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# WOCNCB-CCCN

*Certified Continence Care Nurse (CCCN)*

**Question: 1214**

After anticholinergic therapy is begun for urge incontinence, a patient’s bladder diary shows reduction in frequency but new marked nocturia. What is the best action?

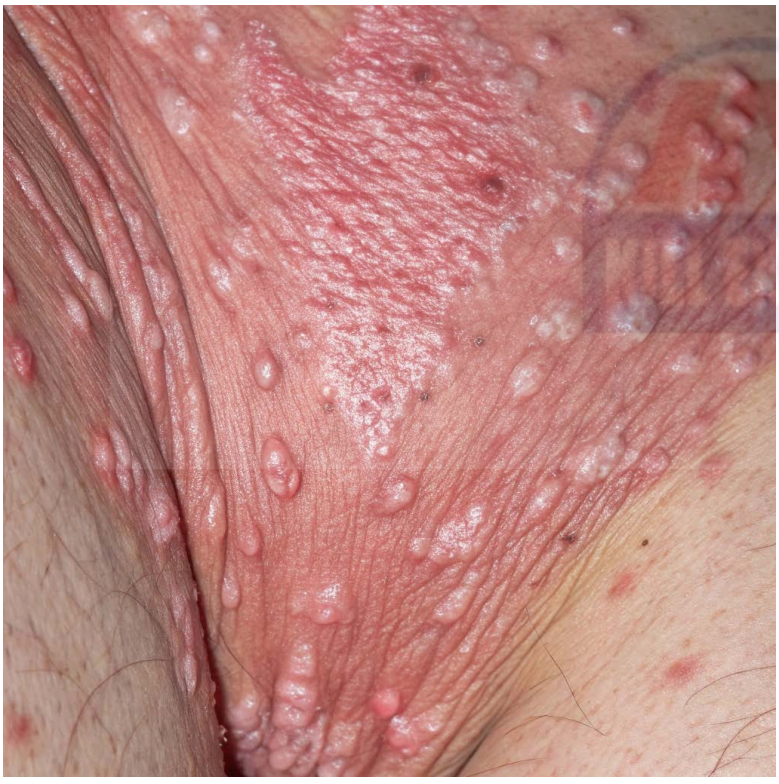
A. Reassess medication timing and fluid intake, and consider dose adjustment
B. Discontinue bladder diary entries
C. Ignore nocturia if daytime symptoms are improved
D. Add overnight catheterization

Answer: A

Explanation: Timed dosing and didactic change can reduce nocturnal symptoms without worsening daytime efficacy.

**Question: 1215**

A 65-year-old female patient with type 2 diabetes mellitus and stress urinary incontinence presents to the continence clinic with perineal dermatitis characterized by erythematous maceration and satellite lesions. She uses ultra-absorbent pads changed every 4-6 hours and applies a thick zinc oxide paste as a barrier. Recent fungal culture confirms Candida albicans overgrowth.



What is the most effective modification to her skin protection regimen to resolve the candidiasis while maintaining containment?

A. Continue zinc oxide paste and add daily application of nystatin powder
B. Discontinue absorbent pads and initiate external female urinary collection device
C. Transition to cyanoacrylate-based skin sealant layered with hydrocolloid wafer
D. Switch to a silicone-based dimethicone barrier film with antifungal-impregnated pads

Answer: D

Explanation: Moisture-associated skin damage in the perineal area from urinary incontinence creates a warm, occluded environment conducive to Candida proliferation, exacerbated by occlusive zinc oxide pastes that trap moisture and impair antifungal penetration. Zinc oxide provides a moisture barrier but has no antifungal properties and can contribute to maceration when layered thickly over absorbent products. Silicone-based dimethicone barrier films form a breathable, non-occlusive protective layer that resists wash-off during cleansing, allows transepidermal water loss to prevent maceration, and permits topical antifungal therapy to reach the skin. Combining this with absorbent pads impregnated with silver or antifungal agents targets both containment and pathogen reduction. Antifungal powders like nystatin can cake in moist environments, worsening occlusion. External collection devices may not be tolerated in ambulatory patients with stress incontinence and can cause pressure injuries. Cyanoacrylate sealants are indicated for denuded skin but sting on application and do not address fungal overgrowth directly.

**Question: 1216**

A nurse notices a sharp ammonia odor, erythema, and macerated skin in the perineal area of a patient with ongoing urinary incontinence. What should be the primary concern?

A. Fungal intertrigo
B. Stevens-Johnson syndrome
C. Incontinence-associated dermatitis
D. Allergic contact dermatitis

Answer: C

Explanation: The described findings are classic for incontinence-associated dermatitis, which is linked to chronic exposure to urine and resulting in skin breakdown.

