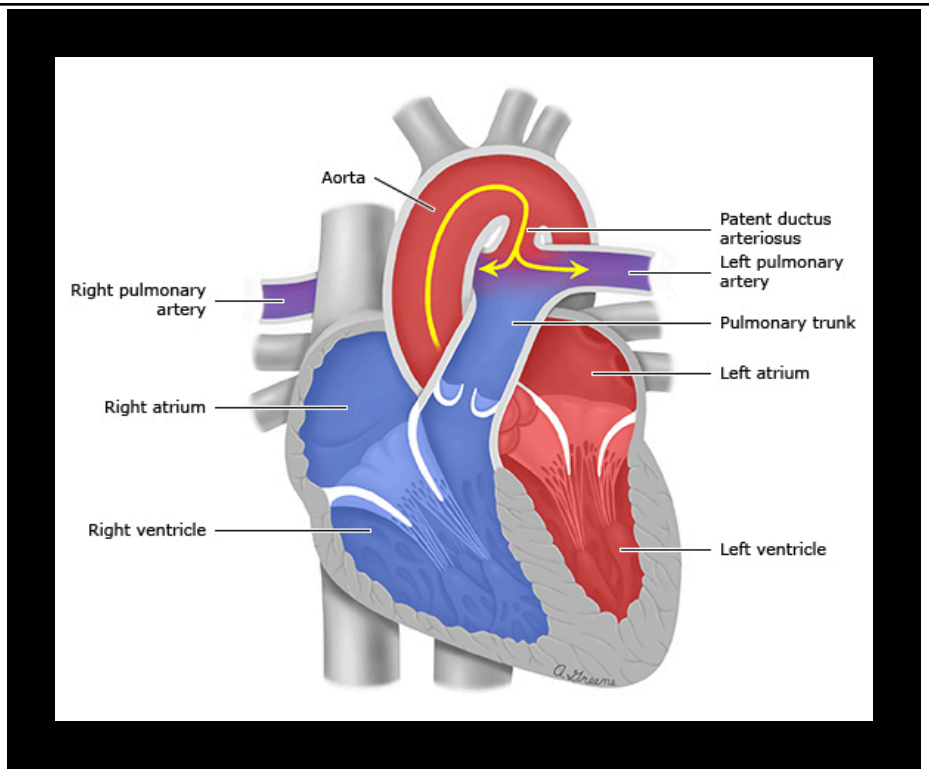
BNURS506 Quiz Answering

Term: Spring 2025
Module 3: Cardiovascular & Pulmonary Systems
Name: Student D

#:	Your Answer	Feedback from Grader	Score
2	A tension pneumothorax would be treated with the placement of a chest tube or catheter to remove the air from the pleural space and expand the lung (Lee, 2025). The patient may also be offered an analgesic for pain (Lee, 2024). Over time as the patient improves, the nurse would assess an improvement in dyspnea, pain, heart rate, lung sounds, and oxygen saturation levels (Lee, 2024). The chest tube should be evaluated for bubbling, which indicates a leak; a reduction in the bubbling is a sign of improvement (Lee, 2024). A follow-up x-ray is also likely to assess the resolution of the pneumothorax (Lee, 2025). After resolution, the patient's primary care physician may also investigate potential etiologies of the pneumothorax with further testing such as pulmonary function tests (Lee, 2025). References: Lee, Y.C.G. (2025, April 24). Clinical presentation and diagnosis of pneumothorax. *UpToDate*. Retrieved on May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnosis-of-pneumothorax?search=tension%20pneumothorax&source=search_result&selectedTitle=1~117&usage_type=default&display_rank=1 Lee, Y.C.G. (2024, June 28). Treatment of primary spontaneous pneumothorax in adults. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-primary-spontaneous-pneumothorax-in-adults?sectionName=INITIAL%20EVALUATION%20AND%20MANAGEMENT&search=tensio	Excellent explanation of treatment for a tension pneumothorax, I was looking for specific discussion surrounding the placement and management of a chest tube. Good job at pointing out the presence of an air leak and how the assessment of the air leak reducing overtime is an indicator that the pneumothorax is decreasing and healing. Thank you for the feedback, I didn't want to focus on the etiologies but that could be useful for the future.	10 / 10

