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Question: 736

A 41-year-old woman undergoes a screening mammogram, which reveals a BI-RADS 3 lesion (probably benign). The radiologist recommends follow-up imaging in 6 months. What is the likelihood of malignancy for a BI-RADS 3 lesion, and what is the most appropriate management?

- A. 10–15% likelihood, immediate biopsy
- B. <2% likelihood, short-interval follow-up
- C. 50% likelihood, surgical excision

Answer: B

Explanation: BI-RADS 3 lesions have a <2% likelihood of malignancy, typically representing benign findings like fibroadenomas. Short-interval follow-up (6 months) is standard to monitor for changes, avoiding unnecessary biopsies. Higher BI-RADS categories (4 or 5) warrant biopsy or excision due to increased malignancy risk.

Question: 737

A 23-year-old woman presents with primary amenorrhea. Exam shows absent uterus and; filepath: G3P1 at 30 weeks gestation presents with severe abdominal pain and vaginal bleeding. Her BP is 160/100 mmHg, pulse 110 bpm, and hemoglobin is 8.5 g/dL. Ultrasound shows a retroplacental hematoma. What is the most appropriate management?

- A. Expectant management with bed rest
- B. Immediate cesarean delivery with blood transfusion
- C. Magnesium sulfate and antihypertensive therapy

Answer: B

Explanation: The patient has a placental abruption, indicated by severe pain, bleeding, hypertension, and retroplacental hematoma on ultrasound. Immediate cesarean delivery is necessary to prevent fetal and maternal compromise, and blood transfusion addresses anemia (hemoglobin 8.5 g/dL). Expectant management risks further abruption, and magnesium sulfate with antihypertensives does not address the acute hemorrhage.

Question: 738

A 29-year-old woman at 36 weeks gestation presents with a positive HIV antibody screen during routine

prenatal testing. A confirmatory Western blot is positive. She has no history of antiretroviral therapy. What is the most appropriate initial management to reduce the risk of vertical transmission?

- A. Begin zidovudine (AZT) monotherapy
- B. Initiate combination antiretroviral therapy (cART)
- C. Plan for elective cesarean delivery only

Answer: B

Explanation: A confirmed HIV diagnosis in pregnancy requires immediate initiation of combination antiretroviral therapy (cART) to suppress viral load and reduce the risk of vertical transmission to the fetus. Zidovudine monotherapy is outdated and less effective than cART. Elective cesarean delivery may be considered if the viral load remains detectable near delivery, but cART is the priority to achieve viral suppression.

Question: 739

A 30-year-old woman presents with a 2-week history of malodorous vaginal discharge. Wet mount shows clue cells, and vaginal pH is 5.2. She reports a new sexual partner. What is the most appropriate initial treatment for this suspected bacterial vaginosis?

- A. Clindamycin 2% vaginal cream for 7 days
- B. Metronidazole 500 mg orally twice daily for 7 days
- C. Fluconazole 150 mg orally single dose

Answer: B

Explanation: Bacterial vaginosis, confirmed by clue cells and elevated vaginal pH, is best treated with oral metronidazole 500 mg twice daily for 7 days, as it effectively targets anaerobic bacteria. Clindamycin is an alternative but less preferred. Fluconazole treats candidiasis, not bacterial vaginosis.

Question: 740

A 31-year-old woman, 8 days postpartum, presents with shortness of breath and right-sided calf pain. Her vital signs show a pulse of 100 bpm, respiratory rate of 24 breaths/min, and oxygen saturation of 92% on room air. A Doppler ultrasound confirms a deep vein thrombosis (DVT) in the right popliteal vein. What is the most appropriate anticoagulant therapy for this patient, considering she is breastfeeding?

- A. Start subcutaneous low-molecular-weight heparin (LMWH)
- B. Initiate oral warfarin with a target INR of 2.0–3.0
- C. Administer intravenous unfractionated heparin (UFH)

Answer: A

Explanation: The patient has a postpartum DVT, a thromboembolic disorder. Subcutaneous LMWH, such as enoxaparin, is preferred in breastfeeding women due to its safety profile and no need for frequent

monitoring. Warfarin is less preferred due to monitoring challenges and potential breast milk transfer. Intravenous UFH is typically used in acute settings but is less practical for outpatient management.

Question: 741

A 31-year-old woman with a history of gestational diabetes presents for a postpartum follow-up 6 weeks after delivery. She is breastfeeding and reports no symptoms of hyperglycemia. The provider orders a 2-hour 75g oral glucose tolerance test (OGTT). The results show: fasting glucose 100 mg/dL, 1-hour glucose 170 mg/dL, and 2-hour glucose 130 mg/dL. What is the most appropriate diagnosis?

