Practice Exam Questions

ABWM

American Board of Wound Management

CWS

Certified Wound Specialist

EXAMAIDES

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Total Question: 330 QAs

Question No: 1
Which one of the following wound care products is covered by Medicare Part B?
A. Skin sealant
B. Wound cleanser
C. Gauze used for cleaning a wound
D. Adhesive tape
Answer: D
Explanation: Medicare Part B covers primary dressings that are applied to a wound as well as secondary dressing supplies, such as adhesive tape, roller gauze, and bandages. Skin sealants, wound cleansers, and gauze used for cleansing a wound that are then discarded are not covered. In order for the costs of dressing supplies to be covered by Medicare, they must be medically necessary. Wound care products are considered medically necessary for surgical wounds left open, infected open wounds, autoimmune disorder wounds, necrotic tissue wounds, and burns- but not for minor injuries.

Question No: 2
The primary role(s) of the lymphatic system related to wound healing is (are):
A. providing an immune response and managing fluid
B. prolonging the inflammatory phase
C. providing nutrition
D. promoting granulation
Answer: A
Explanation: The primary roles of the lymphatic system related to wound healing are providing an immune response and managing fluid. These functions help prevent infection. The lymphatic system regulates immune responses by transporting antigens via lymphatics to lymph nodes where they generate an immune response. If the lymphatic system is impaired and cannot drain freely, then the inflammatory phase of healing may be prolonged, resulting in fibrosis of the tissue. An indication that lymphatic drainage is impaired is persistent edema around a wound.

Question No: 3
Older patients are more prone to xerosis than younger patients because of:
A. thinning of the epidermis
B. sun exposure over extended periods
C. inflammation of the skin
D. loss of sebaceous and sweat glands
Answer: D
Explanation: Older patients are more prone to xerosis (dry skin) than are younger patients because of the loss of sebaceous and sweat glands associated with aging. This allows for excessive transepidermal water loss. Various factors may contribute to xerosis, including underlying diseases such as diabetes; overbathing; harsh soaps; sun damage; and exposure to wind, dry heat, and air conditioning. The stratum corneum requires 10% moisture content to prevent xerosis. Treatment for xerosis includes application of moisturizers that contain lipids, which helps to prevent water loss.

Question No: 4
Debridement that includes debriding up to viable tissue is classified as:
A. noninvasive debridement
B. surgical debridement
C. conservative debridement
D. invasive debridement
Answer: C
Explanation: Debridement that includes debriding up to viable tissue is classified as conservative debridement, whereas debridement into viable tissue is classified as surgical debridement. Other forms of debridement, such as autolytic debridement and enzymatic debridement, are classified as noninvasive debridement. State regulations vary as to which health-care professionals are allowed to carry out conservative or surgical debridement, whereas any health-care provider allowed to do wound care can perform noninvasive debridement.

Question No: 5
Which one of the following may be applied to an infant's skin to treat and prevent diaper rash?
A. Baking soda
B. Benzocaine
C. Zinc oxide
D. Boric acid
Answer: C
Explanation: Zinc oxide may be applied to an infant's skin to treat and prevent diaper rash. Zinc oxide is included in many diaper rash products because it provides an effective barrier to prevent urine and feces from irritating the skin. Petroleum jelly may also be applied to the skin, but products containing boric acid, phenol, or benzocaine may be toxic to infants. Baking soda should also be avoided. Powder is no longer recommended because of the danger that the infant could inhale it, and talc has been implicated in ovarian cancer.

Question No: 6
A patient with an arterial ulcer is a heavy smoker. The best approach to gaining the patient's cooperation in smoking cessation is to:
A. warn the patient of the risk of amputation due to poor circulation
B. provide the patient with smoking cessation aids
C. ask what the patient intends to do about quitting smoking
D. enlist family members to pressure the patient to quit
Answer: B
Explanation: If a patient with an arterial ulcer is a heavy smoker, the best approach to gaining the patient's cooperation in smoking cessation is to provide smoking cessation aids and information about the effects of smoking. Smoking cessation aids may include smoking cessation support groups or programs, nicotine replacement products (patches, inhalers, gum), or prescript ion drugs (bupropion SR, varenicline). Smoking releases carbon monoxide and hydrogen cyanide in the blood and interferes with the delivery of oxygen to the t issues, an nicotine is a vasoconstrictor, resulting in slowed healing.

Question No: 7
The main cause of skin aging is:
A. mechanical damage
B. exposure to ultraviolet (UV) light
C. air pollution
D. exposure to cigarette smoke
Answer: B
Explanation: The main cause of skin aging is exposure to ultraviolet (UV) light. This is an extrinsic cause that may result from exposure to UVA (5% of UV rays) and UVB light. UVA is more associated with aging of the skin because it penetrates more deeply than UVB, but it also damages cells. UVB, on the other hand, is associated with burning, but it also damages the top layers of the skin and can lead to DNA changes that, along with the effects of UVA, result in skin cancer.

