

BNURS506 Quiz Answering

Term: Spring 2025

Module 2: HEENT, Integumentary, & Lymphatic

Name: Student I

#:	Your Answer	Feedback from Grader	Score
1	<p style="text-align: center;">References:</p> <p style="text-align: center;">Feedback:</p>		/ 10
2	<p>A pediatric patient presents to the craniofacial clinic for a pre-operative evaluation. The child has been diagnosed with Crouzon Syndrome (see photo). Based on your knowledge of Crouzon Syndrome, how many surgical procedures would you expect in this child's future? Name and describe at least one of the potential procedures. BONUS: What would be the rationale for surgical repair/reconstruction?</p> <p>Patients with Crouzon syndrome tend to have brachycephaly from bicoronal synostosis (fusing of the sutures prematurely), midface underdevelopment with underbite, bulging eyes with gaze deviations and other ophthalmic problems, beaked nose, cleft palate, conduction or neurosensory hearing deficit and other intracranial anomalies like Chiari malformation and hydrocephalus (Goldstein et al., 2023). All of these anomalies might require surgery, so I would anticipate at least six surgeries, starting with the first necessary one in infancy: cranial surgery to address the bicoronal synostosis. The rationale for this surgery would be to relieve intracranial pressure and allow for typical brain growth. I would expect cranial vault remodeling/expansion, which can done by distraction</p>	<p>Thank you for your very thorough answer. The criteria for full credit was to identify that surgical repair is necessary due to the premature fusion of sutures, that multiple surgeries are necessary during childhood and that you accurately named and described at least one surgery. I removed a point because while a patient may have 6 surgeries, many may only have 2. There is a wide range, depending on patient needs and severity. Addressing the first surgery is a great start, to touch on the need for brain growth. You earned back points due to your mention of more than one surgery and their</p>	10/ 10

	<p>method (slowly to allow for scalp expansion) or conventionally (Al-Namnam et al., 2019).</p> <p style="text-align: center;">References:</p> <p>Goldstein, J.A, Davit, A.J., & Losee, J.E., (2023). <i>Pediatric Plastic Surgery</i>. In B.J. Zitelli, S.C. McIntire, A.J. Nowalk, & J. Garrison (Eds.), <i>Zitelli and Davis' atlas of pediatric physical diagnosis</i> (pp. 873-922). Elsevier, Inc.</p> <p>Al-Namnam, N. M., Hariri, F., Thong, M. K., & Rahman, Z. A. (2019). Crouzon syndrome: Genetic and intervention review. <i>Journal of Oral Biology and Craniofacial Research</i>, 9(1), 37–39. https://doi.org/10.1016/j.jobcr.2018.08.007</p> <p style="text-align: center;">Feedback:</p> <p>Interesting question, with straightforward expectation that required application and critical thinking! I liked the bonus part as well.</p>	<p>rationale. It's also important to complete this surgeries for airway stability!</p> <p>Your APA citation, both in text and in the references looks great.</p>	
<p>3</p>	<p style="text-align: center;">References:</p> <p style="text-align: center;">Feedback:</p>		<p>/ 10</p>
<p>4</p>	<p>Peter is most likely experiencing a retinal detachment, an ophthalmic, sight-threatening emergency, as evidenced by the sudden photopsia</p>	<p>You did a great job here. Your answer is detailed, organized, and clinically on</p>	<p>9.5/ 10</p>

