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Question: 2616

A patient with major depressive disorder is prescribed nortriptyline. Which patient factor most increases the risk of anticholinergic and cardiac adverse effects?

A. Older age
B. Low body mass index only
C. Male sex only
D. Young age

Answer: A

Explanation: Older adults have reduced metabolic clearance, greater sensitivity to anticholinergic effects, and higher vulnerability to conduction abnormalities. Tricyclic antidepressants can cause tachycardia, orthostatic hypotension, urinary retention, delirium, and potentially fatal arrhythmias in overdose.

Question: 2617

A clinician is reviewing the concept of therapeutic index (TI) during a clinical pharmacology conference. Therapeutic index is mathematically defined as the ratio of the median lethal dose (or toxic dose) to the median effective dose:$\mathrm{TI} = \frac{\mathrm{TD}*50}{\mathrm{ED}*50}$ Which prescribed psychotropic medication possesses a narrow therapeutic index, requiring routine therapeutic drug monitoring (serum concentration checks) to avoid severe toxicity?

A. Gabapentin

B. Sertraline

C. Buspirone

D. Lithium carbonate

Answer: D

Explanation: Lithium carbonate has a narrow therapeutic index (TI), meaning the therapeutic dose range (0.6 to $1.2, \mathrm{mEq/L}$) is very close to toxic concentrations ($> 1.5, \mathrm{mEq/L}$). Concentrations above 1.5 mEq/L can cause tremor, ataxia, confusion, seizures, renal failure, and arrhythmias. Consequently, routine therapeutic drug monitoring (TDM) of serum lithium levels is mandatory for safe clinical care.

Question: 2618

A 24 year old patient with depression believes that an antidepressant will change the patient's personality because the patient's social media group describes medication as suppressing authentic emotions. The patient has not previously received psychiatric treatment. Which response is most appropriate?

A. Guarantee that medication cannot affect emotional experience or personality related perceptions

B. Dismiss the concern because information from peers has no influence on treatment behavior

C. Explore the patient's understanding, provide balanced information about expected effects and possible adverse effects, and invite questions

D. Recommend avoiding medication because first treatment decisions should be made without external information

Answer: C

Explanation: Peer accounts and social media can shape beliefs about medication, particularly among patients without prior treatment experience. The clinician should explore what the patient means by personality change and distinguish intended symptom improvement from possible emotional adverse effects. Balanced discussion should acknowledge individual variability, relevant risks, alternatives, and the need to communicate concerns to the prescriber. Guarantees are inappropriate because responses differ. The patient should receive information sufficient for an informed decision rather than having concerns dismissed or being steered automatically toward or away from pharmacological treatment.

Question: 2619

A patient undergoing antipsychotic pharmacotherapy develops hyperprolactinemia, resulting in galactorrhea and amenorrhea. Which specific neuroanatomical pathway blockade by dopamine antagonists is responsible for this endocrine adverse effect?

A. Mesocortical pathway
B. Mesolimbic pathway
C. Nigrostriatal pathway
D. Tuberoinfundibular pathway

Answer: D

Explanation: Dopamine acts as the primary physiological prolactin-inhibiting factor (prolactin-release inhibiting factor) by binding to D_2 receptors on anterior pituitary lactotroph cells. Antipsychotic drugs that block D_2 receptors in the tuberoinfundibular pathway remove this inhibitory tonic control, leading to elevated

prolactin levels (hyperprolactinemia) and associated clinical consequences like galactorrhea and amenorrhea.

Question: 2620

A 40 year old patient with posttraumatic stress disorder identifies a trusted community elder as an important source of emotional support. The patient wants to continue this relationship while receiving evidence based psychotherapy and prescribed medication. The elder has expressed concern that clinical treatment will undermine the patient's cultural identity. Which approach is most appropriate?