Question No: 8
According to the Payne-Martin classification for skin tears, if a patient has a partial-thickness skin tear with a flap that covers the wound with only 0.9 mm of dermis exposed, this would be classified as:
A. category 0
B. category I
C. category II
D. category III
Answer: B
Explanation: Category I. Payne-Martin classification for skin tears. Categories:

I	**Skin tear without tissue loss**	• Linear: Full-thickness wound in wrinkle or furrow, epidermis and dermis pulled apart • Flap: Partial-thickness wound with a flap that can cover the wound with ≤1 mm of the dermis exposed
II	**Skin tear with partial tissue loss**	• Scant tissue loss: Partial-thickness injury and loss of ≤25% of the epidermal flap • Moderate-to-large tissue loss: Partial-thickness injury with loss of >25% of the epidermal flap
III	**Skin tear with complete tissue loss**	Partial-thickness injury with complete loss of the epidermal flap

Question No: 9
Vasculitis is considered what type of disorder?
A. Infectious
B. Autoimmune
C. Genetic
D. Malignant
Answer: B
Explanation: Vasculitis is considered an autoimmune disorder. There are approximately 20 different types of vasculitis, and they affect different organs and have differing levels of severity. General signs and symptoms

common to the different types include fever, weight loss, malaise, widespread purpura, muscle pain, joint pain, neuritis, tinnitus, impaired vision, hypertension, hemoptysis, epistaxis, hematochezia, and abdominal pain. Some types of vasculitis that affect the skin (as well as other organs) include cutaneous small vessel eosinophilic granulomatosis with polyangiitis and Kawasaki disease.

Question No: 10
If a pressure injury has failed to heal despite appropriate antibiotic therapy and optimal treatment, exhibits delayed healing and increased exudate with poor granulation, and low-grade erythema is noted around the wound, these are most likely indications of:
A. local infection
B. increasingly poor perfusion
C. allergic response
D. biofilm development
Answer: D
Explanation: If a pressure injury has failed to heal despite appropriate antibiotic therapy and optimal treatment, exhibits delayed healing and increased exudate with poor granulation, and low-grade erythema is noted around the wound, these are most likely indications of biofilm development. A biofilm is a dense, thin layer of bacteria in a moist adhesive matrix of secreted polymers that clings to the surface of wounds. Multiple bacteria may be present in a biofilm. The biofilm is resistant to antibiotics and to phagocytosis by white blood cells, resulting in degrading and/or nonhealing wounds.

Question No: 11
When using biodebridement with medical maggots, the maggots should NOT be left in place on a wound for more than:
A. 48 hours
B. 72 hours
C. 96 hours
D. 120 hours
Answer: B
Explanation: If using biodebridement with medical maggots, the maggots should not be left in place on a wound for more than 72 hours. After this time, the maggots will begin to migrate and form pupae and will no longer be useful. Maggots debride the wound through the secretion of enzymes. Maggots also reduce infection by digesting bacteria and stimulate granulation. Maggots have two probing appendages that help to mechanically debride a wound. Maggot therapy has been used successfully with various types of wounds, including venous stasis ulcers and diabetic ulcers.

Question No: 12
When using the Modified Wagner Diabetic Foot Ulcer Classification System to assess a patient's foot ulcer, if the ulcer is full thickness and extends to the bone with osteomyelitis present, this classified as:
A. grade 1
B. grade 2
C. grade 3
D. grade 4
Answer: C

Explanation: Grade 3. Modified Wagner Diabetic Foot Ulcer Classification System, Grades:

0	Preulcerative and at risk, skin intact; healed ulcers or bony deformities may be evident.
1	Superficial ulcer, extending into subcutaneous tissue; superficial infection with/without cellulitis.
2	Full-thickness ulcer to tendon, capsule, or joint; no abscess/osteomyelitis.
3	Full-thickness ulcer that may extend to bone with abscess, osteomyelitis, or sepsis of joint; may include deep plantar infections, abscesses, fasciitis, or tendon sheath infection.
4	Gangrene of the forefoot; the rest of the foot is salvageable.
5	Gangrene of the entire foot; amputation is required.

