Chapter 08: Health Problems of Newborns MULTIPLE CHOICE

1. Which term is defined as a vaguely outlined area of edematous tissue situated over the portion of the scalp that presents in a vertex delivery?

   a. Hydrocephalus
   b. Cephalhematoma
   c. Caput succedaneum
   d. Subdural hematoma

ANS: C

Caput succedaneum is defined as a vaguely outlined area of edematous tissue situated over the portion of the scalp that presents in a vertex delivery. The swelling consists of serum or blood (or both) accumulated in the tissues above the bone, and it may extend beyond the bone margin. Hydrocephalus is caused by an imbalance in production and absorption of cerebrospinal fluid. When production exceeds absorption, fluid accumulates within the ventricular system, causing dilation of the ventricles. A cephalhematoma has sharply demarcated boundaries that do not extend beyond the limits of the (bone) suture line. A subdural hematoma is located between the dura and the cerebrum. It should not be visible on the scalp.

DIF: Cognitive Level: Remembering
REF: p. 295

TOP: Nursing Process: Assessment and Maintenance
MSC: Client Needs: Health Promotion
2. Which finding on a newborn assessment should the nurse recognize as suggestive of a clavicle fracture?

a. Positive scarf sign  
   b. Asymmetric Moro reflex  
   c. Swelling of fingers on affected side  
   d. Paralysis of affected extremity and muscles

ANS: B

A newborn with a broken clavicle may have no signs. The Moro reflex, which results in sudden extension and abduction of the extremities followed by flexion and adduction of the extremities, will most likely be asymmetric. The scarf sign that is used to determine gestational age should not be performed if a broken clavicle is suspected. Swelling of the fingers on the affected side and paralysis of the affected extremity and muscles are not signs of a fractured clavicle.

DIF: Cognitive Level: Analyzing  
REF: p. 297  
TOP: Nursing Process: Assessment  
MSC: Client Needs: Health Promotion and Maintenance

3. The parents of a newborn ask the nurse what caused the baby’s facial nerve paralysis. The nurse’s response is based on remembering that this is caused by what?

a. Birth injury  
   b. Genetic defect  
   c. Spinal cord injury  
   d. Inborn error of metabolism
Pressure on the facial nerve (cranial nerve VII) during delivery may result in injury to the nerve. Genetic defects, spinal cord injuries, and inborn errors of metabolism did not cause the facial nerve paralysis. The paralysis usually disappears in a few days but may take as long as several months.

4. A mother is upset because her newborn has erythema toxicum neonatorum. The nurse should reassure her that this is what?

a. Easily treated  
b. Benign and transient  
c. Usually not contagious  
d. Usually not disfiguring

Erythema toxicum neonatorum, or newborn rash, is a benign, self-limiting eruption of unknown cause that usually appears within the first 2 days of life. The rash usually lasts about 5 to 7 days. No treatment is indicated. Erythema toxicum neonatorum is not contagious. Successive crops of lesions heal without pigmentation.
5. What should nursing care of an infant with oral candidiasis (thrush) include? a. Avoid use of a pacifier.

b. Continue medication for the prescribed number of days.

c. Remove the characteristic white patches with a soft cloth.
   Apply medication to the oral mucosa, being careful that none is ingested.

d. Ingested.

ANS: B

The medication must be continued for the prescribed number of days. To prevent relapse, therapy should continue for at least 2 days after the lesions disappear. Pacifiers can be used. The pacifier should be replaced with a new one or boiled for 20 minutes once daily. One of the characteristics of thrush is that the white patches cannot be removed. The medication is applied to the oral mucosa and then swallowed to treat *Candida albicans* infection in the gastrointestinal tract.