A. Tell the patient that the community elder must be excluded from all discussions of recovery
B. Replace evidence based treatment with the elder's preferred approach to avoid cultural conflict
C. Allow the elder to determine which clinical interventions should be used
D. Explore the patient's goals and concerns and, with the patient's informed consent, consider respectful collaboration that preserves clinical responsibilities and cultural safety

Answer: D

Explanation: Trusted community figures may contribute social support, cultural continuity, and engagement, but their participation should be guided by the patient's wishes and appropriate boundaries. With informed consent, the psychologist may explain the treatment goals and explore ways to address concerns about cultural identity. The elder should not replace the prescriber's role or dictate clinical decisions, and the psychologist should not dismiss a meaningful source of support automatically. The integrated plan can respect cultural values while retaining evidence based interventions and clear responsibility for medication management.

Question: 2621

A 65-year-old male with major depressive disorder is started on escitalopram. His past medical history is significant for chronic renal failure with a creatinine clearance of $20\ \mathrm{mL/min}$. The clinician must consider how renal impairment affects drug disposition. For a drug that is eliminated predominantly through hepatic metabolism with minimal unchanged renal excretion, how is the elimination half-life ($t_{1/2}$) typically affected in severe renal disease?

A. The elimination half-life remains largely unchanged unless active metabolites cleared by the kidney contribute to toxicity
B. The elimination half-life is prolonged proportionally to the exact drop in creatinine clearance values
C. The elimination half-life is shortened due to compensatory hyperactivation of biliary excretion pathways
D. The elimination half-life becomes infinite because renal clearance constitutes the sole elimination route

Answer: A

Explanation: Drugs that undergo extensive hepatic biotransformation into inactive metabolites prior to elimination are primarily dependent on liver function rather than renal function. If renal clearance is severely impaired but hepatic metabolism remains intact, the elimination half-life of the parent drug is typically unaffected. However, caution is still required if the metabolites themselves are pharmacologically active and depend on renal excretion for elimination, as metabolite accumulation can cause unexpected toxicity.

Question: 2622

A compound increases the opening frequency of a ligand-gated receptor channel but does not increase the number of receptors on the membrane. At the same agonist concentration, the postsynaptic response becomes larger. Which property of the compound is most consistent with this effect?

A. Positive allosteric modulation that enhances receptor response
B. Negative allosteric modulation that reduces agonist efficacy
C. Competitive antagonism that prevents agonist binding
D. Irreversible antagonism that removes receptors from the membrane

Answer: A

Explanation: Positive allosteric modulators bind to a site distinct from the orthosteric agonist-binding site and enhance the receptor's response to agonist binding. Depending on the receptor, they may increase channel opening frequency, duration, or the probability of activation. Because receptor number is unchanged and the response to a given agonist concentration increases, enhanced receptor function is more consistent than receptor upregulation. Competitive antagonists and negative allosteric modulators would reduce rather than enhance the agonist response.

Question: 2623

A patient with severe traumatic brain injury develops agitation, disinhibition, and emotional lability during rehabilitation. Which medication strategy is most consistent with cautious prescribing?

A. Avoid nonpharmacologic behavioral interventions because they delay medication

response

B. Use high-dose antipsychotic treatment as the first intervention for all agitation

C. Initiate multiple psychotropics simultaneously to achieve rapid behavioral control

D. Begin with low doses and titrate slowly while monitoring cognition and behavior

Answer: D

Explanation: In traumatic brain injury, pharmacologic treatment should begin with the lowest effective dose and slow titration because of increased sensitivity to adverse central nervous system effects. Behavioral and environmental interventions are important first-line or concurrent strategies. Simultaneous polypharmacy, routine high-dose antipsychotic use, and neglecting nonpharmacologic approaches increase risk and are not appropriate default strategies.

Question: 2624

A 49-year-old refugee woman with PTSD and hypertension attributes symptoms to spiritual imbalance. When creating an integrated plan of trauma-focused psychotherapy, an antihypertensive, and traditional healing, which practitioner action most effectively supports the partnership?

