchitis is characterized by a gradual onset of rhinitis and a cough that is initially nonproductive but may change to a loose cough. The manifestations of asthma may vary, with wheezing being a classic sign. The symptoms presented in the question do not suggest asthma.

4. What is a common trigger for asthma attacks in children?

- a. Febrile episodes
- b. Dehydration
- c. Exercise
- d. Seizures

ANS: C

Exercise is one of the most common triggers for asthma attacks, particularly in school-age children. Febrile episodes are consistent with other problems, for example, seizures. Dehydration occurs as a result of diarrhea; it does not trigger asthma attacks. Viral infections are triggers for asthma. Seizures can result from a too-rapid intravenous infusion of theophylline therapy for asthma.

5. The practitioner changes the medications for the child with asthma to salmeterol (Serevent). The mother asks the nurse what this drug will do. The nurse explains that salmeterol (Serevent) is used to treat asthma because the drug produces which characteristic?

1. Decreases inflammation
2. Decreases mucous production
3. Controls allergic rhinitis
4. Dilates the bronchioles

Correct Answer: 4

Rationale 1: Salmeterol (Serevent) is a long-acting beta2-agonist that acts by bronchodilating. Steroids are anti-inflammatory, anticholinergics decrease mucous production, and antihistamines control allergic rhinitis.

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Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Pharmacological and Parenteral Therapies

Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: LO 20.6 Create a nursing care plan for a child with a common acute respiratory condition.

6. Following parental teaching, the nurse is evaluating the parents' understanding of environmental control for their child's asthma management. Which statement by the parents indicates appropriate understanding of the teaching?

1. We will replace the carpet in our child's bedroom with tile.
2. We're glad the dog can continue to sleep in our child's room.
3. We'll be sure to use the fireplace often to keep the house warm in the winter.
4. We'll keep the plants in our child's room dusted.

Correct Answer: 1

Rationale 1: Control of dust in the child's bedroom is an important aspect of environmental control for asthma management. When possible, pets and plants should not be kept in the home. Smoke from fireplaces should be eliminated.

Rationale 2: Control of dust in the child's bedroom is an important aspect of environmental control for asthma management. When possible, pets and plants should not be kept in the home. Smoke from fireplaces should be eliminated.

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7. A child with asthma will be receiving an oral dose of prednisone. The order reads prednisone 2 mg/kg per day. The child weighs 50 lbs. The child will receive ____ milligrams daily. (Round the answer.)

Standard Text: Round the answer to the nearest whole number.

Correct Answer: $45.5 = 46$

Rationale: $22.7 \times 2 = 45.5$ (46)

Global Rationale: $22.7 \times 2 = 45.5$ (46)

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Pharmacological and Parenteral Therapies

Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: LO 07. Plan the nursing care for the child with a chronic respiratory condition.

8. Parents of a child admitted with respiratory distress are concerned because the child won't lie down and wants to sit in a chair leaning forward. Which response by the nurse is the most appropriate?

1. This helps the child feel in control of his situation.
2. The child needs to be encouraged to lie flat in bed.
3. This position helps keep the airway open.
4. This confirms the child has asthma.

Correct Answer: 3

Rationale 1: Leaning forward helps keep the airway open. The child is not in control just because he is leaning forward. Lying flat in bed will increase the respiratory distress. This position does not confirm asthma.

Rationale 2: Leaning forward helps keep the airway open. The child is not in control just because he is leaning forward. Lying flat in bed will increase the respiratory distress. This position does not confirm asthma.

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9. A school nurse is planning care for a school-age child recently diagnosed with asthma. Which items will the school nurse include in the plan of care at the school?

Standard Text: Select all that apply.

1. Maintain a log of quick-relief medication administration.
2. Call the parents if quick-relief medications work appropriately.
3. Assess for symptoms of exercise-induced bronchospasm.
4. Coordinate education of the child's teachers.
5. Conduct a support group for all children with asthma.

Correct Answer: 1,3,4,5

Rationale 1: Appropriate interventions for the school nurse to include in the plan of care include: keeping a log of the quick-relief medications administered; assessing the child for exercise-induced bronchospasms and reporting, if needed; coordinating education of the child's teachers; and conducting a support group for all children in the school with asthma. The nurse would only call the parents if the quick-relief medication was not effective in treating the child's symptoms.

Rationale 2: Appropriate interventions for the school nurse to include in the plan of care include: keeping a log of the quick-relief medications administered; assessing the child for exercise-induced bronchospasms and reporting, if needed; coordinating education of the child's teachers; and conducting a support group for all children in the school with asthma. The nurse would only call the parents if the quick-relief medication was not effective in treating the child's symptoms.