- A. Normal glucose tolerance
- B. Prediabetes
- C. Type 2 diabetes

Answer: B

Explanation: According to the American Diabetes Association, prediabetes is diagnosed with a 2-hour 75g OGTT when the fasting glucose is 100-125 mg/dL, 1-hour glucose is 140-199 mg/dL, or 2-hour glucose is 140-199 mg/dL. This patient's fasting glucose (100 mg/dL) falls within the prediabetes range, and her 1-hour glucose (170 mg/dL) also supports this diagnosis. Type 2 diabetes requires higher thresholds (e.g., 2-hour glucose ≥ 200 mg/dL), and normal glucose tolerance would show lower values across all time points.

Question: 742

A 30-year-old woman, 4 days postpartum, reports excessive fatigue and difficulty staying awake despite adequate sleep opportunities. Her hemoglobin is 10.8 g/dL, and her ferritin is 15 ng/mL (normal: 30–400 ng/mL). She is breastfeeding and denies depressive symptoms. What is the most appropriate management for her fatigue?

- A. Initiate intravenous iron infusion
- B. Prescribe oral iron supplementation and monitor levels
- C. Recommend a sleep study for sleep apnea

Answer: B

Explanation: The patient's fatigue is likely due to iron deficiency anemia, as indicated by low hemoglobin and ferritin levels, common postpartum due to blood loss. Oral iron supplementation is the first-line treatment, with monitoring to assess response. Intravenous iron is reserved for severe or refractory cases. A sleep study is unnecessary without specific sleep apnea symptoms.

Question: 743

A 35-year-old G4P3 at 20 weeks gestation with a history of sickle cell disease presents with severe bone

pain and fever. Labs show hemoglobin of 7.0 g/dL and reticulocyte count of 1%. What is the most appropriate management to address her acute sickle cell crisis?

- A. Administer hydroxyurea and monitor hemoglobin weekly
- B. Initiate intravenous hydration and analgesia and transfuse packed red blood cells
- C. Prescribe oral iron and schedule follow-up in 2 weeks

Answer: B

Explanation: The patient is experiencing an acute sickle cell crisis, indicated by severe pain, anemia, and low reticulocyte count suggesting bone marrow suppression. Intravenous hydration and analgesia manage the crisis, with transfusion to correct severe anemia. Hydroxyurea is contraindicated in pregnancy due to teratogenicity, and oral iron is ineffective in sickle cell disease.

Question: 744

A 39-year-old female presents with a 1-year history of fatigue, joint pain, and Raynaud's phenomenon. Laboratory results show ANA positive at 1:640, anti-Ro antibodies positive, and hemoglobin 11.2 g/dL. Her ESR is 40 mm/hr. Which of the following is the most appropriate management?

- A. Refer to a rheumatologist
- B. Initiate methotrexate 7.5 mg weekly
- C. Start prednisone 20 mg daily

Answer: A

Explanation: The patient likely has Sjögren's syndrome or SLE based on fatigue, joint pain, Raynaud's, positive ANA, and anti-Ro antibodies. Referral to a rheumatologist is appropriate for diagnosis confirmation and management. Methotrexate or prednisone may be used, but initiating these without specialist input is inappropriate for a new autoimmune diagnosis.

Question: 745

A 40-year-old woman with a BRCA1 mutation is considering risk-reducing strategies. She has completed childbearing and has no contraindications to surgery. The most effective option to reduce her risk of ovarian cancer is:

- A. Annual transvaginal ultrasound and CA-125 screening
- B. Combined oral contraceptives
- C. Risk-reducing salpingo-oophorectomy

Answer: C

Explanation: Risk-reducing salpingo-oophorectomy significantly reduces ovarian cancer risk in BRCA1 mutation carriers by removing at-risk tissue. Screening with ultrasound and CA-125 is less effective due

to low sensitivity. Oral contraceptives reduce risk but are less effective than surgery.

Question: 746

A 32-year-old female presents with a 1-month history of a pruritic, erythematous rash on her scalp with associated hair loss. On examination, there are scaly, annular patches with broken hairs. A Wood's lamp examination is negative. What is the most appropriate treatment for this suspected tinea capitis?

- A. Oral griseofulvin 500 mg daily for 6 weeks
- B. Topical ketoconazole 2% shampoo twice weekly
- C. Topical terbinafine 1% cream twice daily

Answer: A

Explanation: Tinea capitis, presenting as scaly, annular patches with hair loss, requires systemic antifungal treatment, as topical therapies do not penetrate hair follicles. Oral griseofulvin is a first-line treatment for 6–8 weeks. Topical ketoconazole shampoo is adjunctive, not primary, therapy. Topical terbinafine is ineffective for tinea capitis due to poor follicular penetration.