A. Focusing only on blood-pressure control and treating trauma symptoms as secondary

B. Introducing trauma-focused therapy only after traditional healing is completed

C. Coordinating with the traditional healer while carefully monitoring blood pressure response

D. Requiring the patient to discontinue traditional practices before starting Western treatment

Answer: C

Explanation: Coordinating with the traditional healer while monitoring physiological parameters demonstrates respect for cultural resources and prioritizes safety. This approach improves adherence, enhances education, and creates a coherent integrated plan that addresses both trauma and medical comorbidity.

Question: 2625

A 36-year-old pregnant patient with severe mania requires pharmacologic treatment. Which decision-making principle most strongly guides agent selection?

A. Extrapolation of short-term efficacy data from non-pregnant adults
B. Reproductive-safety data balanced against the risk of untreated mania
C. Ease of obtaining prior authorization from the insurer
D. Acquisition cost of the medication relative to older agents

Answer: B

Explanation: In pregnancy the central decision-making framework is a careful weighing of each agent's documented teratogenic and perinatal risks against the substantial maternal and fetal risks posed by untreated mania.

Question: 2626

A 19 year old university student presents with anxiety, reduced sleep, rapid speech, and unusually high energy. The student says the symptoms began after starting an intensive study schedule and consuming several energy drinks daily. A parent has a history of bipolar I disorder, but the patient has never received a psychiatric

diagnosis. Which next step is most important for distinguishing a primary mood disorder from substance related or situational symptoms?

A. Obtain a detailed timeline of symptoms, sleep, energy drink and substance exposure, prior episodes, impairment, and family psychiatric history
B. Attribute the presentation to academic stress because the patient has no previous diagnosis
C. Use the family history alone to conclude that the current symptoms represent bipolar disorder
D. Begin an anxiety focused intervention without assessing mood episode history

Answer: A

Explanation: A longitudinal history is essential when symptoms could reflect a primary mood disorder, stimulant exposure, sleep deprivation, or a combination. The clinician should establish the onset and duration of symptoms, changes from baseline, degree of impairment, associated features such as elevated or irritable mood, prior similar episodes, substance and medication exposure, and family psychiatric history. A family history raises clinical suspicion but is not sufficient to establish a diagnosis. The absence of a previous diagnosis does not exclude a first mood episode.

Question: 2627

A 47 year old patient with anxiety reports that prescribed medication helps during the week but that symptoms intensify on weekends when the patient has little structure and limited social contact. The patient concludes that the medication is wearing off psychologically because the patient feels lonely. Which formulation best guides care?

A. Explain that loneliness is unrelated to anxiety symptoms and should be addressed outside treatment

B. Recommend increasing the dose on weekends without consultation with the prescriber

C. Assess medication timing alongside social isolation, activity patterns, symptom triggers, and the patient's expectations of treatment

D. Conclude that weekend symptoms prove the medication is pharmacologically ineffective

Answer: C

Explanation: Symptom patterns may reflect medication timing, environmental triggers, social isolation, activity structure, or several interacting influences. Weekend worsening does not automatically establish medication failure. A functional assessment can identify differences in routines, exposure to stressful situations, sleep, and social support across the week. Psychological strategies may help develop structured activities and address loneliness, while medication timing and effectiveness should be reviewed with the prescriber. Treatment should account for both symptom change and contextual influences rather than assuming a single cause.

Question: 2628

Which medication can exacerbate lithium-induced nephrogenic diabetes insipidus by increasing lithium reabsorption or reducing lithium clearance?

A. A topical corticosteroid

B. A proton pump inhibitor

C. A thiazide diuretic

D. A beta-2 agonist inhaler

Answer: C

Explanation: Thiazide diuretics can increase proximal tubular lithium reabsorption and reduce lithium clearance, raising serum lithium levels and toxicity risk. They may also worsen volume depletion and electrolyte disturbances. Beta-2 agonists, proton pump inhibitors, and topical corticosteroids do not have the same direct effect on lithium handling.

