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Question: 1242

A 70-year-old male with ESRD (eGFR 12 mL/min, on HD) experiences dialysis complications (Kt/V 1.2, hypotension episodes). He requests withdrawal despite capacity (MoCA 26/30). Family objects. The ANP supports after counseling. Which principle underpins non-coercion despite poor outcomes?

A. Non-maleficence
B. Autonomy
C. Fidelity
D. Beneficence

Answer: B
Explanation: Autonomy affirms competent patients' right to refuse life-sustaining HD, even with family dissent, as quality over quantity prevails per NKF ethics, validated by capacity assessment. Beneficence favors continuation. Non-maleficence weighs burdens. Fidelity secondary.

Question: 1243

A 55-year-old female with asthma has persistent daytime symptoms more than once per week and nighttime symptoms twice per month. Her FEV_1 is 80% predicted, and she has had one severe exacerbation requiring hospitalization in the past year. She is currently on daily low-dose ICS plus SABA as-needed. Which intervention aligns most closely with GINA 2024 recommendations?

A. Increase the ICS to medium dose and maintain SABA as-needed.
B. Continue the current regimen and educate on trigger avoidance.
C. Add a LABA to create a low-dose ICS–LABA combination.
D. Switch to as-needed low-dose ICS–formoterol.

Answer: C
Explanation: GINA 2024 recommends that adults with persistent asthma who remain symptomatic or have had exacerbations despite low-dose ICS plus SABA should be escalated to a low-dose ICS–LABA combination, which is more effective than increasing ICS dose alone and reduces the risk of future exacerbations. As-needed ICS–formoterol is primarily recommended as initial therapy in mild asthma, not as a step-up from poorly controlled daily ICS plus SABA. Continuing the current regimen without escalation would not address the ongoing symptoms and exacerbation risk.

Question: 1244

Nutritional counseling for a 75-year-old female with sarcopenia (gait speed 0.7 m/s, ASM/height2 6.8 kg/m2) and albumin 3.4 g/dL. 24-hour recall: protein 0.7 g/kg/day. Recent fall (Berg 52/56). Which leucine-enriched strategy per PROT-AGE equation targets MPS?

A. Casein 20g evening + total 1.2 g/kg/day
B. Soy isolate 35g midday + vitamin D 1000 IU
C. Whey protein 30g post-resistance + leucine 3g
D. Pea protein 25g breakfast + omnivore spread

Answer: C
Explanation: Whey 30g with 3g leucine acutely spikes MPS 25% in elderly per timed PROT-AGE dosing (25-30g/meal, leucine >2.5g), improving gait 0.1 m/s and albumin in RCTs, critical post-fall. Casein sustains nocturnal but suboptimal acute. Pea/soy leucine-poor. Vitamin D adjunctive.

Question: 1245

After a near-miss event in which a patient with atrial fibrillation (CHA2DS2-VASc score 5) was discharged without anticoagulation (INR not checked, apixaban not restarted), the clinic initiates a PDSA project with Just Culture. (Select All that Apply)

A. In the Plan phase, design a discharge checklist that includes mandatory review of anticoagulation status and renal function (CrCl) before finalizing discharge orders
B. In the Act phase, counsel any provider who forgets to complete the checklist because Just Culture requires individual accountability for safety checklists
C. In the Study phase, measure the percentage of high-risk patients discharged with appropriate anticoagulation and the time to therapeutic anticoagulation restart
D. In the Do phase, pilot the checklist on all patients with atrial fibrillation admitted to the hospitalist service

Answer: A,C
Explanation: In the Plan phase, design a discharge checklist that includes mandatory review of anticoagulation status and renal function (CrCl) before finalizing discharge orders is correct because checklists are effective tools in the Plan phase for high-risk transitions. In the Study phase, measure the percentage of high-risk patients discharged with appropriate anticoagulation and the time to therapeutic anticoagulation restart is correct because the Study phase tracks process and outcome measures. In the Do phase, pilot the checklist on all patients with atrial fibrillation admitted to the hospitalist service is a reasonable test, but the question highlights core PDSA elements. In the Act phase, counsel any provider who forgets to complete the checklist because Just Culture requires individual accountability for safety checklists is incorrect because forgetting a checklist item is typically human error or at-risk behavior addressed through coaching and system improvement rather than counseling.

Question: 1246

A 79-year-old community-dwelling female with hypertension and osteoarthritis undergoes frailty

assessment. Her Rockwood Frailty Index is calculated as 0.28 based on 14 deficits out of 50 variables, including unintentional weight loss of 6% over 6 months, exhaustion per CES-D score ≥3, and slow gait speed of 0.65 m/s. Labs reveal hemoglobin 11.5 g/dL and albumin 3.4 g/dL. Recent fall with hip contusion. Which Frailty Index value most precisely stratifies her 5-year mortality risk at 48% per the Canadian Study of Health and Aging?

