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Nursing AANP Family Nurse Practitioner (AANP-FNP) Sample Questions (Q44-Q49):

NEW QUESTION # 44

You have a patient who has tripped and fallen on his face and has a tooth fracture. Upon examination you observe a full fracture of the tooth involving the enamel, dentin, and pulp. Pink tissue is seen in the fracture. This fracture would be classified as which of the following?

- A. Ellis III
- B. Ellis I
- C. Ellis II
- D. avulsion

Answer: A

Explanation:

The correct classification for the described tooth fracture is an Ellis III fracture. This classification is used to identify tooth fractures that involve the full thickness of the tooth, including the enamel, dentin, and pulp layers.

An Ellis III fracture is more severe than Ellis I or Ellis II fractures because it extends through all three layers of the tooth. The enamel, which is the outermost protective layer of the tooth, is compromised, as is the dentin, which forms the bulk of the tooth structure beneath the enamel. Most critically, the pulp, which contains the tooth's nerve and blood supply, is also exposed. The visibility of pink tissue within the fracture site typically indicates that the pulp is involved and possibly damaged, which can lead to pain, sensitivity, and risk of infection.

The presence of pulp exposure in an Ellis III fracture necessitates prompt and specific treatment to prevent complications such as pulp necrosis or infection that could lead to an abscess or more widespread oral health issues. Management of an Ellis III fracture generally involves either a root canal procedure to remove the damaged pulp and seal off the tooth or, if the tooth is too severely damaged, extraction. In either case, a dental specialist, such as an endodontist or oral surgeon, would likely be involved in the treatment.

Immediate steps before seeing a specialist should include covering the exposed area to reduce pain and prevent contamination.

Dental wax or temporary dental cement can be applied to seal off the exposure temporarily. Additionally, it is important to advise the patient to avoid chewing with the fractured tooth and to maintain good oral hygiene to minimize further contamination.

Referral to an oral surgeon or endodontist is crucial for proper management of an Ellis III fracture. These specialists can provide the most appropriate treatment options based on the extent of the fracture and the condition of the tooth and surrounding tissues. Timely and appropriate management is essential to optimize outcomes for the patient and preserve as much of the natural tooth structure as possible.

NEW QUESTION # 45

When examining your patient you find that he has a speech disturbance in which his speech is slow and he finds it hard to express thoughts although his comprehension remains intact. This type of speech disturbance is which of the following?

- A. nonfluent aphasia
- B. fluent aphasia
- C. Wernicke's aphasia
- D. global aphasia

Answer: A

Explanation:

The speech disturbance described in the question is classified as nonfluent aphasia, more specifically associated with impairment in Broca's area of the brain. Nonfluent aphasia, also known as Broca's aphasia, is characterized by slow, laborious speech that is difficult to produce. Individuals with this condition often exhibit a struggle to form complete sentences and express their thoughts verbally. Despite these challenges in speech production, their ability to understand language remains intact, which distinguishes nonfluent aphasia from other types of language disorders.

In nonfluent aphasia, patients typically know what they want to say but face significant difficulties in verbalizing their thoughts. This is reflective of the impairment in Broca's area, located in the frontal lobe of the brain, which is crucial for speech production and processing. The speech produced is often telegraphic, lacking in function words (like "is" or "the") and mainly consisting of content words such as nouns and verbs. This makes the speech appear "nonfluent" or halted.

Moreover, individuals with nonfluent aphasia might also experience impairments in other aspects of language use, such as writing, which is often as laborious as their spoken language. However, their comprehension abilities are typically preserved. They can understand spoken language and are able to engage with others to some extent, acknowledging that they understand even though they cannot respond fluidly.

It's important to differentiate nonfluent aphasia from other types of aphasia such as fluent (Wernicke's) aphasia, where speech remains fluent and grammatically correct but often lacks meaning or relevance; and global aphasia, where both the production and comprehension of language are severely impaired. The specific characteristic of nonfluent aphasia - impaired speech production with

intact comprehension - is key to diagnosing and managing this condition appropriately.

Understanding the nature of nonfluent aphasia helps in tailoring communication methods with affected individuals and planning appropriate therapeutic interventions that focus on gradually improving speech production and helping patients find alternative ways to communicate effectively.

NEW QUESTION # 46

You are assisting in the emergency room with a patient who is having a posterior nosebleed. You might recommend each of the following measures to control the posterior epistaxis except for which one?

- A. firm pressure on the area
- B. embolization
- C. direct cauterization
- D. posterior nasal packing

Answer: A

Explanation:

In the management of a patient experiencing a posterior nosebleed, various medical interventions can be recommended to control the bleeding. However, the effectiveness of these interventions depends on whether the nosebleed is anterior or posterior.

Understanding the difference between these two types of epistaxis is crucial in choosing the appropriate treatment method.

