

WB Staff Nurse Sample Papers

Q1. In diabetic ketoacidosis, which electrolyte imbalance requires urgent correction to avoid cardiac arrhythmias?

- (a) Hypercalcemia
- (b) Hypokalemia
- (c) Hyponatremia
- (d) Hypermagnesemia

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Insulin drives potassium into cells, worsening hypokalemia.

Total body potassium is depleted despite serum levels.

Hypokalemia causes muscle weakness and dangerous arrhythmias.

Frequent ECG and serum potassium monitoring needed.

Replace potassium after confirming urine output.

Avoid potassium if anuric or hyperkalemic.

Correct acidosis to facilitate potassium shift.

Additional Knowledge:

DKA triad: hyperglycemia, ketonemia, metabolic acidosis.

Initial fluid replacement with isotonic saline.

Hourly blood glucose monitoring recommended.

Identify precipitating causes like infection or infarction.

Cerebral edema a rare but serious complication.

Sodium bicarbonate reserved for severe acidosis cases.

Insulin infusion protocols ensure safe correction.

Q2. Which electrolyte imbalance specifically causes peaked T waves on ECG?

- (a) Hypokalemia
- (b) Hyperkalemia
- (c) Hypocalcemia
- (d) Hyponatremia

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Hyperkalemia shortens repolarization causing tall, peaked T waves.

Also broadens QRS complexes and flattens P waves as severity worsens.

May precipitate ventricular fibrillation and cardiac arrest.

Immediate treatment involves calcium gluconate IV.

Shift potassium intracellularly with insulin and glucose.

Remove excess potassium via diuretics or dialysis.

Monitor ECG changes continuously during treatment.

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Additional Knowledge:

Causes of hyperkalemia include renal failure and potassium-sparing diuretics.

Hypokalemia causes flattened T waves and U waves.

Calcium stabilizes cardiac membranes without lowering K^+ .

Sodium bicarbonate helps shift K^+ intracellularly in acidosis.

Dietary potassium restrictions advised in chronic cases.

Chronic hyperkalemia may be asymptomatic initially.

Prevention includes careful medication monitoring.

Q3. A child with acute lymphoblastic leukemia (ALL) is at highest risk of infection due to:

- (a) Chemotherapy-induced neutropenia
- (b) Splenomegaly
- (c) Hypercalcemia
- (d) Increased platelet count

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Chemotherapy suppresses bone marrow reduces neutrophils.

Neutropenia significantly increases infection susceptibility.

Implement neutropenic precautions and isolate as needed.

Monitor for fever as an early infection sign.

Maintain strict hand hygiene by caregivers and healthcare workers.

Administer prophylactic antimicrobials if prescribed.

Educate family on infection prevention at home.

Additional Knowledge:

ALL is the most common childhood cancer.

Bone marrow biopsy confirms diagnosis.

Chemotherapy phases: induction, consolidation, maintenance.

Monitor for drug toxicities and side effects.

Platelet transfusions may be required for thrombocytopenia.

Supportive care improves quality of life.

Psychosocial support for patient and family crucial.

Q4. What characterizes stage 1 hypertension according to the JNC 8 guidelines?

- (a) Systolic 130-139 mm Hg or Diastolic 80-89 mm Hg
- (b) Systolic 120-129 mm Hg and Diastolic <80 mm Hg
- (c) Systolic ≥ 140 mm Hg or Diastolic ≥ 90 mm Hg
- (d) Systolic >160 mm Hg or Diastolic >100 mm Hg

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Stage 1 hypertension diagnosis crucial for early intervention.

Lifestyle modifications are first-line management.



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Logos: IBPS, UPSC, SSC, Railway, and others.

Monitor blood pressure regularly to prevent progression.
Manage comorbidities like diabetes aggressively.
Pharmacologic treatment considered if target organ damage present.
Patient education on diet and exercise essential.
Regular follow-ups needed for BP control.
Additional Knowledge:
Stage 2 hypertension defined with higher values.
Hypertensive emergencies require immediate treatment.
Blood pressure measured properly with validated equipment.
White coat hypertension needs ambulatory BP monitoring.
DASH diet beneficial for management.
Smoking cessation critical.
Stress management reduces BP levels.

Q5. Which is the most reliable symptom indicating late-stage Alzheimer's disease?

- (a) Mild forgetfulness
- (b) Difficulty performing daily activities
- (c) Aggressiveness and agitation
- (d) Difficulty with speech and swallowing

Ans.(d)

Sol. Correct Answer: (d)

Information Booster:

Late-stage includes loss of basic functions like speech and swallowing.
Increased risk of aspiration pneumonia due to dysphagia.
Total dependency for activities of daily living.
Memory loss profound and global.
Behavioral symptoms present earlier but may persist.
Supportive care focused on quality of life.
Multidisciplinary approach essentials include nutrition, nursing, and speech therapy.
Additional Knowledge:
Early Alzheimer's characterized by mild memory issues.
Behavioral symptoms managed with non-pharmacologic strategies.
Advance care planning important early in disease.
Caregiver burden significant and requires support.
Disease progression variable among individuals.
Pharmacologic treatments slow progression modestly.
Dementia screening tools assist early diagnosis.

Q6. In an oncology ward, extravasation of a vesicant drug demands:

- (a) Apply warm compress
- (b) Apply cold compress
- (c) Flush the IV line with saline
- (d) Remove cannula and elevate limb

Ans.(d)

Sol. Correct Answer: (d)

Information Booster:

Stop infusion immediately.

Remove IV line and avoid further flushing.

Elevate limb to reduce swelling.

Apply cold or warm compress as per drug protocol.

Inject antidote locally if prescribed.

Document size and site of infiltration.

Notify oncology team and pharmacist.

Educate staff on vesicant handling precautions.

Additional Knowledge:

Vesicants cause tissue necrosis; early action critical.

Use central line for chemotherapy if long term.

Rotating infusion sites reduces risk.

Examples: Doxorubicin, Vincristine.

Q7. During postoperative care, a patient suddenly develops dyspnea and cyanosis. Immediate nursing action:

(a) Call for help and begin oxygen

(b) Encourage deep breathing exercises

(c) Check IV fluid rate

(d) Obtain temperature reading

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Possible pulmonary embolism or airway obstruction.

Administer oxygen, elevate head of bed.

Maintain patent airway and monitor vital signs.

Notify physician immediately.

Avoid excessive movement to prevent embolus dislodging.

