Chapter 48: Nursing Assessment: Endocrine System

1. When evaluating the laboratory results for a patient with increased secretion of the anterior pituitary hormones, the nurse would expect to find:
   a. decreased serum thyroxine levels.
   b. elevated serum aldosterone levels.
   c. an increase in urinary free cortisol.
   d. low urinary excretion of catecholamines.

2. When the nurse is obtaining the health history, which statement by a patient indicates further assessment of thyroid function may be necessary?
   a. “I notice my breasts are tender lately.”
   b. “I am so thirsty that I drink all day long.”
   c. “I get up several times at night to urinate.”
   d. “I feel a lump in my throat when I swallow.”

3. A patient is admitted with a serum sodium level of 118 mEq/L. The nurse will anticipate the need for which diagnostic test?
   a. Urinary 17-ketosteroids
   b. Antidiuretic hormone level
   c. Growth hormone stimulation test
   d. Adrenocorticotropic hormone level

4. The nurse is interviewing a patient who has a possible thyroid disorder. Which question will provide the most useful information?
   a. “What methods do you use to help cope with stress?”
   b. “Have you experienced any blurring or double vision?”
   c. “Do you have to get up at night to empty your bladder?”
   d. “Have you had any recent unplanned weight gain or loss?”

5. When a patient in the outpatient clinic has an order for blood cortisol testing, which instruction will the nurse provide for the patient?
   a. “Avoid adding any salt to your foods for 24 hours before the test.”
   b. “You will need to lie down for 30 minutes before the blood is drawn.”
   c. “Come to the laboratory to have the blood drawn early in the morning.”
   d. “Do not have anything to eat or drink before the blood test is obtained.”

6. A patient has a total serum calcium level of 13.3 mg/dL (3.3 mmol/L). The nurse will anticipate the need to teach the patient about testing for:
   a. calcitonin levels.
   b. catecholamine levels.
   c. thyroid hormone levels.
   d. parathyroid hormone levels.

7. During a physical examination, the nurse finds that a patient’s thyroid gland cannot be palpated. The most appropriate action by the nurse is to:
   a. palpate the patient’s neck more deeply.
   b. document that the thyroid was nonpalpable.
   c. notify the health care provider immediately.
   d. teach the patient about thyroid hormone testing.

8. When a patient has clinical manifestations of hypothyroidism, which laboratory value should the nurse review to determine whether the hypothyroidism is caused by a problem with the anterior pituitary gland or with the thyroid gland?
   a. Thyroxine (T4) level
   b. Triiodothyronine (T3) level
   c. Thyroid-stimulating hormone (TSH) level
   d. Thyrotropin-releasing hormone (TRH) level

9. When working with a patient who has diabetes mellitus, the nurse reviews the results of testing for glycoxylated hemoglobin (HbA1C) to evaluate for:
   a. glucose levels 2 hours after a meal.
   b. circulating, nonfasting glucose levels.
   c. glucose control over the past 3 months.
   d. hypoglycemic episodes in the past 90 days.

10. When a patient is taking spironolactone (Aldactone), a drug that blocks the action of aldosterone on the kidney, the nurse will monitor for:
    a. decreased urinary output.
    b. evidence of fluid overload.
    c. increased serum sodium levels.
    d. elevated serum potassium levels.
11. Which information about a patient with newly diagnosed diabetes mellitus will be most useful to the nurse in developing strategies for successful adaptation to this disease?
   a. Ideal weight
   b. Value system
   c. Activity level
   d. Visual changes

12. A patient is scheduled for a growth hormone stimulation test. In preparation for the test, the nurse will obtain a
   a. basin of ice.
   b. cardiac monitor.
   c. vial of glargine insulin.
   d. vial of 50% dextrose solution.

13. The nurse will plan patient care that will decrease the patient’s physical and emotional stress when the patient is undergoing
   a. a water deprivation test.
   b. testing for serum T₃ and T₄ levels.
   c. a 24-hour urine test for free cortisol.
   d. a radioactive iodine (I-131) uptake test.

14. A patient is scheduled for a 24-hour urine collection for 17-ketosteroids. The nurse will need to
   a. keep the specimen on ice.
   b. insert a retention catheter.
   c. have the patient void and save that specimen to start the collection.
   d. encourage the patient to drink 2 to 3 L of fluid during the 24 hours.