Question: 747

A 29-year-old woman, 3 days postpartum, presents with a blood pressure of 150/95 mmHg and a headache. She had preeclampsia during pregnancy and received magnesium sulfate intrapartum. Her laboratory results show normal liver enzymes and platelets. What is the most appropriate management for her condition?

- A. Initiate oral labetalol to control hypertension
- B. Restart intravenous magnesium sulfate for seizure prophylaxis
- C. Schedule a head CT scan to evaluate for stroke

Answer: A

Explanation: The patient has postpartum hypertension, likely a continuation of preeclampsia. Oral labetalol is appropriate to control blood pressure and prevent complications. Magnesium sulfate is not indicated without seizures or severe preeclampsia features. A head CT is unnecessary without focal neurological symptoms.

Question: 748

A 28-year-old G1P0 at 30 weeks gestation presents with a rash and joint pain. Labs reveal a positive antinuclear antibody and anti-Ro/SSA antibodies. She has no prior diagnosis of lupus. What is the most appropriate management to prevent fetal complications?

- A. Reassure her and continue routine prenatal care

- B. Start prednisone 20 mg daily and schedule weekly fetal echocardiograms
- C. Initiate hydroxychloroquine and monitor for fetal heart block

Answer: C

Explanation: The patient's presentation and labs suggest systemic lupus erythematosus, with anti-Ro/SSA antibodies conferring a 1–2% risk of fetal congenital heart block. Hydroxychloroquine is safe in pregnancy and reduces lupus flares, with monitoring for heart block via fetal echocardiography. Prednisone is reserved for active flares, and reassurance is inappropriate given the fetal risk.

Question: 749

A 39-year-old female presents with a 2-week history of a pruritic, erythematous rash on her trunk after starting a new medication (amoxicillin). The rash is morbilliform and spares the mucous membranes. She denies fever or systemic symptoms. What is the most appropriate management for this suspected drug-induced contact dermatitis?

- A. Stop amoxicillin and observe with supportive care
- B. Prescribe topical clobetasol 0.05% twice daily
- C. Discontinue amoxicillin and prescribe oral prednisone 40 mg daily

Answer: A

Explanation: The morbilliform rash following amoxicillin use suggests a drug-induced exanthem, not true contact dermatitis, as it is systemic rather than localized. The first step is to discontinue the offending drug (amoxicillin) and provide supportive care, such as antihistamines for itching, as most cases resolve spontaneously. Oral prednisone is reserved for severe reactions with systemic symptoms. Topical clobetasol is inappropriate for a widespread, systemic rash.

Question: 750

A 31-year-old G2P1 at 30 weeks gestation presents with a blood pressure of 150/95 mmHg and 2+ proteinuria. She reports no symptoms. Laboratory results show normal liver enzymes and platelets. What is the most appropriate management for this patient with suspected preeclampsia?

- A. Administer magnesium sulfate and deliver immediately
- B. Start methyldopa and admit for observation
- C. Initiate labetalol and monitor outpatient

Answer: B

Explanation: The patient has preeclampsia without severe features, as indicated by elevated blood pressure and proteinuria without symptoms or laboratory abnormalities. Starting methyldopa and admitting for observation allows for blood pressure control and monitoring for progression to severe preeclampsia, avoiding premature delivery or outpatient management without close supervision.

Question: 751

A 21-year-old woman with a history of irregular menses presents with acute pelvic pain. Ultrasound shows a 5 cm hemorrhagic ovarian cyst. She is hemodynamically stable. The most appropriate management is:

- A. Emergency laparoscopy
- B. Expectant management with follow-up ultrasound
- C. Oral contraceptives to prevent recurrence

Answer: B

Explanation: Hemorrhagic ovarian cysts in stable patients typically resolve spontaneously, warranting expectant management with follow-up ultrasound. Emergency laparoscopy is indicated for hemodynamic instability. Oral contraceptives do not treat acute cysts.

Question: 752

A 40-year-old female presents with a five-day history of productive cough, fever (101°F), and fatigue. She denies shortness of breath. Auscultation reveals rhonchi in the right upper lobe, and a chest X-ray shows no consolidation. Her white blood cell count is 10,500/ μ L. What is the most appropriate management for her condition?