**Question: 1217**

A continence care nurse manages fungal UTI in immunocompromised transplant patient with candiduria, parameters for fluconazole vs amphotericin.

A. Amphotericin always
B. Echinocandin systemic
C. Observe asymptomatic
D. Fluconazole 400 mg daily 14 days if susceptible with catheter removal

Answer: D

Explanation: Fluconazole 400 mg daily 14 days if susceptible with catheter removal achieves high urine levels eradicating Candida in non-neutropenic, removal eliminates biofilm; dose adjusts for renal function post-transplant.

**Question: 1218**

A 8-year-old with caudal regression has fecal and urinary incontinence. Congenital:

A. Sacral agenesis affecting nerves to bowel and bladder
B. Diet
C. Infection
D. Hypermobility

Answer: A

Explanation: Sacral anomaly disrupts innervation.

**Question: 1219**

A bedridden male with chronic diarrhea and impaired mobility is initiated on a fecal management system. Forty-eight hours later, the rectal mucosa is swollen and oozing. What is the highest priority nursing adaptation?

A. Remove the device, assess for mucosal injury, and initiate topical barrier therapy with frequent manual cleansing
B. Continue the device but increase balloon inflation
C. Apply astringent compound to the rectal mucosa
D. Increase device dwell time between changes

Answer: A

Explanation: Fecal management systems can cause mucosal injury with prolonged use; removal and topical barrier, plus routine gentle cleansing, are crucial to allow healing.

**Question: 1220**

A 68-year-old male post-stroke with left hemiparesis and neurogenic bowel dysfunction reports passive fecal soiling despite daily miralax. Caregiver completes a 5-day bowel diary revealing clustered evacuations post-breakfast with prolonged intervals exceeding 72 hours and hard stools. Digital rectal exam confirms soft stool in vault with reduced tone. Which diary-informed behavioral modification, leveraging physiologic reflexes and environmental adaptations, optimizes continence in this mobility-limited patient?

A. Establish prompted toileting 30 minutes post-meals with abdominal massage, forward lean positioning, and gastrocolic reflex stimulation
B. Administer bisacodyl suppository nightly regardless of pattern

C. Increase fluid to 3 liters daily without timing correlation
D. Use containment products exclusively with weekly disimpaction

Answer: A

Explanation: Bowel diary analysis identifies gastrocolic reflex exaggeration postprandially via cephalic-vagal stimulation increasing colonic high-amplitude propagating contractions within 15-45 minutes, predictable in neurogenic bowel. Prompted toileting at this peak exploits physiology for complete evacuation, reducing residual and soiling risk. Forward lean with braced feet elevates intra-abdominal pressure while relaxing puborectalis; clockwise abdominal massage from right lower quadrant stimulates descending colon peristalsis. Hemiparesis accommodation includes left-side support rails and elevated toilet seat for stability. Consistency over 4-6 weeks retrains reflex timing, achieving 70-85% continence improvement in stroke survivors. Bisacodyl dependency risks melanosis coli; untimed fluids dilute without pattern leverage; containment ignores functional potential.

**Question: 1221**

A Parkinson’s disease patient is reporting shuffling walk, two documented falls, and timed up and go test of 17 seconds. Which intervention should be prioritized for continence management?

A. Implementing a timed toileting and mobility safety plan
B. Daily bladder ultrasounds
C. High-dose loperamide therapy
D. Referral for surgical intervention

Answer: A

Explanation: Mobility risk combined with functional incontinence requires scheduled toileting and fall prevention planning.

**Question: 1222**

A 55-year-old woman with a history of pelvic surgery reports new-onset urinary incontinence. Which factor is most likely responsible for her symptoms?