15. When reviewing the laboratory results for a patient’s total calcium level, which information will the nurse need to consider?
   a. The blood glucose is elevated.
   b. The phosphate level is normal.
   c. The serum albumin level is low.
   d. The magnesium level is normal.

16. When the nurse is caring for a patient who was admitted with tetany, which laboratory value should be monitored?
   a. Total protein
   b. Blood glucose
   c. Ionized calcium
   d. Serum phosphate

17. Which information about a patient who is scheduled for an oral glucose tolerance test should be reported to the health care provider before starting the test?
   a. The patient reports having occasional orthostatic dizziness.
   b. The patient has had a 10-pound weight gain in the last month.
   c. The patient drank several glasses of water an hour previously.
   d. The patient takes oral corticosteroids for rheumatoid arthritis.

18. After the nurse manager at the endocrine clinic has completed the orientation of a new RN, which action by the new RN who is caring for a patient with a goiter and possible hyperthyroidism indicates the charge nurse needs to do more teaching?
   a. The RN palpates the neck to check thyroid size.
   b. The RN checks the blood pressure on both arms.
   c. The RN orders nonmedicated eye drops to lubricate the patient’s eyes.
   d. The RN lowers the thermostat to decrease the temperature in the room.

19. When caring for a patient having a water deprivation test, which finding is most important for the nurse to communicate to the health care provider?
   a. The patient complains of intense thirst.
   b. The patient has a 5-lb (2.3 kg) weight loss.
   c. The patient feels dizzy when sitting up on the edge of the bed.
   d. The patient’s urine osmolality does not change after antidiuretic hormone (ADH) is given.

20. A patient with a possible pituitary adenoma is scheduled for a computed tomography (CT) scan with contrast media. Which patient information is most important for the nurse to communicate to the health care provider before the test?
   a. Bilateral poor peripheral vision
   b. Allergies to iodine and shellfish
   c. Recent weight loss of 20 pounds
   d. Complaints of ongoing headaches

Chapter 50: Nursing Management: Endocrine Problems

1. A patient with suspected acromegaly is seen at the clinic. To assist in making the diagnosis, which question should the nurse ask?
a. “Have you had a recent head injury?”
b. “Do you have to wear larger shoes now?”
c. “Are you experiencing tremors or anxiety?”
d. “Is there any family history of acromegaly?”

2. During preoperative teaching for a patient scheduled for transsphenoidal hypophysectomy for treatment of a pituitary adenoma, the nurse instructs the patient about the need to
a. cough and deep breathe every 2 hours postoperatively.
b. remain on bed rest for the first 48 hours after the surgery.
c. be positioned flat with sandbags at the head postoperatively.
d. avoid brushing the teeth for at least 10 days after the surgery.

3. Which nursing action will be included in the postoperative plan of care for a patient who has had a transsphenoidal resection of a pituitary tumor?
a. Monitor urine output every hour.
b. Palpate extremities for dependent edema.
c. Check hematocrit hourly for first 12 hours.
d. Obtain continuous pulse oximetry for 24 hours.

4. A patient is suspected of having a pituitary tumor causing panhypopituitarism. During assessment of the patient, the nurse would expect to find
a. high blood pressure.
b. elevated blood glucose.
c. tachycardia and cardiac palpitations.
d. changes in secondary sex characteristics.

5. Which information will the nurse include when teaching a patient about use of somatropin (Genotropin)?
a. The medication will improve vaginal dryness.
b. Inject the medication subcutaneously every day.
c. Blood glucose levels will decrease when taking the medication.
d. Stop taking the medication if swelling of the hands or feet occurs.

6. A patient is treated with demeclocycline (Declomycin) to control the symptoms of syndrome of inappropriate antidiuretic hormone (SIADH). The nurse determines that the demeclocycline is effective upon finding that the
a. peripheral edema is decreased.
b. patient’s weight has increased.
c. urine specific gravity is increased.
d. patient’s urinary output is increased.

7. When teaching a patient with chronic syndrome of inappropriate antidiuretic hormone (SIADH) about long-term management of the disorder, the nurse determines that additional instruction is needed when the patient says,
a. “I should weigh myself daily and report any sudden weight loss or gain.”
b. “I need to limit my fluid intake to no more than 1 quart of liquids a day.”
c. “I will eat foods high in potassium because the diuretics cause potassium loss.”
d. “I need to shop for foods that are low in sodium and avoid adding salt to foods.”

