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Chapter 1

Integumentary Problems of the Adult Client

1) An obese client with diabetes who had a bowel resection 5 days ago says, "I felt like I split open when I was coughing." On assessment, the nurse notes that the incision edges are separated and a loop of bowel is protruding through the wound. Which nursing actions would be appropriate? **Select all that apply.**

1. Administer one oral tablet of oxycodone prescribed PRN for pain
2. Assess a full set of vital signs
3. Cover the viscera with sterile dressings saturated in normal saline (NS) solution
4. Notify the health care provider (HCP) immediately
5. Place the client in low Fowler's position with knees slightly flexed

✓ **Answer: 2, 3, 4, 5**

Total separation of wound layers with protrusion of the internal viscera through the incision is known as **evisceration**. Evisceration is a medical emergency that can lead to localized ischemia, peritonitis, and shock. **Emergency surgical repair** is necessary. Clients at risk for poor wound healing (eg, obesity, diabetes mellitus) are at increased risk for evisceration.

When an abdominal wound evisceration occurs, the nurse should take the following actions:

- **Remain calm and stay with the client.** Have someone **notify the HCP** immediately and bring sterile supplies. Instruct the client not to cough or strain.
 - **Place the client in low Fowler's position (no more than 20 degrees)** with knees slightly flexed to relieve pressure on the abdominal incision and have the client maintain **absolute bed rest** to prevent tissue injury.
 - **Assess vital signs** (and repeat every 15 minutes) to detect possible signs and symptoms of shock (eg, hypotension, tachycardia, tachypnea).
 - **Cover the viscera with sterile dressings saturated in NS** solution to prevent bacterial invasion and keep the exposed viscera from drying out.
 - **Document** interventions taken and the appearance of the wound and eviscerated organ (eg, color, drainage). If the blood supply is interrupted, the protruding organs can become ischemic (dusky) and necrotic (black).
- (Option 1)** This client should immediately be made **NPO** in preparation for possible emergency surgery. Only IV analgesics should be administered if the client is in pain.

Educational objective:

Emergency nursing management of wound evisceration includes the following:

- Stay with the client and have someone bring sterile supplies
- Notify the HCP and make the client NPO in preparation for emergency surgery
- Place the client in low Fowler's position with knees slightly flexed
- Cover viscera with sterile dressings saturated in NS solution
- Assess vital signs and monitor for signs of shock

2) A parent calls the nursing triage line during the evening. The parent says that a 7-year-old was found playing in an area with poison ivy and asks what to do. Which is the **most** important instruction to give the parent?

- 1. Apply cool, wet compresses for itching*
- 2. Apply topical cortisone ointment to the area*

carcinoma, and melanoma. **Melanomas** grow rapidly and are **highly metastatic**, making them the deadliest form of skin cancer. Basal cell and squamous cell carcinomas generally have a much lower risk of metastasis.

Risk factors for skin cancer include:

- Family or personal history of skin cancer (**Option 1**)
- Celtic ancestry traits (eg, **light skin**, red or blond hair, blue or green eyes, many freckles)
- Aging
- Atypical or high number of **moles** because some skin cancers develop from pre-existing moles (**Option 2**)
- **Immunosuppression** (eg, immunosuppressant medications, HIV), which lowers the body's ability to defend against cancerous mutations (**Option 4**)
- Ultraviolet light exposure (eg, chronic sun exposure, **outdoor occupation**, tanning bed use, history of **severe sunburns**) (**Option 5**)

Clients should be taught to avoid overexposure to sunlight, perform monthly skin checks with the **ABCDE assessment**, and immediately report any abnormal findings to their health care provider. Early detection and treatment significantly improve outcomes.

(Option 3) Acne is not a known risk factor for skin cancer.

Educational objective:

Risk factors for skin cancer include family or personal history of skin cancer, Celtic ancestry traits (eg, light skin, blue eyes), aging, atypical or high number of moles, immunosuppression, and ultraviolet light exposure (eg, chronic sun exposure, outdoor occupation).

9) The nurse is caring for a client in the intensive care unit who suffered partial-thickness burns to 36% of the body. During the first 24 hours, the nurse would anticipate which of the following assessments?

1. Hemoglobin 10.2 g/dL (102 g/L)

2. *Hyperactive bowel sounds*
3. *Serum sodium 152 mEq/L (152 mmol/L)*
4. *Tall, peaked T waves on ECG*

✓Answer: 4

Burn injuries cause tissue damage that leads to increased vascular permeability and fluid shifts (eg, second and third spacing). In the emergent phase after a burn (first 24-72 hours), fluid, proteins, and intravascular components leak into the surrounding interstitium, causing decreased intravascular oncotic pressure and decreased intravascular volume, and resulting in fluid shifts and **hypovolemia**.

Potassium, the predominant intracellular cation, is released when cellular damage occurs, resulting in **hyperkalemia** (potassium > 5.0 mEq [5.0 mmol/L]). Clients with hyperkalemia experience muscle weakness, ECG changes (**tall, peaked T waves**, shortened QT interval), and cardiac arrhythmias (**Option 4**).

(Option 2) The sympathetic nervous system is activated in response to a burn, causing decreased peristalsis. Nausea, vomiting, gastric distension, and paralytic ileus may occur.

(Option 3) Sodium is the most abundant extracellular cation. **Hyponatremia** (sodium <135 mEq/L [135 mmol/L]) occurs as sodium is lost via fluid shifts and insensible losses.

Educational objective:

Burn injuries cause cellular destruction, capillary leaking, and fluid shifts. Fluids are lost during the emergent phase (first 24-72 hours), resulting in hypovolemia and hyponatremia. The blood becomes more viscous and increased hematocrit and hemoglobin values result. Cellular damage releases potassium, which causes hyperkalemia.