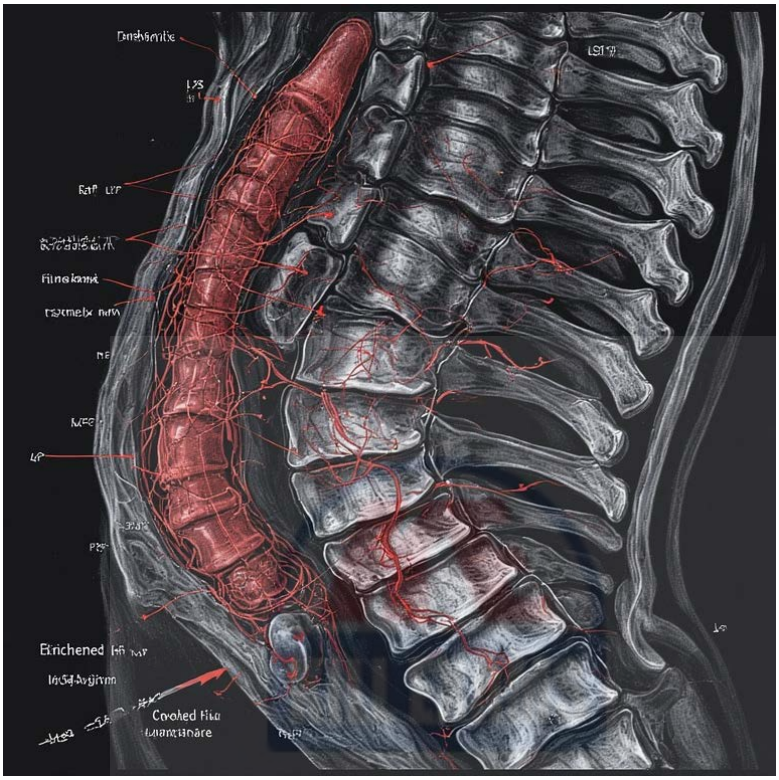
A. Bladder irritants
B. Urethral hypermobility
C. Infection
D. Muscle damage

Answer: D

Explanation: Muscle damage from pelvic surgery is a common cause of urinary incontinence in women. Urethral hypermobility, infection, and bladder irritants are less likely in this context.

**Question: 1223**

A 11-year-old with sacral dimple and enuresis has tethered cord on MRI.



Contributing neurological factor from congenital anomaly:
A. Obstruction no
B. Functional no
C. Tethered spinal cord stretching sacral roots impairing bladder sensation and contractility
D. Irritants no

Answer: C

Explanation: Tethering from anomaly restricts cord movement, damaging roots for neurogenic dysfunction. Image classic findings.

**Question: 1224**

A school-age child with urgency incontinence and emotional anxiety about pad use at school has started a bladder training program. Parents show minimal improvement after two months. What additional strategy should be added?

A. Increase pad absorbency and restrict training
B. Integrate behavioral therapy and coping skills alongside bladder retraining
C. Begin stimulant medication
D. Remove all school toileting opportunities

Answer: B

Explanation: Addressing emotional and behavioral factors in parallel with training is necessary for pediatric cases, not pad intensification or restriction.

**Question: 1225**

A 69-year-old male with urge incontinence on trospium develops acute angle-closure glaucoma requiring emergency intervention. Which revised ophthalmic need mandates permanent plan revision?

A. Development of acute glaucoma
B. Trospium anticholinergic use
C. Urge incontinence persistence
D. Emergency intervention required

Answer: A

Explanation: Development of acute angle-closure glaucoma constitutes an absolute revised need contraindicating all anticholinergics due to pupillary dilation risk in susceptible anatomy, forcing transition to beta-3 agonists or invasive therapies irrespective of prior efficacy. This ocular emergency revision prioritizes vision preservation over continence optimization.

**Question: 1226**

A 61-year-old female with anal sphincter defect 140° on endoanal ultrasound undergoes overlapping sphincteroplasty. Six-month manometry shows squeeze pressure increase from 32 to 78 mmHg, but Wexner 12. Effectiveness?

A. Infection
B. Complete success
C. Anatomical success but functional failure; offer sacral neuromodulation
D. Need biofeedback

Answer: C

Explanation: 50–70% achieve anatomical repair but only 30–40% continence; neuromodulation salvage common.

**Question: 1227**

A 70-year-old male with Parkinson’s uses levodopa and develops nocturia 6 times. Which behavioral strategy?

A. Oxybutynin ER
B. Nighttime desmopressin
C. Afternoon 10 mg immediate-release madopar restriction, legs elevation 2 hours pre-bed, double void, bedside commode
D. Fluid restriction after 4 PM only

Answer: C

Explanation: Afternoon 10 mg immediate-release madopar restriction, legs elevation 2 hours pre-bed, double void, bedside commode addresses dopamine-induced diuresis and orthostatic pooling; restricting peak-dose levodopa reduces nocturnal polyuria 50%, elevation mobilizes 500 mL fluid, commode prevents falls.

**Question: 1228**

A 68-year-old female with overflow incontinence from detrusor underactivity secondary to diabetes uses triple voiding. She wants non-pharmacological management. Which behavioral strategy with specific parameters is supported by 2026 neurogenic bladder guidelines?

