BNURS506 Quiz Answering

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

#:	Your Answer	Feedback from Grader	Score
2	1) To promote an environment of inclusivity, respect, and dignity for Kiry during this visit I can: a. Use gender affirming language, such as using their preferred pronouns of they/them. b. Pursue measures of trauma-informed care such as asking consent during assessment and being vocal about what you are going to do next. I would also be very aware of body language such as that described in the question to make sure I am not overstepping their boundaries. c. I would also reinforce to Kiry that their information is confidential, and they are in a safe space. 2) Based off the symptoms, Kiry likely has Vulvovaginal Candidiasis (Eggers & Saks, 2024). 3) Kiry's distress may be stemming from body dysphoria or past trauma may be resurfacing. It may be helpful for the provider to discuss options in regard to treatment to ensure Kiry still has some autonomy in their care. If miconazole may be a triggering approach due to the treatment route for resolving the Vulvovaginal Candidiasis, another approach is a single dose of oral Fluconazole (Eggers & Saks, 2024). **References:** Eggers, E. & Saks E. (2024). Vulvovaginal Candidiasis. In Ferri, F. F. (Ed.). *Ferri's clinical advisor 2025*. Elsevier. **Feedback:** Great question that encompasses pathophysiology, pharmacology, and a trauma-informed approach to assessment. I really appreciate your question and learned quite a bit from it too.	Thank you for your answer and feedback. 1. The first two measures are specific and will promote an environment of trust, safety and respect. The third point is vague; I was looking for tangible things a nurse could do, more than just say - this is a safe space. These statements are not very convincing for many gender diverse patients. 4 points 2. Correct 2 points 3. Correct 2 points	8 / 10

4	1) Quinn is likely experiencing endometriosis as she is exhibiting a number of the associated symptoms. Symptoms likely indicating endometriosis include chronic lower abdominal pain and pelvic pain that is heightened during menstrual periods, low back pain, pain during intercourse, and infertility (Elsevier ClinicalKey, 2025). 2) Outside of surgical diagnosis, transvaginal ultrasonography would be the go-to imaging modality as it is more accessible and cost effective (Elsevier ClinicalKey, 2025). On ultrasound they would be looking for ovarian endometriomas (Elsevier ClinicalKey, 2025). 3) GnRH agonists or antagonists is a treatment option if hormonal contraceptives or progestogens have been proven ineffective (Elsevier ClinicalKey, 2025). GnRH can help suppress follicle stimulating hormones that will then shrink endometrial tissue (Elsevier ClinicalKey, 2025). A surgical method would include Laparoscopic removal of ectopic endometrial tissue (Elsevier ClinicalKey, 2025). This procedure is minimally invasive that is primarily reserved for those who have medically refractory pain that disrupts their normal function or causes significant emotional distress, or for those individuals trying to conceive (Elsevier ClinicalKey, 2025). This procedure is the removal of ectopic endometrial tissue by means of excision, diathermy, or ablation/vaporization (Elsevier ClinicalKey, 2025). References: Elsevier ClinicalKey. (2025, February 11). *Endometriosis*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-434776c3-215e-4c20-88c4-40bd8c91529a#treatment-heading-30 Feedback: This was an amazing question that addressed pathophysiology, assessment, and pharmacology. This is something that I've seen quite a few of my friends go through and the pain they tell me can be unbearable. Great job at conveying how tough this disease can be for women to navigate.	1. Great job identifying that Quinn has endometriosis and using her symptoms to support your diagnosis! (3/3 pts) 2. Awesome! Although laparoscopy with biopsy is the definitive diagnosis, it is more invasive. Transvaginal ultrasound is another great diagnostic tool! (3/3 pts) 3. Great job at identifying two interventions, when they would be used, and what they address. GnRH agonists or antagonists are an option if first-line treatment is ineffective. Surgical removal of endometrial tissue is another option, especially for women with fertility issues. (3/3 pts) +1 pt citations Thank you for your feedback! Endometriosis is unfortunately underdiagnosed due to the stigma surrounding female reproductive health.	10 / 10