Question No: 13
According to Centers for Medicare & Medicaid Services (CMS) rules regarding standing orders and protocols, they must be:
A. approved by a consensus of the staff
B. developed in house
C. evidence based
D. reviewed at least biennially
Answer: C
Explanation: According to Centers for Medicare & Medicaid Services (CMS) rules regarding standing orders and protocols, they must be evidence based-that is, based on research and best practices. Standing orders are those authorized by the health-care team for specific diagnoses, so is not necessary to obtain a physician's order directly. The purpose of using standing orders and protocols is to ensure consistency in treatment and that staff members can be trained in the orders and protocols and are well prepared to provide optimal-quality care.

Question No: 14
When vibration perception is used to assess sensory status, how long should a patient without sensory neuropathy feel vibrations with a tuning fork applied to the head of the first metatarsal?
A. >5 seconds
B. >10 seconds
C. >15 seconds
D. >20 seconds
Answer: C
Explanation: If using vibration percept ion to assess sensory status, a patient without sensory neuropathy should feel vibrations with a tuning fork applied to the head of the first metatarsal for more than 15 seconds. If the patient does not feel the vibration at all or feels it for a shorter time, this is an indication that the patient has sensory neuropathy. A 128 Hz tuning fork is used for this test, and the patient is instructed to report when he or she first fee ls a vibration and when it stops. A t rial run should be conducted on the hand or arm of the patient so the patient is aware of the sensation to report.

Question No: 15

What is a disadvantage of using petroleum jelly as a skin barrier to prevent maceration?
A. It may cause contact dermatitis
B. It may evaporate
C. It may obscure the underlying tissue
D. It may liquify with heat
Answer: D
Explanation: A disadvantage of using petroleum jelly as a skin barrier to prevent maceration is that it may liquify with heat so that it no longer provides an adequate barrier. Zinc oxide may also be used as a skin barrier; however, because it is opaque, it does not allow visualization of the underlying skin. Other options include liquid film barriers, windowed dressings, and external collection/pouching devices. In some cases, the choice of dressing type may help reduce drainage, such as using alginate packing.

Question No: 16
During which one of the following stages of healing is granulation tissue produced?
A. Hemostasis
B. Inflammation
C. Proliferation
D. Remodeling/Maturation
Answer: C
Explanation: Granulation tissue is produced during the proliferation phase of healing. Phases of healing are as follows:
• Hemostasis (sometimes included as part of the inflammation phase; occurs within minutes of injury): Platelets seal vessels, and thrombin stimulates the clotting mechanism.
• Inflammation (1-5 days): Inflammatory cells seek out and destroy bacteria. Erythema, edema, and pain are present.
• Proliferation (2- 3 weeks): Granulation forms along with epithelization and wound contracture.
• Remodeling/Maturation (up to 2 years): New collagen forms, scarring is reduced, and tissue gains tensile strength.

Question No: 17
If cherry angiomas suddenly develop in large numbers, this may be an indication of:
A. internal malignancy
B. infection
C. impaired circulation
D. colonic polyps
Answer: A
Explanation: If cherry angiomas suddenly develop in large numbers, this may be an indication of internal malignancy (solid tumors). Eruptive cherry angiomas are also associated with human herpesvirus-8 and graft-versus-host disease, and they are seen as an adverse effect to treatment with topical nitrogen mustard, cyclosporine, and ramucirumab. Cherry angiomas are common lesions associated with aging, are typically benign, and can be found on any part of the body. They are small, red-purple vascular lesions that bleed easily if traumatized.

Question No: 18

If a patient has hemosiderin staining on the lower extremities, preventive measures should be taken to prevent:
A. arterial ulcers
B. skin tears
C. infection
D. venous ulcers
Answer: D
Explanation: If a patient has hemosiderin staining on the lower extremities, preventive measures should be taken to prevent venous ulcers. Hemosiderin staining is an indication of chronic venous hypertension. The staining results from leaking of red blood cells into the t issue from damaged vessels. Over time, changes in the texture of the skin occur, and the skin appears shiny and taut with a pronounced lack of elasticity that can easily lead to tissue breakdown and ulcers.

Question No: 19
A patient called and asked for pain medication, but when the nurse comes to the room with an analgesic, the patient is sleeping. This probably indicates that:
A. the patient did not actually have pain
B. the patient is sleeping despite having pain
C. the pain is subsiding without intervention
D. the pain has increased in intensity
Answer: B
Explanation: If a patient called and asked for pain medication, but, when the nurse comes to the room with an analgesic, the patient is sleeping, this probably indicates that the patient is sleeping despite having pain. Although people with persistent pain often have difficulty falling asleep, pain can be debilitating and tiring, so one should not assume that just because a patient falls asleep after complaining of pain that the pain is less severe than the patient had reported. However, the patient's quality of sleep may be impaired. That is, the patient may be restless or arouse easily.