A. 0.15 (pre-frail)
B. 0.25 (frail)
C. 0.28
D. 0.10 (non-frail)

Answer: C
Explanation: A Rockwood Frailty Index of 0.28 falls in the mild frailty range (0.25-0.35), predicting approximately 48% 5-year mortality in validated cohorts like the CSHA, driven by cumulative deficits including weight loss >5%, exhaustion, slowness (gait <0.8 m/s cutoff), and anemia (hemoglobin <12 g/dL in females). Lower values like 0.10 or 0.15 indicate non-frail or pre-frail states with mortality <20%; 0.25 is borderline but underestimates her deficit accumulation relative to age-predicted norms.

Question: 1247

An 80-year-old male with mild cognitive impairment and his wife present for preoperative clearance before elective total knee arthroplasty. The patient has hypertension controlled on amlodipine 10 mg daily (BP 128/76 mm Hg) and asks the nurse practitioner to sign the surgical consent form because "my wife always handles these things." The patient can explain the procedure in general terms but defers all questions to his wife.

A. Conduct a capacity assessment for the specific decision to undergo elective surgery and document findings before determining whether the patient or surrogate should provide consent
B. Refuse to provide clearance until the patient demonstrates independent understanding without input from his wife
C. Allow the wife to sign the consent form as surrogate because the patient's deferral behavior indicates he lacks capacity for surgical decisions
D. Sign the consent form on behalf of the patient because the procedure is low-risk elective surgery and the patient appears agreeable

Answer: A
Explanation: Conduct a capacity assessment for the specific decision to undergo elective surgery and document findings before determining whether the patient or surrogate should provide consent is correct because capacity is not global but decision-specific; mild cognitive impairment does not automatically eliminate capacity, and a structured assessment is required to determine if the patient can provide informed consent or if the surrogate (wife) should be involved. Allow the wife to sign the consent form as surrogate because the patient's deferral behavior indicates he lacks capacity for surgical decisions is incorrect because deferral alone does not prove lack of capacity; formal assessment is necessary. Sign the consent

form on behalf of the patient because the procedure is low-risk elective surgery and the patient appears agreeable is incorrect because providers cannot provide consent for capacitated patients; the patient or authorized surrogate must consent. Refuse to provide clearance until the patient demonstrates independent understanding without input from his wife is incorrect because family involvement in discussions is often beneficial and does not preclude capacity if the patient ultimately expresses a choice after receiving information.

Question: 1248

A 68-year-old female presents with rapid-onset confusion, a stumbling gait, and nystagmus. She has a history of malabsorption and alcohol use. Which of the following should be administered immediately?

A. Risperidone 0.5 mg
B. Intravenous Thiamine (Vitamin B1)
C. Intravenous Glucose (D5W) alone
D. Oral Iron supplements

Answer: B
Explanation: The triad of confusion, ataxia (gait issues), and ophthalmoplegia/nystagmus is classic for Wernicke's Encephalopathy, caused by thiamine deficiency. This is a medical emergency and must be treated with IV thiamine immediately. Importantly, thiamine must be given *before* or with glucose to avoid worsening the condition.

Question: 1249

A 71-year-old woman with palpitations has a 12-lead EKG showing sawtooth flutter waves at 300 bpm with 2:1 AV conduction resulting in ventricular rate of 150 bpm.

A. Indicative of multifocal atrial tachycardia
B. Suggestive of ventricular flutter
C. Normal sinus rhythm
D. Consistent with atrial flutter with rapid ventricular response

Answer: D
Explanation: The option Consistent with atrial flutter with rapid ventricular response is correct because the classic sawtooth flutter waves at 300 bpm with 2:1 conduction producing a ventricular rate of 150 bpm is diagnostic of atrial flutter, requiring rate control and anticoagulation consideration in this age group. The option Indicative of multifocal atrial tachycardia is incorrect because MAT shows multiple distinct P-wave morphologies without flutter waves. The option Normal sinus rhythm is incorrect because there are no P waves and the atrial rate is 300 bpm. The option Suggestive of ventricular flutter is incorrect because QRS complexes are narrow and supraventricular in origin.

Question: 1250

Exercise prescription for 67-year-old female with breast Ca survivor (stage II, taxane neuropathy, FACT-B 125/160). mTNS score 18/32. Off chemo 6 months. Which per ACSM oncology targets CIPN?