8. A patient is hospitalized with possible syndrome of inappropriate antidiuretic hormone (SIADH). The patient is confused and reports a headache, muscle cramps, and twitching. The nurse would expect the initial laboratory results to include
a. an elevated hematocrit.
b. a decreased serum sodium.
c. an increased serum chloride.
d. a low urine specific gravity.

9. A patient with symptoms of diabetes insipidus is admitted to the hospital for evaluation and treatment of the condition. An appropriate nursing diagnosis for the patient is
a. insomnia related to frequent waking at night to void.
b. impaired gas exchange related to fluid retention in lungs.
c. excess fluid volume related to intake greater than output.
d. risk for impaired skin integrity related to generalized edema.

10. Which information will the nurse include when teaching a patient who has been newly diagnosed with Graves’ disease?
   a. Exercise is contraindicated to avoid increasing metabolic rate.
b. Restriction of iodine intake is needed to reduce thyroid activity.
c. Surgery will eventually be required to remove the thyroid gland.
d. Antithyroid medications may take several weeks to have an effect.

11. A few hours after returning to the surgical nursing unit, a patient who has undergone a subtotal thyroidectomy develops laryngeal stridor and a cramp in the right hand. Which action will the nurse anticipate taking next?
a. Infuse IV calcium gluconate.
b. Suction the patient’s airway.
c. Prepare for endotracheal intubation.
d. Assist with emergency tracheostomy.

12. A patient with Graves’ disease has exophthalmos. Which nursing action will be included in the plan of care?
   a. Apply eye patches to protect the cornea from irritation.
   b. Place cold packs on the eyes to relieve pain and swelling.
   c. Elevate the head of the patient’s bed to reduce periorbital fluid.
   d. Teach the patient to blink every few seconds to lubricate the cornea.

13. A patient with hyperthyroidism is treated with radioactive iodine (RAI) at a clinic. Before the patient is discharged, the nurse instructs the patient
   a. that symptoms of hyperthyroidism should be relieved in about a week.
   b. that symptoms of hypothyroidism may occur as the RAI therapy takes effect.
   c. to discontinue the antithyroid medications taken before the radioactive therapy.
   d. about radioactive precautions to take with urine, stool, and other body secretions.

14. A 72-year-old patient is diagnosed with hypothyroidism and levothyroxine (Synthroid) is prescribed. Which assessment is most important for the nurse to make during initiation of thyroid replacement?
   a. Apical pulse rate
   b. Nutritional intake
   c. Intake and output
   d. Orientation and alertness

15. A 78-year-old patient in a long-term care facility has these medications prescribed. After the patient is diagnosed with hypothyroidism, the nurse will need to consult with the health care provider before administration of
   a. docusate (Colace).
   b. diazepam (Valium).
   c. ibuprofen (Motrin).
   d. cefoxitin (Mefoxin).

16. When planning teaching for a patient who was admitted with myxedema coma and diagnosed with hypothyroidism, which strategy will be best for the nurse to use?
   a. Delay teaching until patient discharge.
   b. Ensure privacy by asking visitors to leave.
   c. Provide written handouts of all information.
   d. Offer multiple options for management of therapies.

17. A patient with primary hyperparathyroidism has a serum calcium level of 14 mg/dL (3.5 mmol/L) and a phosphorus of 1.7 mg/dL (0.55 mmol/L). Which nursing action should be included in the plan of care?
   a. Institute routine seizure precautions.
   b. Monitor for positive Chvostek’s sign.
   c. Encourage the patient to remain on bed rest.
   d. Encourage 3000 to 4000 mL of oral fluids daily.

18. Following a parathyroidectomy, a patient develops tingling of the lips and a positive Trousseau’s sign. Which action should the nurse take first?
   a. Administer the ordered muscle relaxant.
   b. Give the ordered oral calcium supplement.
   c. Start the PRN oxygen at 2 L/min per cannula.
   d. Have the patient rebreathe using a paper bag.

19. After radical neck surgery, a patient develops hypoparathyroidism. The nurse should plan to teach the patient about
   a. use of bisphosphonates to reduce bone demineralization.
   b. including whole grains in the diet to prevent constipation.
   c. calcium supplementation to normalize serum calcium levels.
   d. having a high fluid intake to decrease risk for nephrolithiasis.