6. A mother brings her 6-week-old infant in with complaints of poor feeding, lethargy, fever, irritability, and a vesicular rash. What does the nurse suspect?
a. Impetigo  
b. Candidiasis  
c. Neonatal herpes  
d. Congenital syphilis  

ANS: C  

Neonatal herpes is one of the most serious viral infections in newborns, with a mortality rate of up to 60% in infants with disseminated disease. Bullous impetigo is an infectious superficial skin condition most often caused by Staphylococcus aureus infection. It is characterized by bullous vesicular lesions on previously untraumatized skin. Candidiasis is characterized by white adherent patches on the tongue, palate, and inner aspects of the cheeks. Congenital syphilis has multisystem manifestations, including hepatosplenomegaly, lymphadenopathy, hemolytic anemia, and thrombocytopenia.  

DIF: Cognitive Level: Analyzing  
REF: p. 310  
TOP: Nursing Process: Assessment  
MSC: Client Needs: Physiological Integrity  

7. Which is a bright red, rubbery nodule with a rough surface and a well-defined margin that may be present at birth?  

a. Port-wine stain  
b. Juvenile melanoma  
c. Cavernous hemangioma  
d. Strawberry hemangioma  

ANS: D
Strawberry hemangiomas (or capillary hemangiomas) are benign cutaneous tumors that involve only capillaries. They are bright red, rubbery nodules with rough surfaces and well-defined margins. They may or may not be apparent at birth but enlarge during the first year of life and tend to resolve spontaneously by ages 2 to 3 years. A port-wine stain is a vascular stain that is a permanent lesion and is present at birth. Initially, it is a pink; red; or, rarely, purple stain of the skin that is flat at birth; it thickens, darkens, and proportionately enlarges as the infant grows. Melanoma is not differentiated into juvenile and adult forms. A cavernous hemangioma involves deeper vessels in the dermis and has a bluish red color and poorly defined margins.

DIF: Cognitive Level: Understanding    REF: p. 312
TOP: Nursing Process: Assessment    MSC: Client Needs: Health Promotion and Maintenance

8. What is an infant with severe jaundice at risk for developing?
   a. Encephalopathy
   b. Bullous impetigo
   c. Respiratory distress
   d. Blood incompatibility

ANS: A

Unconjugated bilirubin, which can cross the blood–brain barrier, is highly toxic to neurons. An infant with severe jaundice is at risk for developing kernicterus or bilirubin encephalopathy. Bullous impetigo is a highly infectious bacterial infection of the skin. It has no relation to severe jaundice. A blood incompatibility may be the causative factor for the severe jaundice.
9. When should the nurse expect breastfeeding-associated jaundice to first appear in a normal infant?

a. 2 to 12 hours  
b. 12 to 24 hours  
c. 2 to 4 days  
d. After the fifth day

ANS: C

Breastfeeding-associated jaundice is caused by decreased milk intake related to decreased caloric and fluid intake by the infant before the mother’s milk is well established. Fasting is associated with decreased hepatic clearance of bilirubin. Zero to 24 hours is too soon; jaundice within the first 24 hours is associated with hemolytic disease of the newborn. After the fifth day is too late. Jaundice associated with breastfeeding begins earlier because of decreased breast milk intake.

10. Which intervention may decrease the incidence of physiologic jaundice in a healthy full-term infant?

a. Institute early and frequent feedings.
b. Bathe newborn when the axillary temperature is 36.3° C (97.5° F).

c. Place the newborn’s crib near a window for exposure to sunlight. Suggest that the mother initiate breastfeeding when the danger of d. jaundice has passed.

ANS: A

Physiologic jaundice is caused by the immature hepatic function of the newborn’s liver coupled with the increased load from red blood cell hemolysis. The excess bilirubin from the destroyed red blood cells cannot be excreted from the body. Feeding stimulates peristalsis and produces more rapid passage of meconium. Bathing does not affect physiologic jaundice. Placing the newborn’s crib near a window for exposure to sunlight is not a treatment of physiologic jaundice. Colostrum is a natural cathartic that facilitates meconium excavation.