Question: 2629

A patient taking an antipsychotic develops a sustained resting tremor, bradykinesia, and rigidity. Which assessment is most appropriate to document the severity and guide management?

A. Measurement of serum creatine kinase alone
B. Standardized examination for parkinsonian adverse effects, including tremor, rigidity, bradykinesia, and gait
C. Random blood glucose and lipid panel only
D. EEG to assess for focal slowing

Answer: B

Explanation: Drug-induced parkinsonism is identified through focused neurological assessment of tremor, rigidity, bradykinesia, postural reflexes, and gait. Creatine kinase is useful when neuroleptic malignant syndrome is suspected, while metabolic labs and EEG do not quantify extrapyramidal symptoms.

Question: 2630

A 48-year-old patient on a second-generation antipsychotic develops a resting heart rate of 118 bpm and orthostatic dizziness. Which receptor profile most accurately accounts for these cardiovascular effects?

A. Prominent alpha-1 and muscarinic receptor antagonism
B. Pure dopamine D2 receptor blockade without autonomic effects
C. Selective beta-1 receptor agonism increasing contractility
D. Strong histamine H1 antagonism producing only sedation

Answer: A

Explanation: Concurrent alpha-1 blockade reduces vascular tone and produces orthostasis, while muscarinic blockade removes parasympathetic restraint on the sinoatrial node, allowing the observed sinus tachycardia; both effects are common with several second-generation agents.

Question: 2631

A 22-year-old male is brought to the emergency department by campus police after demonstrating acute agitation, paranoia, visual hallucinations, and aggressive behavior at a party. Physical examination reveals vertical and horizontal nystagmus, hypertension ($168/102, \text{mmHg}$), tachycardia ($124, \text{bpm}$), numbness to painful stimuli, and severe muscle rigidity. What substance of abuse is responsible for this toxidrome?

A. MDMA (Ecstasy) intoxication
B. Cannabis overdose
C. Phencyclidine (PCP) intoxication
D. Alcohol withdrawal

Answer: C

Explanation: Phencyclidine (PCP) intoxication presents with a characteristic toxidrome that differentiates it from other hallucinogens and stimulants. Key physical signs include multidirectional nystagmus (rotary, horizontal, and vertical nystagmus), analgesia/numbness, hypertension, tachycardia, muscle rigidity, and acute behavioral agitation or paranoia with unexpected physical strength. PCP acts primarily as an uncompetitive antagonist at NMDA glutamate receptors and an inhibitor of monoamine reuptake.

Question: 2632

A 30 year old patient reports persistent fatigue, low mood, and tingling in the feet. The patient follows a restrictive vegan diet and has not used vitamin supplements. The patient's gait appears mildly unsteady. Which assessment action is most appropriate?

A. Attribute the symptoms to depression because dietary choices are unrelated to neurological function
B. Explore dietary adequacy, neurological symptoms, duration and progression, medical conditions, and appropriate testing for nutritional deficiencies
C. Recommend a supplement without assessing the cause or obtaining a medical history
D. Conduct only a psychosocial assessment because nutritional issues should be addressed separately from psychopharmacology

Answer: B

Explanation: Restrictive dietary patterns can increase the risk of certain nutritional deficiencies. Vitamin B12 deficiency, for example, may cause fatigue, cognitive or mood symptoms, paresthesias, and gait abnormalities. These findings warrant medical evaluation and appropriate testing rather than assuming a primary psychiatric cause. The assessment should clarify food intake, supplement use, gastrointestinal conditions, symptom duration, neurological progression, and other possible causes. Nutritional and medical factors are part of a biopsychosocial assessment because they can affect both symptoms and medication safety.

Question: 2633

Which retrograde endocannabinoid messenger is synthesized on-demand from membrane phospholipid precursors (specifically diacylglycerol) in post-synaptic neurons following calcium influx, and acts as a full agonist at presynaptic CB_1 receptors to suppress neurotransmitter release?