<p>(flashes of light), floaters and progressive visual field loss (curtain) (Feldman et al., 2024). Depending on the type of detachment, surgery might be his best treatment option, with different options: laser or cryopexy retinopexy, pneumatic retinopexy (an intraocular bubble is injected along with retinopexy), scleral buckle (silicone band permanently placed around the globe) or vitrectomy (removing vitreous and flattening the retina), or combinations of the above (Feldman et al., 2024). Recovery instructions would involve positioning: keep your head face down or side-lying for days or weeks, if a gas bubble was used, to keep it pressed against the retina (Boyd 2024). Activity restrictions including no strenuous activity, bending or lifting heavy objects so as to avoid straining and increasing intraocular pressure. Also no flying or traveling to high altitudes, and avoid rubbing or pressing on your eye. Wear an eye shield, especially during sleep, and use prescribed antibiotic or steroid eye drops (National Eye Institute, 2024). Monitor your vision and keep your post-op appointment!</p> <p style="text-align: center;">References:</p> <p>Feldman, B.H., Phelps, P., Miller A.M., Barash, A., Murchsion, A., Justin, G.A, Tsui, J.C., Bhagat, N., Lim, J.I., Lai, K.E., Patel, S.J., Karth, P.A., Gullapalli, V., Starr, M. (2024). <i>Retinal Detachment</i>. American Academy of Ophthalmology. https://eyewiki.org/Retinal_Detachment</p> <p>Boyd, K. (2024). <i>Face-down recovery after retinal surgery</i>. American Academy of Ophthalmology. https://www.aao.org/eye-health/treatments/face-down-recovery-after-retinal-surgery</p> <p>National Eye Institute. (2024, October). <i>Laser surgery and freeze treatment for retinal tears</i>. Retrieved April 18, 2025. https://www.nei.nih.gov/learn-about-eye-health/eye-conditions-and-disease/s/retinal-detachment/laser-surgery-and-freeze-treatment-retinal-tears</p> <p style="text-align: center;">Feedback:</p>	<p>point. You covered all the key treatments and gave really solid post-op instructions. The only tweak I'd suggest is being a little more confident in stating that vitrectomy would probably be the best choice for Peter, considering his cataract history. Otherwise, excellent work!</p>	
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	Well-worded and interesting question, but with three parts took multiple source gathering and time.		
5	<p>References:</p> <p>Feedback:</p>		/ 10
6	<p>The child is likely experiencing otitis media with effusion (OME) as evidenced by their ear pressure/discomfort (touching their ear), possible hearing loss (distraction, not responding when called), and the view under otoscopy (discoloration, bilateral membrane bulging, presence of gas bubbles) (Shin & Liu, 2023). It is typically caused by presence of fluid in the middle ear, and upper respiratory tract infection, childhood, and acute otitis media are risk factors. This presentation is not infectious, so the nurse should take the child's temperature and assess for copious secretions, cough, runny nose to determine if the child is well enough for preschool. If there is no fever and the child's cold symptoms are resolved, their OME would not be cause to send them home. Unlikely that the nurse can medicate the kiddo for ear pain at school, but parents could give Tylenol or ibuprofen. Treatment entails watchful waiting, so not much can be done for the kiddo at school, besides closer monitoring of their balance and accommodating their hearing loss by obtaining the child's attention when talking to them. As the nurse I would recommend a visit to the child's PCP to diagnose the OME and devise a plan. Ultimately they may need a</p>	<p>Great response. covered all aspects of my questions. You are correct, school nurses are limited in pain management. We can get doctors orders and administer meds at school but in this situation its not likely they will need them long term. Coordinating with parents is best practice. other things I have done for mild ear discomfort is a warm pack that can help drain the fluid build up.</p>	10/ 10

	<p>tympanostomy tube depending on the length and severity of the symptoms (Shin & Liu, 2023).</p> <p>References: Shin, J., & Liu, C.C. (2023, May 23). <i>Otitis media with effusion</i>. BMJ Best Practice. Retrieved April 18, 2025. https://bestpractice.bmj.com/topics/en-us/3000306</p> <p>Feedback: This question was well-set up and interesting! I was a little stumped by the part about what can be done for the kiddo at school, so hopefully I addressed that sufficiently.</p>		
7	<p>References:</p> <p>Feedback:</p>		/ 10
8	<p>B. cerumen impaction – inspect ear canal with an otoscope and perform irrigation. Lisa’s symptoms of dizziness, tinnitus, and possible hearing loss point to a problem involving her ear. Cerumen impaction can cause those symptoms, due to accumulation of earwax in external auditory canal. Sound waves are blocked from reaching the tympanic membrane, and dizziness is rare but might occur if wax is pushing on the tympanic</p>	<p>Wonderful job! Your explanation of the pathophysiology behind this question and recommendations for follow up are spot on. Your rationale is concise, and I was able to see how you arrived at the answer.</p>	10 / 10

