BNURS506 Quiz Answering

Term: Spring 2025
Module 5: Digestive & Reproductive
Name: Student I

#:	Your Answer	Feedback from Grader	Score
1	Not answered		/ 10
2	*Identify 3 things you can do to promote an environment of inclusivity, respect, and dignity for Kiry during this visit. (6 points)* 1. Use proper pronoun etiquette (Reeves et al., 2023) a. Introduce yourself and your pronouns – this will reassure the patient that you respect their pronouns and chosen name. If your organization provides badge cards that identify pronouns wear one to affirm your support to all patients. b. Use their pronouns correctly – but if you make a mistake apologize and move on without perseverating or being over-apologetic. c. Change their information in the electronic health record if possible or include their name and pronouns in your documentation – Putting their name and pronouns in the EHR will prevent the traumatic experience of seeing their former name and pronouns on future intake forms and inform future providers. Tell the patient you would like to do this and get their permission. Some patients may prefer to share that information with healthcare providers on a case by case basis considering the current climate. 2. Ask the patient how they would prefer to refer to parts of their body and use gender neutral terminology (Reeves et al., 2023). a. Some patients may be fine with words like “vagina” or “breast” but this may be a trigger for some patients – ask how they refer to their body parts. Kiry is clearly uncomfortable and scared and asking this will put them at ease. b. If unsure – use words such as “chest” or “genitalia” to describe their body. If they use alternate words (i.e. down	Excellent work and thank you for the feedback! Yes, you went above and beyond - I would have been happy with just one of each of the 3 parts - ie, identify myself using pronouns and use theirs appropriately, ask the patient their preference in how to refer to their body parts, and clearly communicate the steps of the exam asking for permission before touching. Still, this is a subject I’m dedicated to so I loved reading your response! I will look into the Reeves article thank you. I also appreciated you specifically stating the potential for trauma and non-adherence to medication. 1. 6 points 2. 2 points 3. 2 points	10 / 10

there) ask them to explain the issue in their own words and use their terminology.
    c. Do not use the interaction as an opportunity to ask them to educate you. Engage in education/CEs to inform yourself of TGNB cultural norms and assume cultural humility in your interactions.
3. Perform the same assessment that you would for any patient – but ensure that you communicate clearly, ask permission, and reassure them that they can ask to stop at any time (Reeves et al., 2023).
    a. Do not avoid assessing Kiry's genitals thoroughly out of your own discomfort. Carefully explain what you will need to do prior to assessment, and ask them if they have questions.
    b. During the assessment clearly communicate what you will do next before you do it.
    c. Reassure Kiry before and during the exam that if they wish to stop or pause that is okay and that you will respect their boundaries.

During the exam, the provider notes white, thick, cottage cheese-like discharge and vulvar erythema. What diagnosis do you anticipate based on these symptoms? (2 points)

- Kiry has Candid Vulvovaginitis (Sobel & Mitchell, 2024).

The provider prescribes miconazole due to its low expense and availability over the counter. The provider instructs Kiry on how to apply the cream. While the provider is talking, you see Kiry grimace and struggle with tears. Regarding medication, what could you discuss with Kiry regarding their options? (2 points)

- Miconazole is given intravaginally as a suppository. Administering the medication this way may trigger a traumatic response and cause them to avoid treating their infection. Considering their discomfort the provider should ask Kiry if they would be more comfortable taking oral fluconazole as an alternative (Sobel, 2024).

References:

