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Nursing ANCC Adult Health Clinical Nurse Specialist Certification (ACNS) Sample Questions (Q82-Q87):

NEW QUESTION # 82

When discussing Human Immunodeficiency virus (HIV) testing with a patient, the CNS knows:

- A. The screening ELISA test (enzyme-linked immunosorbent assay) detects antibodies and is 99% sensitive and specific.
- B. Sexually active homosexual men are the only ones at risk for HIV.
- C. There is no need to recheck the ELISA if negative on the first test.
- D. Receiving blood products from 1985 to 1995 is a risk factor for HIV.

Answer: A

Explanation:

The correct answer is: "The screening ELISA test (enzyme-linked immunosorbent assay) detects antibodies and is 99% sensitive and

specific." It is important to clarify why this statement is correct and to address the misconceptions around HIV risk and testing. Firstly, the ELISA test is a widely used initial screening tool for detecting antibodies to HIV. Antibodies are proteins that the body produces in response to an infection. In the case of HIV, these antibodies generally develop within a few weeks to months after infection. The sensitivity and specificity of the ELISA test being around 99% means that the test is highly effective at correctly identifying those who have and do not have HIV. A test with 99% sensitivity will correctly identify 99% of people with the disease and miss 1%, while a test with 99% specificity will correctly rule out the disease in 99% of people who do not have the disease, mistakenly identifying 1% as positive.

Addressing the first statement, it is a misconception that only sexually active homosexual men are at risk for HIV. HIV can affect anyone, regardless of sexual orientation, age, race, or any other factor. It is transmitted through contact with infected bodily fluids such as blood, semen, vaginal fluids, and breast milk. This can happen through unprotected sexual activities with an infected person, sharing needles for drug use, receiving unsafe injections, transfusions, and from mother to child during childbirth or breastfeeding. Furthermore, the statement about rechecking the ELISA test highlights the concept of the "window period." The window period is the time immediately after infection during which antibodies to HIV are not yet produced in high enough quantities to be detectable by the test. Therefore, if exposure to HIV is suspected, a follow-up test is recommended after the window period, typically around six months, to confirm the initial result. This protocol helps in capturing cases that might have been missed if tested too early after exposure.

Lastly, it is crucial to recognize broader risk factors beyond sexual orientation. Individuals with multiple sexual partners, those who engage in IV drug use, people with a history of sexually transmitted diseases (STDs), and those who were recipients of blood products between 1975 and 1985 (before widespread screening of the blood supply for HIV began) are also at increased risk.

Understanding these factors can help in better targeting education, prevention, and testing efforts to those most at risk.

In summary, the CNS (Clinical Nurse Specialist) must be equipped with accurate and comprehensive knowledge about HIV transmission, testing, and the populations at risk. This ensures appropriate guidance and management of patients concerning HIV testing and prevention strategies.

NEW QUESTION # 83

What medication and dose can be used for abortive therapy in an adult client with symptoms of migraine headache?

- A. ketorolac (Toradol) 100 mg IM
- B. sumatriptan (Imitrex) 6 mg IM
- C. ergotamine (Ergostat) 2 mg SL
- D. amitriptyline (Elavil) 100 mg PO

Answer: C

Explanation:

When treating an adult client experiencing migraine headaches, several medications can be utilized as abortive therapy to alleviate symptoms. Among these options, ergotamine, sumatriptan, and ketorolac are notable choices, each with specific dosages and administration routes tailored to effectively manage migraine attacks.

Ergotamine (Ergostat) is a well-established medication for abortive migraine therapy. It is typically administered sublingually at a dose of 2 mg. Ergotamine works by constricting peripheral and cranial blood vessels and reducing the hyperactivity of the trigeminal nerves, which are associated with migraine pain. The sublingual form ensures quick absorption and rapid onset of action, which is crucial for the effective treatment of acute migraines.