Ensure IV access for emergency medications.

Reassure patient and remain with them.

Record event and interventions accurately.

Continue continuous pulse oximetry monitoring.

Additional Knowledge:

High-risk patients: postoperative immobility, dehydration, obesity.

Preventive: leg exercises, compression devices, early ambulation.

Embolus confirmed with CT or V/Q scan.

Anticoagulants (heparin) prevent recurrence.

Sudden chest pain and dyspnea hallmark symptoms.

Q8. In myocardial infarction, chest pain that persists despite rest is due to:

- (a) Coronary artery spasm
- (b) Myocardial necrosis
- (c) Reflux esophagitis
- (d) Unstable angina

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Necrosis occurs from prolonged ischemia (>30 min).

Pain is crushing, retrosternal, radiating to arm/jaw.

Not relieved by rest or nitroglycerin.

Immediate ECG and cardiac enzyme assessment.

Administer oxygen and pain relief (morphine) promptly.

Prepare for reperfusion therapy (PCI or thrombolysis).

Continuous cardiac monitoring important.

Educate on lifestyle modification and rehab.

Assess for arrhythmias or shock post event.

Additional Knowledge:

Cardiac biomarkers: Troponin I, T elevated for diagnosis.

Aspirin given early to inhibit platelet aggregation.

Beta-blockers reduce myocardial oxygen demand.

Smoking cessation vital for secondary prevention.

Women often present with atypical symptoms.

Rehabilitation includes graded exercise and diet counseling.

Q9. In an ICU patient, a central venous pressure (CVP) reading of 2 cm H₂O indicates:

- (a) Fluid overload
- (b) Normal intravascular volume
- (c) Hypovolemia
- (d) Increased right atrial pressure

Ans.(c)

Sol. Correct Answer: (c)

Information Booster:

Normal CVP: 5–10 cm H₂O (or 2–6 mmHg).

Low value indicates decreased circulating volume.

Assess for poor skin turgor, tachycardia, and hypotension.

Administer isotonic fluids or blood as ordered.

Monitor urine output strictly.

Reassess CVP after each fluid bolus.

Ensure correct transducer zeroing at mid-axillary line.

Watch for catheter-related infections.

Document trends, not isolated values.

Additional Knowledge:

Elevated CVP occurs in heart failure, tamponade, or fluid overload.

Trend monitoring superior to single readings.

CVP reflects right atrial preload status.

Overcorrection may cause pulmonary edema.

In septic states, CVP helps titrate fluid resuscitation.

Level patient's chest at phlebostatic axis for accuracy.

Heparin flush prevents central line clotting.

Maintain sterile technique to prevent line sepsis.

Q10. In medical-surgical nursing, which ECG change indicates hyperkalemia?

- (a) Flat T waves
- (b) Peaked T waves
- (c) Prolonged QT interval
- (d) ST depression

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Tall peaked T waves signify increased serum potassium.

Severe levels may cause sine-wave patterns and cardiac arrest.

Monitor serum electrolytes regularly in renal and trauma patients.

Avoid potassium-sparing diuretics when high K⁺ noted.

Administer calcium gluconate IV to stabilize myocardium.

Give insulin with glucose to shift K⁺ intracellularly.

Sodium bicarbonate useful in associated acidosis.

Initiate emergency dialysis for refractory hyperkalemia.

Record ECG continuously during treatment.

Additional Knowledge:

Normal serum K⁺: 3.5–5.0 mEq/L.

Causes: renal failure, tissue breakdown, massive transfusion.

Symptoms: paresthesia, muscle weakness, bradycardia.

Digitalis toxicity risk increases with hyperkalemia.

Low potassium produces flattened T and U waves.

Dietary restriction: avoid citrus, banana, coconut water.

Regular ECG vital for ICU electrolyte monitoring.

Q11. A patient with acute stroke suddenly becomes confused, develops slurred speech, and right-sided weakness. Priority nursing action?

- (a) Ensure airway, call stroke code/physician, and prepare for emergent brain imaging
- (b) Offer oral fluids and bed rest
- (c) Document and continue scheduled meds
- (d) Apply warm compress to head

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Time-sensitive stroke care: assess airway, breathing, circulation immediately.

Activate stroke protocol for rapid CT scan to determine ischemic vs hemorrhagic.

Note exact time of symptom onset (crucial for thrombolysis eligibility).

Monitor neurologic status using NIHSS or institution tool.

Prepare for potential tPA if ischemic and within window.

Keep patient NPO until swallow screen performed.

Document baseline neuro exam and time actions taken.

Inform family and coordinate with stroke team.

Additional Knowledge:

Thrombolytic window typically within 4.5 hours for IV tPA (subject to protocols).

Contraindications: recent surgery, bleeding, uncontrolled BP.

Rapid BP management may be required pre-thrombolysis.

Mechanical thrombectomy options for large vessel occlusion up to selected time window.

Early mobilization and neuro rehab after stabilization.

Monitor for aspiration risk and provide swallow evaluation.

Educate family about stroke signs (FAST).

Record imaging and lab results.

Q12. Preferred initial therapy for status epilepticus:

- (a) IV lorazepam
- (b) Oral phenytoin
- (c) IM diazepam only
- (d) IV valproic acid

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Lorazepam **rapidly terminates seizures** via GABA potentiation.

Monitor airway, breathing, and oxygen saturation.

Document seizure onset, duration, and interventions.

Prepare IV access and monitoring equipment.

Administer anticonvulsant loading dose after seizure control.

Educate family on seizure first-aid and prevention.

Monitor vitals and ECG.

Collaborate with neurology for further management.

Maintain continuous observation post-seizure.

Provide psychological support for patient/family.

Additional Knowledge:

Phenytoin or fosphenytoin for maintenance therapy.

Avoid abrupt cessation of anticonvulsants.

Monitor electrolytes and glucose.

Document any adverse effects of medications.
Reinforce safety measures: padded bed rails, suction ready.
Track seizure frequency and triggers.
Educate caregivers on emergency protocols.
Maintain detailed seizure log for follow-up.
Collaborate for EEG or imaging as indicated.
Support adherence to long-term therapy plan.