A. Swimming 30 min + yoga
B. Cycling + acupuncture
C. Balance training + low-load RT
D. Brisk walking + vibration platform

Answer: C
Explanation: Balance/RT (proprioceptive focus, 2-3x/week) reduces mTNS 4-6 points via neural adaptation in survivorship guidelines, avoiding compressive modalities. Swimming/yoga adjunctive. Walking non-specific. Cycling neuropathy-aggravating.

Question: 1251

A 65-year-old patient with COPD (FEV1 45% predicted) reports that they can still bathe and dress themselves but can no longer vacuum the house or carry groceries. How should the NP categorize these functional limitations?

A. Total functional dependence
B. Intact IADLs with impaired ADLs
C. Normal functional status for age
D. Intact ADLs with impaired IADLs

Answer: D
Explanation: Vacuuming and carrying groceries are instrumental activities of daily living (IADLs), which require more physical exertion and environmental interaction. Since the patient can still perform self-care tasks like bathing and dressing (basic ADLs), their ADLs are intact while their IADLs are impaired.

Question: 1252

A 62-year-old postmenopausal female presents with 6-month history of urine leakage with coughing/sneezing, no urgency. Pelvic exam shows good support. Most likely incontinence type and first-line treatment?

A. Overflow; alpha-blocker
B. Urge; anticholinergic

C. Stress; pelvic floor exercises
D. Functional; absorbent pads

Answer: C
Explanation: Classic stress urinary incontinence (SUI) from urethral hypermobility/weakness; first-line is supervised pelvic floor muscle training (PFMT/Kegels, 8-week programs yield 50-70% improvement per AUA/ICS guidelines). Urge has urgency; overflow weak stream; functional mobility issue.

Question: 1253

MoCA recall 0/5, recognition 2/5 total 19/30 76yo APOE e4+. Amnestic converter if recall <2.

A. APOE e4+
B. MoCA total 19/30
C. Recall 0/5
D. Recognition 2/5

Answer: C
Explanation: Recall 0/5 predicts 80% AD conversion 2 years.

Question: 1254

In a 72-year-old male with treatment-resistant insomnia (ISI score 22) and mild cognitive impairment (MoCA 24/30), CBT for insomnia (CBT-I) is initiated. Baseline actigraphy shows sleep efficiency of 62% and wake after sleep onset (WASO) of 95 minutes. Which CBT-I component directly counters his stimulus control violations by linking bed to sleep?

A. Stimulus control instructions
B. Relaxation training with progressive muscle relaxation
C. Sleep restriction therapy titrating total sleep time
D. Cognitive restructuring of sleep misperceptions

Answer: A
Explanation: Stimulus control instructions—using the bed only for sleep, leaving bed if awake >20 minutes, consistent rise time—directly extinguish bed-wake associations, boosting sleep efficiency to >85% in CBT-I trials for older adults with MCI, as seen in SHUT-i studies. Cognitive restructuring addresses unhelpful beliefs (e.g., "I must sleep 8 hours") but not behavioral conditioning. Relaxation reduces arousal pre-bed but ignores environmental cues. Sleep restriction consolidates sleep via time-in-bed reduction but requires stimulus control as a foundational pairing to prevent bidirectional interference.

Question: 1255

Incident reporting reveals 12 opioid overprescribes (MME >90/day in frail 80+ yo, fall risk score 4/5). Just Culture codes MA override of alert as?

A. Punitive; license review
B. Blameless; no action
C. Reckless; firing
D. At-risk behavior; redesign alert hierarchy

Answer: D
Explanation: Overrides represent at-risk behavior (choosing expediency over safety in polypharmacy gerontology), warranting system redesign (e.g., hard-stop alerts, pharmacist review) under Just Culture to coach without fear, enhancing reporting for QI [from prior]. Recklessness requires intent; blameless ignores patterns.

Question: 1256

DXA quality: least reliable site in scoliosis?

A. Femoral neck
B. Total hip
C. Lumbar spine
D. Forearm

Answer: D
Explanation: Forearm (1/3 radius) preferred secondary site in spinal deformity (NOF/ISCD); spine unreliable due to artifact.
Hematopoietic/Immune (51-60)

Question: 1257

A 70-year-old male on amiodarone for AFib, TSH 15.8 mIU/L, free T4 2.2 ng/dL (ref 0.8-1.8), T3 85 ng/dL (ref 80-180), no symptoms. Per ATA amiodarone guidelines, management?

A. Monitor TSH every 3 months
B. Propylthiouracil 50 mg TID
C. Levothyroxine 25 mcg + liothyronine
D. Methimazole 10 mg daily

Answer: A
Explanation: Monitor TSH every 3 months because ATA guidelines for amiodarone-induced

hypothyroidism (TSH 15.8 mIU/L, high-normal T4/T3) in asymptomatic elderly recommend observation if mild, as 20% resolve post-discontinuation; treatment if TSH >10 + symptoms or cardiac risk. Antithyroid drugs for hyper. No combo LT4/LT3.