	n%20pneumothorax&topicRef=117242&anchor=H891236955&source=see_link#H891236955 Feedback: A straightforward question with good application of knowledge. Complexity could be added (if desired) by asking the student to describe the pathophysiology of pneumothorax and identify some potential etiologies.		
4	With this set of symptoms, I would suspect pulmonary tuberculosis (TB) in this patient. The patient should be placed in a single occupancy airborne isolation room with negative pressure to prevent droplet infection of other patients and/or staff members, and all staff should wear appropriate face masks for respiratory protection against TB such as N95s or powered air-purifying respirators (PAPR) (Zachary, 2024). Expected course of treatment would consist of 4 drugs administered in 2 phases over the course of 6 months. Traditionally known as RIPE therapy, the drug course includes rifampin, isoniazid, pyrazinamide, and ethambutol (Sterling, 2025). The first two months of treatment include all four drugs, and the next 3-6 months would include 2-3 of the drugs (Sterling, 2025). Symptom improvement typically occurs 2-3 weeks after beginning the treatment (Sterling, 2025). References: Sterling, T.R. (2025, January 24). Treatment of drug-susceptible pulmonary tuberculosis in nonpregnant adults without HIV infection. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-drug-susceptible-pulmonary-tuberculosis-in-nonpregnant-adults-without-hiv-infection?search=tuberculosis%20disease&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=6 Zachary, K.C. (2024, May 23). Tuberculosis transmission and control in healthcare settings. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/tuberculosis-transmission-and-control-in-health-care-settings?search=tuberc	Your answer was brief and direct to the point. I appreciate how you encompassed all answers in one paragraph. I deducted 0.5 point because I was looking for the care plan while the patient is in the ED which includes the basic line and lab before we proceed with starting on anti-TB meds. Overall, great job. Just additional information below: Discharge instructions include home isolation procedures and follow-up at the appropriate clinic to receive medication and ongoing care. Antituberculosis medications should not be instituted in the ED unless there is joint agreement with the consultant and follow-up providers. Prior to commencing therapy, baseline labs are recommended as follows: CBC (platelet count), LFTs, serum urea, and creatinine (Belle & Wise, 2017).	9.5/ 10

	ulosis%20disease%20infection%20control&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1 Feedback: A great, straight forward question! I think the piece about disposition was especially good and complexity could be added by asking the student nurse to evaluate the potential barrier to treatment that is often encountered by those with TB – especially for a patient returning to another country.		
6	I would tell the family that placing 2 separate oxygenation probes allows the clinical team to evaluate whether the issue with the infant's heart is centered around the patency of the ductus arteriosus (Altman, 2024). A diagram would be helpful in this context for the family to see a diagram of the heart and understand the location and function of the ductus arteriosus; see example of such a diagram below. While showing the family the diagram, I would explain how the probe on the right hand reflects the amount of oxygen in the blood *before* it passes through the ductus arteriosus while the probe on the left foot reflects the amount of oxygen in the blood *after* it passes through the ductus arteriosus (Altman, 2024). This measured difference offers the clinical team insight into what might be wrong and how to address it (Altman, 2024). Cyanosis differing from one side of the patient to the other can be indicative of left-sided obstructive lesions such as aortic stenosis, coarctation of the aorta, and interrupted aortic arch (Geggel, 2024). Aortic stenosis consists of a narrowing of the aortic valve while coarctation consists of a narrowing of the aorta itself (Geggel, 2024). An interrupted aortic arch means the anatomical structure of the aorta is such that blood flow is obstructed completely (Geggel, 2024). In all three cases, knowing whether this anatomical feature is present before the ductus arteriosus or after helps determine the intervention (Geggel, 2024).	GRADING CRITERIA: 1. Correct placement of sat probes 2. Rationale for placement 3. An explanation that the baby likely has a ductal dependent lesion and needs a PDA (patent ductus arteriosus) in order to survive until surgery. 4. Explanation of blood mixing leading to the different sat measurements 5. APA formatting The clue in this question was that the baby is on prostaglandin! This is used to *keep* the ductus arteriosus patent in heart defects in which pulmonary or systemic flow is obstructed and without the PDA the defect would be fatal (*ductal dependent lesions)*. I was looking to have it called out that the defect must be ductal dependent (like the aortic stenosis and other defects you mentioned). Otherwise, your answer is a good answer, and correctly	9/ 10