A. Scheduled voiding every 3 hours with lean-forward posture, suprapubic tapping 20 times, then Credé if residual >100 mL
B. Bladder retraining with 15-minute delay increments weekly
C. Pelvic floor down-training with diaphragmatic breathing
D. Timed voiding every 4 hours with double void only

Answer: A

Explanation: Scheduled voiding every 3 hours with lean-forward posture, suprapubic tapping 20 times, then Credé if residual >100 mL is indicated for hypocontractile bladder; tapping stimulates sacral reflex in partial lower motor neuron lesions, lean-forward increases intra-abdominal pressure 15 cm H2O, and selective Credé only when bladder scan confirms volume prevents high-pressure reflux.

**Question: 1229**

A 40-year-old man with incomplete bladder emptying, a weak urinary stream, and delayed initiation of voiding is suspected of retention. Which factor would most likely be confirmed as a contributing etiology?

A. Polyuric nocturnal drinking
B. Essential hypertension
C. Chronic exercise-induced muscle pain
D. Bladder outlet obstruction possibly from prostate enlargement

Answer: D

Explanation: Prostate enlargement and outlet obstruction are common causes of incomplete voiding in men, making them most probable when examining such symptomatology.

**Question: 1230**

A continence care nurse mentors ICU staff on indwelling catheter removal protocols for a delirious 75-

year-old post-hip fracture, using nurse-driven parameters and delirium screening to prevent UTIs in elderly with transient cognition issues.

A. Automatic stop order day 7 with no assessment
B. Retain until discharge regardless
C. Physician order only weekly review
D. HOUDINI protocol daily with CAM-ICU scoring and removal if no indication

Answer: D

Explanation: HOUDINI protocol daily with CAM-ICU scoring and removal if no indication empowers nurses to discontinue unnecessary catheters reducing dwell time and CAUTI by 60% in delirious elders where confusion masks symptoms; integrating cognition tools ensures safe removal avoiding retention from overlooked alternatives.

**Question: 1231**

A 70-year-old male with penile cancer requiring partial penectomy draws away and cries when shown prosthesis options. Interpreting nonverbal coping?

A. Infection fear
B. Pain
C. Anticipatory grief for genital integrity and masculine identity
D. Cost

Answer: C

Explanation: Genital cancer threatens core masculinity. Pre-operative sexual counseling mandatory.

**Question: 1232**

A parent of a child with cerebral palsy asks how best to promote their child's activity and continence independence at school. The school offers only one accessible restroom far from classrooms. What principle and solution align with optimal patient-centered support?

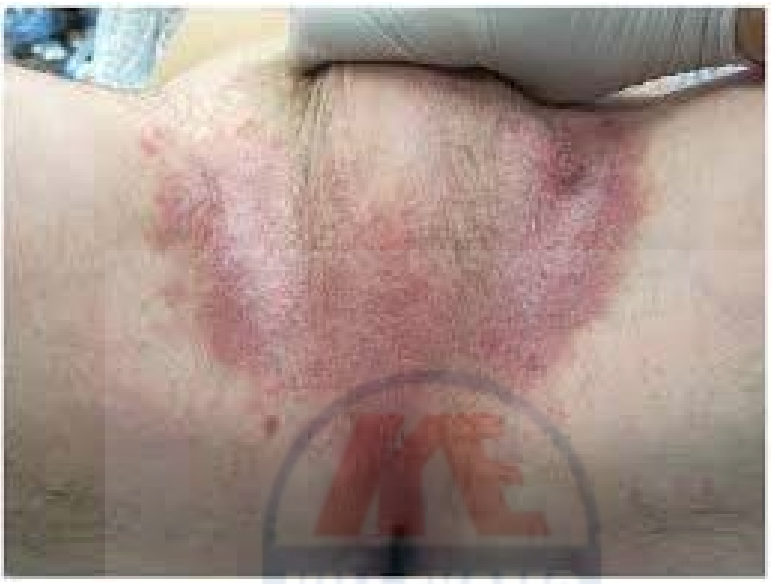
A. Expect the child to "hold it" until home
B. Coordinate advocacy for restroom access, adaptive equipment, individualized schedules, and staff education to reduce barriers and support functional goals
C. Accept current arrangements without further adaptation
D. Limit activity during school hours to prevent accidents

Answer: B

Explanation: Patient-centered care must address structural, environmental, and educational barriers, aligning care with patient/family goals and maximizing participation and activity regardless of disability.

**Question: 1233**

A 75-year-old female with urge incontinence and mobility impairment uses bedside commode with pads. She has bilateral inguinal intertrigo.