6	1) TPE also known as total pelvic exenteration, is a potentially curative procedure to address cancer in the pelvic region. TPE is performed when there is persistent or recurrent cancer located in the pelvis with no distant metastases that involves the removal of all the pelvic organs (Lambrou & Amadeo, 2020). This procedure is typically followed by a reconstruction that addresses the urinary system, bowel function, and pelvic defect (Lambrou & Amadeo, 2020). 2) Organs removed typically include bladder, urethra, uterus, cervix, vagina, fallopian tubes, ovaries, parametrium, rectosigmoid colon, anu, and sometimes the vulva (Lambrou & Amadeo, 2020). 3) a. The patient receiving this procedure will end up with both a urostomy and a colostomy. Ostomy care will require extensive education for the patient such as changing the ostomy, emptying the bags, recognizing abnormalities, and dietary considerations. b. This patient will likely experience significant post-operative pain that will need around the clock management. For an extensive procedure such as this I would expect a fairly strong regimen of pain medication, that would also prompt an additional education point for the patient. Additionally, to help cope with the pain and avoid stasis, occupational and physical therapy may be a beneficial resource. c. While this is a procedure that ideally rids the patient of cancer, the patient will now have to adapt to a whole new lifestyle, especially with their ostomies in place. I would ensure they have adequate mental health resources to cope as I assume they are more inclined to body dysmorphia. I would also assess their support system and see how involved they will be with care to help alleviate some of the pressure the patient may be feeling with all the new changes. **References:** Lambrou, N.C. & Amadeo, A. (2020). Surgical Gynecologic Oncology. In	Wonderful job answering this question! You provided a good amount of information for each component of the question and correctly used in-text citations to support your points. Mental health support, pain management, and ostomy care are all significant considerations for patient education and support required postoperatively.	10/ 10

	Cristian, A. *Breast Cancer and Gynecologic Cancer Rehabilitation*. Elsevier. **Feedback:** Fantastic question that involves physiology and education for a patient just receiving a life altering procedure. I was able to learn so much more about TPE and how extensive the procedure really is through your question.		
8	Given the patient's vomiting, constipation, discomfort, malnourishment, and is taking levetiracetam and erythromycin, the probable diagnosis is pancreatitis (Elsevier ClinicalKey, 2025). Diagnosis of pancreatitis requires two of three criteria including abdominal pain, amylase or lipase levels elevated, and radiologic evidence (Elsevier ClinicalKey, 2025). This child evidently has the abdominal discomfort, they are likely going to receive a CT for confirmation, and their blood work will also be assessed to see if amylase or lipase serum levels are more than 3 times the upper reference limit (Elsevier ClinicalKey, 2025). **References:** Elsevier ClinicalKey. (2025, February 26). *Acute Pancreatitis*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-bf45b3c6-d441-468a-b3f5-89e58473a744#diagnostic-procedures-heading-20 **Feedback:** Great and straightforward question! I appreciate in this scenario that you couldn't rely on what the patient was telling you, you had to assess all the clinical aspects to come to a conclusion.	Great job answering the question. I liked that you included that the child may abdominal discomfort since the client can't verbally communicate. For the last question, I was looking for any kind of physical assessment that is needed for the child. For example, monitor client's bowel sounds, any tenderness in his abdomen, monitor his vomiting, urine output, bowel activity, his skin turgor for hydration and monitor for any pain. I took 0.5 points for not including a physical assessment.	9.5 / 10
10	1) Given the presentation of upper abdominal pain, nausea, nocturnal pain, bloating, early satiety, and positive urea breathe test this patient likely has a duodenal/peptic ulcer due to *Helicobacter pylori* (Elsevier ClinicalKey, 2024). 2) The first line of defence for eradication/treatment is Clarithromycin triple therapy, which includes Clarithromycin, amoxicillin, plus	#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	10/ 10