	Reeves, K., Job, S., Blackwell, C., Sanchez, K., Carter, S., & Taliaferro, L. (2023). Provider cultural competence and humility in healthcare interactions with transgender and nonbinary young adults. *Sigma Theta Tau Journal of Nursing Scholarship, 56*(1), 18-30. https://doi.org/10.1111/jnu.12903 Sobel, J. D. (2024, December 15). Candid vulvovaginitis in adults: Treatment of acute infection. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/candida-vulvovaginitis-in-adults-treatment-of-acute-infection Sobel, J. D., & Mitchell, C. (2024, April 10). Candida vulvovaginitis: Clinical manifestations and diagnosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/candida-vulvovaginitis-clinical-manifestations-and-diagnosis Feedback: I really liked this question and found it interesting and thoughtful! Especially in the current climate, it is important for nurses and providers to be educated on this topic. This did take me a while to answer, but I also might have gone too in-depth for the first question. I enjoyed answering it though and if you haven't read the article from Reeves et al. posted above it was really great and had some excellent qualitative data. Nice work!		
3	Not answered		/ 10
4	*What is the most likely diagnosis? Why? (hint: include risk factors and symptoms)* ● Diagnosis: Endometriosis ● Risk factors: family history, nulliparity (no births), younger onset of periods (<11), late menopause, short menstrual cycles, heavy bleeding, cervical/anatomical strictures, tall, low BMI (Schenken, 2024). ● Symptoms: pelvic pain, dysmenorrhea, dysuria, infertility, severe pain during periods and/or intercourse, bowel/bladder dysfunction,	1. Great job identifying that Quinn likely has endometriosis! While you did provide a thorough answer regarding all the symptoms and risk factors for endometriosis. I was looking for the learner to use Quinn's specific symptoms (dysmenorrhea, painful	10 / 10

	heavy bleeding, and low back pain that worsens during menstruation (Schenken, 2025). *What is one of the diagnostic approaches that would help support suspicion or confirm the diagnosis? (State one method and a sentence on what it looks for)* ● Surgical diagnosis is the gold standard and the definitive method for diagnosis but is invasive and the provider will likely start with less invasive methods. This will include an ultrasound to exclude other causes and look for physical signs of endometriosis, visual inspection via vaginal exam, and/or cystoscopy to perform a biopsy (Schenken, 2025). *What two pieces of education could you provide the patient regarding management? (Answers can include pharmacological interventions, surgical interventions, or supportive resources. Give 1-2 sentences on when and why each intervention is used)* ● Surgical interventions: There are two options for surgical treatment, which are conservative or definitive surgery. In conservative surgery, lesions are removed, with the goal of preserving the uterus/ovaries and fertility. Definitive surgery includes the removal of the uterus and/or ovaries and is typically performed when other options have been tried and failed, but it will cause infertility and surgical menopause (Lebovic, 2024). ● Pharmacological Interventions: For pain, patients with endometriosis should take NSAIDs (400mg Q4-6H). This should be combined with hormonal contraceptives administered according to patient preference (IUD, pill, patch, ring, implant). This is given with the intention of lessening the severity or stopping periods to prevent the painful symptoms caused by endometriosis (Schenken, 2025b). References: Lebovic, D. I. (2024, March 20). Endometriosis: Surgical management of pelvic pain. *UpToDate.* Retrieved May 30, 2025, from	intercourse, infertility, etc) and her risk factor (reproductive age) as part of the rationale to support the diagnosis. However, I will not take any points off as you did provide detailed general information 🙂 (3/3 pts) 2. Laparoscopy with biopsy is the definitive diagnostic approach to confirm endometriosis. Excellent! (3/3 pts) 3. Awesome job! The purpose of this question was to just name any two interventions (whether it be medication, surgery, or supportive) and when it would be appropriate to use and how it helps. Thank you for going above and beyond by including several examples! Great job! (3/3 pts) +1 pt citations Thank you for the feedback! Glad you enjoyed learning about endometriosis.	

	https://www.uptodate.com/contents/endometriosis-surgical-management-of-pelvic-pain Schenken, R. S. (2024, December 3). Endometriosis in adults: Pathogenesis, epidemiology, and clinical impact. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/endometriosis-in-adults-pathogenesis-epidemiology-and-clinical-impact Schenken, R. S. (2025a, February 20). Endometriosis in adults: Clinical features, evaluation, and diagnosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/endometriosis-in-adults-clinical-features-evaluation-and-diagnosis Schenken, R. S. (2025b, March 14). Endometriosis: Medical treatment of pelvic pain. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/endometriosis-medical-treatment-of-pelvic-pain Feedback: I found this question to be a great exploration of the causes and treatment of endometriosis. It was very thoughtfully written and thorough. I do think that some components of the questions could have been shorter (i.e. name one intervention, or just risk factors etc.). The goal of the question still would have been met this way. However, I still thought it was a great question, and I enjoyed answering it. Nice job!		
5	Not answered		/ 10
6	*What is a TPE, and why is it a curative option? (2-3 sentences is sufficient)* ● TPE stands for Total Pelvic Exenteration. It is a surgical procedure to remove the uterus, tubes, ovaries, parametrium, bladder, rectum, vagina, urethra, and some muscle. Since the patient's cancer is localized to the pelvis for now, this procedure would remove all	Amazing job answering this question! Each component is correct, and I appreciated how you also drew on your own experience in caring for these patients.	10/ 10