- A. Azithromycin 500 mg on day 1, then 250 mg daily for 4 days
- B. Nebulized albuterol and oral prednisone
- C. Supportive care with hydration and rest

Answer: C

Explanation: The patient's productive cough, fever, fatigue, and rhonchi, with a normal chest X-ray, suggest acute bronchitis, likely viral given the absence of consolidation. Supportive care with hydration and rest is appropriate for uncomplicated viral bronchitis. Azithromycin is not indicated without evidence of bacterial infection. Albuterol and prednisone are used for bronchospasm or asthma, which are not supported by the presentation.

Question: 753

A 45-year-old woman presents with vaginal bleeding and pelvic pain. Pelvic ultrasound shows a 4 cm complex adnexal mass with solid components. CA-125 is 60 U/mL. She has a history of endometriosis. What is the most appropriate next step?

- A. Laparoscopic cystectomy
- B. Repeat ultrasound in 6 months
- C. Refer to gynecologic oncology

Answer: C

Explanation: A complex adnexal mass with solid components and elevated CA-125 in a woman with a history of endometriosis raises concern for malignant transformation (e.g., endometrioid or clear cell carcinoma). Referral to gynecologic oncology for evaluation and possible staging is indicated. Observation or cystectomy is inappropriate given the risk of malignancy.

Question: 754

A 26-year-old female presents with a 1-week history of painful genital lesions. Her BMI is 23 kg/m², and vital signs are normal. On exam, you note multiple shallow, painful ulcers on the labia majora with inguinal lymphadenopathy. A viral culture confirms herpes simplex virus (HSV). What is the most appropriate treatment?

- A. Acyclovir
- B. Doxycycline
- C. Fluconazole

Answer: A

Explanation: Painful genital ulcers with lymphadenopathy and a positive HSV culture confirm genital herpes. Acyclovir is the first-line antiviral treatment for acute episodes. Doxycycline treats bacterial infections like chlamydia, and fluconazole is for fungal infections, neither of which is indicated here.

Question: 755

A 34-year-old G3P2 at 39 weeks gestation presents in labor. Her Group B Streptococcus (GBS) culture at 36 weeks was positive. She has a penicillin allergy with anaphylaxis. What is the appropriate intrapartum antibiotic prophylaxis?

- A. Clindamycin
- B. Cefazolin
- C. Vancomycin

Answer: A

Explanation: For GBS-positive women with penicillin anaphylaxis, clindamycin is the preferred intrapartum prophylaxis if GBS is susceptible. Cefazolin is a cephalosporin and contraindicated in severe penicillin allergy due to cross-reactivity. Vancomycin is reserved for clindamycin-resistant GBS or unknown susceptibility, which is not indicated here.

Question: 756

A 26-year-old woman with a history of pelvic inflammatory disease (PID) is seeking contraception. She has no recent infections and a normal pelvic exam. Her BMI is 22 kg/m², and she prefers a long-acting method. What is the most appropriate contraceptive option, considering her history?

- A. Copper IUD
- B. Levonorgestrel 52 mg IUD
- C. Etonogestrel implant

Answer: B

Explanation: The levonorgestrel 52 mg IUD is safe and effective in women with a history of PID, provided there is no active infection. It also reduces the risk of recurrent PID by thickening cervical mucus. The copper IUD may increase PID risk in the first 20 days post-insertion. The etonogestrel implant is effective but does not offer PID protection.

Question: 757

A 53-year-old woman with a history of breast cancer (treated 5 years ago) presents for follow-up. A screening mammogram reveals a new BI-RADS 4 lesion in the contralateral breast. A core biopsy confirms lobular carcinoma in situ (LCIS). What is the lifetime risk of developing invasive breast cancer, and what is the most appropriate management?

- A. 10–15% risk, tamoxifen therapy
- B. 25–40% risk, bilateral mastectomy
- C. 5–10% risk, annual mammography

Answer: A

Explanation: Lobular carcinoma in situ (LCIS) confers a 25–40% lifetime risk of invasive breast cancer (bilateral risk). Tamoxifen is recommended for chemoprevention in high-risk women, reducing risk by 50%. Bilateral mastectomy is an option for some but not standard, and annual mammography alone is insufficient without risk reduction.

Question: 758

A 44-year-old woman undergoes a hysterectomy and is prescribed intravenous morphine for postoperative pain. The nurse practitioner fails to verify the patient's reported opioid allergy, resulting in an anaphylactic reaction. What legal issue is most likely associated with this incident?

- A. Negligence due to inadequate allergy verification
- B. Failure to obtain informed consent
- C. Violation of patient confidentiality

Answer: A

Explanation: Failing to verify a reported opioid allergy before administering morphine constitutes negligence, as it deviates from the standard of care and directly causes harm (anaphylaxis). Informed

consent is not the primary issue, as the error stems from inadequate assessment. Confidentiality is not relevant in this scenario.



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