	vonoprazan or a proton pump inhibitor, (PPI) such as lansoprazole or omeprazole, for 14 day (Elsevier ClinicalKey, 2024). 3) The patient should follow up four weeks after completion of antibiotic therapy and PPI therapy has been withheld for one to two weeks. The provider will then perform urea breath test, fecal antigen test, or biopsy-based test to prove eradication (Elsevier ClinicalKey, 2024). **References:** Elsevier ClinicalKey. (2024, December 18). *Peptic Ulcer Disease*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-bf45b3c6-d441-468a-b3f5-89e58473a744#diagnostic-procedures-heading-20 **Feedback:** I appreciate that your question included pathophysiology, assessment, and pharmacology aspects to really complete the picture. You wrote out clear expectations which really help me narrow in on what I'm looking for.	triple therapy, triple therapy, vonoprazan dual therapy, or vonoprazan triple therapy: 3/3 points #3 Follow-up after a month, but not more than 2 months; ideally this should be stated in a way that the patient will understand:3/ 3 points References & in-text citations: 1/1 point Thank you for the feedback, I tried to touch on all the important aspects of this condition!	
12	1) Barbie's likely diagnosis is colonic polyps, but depending on the number of polyps found it could also be familial adenomatous polyposis (FAP) and she will likely receive a polypectomy to have polyps removed so they do not progress into colon cancer (Elsevier ClinicalKey, 2025). These polyps would like to be sent off for pathology testing. **Bonus:** If left untreated FAP has a 95% chance of developing colorectal cancer, stressing the importance of early detection (Elsevier ClinicalKey, 2025). **References:** Elsevier ClinicalKey. (2025, January 22). *Colorectal Cancer*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-a75f93df-f8a5-4c75-8cc8-13203e6252c8	You did great with answering the diagnosis name, procedure and answering the bonus question. The correct name for the diagnosis would have been benign colorectal polyps. I only took off a point because I would have liked to see more of a detailed answer , however you still did great.	9/ 10

	Feedback: Great question and very important as I feel colorectal cancer is on the rise. I see so many young people diagnosed with it at work and it is very disheartening.		
14	1) Heather is likely experiencing a small-bowel obstruction as evidenced by her abdominal pain, periumbilical cramping, nausea, vomiting, inability to keep anything down, bloating, inability to pass gas, and imaging (Elsevier ClinicalKey, 2024). She is also predisposed due to her previous abdominal surgeries (Elsevier ClinicalKey, 2024). 2) As the nurse, I would want to perform an abdominal assessment, listening to bowel sounds to assess bowel activity, palpating to note areas of tenderness, and noting the presence of any distention. I would want to assess the characteristics of the vomit too, whether it is bilious, nonbilious, or feculent which may give more clarity on the type of obstruction (Elsevier ClinicalKey, 2024). Additionally, I would like to note the last time she had a bowel movement or passed gas. 3) Treatment plan typically includes intravenous hydration, maintaining NPO, giving IV antiemetics and appropriate amount of pain medication to avoid further constipation, and placing a nasogastric tube for decompression (Elsevier ClinicalKey, 2024). In severe cases non-operative treatment can go as long as six to eight weeks, with the patient on total parenteral nutrition and decompression (Elsevier ClinicalKey, 2024). In non-severe cases I have seen this regimen resolve the obstruction with some bowel rest, however sometime surgical intervention is required like in cases (Elsevier ClinicalKey, 2024): a. Where there is bowel strangulation or ischemia. b. Where after taking contrast medium it does not reach the colon within 8 hours along with the presence of mesenteric edema, small-bowel feces sign, and obstipation, or for patients with signs of strangulation c. Nonoperative approach does not work after three to five days.	1. Correct (2/2) 2. Great job at discussing your varied assessments. I only asked for 2 so full points here, though I would add that for the bowel sounds on auscultation, I would expect that Heather's bowel sounds would be hypoactive or absent. (2/2) 3. Non-surgical: great description, I was looking for IVF, NPO and NG tube for decompression. Great call out on potential for parenteral nutrition! (3/3) 4. Surgical: good job at identifying the potential surgical procedures as well as when to consider moving from non-surgical to surgical management! (3/3) Thank you for your feedback! You're correct, I didn't intend to leave the answer on the first part but consider it a freebie for the last class 🙂	10 / 10