20. Which assessment finding for a patient who takes levothyroxine (Synthroid) to treat hypothyroidism indicates that the nurse should contact the health care provider before administering the medication?
   a. Increased thyroxine (T4) level
   b. Blood pressure 102/62 mm Hg
   c. Distant and difficult to hear heart sounds
   d. Elevated thyroid stimulating hormone level

21. When caring for a patient with a diagnosis of Cushing syndrome, which data will the nurse expect to find during the admission assessment?
   a. Chronically low blood pressure
   b. Bronzed appearance of the skin
   c. Decreased axillary and pubic hair
   d. Purplish red streaks on the abdomen
22. A patient with Cushing syndrome who is admitted for adrenalectomy has a nursing diagnosis of disturbed body image related to changes in appearance caused by the effects of the disease. Which intervention by the nurse will be most helpful?
   a. Reassure the patient that the physical changes are very common in patients with Cushing syndrome.
   b. Discuss the use of diet and exercise in controlling the weight gain associated with Cushing syndrome.
   c. Teach the patient that most of the physical changes caused by Cushing syndrome will resolve after surgery.
   d. Remind the patient that the metabolic impact of Cushing syndrome is of more importance than appearance.

23. When a patient is hospitalized with acute adrenal insufficiency, which assessment finding by the nurse indicates that the prescribed therapies are effective?
   a. Increasing serum sodium levels
   b. Decreasing blood glucose levels
   c. Decreasing serum chloride levels
   d. Increasing serum potassium levels

   a. “I double my dose of hydrocortisone on the days that I go for a run.”
   b. “I frequently eat at restaurants, and so my food has a lot of added salt.”
   c. “I had the stomach flu earlier this week and couldn’t take the hydrocortisone.”
   d. “I take twice as much hydrocortisone in the morning as I do in the afternoon.”

25. A patient with systemic lupus erythematosus has a prescription for 2 weeks of high-dose prednisone therapy. When teaching the patient about the prednisone, which information is most important for the nurse to include?
   a. Call the doctor if you experience any mood alterations with the prednisone.
   b. Do not stop taking the prednisone suddenly; it should be decreased gradually.
   c. A weight-bearing exercise program will help minimize the risk for osteoporosis.
   d. Weigh yourself daily to monitor for weight gain caused by water or increased fat.

26. When caring for a patient who has an adrenocortical adenoma, causing hyperaldosteronism, the nurse should
   a. provide a potassium-restricted diet.
   b. monitor the blood pressure every 4 hours.
   c. monitor blood glucose level every 4 hours.
   d. relieve edema by elevating the extremities.

27. A patient admitted to the hospital with hypertension is diagnosed with a pheochromocytoma. The nurse will plan to monitor the patient for
   a. flushing.
   b. headache.
   c. bradycardia.
   d. hypoglycemia.

28. After a patient with a pituitary adenoma has had a hypophysectomy, the nurse will plan to do discharge teaching about the need for
   a. oral corticosteroids to replace endogenous cortisol.
   b. chemotherapy to prevent reoccurrence of the tumor.
   c. insulin use to maintain blood glucose at normal levels.
   d. sodium restriction to prevent fluid retention and hypertension.

29. When developing a plan of care for a patient with syndrome of inappropriate antidiuretic hormone (SIADH), which interventions will the nurse include?
   a. Encourage fluids to 2000 mL/day.
   b. Offer patient hard candies to suck on.
   c. Monitor for increased peripheral edema.
   d. Keep head of bed elevated to 30 degrees.

30. Which action should the nurse take first when caring for a patient who has just arrived on the unit after a thyroidectomy?
   a. Check the dressing for bleeding.
   b. Assess respiratory rate and effort.
   c. Take the blood pressure and pulse.
   d. Support the patient’s head with pillows.

31. A patient with Cushing syndrome returns to the surgical unit following an adrenalectomy. During the initial postoperative period, the nurse gives the highest priority to
   a. monitoring for infection.
   b. protecting the patient’s skin.
   c. maintaining fluid and electrolyte status.
   d. preventing severe emotional disturbances.
32. Which information obtained by the nurse when caring for a patient who has diabetes insipidus (DI) is most important to report to the health care provider?
   a. The patient had a recent head injury.
   b. The patient is confused and lethargic.
   c. The patient has a urine output of 400 mL/hr.
   d. The patient’s urine specific gravity is 1.003.

