

Nursing

ONCC-AOCNP

Advanced Oncology Certified Nurse Practitioner



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Question: 1

A peripherally inserted central venous catheter (PICC line) has the following advantages EXCEPT:

- A. single or multi-lumen catheters are available.
- B. access may be accomplished without the use of needles.
- C. removal may be done under local anesthesia.
- D. there is a decreased risk of infection after insertion.

Answer: D

Explanation:

Peripherally inserted central venous catheters have advanced the effectiveness of blood withdrawal and administration of fluids and blood products without the need for repetitive needle sticks that are painful and may compromise the peripheral veins. They can be placed by specially trained nurses and left in place for as long as 60 days. They are usually threaded through an arm vein to the superior vena cava. Daily dressing changes and flushing with heparin/saline using sterile technique is required. They do, however, provide a potential entry port for bacteria and must be removed if this occurs. One other disadvantage is that they may limit activities such as athletics or swimming or distort the patient's body image, resulting in shame or avoidance of socialization.

Question: 2

The most common complication of central venous access devices (CVAD) is:

- A. infection.
- B. occlusion.
- C. malposition.
- D. break in the line.

Answer: A

Explanation:

The most common problem with CVAD is infection. The incidence may range from 2% to 60% depending on the type of device, the length of time it is in place, or on the antiseptic care it receives. Infection may affect the device at its exit site, inside the tubing, or surrounding the port pocket. Some infections can be cleared without removal of the device but many cannot and the CVAD will need to be replaced. Occlusion is the second most common problem and may be caused by thrombus in the line, fibrin accumulation at the tip, or by precipitation of drugs given with incompatible fluids. Clearing of the line may sometimes be successful with fibrinolytic drugs (e.g., tissue plasminogen activator [tPA]) or ethanol or sodium bicarbonate. Malpositioning may also impair line function and, if it cannot be corrected by

manipulation, will have to be replaced. Finally breaks in the line can cause bleeding or air embolus or infection.

Question: 3

Procedures to decrease the spread of cancer during surgery include all of the following EXCEPT:

- A. Ligation of local blood vessels and lymphatics
- B. Irrigation of wounds with cytotoxic agents
- C. Cleansing of surgical instruments with antibacterial agents
- D. Using a "no-touch" technique in handling malignant tissue

Answer: C

Explanation:

A major principle of cancer surgery is to avoid spreading cancer cells locally or systemically. This is especially important during excision of a localized cancer with curative intent. Several techniques are employed to diminish the risk of spread. These include ligation of local blood vessels and regional lymphatics to preclude spread by interfering with typical pathways of tumor dissemination; irrigation of wounds and cleansing of surgical instruments with cytotoxic agents; changing surgical gloves frequently; and using a "no-touch" technique in handling malignant tissue. One of the objectives of postoperative chemotherapy is the destruction of microscopic tumor cells that may have spread from the main tumor.

Question: 4

A surgical procedure may be used to prevent all of the following cancers EXCEPT:

- A. Breast
- B. Pancreas
- C. Ovarian
- D. Testicular

Answer: B

Explanation:

Using a surgical procedure to prevent a cancer is often considered for high-risk individuals. Prophylactic mastectomy may be employed for those women with a very strong family history of the disease or those who are positive for one of the BCRA genes, or those who have had a malignancy in the contra-lateral breast. This is nearly always an elective procedure but the availability of cosmetic reconstruction surgery has made this a viable option for many high-risk women. This approach has also been used for cryptorchid testes with orchiopexy, colectomy in patients with familial polyposis or inflammatory bowel disease, or oophorectomy in those with a strong family history of ovarian cancer. Many premalignant lesions such as Barrett esophagus, colonic adenomatous polyps, or dysplastic skin lesions are often

excised as well. The future may hold the possibility of removal of vital organs such as the pancreas or lung for replacement with natural or artificial ones.

Question: 5

Which of the following surgical procedures would be most reasonable for a patient with stage I kidney cancer, a history of recent myocardial infarction, diabetes, and poor renal function?

- A. Radical nephrectomy.
- B. Total nephrectomy.
- C. Laparoscopic partial nephrectomy.
- D. No surgery; radiation and/or chemotherapy only.

Answer: C

Explanation:

The possible consequences of radical surgery for cure must often be weighed against the risk of possible complications or even death. Patients with metabolic disorders, such as diabetes, and poor cardiac, pulmonary, or renal function present a higher risk. In the current case, stage I kidney cancer indicates the tumor is less than 7 cm in its widest diameter and confined to the kidney. While total or even radical nephrectomy might have been considered in the past, the availability of laparoscopic surgery with subtotal nephrectomy may now be the treatment of choice for such a patient. Five-year survival rates for stage I kidney cancer approach 90% but nephron-sparing surgery should be strongly considered in this type of high-risk patient.

Question: 6

Which of the following is true regarding radiation therapy?