	cancer and potential areas that could cause another recurrence. This is an invasive option that is only used when less invasive options have failed and will not be curative for patients with cancers that have spread to the lymph, blood, or peritoneum (Mann, 2023). *What organs/anatomical body parts are involved in this surgery (name at least 5)?* ● Also listed above: Uterus, fallopian tubes, ovaries, parametrium, bladder, rectum, vagina, urethra, and some muscle *What are some postoperative and patient care considerations involved with this surgery? Hint: Please consider topics such as mental health, drains/ostomies, infection, etcetera. Name and briefly discuss at least 3 considerations.* ● Cognitive behavioral therapy: This is an extensive surgery that will have lifelong changes to the body and require extensive changes to lifestyle. The patient will have a urostomy and colostomy which require extensive care, and they will also experience a loss of their sex life as the vagina is removed. The recovery is extensive and painful, and the patient will require support both from family/friends and a trained professional (Mann, 2023). ● Immediate post-op management: Some patients will require an ICU stay to manage their hemodynamics due to the large fluid shifts that occur and for possible flap monitoring depending on the surgical technique (typically an omental flap is used but I have seen some free flaps which require hourly monitoring – that's my anecdotal experience). They may require a short period of intubation, vasopressors, and fluid/blood resuscitation (Mann, 2023). ● Wound care: Depending on the surgical technique, the patient will likely have drains (usually JP) that they will need to care for after discharge. Additionally, they will have a new ostomy and urostomy. These all require extensive nursing education and teaching about management (particularly for ostomies), including monitoring, dressings/pouches, and self-catheterization. Wound Ostomy RNs should be engaged immediately to begin teaching the patient and providing recommendations for dressings/care (Mann, 2023).	Not many people have experience caring for patients who have undergone a TPE, and I would love to hear more about your experience. Caring for my first TPE patient was a significant learning experience, and I agree that it's a life-altering decision, not one taken lightly.	

	References: Mann, W. J. (2023, November 17). Exenteration for gynecologic cancer. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/exenteration-for-gynecologic-cancer Feedback: I have cared for many of these patients, and I have always struggled with the extensive effect it has on their life. I thought this question was straight forward, and did not require extensive time/search to understand the concepts, which I appreciated. I also like that this question was focused on nursing interventions. Nice job!		
7	Not answered		/ 10
8	*Given his symptoms and risk factors, could this be an indication of acute pancreatitis? What labs and assessments are necessary to confirm that the client has pancreatitis?* ● Risk factors for pancreatitis: the patient's medically complex care including enteral feeding, and his medications (acetaminophen, erythromycin) are risk factors for developing acute pancreatitis (Hawa et al., 2023; Vege, 2025). ● Symptoms of pancreatitis: Malnourishment, abdominal pain, persistent vomiting, and agitation/discomfort are all signs of acute pancreatitis. Constipation is a less common sign but is common in patients with cerebral palsy and may be exacerbated by acute pancreatitis (Barkoudah & Aravamuthan, 2024; Hawa et al., 2023). ● Assessments: A standard physical assessment and a focused abdominal exam should be performed and a pain response in the mid-epigastric, right or left upper quadrants is expected (Schwarzenberg, 2024). The GJ tube should also be evaluated for patency and correct placement as dislodgement could be a	Great job with answering all parts of the question. Your answers were easy to understand. For the first question, a yes or no would have been enough and a list of the client's symptoms. I was hoping that students were familiar with the names of the medication because they all had to do with gut motility except levetiracetam. Thanks for your feedback!	10 / 10

differential cause of the patient's symptoms (Schwarzenberg, 2024).