33. A patient with Graves’ disease is admitted to the emergency department with thyroid storm. Which of these prescribed medications should the nurse administer first?
   a. propranolol (Inderal)
   b. propylthiouracil (PTU)
   c. methimazole (Tapazole)
   d. iodine (Lugol’s solution)

34. Which assessment finding for a 24-year-old patient admitted with Graves’ disease requires the most rapid intervention by the nurse?
   a. BP 166/100 mm Hg
   b. Bilateral exophthalmos
   c. Heart rate 136 beats/minute
   d. Temperature 104.8° F (40.4° C)

35. While assessing a patient who has just arrived in the postanesthesia recovery unit (PACU) after a thyroidectomy, the nurse obtains these data. Which information is most important to communicate to the surgeon?
   a. The patient is sleepy and hard to arouse.
   b. The patient has increasing swelling of the neck.
   c. The patient is complaining of 7/10 incisional pain.
   d. The patient’s cardiac monitor shows a heart rate of 112.

36. When providing postoperative care for a patient who had a bilateral adrenalectomy, which assessment information requires the most rapid action by the nurse?
   a. The blood glucose is 176 mg/dL
   b. The lungs have bibasilar crackles.
   c. The patient’s BP is 88/50 mm Hg.
   d. The patient has 5/10 incisional pain.

37. Which of these nursing actions in the plan of care for a patient who has diabetes insipidus will be most appropriate for the RN to delegate to an experienced LPN/LVN?
   a. Titrate the infusion of 5% dextrose in water.
   b. Teach patient how to use DDAVP nasal spray.
   c. Assess patient’s hydration status every 8 hours.
   d. Administer subcutaneous desmopressin (DDAVP).

38. A patient is admitted with possible syndrome of inappropriate antidiuretic hormone (SIADH). Which information obtained by the nurse is most important to communicate rapidly to the health care provider?
   a. The patient complains of dyspnea with activity.
   b. The patient has a urine specific gravity of 1.025.
   c. The patient has a recent weight gain of 8 lb.
   d. The patient has a serum sodium level of 119 mEq/L.

39. After receiving change-of-shift report about the following four patients, which patient should the nurse assess first?
   a. A 31-year-old with Cushing syndrome and a blood glucose level of 244 mg/dL
   b. A 22-year-old admitted with syndrome of inappropriate antidiuretic hormone (SIADH) who has a serum sodium level of 130 mEq/L
   c. A 70-year-old who recently started taking levothyroxine (Synthroid) and has an irregular pulse of 134
   d. A 53-year-old who has Addison’s disease and is due for a scheduled dose of hydrocortisone (Solu-Cortef).

Chapter 49: Nursing Management: Diabetes Mellitus

1. A patient with newly diagnosed type 2 diabetes mellitus asks the nurse what “type 2” means in relation to diabetes. Which statement by the nurse about type 2 diabetes is correct?
   a. Insulin is not used to control blood glucose in patients with type 2 diabetes.
   b. Complications of type 2 diabetes are less serious than those of type 1 diabetes.
   c. Type 2 diabetes is usually diagnosed when the patient is admitted with a hyperglycemic coma.
   d. Changes in diet and exercise may be sufficient to control blood glucose levels in type 2 diabetes.

2. A patient screened for diabetes at a clinic has a fasting plasma glucose level of 120 mg/dL (6.7 mmol/L). The nurse will plan to teach the patient about
   a. self-monitoring of blood glucose.
   b. use of low doses of regular insulin.
   c. lifestyle changes to lower blood glucose.
   d. effects of oral hypoglycemic medications.
3. Which action by a type 1 diabetic patient indicates that the nurse should implement teaching about exercise and glucose control?
   a. The patient always carries hard candies when engaging in exercise.
   b. The patient goes for a vigorous walk when the glucose is 200 mg/dL.
   c. The patient has a peanut butter sandwich before going for a bicycle ride.
   d. The patient increases daily exercise when ketones are present in the urine.

4. When assessing the patient experiencing the onset of symptoms of type 1 diabetes, which question is most appropriate for the nurse to ask?
   a. “Have you lost any weight lately?”
   b. “How long have you felt anorexic?”
   c. “Is your urine unusually dark colored?”
   d. “Do you crave fluids containing sugar?”

5. To evaluate the effectiveness of treatment for a patient with type 2 diabetes who is scheduled for a follow-up visit in the clinic, which test will the nurse plan to schedule for the patient?
   a. Urine dipstick for glucose
   b. Oral glucose tolerance test
   c. Fasting blood glucose level
   d. Glycosylated hemoglobin level

6. A patient who has just been diagnosed with type 2 diabetes has a nursing diagnosis of imbalanced nutrition: more than body requirements. Which patient goal is most important for this patient?
   a. The patient will have a glycosylated hemoglobin level of less than 7%.
   b. The patient will have a diet and exercise plan that results in weight loss.
   c. The patient will choose a diet that distributes calories throughout the day.
   d. The patient will state the reasons for eliminating simple sugars in the diet.