Posterior nosebleeds, which account for approximately 5-10% of all nosebleeds, originate from the back portions of the nose where the blood vessels are larger and thus potentially more difficult to manage. These types of bleeds are often more severe and may require advanced medical interventions.

The common treatments for posterior epistaxis include: 1. ****Direct Cauterization****: This process involves using heat or a chemical agent to burn the bleeding vessel, sealing it to stop the bleeding. This method is effective for accessible bleeding sites and can be performed under local anesthesia. 2. ****Posterior Nasal Packing****: This involves placing a special gauze or an inflatable balloon in the nasal cavity to apply pressure directly to the source of the bleeding. This is often used when cauterization is not possible or effective. 3. ****Embolization****: This is a more invasive procedure where materials are used to block the bleeding vessel through an endovascular approach. It is typically reserved for severe cases or when other interventions have failed. 4. ****Surgery****: In some severe cases, surgical intervention might be necessary to directly ligate (tie off) the bleeding vessels.

On the other hand, firm pressure on the area, generally applied by pinching the soft part of the nose, is a technique usually recommended for anterior nosebleeds. Anterior nosebleeds originate from the front part of the nasal septum and are typically less severe. Applying pressure helps to compress the bleeding vessels, which can control the bleeding effectively in many cases of anterior epistaxis.

Therefore, in the context of treating a posterior nosebleed, recommending firm pressure on the nasal area is generally ineffective. This method does not adequately address the deeper, more posteriorly located sources of bleeding. Instead, the treatments listed under options such as direct cauterization, posterior nasal packing, embolization, or surgery are more appropriate and effective for managing a posterior nosebleed. Hence, the correct answer to the question of which measure might not be recommended for controlling posterior epistaxis is "firm pressure on the area."

NEW QUESTION # 47

What is the lifetime risk to the average American man of having latent prostate cancer?

- A. 40%
- B. 10%
- C. 3%
- D. 67%

Answer: A

Explanation:

The correct answer is 40%. This means that 40% of American men are estimated to develop latent prostate cancer during their lifetimes. Latent prostate cancer refers to cancer that is present in the prostate gland but has not yet caused any symptoms or signs detectable by current medical exams and technologies. It is often found incidentally during autopsies or other medical procedures that are not specifically aimed at detecting prostate cancer.

Latent prostate cancer, although it exists in the body, might never progress to a more severe or clinically significant stage. Therefore, although 40% of men might have this form of cancer, only a fraction of them will experience health problems or require treatment. Specifically, the lifetime risk of developing clinically significant prostate cancer, which requires intervention due to symptoms or potential for health deterioration, is about 10%. This reflects the disparity between having the disease and the disease causing issues

that necessitate medical attention.

Furthermore, the risk of dying from prostate cancer is approximately 3%. This statistic highlights the effectiveness of current diagnostic and treatment strategies which can manage the disease in a way that minimizes mortality. It is also indicative of the nature of many prostate cancers, which can be slow-growing and less aggressive compared to other types of cancer.

These statistics emphasize the importance of regular medical check-ups and screenings, such as prostate-specific antigen (PSA) tests, which can help in early detection and management of prostate cancer. Early detection significantly increases the chances of successful treatment and management of prostate cancer, potentially reducing the progression from latent to more aggressive forms of the disease.

NEW QUESTION # 48

High risk factors for hearing loss in infants include all of the following except:

- A. gestational diabetes in mother's pregnancy
- B. low Apgar scores at birth
- C. hyperbilirubinemia
- D. seizures

Answer: A

Explanation:

High-risk factors for hearing loss in infants include a variety of conditions and situations that can occur before, during, or after birth. Factors such as frequent ear infections, rubella, cytomegalovirus (CMV), and toxoplasmosis infections have been directly linked to an increased risk of hearing impairment in infants. These conditions can affect the development of the auditory system or cause damage to parts of the ear responsible for hearing. Hyperbilirubinemia, which leads to a condition known as jaundice in infants, can also affect hearing due to the potential damage it can cause to the brain's auditory pathways if bilirubin levels become excessively high. Low Apgar scores at birth, a measure of a newborn's health immediately after delivery, can indicate difficulties such as asphyxia, infection, or trauma, which are associated with hearing loss. Similarly, seizures in newborns may indicate neurological issues that could affect hearing.

However, gestational diabetes in a mother's pregnancy does not directly correlate with an increased risk of hearing loss in infants. Gestational diabetes primarily affects the mother's glucose levels and, while it can lead to other complications in newborns such as higher birth weights and subsequent delivery issues, it is not a known risk factor for hearing impairment. Therefore, gestational diabetes in a mother's pregnancy is the correct answer to the question about which condition does not increase the risk of hearing loss in infants.

Understanding these risk factors is crucial for early intervention and management to potentially mitigate the impact of hearing loss in infants. Early detection through newborn hearing screening programs is essential for identifying hearing impairment as soon as possible to provide timely treatment and support.

NEW QUESTION # 49

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