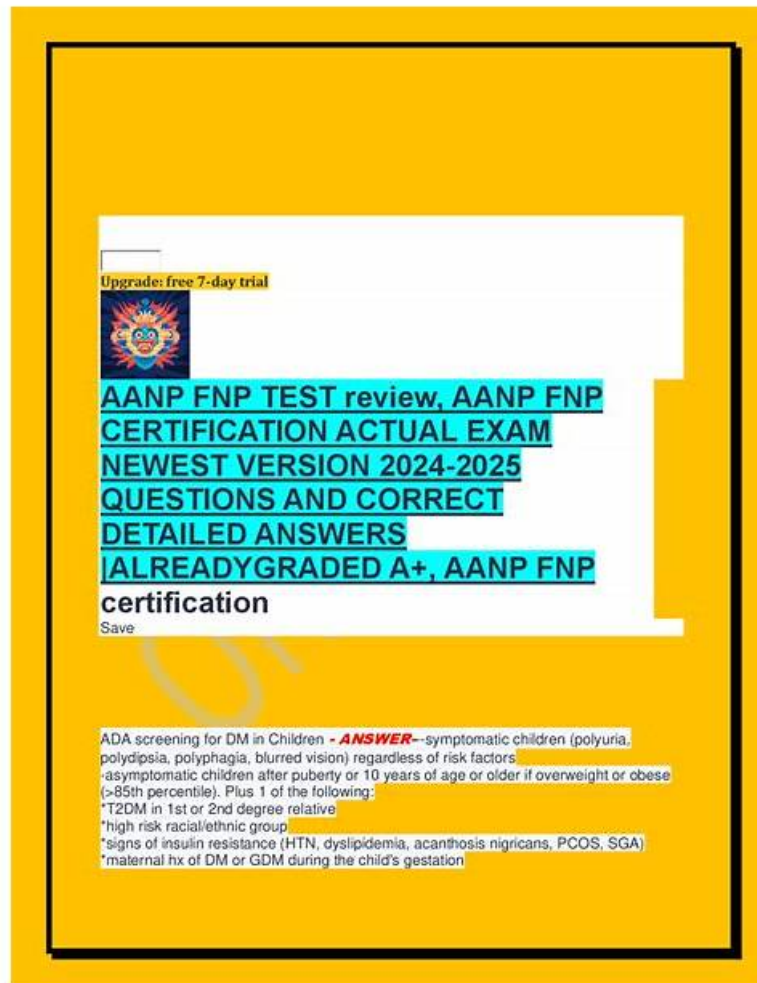


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Nursing AANP Family Nurse Practitioner (AANP-FNP) Sample Questions

(Q100-Q105):

NEW QUESTION # 100

Sandra is a 40-year-old sexually active female patient who complains of right upper quadrant abdominal pain. You find that there is tenderness upon palpation of the area. This is indicative of which of the following conditions/diseases?

- A. Jarisch-Herxheimer reaction
- B. Reiter's syndrome
- C. syphilis
- **D. Fitz-Hugh-Curtis syndrome**

Answer: D

Explanation:

Fitz-Hugh-Curtis syndrome is a rare complication of pelvic inflammatory disease (PID), primarily associated with *Chlamydia trachomatis* and *Neisseria gonorrhoeae* infections. This syndrome is characterized by inflammation of the liver capsule and the formation of adhesions between the liver and the surrounding peritoneal structures. The condition is named after the physicians Thomas Fitz-Hugh, Jr. and Arthur Hale Curtis, who first described it in the 1930s.

The typical clinical presentation of Fitz-Hugh-Curtis syndrome includes sudden onset of right upper quadrant abdominal pain, which is often sharp and may be referred to the shoulder or right chest. This pain can be exacerbated by movement or breathing and is due to the irritation of the diaphragm by the inflamed liver capsule. Additionally, patients might experience symptoms typical of PID, such as lower abdominal pain, fever, vaginal discharge, and dyspareunia (pain during sexual intercourse).

The diagnosis of Fitz-Hugh-Curtis syndrome is primarily clinical but can be supported by imaging studies such as ultrasound, CT scan, or MRI, which may show thickening of the liver capsule or adhesions. Laparoscopy is considered the definitive diagnostic tool as it allows direct visualization of the "violin string" adhesions between the liver and the anterior abdominal wall or other structures.