7. A patient who has type 1 diabetes plans to take a swimming class daily at 1:00 PM. The clinic nurse will plan to teach the patient to
   a. check glucose level before, during, and after swimming.
   b. delay eating the noon meal until after the swimming class.
   c. increase the morning dose of neutral protamine Hagedorn (NPH) insulin.
   d. time the morning insulin injection so that the peak occurs while swimming.

8. An 18-year-old with newly diagnosed type 1 diabetes has received diet instruction. The nurse determines a need for additional instruction when the patient says,
   a. “I may have an occasional alcoholic drink if I include it in my meal plan.”
   b. “I will need a bedtime snack because I take an evening dose of NPH insulin.”
   c. “I may eat whatever I want, as long as I use enough insulin to cover the calories.”
   d. “I will eat meals as scheduled, even if I am not hungry, to prevent hypoglycemia.”

9. Which action is most important for the nurse to take in order to assist a diabetic patient to engage in moderate daily exercise?
   a. Remind the patient that exercise will improve self-esteem.
   b. Determine what type of exercise activities the patient enjoys.
   c. Give the patient a list of activities that are moderate in intensity.
   d. Teach the patient about the effects of exercise on glucose level.

10. The nurse has been teaching the patient to administer a dose of 10 units of regular insulin and 28 units of NPH insulin. The statement by the patient that indicates a need for additional instruction is,
    a. “I need to rotate injection sites among my arms, legs, and abdomen each day.”
    b. “I will buy the 0.5 mL syringes because the line markings will be easier to see.”
    c. “I should draw up the regular insulin first after injecting air into the NPH bottle.”
    d. “I do not need to aspirate the plunger to check for blood before injecting insulin.”

11. After the nurse has finished teaching a patient about self-administration of the prescribed aspart (NovoLog) insulin, which patient action indicates good understanding of the teaching?
    a. The patient avoids injecting the insulin into the upper abdominal area.
    b. The patient cleans the skin with soap and water before insulin administration.
    c. The patient places the insulin back in the freezer after administering the prescribed insulin dose.
    d. The patient pushes the plunger down and immediately removes the syringe from the injection site.

12. A patient receives aspart (NovoLog) insulin at 8:00 AM. Which time will it be most important for the nurse to monitor for symptoms of hypoglycemia?
    a. 9:00 AM
    b. 11:30 AM
    c. 4:00 PM
    d. 8:00 PM
13. Which patient action indicates a good understanding of the nurse’s teaching about the use of an insulin pump?
   a. The patient changes the site for the insertion site every week.
   b. The patient programs the pump to deliver an insulin bolus after eating.
   c. The patient takes the pump off at bedtime and starts it again each morning.
   d. The patient states that diet will be less flexible when using the insulin pump.

14. When teaching a diabetic patient who has just been started on intensive insulin therapy about mealtime coverage, which type of insulin will the nurse need to discuss?
   a. glargine (Lantus)
   b. lispro (Humalog)
   c. detemir (Levemir)
   d. NPH (Humulin N)

15. Which information will the nurse include when teaching a patient who has type 2 diabetes about glyburide (Micronase, DiaBeta, Glynase)?
   a. Glyburide decreases glucagon secretion from the pancreas.
   b. Glyburide stimulates insulin production and release from the pancreas.
   c. Glyburide should be taken even if the morning blood glucose level is low.
   d. Glyburide should not be used for 48 hours after receiving IV contrast media.

16. Which patient statement after the nurse has completed teaching a patient with type 2 diabetes about taking glipizide (Glucotrol) indicates a need for additional teaching?
   a. “Other medications besides the Glucotrol may affect my blood sugar.”
   b. “If I overeat at a meal, I will still take just the usual dose of medication.”
   c. “When I become ill, I may have to take insulin to control my blood sugar.”
   d. “My diabetes is not as likely to cause complications as if I needed to take insulin.”

17. A patient with type 2 diabetes that is well-controlled with metformin (Glucophage) develops an allergic rash to an antibiotic and the health care provider prescribes prednisone (Deltasone). The nurse will anticipate that the patient may
   a. need a diet higher in calories while receiving prednisone.
   b. require administration of insulin while taking prednisone.
   c. develop acute hypoglycemia while taking the prednisone.
   d. have rashes caused by metformin-prednisone interactions.