- Labs: serum amylase, lipase, CBC, BMP (w/ mag, phos, iCal), LFTs, BG, fat soluble vitamin levels, and if the patient is able to stool a fecal elastase level is indicated (Schwarzenberg, 2024).
- Imaging: The patient should have an ultrasound of their pancreatic area to look for gallstones. An abdominal CT/MRI should also be ordered to definitively look for abnormalities around the pancreas. Imaging should also be used to rule out other pathology such as GJ tube dislodgement, VP shunt malfunction, bowel obstruction (r/t constipation and/or GJ/VP obstruction), or peritonitis (r/t VP shunt). The nurse should confirm that the VP shunt is set correctly after the MRI (Barkoudah & Aravamuthan, 2024; Haridas & Tomita, 2024; Hawa et al., 2023; Schwarzenberg, 2024).
- This patient could also have chronic pancreatitis and his symptoms (malnourishment) suggest that this has been happening for some time. Additionally his tube feeding formula should be evaluated for high fat content that may contribute to pancreatitis (Schwarzenberg, 2024).

References:

Barkoudah, E., & Aravamythan, B. (2024, June 5). Cerebral palsy: Classification and clinical features. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/cerebral-palsy-classification-and-clinical-features

Haridas, A & Tomia, T. (2024, December 20). Hydrocephalus in children: Management and prognosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/hydrocephalus-in-children-management-and-prognosis

Hawa, K., Corker, L., Hornung, L., Noritz, G., Gariepy, C., Shaikhkhalil, A., & Abu-El-Haija, M. (2023). Pancreatitis in the complex care

	population: Presentation, incidence, and severity. *Journal of Pediatric Gastroenterology and Nutrition, 75*(6), 749-754. https://doi.org/10.1097/MPG.0000000000003610 Schwarzenberg, S. J. (2024, September 6). Clinical manifestations and diagnosis of chronic and acute recurrent pancreatitis in children. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-chronic-and-acute-recurrent-pancreatitis-in-children Vege, S. S. (2025, January 6). Etiology of acute pancreatitis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/etiology-of-acute-pancreatitis Feedback: I liked the complexity of this patient, and the story told. I do think that this patient could have a dozen other GI diagnoses and exploring that more in the question would have been interesting. I also think the phrasing of the first question was a little confusing because it didn't directly ask for symptoms/risk factors, it just asked if the patient could have acute pancreatitis. I guessed that the author was looking for risks/symptoms in the answer. Overall, this was a really interesting question. Nice work!		
9	Not answered		/ 10
10	*What is this patient's most likely diagnosis? Please include rationale by using this patient's clinical presentation. 3 points* ● Diagnosis: Peptic Ulcer Disease (PUD) secondary to H. Pylori infection ● Rationale: The patient's symptoms of upper abdominal pain and nausea are generic, but the bloating and satiety after small amounts of food and worsening symptoms at night are all more specific to PUD. The positive breath test indicated the patient has an H. Pylori infection which can cause PUD. Definitive diagnosis to rule out other causes can be done with upper endoscopy, but that is not	#1 Correct diagnosis of peptic ulcer disease, rationalized by patient's signs and symptoms: 3/3 points #2 Any of the following options to eradicate *H.pylori* w/specific medications: Optimized bismuth quadruple therapy, low-dose rifabutin triple therapy, triple therapy,	8/ 10

	necessarily indicated considering the patient does not have “alarm features” (Lamont, 2023; Longstreth & Lacy, 2025; Vakil, 2024b). *Considering the positive urea breath test, what treatment regimen would you expect to be prescribed for this patient? Please include specific medications used in the chosen treatment regimen. (Hint: expected answer is a type of eradication therapy) 3 points* ● Eradication therapy: Bismuth quadruple therapy is the first line treatment for H. Pylori infection. This regimen includes: BID PPI, high dose bismuth subsalicylate QID, tetracycline, and metronidazole TID or QID. The patient should take this for 10-14 days (Shah et al., 2025). ● The patient should also discontinue any NSAIDs (Vakil, 2024a). *The patient asks when she should schedule a follow-up appointment. What should you tell her? 3 points* ● The patient will need to come back for follow-up weeks after eradication treatment is complete to re-test for H. Pylori (Shah et al., 2025). ● The patient will need to stop their PPI two weeks before retesting and can switch to an H2 receptor agonist of antacids (tums) for symptom management (Shah et al., 2025). References: Lamont, J. T. (2023, July 13). Indications and diagnostic tests for Helicobacter pylori infection in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/indications-and-diagnostic-tests-for-helicobacter-pylori-infection-in-adults Longstreth, G. F., & Lacy, B. E. (2025, January 16). Approach to the adult with dyspepsia. *UpToDate*. Retrieved May 30, 2024, from	vonoprazan dual therapy, or vonoprazan triple therapy: 3/3 points #3 Missing number of weeks in answer; Follow-up after a month, but not more than 2 months, state in simple language that patient will understand: 1/3 points References & in-text citations: 1/1 point Thank you for your feedback, I tried to make the questions specific enough, but still encourage critical thinking.	