A. Substance P
B. 2-Arachidonoylglycerol (2-AG)
C. Agmatine
D. Gamma-hydroxybutyrate (GHB)

Answer: B

Explanation: 2-Arachidonoylglycerol (2-AG) and Anandamide (AEA) are endogenous cannabinoids (endocannabinoids). Following post-synaptic depolarization and Ca^{2+} influx, 2-AG is synthesized on-demand by phospholipase C and diacylglycerol lipase (DAGL) from membrane lipid precursors. 2-AG diffuses retrogradely across the synaptic cleft to bind presynaptic CB_1 receptors ($G_{\alpha i/o}$-coupled). CB_1 activation inhibits presynaptic voltage-gated calcium channels and opens potassium channels, reducing presynaptic neurotransmitter exocytosis

(mediating short- and long-term synaptic depression, such as DSI and DIR).

Question: 2634

A 68-year-old female presents with a 2-year history of progressive resting tremor in her right hand ("pill-rolling"), bradykinesia, cogwheel rigidity, and a stooped, shuffling gait. Positron emission tomography (PET) using ^{18}F-DOPA demonstrates a marked loss of dopaminergic nerve terminals in the posterior putamen. What intraneuronal pathological hallmark defines Idiopathic Parkinson's Disease?

A. Intranuclear TDP-43 inclusion bodies localized within the anterior horn cells of the spinal cord
B. Intracytoplasmic inclusions composed of misfolded, aggregated alpha-synuclein protein (Lewy bodies) in the substantia nigra pars compacta
C. Hyperphosphorylated tau protein forming neurofibrillary tangles in the parietal cortex
D. Extracellular beta-amyloid plaques deposited in the dentate gyrus

Answer: B

Explanation: Idiopathic Parkinson's Disease is a progressive neurodegenerative synucleinopathy characterized pathologically by the loss of neuromelanin-containing dopaminergic neurons in the substantia nigra pars compacta (*SNc*) and the presence of intraneuronal cytoplasmic inclusion bodies called Lewy bodies. Lewy bodies are composed primarily of aggregated, misfolded α-synuclein protein. Loss of *SNc* projection neurons reduces dopamine delivery to the striatum, causing excessive inhibitory drive from the basal ganglia to the motor thalamus and generating classic parkinsonian motor signs.

Question: 2635

A patient with chronic low back pain undergoes imaging that reveals a degenerative spinal abnormality. The abnormality is common among people without pain, and its severity does not correlate with the patient's reported disability. The patient also has poor sleep, fear of movement, and heightened pain sensitivity. Which interpretation best reflects contemporary understanding of chronic pain?

A. Pain reflects interactions among peripheral input, central processing, and contextual factors
B. Psychological and sleep-related factors prove that the pain is fabricated
C. Chronic pain is determined exclusively by the degree of peripheral tissue damage
D. Imaging findings alone establish the cause and severity of pain

Answer: A

Explanation: Chronic pain is a multidimensional experience shaped by peripheral nociceptive input, central nervous system processing, attention, expectations, mood, sleep, learning, and social context. Structural abnormalities on imaging may be relevant, incidental, or only partly related to symptoms, so they must be interpreted alongside history and examination. Poor sleep, fear avoidance, and heightened sensitivity can amplify pain and disability without implying that the pain is fabricated. A biopsychosocial formulation helps explain why pain severity and imaging findings may not correspond closely.

Question: 2636

A 52-year-old male with chronic schizophrenia who has experienced poor adherence

to daily oral antipsychotic regimens is being transitioned to a long-acting injectable (LAI) second-generation antipsychotic. The psychiatric team selects paliperidone palmitate. To achieve therapeutic plasma concentrations rapidly without requiring concurrent oral supplementation during initiation, which specific dosing strategy must be executed on days 1 and 8 of treatment?

