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Question: 1

A patient with a nephrostomy tube complains of pain and tenderness at the insertion site. The nurse assesses the site and notes erythema and warmth. What is the most likely cause of these findings?

A. Tube dislodgement
B. Infection
C. Allergic reaction to the tube material
D. Urine leakage around the tube

Answer: B

Explanation: The most likely cause of pain, tenderness, erythema, and warmth at the nephrostomy tube insertion site is infection. Infection can occur when microorganisms invade the area around the tube, leading to localized inflammation and signs of infection. Tube dislodgement, allergic reaction, and urine leakage may cause different symptoms or findings but are less likely to present with the specific signs mentioned in the question.

Question: 2

Which of the following is a potential complication of a continent urinary diversion?

A. Nephrostomy tube dysfunction
B. Fecal impaction
C. Enterocutaneous fistula
D. Hernia

Answer: D

Explanation: Hernia refers to the protrusion of an organ or tissue through a weakened area in the abdominal wall. In the case of a continent urinary diversion, hernia can occur around the stoma site or at the site where the bowel is brought through the abdominal wall. It can lead to pain, discomfort, and potential bowel obstruction. Regular assessment and appropriate management are necessary to prevent complications associated with hernia in patients with a continent urinary diversion.

Question: 3

Which of the following peristomal complications is characterized by the separation of the mucocutaneous junction around the stoma?

A. Prolapse
B. Dermatitis
C. Pyoderma gangrenosum
D. Mucocutaneous separation

Answer: D

Explanation: Mucocutaneous separation refers to the separation of the mucosal lining from the surrounding skin at the stoma site. It can occur due to excessive tension, poor surgical technique, or trauma. Mucocutaneous separation can lead to leakage, skin irritation, and difficulty in maintaining a secure pouch seal. Prompt assessment and appropriate management are necessary to promote healing and prevent complications.

Question: 4

A patient with an ileostomy is at risk for fluid and electrolyte imbalances. Which of the following electrolyte abnormalities is commonly associated with an ileostomy?

A. Hyperkalemia
B. Hypernatremia
C. Hypocalcemia
D. Hypokalemia

Answer: D

Explanation: Hypokalemia, a low potassium level, is commonly associated with an ileostomy. The small intestine, which is bypassed or partially bypassed in an ileostomy, is the primary site of potassium absorption. With the loss of fecal matter through the ileostomy, there is an increased risk of potassium depletion. Hypernatremia (high sodium level), hypocalcemia (low calcium level), and hyperkalemia (high potassium level) are less commonly associated with an ileostomy.

Question: 5

A patient with an ostomy is taking multiple medications. The nurse recognizes the importance of medication management and educates the patient about:

A. Crushing all medications to facilitate absorption.
B. Taking medications at the same time as ostomy appliance changes.
C. Avoiding enteric-coated or extended-release formulations.
D. Stopping all medications that may cause diarrhea.

Answer: C

Explanation: When managing medications for patients with an ostomy, it is important to avoid enteric-coated or extended-release formulations. These formulations may not dissolve properly or be adequately absorbed in the altered gastrointestinal tract. Crushing medications should be done only under the guidance of a healthcare provider, as some medications should not be crushed.

Taking medications at the same time as ostomy appliance changes is not necessary unless specifically instructed by the healthcare provider. Discontinuing medications without medical supervision is not recommended and should be discussed with the healthcare provider.

Question: 6

A patient with a colostomy reports experiencing frequent leakage of stool around the stoma. The nurse suspects peristomal dermatitis. What is the most appropriate intervention for managing this condition?

A. Applying a protective skin barrier around the stoma.
B. Using absorbent dressings to absorb excess moisture.
C. Ensuring a proper fit of the ostomy pouching system.
D. Applying topical corticosteroids to the affected area.

Answer: C

Explanation: The most appropriate intervention for managing peristomal dermatitis is to ensure a proper fit of the ostomy pouching system. A proper fit helps create a secure seal around the stoma, preventing leakage of stool onto the surrounding skin. Applying a protective skin barrier can also be useful in preventing skin irritation, but it may not address the underlying cause of leakage. Using absorbent dressings and topical corticosteroids are not typically the first-line interventions for managing peristomal dermatitis.

Question: 7

A patient with an ileostomy reports that the stoma is protruding significantly and causing discomfort. The nurse assesses the stoma and notes that it appears to be larger than usual. What is the most likely cause of this finding?

A. Necrosis
B. Retraction
C. Prolapse
D. Hernia

Answer: C

Explanation: Prolapse refers to the protrusion of the stoma beyond the normal level of the abdominal wall. It occurs when the stoma extends outward due to weakened or stretched muscles around the stoma site. Prolapse can cause discomfort and may require intervention or surgical correction.

Question: 8

A patient who underwent ostomy surgery develops a wound dehiscence. Which of the following actions should the nurse prioritize?