18. A hospitalized diabetic patient who received 34 U of NPH insulin at 7:00 AM is away from the nursing unit, awaiting diagnostic testing when lunch trays are distributed. To prevent hypoglycemia, the best action by the nurse is to
   a. save the lunch tray to be provided upon the patient’s return to the unit.
   b. call the diagnostic testing area and ask that a 5% dextrose IV be started.
   c. ensure that the patient drinks a glass of milk or orange juice at noon in the diagnostic testing area.
   d. request that the patient be returned to the unit to eat lunch if testing will not be completed promptly.

19. A patient with type 1 diabetes has been using self-monitoring of blood glucose (SMBG) as part of diabetes management. During evaluation of the patient’s technique of SMBG, the nurse identifies a need for additional teaching when the patient
   a. washes the puncture site using soap and warm water.
   b. chooses a puncture site in the center of the finger pad.
   c. hangs the arm down for a minute before puncturing the site.
   d. says the result of 130 mg indicates good blood sugar control.

20. Which action should the nurse take first when teaching a patient who is newly diagnosed with type 2 diabetes about home management of the disease?
   a. Ask the patient’s family to participate in the diabetes education program.
   b. Assess the patient’s perception of what it means to have diabetes mellitus.
   c. Demonstrate how to check glucose using capillary blood glucose monitoring.
   d. Discuss the need for the patient to actively participate in diabetes management.

21. A diagnosis of hyperglycemic hyperosmolar nonketotic coma (HHNC) is made for a patient with type 2 diabetes who is brought to the emergency department in an unresponsive state. The nurse will anticipate the need to
   a. give 50% dextrose as a bolus.
   b. insert a large-bore IV catheter.
   c. initiate oxygen by nasal cannula.
   d. administer glargine (Lantus) insulin.

22. A patient with type 1 diabetes who uses glargine (Lantus) and lispro (Humalog) insulin develops a sore throat, cough, and fever. When the patient calls the clinic to report the symptoms and a blood glucose level of 210 mg/dL, the nurse advises the patient to
   a. use only the lispro insulin until the symptoms of infection are resolved.
   b. monitor blood glucose every 4 hours and notify the clinic if it continues to rise.
   c. decrease intake of carbohydrates until glycosylated hemoglobin is less than 7%.
   d. limit intake of calorie-containing liquids until the glucose is less than 120 mg/dL.
23. The health care provider suspects the Somogyi effect in a patient whose 7:00 AM blood glucose is 220 mg/dL. Which action will the nurse plan to take?
   a. Check the patient’s blood glucose at 3:00 AM.
   b. Administer a larger dose of long-acting insulin.
   c. Educate about the need to increase the rapid-acting insulin dose.
   d. Remind the patient about the need to avoid snacking at bedtime.

24. Intramuscular glucagon is administered to an unresponsive patient for treatment of hypoglycemia. Which action should the nurse take after the patient regains consciousness?
   a. Assess the patient for symptoms of hyperglycemia.
   b. Give the patient a snack of crackers and peanut butter.
   c. Have the patient drink a glass of orange juice or nonfat milk.
   d. Administer a continuous infusion of 5% dextrose for 24 hours.

25. Which question by the nurse will help identify autonomic neuropathy in a diabetic patient?
   a. “Have you observed any recent skin changes?”
   b. “Do you notice any bloating feeling after eating?”
   c. “Do you need to increase your insulin dosage when you are stressed?”
   d. “Have you noticed any painful new ulcerations or sores on your feet?”

26. A patient with type 2 diabetes has sensory neuropathy of the feet and legs and peripheral arterial disease. Which information will the nurse include in patient teaching?
   a. Choose flat-soled leather shoes.
   b. Set heating pads on a low temperature.
   c. Buy callus remover for corns or calluses.
   d. Soak the feet in warm water for an hour every day.

27. The nurse obtains the following information about a patient before administration of metformin (Glucophage). Which finding indicates a need to contact the health care provider before giving the metformin?
   a. The patient’s blood glucose level is 166 mg/dL.
   b. The patient’s blood urea nitrogen (BUN) level is 60 mg/dL.
   c. The patient is scheduled for a chest x-ray in an hour.
   d. The patient has gained 2 lb (0.9 kg) since yesterday.