Q13. Kussmaul's respiration is typically seen in:

- (a) Respiratory acidosis
- (b) Metabolic acidosis
- (c) Metabolic alkalosis
- (d) Respiratory alkalosis

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Deep, rapid respirations help **blow off CO₂** to compensate for metabolic acidosis.
Common in **diabetic ketoacidosis** and severe renal failure.
Monitor **ABG values** to assess pH and bicarbonate levels.
Assess for dehydration and electrolyte imbalance.
Maintain IV access for fluid and insulin therapy.
Observe mental status and consciousness level.
Support oxygenation if hypoxemic.
Document respiratory rate, depth, and pattern.
Educate caregivers about early recognition.
Prevent further stress to the patient, which may worsen acidosis.

Additional Knowledge:

Late signs of acidosis: hypotension, bradycardia, arrhythmias.
Kussmaul's breathing differs from **Cheyne–Stokes** (cyclic apnea and hyperventilation).
Monitor glucose in diabetic patients.
Correct underlying cause promptly to prevent complications.
Electrolyte replacement may be necessary.
Avoid excessive oxygen in DKA; may worsen acidosis.
Maintain patient comfort and safety.
ABG monitoring helps titrate therapy.
Support family in understanding condition.
Early recognition reduces morbidity and mortality.

Q14. Korsakoff's psychosis is associated with deficiency of:

- (a) Thiamine
- (b) Riboflavin
- (c) Niacin
- (d) Folic acid

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Caused by chronic alcoholism → thiamine deficiency.

Features: confusion, confabulation, memory loss.

Nursing: administer IV thiamine before glucose.

Encourage balanced diet and abstinence.

Monitor for Wernicke's encephalopathy symptoms.

Provide emotional and psychological support.

Maintain fluid–electrolyte balance.

Additional Knowledge:

Thiamine = Vitamin B1 essential for glucose metabolism.

Chronic alcoholics → poor absorption and intake.

Confabulation = filling memory gaps with false details.

Wernicke's + Korsakoff's → same spectrum disorder.

Encourage participation in deaddiction therapy.

Regular neuro-assessment for improvement.

Q15. Which isolation is required for a patient with pulmonary tuberculosis?

- (a) Contact isolation
- (b) Airborne isolation
- (c) Droplet isolation
- (d) Protective isolation

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Airborne isolation → N95 mask, negative-pressure room.

TB spreads via droplet nuclei $<5\ \mu\text{m}$.

Nursing: ensure door closed always.

Educate patient to cover mouth when coughing.

Perform hand hygiene before and after care.

Limit transport unless essential; use surgical mask on patient.

Document daily respiratory assessment.

Monitor for medication adherence (DOTS).

Maintain infection control checklist.

Additional Knowledge:

Airborne diseases: TB, measles, varicella.

Rifampicin → orange urine; isoniazid → hepatotoxic.

Nurses must ensure liver function monitoring.

BCG vaccine provides partial protection.

Sputum negative → discontinue isolation.

Ventilation and sunlight reduce bacterial survival.

Provide psychological support — stigma is common.

Report all TB cases to public health authority.

Q16. During active labor, late decelerations in fetal heart rate indicate:

- (a) Umbilical cord compression
- (b) Fetal head compression
- (c) Maternal supine hypotension
- (d) Uteroplacental insufficiency

Ans.(d)

Sol. Correct Answer: (d)

Information Booster:

Late decelerations occur after contraction peak, signaling fetal hypoxia.

Causes include decreased uteroplacental blood flow.

Maternal repositioning and oxygen administration help.

Discontinue oxytocin if infusion ongoing.

Continuous fetal monitoring critical.

Emergency delivery may be necessary.

Additional Knowledge:

Early decelerations benign, due to head compression.

Variable decelerations indicate cord compression.

Prolonged decels signify severe distress.

Tocodynamometer monitors contraction pattern.

Correct maternal hypotension promptly.

Document fetal heart pattern meticulously.

Intrauterine resuscitation first step before delivery decision.

Q17. Which stage of labor is characterized by the complete dilation of the cervix until delivery of the fetus?

- (a) First stage
- (b) Second stage
- (c) Third stage
- (d) Fourth stage

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Second stage begins with complete cervical dilation (10 cm).

Ends with the birth of the baby.

Characterized by strong, frequent contractions and active maternal pushing.

Close monitoring of fetal heart rate essential.

Prepare delivery equipment and personnel during this stage.

Assist mother with breathing techniques to reduce fatigue.

Immediate newborn care initiated after delivery.

Additional Knowledge:

First stage involves cervical dilation and effacement.

Third stage: delivery of placenta.

Fourth stage: postpartum recovery.

Complications include fetal distress and perineal tears.
Positioning important for effective delivery.
Episiotomy if indicated for difficult delivery.
Maternal vital signs monitored throughout labor.

Q18. In OBG, what is the main advantage of partograph use?

- (a) Predict gestational diabetes risk
- (b) Identify abnormal labor progress early
- (c) Estimate blood loss
- (d) Record psychological changes

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Records progress of labor in maternal and fetal parameters.
Includes cervical dilatation, fetal heart rate, contractions, and descent.
Alert and action lines help detect delay timely.
Prevents prolonged or obstructed labor complications.
Guides appropriate intervention or referral.
Promotes standard documentation during labor.
Reduces maternal and neonatal morbidity.
Easy to interpret by trained birth attendants.
Promotes continuity of care during labor shift.

Additional Knowledge:

Recommended by WHO for all institutional deliveries.
Ensures rational use of oxytocin and timely decision-making.
Helps in early detection of fetal distress patterns.
Effective in both rural and tertiary setups.
Training all healthcare providers in partograph interpretation increases safety.

Q19. Which uterine position increases the risk of prolapse?

- (a) Anteverted
- (b) Retroverted
- (c) Mid-position
- (d) Axial

Ans.(b)

Sol. Correct Answer: (b)

Information Booster:

Retroverted uterus lacks anterior support → prone to descent.
Common postpartum or postmenopausal.
Nursing: teach pelvic floor exercises (Kegels).
Prevent chronic constipation, heavy lifting.
Pessary support may be indicated.



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IBPS, IAS, UPSC, SSC, RAILWAY, BANK, and other exam logos.

Additional Knowledge:

Uterine prolapse graded I–III based on descent.
Vaginal hysterectomy indicated for severe cases.
Estrogen therapy improves pelvic tone post-menopause.
Encourage weight management to reduce pressure.
Nursing: monitor urinary retention or infection.
Educate on perineal hygiene and pessary maintenance.