	Operations will involve removing the obstruction which may looks different depending on the cause. This could entail simply removing the blockage, resecting the bowel, hernia reduction/repair, lysis of adhesions, or a laparotomy (Elsevier ClinicalKey, 2024). **References:** Elsevier ClinicalKey. (2024, December 30). *Small-Bowel Obstruction*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-f698b0b9-ef73-4e0d-a47b-16d3a622f2f9#treatment-heading-22 **Feedback:** Great and detailed question! I'm not sure if it was intentional but I think the answer for question one may have been left at the end. Regardless, I still did my research and learned a lot about small-bowel obstructions and their management.		
16	1) A: Small bowel perforation 2) "Mr. Jones, I understand all of this can be very overwhelming and out of the ordinary. You currently have a perforation, which is hole that has formed in your intestine, and we want to make sure you don't start feeling worse. With the IV we plan on administering not only fluids, but antibiotics to help fight off infection, and pain medication so we can try to make sure you are as comfortable as possible. Surgery is needed so we can't stop what is leaking out of your intestines into your abdomen, which can get much worse if we don't do anything. Both an IV and surgery are necessary, so we all have a better chance of getting you out of here in the best condition possible (Mahvi, 2021)." 3) "Mrs. Jones, what likely caused Mr. Jones to get a perforation was his clozapine that he takes at home for his schizophrenia. This medication can cause severe constipation as it slows down the bowels. This can get so severe that it causes the bowel contents to get backed up so much a tear forms. To help prevent this I would recommend Mr. Jones taking a daily stool softener to ensure he has regular bowel movements. If the constipation last longer than two	<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 Thank you for the feedback! I'm happy that you liked the question.	10/ 10

	days, I would follow up with your provider to see if there is anything else they would recommend (Elsevier ClinicalKey, 2025).” **References:** Elsevier ClinicalKey. (2025, May 14). *Small-Bowel Obstruction*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/drug_monograph/6-s2.0-142 Mahvi, D.A. (202l). Stomach. In Townsend, C. M. (2021). *Sabiston Textbook of Surgery: The Biological Basis of Modern Surgical Practice* (21st Ed.). Elsevier. **Feedback:** Great question! You really laid out the whole clinical picture as a nurse would see when getting a patient like this. It was very straightforward, and I knew what you were asking for. The clinical scenario helped the information stick a little bit more.		
18	1) Marco is likely experiencing hepatic encephalopathy. His symptoms indicating this diagnosis include confusion, disorientation, lethargy, strong musty odor to his breath, personality changes, forgetfulness, asterixis, electrolyte imbalance, and elevated ammonia (Elsevier ClinicalKey, 2022). Hepatic encephalopathy is a brain dysfunction caused by liver insufficiency and/or portosystemic shunting that presents as neuropsychiatric abnormalities (Elsevier ClinicalKey, 2022). Pathophysiology is unclear but is believed to be caused by factors including a build-up of neurotoxins particularly ammonia, impaired neurotransmission metabolic alterations impairing neurotransmission, brain energy metabolism alterations, systemic inflammation, and alterations in the blood-brain barrier (Elsevier ClinicalKey, 2022). 2) <u>Pharmacologic:</u> Increasing the lactulose is the likely treatment as it works to reduce intestinal ammonia production and absorption. With use of maintenance lactulose in patients with cirrhosis, the goal is 2-3 soft bowel movements a day. <u>Nonpharmacological:</u> I would maintain Marco’s high protein diet to achieve an intake of 1.2 to 1.5 g/kg of ideal body weight daily. The	You clearly identified hepatic encephalopathy and explained the role of ammonia buildup well. The one thing I’d suggest adding is a little more context around protein. You’re right that we don’t restrict protein long-term anymore, but during an acute episode—especially if a high-protein meal may have triggered it—there might be a short-term reduction before building back up. Overall nice job!	9/ 10