DIF: Cognitive Level: Applying REF: p. 316

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

11. What is an important nursing intervention for a full-term infant receiving phototherapy?

a. Observing for signs of dehydration
b. Using sunscreen to protect the infant’s skin
c. Keeping the infant diapered to collect frequent stools
d. Informing the mother why breastfeeding must be discontinued

ANS: A
Dehydration is a potential risk of phototherapy. The nurse monitors hydration status to be alert for the need for more frequent feedings and supplemental fluid administration. Lotions are not used; they may contribute to a “frying” effect. The infant should be placed nude under the lights and should be repositioned frequently to expose all body surfaces to the lights. Breastfeeding is encouraged. Intermittent phototherapy may be as effective as continuous therapy. The advantage to the mother and father of being able to hold their infant outweighs the concerns related to clearance.

DIF: Cognitive Level: Applying

REF: p. 318

TOP: Nursing Process: Implementation

MSC: Client Needs: Physiological Integrity

12. Rh hemolytic disease is suspected in a mother’s second baby, a son. Which factor is important in understanding how this could develop?

   a. The first child was a girl.
   b. The first child was Rh positive.
   c. Both parents have type O blood.
   d. She was not immunized against hemolysis.

ANS: B

Hemolytic disease of the newborn results from an abnormally rapid rate of red blood cell (RBC) destruction. The major causes of this are maternal–fetal Rh and ABO incompatibility. If an Rh-negative mother has previously been exposed to Rh-positive blood through pregnancy or blood transfusion, antibodies to this blood group antigen may develop so that she is isoimmunized. With further exposure to Rh-positive blood, the maternal antibodies agglutinate with the RBCs of the fetus that has the antigen and destroy the cells. Hemolytic disease caused by ABO incompatibilities can be present with the first pregnancy. The gender of the first
child is not a concern. Blood type is the important consideration. If both parents have type O blood, ABO incompatibility should not be a possibility.

13. When should the nurse expect jaundice to be present in a full-term infant with hemolytic disease?

a. At birth  
b. Within 24 hours after birth  
c. 25 to 48 hours after birth  
d. 49 to 72 hours after birth

ANS: B

In hemolytic disease of the infant, jaundice is usually evident within the first 24 hours of life. Infants with hemolytic disease are usually not jaundiced at birth, although some degree of hepatosplenomegaly, pallor, and hypovolemic shock may occur when the most severe form, hydrops fetalis, is present. Twenty-five to 72 hours after birth is too late for hemolytic disease of the infant. Jaundice at these ages is most likely caused by physiologic or early-onset breastfeeding jaundice.
14. A woman who is Rh-negative is pregnant with her first child, and her husband is Rh positive. During her 12-week prenatal visit, she tells the nurse that she has been told that this is dangerous. What should the nurse tell her?

a. That no treatment is necessary  
b. That an exchange transfusion will be necessary at birth  
c. That no treatment is available until the infant is born  
   That administration of Rh immunoglobulin is indicated at 26 to 28 d. weeks of gestation  

ANS: D

The goal is to prevent isoimmunization. If the mother has not been previously exposed to the Rh-negative antigen, Rh immunoglobulin (RhIg) is administered at 26 to 28 weeks of gestation and again within 72 hours of birth. The intramuscular administration of RhIg has virtually eliminated hemolytic disease of the infant secondary to the Rh factor. Unless other problems coexist, the newborn will not require transfusions at birth.

MSC: Client Needs: Physiological Integrity

15. The nurse is planning care for an infant receiving calcium gluconate for treatment of hypocalcemia. Which route of administration should be used? a. Oral  
b. Intramuscular  
c. Intravenous  
d. Intraosseous
ANS: C

Calcium gluconate is administered intravenously over 10 to 30 minutes or as a continuous infusion. If it is given more rapidly than this, cardiac dysrhythmias and circulatory collapse may occur. Early feedings are indicated, but when the ionized calcium drops below 3.0 to 4.4 mg/dL, intravenous calcium gluconate is necessary. Intramuscular or intraosseous administration is not recommended.