	https://www.uptodate.com/contents/approach-to-the-adult-with-dyspepsia Shah, S. C., Kao, J. Y., & Moss, S. F. (2025, May 9). Treatment of Helicobacter pylori infection in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/treatment-of-helicobacter-pylori-infection-in-adults Vakil, N. B. (2024a, September 25). Peptic ulcer disease: Treatment and secondary prevention. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/peptic-ulcer-disease-treatment-and-secondary-prevention Vakil, N. B. (2024b, September 27). Peptic ulcer disease: Clinical manifestations and diagnosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/peptic-ulcer-disease-clinical-manifestations-and-diagnosis Feedback: I liked this question a lot! It definitely triggered some critical thinking and I thought the visual was a great addition. You provided a great case study with enough context that I did not have to guess if I was on the right track, but I still learned a lot. I am now wondering if I have PUD. Nice job!		
11	Not answered		/ 10
12	*What is Barbies diagnosis and name the planned surgical procedure for this patient?* ● Diagnosis: Barbie has adenomatous polyposis (Macrae, 2024). ● Surgical procedure: considering that the polyps are small a polypectomy should be done first with yearly colonoscopies for surveillance. Depending on the number of polyps present a colectomy should be considered (Macrae et al., 2025).	You did great with providing information over procedure name and answering the bonus question with detail. The diagnosis I was looking for however was benign colorectal polyps. I didn't break my question into points, so given that you got most correct, I	8/ 10

	What is the significance of early detection of polyps for Barbie? ● Early detection of polyps indicates high likelihood of developing colorectal cancer, and although her symptoms are mild the presence of symptoms is associated with worse prognosis Macrae et al., 2025) References: Macrae, F. A. (2024, April 17). Overview of colon polyps. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/overview-of-colon-polyps Macrae, F. A., Parikh A. R., Ricciardi, R. (2025, March 6). Clinical presentation, diagnosis, and staging of colorectal cancer. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/clinical-presentation-diagnosis-and-staging-of-colorectal-cancer Feedback: I had no idea there were so many types of polyps! I liked the topic of this question, but I found it very difficult to answer. I think that more context would have been very helpful (i.e. number of polyps, types of polyps family had). I also found the surgical procedure aspect of the question confusing, because the story already stated that she was going for a polypectomy. Overall, I think this question was intriguing, and I liked the topic, but it just could have used more context.	gave the majority of points. Thanks for your feedback, there are many types of polyps.	
13	Not answered		/ 10
14	*What do you suspect that Heather is suffering from? (2 pts) Small bowel obstruction* ● Heather has a mechanical small bowel obstruction r/t a stricture that can be seen on her CT (Bordeianou & Yeh, 2023).	1. Correct, great description! (2/2) 2. Awesome description of the abdominal exam with percussion, inspection, palpation and auscultation.	10 / 10