Q20. In obstetric nursing, Leopold's second maneuver determines:

- (a) Fetal lie
- (b) Fetal presentation
- (c) Fetal back and limbs
- (d) Fetal descent

Ans.(c)

Sol. Correct Answer: (c)

Information Booster:

Second maneuver → hands on lateral abdomen.
Palpate smooth, convex back on one side; small parts (limbs) on other.
Confirms fetal position (e.g., left occipitoanterior).
Nursing: ensure bladder empty before palpation.
Use warm hands; position mother supine with knees slightly flexed.
Gentle palpation prevents discomfort.
Record findings in partograph.
Repeat in each antenatal visit for fetal monitoring.
Avoid in preterm labor or threatened abortion.

Additional Knowledge:

1st maneuver: fundal part (head/breech).
3rd: presenting part over symphysis.
4th: degree of engagement.
Fetal lie = relation of long axis of fetus to mother.
Leopold's useful in identifying multiple pregnancies.
Nurses use this skill in labor triage units.
Fetal back → best site for FHR auscultation.
Document findings precisely for shift handover.

Q21. In a postpartum woman, the uterus is normally palpable at the level of the umbilicus on:

- (a) Day 1
- (b) Day 3
- (c) Day 7
- (d) Day 10

Ans.(a)

Sol. Correct Answer: (a)

Information Booster:

Immediately after delivery: fundus midway between umbilicus and symphysis.
12 hours later → at umbilicus.
Descends ~1 cm/day thereafter.

Not palpable abdominally after 10–14 days.

Nursing: check involution daily.

Support uterus during palpation to prevent inversion.

Observe for subinvolution (boggy uterus, excessive lochia).

Encourage breastfeeding — oxytocin aids involution.

Document fundal height and consistency.

Additional Knowledge:

Uterine atony → major cause of postpartum hemorrhage (PPH).

Empty bladder before fundal assessment.

Lochia rubra (1–3 days), serosa (4–10), alba (after 10 days).

Nurses report foul odor → infection suspicion.

Encourage early ambulation.

Educate mother on uterine changes postpartum.

Subinvolution → treat with ergometrine or oxytocin.

Strict perineal hygiene prevents infection.

Q22. What is the immediate intervention to be performed on a mother at term gestation, who is experiencing moderate vaginal bleeding, indicating abruptio placenta?

- (a) Strict monitoring of intake and output
- (b) Delivery of the foetus
- (c) Weekly monitoring of coagulation studies until the time of delivery
- (d) Complete bed rest for remaining period of the pregnancy

Ans.(b)

Sol. Abruptio placentae is a serious obstetric emergency where the placenta prematurely separates from the uterine wall, leading to bleeding and compromised fetal oxygenation. In a term pregnancy with moderate bleeding, the immediate intervention is delivery of the fetus to prevent maternal and fetal complications. Delaying delivery can result in fetal distress, stillbirth, or maternal hemorrhage.

Explanation of options: (a) Strict monitoring of intake and output – While useful in overall maternal care, it is not sufficient as an immediate intervention for abruptio placenta. (b) Delivery of the foetus – This is the correct answer. Prompt delivery is indicated to manage abruptio placenta, especially at term, to prevent further bleeding and fetal compromise. (c) Weekly monitoring of coagulation studies until the time of delivery – This is inadequate in acute bleeding situations where immediate action is necessary. (d) Complete bed rest for remaining period of the pregnancy – Not appropriate in a case of moderate bleeding with abruptio, as it can endanger both mother and fetus.

Q23. Identify the type of abortion where the changes progress to a state from where continuation of the pregnancy becomes impossible.

- (a) Threatened abortion
- (b) Inevitable abortion
- (c) Complete abortion
- (d) Missed abortion

Ans.(b)

Sol. Inevitable abortion refers to a stage where clinical signs indicate that the pregnancy cannot continue. The cervix is dilated, bleeding is profuse, and there is rupture of membranes or uterine contractions. At this point, despite no expulsion of products of conception yet, the process of miscarriage is irreversible.

Explanation of options: (a) Threatened abortion – In this type, there is vaginal bleeding but the cervix remains closed, and the pregnancy may still continue successfully with rest and monitoring. (b) Inevitable abortion – This is the correct answer. It is diagnosed when abortion is in progress with cervical dilation and other signs that make continuation of pregnancy impossible. (c) Complete abortion – This refers to the complete expulsion of all products of conception from the uterus. It is a concluded event, not a progressive stage. (d) Missed abortion – In missed abortion, the fetus is non-viable but retained inside the uterus without any symptoms like bleeding or pain, and the cervix is closed.

Q24. Which hormone is produced by the placenta and helps in the development of mammary glands during pregnancy?

- (a) Estrogen
- (b) Progesterone
- (c) Human Placental Lactogen (hPL)
- (d) Relaxin

Ans.(c)

Sol. Human Placental Lactogen (hPL), produced by the placenta, plays a key role in preparing the mammary glands for lactation by promoting breast tissue development.

Explanation of each option:

- (a) Estrogen: Estrogen levels rise during pregnancy and are involved in the development of reproductive tissues, including the breasts. However, it does not specifically focus on preparing the mammary glands for lactation. Estrogen primarily aids in the formation of the ductal system in the breasts.
- (b) Progesterone: Progesterone supports early pregnancy by preparing the uterus for implantation and preventing uterine contractions. While it also plays a role in breast tissue growth, it is not the hormone responsible for developing mammary glands for lactation.
- (c) Human Placental Lactogen (hPL): Correct answer. hPL, produced by the placenta, directly impacts the development of the mammary glands by stimulating breast tissue growth and preparing them for lactation. It also helps to modify the maternal metabolism to ensure an adequate supply of nutrients for both the mother and fetus.
- (d) Relaxin: Relaxin is primarily involved in softening the cervix and relaxing the pelvic ligaments during labor. It does not directly contribute to the development of mammary glands.

Q25. Lochia serosa is normally seen during which days after delivery?

- (a) Day 1–3
- (b) Day 4–10
- (c) Day 11–14
- (d) After 15 days

Ans.(b)

Sol. Lochia serosa is a pink or brown discharge occurring between the 4th to 10th postpartum day. It contains leukocytes, mucus, and wound exudate but fewer red blood cells. Its presence reflects a normal healing process of the endometrium after delivery. It gradually transitions to lochia alba if no infection or complications occur.

