GENITOURINARY DISORDER

1. A. Foul-smelling discharge from the penis
   Symptoms of gonorrhea in men include purulent, foul-smelling drainage from the penis and painful urination.
2. D. Pulse
   An elevated serum potassium level may lead to a life-threatening cardiac arrhythmia, which the nurse can detect immediately by palpating the pulse. In addition to assessing the client's pulse, the nurse should place the client on a cardiac monitor because an arrythmia can occur suddenly.
3. D. "I will need to get a urine culture when I am finished taking the pills."
   After completing the drug therapy, it will be necessary to obtain a urine culture to accurately determine the effectiveness of the antibiotic. It is possible for symptoms to be relieved, but bacteria to still be present in the urine. The client should complete the full course of prescribed therapy and not stop taking the drug because symptoms have disappeared.
4. D. Acute pain.
   Palliative care for the client with advanced cancer includes pain management, emotional support, and comfort measures
5. B. douching unless instructed to do so by the health care provider (HCP)
   Douching may disrupt the normal flora of the vaginal lactobacilli and change the pH, which could result in overgrowth of other bacteria.
6. D. Ask a family member to bring the medications from home in the original vials for proper identification and administration times.
   It is critical for medication safety to know the name, dosage, and times of administration of the medication taken at home. The family should bring the medication bottles to the hospital. The nurse should document the medication on the medical record from the bottles to ensure accuracy before the medication is prescribed and administered.
7. A. Given in small amounts throughout each shift.
   Thirst is a strong motivation to drink. Giving small amounts of fluid over all 3 shifts will help minimize thirst.
8. A. "Take the prescribed dose as soon as you remember it, and if it is very close to the time for the next dose, delay that next dose."
   Antibiotics have the maximum effect when the level of the medication in the blood is maintained. However, because nitrofurantoin is readily absorbed

from the gastrointestinal tract and is primarily excreted in urine, toxicity may develop by doubling the dose.

9. B. continue to improve over a period of weeks.
   The kidneys have a remarkable ability to recover from serious insult. Recovery may take 3 to 12 months.
10. B. Increase daily fluid intake to at least 2 to 3 L.
    A high daily fluid intake is essential for all clients who are at risk for calculi formation because it prevents urinary stasis and concentration, which can cause crystallization.
11. B. dysuria.
    Dysuria and a mucopurulent urethral discharge characterize gonorrhea in men. Gonococcal symptoms are so painful and bothersome for men that they usually seek treatment with the onset of symptoms.
12. D. Prepare the client and equipment, create a sterile field, put on gloves, clean the urinary meatus, and insert the catheter until urine flows.
    Preparing the client and equipment, creating a sterile field, putting on gloves, cleaning the urinary meatus, and inserting the catheter until urine flows are all the vital steps for inserting a straight catheter.
13. D. 3 months.
    At the time a client receives a progestin injection, a follow-up appointment should be made for 3 months later. The nurse should emphasize the need to adhere to the medication schedule to prevent an unplanned pregnancy.
14. E. length of time since symptoms presented
    C. presence of any enlarged lymph nodes on examination
    A. history of unprotected sex (sex without a condom)
    F. history of fever or chills
    D. allergies to any medications
    The client is suspected of having a sexually transmitted infection. Therefore, the client's sexual history, assessment, and examination must be documented, including symptoms (such as fever, chills, and enlarged glands) and their onset and duration. Allergies are critical to document for every client, but are especially noteworthy in this case because antibiotics will be prescribed. If a sexually transmitted infection is confirmed, sexual contacts need to be treated. To protect privacy, the names and phone numbers should never be placed in the medical record.

15. D. helping the client walk
    The discomfort associated with gas pains is likely to be relieved when the client ambulates. The gas will be more easily expelled with exercise. The anesthesia, analgesics, and immobility have altered normal peristalsis. Peristalsis will be stimulated by exercise.
16. A. Increasing fluid intake to 3 L/day
    Acute pyelonephritis is a sudden inflammation of the interstitial tissue and renal pelvis of one or both kidneys. Infecting bacteria are normal intestinal and fecal flora that grow readily in urine. Pyelonephritis may result from procedures that involve the use of instruments (such as catheterization, cystoscopy, and urologic surgery) or from hematogenic infection. The most important nursing intervention is to increase fluid intake to 3 L/day. Doing so helps empty the bladder of contaminated urine and prevents calculus formation.
17. B. Decreased urine output.
    A sudden change in urine output is typical of acute renal failure. Most commonly, the initial change is greatly decreased urine output.
18. C. Use sterile technique when irrigating the catheter.
    If the catheter is blocked by blood clots, it may be irrigated according to physician's orders or facility protocol. The nurse should use sterile technique to reduce the risk of infection.
19. C. To keep the catheter free from clot obstruction.
    Continuous irrigation, usually consisting of sterile normal saline, is used after TURP to keep blood clots from obstructing the catheter and impeding urine flow.
20. D. Uremia
    Uremia is the buildup of nitrogenous wastes in the blood, evidenced by an elevated blood urea nitrogen and creatine levels. Uremia, anemia, and acidosis are consistent clinical manifestations of chronic renal failure.
21. A. White blood cell (WBC) count of 20,000/mm3 (0.02 L)