	Beyond the CT scan, what additional assessments might you as the nurse perform to confirm your suspicion? Name 2 assessments and what assessment findings you would expect to find with Heather's diagnosis. (2 pts) ● Abdominal exam (Bordeianou & Yeh, 2023). ○ Inspection: look for distention, and assess location of surgical scars ○ Auscultation: will hear high-pitched or muffled sounds, as obstruction progresses sounds will be hypoactive ○ Percussion: hyperresonance will be heard over distended areas. Dullness will be heard over loops filled with fluid. If tenderness is present during percussion the patient may have peritonitis. If there is tympany, especially over the liver, the patient may have free-air r/t a perforation ○ Palpation: feel for masses to identify causes of obstruction (hernias, tumors, etc) ● Look for signs of dehydration or SIRS response (Bordeianou & Yeh, 2023). ○ Tachycardia ○ Low UOP ○ Orthostatic hypotension ○ Dry mucous membranes *What is included in typical treatment of this condition? List general management for non-surgical and surgical options. (6 pts)* ● Surgical or non-surgical: fluid resuscitation, electrolyte repletion, NPO, NG tube for decompression (Bordeinou & Yeh. 2024). ● Non-surgical management: Administer water-soluble contrast (Gastrografin) because it is a hyperosmolar solution that will draw fluid into the bowel and stimulate peristalsis. Laxatives (magnesium oxide), probiotics, and simethicone may also be helpful. For this patient who has a visible stricture this will likely fail and she will need surgery (Bordeianou & Yeh, 2024). ● Surgical management: This is the best option for this patient. An exploratory laparotomy will be done to identify the problem and	Great job at identifying the hypoactive bowel sounds! Great addition of SIRS criteria, dehydration is a concern with SBOs. (2/2) 3. Non-surgical: yes, you got it! Great job at identifying the gastrografin study as well! (3/3) 4. Surgical: also great job, yes she would likely need an exploratory laparotomoy with lysis of adhesions. It could potentially be that she would need a bowel resection if the bowel is necrotic. Great job discussing the post-op care required of a nurse who is caring for a patient like this. (3/3) Thank you for the feedback! Yes, totally forgot to remove that answer, consider it a freebie for the last class 🙂 And totally agree about the nursing scope piece, I appreciate the feedback about a multiple choice, that would have been a good inclusion.	

	repair it. Post-operatively they should be NPO, have an NG tube for decompression, and receive supportive care (i.e. fluids, pain medication, nausea/vomiting management, etc.). (Bordeianou & Yeh, 2024). References: Bordeianou, L., & Yeh, D. D. (2023, December 4). Etiologies, clinical manifestations, and diagnosis of mechanical small bowel obstruction in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/etiologies-clinical-manifestations-and-diagnosis-of-mechanical-small-bowel-obstruction-in-adults Bordeianou, L., & Yeh, D. D. (2024, March 29). Management of small bowel obstruction in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/management-of-small-bowel-obstruction-in-adults Feedback: I thought this was a very straightforward question and I thought the CT imaging was great. I think your answer to the first question was accidentally included 😊. If it hadn't been included my only feedback would be that it is outside nursing scope of practice to interpret CTs, and although it's a fairly obvious image, I think that if you wanted us to answer off the imaging and symptoms a multiple-choice question would be better rather than open-ended. Overall, I thought it was a good question. Great job!		
15	Not answered		/ 10
16	*Which of the following is the most likely causing Mr. Jones' symptoms?* ● C – Small bowel perforation *How should the nurse respond to this?*	<u>Grading Criteria</u> 1.Multiple Choice: 2/2 2.Response to Pt: 4/4 3.Response to Wife: 3/3 4.APA Format: 1/1	10/ 10

	● The nurse should reassure the patient that they are safe and empathize with the patient's feelings of fear. The nurse should explain the diagnosis in patient friendly language and tell the patient that if untreated this could be an emergency. The nurse should allow the patient to ask questions and anticipate the patient will be upset and use de-escalation techniques. The nurse should also tell the patient that getting an IV is really important and ask how they could make him comfortable so that they can place one. ● Medical information taken from Odom (2023). *How should the nurse respond, keeping in mind Mr. Jone's PMH/home medications?* ● Clozapine is a second-generation antipsychotic used to treat schizoaffective disorders. Decreased motility is a common side effect which causes constipation, and severe constipation left untreated can result in bowel perforation. Mr. Jones should be instructed to regularly take laxatives (Colace, MiraLAX, or stimulant if needed – senna, Bisacodyl) and be aware of how frequently he is stooling and proactively address constipation. A high fiber diet with fruits, vegetables, whole grains, and 8-12 glasses of water will also help maintain bowel health (UpToDate Lexidrug, n.d.; Wald & Rao, 2025). Considering Mr. Jones' diagnosis of schizophrenia, Mrs. Jones should be aware of the potential symptoms and encourage Mr. Jones to make these lifestyle changes. References: Odom, S. R. (2023, July 5). Overview of gastrointestinal tract perforation. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/overview-of-gastrointestinal-tract-perforation	Thank you for the feedback. You are 100% right about including what's seen on the image to make it a more nursing appropriate question (honestly thought I had but it obviously got missed while I was typing everything out).	

