ATI RN targeted medical surgical gastrointestinal online practice 2023

a nurse is assessing a client who has Crohn's disease. which of the following findings should the nurse expect? - ✓✓ANSWER✓✓>>-fatty diarrheal stools

Steatorrhea, or fatty stool, is an expected finding in a client who has Crohn's disease.

a nurse is assessing a client who has peritonitis. which of the following findings should the nurse expect? - ✓✓ANSWER✓✓>>-board-like abdomen

A board-like, distended abdomen, accompanied by extreme pain and tenderness, is an expected finding for a client who has peritonitis.

a nurse is assessing a client who has upper gastrointestinal bleeding. which of the following findings should the nurse expect? - ✓✓ANSWER✓✓>>-hypotension

A client who has upper gastrointestinal bleeding is at risk for hemorrhagic shock. Hypotension is a manifestation of hemorrhagic shock.

a nurse is assessing a client who is postoperative following a gastrectomy. the nurse should identify which of the following findings as an indication of abdominal distension? - ✓✓ANSWER✓✓>>-hiccups

Following surgery, hiccups can be caused by irritation of the phrenic nerve, due to abdominal distension. If the hiccups are intractable, the nurse should anticipate a prescription for chlorpromazine. This is because persistent hiccups are distressful to the client and can lead to complications, such as vomiting.

a nurse is caring for a client in an endoscopy suite at a surgical center.
a nurse is assessing the client following the procedure. which of the following findings should the nurse report to the provider?
select all that apply.

throat sensation
voice quality
temperature
oxygen saturation
pain
swallowing ability

bloating - ✓✓ANSWER✓✓>>-swallowing ability
-pain
-oxygen saturation
-temperature

a nurse is caring for a client on a medical-surgical unit.
click to highlight the findings that require immediate follow-up. to deselect a finding, click on the finding again.

nurses notes:
drainage from NG is dark brown drainage with small amount of old blood noted.
coughing and hoarse voice after swallowing.
client supports abdomen when coughing.
client reports feeling of abdominal fullness and is unable to belch.

vital signs:
day 9:
oxygen saturation 90% on room air - ✓✓ANSWER✓✓>>-coughing and hoarse voice after swallowing.
-oxygen saturation 90% on room air
-client reports feeling of abdominal fullness and is unable to belch.

a nurse in the emergency department (ED) is caring for a male client.
complete the diagram by dragging from the choices below to specify what condition the client is most likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.

actions to take:
-obtain a stool culture
-prepare to insert a NG (nasogastric) tube for the client
-prepare to administer insulin to the client
-prepare to administer a bismuth salt
-place the client on contact precautions

potential condition:
-pancreatitis
-ulcerative colitis
-c. difficile infection
-peptic ulcer disease

parameters to monitor:
-h. pylori level
-blood in stools

-amylase level
-erythrocyte sedimentation rate
-jaundice - ✓✓ANSWER✓✓>>actions to take:
-prepare to insert a NG (nasogastric) tube for the client
-prepare to administer insulin to the client

potential condition:
-pancreatitis

parameters to monitor:
-amylase level
-jaundice

a nurse is admitting a client who has acute pancreatitis. which of the following actions should the nurse take first? - ✓✓ANSWER✓✓>>-identify the client's current level of pain

The first action the nurse should take when using the nursing process is to assess the client. Clients who have acute pancreatitis often have severe abdominal pain. By assessing the client's level of pain, the nurse can identify the need for, and implement interventions, to alleviate the client's pain. Therefore, this is the priority action the nurse should take.

a nurse is assessing a client immediately following a paracentesis for the treatment of ascites. which of the following findings indicates the procedure was effective? - ✓✓ANSWER✓✓>>-decreased shortness of breath

Increased abdominal fluid can limit the expansion of the diaphragm and prevent the client from taking a deep breath. After excess peritoneal fluid is removed, the diaphragm will expand more freely. The nurse should identify this finding as an indicator that the procedure was effective.

a nurse is assessing a client who has a duodenal ulcer. which of the following findings should the nurse expect? - ✓✓ANSWER✓✓>>-the client reports that pain occurs during the night

Pain associated with a duodenal ulcer occurs when the stomach is empty, which is typically 1.5 to 3 hr after meals and during the night.

a nurse is assessing a client who has acute hepatitis B. which of the following findings should the nurse expect? - ✓✓ANSWER✓✓>>-joint pain

Joint pain is an expected finding in a client who has acute hepatitis B.

a nurse is assessing a client who has appendicitis. which of the following findings should the nurse expect? (Select all that apply.)

oral temperature of 38.4 C (101.1 F)
decreased WBC count
bloody diarrhea
N/V
RLQ pain - ✓✓ANSWER✓✓>>-oral temperature of 38.4 C (101.1 F)
-nausea and vomiting
-right lower quadrant pain

a nurse is caring for a client who has a new ileostomy.
click to highlight the day 4 findings that require immediate follow-up. to deselect a finding, click on the finding again.

ileostomy pouch changed
skin around the stoma is inflamed and excoriated
client will not look at stoma
client states they are not interested in learning about stoma care
ileostomy stoma is red
urine output 650 mL/24 hr
weight 78.2 kg (172 lb)
stoma draining moderate brown liquid stool
client placed on a low-residue diet
client reports abdominal cramping, abdomen is distended and firm - ✓✓ANSWER✓✓>>-skin around the stoma is inflamed and excoriated
-client will not look at stoma
-client states they are not interested in learning about stoma care
-urine output 650 mL/24 hr
-weight 78.2 kg (172 lb)
-client reports abdominal cramping, abdomen is distended and firm

a nurse is caring for a client who has colorectal cancer and is receiving chemotherapy. the client asks the nurse why blood is being drawn for a carcinoembryonic antigen (CEA) level. which of the following responses should the nurse make? - ✓✓ANSWER✓✓>>-"the CEA determines the efficacy of your chemotherapy."

A provider uses the CEA level to determine the efficacy of the chemotherapy. The client's CEA levels will decrease if the chemotherapy is effective.

a nurse is caring for a client who has GERD and a new prescription for metoclopramide. the nurse should plan to monitor for which of the following adverse effects? - ✓✓ANSWER✓✓>>-ataxia

The nurse should plan to monitor the client for extrapyramidal symptoms, such as ataxia, and should report any of these findings to the provider.