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## Nursing AANP Family Nurse Practitioner (AANP-FNP) Sample Questions (Q100-Q105):

### NEW QUESTION # 100

Of the following, which vaginal condition would be considered the only one that would have an alkaline pH on the exam?

- A. Viral vaginosis
- B. Trichomoniasis
- C. Bacterial vaginosis
- D. Chlamydia vaginitis

**Answer: C**

Explanation:

Among the listed vaginal conditions, bacterial vaginosis is the condition associated with an alkaline pH during examination. Normally, the vaginal environment maintains a slightly acidic pH, typically around 4.0. This acidity is primarily due to the presence of lactic acid produced by lactobacilli, the predominant healthy bacteria in the vagina. The acidic environment helps to prevent the growth of pathogenic bacteria and maintains vaginal health.

However, in the case of bacterial vaginosis, there is a disruption in the normal bacterial flora of the vagina. This disruption leads to a decrease in lactobacilli and an overgrowth of other types of bacteria such as Gardnerella vaginalis and other anaerobes. This shift in the bacterial composition reduces the lactic acid production, thereby increasing the pH to more alkaline levels, often noted as above 4.5.

It is important to distinguish bacterial vaginosis from other conditions such as trichomoniasis, viral vaginosis, and chlamydia vaginitis. Trichomoniasis, caused by the protozoan Trichomonas vaginalis, can also lead to an elevated vaginal pH but is typically associated with other distinct symptoms like frothy yellow-green discharge and is sexually transmitted. Viral infections in the vagina, such as those caused by herpes simplex virus, do not typically alter the pH significantly. Chlamydia vaginitis, caused by the bacterium Chlamydia trachomatis, primarily results in an inflammatory response and typically does not affect the vaginal pH to become alkaline. Therefore, when considering a vaginal condition characterized by an alkaline pH observed during an examination, bacterial vaginosis is the most likely diagnosis among the options provided. It's crucial for healthcare providers to recognize this condition not only by pH but also by other symptoms and diagnostic tests to ensure appropriate treatment and management. Bacterial vaginosis is not considered a sexually transmitted disease (STD), but rather a dysbiosis (imbalance) of the normal vaginal flora. This distinction categorizes it as vaginosis rather than vaginitis, which typically implies an inflammatory condition of the vagina.

### NEW QUESTION # 101

You are doing a physical assessment of a female patient whose probable diagnosis is Addison's disease. If this is indeed the final diagnosis you would expect to find all but which of the following during this examination?

- A. loss of hair in the axillary and pubic region
- B. loss of weight
- C. bradycardia
- D. orthostatic hypotension

**Answer: C**

Explanation:

Addison's disease, also known as primary adrenal insufficiency, is a condition where the adrenal glands do not produce sufficient steroid hormones, including cortisol and aldosterone. This insufficiency leads to a variety of symptoms and signs that can be identified during a physical examination. Here, we will discuss each of the listed findings and clarify which one is not typically associated with Addison's disease.

**\*\*Loss of Weight:\*\*** Weight loss is a common symptom in Addison's disease. Due to the lack of cortisol, which plays a critical role in metabolism and the management of carbohydrates, proteins, and fats, patients often experience decreased appetite and significant weight loss.

**\*\*Bradycardia:\*\*** Contrary to what might be expected, Addison's disease is more commonly associated with tachycardia rather than bradycardia. Bradycardia, or a slower than normal heart rate, is not a typical finding in Addison's disease. Cortisol deficiency generally leads to low blood pressure, and the body often compensates by increasing heart rate, resulting in tachycardia. Therefore, bradycardia would be the finding you would not expect in a patient with Addison's disease during a physical examination.

**\*\*Loss of Hair in the Axillary and Pubic Region:\*\*** Addison's disease can also impact androgen levels, leading to changes in hair distribution. The decrease in androgens can result in the thinning or loss of pubic and axillary hair, making this a relevant finding in the assessment of someone with suspected Addison's disease.

**\*\*Orthostatic Hypotension:\*\*** This is another common finding in Addison's disease. Due to aldosterone deficiency, there is less sodium retention which can lead to a decrease in blood volume, exacerbating the issue of low blood pressure. Patients with Addison's disease often experience a significant drop in blood pressure upon standing, known as orthostatic hypotension. In conclusion, during the physical assessment of a patient suspected of having Addison's disease, the presence of bradycardia would be unusual and not expected. The symptoms consistent with Addison's disease include weight loss, loss of hair in the axillary and pubic regions, orthostatic hypotension, and typically tachycardia, not bradycardia. Other signs to look for include hyperpigmentation of the buccal mucosa and other pressure areas, as well as muscle wasting.

### NEW QUESTION # 102

You are deciding what type of medication to prescribe for your patient for treatment of a peptic ulcer. If you prescribe nizatidine what type of drug are you prescribing?

- A. mucosal healing agent
- B. antacid
- C. histamine2 antagonist
- D. proton pump inhibitor

**Answer: C**

Explanation:

If you are considering prescribing nizatidine for the treatment of a peptic ulcer, you are choosing a medication that falls under the category of histamine2 (H2) antagonists. Nizatidine works by blocking histamine receptors on the cells in the stomach lining that produce acid. Specifically, it targets the H2 receptors, leading to decreased production of stomach acid.

H2 antagonists such as nizatidine are particularly useful in reducing gastric acid secretion and increasing the pH of the stomach, which can help in healing or preventing ulcers. By decreasing the amount of acid produced, these medications allow the stomach lining and any existing ulcerations more opportunity to heal.