28. Amitriptyline (Elavil) is prescribed for a diabetic patient who has burning foot pain at night. Which information should the nurse include when teaching the patient about the new medication?
   a. Amitriptyline will decrease the depression caused by your foot pain.
   b. Amitriptyline will correct some of the blood vessel changes that cause pain.
   c. Amitriptyline will improve sleep and make you less aware of nighttime pain.
   d. Amitriptyline will help prevent the transmission of pain impulses to the brain.

29. A patient with type 2 diabetes is admitted for an outpatient coronary arteriogram. Which information obtained by the nurse is most important to report to the health care provider before the procedure?
   a. The patient’s admission blood glucose is 128 mg/dL.
   b. The patient’s most recent Hb A1C was 6.5%.
   c. The patient took the prescribed metformin (Glucophage) today.
   d. The patient took the prescribed captopril (Capoten) this morning.

30. After the home health nurse has taught a patient and family about how to use glargine and regular insulin safely, which action by the patient indicates that the teaching has been successful?
   a. The patient administers the glargine 30 to 45 minutes before eating each meal.
   b. The patient’s family fills the syringes weekly and stores them in the refrigerator.
   c. The patient draws up the regular insulin and then the glargine in the same syringe.
   d. The patient disposes of the open vials of glargine and regular insulin after 4 weeks.

31. The nurse teaches the diabetic patient who rides a bicycle to work every day to administer morning insulin into the
   a. arm.
   b. thigh.
   c. buttock.
   d. abdomen.

32. Which information about a patient who receives rosiglitazone (Avandia) is most important for the nurse to report immediately to the health care provider?
   a. The patient’s blood pressure is 154/92.
   b. The patient has a history of emphysema.
   c. The patient’s noon blood glucose is 86 mg/dL.
   d. The patient has chest pressure when ambulating.

33. A pregnant patient who has no personal history of diabetes, but does have a parent who is diabetic is scheduled for the first prenatal visit. Which action will the nurse plan to take on this initial visit?
a. Teach about appropriate use of regular insulin.
b. Discuss the need for a fasting blood glucose level.
c. Schedule an oral glucose tolerance test for the twenty fourth week of pregnancy.
d. Provide education about increased risk for fetal problems with gestational diabetes.

34. A patient is admitted with diabetic ketoacidosis (DKA) and has a serum potassium level of 2.9 mEq/L. Which action prescribed by the health care provider should the nurse take first?
   a. Infuse regular insulin at 20 U/hr.
   b. Place the patient on a cardiac monitor.
   c. Administer IV potassium supplements.
   d. Obtain urine glucose and ketone levels.

35. A diabetic patient is admitted with ketoacidosis and the health care provider writes these orders. Which order should the nurse implement first?
   a. Administer regular IV insulin 30 U.
   b. Infuse 1 liter of normal saline per hour.
   c. Give sodium bicarbonate 50 mEq IV push.
   d. Start an infusion of regular insulin at 50 U/hr.

36. When the nurse is assessing a patient who is recovering from an episode of diabetic ketoacidosis, the patient reports feeling anxious, nervous, and sweaty. Which action should the nurse take first?
   a. Administer 1 mg glucagon subcutaneously.
   b. Obtain a glucose reading using a finger stick.
   c. Have the patient drink 4 ounces of orange juice.
   d. Give the scheduled dose of lispro (Humalog) insulin.

37. Which information from the patient’s health history is most important for the nurse to communicate to the health care provider when a patient has an order for an oral glucose tolerance test?
   a. The patient uses oral contraceptives.
   b. The patient runs several days a week.
   c. The patient has a family history of diabetes.
   d. The patient had a viral illness 2 months ago.

38. Which of these laboratory values, noted by the nurse when reviewing the chart of a hospitalized diabetic patient, indicates the need for rapid assessment of the patient?
   a. Hb A1C of 5.8%
   b. Noon blood glucose of 52 mg/dL
   c. Hb A1C of 6.9%
   d. Fasting blood glucose of 130 mg/dL

39. The nurse and LPN/LVN are caring for a type 2 diabetic patient who is admitted for gallbladder surgery. Which nursing action can the nurse delegate to the LPN/LVN?
   a. Communicate the blood glucose and insulin dose to the circulating nurse in surgery.
   b. Discuss the reason for the use of insulin therapy during the immediate postoperative period.
   c. Administer the prescribed lispro (Humalog) insulin before transferring the patient to surgery.
   d. Plan strategies to minimize the risk for hypo- or hyperglycemia during the postoperative hospitalization.