	<p>membrane (Schwartz et al., 2017). I would consider a recent flight and the pressure changes as a contributing factor, as well as her prediabetes possible radiation therapy to the head, neck area from her breast cancer treatment, as those are risk factors (Schwartz et al., 2017). As her nurse, I would absolutely visualize both ears with otoscopy and perform irrigation if I see an impaction: dark yellow, black or brown wax that is hardened and possibly obstructing the view of the external auditory canal or eardrum. She would benefit from a full external auditory canal and eardrum assessment including audiometry and/or tympanometry, so along with her symptoms of being impacted, it is recommended to remove the impaction via irrigation for symptom alleviation and full diagnostic assessment (Schwartz et al., 2017).</p> <p style="text-align: center;">References:</p> <p>Schwartz, S. R., Magit, A. E., Rosenfeld, R. M., Ballachanda, B. B., Hackell, J. M., Krouse, H. J., Lawlor, C. M., Lin, K., Parham, K., Stutz, D. R., Walsh, S., Woodson, E. A., Yanagisawa, K., & Cunningham Jr, E. R. (2017). Clinical Practice Guideline (Update): Earwax (Cerumen Impaction). <i>Otolaryngology–Head and Neck Surgery</i>, 156(1_suppl), S1–S29. https://doi.org/10.1177/0194599816671491</p> <p style="text-align: center;">Feedback:</p> <p>I was a bit intimidated at first by the possible choices, but I was able to rule out the others: a. (not hypotensive) and c. (no recent medication changes), and landed with the HEENT related answer. I actually learned a lot from this interesting question and I appreciated that while you were looking for a rationale, you included a rubric for me to reference for my answer. Nice work!</p>	<p>Thank you for your valuable feedback! You included additional rationale in the feedback that was also spot on!</p>	
<p>9</p>			<p>/ 10</p>

	<p>References:</p> <p>Feedback:</p>		
10	<p>Since John's mole is irregularly shaped, I would consider it likely atypical/dysplastic and assess for additional atypical characteristics that might point to melanoma by following ABCDE criteria (Ball et al., 2023, Chapter 9):</p> <p>A – asymmetry of lesion: one half does not match the other B – borders: irregularly shaped, ragged edges. C – color: not same throughout, with differing shades of brown or black, or with red, blue, white patches D – diameter: more than 6mm or growing E – evolution: changes in existing lesions.</p> <p>We know that it is irregularly shaped, but is it new? Does it have any other ABCDE components?</p> <p>Many melanomas show all the ABCDE features but some show only 1 or 2 (National Cancer Institute, 2022). The only way to definitively determine if it is melanoma is by excision and biopsy with pathology. He does have several risk factors including multiple nevi, family history of melanoma, and chronic sun exposure (National Cancer Institute, 2022).</p> <p>I might spend a minute during his visit to look at the Melanoma Risk Assessment Tool: online calculator (National Cancer Institute, n.d.) which considers a person's demographics, skin characteristics and physical exam to calculate 5-year risk of developing melanoma.</p> <p>References: Ball, J., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart, R. W. (2023). <i>Seidel's guide to physical examination: An interprofessional approach</i> (10th ed.). Elsevier.</p>	<p>This answer is clear and well thought out! The ABCDE criteria are crucial to assessment, and I liked how you mentioned that there are other assessment questions needed from John to get a better understanding of whether his mole is more atypical or melanoma. Melanoma indeed displays all of the ABCDE criteria, while other moles only feature some, which is a crucial way to distinguish between atypical/dysplastic nevi and melanoma. I appreciate your mentioning that a biopsy is needed to diagnose his mole.</p> <p>You could have discussed the presentation of normal nevi, but otherwise, you did a fantastic job! From your feedback, you tried to differentiate his mole on the exam based on the clues within the question. This wasn't the intent, but I can see how this may be confusing, so thank you for your feedback.</p>	9.5/ 10

	<p>National Cancer Institute. (n.d.). <i>Melanoma Risk Assessment Tool</i>. Retrieved April 20, 2025, from https://mrisktool.cancer.gov/calculator.html</p> <p>National Cancer Institute (2022, November 17). <i>Common Moles, Dysplastic Nevi, and Risk of Melanoma</i>. Retrieved April 20, 2025, from https://www.cancer.gov/types/skin/moles-fact-sheet</p> <p style="text-align: center;">Feedback:</p> <p>Well set-up question, with a very relevant subject. I think I complicated it by trying to differentiate on exam between a dysplastic nevus and melanoma. I realized we really needed more information from his assessment.</p>		
11	<p style="text-align: center;">References:</p> <p style="text-align: center;">Feedback:</p>		/ 10
12	<p>This woman is likely being worked up for systemic lupus erythematosus (SLE) based on her constellation of constitutional symptoms including fatigue, joint pain, muscle weakness, and swelling, her neuropsychiatric symptoms of anxiety, depression, forgetfulness, and the hallmark photosensitive rash (Aringer et al., 2019). Ocular symptoms including dry eyes may also be seen. Serological studies that aid in diagnosing SLE include testing for antinuclear antibody (ANA), anti- dsDNA antibodies, anti-Sm antibodies and complement levels (C3, C4, CH50), and antiphospholipid antibodies (Gordon et al., 2018). Typically dry eyes is more commonly associated with another autoimmune disease, Sjogren's</p>	<p>You have accurately diagnosed this patient with systemic lupus erythematosus and named at least three appropriate labs that would be ordered. I appreciate your connection to Sjögren's Syndrome as well, it is important to explore all possibilities, especially with how complex autoimmune diseases can be. I also appreciate your thorough use of</p>	10/ 10