MSC: Client Needs: Physiological Integrity

16. The nurse is caring for an infant who will be discharged on home phototherapy. What instructions should the nurse include in the discharge teaching to the parents?

   a. Apply an oil-based lotion to the infant’s skin two times per day to prevent the skin from drying out under the phototherapy light.

   b. Keep the eye shields on the infant’s eyes even when the phototherapy light is turned off.

   c. Take the infant’s temperature every 2 hours while the newborn is under the phototherapy light. Make a follow-up visit with the health care provider within 2 or 3 days after your infant has been on phototherapy.

ANS: D

With short hospital stays, infants may be discharged with a prescription for home phototherapy. It is the responsibility of the nurse planning discharge to include important information such as the need for a follow-up visit with the health care provider in 2 or 3 days to evaluate feeding and elimination pattern and to have
blood work done if needed. The parents should be taught to not apply oil or lotions to prevent increased tanning; the baby’s eye shields can come off when the phototherapy lights are turned off, and the infant’s temperature needs to be monitored but not taken every 2 hours.

DIF: Cognitive Level: Applying REF: p. 322

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Physiological Integrity

17. The nurse is caring for a breastfed full-term infant who was born after an uneventful pregnancy and delivery. The infant’s blood glucose level is 36 mg/dL. Which action should the nurse implement?

a. Bring the infant to the mother and initiate breastfeeding.
b. Place a nasogastric tube and administer 5% dextrose water.
c. Start a peripheral intravenous line and administer 10% dextrose.

Monitor the infant in the nursery and obtain a blood glucose level in 4 d. hours.

ANS: A

A full-term infant born after an uncomplicated pregnancy and delivery who is borderline hypoglycemic, as indicated by a blood glucose level of 36 mg/dL, and who is clinically asymptomatic should probably reestablish normoglycemia with early institution of breast or bottle feeding. The newborn does not require a nasogastric tube and 5% dextrose water or a peripheral intravenous line with 10% dextrose because the blood glucose level is only borderline. The infant does need to be monitored, but breastfeeding should be started and the blood glucose level checked in 1 to 2 hours.
18. A pregnant client asks the nurse to explain the meaning of “cephalopelvic disproportion.” Which explanation should the nurse give to the client?

a. “It means a large for gestational age fetus.”
b. “It is the narrow opening between the ischial spines.”
c. “There is an uneven size between the fetus’ presenting part and the pelvis.”
d. “The shape of the pelvis is an android shape and is unfavorable for vaginal delivery.”

ANS: C

Cephalopelvic disproportion means a disproportion (or uneven size) between the fetus’ presenting part and the maternal pelvis. It does not mean a large for gestational age fetus or that the pelvis is an android shape. The narrow opening between the ischial spines is called the transverse measurement.

19. The nurse is caring for a newborn with Erb palsy. The nurse understands that which reflex is absent with this condition?
a. Root reflex  
b. Suck reflex  
c. Grasp reflex  
d. Moro reflex  

ANS: D  
Erb palsy (Erb-Duchenne paralysis) is caused by damage to the upper plexus and usually results from stretching or pulling away of the shoulder from the head. The Moro reflex is absent in a newborn with Erb palsy. The root and suck reflex are not affected. A grasp reflex is present in newborns because the finger and wrist movements remain normal.

DIF:  Cognitive Level: Analyzing  
REF:  p. 299  
TOP:  Nursing Process: Assessment  
MSC: Client Needs: Physiological Integrity  

20. A newborn has been diagnosed with brachial nerve paralysis. The nurse should assist the breastfeeding mother to use which hold or position during feeding?

  a. Reclining  
  b. The cradle hold  
  c. The football hold  
  d. The cross-over hold  

ANS: C
In brachial nerve paralysis, the affected arm is gently immobilized on the upper abdomen. Tucking the newborn under the arm (football hold) puts less pressure on the newborn’s affected extremity. The other positions place the newborn’s body next to the mother’s and can cause pressure on the affected arm.