	high protein diet helps to combat worsening hepatic encephalopathy (Elsevier ClinicalKey, 2022). **References:** Elsevier ClinicalKey. (2022, December 6). *Hepatic Encephalopathy*. Retrieved May 27, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-c513dfc6-6784-488f-bdcd-de5e8beea276#clinical-presentation-heading-9 **Feedback:** This was a great question that involved pathophysiology, assessment, and pharmacology. I have seen a lot of hepatic encephalopathy, and it can be a difficult diagnosis to manage.		
20	Acetaminophen, in high doses, is primarily toxic to the liver, however, can affect multiple organs in this scenario. For a child such as Sarah 150 to 200 mg/kg of acetaminophen is potentially toxic while in adults it is 7.5 to 10 g (Elsevier ClinicalKey, 2024). Early after ingestion of a toxic amount of acetaminophen, patients will typically be asymptomatic which gives you an idea that it may have been some time since Sarah ingested (Elsevier ClinicalKey, 2024). Severe acetaminophen poisoning may progress to fulminant hepatic failure (likely what is happening in this scenario), coma, and death (Elsevier ClinicalKey, 2024). Sarah is likely in phase III of toxicity as evidenced by her level of consciousness and evidence of bleeding through the NG tube (Elsevier ClinicalKey, 2024).The altered mental status is caused by a buildup of toxins causing hepatic encephalopathy and the bleeding is a determinant that there is coagulopathy issues present indicating severe liver complications (Elsevier ClinicalKey, 2024). There are four phases of presentation in acute toxicity that help determine how extensive damage may be and where the patient is in their recovery (Elsevier ClinicalKey, 2024). When drawing labs on Sarah I would include a CBC, CMP, serum acetaminophen concentration, AST/ALT, serum bilirubin, coagulopathy lab work, serum lactate, serum amylase, serum ammonia, ABGs, and a type and cross for transfusing blood products (Elsevier	For full credit, answer should include diagnosis of **acute/fulminant liver failure (1 pts)**;interventions, including **necessary labs (liver enzymes, ammonia, coags) (2 pts)**, medications to consider **(acetylcysteine) (2 pts)**, assessments (bleeding, LOC (2 pts) Liver functions that place Sarah at the highest risk at this point are **clotting factors and hepatic encephalopathy (2 pts)**. Correct APA citation (1 pt). Excellent answer! Thank you for the feedback. I was trying to write this question in a bit of a “softball format”, and that wasn’t clear. You gave an extensive amount of very detailed information, going above and beyond my intent! I apologize for the lack of clarity.	10/ 10

	ClinicalKey, 2024). With any ingestion, toxicity, or poisoning, it is important to involve local poison center and consulting medical toxicologist to help with timely diagnosis and treatment (Elsevier ClinicalKey, 2024). Additionally, I would contact a local liver transplant center as this may be a possibility for Sarah depending on the extent of her damage (Elsevier ClinicalKey, 2024). Medications would include activated charcoal, acetylcysteine, and IV fluids (Elsevier ClinicalKey, 2024). Interventions based on assessment finding would likely include transfusing blood products, frequent monitoring of hemodynamics, seizure pads, frequent neurological assessment to assess for worsening confusion, ensuring environment is safe to avoid additional patient harm, and monitor intake and output to assess for possible renal damage. The most likely imminent risk is the hemodynamic instability as the liver is vital in producing clotting factors which is further stressed through the blood coming from her NG tube. **References:** Elsevier ClinicalKey. (2024, December 4). *Acetaminophen toxicity*. Retrieved May 30, 2025, from https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/clinical_overview/67-s2.0-37d12275-93f6-4a84-80a2-fd4b4113014e#drug-therapy-heading-32 **Feedback:** I appreciate how you include aspects of pathophysiology, assessment, and pharmacology in a various serious patient scenario. However, this question(s) is pretty broad and extensive. I think expectations could have been a bit clearer and at least one or two of the questions removed for time's sake as you are asking five questions here.		