	<p>Syndrome, so I would test for anti-Ro/SS-A and/or anti-La/SS-B antibodies, which would be positive in Sjogren's (St.Clair, 2021) and help in differentiating her syndromes.</p> <p style="text-align: center;">References:</p> <p>Aringer, M., Costenbader, K., Daikh, D., Brinks, R., Mosca, M., Ramsey-Goldman, R., Smolen, J. S., Wofsy, D., Boumpas, D. T., Kamen, D. L., Jayne, D., Cervera, R., Costedoat-Chalumeau, N., Diamond, B., Gladman, D. D., Hahn, B., Hiepe, F., Jacobsen, S., Khanna, D., ... Johnson, S. R. (2019). 2019 European League Against Rheumatism/American College of Rheumatology classification criteria for systemic lupus erythematosus. <i>Annals of the Rheumatic Diseases</i>, 78(9), 1151–1159. https://doi.org/10.1136/annrheumdis-2018-214819</p> <p>Gordon, C., Amissah-Arthur, M. B., Gayed, M., Brown, S., Bruce, I. N., D'Cruz, D., Empson, B., Griffiths, B., Jayne, D., Khamashta, M., Lightstone, L., Norton, P., Norton, Y., Schreiber, K., Isenberg, D., & British Society for Rheumatology Standards, Audit and Guidelines Working Group (2018). The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults: Executive Summary. <i>Rheumatology (Oxford, England)</i>, 57(1), 14–18. https://doi-org.offcampus.lib.washington.edu/10.1093/rheumatology/kex291</p> <p>St Clair, E.W. (2021). Sjogren's syndrome. In G.S. Firestein (Ed.), <i>Firestein & Kelley's Textbook of Rheumatology</i> (11th ed., pp. 1284-306). Elsevier.</p> <p style="text-align: center;">Feedback:</p> <p>I like how we had to deduce the differential for her symptoms. Interesting question with straightforward expectation. I enjoyed this one!</p>	<p>resources to back up your answer. Great job and I appreciate your feedback!</p>	
13			/ 10

	<p>References:</p> <p>Feedback:</p>		
14	<p>One day, the parents noticed a black line on their 9-year-old daughter's nail but were unsure how long it had been there. There was no previous history of skin or nail issues. The parents initially thought it might be due to an accidental injury, so they decided to wait and observe. A few months later, the black line was still present, even though the nail continued to grow. They then decided to take their daughter to see a dermatologist. What kind of diagnosis would you rule out first and why? Describe this disease in a short paragraph.</p> <p>Per Ball et al., (2023, Chapter 9), pigmented bands in the nails may be normal in persons of color, so knowing if she is of African descent would be useful. Also, medications and infections can cause nail discoloration, so assessing for those factors would help with the diagnosis. If there are no known medications, infections, or trauma (as the parents indicate no change or growth after months of watchful waiting), I would want to primarily rule out nail apparatus melanoma (NAM), which is characterized by the longitudinal black line on the nail bed (melanonychia). NAM is very rare in children and must be diagnosed via histopathology with a painful biopsy of the nail (Ansari et al., 2021). Biopsy may also lead to permanent nail deformity, so it should be done only with high melanoma suspicion or by parental request (Ansari et al., 2021).</p> <p>References:</p>	<p>This is a thoughtful and well-rounded response. You demonstrated strong clinical reasoning by acknowledging the importance of considering normal variants in nail pigmentation based on ethnic background, and you also incorporated differential diagnoses like medication or infection. Your mention of the risks associated with biopsy in pediatric cases, including the potential for nail deformity, shows a nuanced understanding of the condition and a patient-centered approach.</p>	10/ 10