	UpToDate Lexidrug. (n.d.). Clozapine: Drug information. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/clozapine-drug-information Wald, A., & Rao, S. SC. (2025, May 19). Management of chronic constipation in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/management-of-chronic-constipation-in-adults Feedback: I really liked the story you created with this question. I thought the imaging and clinical picture was interesting, but it is out of nursing scope of practice to interpret CTs. Although I (think) was able to piece it together with the other information, it would have been more pertinent to nursing if you included some of the radiology report finding (i.e. free air seen). However, the following questions were very nursing-centric, and I really liked that! Overall, I think this was a thoughtful question and I enjoyed answering it. Nice job!		
17	Not answered		/ 10
18	*What complication of cirrhosis is Marco most likely experiencing, and what is the underlying pathophysiology?* ● Complication: Hepatic encephalopathy (Grade II) secondary to decompensated cirrhosis (Goldberg & Chopra, 2025). ● Pathogenesis: Normally, ammonia is produced in the GI tract by digesting nitrogen (protein) and then enters portal circulation and mitochondria in the liver where it is converted into urea and excreted through the kidneys. In patients with liver dysfunction, this process is altered which allows ammonia to enter the blood stream. The kidneys try to compensate by excreting ammonia through the urine, but in patients with cirrhosis the kidneys become impaired over time, and this results in increased ammonia levels in the blood	This was a strong response. You gave a really clear explanation of ammonia metabolism and how it goes wrong in liver disease. Your treatment priorities were well explained, and I liked the added detail about muscle breakdown. Nice job! And thanks for the insight about the newer terminology, it's clear I've been away from patient care for awhile! :)	/ 10

	stream. Ammonia is a neurotoxin and over time this will cause abnormal neurological responses resulting in hepatic encephalopathy (Ridola & Riggio, 2024b). *Identify one pharmacologic and one non-pharmacologic treatment priority for this condition. Briefly explain the rationale for each.* ● Lactulose: Lactulose is digested by gut flora which creates an acidic pH causing ammonia to be nonabsorbable. This nonabsorbable ammonia is then trapped in feces and excreted without entering the blood stream and reduces serum ammonia levels over time (Ridola & Riggio, 2024a). ● Nutritional support: Ammonia breaks down amino acids in muscle tissue causing muscle wasting. Muscles also metabolize ammonia, and breakdown of muscle also releases ammonia (Ridola & Riggio, 2024b). To counteract this, patients with hepatic encephalopathy should receive a well-balanced diet with 35-40 kcal/kg and 1.2 g/kg of protein daily, eat small meals throughout the day, and eat a snack before bed (Ridola & Riggio, 2024a). References: Goldberg, E., & Chopra, S. (2025, April 25). Cirrhosis in adults: Overview of complications, general management, and prognosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/cirrhosis-in-adults-overview-of-complications-general-management-and-prognosis Ridola, L., & Riggio, O. (2024a, September 19). Hepatic encephalopathy in adults: Treatment. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/hepatic-encephalopathy-in-adults-treatment Ridola, L., & Riggio, O. (2024b, September 27). Hepatic encephalopathy in adults: Clinical manifestations and diagnosis. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/hepatic-encephalopathy-in-adults-clinical-manifestations-and-diagnosis		