A. Applying sterile dressings to the wound.
B. Notifying the healthcare provider immediately.
C. Placing the patient in a low Fowler's position.
D. Administering analgesics for pain management.

Answer: B

Explanation: Wound dehiscence, the partial or complete separation of the wound edges, is a surgical complication that requires immediate attention. The nurse should prioritize notifying the healthcare provider immediately to ensure prompt evaluation and appropriate interventions. Applying sterile dressings to the wound may be necessary, but it is secondary to notifying the healthcare provider. Placing the patient in a low Fowler's position and administering

analgesics are not directly related to managing wound dehiscence.

Question: 9

Which of the following is a potential complication of a colostomy?

A. Prolapse
B. Urinary tract infection
C. Pyoderma gangrenosum
D. Nephrostomy tube dysfunction

Answer: A

Explanation: Prolapse refers to the protrusion of the colostomy stoma beyond the peristomal skin. It can occur due to increased intra-abdominal pressure or weakened abdominal muscles. Prolapse can lead to difficulty in pouch application, leakage, and skin irritation. Regular assessment and appropriate management are necessary to prevent complications associated with colostomy prolapse.

Question: 10

A patient with an ileostomy reports skin irritation and leakage of stool around the stoma. The nurse suspects that the patient may benefit from using a different containment modality. Which ofthe following options would be the most appropriate alternative for managing the patient's ostomy?

A. Pouch with a convex shape.
B. Pouch with an open-ended design.
C. Absorptive dressing applied to the stoma.
D. Barrier ring placed around the stoma.

Answer: A

Explanation: A pouch with a convex shape would be the most appropriate alternative for managing the patient's ostomy. A convex pouch helps create a better seal around the stoma, reducing the risk of leakage and skin irritation. An open-ended pouch design may not provide sufficient protection against leakage. Absorptive dressings are more commonly used for peristomal complications and may not address the issue of stool leakage. Barrier rings are typically used to fill in uneven skin contours and improve pouch adhesion but may not directly address the problem of leakage.

Question: 11

A patient with a urostomy presents with signs of urinary tract infection, including dysuria and cloudy urine. Which of the following actions should the nurse prioritize?

A. Assess the stoma for signs of infection.
B. Increase the patient's fluid intake.
C. Collect a urine sample for culture and sensitivity.
D. Administer antibiotics as prescribed.

Answer: C

Explanation: The nurse should prioritize collecting a urine sample for culture and sensitivity to identify the specific bacteria causing the infection and determine the most appropriate antibiotic treatment. Assessing the stoma for signs of infection is important but should be done in conjunction with obtaining a urine sample. Increasing fluid intake and administering antibiotics may be appropriate interventions based on the culture results and healthcare provider's prescription.

Question: 12

A patient with an enterocutaneous fistula presents with persistent drainage from the wound site. Which of the following interventions is most appropriate for managing the fistula?

A. Applying a sterile dressing to the wound.
B. Initiating total parenteral nutrition (TPN).
C. Administering antibiotics as prescribed.
D. Consulting a wound care specialist.

Answer: D

Explanation: Managing an enterocutaneous fistula often requires a multidisciplinary approach, including the involvement of a wound care specialist. The specialist can provide expertise in managing complex wounds and fistulas, including the selection and application of appropriate dressings. Total parenteral nutrition (TPN) and antibiotics may be necessary in some cases but should be prescribed by the healthcare provider based on the individual patient's needs.

Question: 13

Which of the following is a surgical complication that can occur in a patient with an ileostomy?

A. Dermatitis
B. Dehiscence
C. Mucocutaneous separation
D. Pyoderma gangrenosum

Answer: B

Explanation: Dehiscence refers to the separation or opening of the surgical incision or anastomosis. In the case of an ileostomy, dehiscence can occur at the stoma site or at the site where the bowel is brought through the abdominal wall. It is a serious complication that can lead to infection, peritonitis, and the need for surgical intervention. Prompt recognition and appropriate management are crucial in preventing further complications.

Question: 14

A patient with an ostomy reports crusting around the stoma site. The nurse explains that crusting can be managed by:

A. Applying a skin barrier wipe to the stoma.
B. Using an adhesive remover to clean the stoma.
C. Applying a thin layer of petroleum jelly to the stoma.
D. Using warm water and a washcloth to gently cleanse the stoma.

Answer: D

Explanation: Crusting around the stoma site can be managed by using warm water and a washcloth to gently cleanse the stoma. This helps remove the dried secretions and debris that contribute to crusting. Applying a skin barrier wipe can help protect the skin, but it may not effectively remove the crust. Petroleum jelly may create a barrier but does not address the underlying cause of crusting. Adhesive removers are typically used to remove adhesive residue from the skin and are not specifically indicated for managing crusting.

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