Treatment of Fitz-Hugh-Curtis syndrome involves managing the underlying chlamydial or gonococcal infection with appropriate antibiotics, typically a 14-day course. It is crucial to treat both the patient and their sexual partners to prevent reinfection and further complications. In some cases, where adhesions cause severe ongoing pain or other complications, surgical intervention might be necessary to remove the adhesions.

As a sexually transmitted disease complication, prevention of Fitz-Hugh-Curtis syndrome is primarily through safe sexual practices, including the use of condoms and regular STI screening. This approach can help prevent the occurrence of PID and its complications, including Fitz-Hugh-Curtis syndrome.

NEW QUESTION # 101

When taking a patient's past medical history you would ask about all of the following EXCEPT:

- A. surgeries
- B. TB test
- C. childhood and adult illnesses
- **D. dietary patterns**

Answer: D

Explanation:

When taking a patient's past medical history, the healthcare provider generally focuses on gathering information that directly pertains to the patient's medical conditions, treatments, and overall health status. This typically includes inquiries about:

****Childhood and Adult Illnesses:**** Understanding a patient's history of illnesses, both in childhood and adulthood, is crucial. This information helps in recognizing patterns of chronic or genetic diseases and provides insights into potential future health risks or ongoing management of existing conditions.

****TB Test:**** Information about tuberculosis tests is relevant as TB is a critical infectious disease with potential long-term health implications. Knowing whether a patient has been tested, and the results of those tests, can significantly affect clinical decisions, especially in managing immunocompromised patients or those with symptoms of tuberculosis.

****Surgeries:**** Knowledge of any past surgical interventions provides insights into the patient's medical history and can impact future healthcare decisions. Details of surgical history, including the type of surgeries and their outcomes, are essential for a comprehensive understanding of a patient's current health status and potential complications.

****Dietary Patterns:**** Although knowing a patient's dietary habits can be helpful, especially in the context of nutritional assessments or chronic diseases management (like diabetes or heart diseases), it is typically not part of the core past medical history. Dietary patterns are usually discussed within the scope of a psychosocial history, which examines lifestyle factors and social determinants of health that can influence a patient's well-being. This includes the patient's eating habits, exercise routines, and other lifestyle choices.

In summary, while childhood and adult illnesses, TB tests, and surgeries are integral components of a patient's past medical history,

dietary patterns are generally classified under psychosocial history. This distinction is important for organizing the patient interview and ensuring that the most relevant information is gathered efficiently to inform medical decision-making.

NEW QUESTION # 102

Which of the following physiological changes would NOT be seen during pregnancy?

- A. The thyroid becomes diffusely enlarged by up to 15%.
- B. Plasma volume will increase 50% by the end of the third trimester.
- C. Hemoglobin and hematocrit are decreased.
- D. Cardiac output decreases by 1/3 by the last two trimesters.

Answer: D

Explanation:

During pregnancy, numerous physiological changes occur to support the developing fetus and prepare the mother's body for labor. Understanding these changes is important not only for medical professionals but also for expectant mothers to recognize what is normal during pregnancy. Here, we will discuss why the statement that "Cardiac output decreases by 1/3 by the last two trimesters" is incorrect, and what actually happens to cardiac output during pregnancy.

Firstly, cardiac output, which is the amount of blood pumped by the heart per minute, actually increases during pregnancy, not decreases. This increase is necessary to accommodate the enhanced metabolic needs of the mother and the growing fetus. Typically, cardiac output increases by about 30-50% by the end of the third trimester compared to pre-pregnancy levels. This increase is facilitated by an increase in both the heart rate (tachycardia) and stroke volume (the amount of blood ejected with each heartbeat). The initial statement that cardiac output decreases by 1/3 during the last two trimesters is therefore incorrect. The rise in cardiac output begins as early as the first trimester and peaks during the mid-second to third trimesters. This physiological adaptation helps to transport sufficient oxygen and nutrients to the fetus via the placenta and also supports the mother's increased metabolic demands. Other changes that accompany the increase in cardiac output include a decrease in systemic vascular resistance and an increase in blood volume. Plasma volume may increase by as much as 50%, which dilutes red blood cells leading to physiological anemia, often referred to as dilutional anemia of pregnancy. The heart may also enlarge slightly during pregnancy due to increased workload. Additionally, the statement mentions other physiological changes like the diffuse enlargement of the thyroid gland. Indeed, the thyroid gland can become slightly enlarged during pregnancy due to increased demands for thyroid hormones, which are crucial for fetal development, particularly brain development.