Explanation of each option:

- (a) Day 1–3 – This phase is characterized by lochia rubra, which is bright red and mainly consists of blood and decidual tissue.
- (b) Day 4–10 – Correct. Lochia serosa is commonly seen during this period and is part of normal recovery.
- (c) Day 11–14 – Lochia alba, which is yellowish or white, typically starts appearing at this stage, replacing lochia serosa.
- (d) After 15 days – By this time, discharge becomes minimal or stops; presence of red or foul-smelling discharge here may indicate infection.

Q26. Which health care agency focuses on global health issues?

- (a) Public health agencies
- (b) International health agencies
- (c) National health agencies
- (d) Substance abuse agencies

Ans.(b)

Sol. Sol.: International health agencies, such as the World Health Organization (WHO), address global health issues, coordinate international cooperation, and manage global health crises.

Explanation of each option:

- (a) Public health agencies: Focus on national or local public health, not global health.
- (b) International health agencies: Correct answer. These agencies, like WHO, address health issues that cross borders.
- (c) National health agencies: Focus on the health of a single country, not the global community.
- (d) Substance abuse agencies: Focus on substance use disorders and recovery, not global health concerns.

Q27. Which chemical is a known occupational hazard for healthcare workers?

- (a) Mercury
- (b) Sodium chloride
- (c) Baking soda
- (d) Ethanol

Ans.(a)

Sol. Solution: Mercury, found in thermometers and some medical equipment, is toxic and can cause neurological and other health issues if mishandled. Explanation:

- (a) Mercury: Correct answer. A hazardous chemical, exposure to mercury is a known occupational hazard.
- (b) Sodium chloride: Common table salt, not a healthcare-specific hazard.
- (c) Baking soda: Not toxic or harmful in healthcare settings.
- (d) Ethanol: Widely used in healthcare, but not as hazardous as mercury.

Q28. At what age is the Pentavalent Vaccine (1st dose) given?

- (a) At birth
- (b) 6 weeks
- (c) 10 weeks
- (d) 14 weeks

Ans.(b)

Sol. Sol. The Pentavalent vaccine (1st dose) is administered at 6 weeks of age as part of the routine immunization schedule. This vaccine protects against five diseases: Diphtheria, Pertussis, Tetanus (DPT), Hepatitis B, and Haemophilus influenzae type B (Hib). It is given intramuscularly in the anterolateral thigh muscle.

Explanation of Options:

- (a) At birth: Vaccines given at birth include BCG, OPV (birth dose), and Hepatitis B (birth dose). The Pentavalent vaccine is not administered at birth.
- (b) 6 weeks: The 1st dose of the Pentavalent vaccine is given at 6 weeks of age, initiating protection against five serious diseases.
- (c) 10 weeks: The 2nd dose of the Pentavalent vaccine is given at 10 weeks, not the 1st dose.
- (d) 14 weeks: The 3rd dose of the Pentavalent vaccine is administered at 14 weeks, completing the primary vaccination schedule.

Q29. What is the role of the Janani Express Yojana in the referral system?

- (a) Distributes free medicines
- (b) Delivers food to patients
- (c) Provides free transport to health facilities
- (d) Sends mobile health vans to villages

Ans.(c)

Sol. Ans. (c)

Explanation: Janani Express Yojana ensures free and timely transportation of pregnant women and sick newborns from home to health facility and back, thus strengthening the referral system under RMNCH+A.

Q30. Under which national health strategy are MCH Wings primarily developed?

- (a) Ayushman Bharat
- (b) National Urban Health Mission
- (c) RMNCH+A under NHM
- (d) National Mental Health Programme

Ans.(c)

Sol. Ans. (c) Explanation: MCH Wings are part of infrastructure strengthening under RMNCH+A, which is a key pillar of the National Health Mission (NHM). It aims to provide continuum of care and reduce maternal and child mortality through institutional support.

Q31. Audio-visual aids in health education are used to:

- (a) Make the session boring
- (b) Confuse the audience
- (c) Clarify and reinforce messages
- (d) Replace verbal teaching

Ans.(c)

Sol. Audio-visual (AV) aids are essential tools in health education to simplify, clarify, and reinforce complex information. These include charts, posters, flip charts, videos, and projectors that combine visual and auditory elements to make the learning process more engaging and memorable. AV aids cater to different learning styles and help improve understanding and retention, especially in populations with low literacy. They do not aim to replace verbal teaching but to support and strengthen it. Effective use of AV materials increases participation, stimulates interest, and aids in long-term behavior change.

Explanation of each option:

- (a) Make the session boring – This is incorrect. AV aids are specifically used to make learning more dynamic and engaging. When used properly, they enhance rather than diminish interest.
- (b) Confuse the audience – AV aids, when selected and used appropriately, help simplify concepts. Poorly designed aids may confuse, but that's due to poor execution, not the inherent nature of AV aids.
- (c) Clarify and reinforce messages – Correct. AV aids break down difficult concepts, use visual memory cues, and provide repetition, which helps reinforce key health messages effectively.
- (d) Replace verbal teaching – AV aids complement verbal teaching but cannot replace the interaction and explanation provided by a health educator.

Q32. The food supplements in the Mid-Day Meal Scheme should provide a minimum of:

- (a) 300 calories with 5 gm of proteins
- (b) 250 calories with 5 to 10 gm of proteins
- (c) 300 calories with 8 to 12 gm of protein
- (d) 250 calories with 8 to 12 gm of protein

Ans.(c)

Sol. As per the Mid-Day Meal Scheme (MDMS) guidelines in India, the nutritional content of the meal should ensure a minimum of 300 kilocalories and 8–12 grams of protein per child per school day for primary classes. This standard is designed to improve nutritional levels among children and promote better school attendance and performance.

Explanation of options: (a) 300 calories with 5 gm of proteins – The calorie count is correct, but protein quantity is too low, making it insufficient. (b) 250 calories with 5 to 10 gm of proteins – Falls short in calories compared to the minimum requirement under the scheme. (c) 300 calories with 8 to 12 gm of protein – This is the correct answer. It aligns with national nutritional standards for school children. (d) 250 calories with 8 to 12 gm of protein – While protein range is acceptable, calories are lower than the prescribed minimum.

Q33. Which committee is also known as the 'Health Survey and Planning Committee'?

- (a) Shrivatsav Committee
- (b) Jungalwalla Committee
- (c) Mudaliar Committee
- (d) Bhore Committee

Ans.(c)

Sol. The Mudaliar Committee, officially known as the Health Survey and Planning Committee (1962), was established to assess the recommendations of the Bhore Committee and evaluate the progress of health development in India. It emphasized strengthening district hospitals, improving the quality of medical education, and reducing the doctor-to-population ratio. It laid the foundation for improving secondary-level health care services in India.

