Pediatric Lab Questions

1)The nurse is giving discharge instructions to parents of a 6-month-old who has a urinary stent following repair of hypospadias. The nurse should tell the parents to :

a) Limit fruit juices

b) Measure urinary output in the bag daily

c) Avoid tub baths until the stent is removed --

d) Clean the penis tip 3 to 4 times a day with soap and water .

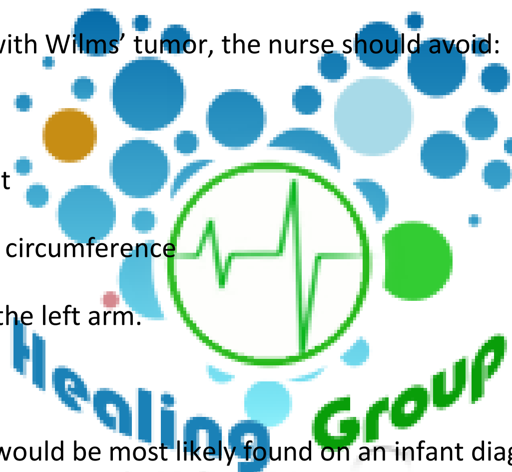
2) When assessing a toddler with Wilms' tumor, the nurse should avoid:

a) Palpating the abdomen --

b)Positioning the child upright

c) Measuring the child's chest circumference

d)Taking a blood pressure in the left arm.



3) Which assessment finding would be most likely found on an infant diagnosed with Hirschsprung's disease?

a)Scaphoid abdomen

b)Cyanosis of distal extremities

c)Hyperactive reflexes

d)Weight less than normal for height and age.

4)An 8-month-old is admitted for severe diarrhea. Which of the following would be a significant finding for this child?

a)Absent bowel sounds

b)Depressed anterior fontanel

c)Pale yellow urine

d)Marked skin turgor

5)A child is admitted with gastroenteritis. To prevent the spread of this disease, the nurse should:

a)Observe standard precautions

b)Administer antibiotics as soon as possible

c)Single-bag all linens

d)Use sterilizable eating utensils

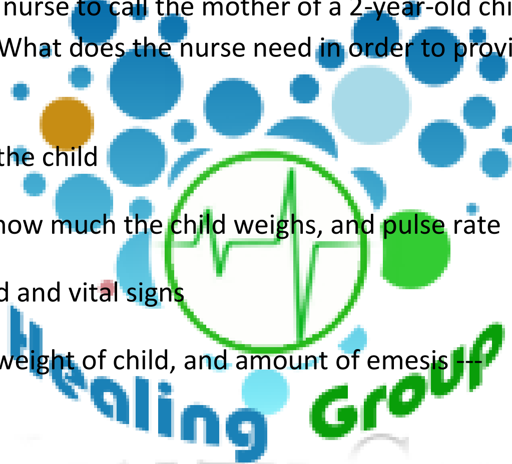
6)A physician asked the office nurse to call the mother of a 2-year-old child and provide the mother with oral rehydration instructions. What does the nurse need in order to provide the mother with rehydration information?

a)The developmental level of the child

b)What the child likes to eat, how much the child weighs, and pulse rate

c)Electrolyte status of the child and vital signs

d)Number of diarrhea stools, weight of child, and amount of emesis ---



7)To prevent hypernatremia in young children during the summer months the nurse would instruct parents to

a)Restrict the amount of salt in the child's diet.

b)Provide concentrated sugar fluids.

c)Limit fluid intake.

d)Provide extra fluids. ---

8) The nurse is aware that the most common assessment finding in a child with ulcerative colitis is:
a)Intense abdominal cramps
b)Profuse diarrhea
c)Anal fissures
d)Abdominal distention

9) Gastroesophageal reflux disease (GERD) weakens the lower esophageal sphincter, predisposing older persons to risk for impaired swallowing. In managing the symptoms associated with GERD, the nurse should assign the highest priority to which of the following interventions?

a)Decrease daily intake of vegetables and water, and ambulate frequently.

b)Drink coffee diluted with milk at each meal, and remain in an upright position for 30 minutes.

c)Eat small, frequent meals, and remain in an upright position for at least 30 minutes after eating .

d)Avoid over-the-counter drugs that have antacids in them.

10)The most frequently used diagnostic test for persons with GERD is:

a)A barium enema.

b)An upper endoscopy.

c)A barium swallow.

d)Acid perfusion tests.

11)The surgical procedure of choice for older patients with GERD and Barrett's esophagus that is not reversible with medical management is:

a)Esophagectomy.

b)Total laryngectomy

c)Nissen's fundoplication.

d)Labyrinthectomy.