	Feedback: I thought this was a great question! I liked that you focused on the pathophysiology, and it was good for me to review the urea cycle. One thing I learned in this question is that NASH is now called MASLD or metabolic dysfunction-associated steatohepatitis according to UpToDate. I'll probably still call it NASH for a while, but I thought this was good to share. Nice job!		
19	Not answered		/ 10
20	*What would you teach your orientee about Sarah's likely diagnosis and the rationale for necessary lab, medication and assessment interventions for Sarah?* ● Diagnosis: acetaminophen overdose (or poisoning) ● Labs (Heard & Dart, 2023). ○ Serum acetaminophen level will allow estimation of time since ingestion and guide acetylcysteine dosing ○ BMP, LFTs, CBC, ABG, Lactate, and Coags should be drawn to evaluate liver and kidney function, metabolic disturbances, and to guide massive transfusion (blood products and to correct coagulopathies). If the ability to run a TEG is available, that can guide correction of coagulopathies with more accuracy ○ Ammonia levels should be drawn to monitor for possible hepatic encephalopathy ● Medications (Heard & Dart, 2025) ○ Acetylcysteine: all patients who have signs of liver failure should receive acetylcysteine, which is the antidote to acetaminophen ○ Supportive care: This patient is hemodynamically unstable and may need vasoactive drugs. She may also need to be intubated due to her declining LOC and would need sedation and pain management ● Assessments (Heard & Dart, 2023)	For full credit, answer should include diagnosis of **acute/fulminant liver failure (1 pt - removing 0.5 points because the diagnosis in question is acute liver failure – as a result of the overdose)**;interventions, including **necessary labs (liver enzymes, ammonia, coags) (2 pts)**, medications to consider **(acetylcysteine) (2 pts)**, assessments (**bleeding, LOC, 2 pts - removing 0.5 for lack of mention of assessing for increased bleed**) Liver functions that place Sarah at the highest risk at this point are **clotting factors and hepatic encephalopathy (2 pts)**. **APA citation (1 pt).** Excellent answer! You did a great job answering this question.Thank you so much for your clear, complete answer. Thank you for the feedback, and I'm sorry that there was some lack of clarity in the question. Acute liver failure is my favorite patient, too! They are SO sick, but if you can support them through the	9/ 10

	○ Full head to toe assessment should be performed – expect right upper quadrant pain, nausea, vomiting, lethargy, and possibly jaundice ○ Focused neuro exam to assess for hepatic encephalopathy ○ Careful urine output monitoring – consider a foley for strict I/O as these patients are at high risk for concurrent renal failure ● Interventions (Heard & Dart, 2025) ○ In addition to supportive care and medications listed above, patient may require hemodialysis to remove ammonia and/or treat acute kidney injury associated with liver failure *What primary functions of the liver will cause the most immediate risk to Sarah?* ○ Waste excretion: the urea cycle is conducted in the liver to remove ammonia. Sarah is already showing signs of neurological decompensation that may be related to bleeding, but she could still be encephalopathic from increased ammonia levels. Additionally, this patient is at risk for cerebral edema considering the severity of their decompensation and should be carefully monitored for signs of increased ICP (Squires, 2024). ○ Production of clotting factors: the liver is responsible for producing several components of the clotting cascade, and liver failure causes abnormal clotting mechanisms which can result in bleeding and DIC (Squires, 2024). ○ Although not a primary function of the liver, the kidneys and liver work together closely. Liver failure may also result in acute kidney injury. This may require dialysis/CRRT, and there is a lower threshold to start if elevated ammonia levels are present and cerebral edema is present (Squires, 2024). References: Heard, K., & Dart, R. (2023, December 5). Clinical manifestations and diagnosis of acetaminophen (paracetamol) poisoning in children and adolescents. *UpToDate*. Retrieved May 30, 2025, from	critical illness and see them through transplant, it is so fulfilling.	

	https://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-acetaminophen-paracetamol-poisoning-in-children-and-adolescents Heard, K., & Dart, R. (2025, May 22). Acetaminophen (paracetamol) poisoning: Management in children and adults. *UpToDate*. Retrieved May 30, 2025, from https://www.uptodate.com/contents/acetaminophen-paracetamol-poisoning-management-in-adults-and-children Squires, J. E. (2024, July 2025). Acute liver failure in children: Management, complications, and outcomes. *UpToDate.* Retrieved May 30, 2025, https://www.uptodate.com/contents/acute-liver-failure-in-children-management-complications-and-outcomes Feedback: I thought this was a great question, and while I'm not sure if I would be able to teach an orientee all of this while running for the Belmont, we would surely go over it after! I really enjoyed answering this question because ALF is one of my favorite patient populations to care for because of its complexity, so thank you for the opportunity to think about my favorite organ some more. My only feedback is about the first question where I was unsure if the word interventions was meant to describe the labs/meds/assessments, or was its own category to answer. Overall, nice work!		