A. Titrating the oral equivalent dose upward from 3 mg to 12 mg daily prior to administering the first LAI injection
B. Administering a single gluteal loading dose of 400 mg eq. combined with oral paliperidone for 14 days
C. Initiating therapy with a monthly maintenance dose of 75 mg eq. split into bi-weekly intervals
D. Administering 150 mg eq. deltoid injection on day 1 followed by 100 mg eq. deltoid injection on day 8

Answer: D

Explanation: Paliperidone palmitate once-monthly formulations require a specific initiation regimen to reach therapeutic window rapidly due to the pharmacokinetic profile of the nanocrystalline suspension. The recommended initiation involves administering an initial loading dose of 150 mg equivalent in the deltoid muscle on day 1, followed by a second loading dose of 100 mg equivalent in the deltoid muscle one week later (day 8), both without needing oral supplementation.

Question: 2637

Which family-history domain is most relevant when assessing differential prevalence and presentation of psychiatric disorders across diverse populations?

A. Family psychiatric diagnoses, treatment access, migration and adversity history, cultural explanatory models, and medical comorbidities

B. Only parental educational attainment
C. Only the family's country of birth without clinical context
D. Only the presence or absence of a documented genetic test

Answer: A

Explanation: Culturally responsive assessment considers family psychiatric history alongside social determinants, migration and adversity, access to care, cultural explanations of distress, and medical comorbidity. These factors affect prevalence estimates, symptom expression, diagnosis, treatment engagement, and monitoring.

Question: 2638

A 30-year-old female presents with a 2-year history of sudden, unpredictable episodes where her legs give way and she collapses to the ground while remaining fully conscious, triggered by laughing or surprise. She also reports severe daytime sleepiness and hypnagogic hallucinations. What neurodiagnostic test sequence is required to confirm Narcolepsy Type 1?

A. Overnight Polysomnography (PSG) followed immediately by a Multiple Sleep Latency Test (MSLT) demonstrating mean sleep latency < 8 minutes and ≥ 2 Sleep-Onset REM Periods (SOREMPs)
B. Lumbar puncture measuring red blood cell count alone
C. Single non-contrast head CT scan
D. Single 20-minute resting electroencephalogram

Answer: A

Explanation: Confirming the diagnosis of Narcolepsy Type 1 requires a standardized

two-part neurodiagnostic sleep evaluation: 1) An overnight Polysomnogram (PSG) to ensure adequate baseline sleep ($\geq$ 6 hours) and rule out sleep apnea or movement disorders, followed immediately the next morning by 2) A Multiple Sleep Latency Test (MSLT). The MSLT measures daytime sleepiness across 4 or 5 nap opportunities spaced 2 hours apart. Diagnostic criteria for narcolepsy require a mean sleep onset latency of $<$ 8 minutes and the presence of two or more Sleep-Onset REM Periods (SOREMPs, where REM sleep occurs within 15 minutes of sleep onset across the naps and preceding PSG).

Question: 2639

Which condition is most likely to produce focal seizures secondary to a structural brain lesion?

A. Migraine without aura
B. Low-grade glioma
C. Vitamin D deficiency
D. Iron deficiency anemia

Answer: B

Explanation: Brain tumors, including low-grade gliomas, can irritate or disrupt cortical tissue and produce focal seizures. Iron deficiency, migraine without aura, and vitamin D deficiency are not typical direct causes of focal structural seizure foci, although severe metabolic disturbances can lower the seizure threshold.

Question: 2640

A 52-year-old patient develops fever, severe rigidity, and creatine kinase of 2,800

U/L five days after an antipsychotic dosage increase. Which immediate management step is required?

A. Increase the antipsychotic dose to overcome presumed under-treatment
B. Switch immediately to a long-acting injectable formulation of the same agent
C. Discontinue the antipsychotic and arrange urgent medical evaluation and supportive care
D. Continue the current dose and add an anticholinergic agent for rigidity

Answer: C

Explanation: The constellation of fever, rigidity, and markedly elevated creatine kinase is highly suggestive of neuroleptic malignant syndrome. Immediate cessation of the dopamine antagonist and intensive medical supportive care are mandatory.