12)In planning care for a patient with ulcerative colitis, the nurse should anticipate which of the following diagnostic procedures?

a)Sigmoidoscopy

b)Colonoscopy

c)Rectal mucosa biopsy

d)All of the above

13)The most common surgical procedures for patients with ulcerative colitis are:

a)Subtotal colectomy and ileostomy.---

b)Colostomy and ileo-conduit.

c)Laparoscopic gastrectomy

d)Segmental resection or colostomy.

14)Which of the following instructions should be provided to parents of an infant with gastroesophageal reflux?

a)Elevate the head of the crib at all times.

b)Burp every 3-4 ounces with feeding.

c)Feed every 4-5 hours to prevent overfeeding.

d)Place in a seated position for 10 minutes after feedings.

15)Which intervention would the nurse include in care of an infant following surgical repair of a cleft lip?

a)Position the infant in the supine position for feedings, to avoid aspiration.

b)Administer pain medications as ordered.

c)Use a special feeding device with shorter nipples.

d)Let the infant touch the suture lines as a means of self-comforting

16)Which assessment finding would lead the nurse to suspect esophageal atresia in an infant?

a)Excessive drooling

b)Abdominal distention

c)Hypotonicity

d)Excessive crying

17)A nurse reviews the record of a newborn infant and notes that a diagnosis of esophageal atresia with tracheoesophageal fistula is suspected. The nurse expects to note which most likely sign of this condition documented in the record?

a) increased crying

b) coughing at nighttime

c) chocking with feedings

d) severe projectile vomiting

18) What diet should the nurse recommend for a child with celiac disease?

a) wheat and oats

b) rice and corn

c) cookies and ice cream

d) pasta and noodles

19) Which of the following statements when made by the mother of a child with celiac disease indicates that she understands the diet of her child?

a) my child can eat rice

b) my child can eat oats

c) my child can eat biscuits

d) my child can eat pasta .

20) The nurse performs discharge teaching for a client with sickle cell anemia. Which of the following statements indicates the client possesses an adequate understanding of the disease?

a) I promise to drink plenty of fluids every day."

b) I will no longer take walks with my friends."

c) I am really careful about my weight."

d) I know my health risks."

21) The nurse prepares to teach the client how to manage iron deficiency anemia. This activity is related to the results of which of the following laboratory tests:

a) an increase in hematocrit and red blood cell count.

b) normal platelet count and increased mean corpuscular volume (mcv).

c) a decreased hemoglobin and mean corpuscular hemoglobin (mch).

d) an increased erythrocyte sedimentation rate (esr) and mean corpuscular volume (mcv).

22) After a client is admitted to the pediatric unit with a diagnosis of acute lymphocytic leukemia, the laboratory test indicates that the client is neutropenic. The nurse should perform which of the following?

a) Advise the client to rest and avoid exertion

b) Prevent client exposure to infections

c) Monitor the blood pressure frequently

d) Observe for increased bruising

23) Because of a common problem associated with the ingestion of an iron preparation, the nurse teaches the client to perform which of the following?

a) Decrease fluid and fiber intake

b) Take iron preparations with food

c) Notify the physician if stools turn dark

d) Take ferrous sulfate with milk

24) The parents of a pediatric client who has sickle cell anemia ask about the cause of the disorder. Which response by the LVN/LPN would best describe the cause?

a) "It is an inherited disorder caused by abnormal hemoglobin synthesis."

b) "It is a rare, malignant disorder of the lymphatic system."

c) "It is caused by an increased demand for iron in the blood stream."

d) "It is caused by a recessive trait that primarily affects African-Americans."

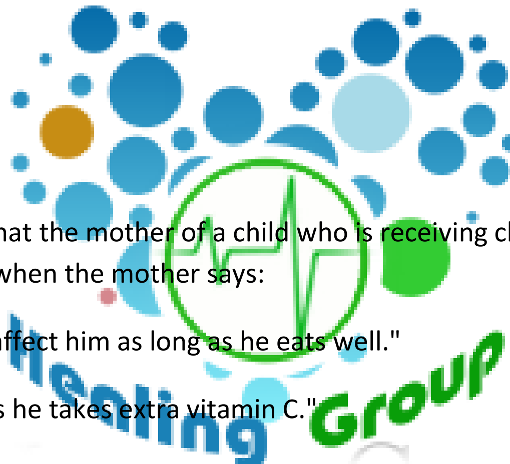
25) When reviewing the management of sickle cell anemia with a parent, the LVN/LPN understands that additional teaching would be needed if the parent said that which of the following circumstances contributed to a crisis?

a) Fever

b) Emotional stress

c) Foods that are low in iron

d) Excessive vomiting



26) The LVN/LPN recognizes that the mother of a child who is receiving chemotherapy understands home management teaching when the mother says:

a) "The chemotherapy won't affect him as long as he eats well."

b) "He can go skiing, as long as he takes extra vitamin C."

c) "He won't need to have further blood tests until the chemotherapy is done."

d) "I will need to monitor his travel to avoid people and public places to prevent exposure to infections."