21. The parents of an infant with a cleft palate ask the nurse, “What follow-up care will our infant need after the repair?” Which is an accurate response by the nurse?

a. “Your infant will not need any subsequent follow-up care.”

b. “Your infant will only need to be evaluated by an audiologist.”

c. “Your infant will only need follow-up with a speech pathologist.”

d. “Your infant will need follow-up with audiologists and orthodontists.”

ANS: D

A cleft palate means that audiologists will evaluate the child’s hearing throughout early childhood and work closely with otolaryngologists to determine if pressure equalizing (PE) tubes are needed. An infant with a cleft palate will also go through multiple phases of orthodontic intervention to align the teeth and the maxillary arches. Follow-up will be needed as the child grows. Following up with only an audiologist or only a speech pathologist would not be adequate.
22. The nurse is caring for a child after a cleft palate repair who is on a clear liquid diet. Which feeding device should the nurse use to deliver the clear liquid diet?

a. Straw  
b. Spoon  
c. Sippy cup  
d. Open cup

ANS: D

Acceptable feeding devices after a cleft palate repair include open cup for liquids, but rigid utensils such as spoons, straws, and hard-tipped sippy cups should be avoided to prevent accidental injury to the repair.

DIF: Cognitive Level: Applying  
REF: p. 307

23. A mother has just given birth to a newborn with a cleft lip. Sensing that something is wrong, she starts to cry and asks the nurse, “What is wrong with my baby?” What is the most appropriate nursing action?

a. Encourage the mother to express her feelings.  
b. Explain in simple language that the baby has a cleft lip.
Provide emotional support until the practitioner can talk to the mother. Tell the mother a pediatrician will talk to her as soon as the baby is examined.

ANS: B

It is best to explain in simple terms the nature of the defect and to reinforce and help clarify information given by the practitioner before the newborn is shown to the parents. Parents may not be ready to talk about their feelings during the first few days after birth. The nurse should provide information about the child’s condition while waiting for the practitioner to speak with the family after the examination. The mother needs simple explanations of her child’s condition during this period of waiting.


MSC: Client Needs: Psychosocial Integrity

24. An infant requires surgery for repair of a cleft lip. An important priority of the preoperative nursing care is which?

a. Initiating discharge teaching
b. Performing baseline physical and behavioral assessment
c. Observing for allergic reactions to preoperative antibiotics
d. Determining whether this defect exists in other family members

ANS: B

It is essential to assess the infant before surgery to obtain a baseline. Postoperative changes can be identified and a determination can be made regarding pain or change in status. The parents are not ready for discharge teaching. Their focus is
on the congenital defect and surgery. Although a remote possibility, allergic reactions rarely occur on the first dose. Determining whether this defect exists in other family members is an important part of the history but is not a priority before surgery.

DIF: Cognitive Level: Analyzing REF: p. 305

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity

25. The nurse is caring for an infant with hemolytic disease. Which medication should the nurse anticipate to be prescribed to decrease the bilirubin level?

a. Phenytoin (Dilantin)

b. Valproic acid (Depakene)

c. Carbamazepine (Tegretol)

d. Phenobarbital (Phenobarbital)

ANS: D

Phenobarbital is used to decrease the bilirubin level in a newborn with hemolytic disease. Phenobarbital promotes (1) hepatic glucuronyl transferase synthesis, which increases bilirubin conjugation and hepatic clearance of the pigment in bile, and (2) protein synthesis, which may increase albumin for more bilirubin binding sites. Dilantin, Depakene, and Tegretol are antiseizure medications and do not lower bilirubin levels.