	<p>Ball, J., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart, R. W. (2023). <i>Seidel's guide to physical examination: An interprofessional approach</i> (10th ed.). Elsevier.</p> <p>Ansari, M. S., Mahmoudi, H., Sadeghinia, A., Azizzadeh-Roodpishi, S., Ghanadan, A., & Daneshpazhooh, M. (2021). Dermoscopic Evaluation of Longitudinal Melanonychia in Children: A Prospective Study. <i>Indian Journal of Dermatology</i>, 66(4), 445. https://doi.org/10.4103/ijid.IJD_722_20</p> <p style="text-align: center;">Feedback:</p> <p>Interesting question with straightforward expectations! I liked how you chose a patient population that was rare for this condition, so I had to consider the benefits of biopsy.</p>		
15	<p style="text-align: center;">References:</p> <p style="text-align: center;">Feedback:</p>		/ 10
16	<p>The presence of Reed-Sternberg cells in the lymph node biopsy indicate Classic Hodgkin Lymphoma (CHL) as these are the diagnostic cell of CHL (Fend, 2025, Chapter 27). They are large, multinucleated cells, with an accentuated membrane, pale chromatin, and single large eosinophilic nucleolus (Fend, 2025), and they only occur in CHL, thus establishing a</p>	<p>Yes, you nailed it. Full points.</p> <p>Reed-Sternberg (RS) Cells are the hallmark of Hodgkin's lymphoma. RS cells are typically large and binucleate and are often described</p>	10 / 10

	<p>diagnosis. Considering his left cervical supraclavicular and right inguinal nodes are palpable and both contain the RS cells, and his lab values are already abnormal, I would suspect advanced disease. Based on the Ann Arbor classification, with lymph node involvement distributed on opposite sides of his diaphragm, he would at least be classified as a stage III (Cheson, et al., 2014). PET and CT scan would be needed to diagnose bulk and liver, spleen, and bone marrow involvement and formally stage his disease.</p> <p style="text-align: center;">References:</p> <p>Cheson, B. D., Fisher, R. I., Barrington, S. F., Cavalli, F., Schwartz, L. H., Zucca, E., & Lister, T. A. (2014). Recommendations for Initial Evaluation, Staging, and Response Assessment of Hodgkin and Non-Hodgkin Lymphoma: The Lugano Classification. <i>Journal of Clinical Oncology</i>, 32(27), 3059–3067. https://doi.org/10.1200/JCO.2013.54.8800</p> <p>Fend, F. (2025). Classic Hodgkin Lymphoma. In E.S. Jaffe, D.A. Arber, E. Campo, A. Orazi, L. Quintanilla-Martinez, L.M. Rimsza, S.H. Swerdlow (Eds.), <i>Hematopathology</i> (3rd ed., pp. 563-584). Elsevier.</p> <p style="text-align: center;">Feedback:</p> <p>This was an interesting question! Histology can be intimidating but hopefully the answer you were looking for was straightforward. The staging aspect was challenging, and I had to bolster my reference article with visuals found online to understand it. Either way, it was worthwhile and I probably won't forget that lymph nodes on opposite sides of the diaphragm indicate more advanced disease. You set up this question well.</p>	<p>as having an owl eye appearance. The presence of RS cells is critical because it differentiates Hodgkin and Non-Hodgkin lymphomas which have different prognosis, staging, and treatment protocols. (5 pts)</p> <p>Based on the Ann-Arbor Staging for Hodgkin lymphoma, Nigel has stage III because there is involvement of lymph nodes on both sides of the diaphragm. (5 pts)</p>	
17	References:		/ 10