- A. Radioisotopes used in treatment emit only beta rays.
- B. Therapeutic doses are often described in grays: Gy or cGy where 1 Gy equals 1 rad.
- C. Radiation sources include linear accelerator and radioactive isotopes.
- D. Brachytherapy refers to radiation to the arm.

Answer: C

Explanation:

Radiation therapy constitutes an important treatment modality for many cancers and it is estimated that some 60% of cancer patients receive some sort of radiation therapy. This may be in the form of external beam (teletherapy) or localized from a sealed radiation source (brachytherapy). The latter is often used with implants to treat prostate cancer or other localized malignancies. X-rays and gamma rays may be produced by a linear accelerator or cobalt-60 while radioactive isotopes such as iodine-131 or cesium-137 emit both beta and gamma rays. Dose measurements are now usually expressed in grays (Gy) or centigrays (cGy) where an absorbed dose of 1 Gy equals 100 rads (the older unit of absorbed

dose) and 1 cGy equals 1 rad. Radiation protective badges are usually expressed in dose equivalent units called millirem (mrem).

Question: 7

Which of the following tissues or organs respond to radiation therapy rapidly?

- A. Bone marrow.
- B. Thyroid.
- C. Brain.
- D. Uterus.

Answer: A

Explanation:

The purpose of radiation therapy is to kill malignant tissues while affecting the surrounding normal tissue as little as possible. All tissues respond to ionizing radiation but differ in the speed and magnitude of response. Likewise, some tumors are considered radiosensitive (e.g., lymphomas) while others are more resistant (e.g., some squamous cell tumors). Rapidly proliferating tissues such as bone marrow, gastrointestinal epithelium, or skin tend to respond acutely and account for early side effects in these sites. Skin erythema, neutropenia, and gastrointestinal disturbances are all common early side effects. Lung, liver, kidney, brain, and heart are considered intermediate responders while late effects are more often seen in such organs as the pancreas, thyroid, pituitary, cartilage, and uterus. Different body areas have certain dose limitations and shielding of tissues surrounding the tumor is an important part of radiation therapy.

Question: 8

For patients receiving radiation implants, protection methods for hospital personnel and visitors include all of the following EXCEPT:

- A. Portable radiation shields
- B. Remaining 12 feet from patient if possible
- C. Radiation warning on patient's wristband
- D. Special disposal of all body fluids and items in direct contact with patient

Answer: B

Explanation:

Protection from radiation for hospital personnel and visitors is important to avoid contamination. Portable radiation shields are useful tools and patients are often placed in private rooms with specialized equipment for radiation protection and disposal. Hospital personnel and visitors should remain 6 feet away from the patient, if possible. All body fluids and items that come in direct contact with these patients must be disposed of in specialized containers. Radiation warning signs are placed on

the patient's wristband, chart, and the door of the room. Most hospitals have radiation safety officers who are responsible for monitoring exposure and usually test exposure at 1 meter from the patient behind the shield and at the door of the room. Sometimes it is possible to temporarily remove the radiation source from the patient receiving brachytherapy while nursing personnel or visitors are present.

Question: 9

Early effects of radiation therapy may cause:

- A. alopecia.
- B. skin atrophy.
- C. hypothyroidism.
- D. pericarditis.

Answer: A

Explanation:

Side effects of radiation therapy are usually divided into acute, which occur during or shortly after the treatment, and intermediate/late, which occur months to years afterwards. Acute changes are most often seen in rapidly proliferating tissues such as skin and hair follicles, gastrointestinal mucosa, and bone marrow. Therefore, erythema, moist or dry desquamation, and some pigmentation are acute skin reactions, while delayed ones include fibrosis, atrophy, and telangiectasia. Carcinogenesis is a general late radiation reaction that may occur at all sites. Head and neck irradiation may lead to late hypothyroidism and dental caries while chest radiation may cause delayed pulmonary fibrosis, pericarditis or myocardial infarction, and esophageal stricture. Abdominal targets may cause late bowel stricture and obstruction while pelvic radiation may lead to eventual ovarian failure and sterility in women.

Question: 10

Which of the following would not be appropriate therapy for noninvasive bladder cancer?

- A. Transurethral fulguration.
- B. Intravesical chemotherapy.
- C. Radical cystectomy with urinary diversion.
- D. Laser therapy.

Answer: C

Explanation:

The major goals of treatment for noninvasive bladder cancer are to prevent invasive disease, prevent the loss of the bladder, and improve survival. Most bladder cancers are urothelial (formerly called transitional cell carcinomas) and may be multifocal in origin. Hematuria is the most frequent sign. The

treatment approach is to eradicate the noninvasive cancer by transurethral resection, often using electrical fulguration or laser treatment. Intravesical chemotherapy, often with mitomycin C alone or in combination, has been shown to prevent recurrence of the cancer in many cases. Radical cystectomy with urinary diversion is appropriate treatment for invasive bladder cancer; preoperative chemotherapy has been found to prolong survival compared with surgery alone.

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