DIF: Cognitive Level: Analyzing REF: p. 318

TOP: Nursing Process: Implementation MSC: Client Needs: Physiological Integrity
26. A 4-month-old infant is discharged home after surgery for the repair of a cleft lip. What should instructions to the parents include?

a. Provide crib toys for distraction.
b. Breast- or bottle-feeding can begin immediately.
c. Give pain medication to the infant to minimize crying.
d. Leave the infant in the crib at all times to prevent suture strain.

ANS: C

Pain medication and comfort measures are used to minimize infant crying. Interventions are implemented to minimize stress on the suture line. Although crib toys are important, the child should not be left in the crib for prolonged periods. Feeding begins with alternative feeding devices. Sucking puts stress on the suture line in the immediate postoperative period. The infant should not be left in the crib but should be removed for appropriate holding and stimulation.


MSC: Client Needs: Physiological Integrity

MULTIPLE RESPONSE

1. The nurse is teaching a new nurse about types of physical injuries that can occur at birth. Which soft tissue injuries should the nurse include in the teaching? (Select all that apply.)
a. Petechiae  
b. Retinal hemorrhage  
c. Facial paralysis  
d. Cephalhematoma  
e. Subdural hematoma  
f. Subconjunctival hemorrhage  

ANS: A, B, F

Soft tissue injuries that can occur at birth include petechiae, retinal hemorrhage, and subconjunctival hemorrhage. Facial paralysis and cephalhematoma are head injuries that occur at birth, and a subdural hematoma is considered a neurologic injury related to the birthing process.  

DIF: Cognitive Level: Applying  
REF: p. 294

TOP: Integrated Process: Teaching/Learning

MSC: Client Needs: Physiological Integrity

2. Which interventions should the nurse implement for a newborn with a subgaleal hemorrhage? (Select all that apply.)

a. Monitor bilirubin levels.  
b. Monitor hematocrit levels.  
c. Prepare the newborn for skull radiography.  
d. Monitor the newborn’s level of consciousness.  
e. Place a warm compress on the affected area.
An increase in serum bilirubin levels may occur as a result of the degrading red blood cells within the hematoma. Monitoring the newborn for changes in level of consciousness and a decrease in the hematocrit are keys to early recognition and management. Computed tomography or magnetic resonance imaging, not skull radiography, is useful in confirming the diagnosis. A warm compress would be contraindicated because it may dilate blood vessels and increase bleeding.

DIF:  Cognitive Level: Applying       REF:  p. 296
TOP: Nursing Process: Implementation  MSC: Client Needs: Physiological Integrity

3. Which birth injuries should the nurse assess for if an infant was born with the use of a vacuum extractor? (Select all that apply.)

a. Torticollis
b. Brachial palsy
c. Fractured clavicle
d. Cephalhematoma
e. Subgaleal hemorrhage

ANS: B, D, E

Brachial palsy, cephalhematoma, and subgaleal hemorrhage are birth injuries associated with vacuum-assisted extraction. Fractured clavicles are injuries associated with infants who are large for gestational age or weigh more than 4000 g. Torticollis is a condition that occurs from a brachial plexus injury.
4. An infant with an isolated cleft lip is being bottle fed. Which actions should the nurse plan to implement to assist with the feeding? (*Select all that apply.*)

a. Use an NUK nipple.
b. Use cheek support.
c. Enlarge the nipple opening.
d. Position the infant upright.
e. Thicken the formula with rice cereal.

ANS: A, B, D

A bottle-fed infant with an isolated cleft lip should be fed with cheek support (squeezing the cheeks together to decrease the width of the cleft), which may help the infant achieve an adequate anterior lip seal during feeding. Systems that have a wider base, such as an NUK (orthodontic) nipple or a Playtex nurser, allow the infant with a cleft lip to feed more successfully. The infant should be positioned upright with the head supported. This position helps gravity to direct the flow of liquid so that it is swallowed rather than entering into the nasal cavity. Enlarging the nipple opening would allow too much milk too fast for an infant with a cleft palate. Thickening the formula with rice cereal is done for infants with gastroesophageal reflux, not cleft lip.
5. The nurse suspects a newborn has a fractured clavicle. What are signs of a fractured clavicle? *(Select all that apply.)*

a. An asymmetric Moro reflex
b. Limited use of the affected arm
c. Crying when the arm is moved
d. Muscles of the hand are paralyzed
e. The arm hangs limp alongside the body