	Feedback:		
18	<ol style="list-style-type: none"> 1. To examine the thyroid gland from behind, ask the patient to gently extend their neck and turn it laterally away. With two fingers of each hand on the sides of the trachea, have the patient swallow the water they've sipped, and feel for movement of the gland. Then with your right hand, displace the trachea to the left and with the first three fingers of your left hand, palpate the left lobe as the patient swallows. Repeat with opposite hands to palpate the right lobe (Ball et al., 2023, Chapter 11). 2. The patient has hyperthyroidism, as evidenced by her elevated Free T4 and T3, suppressed TSH, and physical exam of tachycardia, weight loss despite good appetite, heat intolerance, low grade fever, exophthalmos, irregular menstruation, and diffusely enlarged thyroid (goiter) (Ball et al., 2023, Chapter 11). 3. The provider might prescribe an antithyroid medication as a form of treatment, a thionamide such as carbimazole, to treat hyperthyroidism caused by overproduction and secretion of thyroid hormones. Thioamides inhibit thyroperoxidase-catalyzed reactions, blocking iodine consumption in the thyroid and inhibiting thyroid hormone synthesis (Elsevier Point of Care, 2023). <p style="text-align: center;">References:</p> <p>Ball, J., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart, R. W. (2023). <i>Seidel's guide to physical examination: An interprofessional approach</i> (10th ed.). Elsevier.</p>	<p>Question 1: You correctly identified all the key points in the physical assessment of the thyroid gland from behind - 4/4 pts</p> <p>Question 2: Hyperthyroidism is technically correct, but I was looking for a more specific diagnosis given the symptoms like exophthalmos which is Graves' disease-2.5/3 pts</p> <p>Question 3: You correctly identified a potential medication to be prescribed with a good explanation of the mechanism and rationale for prescribing said medication-3/3 pts</p> <p>Thank you for the feedback!</p>	9.5/ 10

	<p>Elsevier Point of Care. (2023). <i>Hyperthyroidism</i>. Retrieved April 21, 2025 from https://www-clinicalkey-com.offcampus.lib.washington.edu#!/content/clinical_overview/67-s2.0-84664ee5-ad10-40a2-995c-ae16c1a198d9</p> <p>Feedback: I appreciated that the first two answers could be found in one of our text books. The third question required additional research but most of these questions did. Overall, a nicely worded, clear, interesting question!</p>		
19	<p>References:</p> <p>Feedback:</p>		/ 10
20	<p>You are a case manager for Mr. Jefferson, 75-year-old male. He went to urgent care with complaints of abdominal pain that has lasted about 3 months. He reports experiencing nausea intermittently throughout the day and has had several on and off episodes of a UTI in the past months. His past medical history is significant for metastatic melanoma, with known lymph node involvement. He denies any vomiting but has been having changes in his bowel movements and a decrease in his appetite. He appears fatigued and has shared that he is emotional drained. In his assessment findings, his abdomen is tender in the lower quadrants, no rebound tenderness and mild distension.</p> <p>As the nursing case manager for Mr. Jefferson and meeting him every other week, place the following nursing actions in order of priority? Explain rationale.</p> <ul style="list-style-type: none"> ▪ A. Educate the patient about dietary changes to reduce nausea and improve appetite ▪ B. Notify the provider about the persistent abdominal pain and recurrent UTIs ▪ C. Administer anti-nausea medication as prescribed ▪ D. Encourage fluid intake to prevent further urinary tract infections 	<p>Great job answering the question. You got the order of the actions right. I like how you included that you would be clustering your care and doing action B and C together. That's a great way to efficiently work as a nurse and check whether his nausea medications are effective for him before providing him fluids.</p> <p>Thanks for the feedback. You were on the right track with the answers.</p>	10 / 10

B, C, D, A. I would prioritize notifying the provider of his urgent care visit, three month history of abdominal pain with tenderness and distention, nausea, changes in bowel habits, recurrent UTIs, and decreased appetite, as I would be concerned for metastases to the colon from the metastatic melanoma (Elsevier Point of Care, 2025) Then I would administer anti-nausea medication as prescribed, if he is currently nauseated (the question prompt states the nausea is intermittent). B and C could be done simultaneously while waiting for the provider to call back. Once the patient is in a more comfortable state with nausea relief and ability to tolerate PO, I would provide and encourage fluids and for hydration, symptom relief, and UTI prevention. Once these physiological needs are met and the priority notification to the provider has been made, I would begin education to help him remain comfortable, decrease his nausea, and increase his nutritional intake.

References:

Elsevier Point of Care. (2025, April 1). Melanoma. Retrieved on April 21, 2025 from, https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-aad4001-571b-416c-9e34-ac07ae14c6f9

Feedback:

This was a cool question! I liked having to put the answers in order, as it allowed me to prioritize his basic needs and safety. It required application of his medical history with his current health status and then nursing priorities. I think I caught where you were setting up the question, but if not, I'm curious as to what you think is going on with him!