Adapted from “Cyanotic congenital heart disease (CHD) in the newborn: Causes, evaluation, and initial management,” by R.L. Geggel, 2024, *UpToDate.* https://www-uptodate-com.offcampus.lib.washington.edu/contents/cyanotic-congenital-heart-disease-chd-in-the-newborn-causes-evaluation-and-initial-management?search=ductal%20dependent%20lesions&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

References:

Altman, C.A. (2024, June 13). Evaluation of suspected critical congenital heart disease (CHD) in the newborn. *UpToDate*. Retrieved May 3, 2025

explains where and why the sat probes are placed so specifically. Excellent answer and image.

Thank you for this feedback. I didn’t think my question was hard, but I’m realizing it was!

	from https://www-uptodate-com.offcampus.lib.washington.edu/contents/evaluation-of-suspected-critical-congenital-heart-disease-chd-in-the-newborn?search=neonate%20congenital%20heart%20disease&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1 Geggel, R.L. (2024, September 6). Cyanotic congenital heart disease (CHD) in the newborn: Causes, evaluation, and initial management. *UpToDate*. Retreived May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/cyanotic-congenital-heart-disease-chd-in-the-newborn-causes-evaluation-and-initial-management?search=ductal%20dependent%20lesions&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H87807098 Feedback: This was a challenging question for me – digging back into nursing school to remember anything about CHD, relearn, and then try to put that into words understandable by someone non-medical. Interesting because I did a question similar last module and didn't think it was too challenging of a question but when it's a subject you don't know – it's quite the challenge! Good application of knowledge. I was wishing for a bonus question about the prostaglandin. 😊		
8	Postural orthostatic tachycardia syndrome (POTS) is most likely causing Jenny's symptoms. The nurse performed the key test for POTS by taking her blood pressure and heart rate while sitting and then again after rising within 10 minutes; in patients with POTS, the heart rate will rise by at least 30 beats per minute from the patient's baseline with little to no effect on the blood pressure (Cheshire, 2024). Jenny's heart rate went from 96 bpm to 130 bpm while her blood pressure did not vary significantly. To further confirm this diagnosis, the clinician could perform a tilt table test; this would entail the patient lying on a table that can be tilted upright, mimicking the	You did a great job identifying POTS and addressing every portion of the question. While her change in VS does indicate POTS, the tilt-table test is the gold standard test to diagnose the condition, as it's more specific and sensitive than a random sampling of HR during an office visit. Grading Criteria:	10/ 10

	function of standing, while monitoring the blood pressure and heart rate changes (Cheshire, 2024). POTS patients have low blood volume which is causing the responding reflexive tachycardia in order to improve venous blood return to the heart. (Cheshire, 2024). Jenny can be encouraged to increase salt and fluid intake to manage symptoms with a goal of 3 liters of fluid a day and 8-12 g sodium chloride. Increasing salt and fluid intake will increase Jenny's blood volume which will start to address many of the symptoms she is experiencing (Cheshire, 2024). An intravenous bolus could be started in the primary care office if Jenny is unable to initially begin oral intake of increased fluid volume. Jenny should also be advised to find an exercise regimen as many patients restrict physical activity in an effort to manage POTS symptoms (Cheshire, 2024). If exercise in an upright position is intolerable, she could pursue activities in alternate positions such as semi-recumbent cycling, rowing, or swimming (Cheshire, 2024). She can also be encouraged to remain upright as much as possible throughout the day and to avoid prolonged stretches of time in bed or lying down (Cheshire, 2024). References: Cheshire, W.P. (2024, October 10). Postural tachycardia syndrome. *UpToDate*. Retrieved May 4, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/postural-tachycardia-syndrome?search=postural%20orthostatic%20tachycardia%20syndrome&topicRef=89916&source=see_link Feedback: This was a very good question! Nice balance of identification but also application, especially the question asking for the rationale of the lifestyle modifications. Only thing that confused me was the test question. From what I read it seemed like the nurse had already done the test so I wasn't sure what else you were looking for? I included the bed tilt test, though it seemed like, from what I was reading, that the sitting and standing vital sign measurements are the typical test. Hopefully didn't miss anything! Thanks for the Ehlers Danlos clue! 😊	2/2: proper identification of POTS 2/2: identifying the tilt-table test as testing to confirm/diagnose the condition 5/6: lifestyle modifications with brief rationale (2 points each) [1 point deducted due to no rationale for remaining upright as much as possible throughout the day] Bonus: 1/2, the answer properly describes one of the potential physiological mechanisms that causes POTS [physiology of condition briefly noted but did not note the cause of the low blood volume. I'm being a bit more critical of the answer since it's a bonus question.]	