Explanation of options: (a) Shrivatsav Committee – This committee focused on the integration of health services and development of community health workers. (b) Jungalwalla Committee – Known for suggesting integration of medical and health services, particularly focusing on unified cadre and service conditions. (c) Mudaliar Committee – This is the correct answer. It is officially referred to as the Health Survey and Planning Committee. (d) Bhore Committee – It was the Health Survey and Development Committee (1946) and focused on establishing a comprehensive health service system for India.

Q34. A client diagnosed with generalized anxiety disorder is prescribed buspirone (BuSpar). Which statement by the client indicates a need for further teaching?

- (a) "I can take this medication whenever I feel anxious."
- (b) "It may take a few weeks before I notice an improvement in my anxiety."
- (c) "I should avoid drinking alcohol while taking this medication."
- (d) "I need to take this medication consistently as prescribed."

Ans.(a)

Sol. Ans. (a) "I can take this medication whenever I feel anxious."

Explanation:

Buspirone (BuSpar) is **not a PRN (as-needed) medication** like benzodiazepines (e.g., lorazepam, alprazolam). It must be **taken consistently** as prescribed to be effective, and it **may take 2-4 weeks for therapeutic effects** to appear. This response suggests the client misunderstands how to use the medication, indicating the need for further teaching.

Why Other Options Are Incorrect:

(b) "It may take a few weeks before I notice an improvement in my anxiety." ☒ **Correct statement**

Buspirone **does not provide immediate relief**; its therapeutic effects develop over time.

(c) "I should avoid drinking alcohol while taking this medication." ☒ **Correct statement**

Alcohol can increase **CNS depression** and should be avoided.

(d) "I need to take this medication consistently as prescribed." ☒ **Correct statement**

Buspirone must be taken **regularly** to maintain its effectiveness.

Key Nursing Approach:

☒ **Educate the client** that Buspirone is a long-term anxiety treatment and **not for immediate relief**.

☒ **Reinforce adherence** to scheduled dosing. ☒ **Monitor for side effects** such as dizziness, nausea, or headache.

Q35. A client with schizophrenia is experiencing auditory hallucinations. Which nursing intervention is most appropriate?

- (a) Encourage the client to listen to music to distract from the hallucinations.
- (b) Tell the client that the voices are not real.
- (c) Instruct the client to avoid discussing the hallucinations.
- (d) Advise the client to focus on the hallucinations to understand them better.

Ans.(a)

Sol. Ans. (a) Encourage the client to listen to music to distract from the hallucinations.

Explanation:

Encouraging the client to listen to music provides a **positive distraction** and helps them focus on external stimuli rather than the hallucinations. This approach can reduce the intensity of the auditory hallucinations and promote **emotional stability**.

Why Other Options Are Incorrect:

(b) Tell the client that the voices are not real. ☒

This dismisses the client's experience and may increase **distress and mistrust**. Clients with schizophrenia often perceive hallucinations as real and challenging their validity may escalate their anxiety.

(c) Instruct the client to avoid discussing the hallucinations. ✗

Avoiding discussion can make the client feel invalidated and **discourage open communication**. Acknowledging their experience is essential for building trust.

(d) Advise the client to focus on the hallucinations to understand them better. ✗

Focusing on the hallucinations can increase the client's **distress and preoccupation** with the voices, worsening their symptoms.

Key Nursing Approach:

✓ **Encourage distractions** like music or activities to help the client focus on external, real-world stimuli.

✓ **Acknowledge the client's experience** without agreeing or dismissing the hallucination. ✓ **Promote coping strategies** to help the client manage their symptoms effectively.

Q36. A client tells a nurse, "Everyone would be better off if I wasn't alive." Which nursing diagnosis would be made based on this statement?

- (a) Disturbed thought processes
- (b) Ineffective coping
- (c) Risk for self-directed violence
- (d) Impaired social interaction

Ans.(c)

Sol. Ans. (c) Risk for self-directed violence

Explanation:

The client's statement **suggests suicidal ideation** and **potential self-harm risk**. The most appropriate nursing diagnosis is "**Risk for self-directed violence**," as it indicates the need for immediate intervention to ensure safety.

Why Other Options Are Incorrect:

(a) Disturbed thought processes ✗

This diagnosis is more appropriate for clients with **delusions, hallucinations, or disorganized thinking**, which is not evident here.

(b) Ineffective coping ✗

While the client may have difficulty coping, **suicidal ideation** takes priority over general coping issues.

(d) Impaired social interaction ✗

Social withdrawal may be a symptom, but **suicidal ideation requires urgent intervention**, making **risk for self-directed violence** the priority diagnosis.

Key Nursing Approach:

✓ **Assess for suicide risk (plan, means, intent)** ✓ **Ensure immediate safety (supervision, hospitalization if needed)** ✓ **Provide emotional support and crisis intervention**

Q37. A client with obsessive-compulsive disorder (OCD) spends several hours each day washing their hands. What is the most appropriate initial nursing intervention?

- (a) Allow the client to continue the behavior to reduce anxiety.
- (b) Restrict the client's access to washing facilities.
- (c) Encourage the client to participate in a scheduled activity when the urge to wash hands arises.
- (d) Explain to the client that the behavior is irrational.

Ans.(c)

Sol. Ans. (c) Encourage the client to participate in a scheduled activity when the urge to wash hands arises.

Explanation:

OCD is characterized by **obsessions (intrusive thoughts)** and **compulsions (repetitive behaviors)** that are performed to reduce anxiety. Encouraging the client to participate in **alternative activities** helps provide a **distraction** from the compulsion and gradually reduces reliance on it. This approach is part of **behavioral therapy** to help manage OCD symptoms.

Why Other Options Are Incorrect:

(a) Allow the client to continue the behavior to reduce anxiety. ✗

Allowing compulsions to continue **reinforces** them and does not help the client develop healthier coping strategies.

(b) Restrict the client's access to washing facilities. ✗

This may **increase distress and resistance**, leading to heightened anxiety and agitation. A gradual approach is more effective.

(d) Explain to the client that the behavior is irrational. ✗

Clients with OCD **already recognize** that their compulsions are excessive, but they feel **unable to stop** due to overwhelming anxiety. Simply telling them it's irrational is not helpful.