Recommended cleanser and barrier?
A. Chlorhexidine wash with alcohol-free barrier film
B. Peroxide rinse with calamine barrier
C. Mild soap pH 5.5 cleanser with silicone cream
D. Saline irrigation with antifungal ointment

Answer: C

Explanation: Harsh cleansers strip lipids. pH-balanced cleansers preserve mantle, silicone barriers breathe and protect folds without occlusion. Chlorhexidine cytotoxic. Peroxide drying.

**Question: 1234**

A nonverbal adult with severe intellectual disability develops odor and chronic MASD under absorbent containment. Family is unable to express care concerns clearly. What adaptation aligns with population and psychosocial needs?

A. Schedule increased containment changes, regular skin checks, and integrate social work and speech therapy for communication
B. Limit all changes to once daily
C. Ignore care plan until caregiver requests
D. Switch to only topical antifungal wipes

Answer: A

Explanation: Routine care, regular assessments, and multidisciplinary support address complications and

population-specific needs when communication is impaired.

**Question: 1235**

In burn unit education, the continence care nurse addresses hypermetabolic incontinence with fluid management parameters, caffeine restriction, and desmopressin timing to prevent dehydration.

A. 1.5x maintenance fluids, no caffeine limit, morning desmopressin
B. 2-3 ml/kg/hr, restrict caffeine/theobromine, evening desmopressin
C. Maintenance only, caffeine ok, noon dose
D. 4 ml/kg/hr, increase caffeine, no desmopressin

Answer: B

Explanation: 2-3 ml/kg/hr, restrict caffeine/theobromine, evening desmopressin counters catecholamine-driven diuresis, xanthines worsen urgency, nocturnal dosing concentrates without daytime hypotension risk in fluid-resuscitated patients.

**Question: 1236**

A 71-year-old female post-colorectal surgery with low anterior resection has fecal incontinence managed with loperamide 2 mg TID and bulking agents. Bowel diary over 7 days shows 18 incontinent episodes, Wexner score 16. Anorectal manometry reveals resting pressure 28 mmHg, squeeze increment 45 mmHg. What evaluates sacral neuromodulation candidacy most accurately?

A. Resting pressure >40 mmHg baseline
B. Normal pudendal nerve terminal motor latency bilaterally
C. Intact sensory thresholds on rectal balloon testing and >50% temporary test phase reduction
D. Absence of rectal prolapse on defecography

Answer: C

Explanation: Latest SNM indications for fecal incontinence require preserved rectal sensation (first sensation <50 mL) and ≥50% episode reduction during peripheral nerve evaluation phase. Low pressures reflect internal sphincter damage amenable to neuromodulation if sensory pathways intact.

**Question: 1237**

A 70-year-old female hospitalized after a fall is found to have new-onset urinary retention. She uses anticholinergic medications for depression and receives limited mobility therapy. What best describes the multifactorial etiology?

A. Exclusive effect of infection
B. Both medication effects and reduced mobility contribute to retention
C. Only bladder muscle hypertrophy
D. Tobacco use is the sole cause

Answer: B

Explanation: Anticholinergic medications reduce bladder contractility, while immobility impedes functional voiding, making both significant, modifiable contributors to retention.

**Question: 1238**

A 69-year-old female with spinal cord injury T6 uses reflex voiding with condom catheter. She develops autonomic dysreflexia during changes. Which behavioral strategy prevents episodes?

A. Add oxybutynin transdermal
B. Use silicone catheter changed weekly
C. Perform tapping over suprapubic area 10 times before removing condom, void into urinal, then change
D. Increase fluid to 2500 mL

Answer: C

Explanation: Perform tapping over suprapubic area 10 times before removing condom, void into urinal, then change triggers controlled reflex voiding below injury level, emptying bladder before manipulation; prevents bladder distension >400 mL triggering sympathetic surge and hypertension up to 250 mmHg.

**Question: 1239**

A 75-year-old male in memory care unit on mirabegron develops QTc 480 ms. Evaluating medication?

A. Safe in elderly
B. Reduce dose
C. Immediate discontinuation; risk torsades
D. Add amiodarone

Answer: C

Explanation: Mirabegron contraindicated QTc >450 ms in males per latest labeling.

**Question: 1240**

A 14-year-old male bedwetter is discovered to have a large postvoid residual (>200 mL), absence of urge, and distended bladder on ultrasound. Daytime voiding is infrequent, and urine stream is weak. Which dysfunction fits best?

A. Non-neurogenic voiding dysfunction (dysfunctional voiding)
B. Nocturnal enuresis
C. Urge incontinence
D. Functional incontinence

Answer: A

Explanation: Large residuals, decreased sensation, infrequent voiding, and weak stream in a child point strongly to a voiding dysfunction, not primary nocturnal enuresis.

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