10	Based on this image I would suspect bacterial endocarditis and would anticipate an antibiotic regimen specific to the organisms identified from the blood cultures (Wang & Holland, 2024). This patient is at risk for an embolic event and would also require an antithrombotic regimen to reduce the risk of embolism (Wang & Holland, 2024). The nurse should be watchful for signs of stroke in the patient. Given the location of the vegetation on the left side, if the infection does not resolve, the patient may require surgical intervention of the mitral valve (Wang & Gaca, 2024). The patient may also develop new conduction abnormalities due to the infection and will require hemodynamic and cardiac status monitoring including frequent echocardiograms during treatment (Wang & Holland, 2024) References: Wang, A., & Gaca, J.G. (2024, February 1). Surgery for left-sided native valve infective endocarditis. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/surgery-for-left-sided-native-valve-infective-endocarditis?search=bacterial%20endocarditis&topicRef=118215&source=see_link Wang, A., & Holland, T.L. (2024, November 5). Overview of management of infective endocarditis in adults. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-management-of-infective-endocarditis-in-adults?search=bacterial%20endocarditis&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1 Feedback: A really great question, nice work! I thought this was a good balance between identification and application. I know the piece about how the complications would present wasn't necessary, but still a good idea. If you didn't want to overwhelm the student, you could ask them to identify one complication and how it would present.	Great job accurately identifying the patient's diagnosis and the go-to treatment! Antithrombotic regimen would be an important adjunctive medication in this patient's treatment regimen that I would also like to see as this patient's nurse. Also, yes, if antibiotics were ineffective, surgical intervention may be indicated. Good job on identifying potential complications and thank you for your feedback!	10/ 10

12	1. The EKG shows an elevated ST segment. 2. Labs should include biomarkers of myocardial infarction such as troponin, as well as electrolytes and a complete blood count with platelets (Reeder & Mahler, 2025). 3. Based on this scenario and EKG, I would suspect a myocardial infarction, or ST elevated myocardial infarction (STEMI) (Reeder & Mahler, 2025). ST elevation indicates severe and localized ischemia to the heart (Goldberger & Prutkin, 2024). This means that one or more of the blood vessels supplying blood to the heart is occluded and the myocardial tissue is dying. 4. Reperfusion of the heart is the primary goal after diagnosis (Reeder & Kennedy, 2025). A strategy that is both procedural and pharmaceutical would be administration of a fibrinolytic agent followed by angiography with percutaneous coronary intervention (Gibson & Cutlip, 2024). Nitrates and morphine are also routinely administered to ease discomfort from chest pain (Reeder & Kennedy, 2025). References: Gibson, C.M., & Cutlip, D. (2024, November 8). Acute ST-elevation myocardial infarction: Selecting a reperfusion strategy. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/acute-st-elevation-myocardial-infarction-selecting-a-reperfusion-strategy?search=STEMI&topicRef=66&source=see_link Goldberger, A.L., & Prutkin, J.M. (2024, April 24). Electrocardiogram in the diagnosis of myocardial ischemia and infarction. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/electrocardiogram-in-the-diagnosis-of-myocardial-ischemia-and-infarction?search=STEMI&topicRef=66&source=see_link Reeder, G.S., & Kennedy, H.L. (2025, April 21). Overview of the acute management of ST-elevation myocardial infarction. *UpToDate*.	1. 1/1 correctly identifies ST segment elevation 2. 2/2 Correct labs included 3. 3/3 you got it ! 4. 4/4 The emphasis on reperfusion is good, and mentioning fibrinolytics with PCI shows understanding	10/ 10

	Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-the-acute-management-of-st-elevation-myocardial-infarction?search=STEMI&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1 Reeder, G.S., & Mahler, S.A. (2025, April 18). Initial evaluation and management of suspected acute coronary syndrome (myocardial infarction, unstable angina) in the emergency department. *UpToDate.* Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/initial-evaluation-and-management-of-suspected-acute-coronary-syndrome-myocardial-infarction-unstable-angina-in-the-emergency-department?sectionName=CARDIAC%20BIOMARKERS%20AND%20OTHER%20LABORATORY%20TESTING&search=STEMI&topicRef=66&anchor=H16&source=see_link#H16 Feedback: I haven't interpreted an EKG in a long while so I had to dig on this one. There is a good balance in the question of identification paired with application. Since there were several parts to the question, you could potentially create a rubric, especially if you wanted the student to really focus on certain aspects – ie, make those parts worth more points.		
14	I would suspect pulmonary embolism for this patient and would anticipate the physician ordering supplemental oxygen, potentially intravenous fluid (though this patient's blood pressure is not critically low at this point), anticoagulant therapy, and close monitoring of changes to hemodynamics (Weinberg & Rali, 2025). Suspected pulmonary embolism would indicate a chest x-ray for imaging in order to assess presence of abnormalities in the lungs (Thompson, Karhbel, & Pena, 2025). Abnormal lab values may include elevated white blood cell count, increased erythrocyte sedimentation rate, elevated lactate and lactate dehydrogenase, and elevated aspartate aminotransferase (hompson, Karhbel, & Pena, 2025).	Great example of Pulmonary embolism. The correct answer is Acute on Chronic CHF based on his symptoms of activity intolerance, wheezing, vital signs including hypoxemia, BLE edema are concerning symptoms of CHF exacerbation. Pain and Swelling in BLE can be caused by fluids build up in the extremities. Chest pain is caused by oxygen demand due to volume overload and wheezing as well. BP is concerned because this patient needs	5 / 10

	References: Thompson, B.T., Kabrhel, C., & Pena, C. (2025, February 27). Clinical presentation and diagnostic evaluation of the nonpregnant adult with suspected acute pulmonary embolism. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnostic-evaluation-of-the-nonpregnant-adult-with-suspected-acute-pulmonary-embolism?search=pulmonary%20embolism%20diagnosis&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2 Weinberg, A.S, & Rali, P. (2025, April 2). Acute pulmonary embolism in adults: Treatment overview and prognosis. *UpToDate*. Retrieved May 3, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/acute-pulmonary-embolism-in-adults-treatment-overview-and-prognosis?search=pulmonary%20embolism&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2 Feedback: Interesting question with a good balance between straightforward identification and application. If you wanted to enhance the application aspect of the question, you could focus on one of the signs, symptoms, or lab values that would indicate the nurse needs to notify the provider to elevate the intervention.	to be diuresed. We can suspect PE if the patient is having chest pain when taking breaths.	
16	My coworker may have Raynaud's syndrome. In patients with Raynaud's syndrome, the vasculature has a heightened response to cold temperatures or emotional stress (Wigley, 2024). In response to either of these conditions, the patient's blood vessels in their fingers constrict, reducing blood flow and producing the color changes experienced by my coworker (Wigley, 2024). Color changes can continue as blood flow to the fingertips is further constricted and the skin can turn blue and purple (Wigley, 2024). Without other medical history from my coworker, I would	You did a great job answering all parts of the questions. I liked that you included the part of color changes and you figured out that this was a primary syndrome. Thanks for your feedback on this question. My intention was to do	10 / 10