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Chapter 3: Ulnar Fracture

1. Which is an accurate statement concerning a child's musculoskeletal system and how it may be different from adults?

- a. Growth occurs in children as a result of an increase in the number of muscle fibers.
- b. Infants are at greater risk for fractures because their epiphyseal plates are not fused.
- c. Because soft tissues are resilient in children, dislocations and sprains are less common than in adults.
- d. Their bones have less blood flow.

ANS: C

Because soft tissues are resilient in children, dislocations and sprains are less common than in adults. A child's growth occurs because of an increase in size rather than an increase in the number of the muscle fibers. Fractures in children younger than 1 year are unusual because a large amount of force is necessary to fracture their bones. A child's bones have greater blood flow than an adult's bones.

2. When infants are seen for fractures, which nursing intervention is a priority?

- a. No intervention is necessary. It is not uncommon for infants to fracture bones.
- b. Assess the family's safety practices. Fractures in infants usually result from falls.
- c. Assess for child abuse. Fractures in infants are often nonaccidental.
- d. Assess for genetic factors.

ANS: C

Fractures in infants warrant further investigation to rule out child abuse. Fractures in children younger than 1 year are not common because of the cartilaginous quality of the skeleton; a large amount of force is necessary to fracture their bones. Infants should be cared for in a safe environment and should not be falling. Fractures in infancy are usually nonaccidental rather than related to a genetic factor.

3. A mother whose 7-year-old child has been placed in a cast for a fractured right arm reports he will not stop crying even after taking Tylenol with codeine. He also will not straighten the fingers on his right arm. The nurse tells the mother to do which?

- a. Take him to the emergency department.
- b. Put ice on the injury.
- c. Avoid letting him get so tired.
- d. Wait another hour. If he is still crying, call back.

ANS: A

Unrelieved pain and the child's inability to extend his fingers are signs of compartmental syndrome, which requires immediate attention. Placing ice on the extremity is an inappropriate action for the presenting symptoms. It is inappropriate for the nurse to tell the mother who is concerned about her child to avoid letting him get so tired. A child who has signs and symptoms of compartmental syndrome should be seen immediately. Waiting an hour could compromise the recovery of the child.

4. When assessing a child for an upper extremity fracture, the nurse should know that these fractures most often result from:

- a. automobile accidents.
- b. falls.
- c. physical abuse.
- d. sports injuries.

ANS: B

The major cause of children's fractures is falls. Because of the protection reflexes, the outstretched arm often receives the full force of the fall. Automobile accidents, physical abuse, and sports injuries may result in fractures to any bone.

5. Which statement is most correct with regard to childhood musculoskeletal injuries?

- a. After the injury is iced, the swelling decreases, indicating the injury is not severe.
- b. The presence of localized tenderness indicates a more serious injury.
- c. The more swelling there is, the less severe the injury is.
- d. The less willing the child is to bear weight, the more serious the injury is.

ANS: D

An inability to bear weight on the affected extremity is indicative of a more serious injury. With a fracture, general manifestations include pain or tenderness at the site, immobility or decreased range of motion, deformity of the extremity, edema, and inability to bear weight. A decrease in swelling after icing does not identify the degree of the injury. Localized tenderness along with limited joint mobility may indicate serious injury, but an inability to bear weight on the extremity is a more reliable sign. The degree of swelling does not indicate how serious the injury is.

6. In caring for a child with a compound fracture, what should the nurse carefully assess for?

- a. Infection

- b. Osteoarthritis
- c. Epiphyseal disruption
- d. Periosteum thickening

ANS: A

Because the skin has been broken, the child is at risk for organisms to enter the wound. The incidence of osteoarthritis and the chance of epiphyseal disruption are not increased with compound fracture. Periosteum thickening is part of the healing process and is not a complication.

7. A child who has fractured his forearm is unable to extend his fingers. The nurse knows that this:

- a. is normal following this type of injury.
- b. may indicate compartmental syndrome.
- c. may indicate fat embolism.
- d. may indicate damage to the epiphyseal plate.

ANS: B

Swelling causes pressure to rise within the immobilizing device leading to compartmental syndrome. Signs include severe pain, often unrelieved by analgesics, and neurovascular impairment. It is not uncommon in the forearm, so the inability to extend the fingers may indicate compartmental syndrome. It is not normal that the child is unable to extend his fingers; this indicates neurovascular compromise of some type. Paresthesia or numbness or loss of feeling can indicate a neurovascular compromise and can result in paralysis. Fat embolism causes respiratory distress with hypoxia and respiratory acidosis. Paresthesia is not related to damage to the epiphyseal plate.