Key Nursing Approach:

✓ **Encourage alternative activities** to break the compulsive cycle. ✓ **Use gradual exposure therapy** instead of sudden restrictions. ✓ **Provide support** and help the client develop healthier coping mechanisms.

Q38. During a group therapy session, a client diagnosed with bipolar disorder becomes increasingly agitated and disruptive. What is the nurse's best course of action?

- (a) Ask the client to leave the session immediately.
- (b) Attempt to de-escalate the situation by speaking calmly to the client.
- (c) Ignore the behavior to avoid reinforcing it.
- (d) Restrain the client to prevent harm to others.

Ans.(b)

Sol. Ans. (b) Attempt to de-escalate the situation by speaking calmly to the client.

Explanation:

Speaking calmly to the client is the **most appropriate first action** to **de-escalate agitation**. A calm and reassuring tone can help reduce the client's distress and prevent escalation. This intervention prioritizes maintaining the safety of the group while preserving the therapeutic environment.

Why Other Options Are Incorrect:

(a) Ask the client to leave the session immediately. ✗

Asking the client to leave without first attempting de-escalation may increase their **agitation** and reinforce feelings of rejection or isolation.

(c) Ignore the behavior to avoid reinforcing it. ✗

Ignoring the behavior can allow it to escalate, potentially disrupting the group further and risking harm.

(d) Restrain the client to prevent harm to others. ✗

Restraint is a **last resort** used only if the client poses an immediate danger to themselves or others, and all other measures have failed.

Key Nursing Approach:

✓ **De-escalate first** with a calm and supportive approach. ✓ **Protect the therapeutic environment** while addressing the client's behavior. ✓ Use **restraint or removal** only if the situation escalates to a safety concern.

Q39. What type of delusion is most common in schizophrenia?

- (a) Believing they are being watched.
- (b) Believing they are a celebrity.
- (c) Believing their thoughts are controlled.
- (d) Believing they can fly.

Ans.(a)

Sol. Believing they are being watched: This is the most common type of delusion seen in schizophrenia, known as persecutory delusions. Believing they are a celebrity: While possible, grandiose delusions are less common. Believing their thoughts are controlled: This is also a known delusion but less frequent than persecutory types. Believing they can fly: Delusions of this nature are rare and usually seen in other psychiatric disorders.

Q40. Attention-deficit hyperactivity disorder (ADHD) is characterized by all of the following EXCEPT:

- (a) Impulsivity.
- (b) Inattention.
- (c) Hyperactivity.
- (d) Social withdrawal.

Ans.(d)

Sol. Ans: (d) Social withdrawal.

Explanation:

Attention-deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder with symptoms that include **impulsivity**, **inattention**, and **hyperactivity**. These symptoms can interfere with social, academic, and occupational functioning.

Key Symptoms of ADHD:**1. Impulsivity (Option a):**

This involves acting without thinking, interrupting others, difficulty waiting for one's turn, or making quick decisions without considering the consequences.

2. Inattention (Option b):

Individuals with ADHD may find it hard to focus on tasks, get easily distracted, have difficulty organizing activities, and fail to pay attention to details.

3. Hyperactivity (Option c):

This may manifest as constant movement, fidgeting, an inability to stay seated, excessive talking, or feeling restless.

Why Social Withdrawal Is NOT a Characteristic:

Social withdrawal (Option d) is **not a common symptom** of ADHD. Children and adults with ADHD are often socially active but may struggle with social interactions due to their impulsivity and hyperactive behavior, making it difficult for them to follow social cues.

While they may have difficulties forming friendships or maintaining social boundaries, it typically stems from impulsive behavior or lack of focus rather than a deliberate desire to withdraw from social contact.

Social withdrawal is more commonly associated with conditions like **anxiety disorders, depression, or autism spectrum disorders** where individuals may avoid social interactions or isolate themselves due to fear, anxiety, or a lack of social interest.

Summary:

ADHD is characterized by **impulsivity, inattention, and hyperactivity**. Social withdrawal is not a typical feature, making **(d) Social withdrawal** the correct answer as it **does not** describe a primary characteristic of ADHD.

Q41. The Integrated Child Development Services (ICDS) scheme focuses on improving the health and nutrition of:

- (a) Adolescents
- (b) Pregnant women and children below 6 years
- (c) Elderly population
- (d) School-going children

Ans.(b)

Sol. Ans (b) The **Integrated Child Development Services (ICDS)** scheme is a government program aimed at improving the nutrition and health status of **pregnant women and children below 6 years of age**, as well as **lactating mothers and adolescent girls** in some components. The ICDS provides a package of services, including supplementary nutrition, health check-ups, immunization, and pre-school education.

Information Booster:

1. **Launched in 1975**, ICDS is one of the world's largest programs for early childhood development.

2. **Services provided under ICDS:**

Supplementary Nutrition: Provides nutrition to malnourished children, pregnant and lactating women.

Immunization: Vaccination against preventable diseases like polio, measles, etc.

Health Check-ups: Regular health monitoring of children and mothers.

Pre-school non-formal education: Learning and cognitive development for children aged 3 to 6 years.

Referral Services: Referring children and mothers to health facilities when needed.

Nutrition and Health Education: To promote health-seeking behavior and improve nutrition intake.

3. The program is implemented through **Anganwadi centres** located in villages and urban slums. Anganwadi workers are key field functionaries who deliver the services of ICDS.

4. **Target beneficiaries:**

Children below 6 years of age

Pregnant and lactating mothers

Adolescent girls (in some states under special schemes)

Q42. At what age does the Moro reflex, where the infant startles and extends arms and legs before pulling them back in, typically disappear?

- (a) 3-4 months
- (b) 6-9 months
- (c) 9-12 months
- (d) 12-15 months

Ans.(a)

Sol. Ans. (a) Sol. The Moro reflex, also known as the startle reflex, is a primitive reflex that is present at birth and typically disappears by 3-4 months of age. This reflex is triggered when a baby experiences a sensation of falling or hears a loud noise. The infant responds by extending their arms and legs, then retracting them, often with a cry. For example, if a baby is suddenly lowered slightly while lying down, they might throw their arms out as if to catch themselves.

Q43. Which hereditary disease is most closely linked to aneurysm?