In summary, the correct physiological change during pregnancy regarding cardiac output is an increase, not a decrease. This increase is a crucial adaptation that helps meet the heightened metabolic demands of both the mother and fetus. Misunderstanding such fundamental changes can lead to confusion about what is normal in pregnancy and potentially misguide clinical assessments and interventions.

NEW QUESTION # 103

Edward is a 50-year-old male patient who has peripheral vascular disease. You are prescribing a neuropathic analgesic for him. Which of the following drugs would you prescribe?

- A. Pentoxifylline
- B. Amitriptyline
- C. Clindamycin
- D. Persantine

Answer: B

Explanation:

In addressing the question of which neuropathic analgesic to prescribe for Edward, a 50-year-old male patient with peripheral vascular disease, it is important to consider the nature and mechanism of the medications available. Peripheral vascular disease primarily affects blood vessels outside of the heart and brain and can often lead to complications such as pain and numbness, typically in the legs. The treatment goal in such cases often includes managing symptoms and improving quality of life.

Among the options listed, Amitriptyline appears repeatedly and is the appropriate choice for treating neuropathic pain in Edward's case. Amitriptyline is a tricyclic antidepressant that is widely used not only for its primary function as an antidepressant but also for its efficacy in treating neuropathic pain. This type of pain is common in patients with peripheral vascular disease due to nerve damage caused by reduced blood flow.

The reason Amitriptyline is effective in such cases lies in its mechanism of action. It increases the levels of neurotransmitters in the nervous system, such as serotonin and norepinephrine, which help modulate pain perception. Amitriptyline also blocks the reuptake of these neurotransmitters, making them more available in the brain, which can help alleviate pain.

The other options listed such as Pentoxifylline, Persantine, and Clindamycin do not primarily address neuropathic pain. Pentoxifylline is often used to improve blood flow in patients with circulation problems, not specifically for pain relief. Persantine is another medication that helps prevent blood clots but does not have analgesic properties. Clindamycin is an antibiotic with no role in pain management.

Therefore, among the given choices, Amitriptyline would be the most suitable prescription for Edward to help manage his neuropathic pain associated with peripheral vascular disease. It is crucial, however, to monitor the patient for any potential side effects such as sedation, dry mouth, or urinary retention, which are commonly observed with tricyclic antidepressants. Adjustments to dosage or alternative therapies may be considered based on the patient's response and any adverse effects experienced.

NEW QUESTION # 104

You have an older patient who has been diagnosed with chronic kidney disease (CKD). At what stage of the disease would you consider renal replacement therapy?

- A. stage 3
- **B. stage 4**
- C. stage 1
- D. stage 2

Answer: B

Explanation:

Chronic Kidney Disease (CKD) is categorized into five stages based on the glomerular filtration rate (GFR), a measure of kidney function. These stages help in determining the severity of kidney damage and guide treatment decisions. Stage 4 CKD is characterized by a severe decrease in GFR (15-29 ml/min/1.73 m²). At this stage, the kidneys have lost nearly all their ability to do their job effectively, which is crucial for filtering waste and excess fluid from the blood.

Renal replacement therapy (RRT), which includes dialysis or kidney transplantation, becomes a critical consideration in stage 4 CKD. Dialysis performs the function of the kidneys by filtering waste products and excess sodium and fluid from the blood when the kidneys can no longer do so efficiently. This intervention is vital to prevent the accumulation of toxins and fluid in the body, which can be life-threatening.

The decision to initiate renal replacement therapy is usually made based on several factors, including the patient's symptoms, level of kidney function, overall health, and quality of life. Common symptoms that may prompt the initiation of dialysis in stage 4 include severe fatigue, difficulty breathing, excessive fluid retention, and elevated potassium levels, which can be dangerous.

Consulting with a nephrologist, a specialist in kidney care, is essential when considering renal replacement therapy. The nephrologist will evaluate the progression of kidney disease, discuss the different modalities of dialysis (such as hemodialysis or peritoneal dialysis), or assess the suitability for a kidney transplant. This consultation also provides an opportunity to address any concerns the patient might have regarding the impact of RRT on their daily life and long-term health.

It is important to note that not all patients in stage 4 CKD will require immediate renal replacement therapy. Some patients may progress to end-stage renal disease (stage 5) more slowly and might not need dialysis for months or even years. Regular monitoring and early nephrological consultation are therefore crucial to optimize the timing of dialysis initiation and to prepare both the patient and their family for the changes that lie ahead.

NEW QUESTION # 105

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