Chapter 4: Urinary Tract Infection and Pyelonephritis

MULTIPLE CHOICE

1. Which statement made by a school-age girl indicates the need for further teaching about the prevention of urinary tract infections?

- a. I always wear cotton underwear.
- b. I really enjoy taking a bubble bath.
- c. I go to the bathroom every 3 to 4 hours.
- d. I drink four to six glasses of fluid every day.

ANS: B

Bubble baths should be avoided because they tend to cause urethral irritation, which leads to urinary tract infection. It is desirable to wear cotton rather than nylon underwear. Nylon tends to

hold in moisture and promote bacterial growth, whereas cotton absorbs moisture. Children should be encouraged to urinate at least four times a day. An adequate fluid intake prevents the buildup of bacteria in the bladder.

2. The nurse assessing a child with acute poststreptococcal glomerulonephritis should be alert for which finding?

- a. Increased urine output
- b. Hypotension
- c. Tea-colored urine
- d. Weight gain

ANS: C

Acute poststreptococcal glomerulonephritis is characterized by hematuria, proteinuria, edema, and renal insufficiency. Tea-colored urine is an indication of hematuria. In acute poststreptococcal glomerulonephritis, the urine output may be decreased and the blood pressure increased. Edema may be noted around the eyelids and ankles in patients with acute poststreptococcal glomerulonephritis; however, weight gain is associated with nephrotic syndrome.

3. The mother of a child who was recently diagnosed with acute glomerulonephritis asks the nurse why the physician keeps talking about casts in the urine. The nurse's response is based on the knowledge that the presence of casts in the urine indicates:

- a. glomerular injury.
- b. glomerular healing.
- c. recent streptococcal infection.
- d. excessive amounts of protein in the urine.

ANS: A

The presence of red blood cell casts in the urine indicates glomerular injury. Casts in the urine are abnormal findings and are indicative of glomerular injury, not glomerular healing. A urinalysis positive for casts does not confirm a recent streptococcal infection. Casts in the urine are unrelated to proteinuria.

4. What is a clinical finding that warrants further intervention for the child with acute poststreptococcal glomerulonephritis?

- a. Weight loss to within 1 pound of the preillness weight
- b. Urine output of 1 milliliter per kilogram per hour
- c. A normal blood pressure
- d. Inspiratory crackles

ANS: D

Children with excess fluid volume may have pulmonary edema. Inspiratory crackles indicate fluid in the lungs. Pulmonary edema can be a life-threatening complication. Weight loss to within 1 pound of the preillness weight is an indication that the child is responding to treatment. A urine output of 1 milliliter per kilogram per hour is an acceptable urine output and indicates that the child is responding to treatment. A normal blood pressure is also an indication that the child is responding to treatment.

5. Which diagnostic finding is assessed by the nurse when a child has primary nephrotic syndrome?

- a. Hyperalbuminemia
- b. Positive ASO titer
- c. Leukocytosis
- d. Proteinuria

ANS: D

Large amounts of protein are lost through the urine as a result of an increased permeability of the glomerular basement membrane. Hypoalbuminemia is present because of loss of albumin through the defective glomerulus and the liver's inability to synthesize proteins to balance the loss. ASO titer is negative in a child with primary nephrotic syndrome. Leukocytosis is not a diagnostic finding in primary nephrotic syndrome.

6. Which finding indicates that a child receiving prednisone for primary nephrotic syndrome is in remission?

- a. Urine is negative for casts for 5 days.
- b. Urine is 0 to trace for protein for 5 to 7 days.
- c. Urine is negative for protein for 2 weeks.
- d. Urine is 0 to trace for blood for 1 week.

ANS: B

The child receiving steroids for the treatment of primary nephrotic syndrome is considered in remission when the urine is 0 to trace for protein for 5 to 7 days. The absence of casts in the urine gives no indication about the child's response to treatment. The child with primary nephrotic syndrome is considered to be in remission when the urine is negative for protein for 5 to 7 consecutive days. The absence of proteinuria for 2 consecutive weeks indicates a continued remission. The presence or absence of hematuria is not used to determine remission in primary nephrotic syndrome.

7. Which of the following statements made by a parent of a child with nephrotic syndrome indicates an understanding of a no-added-salt diet?

- a. I only give my child sweet pickles.
- b. My child just puts a little salt on his food.
- c. I let my child have slightly salted potato chips.
- d. I do not put any salt in foods when I am cooking.