Ketorolac (Toradol) is another option for the abortive treatment of migraine. This medication is a nonsteroidal anti-inflammatory drug (NSAID) that helps reduce inflammation and pain. For migraine attacks, ketorolac can be administered intramuscularly with a typical dose ranging from 30-60 mg. The intramuscular route of administration provides a fast-acting effect, making it suitable for severe migraine episodes.

Sumatriptan (Imitrex) is also widely used in treating migraines. It belongs to a class of medications known as triptans, which specifically target serotonin receptors to reduce inflammation and constrict blood vessels, thereby relieving migraine symptoms. Sumatriptan can be administered subcutaneously at a dose of 6 mg for rapid relief from migraine. This route ensures quick drug absorption and onset of action, which is essential during acute migraine attacks.

It is important to note that amitriptyline (Elavil), although used in migraine management, is not typically employed as abortive therapy but rather as a preventive treatment. Amitriptyline is an antidepressant that can help reduce the frequency and severity of migraines when taken regularly at doses like 100 mg orally; however, it does not provide immediate relief of symptoms once a migraine has started. Each of these medications serves a specific role in managing different aspects of migraine attacks. The choice of drug and dosage should be tailored to the individual patient's medical history, severity of symptoms, and response to previous treatments, under the guidance of a healthcare provider.

NEW QUESTION # 84

You are treating your patient with a 5HT4 agonist for his gastrointestinal disorder. Of the following, which would you prescribe?

- A. Cisapride.
- B. Senna.
- C. Alosetron.
- **D. Tegaserod.**

Answer: D

Explanation:

To address the question of which medication to prescribe for a patient's gastrointestinal disorder using a 5HT4 agonist, it is essential to understand the pharmacological role of each option listed. Here is an expanded explanation of the drug choices provided:

Tegaserod: This medication is a 5HT4 agonist and is used specifically to treat certain gastrointestinal disorders, particularly those associated with symptoms of irritable bowel syndrome (IBS) predominantly featuring constipation. Tegaserod works by enhancing the release of neurotransmitters that increase the movement of the intestines, thereby promoting bowel movements and alleviating constipation. Due to its mechanism of action targeting the 5HT4 receptor, tegaserod is the correct choice when a 5HT4 agonist is indicated for gastrointestinal issues.

Senna: Senna is categorized as a stimulant laxative. It operates by stimulating the muscles in the intestines, which helps to facilitate the movement of stool through the bowel. Though effective for constipation, Senna does not function as a 5HT4 agonist and therefore does not fit the requirement for the medication needed in this scenario.

Cisapride: Previously used as a pro-motility agent, Cisapride enhances the release of acetylcholine at the myenteric plexus, which stimulates gastrointestinal motility and accelerates gastric emptying. It acts on serotonin receptors, but its primary action is not on the 5HT4 receptor. Furthermore, due to concerns about serious cardiac side effects, its availability is highly restricted in many countries.

Alosetron: This medication is a 5HT3 antagonist used primarily to manage severe diarrhea-predominant irritable bowel syndrome (IBS) in women. By blocking the 5HT3 receptors, alosetron slows the movement of stools through the intestines, which is the opposite effect of what is typically desired with a 5HT4 agonist. Therefore, alosetron is not suitable for the requirement of a 5HT4 agonist.

In conclusion, for a patient needing a 5HT4 agonist for treating a gastrointestinal disorder, Tegaserod is the appropriate prescription among the options listed. It directly targets the 5HT4 receptors and is effective in enhancing gut motility, specifically in cases related to constipation-predominant IBS. Other drugs listed either do not target the 5HT4 receptor or have different primary indications and mechanisms of action that do not align with the therapeutic needs specified.

NEW QUESTION # 85

After an 1 mg overnight dexamethasone suppression test, when should cortisol be tested?

- **A. 8:00 AM**
- B. 3:00 PM
- C. Midnight.
- D. Noon.