	assume her Raynaud's to be a primary syndrome, meaning there are no other underlying disease processes responsible for the syndrome. My coworker would have secondary Raynaud's syndrome if the phenomena was occurring secondary to a disease process associated with vasoconstriction such as lupus (Wigley, 2024). References: Wigley, F.M. (2024, August 21). Pathogenesis and pathophysiology of Raynaud phenomenon. *UpToDate*. Retrieved May 4, 2025, from https://www-uptodate-com.offcampus.lib.washington.edu/contents/pathogenesis-and-pathophysiology-of-raynaud-phenomenon?search=raynauds&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3 Feedback: This was a fun question to look into, nice job. I like the way you put your "patient" in a situation outside of a clinic or hospital. If you wanted to add more application to it, you could ask the student to identify things the coworker could do to prevent vasoconstriction, other than avoiding cold.	something different than my previous questions and to have a different perspective on diseases. You did great!	
18	Ron has several contributing factors that increased his risk of deep vein thrombosis (DVT) including active malignancy, recent major surgery, being on strict bedrest, history of smoking, and potential injury to his vasculature due to a history of Type 2 Diabetes (Bauer & Lip, 2025). As the patient has been assessed and is not at risk for bleeding, oral anticoagulation medication would be the anticipated initial treatment to prevent progression of the thrombus and embolization (Lip & Stevens, April 22, 2025). Options for oral medications include factor Xa inhibitors such as rivaroxaban, direct thrombin inhibitors such as dabigatran, or warfarin (Lip & Stevens, March 21, 2025). These medications block clotting factors which will reduce the risk of the clot growing. Without treatment or had the condition gone unnoticed, the thrombus may have gotten larger or broken away from the distal limb and traveled to the heart or brain causing myocardial infarction or stroke (Lip & Stevens, April 22, 2025).	Great job on this! You were incredibly thorough and I appreciate the use of in-text citations. You went above and beyond with the responses and descriptions. Thanks for your feedback as well,it is interesting how important patient input is on medication selection, as I'm sure some patients are not compliant due to the prescribed route of the medication (like not wanting to give themselves SQ injections initially). Great work!	10/ 10

References:

Bauer, K.A., & Lip, G.Y.H. (2025, April 24). Overview of the causes of venous thrombosis in adults. *UpToDate*. Retrieved May 4, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-the-causes-of-venous-thrombosis-in-adults?search=deep%20vein%20thrombosis%20risk%20factors&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Lip, G.Y.H., & Stevens, S.M. (2025, April 22). Overview of the treatment of lower extremity deep vein thrombosis (DVT). *UpToDate*. Retrieved May 4, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-the-treatment-of-lower-extremity-deep-vein-thrombosis-dvt?search=deep%20vein%20thrombosis%20treatment&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

Lip, G.Y.H., & Stevens, S.M. (2025, March 21). Venous thromboembolism: Anticoagulation after initial treatment. *UpToDate*. Retrieved May 4, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/venous-thromboembolism-anticoagulation-after-initial-management?sectionName=SELECTION%20OF%20AGENT&search=deep%20vein%20thrombosis&topicRef=1362&anchor=H28215414&source=see_link#H28215414

Feedback:

I thought this question was well-rounded and asked the student not only to identify a problem and understand the underlying pathophysiology but then apply that knowledge to potential interventions. While I was researching, I discovered that patient input on the selection of the medication is a critical piece because of potential need for follow-up and adherence to a regimen. If you wanted to expand complexity, you could include this aspect.

20	Robert has 3 symptoms that are suggestive of excessive fluid build-up due to heart failure: jugular vein distention (JVD), hepatomegaly, and bilateral pitting edema (Colucci & Borlaug, 2025). It would be critical to identify the root cause of Robert's symptoms as a cardiac related diagnosis would dramatically change the course of Robert's treatment. Specifically, jugular vein distention, edema, and JVD are suspicious of right-sided heart failure, but further testing would need to be done to ascertain if right-sided heart failure is due to left-sided heart failure or some other cause (Colucci & Borlaug, 2025). The clinician's interventions must be specific to the cause and without this, Robert is at risk for a major cardiovascular event. References: Colucci, W.S., & Borlaug, B.A. (2025, April 21). Heart failure: Clinical manifestations and diagnosis in adults. *UpToDate*. Retrieved May 4, 2025 from https://www-uptodate-com.offcampus.lib.washington.edu/contents/heart-failure-clinical-manifestations-and-diagnosis-in-adults?search=right%20sided%20heart%20failure&topicRef=127128&source=see_link Feedback: A very helpful photo of JVD and an interesting way to ask this question. I wasn't entirely sure I gave you enough detail on the second part of the question. If you wanted something more specific – other than Robert being at risk for a major cardiac event without intervention – then you might consider more specificity in the question.	Thoughtful answer with strong clinical reasoning in which you tied symptoms to fluid overload and differential diagnoses. You also recognized the importance of precise diagnosis for targeted treatment. I would have given full points if you included a brief reference to specific treatment changes in COPD vs HF. And I appreciate your feedback, maybe that depended on how I asked the question.	8.5/ 10