Question: 1258

A 32-year-old female with a history of asthma reports intermittent wheezing and nighttime symptoms 2–3 nights per month. Her most recent FEV_1 is 84% predicted, and she has had one mild exacerbation requiring a short course of oral corticosteroids in the past year. According to the 2024 GINA strategy, which initial daily controller regimen is most appropriate?

A. As-needed low-dose inhaled corticosteroid–formoterol (ICS–formoterol)
B. Daily medium-dose ICS–LABA
C. Daily low-dose inhaled corticosteroid (ICS) plus as-needed SABA
D. Daily low-dose ICS–formoterol

Answer: D
Explanation: GINA 2024 classifies this patient as having mild-to-moderate asthma with partially controlled symptoms and one recent exacerbation. For adults and adolescents, GINA recommends a preferred Track-1 approach in which most patients start with daily low-dose ICS–formoterol as both maintenance and reliever therapy, which reduces exacerbations more effectively than SABA alone and improves symptom control. As-needed low-dose ICS–formoterol is typically reserved for patients with very mild, infrequent symptoms and no exacerbation risk. Daily low-dose ICS plus SABA is still acceptable but no longer preferred, and medium-dose ICS–LABA is reserved for persistent poor control on low-dose therapy.

Question: 1259

A 62-year-old patient with Type 2 Diabetes and Hypertension has a PHQ-9 score of 15. The patient is already on an SSR**I.** What is the most appropriate next step?

A. Augment with an atypical antipsychotic
B. Add a second SSRI to the regimen
C. Evaluate for medication adherence and potential side effects
D. Increase the SSRI to the maximum dose immediately

Answer: C
Explanation: Before making changes to a psychiatric regimen for a "moderate" score, the clinician must ensure the patient is actually taking the medication as prescribed and check for side effects or drug-drug interactions that might be hindering progress.

Question: 1260

A 80-year-old male with a history of multiple "mini-strokes" (TIAs) presents with a stepwise decline in memory and new gait instability. This pattern is most consistent with:

A. Creutzfeldt-Jakob Disease
B. Depression
C. Alzheimer's Disease
D. Vascular Dementia

Answer: D
Explanation: Vascular dementia often presents with a "stepwise" decline (sudden drops in function followed by plateaus) and is associated with cerebrovascular disease. Gait disturbances and focal neurological deficits are also common features.

Question: 1261

A 70-year-old male with known CAD has a chest X-ray showing no acute findings but prominent aortic knob calcification.

A. Suggestive of pulmonary embolism
B. Normal for age
C. Consistent with acute aortic dissection
D. Indicative of chronic atherosclerotic changes without acute process

Answer: D
Explanation: The option Indicative of chronic atherosclerotic changes without acute process is correct because aortic knob calcification is a common incidental finding of atherosclerosis in older adults and does not represent an acute emergency when no widening or other signs are present. The option Consistent with acute aortic dissection is incorrect because there is no mediastinal widening or double contour. The option Normal for age is incorrect as a standalone interpretation because documentation of vascular calcification is clinically relevant for risk assessment. The option Suggestive of pulmonary embolism is incorrect because CXR is usually normal or nonspecific in PE.

Question: 1262

PDSA funnel chart shows pneumonia vax stability post-education (n=200, 88%). Next?

A. Retrain all
B. Expand vaccines
C. New project

D. Sustain monitoring

Answer: D
Explanation: Funnel confirms control (no special causes), shifting to sustainment phase [from prior].

Question: 1263

An 80-year-old patient undergoes an echocardiogram as part of a preoperative clearance. The results show a left ventricular ejection fraction (LVEF) of 60%, mild left atrial enlargement, and a reversal of the E/A ratio on Doppler flow (E < A). The patient has no history of dyspnea or edema. How should the nurse practitioner interpret the E/A ratio finding?

A. It indicates normal age-related diastolic filling changes due to decreased ventricular compliance
B. It indicates severe mitral stenosis requiring valve replacement
C. It is a precursor to hypertrophic obstructive cardiomyopathy
D. It indicates acute systolic heart failure

Answer: A
Explanation: In the aging heart, the left ventricle becomes less compliant and relaxes more slowly. This leads to a greater reliance on the "atrial kick" for ventricular filling. On Doppler echocardiography, the E wave (early passive filling) becomes smaller and the A wave (atrial contraction) becomes larger, leading to a reversed E/A ratio. In an asymptomatic older adult, this is a normal age-related change and does not necessarily indicate clinical diastolic heart failure (HFpEF) unless associated with symptoms and other structural markers.

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