ANS: D

A no-added-salt diet means that no salt should be added to foods, either when cooking or before eating. All types of pickles and potato chips are high in sodium and should not be served to the child on a no-added-salt diet. The child should not be allowed to use a salt shaker at meals when on a no-added-salt diet.

8. Which is an appropriate intervention for a child with nephrotic syndrome who is edematous?

- a. Teach the child to minimize body movements.
- b. Change the child's position every 2 hours.

- c. Avoid the use of skin lotions.
- d. Bathe every other day.

ANS: B

Frequent position changes decrease pressure on body parts and help relieve edema in dependent areas. The child with edema is at risk for impaired skin integrity. It is important for the child to change position frequently to prevent skin breakdown. Applying lotion to the skin helps to increase circulation. Bathing daily removes irritating body secretions from the skin.

9. A child with secondary enuresis who complains of dysuria or urgency should be evaluated for which condition?

- a. Hypocalciuria
- b. Nephrotic syndrome
- c. Glomerulonephritis
- d. Urinary tract infection

ANS: D

Complaints of dysuria or urgency from a child with secondary enuresis suggest the possibility of a urinary tract infection. An excessive loss of calcium in the urine (hypercalciuria) can be associated with complaints of painful urination, urgency, frequency, and wetting. Nephrotic syndrome is not usually associated with complaints of dysuria or urgency. Glomerulonephritis is not a likely cause of dysuria or urgency.

10. What should the nurse include in a teaching plan for the parents of a child with vesicoureteral reflux?

- a. Screening for urinary tract infection (UTI) if febrile
- b. Suggestions for how to maintain fluid restrictions
- c. The use of bubble baths as an incentive to increase bath time
- d. The need for the child to hold urine for 6 to 8 hours

ANS: A

A child with vesicoureteral reflux is screened for a UTI if febrile. Fluids are not restricted when a child has vesicoureteral reflux. In fact, fluid intake should be increased as a measure to prevent urinary tract infections. Bubble baths should be avoided to prevent urethral irritation and possible urinary tract infection. To prevent urinary tract infections, the child should be taught to void frequently and never resist the urge to urinate.

11. Which intervention is appropriate when examining a male infant for cryptorchidism?

- a. Cooling the examiners hands
- b. Taking a rectal temperature
- c. Placing the infant on the examination table
- d. Warming the room

ANS: D

For the infants comfort, the infant should be examined in a warm room with the examiners hands warmed. Testes can retract into the inguinal canal if the infant is upset or cold. Examining the infant with cold hands is uncomfortable for the infant and is likely to cause the infants testes to retract into the inguinal canal. It may also cause the infant to be uncooperative during the

examination. A rectal temperature yields no information about cryptorchidism. When possible, the infant should be examined in the caregivers lap to elicit cooperation and avoid upsetting the infant.

12. Parents ask the nurse, When should our child's hypospadias be corrected? The nurse responds based upon the knowledge that correction of hypospadias should be accomplished by the time the child is:

- a. 1 month of age.
- b. 6 to 8 months of age.
- c. school age.
- d. sexually mature.

ANS: B

The correction of hypospadias should ideally be accomplished by the time the child is 6 to 8 months of age and before toilet training. Surgery to correct hypospadias is not performed when the infant is less than 6 months of age. It is preferable for hypospadias to be surgically corrected before the child enters school so that the child has normal toileting behaviors in the presence of his peers. Corrective surgery for hypospadias is done long before sexual maturity.

13. A nurse is teaching a class on acute renal failure. The nurse relates that acute renal failure as a result of hemolytic-uremic syndrome is classified as:

- a. prerenal.
- b. intrarenal.
- c. postrenal.
- d. chronic.

ANS: B

Intrarenal acute renal failure is the result of damage to kidney tissue. Possible causes of intrarenal acute renal failure are hemolytic uremic syndrome, glomerulonephritis, and pyelonephritis. Prerenal acute renal failure is the result of decreased perfusion to the kidney. Possible causes include dehydration, septic and hemorrhagic shock, and hypotension. Postrenal acute renal failure results from obstruction of urine outflow. Conditions causing postrenal failure include ureteropelvic obstruction, ureterovesical obstruction, or neurogenic bladder. Renal failure caused by hemolytic-uremic syndrome is of the acute nature. Chronic renal failure is an irreversible loss of kidney function, which occurs over months or years.

14. Which dietary modification is appropriate for a child with chronic renal failure?

- a. Decreased salt
- b. Decreased fat
- c. Increased potassium
- d. Increased phosphorus

ANS: A

Salt is restricted to prevent fluid overload and hypertension. A low-fat diet is not relevant to chronic renal failure. Potassium intake may be restricted because of the kidneys inability to remove it. Phosphorus is restricted to help prevent bone disease.