Question No: 20
How long after exposure to the sun do the redness and burning associated with sunburn usually occur?
A. 1-2 hours
B. 2-4 hours
C. 4-6 hours
D. 6- 8 hours
Answer: B
Explanation: The redness and burning associated with sunburn usually occur 2- 4 hours after exposure to the sun and do not peak for 24 hours. Because of this, people exposed to the sun often are unaware that they have gotten sunburned until hours later, even with second-degree burns and blistering. First-degree sunburns involve only the epidermis and are characterized by redness and pain. Second-degree sunburns extend into the dermis and cause pain, blistering, and swelling.

Question No: 21
The outermost layer of the epidermis is the:
A. stratum lucidum
B. stratum granulosum

C. stratum corneum
D. stratum spinosum
Answer: C
Explanation: Layers of the skin are as follows:
• Stratum corneum: Outermost layer of the skin, a keratin layer that protects the skin and retains moisture.
• Stratum lucidum: Transparent layer, found on the palms of the hands and soles of the feet.
• Stratum granulosum: Prevents water loss.
• Stratum spinosum: Maintains flexibility and strength.
• Stratum basale: Deepest layer in which new skin cells develop; it contains keratin and melanocytes.

Question No: 22
With a support surface, envelopment refers to:
A. the ability to redistribute load
B. the ability to conform to irregularities in the patient's body
C. the change in pressure over a distance
D. the depth of penetration into the support surface
Answer: B
Explanation: With a support surface, envelopment refers to the ability to conform to irregularities in the patient's body, which may be caused by bony protuberances, clothing, or bedding. The pressure gradient (or pressure differential) is the change in pressure over a distance. Pressure redistribution is the ability to redistribute a load. Immersion is the depth of penetration into a support surface. The immersion depth varies depending on the thickness of the support surface and its elasticity or stiffness.

Question No: 23
Which one of the following wound care treatments is used to stimulate the production of granulation tissue in diabetic neuropathic ulcers?
A. Becaplermin gel 0.01%
B. A sodium chloride dressing
C. Castor oil
D. Manuka honey
Answer: A
Explanation: Becaplermin gel 0.01% is used to stimulate production of granulation tissue in diabetic neuropathic ulcers. Becaplermin is a genetically engineered product from human platelet-derived growth factors.
The product must be kept under refrigeration, and its use is contraindicated if the wound is infected or has necrotic t issue. Becaplermin is spread on the wound to a layer approximately 2 mm deep once daily, covered with a moist gauze dressing, and left in place for 12 hours. After this time, the dressing is removed and the wound is rinsed with normal saline.

Question No: 24
Which one of the following vitamins is an antioxidant that plays an essential role in collagen synthesis?
A. Vitamin D
B. Vitamin K
C. Vitamin A

D. Vitamin C
Answer: D
Explanation: Vitamin C (i.e., ascorbic acid) is an antioxidant that plays an essential role in collagen synthesis. Vitamin C also facilitates the absorption of iron, activates copper, and contributes to the immune response. The recommended daily intake is 60- 90 mg per day. Vitamin C is found in citrus fruits such as oranges, lemons, grapefruit; bell peppers; tomatoes; white potatoes; and cruciferous vegetables such as cabbage, broccoli, and cauliflower. However, studies have not shown that megadoses of vitamin C promote faster healing.

Question No: 25
When a patient leans forward while sitting in a wheelchair, this position:
A. increases pressure on the ischial tuberosities
B. decreases pressure on the ischial tuberosities
C. has no effect on pressure distribution
D. increases pressure on the coccygeal area
Answer: B
Explanation: When a patient leans forward while sitting in a wheelchair, this position decreases pressure on the ischial tuberosities as well as the coccygeal area. If a patient has sufficient upper extremity strength, performing an in-chair pushup reduces the pressure on the buttocks area. The patient may also lean to one side to relieve pressure on the contra lateral side and then lean to the other side. Patients should be advised to sit as upright as possible in the chair and avoid slouching.

Question No: 26
A patient is diagnosed with lymphedema after a mastectomy. On assessment, the nurse finds fibrosis but slight pitting edema, with only minimal response to elevation. On the 0-3 staging system for lymphedema, this would be classified as:
A. stage 0
B. stage 1
C. stage 2
D. stage 3
Answer: C
Explanation: Stage 2. Lymphedema staging:

0	Normal in appearance but abnormal transport of lymph; limb may feel heavy
1	Mild pitting edema present but responds to elevation; tissue is soft
2	Fibrosis evident, minimal pitting edema, fat deposition, minimal response to elevation
3	Severe swelling, fibrosis, and fat deposition but absence of pitting edema; trophic skin changes; cellulitis; disfigurement

Question No: 27
Acne during adolescence is generally triggered by:
A. increased testosterone levels