Other drugs in the H2 antagonist class include cimetidine, famotidine, and ranitidine HCl. These medications share a similar mechanism of action with nizatidine, though they may differ in potency, duration of action, and side effects. Nizatidine is often chosen for its efficacy and favorable side effect profile.

It is important to differentiate H2 antagonists from other types of drugs used to treat peptic ulcers, such as proton pump inhibitors (PPIs) and antacids. PPIs work by a different mechanism, inhibiting the proton pump in the stomach lining that is responsible for the final step in acid production. Antacids, on the other hand, neutralize existing stomach acid rather than reducing its production.

When prescribing nizatidine, it is essential to consider the specific needs of the patient, their medical history, and any potential interactions with other medications they may be taking. As with any medication, monitoring the patient's response and adjusting the treatment as necessary is crucial for effective management of peptic ulcers.

### NEW QUESTION # 103

If a patient comes to the clinic complaining of an abrupt onset of unilateral facial paralysis with no other symptoms, which of the following might the nurse practitioner suspect?

- A. Bell's palsy
- B. Polymyalgia rheumatica
- C. Temporal arteritis
- D. Tic Douloureux

**Answer: A**

Explanation:

When a patient presents with the sudden onset of unilateral facial paralysis and no accompanying symptoms, Bell's palsy is a primary condition to consider. Bell's palsy is a neurological disorder that results in temporary weakness or paralysis of the facial muscles.

This condition is thought to stem from inflammation or compression of the facial nerve, known as cranial nerve VII. The exact cause of this inflammation is not always clear, but it is often linked to viral infections that can cause swelling of the nerve.

The hallmark of Bell's palsy is the rapid onset of paralysis, typically unfolding over hours to a day, and generally affecting only one side of the face. Patients may notice that they are unable to move their facial muscles on the affected side. This can include the inability to close the eye, raise the eyebrow, smile, or frown on that side. The face might look drooped or asymmetrical. Despite the dramatic presentation, most patients with Bell's palsy experience a significant improvement in symptoms within weeks, and complete

recovery is possible within several months.

While Bell's palsy is a likely diagnosis in cases of sudden unilateral facial paralysis, other conditions might also be considered. These include: - **Tic Douloureux (Trigeminal Neuralgia)**: This condition affects the trigeminal nerve, another cranial nerve, but it is characterized by severe, episodic facial pain rather than muscle paralysis. - **Temporal arteritis**: This involves inflammation of the arteries in the temple area of the head. It can cause pain and, in severe cases, vision loss, rather than facial paralysis. - **Polymyalgia rheumatica**: This is an inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders and hips, rather than isolated facial paralysis.

Given these alternatives, Bell's palsy remains the most consistent with the symptoms of abrupt unilateral facial paralysis without other accompanying signs. Diagnosis is typically clinical but can be supported by ruling out other causes through patient history, physical examination, and possibly imaging or other diagnostic tests. Treatment for Bell's palsy may involve corticosteroids to reduce inflammation and swelling around the facial nerve. In some cases, antiviral medications may be used, especially if a viral infection is suspected to be the underlying cause.

#### NEW QUESTION # 104

Your patient complains of a sudden onset of palpitations and dizziness. The ECG shows peaked QRS complex and p waves are present, with a HR of 155. This is known as which of the following?

- A. atrial fibrillation
- B. none of the above
- C. mitral valve prolapse
- D. paroxysmal atrial tachycardia

**Answer: D**

Explanation:

To diagnose and understand the ECG findings and symptoms described, it is essential to first interpret the ECG characteristics and relate them to clinical manifestations. The ECG shows a rapid heart rate of 155 beats per minute, which falls under the category of tachycardia. The presence of p waves indicates that the atria are still being activated in a regular manner, which helps differentiate the type of tachycardia. The description of "peaked QRS complexes" can be somewhat ambiguous but typically might suggest high amplitude or sharp QRS complexes, which are not commonly seen in tachycardias originating above the ventricles (supraventricular tachycardias). However, in this context, it seems to imply a distinct, clear QRS complex, suggesting that the ventricles are being activated in a normal fashion, pointing away from ventricular tachycardias.

Based on the symptoms of palpitations and dizziness accompanying the fast heart rate, and given that the ECG shows a tachycardia with recognizable p waves and normal QRS complexes, the most likely diagnosis is Paroxysmal Atrial Tachycardia (PAT). PAT, also known as Paroxysmal Supraventricular Tachycardia (PSVT), is a condition where episodes of sudden, rapid heart rate originate in the atria or atrioventricular node. These episodes can start and stop abruptly, hence the term "paroxysmal." In PAT, the heart rate typically ranges from 140 to 250 beats per minute. The presence of palpitations (a sensation of the heart racing or pounding) and dizziness (which can result from decreased cardiac output due to the rapid heart rate) aligns well with this diagnosis. The treatment options for PAT include maneuvers that stimulate the vagus nerve such as carotid massage, as well as pharmacological interventions with calcium-channel blockers or beta blockers, which help slow the heart rate and control the rhythm.

In contrast, other conditions listed such as atrial fibrillation, which is characterized by an irregularly irregular rhythm and absent p waves, and mitral valve prolapse, typically associated with mid-systolic clicks and potential regurgitation murmurs on auscultation, do not fit the ECG findings or the patient's presentation in this scenario.

Therefore, the correct diagnosis in this case, given the ECG findings of a rapid heart rate with clear p waves and peaked QRS complexes, along with the clinical presentation of sudden onset palpitations and dizziness, is indeed Paroxysmal Atrial Tachycardia.

#### NEW QUESTION # 105

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