Question: 2641

A 44-year-old immigrant woman with PTSD attributes symptoms to spiritual imbalance and prefers traditional healing. She has limited English proficiency and intermittent insurance. Which factors most strongly predict low medication utilization?

A. Gender differences in trauma neurobiology without cultural or access context
B. Cultural explanatory models intersecting with language and economic barriers
C. Middle-adult age alone determining absolute nonresponse risk
D. Strong social support fully overriding spiritual explanatory models

Answer: B

Explanation: Spiritual explanatory models combined with language barriers and

residual cost create multiple obstacles to pharmacological utilization. These biopsychosocial factors outweigh isolated age or gender variables.

Question: 2642

A 46 year old patient with depression has experienced little improvement during treatment. The patient reports taking the prescribed medication inconsistently because of nausea, but the patient fears that admitting this will lead the clinician to label them noncompliant. Which response is most appropriate?

A. Interpret the patient's reluctance to disclose symptoms as evidence of deliberate deception
B. Assume that the medication is ineffective and recommend a higher dose immediately
C. Explain that nausea is a necessary part of successful treatment and should not be reported
D. Ask about adverse effects and medication use nonjudgmentally, then coordinate a safe review with the prescriber

Answer: D

Explanation: Adherence difficulties are often influenced by adverse effects, expectations, stigma, and concerns about clinician judgment. A nonjudgmental conversation improves the accuracy of information needed to evaluate treatment. Inconsistent use may make it difficult to determine whether the medication has been adequately tried, while nausea may require clinical review. The psychologist should communicate relevant findings to the prescriber rather than recommend unsupervised dose changes. The patient's fear of being labeled noncompliant is itself an important determinant of disclosure and treatment engagement, so preserving a collaborative relationship is essential.

Question: 2643

A 57 year old patient with depression says that a spouse insists on monitoring every medication dose because the spouse fears a relapse. The patient feels infantilized and has begun concealing doses to preserve autonomy. Which response is most appropriate?

A. Tell the patient to stop medication to demonstrate independence
B. Explore autonomy, safety, the couple's concerns, and a mutually acceptable support plan consistent with the patient's informed choices
C. Recommend that the spouse assume complete control because relapse prevention outweighs the patient's preferences
D. Exclude the patient's relationship context from assessment because medication adherence is an individual behavior

Answer: B

Explanation: Social support can improve treatment engagement, but excessive monitoring may undermine autonomy and contribute to concealment or conflict. The clinician should assess the patient's preferences, treatment understanding, relapse history, and any genuine safety concerns. With the patient's consent, collaborative discussion may help establish support that respects independence while addressing the spouse's fears. Medication decisions remain between the patient and prescriber, subject to relevant legal and safety considerations. The goal is not to maximize surveillance but to support safe, sustainable treatment that the patient can accept and participate in honestly.

Question: 2644

A 48-year-old female patient with recurrent major depressive disorder undergoes pharmacogenomic testing following multiple antidepressant failures. The results show she is a CYP2D6 ultra-rapid metabolizer. How does this metabolic phenotype alter her systemic response to standard doses of CYP2D6-metabolized tricyclic antidepressants or SSRIs like paroxetine?

A. She cannot absorb the drug across the small intestine
B. Her central nervous system lacks serotonin receptors entirely
C. She accumulates high toxic drug levels, experiencing life-threatening toxicity at low doses
D. She metabolizes the drug at an accelerated rate, resulting in subtherapeutic plasma concentrations and lack of clinical response at standard doses

Answer: D

Explanation: CYP2D6 ultra-rapid metabolizers possess gene duplications or multiplications leading to excessive functional enzyme expression. Standard doses of drugs metabolized primarily by CYP2D6 (such as many TCAs, venlafaxine, and paroxetine) are cleared rapidly, producing subtherapeutic steady-state plasma concentrations (C_{ss}) and apparent treatment resistance unless higher doses or alternative non-CYP2D6-metabolized agents are selected.

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