    An increased WBC count indicates infection, probably resulting from peritonitis, which may have been caused by insertion of the peritoneal catheter into the peritoneal cavity. Peritonitis can cause the peritoneal

membrane to lose its ability to filter solutes; therefore, peritoneal dialysis would no longer be a treatment option for this client.

22. D. the cells could cause various conditions and help identify a problem early.
The Pap smear identifies atypical cervical cells that may be present for various reasons. Cancer is the most common possible cause, but not the only one.

23. A. at least 3,000 mL of fluids daily.
Instructions should be as specific as possible, and the nurse should avoid general statements such as "as much as possible." A specific goal is most useful.

24. A. "I can usually go 8 to 10 hours without needing to empty my bladder."
Stasis of urine in the bladder is one of the chief causes of bladder infection, and a client who voids infrequently is at greater risk for reinfection.

25. D. Kegel exercises
Kegel exercises are noninvasive and are recommended as the initial intervention for incontinence.

26. A. High purine
To control uric acid calculi, the client should follow a low-purine diet, which excludes high-purine foods such as organ meats. The other diets do not control uric acid calculi.

27. A. Diaphragms should not be used if the client develops acute cervicitis.
The teaching plan should include a caution that a diaphragm should not be used if the client develops acute cervicitis, possibly aggravated by contact with the rubber of the diaphragm. Some studies have also associated diaphragm use with increased incidence of urinary tract infections.

28. A. Monitor patient blood pressure.
Blood pressure control is a priority assessment in clients with poststreptococcal glomerulonephritis. The blood pressure can be increased for up to 6 weeks after treatment.

29. F. rash
C. blood in the urine
E. fever above 100° F (37.8° C)
The nurse should instruct the client to report signs of adverse reaction to the antibiotic or indications that the urinary tract infection is not clearing.

Blood in the urine is not an expected outcome, rash is an adverse response to the antibiotic, and an elevated temperature indicates a persistent infection. These signs should be reported to the HCP

30. A. A low-protein diet with a prescribed amount of water
    Although dialysis removes water, creatinine, and urea from the blood, the client's diet must still be monitored.
31. C. Premature ejaculation.
    Premature ejaculation is when a man consistently achieves ejaculation or orgasm before or soon after entering the vagina.
32. D. administering meperidine
    During episodes of renal colic, the pain is excruciating. It is necessary to administer opioid analgesics to control the pain.
33. C. "It's a late manifestation of respiratory tuberculosis."
    Genitourinary TB is usually a late manifestation of respiratory TB and can occur if the disease spreads through the bloodstream from the lungs. Bacillus in the urine is infectious, and urine should be handled cautiously. A condom should be used during sex to prevent spread of the infection.
34. B. Administer an opioid analgesic as prescribed.
    If infection or blockage caused by calculi is present, a client can experience sudden severe pain in the flank area, known as renal colic. Pain from a kidney stone is considered an emergency situation and requires analgesic intervention.
35. B. may not cause symptoms until serious complications occur.
    Many women do not seek treatment because they are unaware that they have gonorrhea. They may be symptom-free or have only very mild symptoms until the disease progresses to pelvic inflammatory disease
36. C. Do a breast examination and report the results to the physician.
    This concern warrants the nurse's performing an examination and reporting the results to the physician. Hormone fluctuations do cause breast discomfort, but an examination must be done at this time to assess the breast
37. A. Maintain a daily fluid intake of 2,000 to 3,000 mL.
    Maintaining a fluid intake of 2,000 to 3,000 mL/day is likely to be most effective in preventing urinary tract infection.

38. A. more than 50% of the cases are attributed to organic causes.
    ED is multifactorial in origin, and more than 50% of the cases can be attributed to organic causes, which include alteration in vascular supply, hormonal changes, neurologic dysfunction, medications, and associated systemic diseases, such as diabetes mellitus or alcoholism
39. C. Urine pH of 3.0
    Normal urine pH is 4.5 to 8; therefore, a urine pH of 3.0 is abnormal and requires further investigation.
40. C. Instruct the client about the need to collect urine for 24 hours.
    A creatinine clearance test is a 24-hour urine test that measures the degree of protein breakdown in the body.