15. Which condition is characterized by a history of bloody diarrhea, fever, abdominal pain, and low hemoglobin and platelet counts?

- a. Acute viral gastroenteritis
- b. Acute glomerulonephritis
- c. Hemolytic-uremic syndrome
- d. Acute nephrotic syndrome

ANS: C

Hemolytic-uremic syndrome is an acute disorder characterized by anemia, thrombocytopenia, and acute renal failure. Most affected children have a history of gastrointestinal symptoms, including bloody diarrhea. Anemia and thrombocytopenia are not associated with acute gastroenteritis. The symptoms described are not suggestive of acute glomerulonephritis or nephrotic syndrome.

16. Which is a true statement describing the differences in the pediatric genitourinary system compared with the adult genitourinary system?

- a. The young infants kidneys can more effectively concentrate urine than can an adults kidneys.
- b. After 6 years of age, kidney function is nearly like that of an adult.
- c. Unlike adults, most children do not regain normal kidney function after acute renal failure.
- d. Young children have shorter urethras, which can predispose them to urinary tract infections.

ANS: D

Young children have shorter urethras, which can predispose them to urinary tract infections. The young infants kidneys cannot concentrate urine as efficiently as those of older children and adults because the loop of Henle is not yet long enough to reach the inner medulla, where concentration and reabsorption occur. By 6 to 12 months of age, kidney function is nearly like that of an adult. Unlike adults, most children with acute renal failure regain normal function.

MULTIPLE RESPONSE

1. A nurse is planning care for a child admitted with nephrotic syndrome. Which interventions should be included in the plan of care? Select all that apply.

- a. Administration of antihypertensive medications
- b. Daily weights
- c. Salt-restricted diet
- d. Frequent position changes
- e. Teach parents to expect tea-colored urine

ANS: B, C, D

A child with nephrotic syndrome will need to be monitored closely for fluid excess so daily weights are important. The diet is salt restricted to prevent further retention of fluid. Because of the fluid excess, frequent position changes are required to prevent skin breakdown. Nephrotic syndrome does not require antihypertensive medications. These are administered for acute glomerulonephritis. Tea-colored urine is expected with acute glomerulonephritis, but not nephrotic syndrome. The urine in nephrotic syndrome is frothy indicating protein is being lost in the urine.

2. A nurse is assessing an infant for urinary tract infection (UTI). Which assessment findings should the nurse expect? Select all that apply.

- a. Change in urine odor or color
- b. Enuresis
- c. Fever or hypothermia
- d. Voiding urgency
- e. Poor weight gain

ANS: A, C, E

The signs of a UTI in an infant include fever or hypothermia, irritability, dysuria as evidenced by crying when voiding, change in urine odor or color, poor weight gain and feeding difficulties. Enuresis and voiding urgency would be assessed in an older child.

Chapter 5: Gastroenteritis, Fever, and Dehydration

MULTIPLE CHOICE

1. Which is the best nursing response to a mother asking about the cause of her infant's bilateral cleft lip?

- a. Did you have trouble with this pregnancy?
- b. Do you know of anyone in your or the father's family born with cleft lip or palate problems?
- c. This defect is associated with intrauterine infection during the second trimester.
- d. Was your husband in the military and involved in chemical warfare?

ANS: B

Cleft lip and palate result from embryonic failure resulting from multiple genetic and environmental factors. A genetic pattern or familial risk seems to exist. A troublesome pregnancy has not been associated with bilateral cleft lip. The defect occurred at approximately 6 to 8 weeks of gestation. Second-trimester intrauterine infection is not a known cause of bilateral cleft lip. Chemical warfare is not significantly associated with bilateral cleft lip and palate.

2. Which nursing intervention is most helpful to parents of a neonate with bilateral cleft lip?

- a. Assure the parents that the correction will be immediate and uncomplicated.
- b. Show the parents before-and-after pictures of an infant whose cleft lip has been successfully repaired.
- c. Teach the parents about long-term enteral feedings.
- d. Refer the parents to a community agency that addresses this problem.

ANS: B

Showing the parents pictures of successful lip repair promotes bonding and enhances coping ability. Correction is usually done around 4 weeks but may be done as early as 2 to 3 days after birth. The infant with a bilateral cleft lip can be fed orally using a compressible, longer nipple, and by making a larger hole in the nipple. Long-term enteral feedings are not usually indicated. A community agency referral is not appropriate at this time and may not be indicated long term.