Answer: A

Explanation:

The optimal timing for testing cortisol after an overnight 1 mg dexamethasone suppression test is at 8:00 AM. This timing is chosen because cortisol levels exhibit a diurnal rhythm, with their peak naturally occurring in the early morning hours, typically around 8:00 AM. The purpose of testing at this time is to assess how effectively dexamethasone has suppressed the cortisol production, which is especially relevant in the diagnosis and assessment of conditions like Cushing's syndrome.

In the context of the dexamethasone suppression test, a patient is given a dose of dexamethasone, which is a potent synthetic glucocorticoid, at night. Dexamethasone acts similarly to cortisol but has a much stronger effect. It is expected to suppress the secretion of cortisol by acting on the hypothalamus and pituitary gland, which in turn should reduce the production of adrenocorticotropic hormone (ACTH) and subsequently cortisol by the adrenal glands.

Testing cortisol levels at 8:00 AM after the administration of dexamethasone provides critical information. If the cortisol levels are not adequately suppressed (typically less than 1.8 µg/dL or 50 nmol/L), this suggests that the negative feedback mechanism controlling cortisol release is not functioning properly, which is a hallmark of Cushing's syndrome. In cases where the cortisol level is higher than 5 µg/dL, it strongly points towards a diagnosis of Cushing's syndrome, requiring further investigation and confirmation through additional tests.

Therefore, testing at 8:00 AM maximizes the diagnostic accuracy of the test under the influence of the physiological peak of cortisol. Testing at any other time could yield misleading results as the natural fluctuation in cortisol levels throughout the day might interfere with the interpretation of the suppression test outcomes. Thus, adherence to the 8:00 AM testing time is crucial for correct diagnosis and management of diseases related to cortisol dysfunction.

NEW QUESTION # 86

A patient comes into the emergency room with severe asthmatic exacerbation. The ACCRN knows that the first-line treatment for this is which of the following?

- A. Albuterol metered dose inhaler
- B. adrenaline injection
- C. low - medium dose steroid metered dose inhaler
- D. nebulizer treatment

Answer: A

Explanation:

When a patient presents to the emergency room with severe asthmatic exacerbation, it is critical for healthcare providers to initiate appropriate and effective treatment immediately. The question posed regards the first-line treatment for such a situation, and the correct answer is the use of an albuterol metered dose inhaler (MDI).

Albuterol is a fast-acting bronchodilator that works by relaxing the muscles around the airways, which helps to open them up quickly and ease the breathing process. It is typically administered through an inhaler, which allows the medication to go directly into the lungs where it is needed most. This direct route ensures that the medication acts quickly, which is crucial in a severe asthma attack where every second counts.

The symptoms of a severe asthmatic exacerbation can include tachypnea (rapid breathing), disappearance or lack of wheezing due to severe airway narrowing, use of accessory muscles to breathe, diaphoresis (sweating), and exhaustion. These signs indicate that the patient is struggling to get enough air and requires immediate intervention to prevent further respiratory distress or potential respiratory failure.

While there are other treatments available, such as adrenaline injection and nebulizer treatments, these are generally considered in specific circumstances or when initial treatments with a metered dose inhaler are not sufficient. Adrenaline injections are typically reserved for life-threatening reactions such as anaphylaxis and are not the standard first-line therapy for asthma exacerbations. Nebulizer treatments, which convert liquid medication into a mist that can be inhaled, are another option but may not be the most immediate choice for emergency response, depending on the situation and resources available.

Low to medium dose steroids are also used in the management of asthma, mainly to reduce inflammation and prevent future exacerbations. However, these are not typically used as the first-line treatment in acute, severe exacerbations as their action is not as fast as bronchodilators like albuterol.

In summary, the first-line treatment for a severe asthmatic exacerbation in an emergency setting is an albuterol metered dose inhaler. This treatment choice is preferred for its rapid action and effectiveness in opening the airways, thereby providing quick relief to the patient experiencing severe respiratory distress.

NEW QUESTION # 87

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