ANS: A, B, C

A newborn with a fractured clavicle may have no signs, but the nurse should suspect a fracture if an infant has limited use of the affected arm, malpositioning of the arm, an asymmetric Moro reflex, or focal swelling or tenderness or cries when the arm is moved. Paralyzed hand muscles and an arm that hangs limp alongside the body are signs of Erb palsy.

DIF: Cognitive Level: Analyzing

REF: p. 297

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiological Integrity

6. The nurse is preparing to administer a topical application of 1 ml of nystatin (Mycostatin) to an infant with oral thrush. Which actions should the nurse plan to implement? *(Select all that apply.)*

a. Administer after a feeding.
b. Use a sponge applicator to swab the oral mucosa and tongue.
c. Administer after warming the medication under running warm water.
d. If white patches are no longer present, hold the medication.  
   Deposit the remainder of the dose in the mouth with a syringe so the

    e. infant swallows a small amount.

ANS: A, B, E

To administer a topical application of nystatin for oral thrush, the medication should be distributed over the surface of the oral mucosa and tongue with an applicator or syringe. The remainder of the dose is deposited in the mouth to be swallowed by the infant to treat any gastrointestinal lesions. The nystatin should be administered after feedings. The medication should not be warmed before administration, and the medication should continue to be administered until discontinued by the health care provider.

DIF:  Cognitive Level: Analyzing        REF:  p. 310
TOP:  Nursing Process: Assessment       MSC: Client Needs: Health Promotion and Maintenance

7. The nursery nurse is aware that which are risk factors for hyperbilirubinemia? (Select all that apply.)

   a. An infant born prematurely
   b. An infant born to a mother with diabetes
   c. An infant born to a white mother
   d. An infant fed exclusively with formula
   e. An infant born with a metabolic disease

ANS: A, B, E
Prematurity increases the risk of hyperbilirubinemia. An infant born to a mother with diabetes is also at risk for hyperbilirubinemia. Infants with metabolic disorders such as galactosemia or hypothyroidism may also develop hyperbilirubinemia. Neonates of East Asian ethnicity (China, Taiwan, Macao, Hong Kong, Japan, and Korea) are at higher risk for high mean serum bilirubin levels than neonates of any different ethnic origin. Exclusive breastfeeding is another risk factor for neonatal hyperbilirubinemia, not feeding exclusively with formula.

DIF: Cognitive Level: Analyzing REF: p. 313
TOP: Nursing Process: Assessment MSC: Client Needs: Physiological Integrity

MATCHING

Match the cranial syndrome or sequence with its facial features.

a. Crouzon syndrome
b. Apert syndrome
c. Treacher Collins syndrome
d. Pierre Robin sequence

1. Craniosynostosis resulting in a prominent forehead

2. Shallow orbits and underdevelopment of the middle third of the face
3. Asymmetric facial deformity, including absent cheekbones

4. Displacement of the chin as a result of micrognathia

1. ANS: B
   DIF: Cognitive Level: Understanding
   REF: p. 300
   TOP: Nursing Process: Assessment
   and Maintenance
   MSC: Client Needs: Health Promotion

2. ANS: A
   DIF: Cognitive Level: Understanding
   REF: p. 300
   TOP: Nursing Process: Assessment
   and Maintenance
   MSC: Client Needs: Health Promotion

3. ANS: C
   DIF: Cognitive Level: Understanding
   REF: p. 300
   TOP: Nursing Process: Assessment
   and Maintenance
   MSC: Client Needs: Health Promotion

4. ANS: D
   DIF: Cognitive Level: Understanding
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