- (a) Cystic fibrosis
- (b) Lupus erythematosus
- (c) Myocardial infarction
- (d) Marfan's syndrome

Ans.(d)

Sol. Answer:(d) Marfan's syndrome

Explanation:

- **Marfan syndrome** is a genetic disorder that affects the body's connective tissue. This connective tissue helps to support the body's structures, including blood vessels. People with Marfan syndrome are at a higher risk of developing aortic aneurysms, which are bulges in the aorta, the main artery that carries blood from the heart to the rest of the body.
- **Cystic fibrosis** is a genetic disorder that affects the lungs and other organs.
- **Lupus erythematosus** is an autoimmune disease that can cause inflammation throughout the body.
- **Myocardial infarction** is a heart attack and is not a hereditary disease.

Therefore, Marfan's syndrome is the most closely linked hereditary disease to aneurysm.

Q44. A newborn is most likely to experience hypoglycemia due to:

- (a) Immature lungs
- (b) Immature liver
- (c) Immature kidneys
- (d) Immature intestines

Ans.(b)

Sol. Immature liver

Explanation:

- The liver is responsible for converting glycogen (stored glucose) into glucose when blood sugar levels drop.
- In newborns, the liver is immature and may not be able to produce enough glucose to maintain normal blood sugar levels.
- This, combined with other factors like low glycogen stores at birth, makes newborns susceptible to hypoglycemia.

While the other options (immature lungs, kidneys, and intestines) can contribute to other health issues, they are not directly responsible for hypoglycemia in newborns.

Q45. A newborn is diagnosed with patent ductus arteriosus (PDA), a condition where a fetal blood vessel fails to close after birth. Which assessment finding would be MOST concerning for this infant?

- (a) Slow heart rate (bradycardia)
- (b) Weak peripheral pulses
- (c) Persistent feeding difficulties
- (d) Lethargy

Ans.(c)

Sol. (c) Persistent feeding difficulties

Explanation-

A patent ductus arteriosus (PDA) allows blood to bypass the lungs, increasing the workload on the heart. This can lead to heart failure, which manifests in symptoms such as poor feeding, rapid breathing, sweating, and failure to gain weight.

While bradycardia, weak pulses, and lethargy can also be indicative of heart problems, persistent feeding difficulties are a more specific and concerning sign of heart failure in this context.

Q46. A 6-year-old child presents with sudden onset of pain in the hip, following a recent upper respiratory infection. This is most likely a case of:

- (a) Septic Arthritis
- (b) Tubercular Arthritis
- (c) Transient Synovitis
- (d) Juvenile Idiopathic Arthritis (JIA)

Ans.(c)

Sol.

c) Transient Synovitis

Here's why the other options are less likely:

- **a) Septic Arthritis:** This is a serious infection of the joint and typically presents with fever, redness, and severe pain. While it can occur in children, it's less common than transient synovitis and wouldn't necessarily follow a respiratory infection.
- **b) Tubercular Arthritis:** This is a rare form of arthritis caused by tuberculosis bacteria. It usually develops gradually and wouldn't typically follow a recent upper respiratory infection.
- **d) Juvenile Idiopathic Arthritis (JIA):** While JIA can affect children as young as 6, it usually has a more prolonged course than the sudden onset described here.

Transient synovitis is a common condition in children that causes temporary inflammation in the hip joint. It often follows a viral illness and presents with sudden hip pain, sometimes with limping. It typically resolves within a few days without any long-term complications.

Q47. In neonates, which of the following mechanisms is primarily responsible for heat generation?

- (a) Shivering
- (b) Vasoconstriction
- (c) Brown adipose tissue metabolism
- (d) Increased physical activity

Ans.(c)

Sol. Ans. (c) In neonates, brown adipose tissue (BAT) metabolism is primarily responsible for heat generation. Unlike adults, who rely on mechanisms like shivering and vasoconstriction to generate heat, neonates have a special type of fat known as brown adipose tissue. BAT is highly vascularized and contains a higher number of mitochondria, which enables it to generate heat through non-shivering thermogenesis. This process helps newborns maintain their body temperature, especially in the early days after birth, as they have limited ability to generate heat through muscle activity or shivering. Therefore, option (c) is the correct answer.

Q48. In an infant with a large VSD, What sign is most commonly observed?

- (a) Failure to thrive.
- (b) Cyanosis.
- (c) High blood pressure.
- (d) Clubbing of fingers.

Ans.(a)

Sol. Ans. (a)

Failure to thrive is the most commonly observed sign in an infant with a large ventricular septal defect (VSD). A large VSD allows blood to flow from the left ventricle to the right ventricle, leading to increased pulmonary blood flow. This results in congestive heart failure, causing the infant to be unable to gain weight and grow properly, thus presenting with failure to thrive.

Other Options:

- (b) Cyanosis: While cyanosis can occur in some cases of VSD, it is more commonly associated with defects that cause right-to-left shunting. In large VSDs, the shunting is typically left-to-right, resulting in increased blood flow to the lungs rather than systemic cyanosis.
- (c) High blood pressure: High blood pressure is not a typical sign of a large VSD. In fact, infants with significant left-to-right shunting often present with signs of heart failure rather than hypertension.
- (d) Clubbing of fingers: Clubbing is usually associated with chronic hypoxia and cyanotic heart defects. In cases of large VSD, clubbing may not be present unless the condition leads to significant pulmonary hypertension over time.

Failure to thrive is the most significant clinical sign observed in infants with large VSD due to the heart's inability to maintain adequate circulation and nutrition.

Q49. At what age do most babies start to sit without support?

- (a) 3 Months
- (b) 6 Months
- (c) 9 Months
- (d) 1 Year

Ans.(b)

Sol. Ans. (b)

3 Months: Babies can hold their head up but can't sit without support.

6 Months: Most babies can sit without support around this time.

9 Months: Babies are usually more mobile, crawling, and pulling up.

1 Year: Babies are starting to stand or walk.

Q50. The correct method to dispose of used syringes and needles is to

- (a) Recap and place in yellow bag
- (b) Break needle manually before disposal
- (c) Place directly in white translucent puncture-proof container
- (d) Wash and reuse after boiling

Ans.(c)

Sol. Sharps are discarded immediately after use into white translucent puncture-proof containers to avoid needle-stick injuries.

Explanation of options: (a) **X** – Recapping causes accidental pricks. (b) **X** – Manual breaking unsafe. (c) **✓** – Standard practice as per BMW Rules 2016. (d) **X** – Reuse of syringes is strictly prohibited.



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