BNURS506 Quiz Answering

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

#:	Your Answer	Feedback from Grader	Score
1	1) The student's symptoms (severe and worsening scrotal pain, pallor, distress, and cupping his genitals) strongly suggest testicular torsion which is a surgical emergency. Testicular torsion occurs when the spermatic cord twists, cutting off blood flow to the testicle. Without prompt intervention, typically within 4 to 6 hours, irreversible damage and testicular loss can occur. Therefore, urgent medical evaluation is essential to preserve testicular viability and future fertility (Brenner & Ojo, 2025). 2) The nurse should call 911 or arrange for urgent transport to the emergency department without delay. Physical examination should be limited to avoid worsening the condition. While waiting, the nurse should stay with the student, offer reassurance, and contact the student's parents so they can meet them at the hospital. Documentation of the symptoms, timing, and the student's report of injury is also important for continuity of care (DynaMedex, 2025). 3) The nurse should educate the student and family that testicular pain, even when minor or resulting from sports injury, should always be reported immediately. Testicular torsion can occur without trauma and may start with subtle or intermittent discomfort. Wearing a cup for any contact or high-impact sport may help prevent torsion or other injuries to the testicle. The parents should talk to their son about the risks of keeping severe scrotal pain a secret, reassure him that there is nothing to be embarrassed about and encourage him to them or an adult if they are having sudden, severe scrotal pain. This is the best way to prevent loss of a testicle (DynaMedex, 2025).	Correct identification of diagnosis based on symptoms. For the assessment, Calling 911 is a great idea if the parents/guardians are not available and or if the student is not stable. We try to have parents pick up students if at all possible. Great patient education. when you mention loss of testicle I would add loss of fertility of that tesicle.	10/ 10

	References: Brenner, J. S., & Ojo, A. (2025). Causes of scrotal pain in children and adolescents. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/causes-of-scrotal-pain-in-children-and-adolescents DynaMedex. (2025). *Acute scrotum in children - Approach to the patient*. Retrieved June 6, 2025, https://www-dynamedex-com/approach-to/acute-scrotum-in-children-approach-to-the-patient Feedback: This is a engaging clinical scenario! I like how you incorporated school-based context while still guiding learners to recognize a true medical emergency. Nice work!		
2	References: Feedback:		/ 10
3	1. Based on the patient's presentation (severe, worsening lower abdominal pain, vaginal bleeding, and vomiting), the most likely diagnosis is a ruptured ectopic pregnancy, which is a life-threatening emergency. A vaginal ultrasound often		

	reveals no intrauterine pregnancy despite a positive pregnancy test and may show free fluid in the pelvis or abdomen, suggesting internal bleeding. In some cases, a mass outside the uterus, such as in the fallopian tube, may also be seen. Given her acute worsening, the ultrasound findings likely confirmed a ruptured ectopic pregnancy, requiring immediate surgical intervention, often via laparoscopy or laparotomy to control bleeding and remove the affected tissue (DynaMedex, 2024). 2. Beta-human chorionic gonadotropin is a hormone produced by the placenta shortly after implantation. In early pregnancy, B-hCG levels typically double every 48 to 72 hours and it is used both to confirm pregnancy and assess whether the pregnancy is progressing normally. In suspected ectopic pregnancy, B-hCG levels may rise more slowly or plateau. If the B-hCG level is above the discriminatory zone of 2000 mIU/mL and no intrauterine pregnancy is seen on ultrasound, this strongly suggests an ectopic pregnancy (Tulandi, 2025). 3. Postoperatively, the nurse should monitor vital signs, assess the surgical site, and track hemoglobin and hematocrit levels. Pain management, nausea control, and fluid status should also be addressed. Monitor for signs of infection, such as fever or increased pain, and assess urine output to evaluate renal perfusion. Emotional support is also critical, as the loss of a pregnancy (particularly in an emergent setting) can be traumatic. The patient's underlying conditions (endometriosis, hypothyroidism, smoking) should also be factored into postoperative care and follow-up planning, especially if future fertility is a concern (DynaMedex, 2024). References: DynaMedex. (2024). *Early pregnancy bleeding - Approach to the patient.* Retrieved June 6, 2025, https://www-dynamedex-com/approach-to/early-pregnancy-bleeding-approach-to-the-patient Tulandi, T. (2025) Ectopic pregnancy: Clinical manifestations and diagnosis. *UpToDate.* Retrieved June 6, 2025,	Thank you so much for your encouraging feedback. Everyone saw this question differently, but you read the question as I imagined. It was about learning questions about ectopic pregnancy and its complications. I gave clear details like the history of endometriosis which does not always cause ectopic pregnancy but all the miscarriages that I have known, they all had history of endometriosis which is the reason for this scenario. I don't know if I made sense to you. I really appreciate your feedback.	10/ 10

	https://www-uptodate-com/contents/ectopic-pregnancy-clinical-manifestations-and-diagnosis Feedback: This is a strong and thoughtfully written scenario. You did a great job layering the patient's symptoms overtime. It's a great example of how to present a broad topic like first-trimester complications in a way that's clinically relevant, and educational. Nicely done!		
4	References: Feedback:		/ 10
5	1. Infertility is diagnosed when a couple is unable to conceive after 12 months of regular, unprotected intercourse if the woman is under 35 years old, or after 6 months if over 35 (DynaMedex, 2024). Since this patient is 32 and has been trying for 9 months, she has not yet met the formal criteria for infertility. However, given the presence of irregular cycles and symptoms suggestive of a possible underlying condition, a preliminary workup is reasonable even before the year month mark, especially to rule out any treatable reproductive issues. 2. One likely possibility is endometriosis, a condition where endometrial-like tissue grows outside the uterus. This often causes dysmenorrhea (painful periods), pelvic pain, and infertility, and may also lead to chronic inflammation	I really like how you answered 1. --with sensitivity and patient-centered individualized care. I would agree that she deserves a work up earlier than 1 year! Your answers were exemplary, and packed with relevant details, with reference back to our case patient. I didn't even think of an HSG, but yes, those are commonly part of the infertility	10/ 10

	and adhesions affecting fertility. Her long history of painful periods, along with recent lower left quadrant pain and bloating, aligns with this (DynaMedex, 2025). Another potential diagnosis is polycystic ovary syndrome (PCOS), particularly in the setting of irregular cycles. PCOS is an endocrine disorder characterized by anovulation, irregular menstruation, and sometimes infertility. To support this differential, the nurse should ask about weight changes, acne, hirsutism, hair thinning, or blood sugar issues. They might also ask about her cycle tracking in more detail (length, regularity, ovulation patterns) and assess whether she has ever been evaluated for ovulatory function (DynaMedex, 2025) 3. Initial testing today might include a pelvic exam and transvaginal ultrasound to assess for ovarian cysts, endometriomas, or uterine anomalies. Lab tests may include serum hormone levels such as LH, FSH, TSH, prolactin, and androgens, along with day 21 progesterone (if cycles are regular enough to estimate ovulation). A baseline metabolic panel and A1C may also be indicated if PCOS is suspected. Further evaluations could include a hysterosalpingogram (HSG) to check for tubal patency and a laparoscopy if endometriosis is highly suspected and not evident on imaging. A semen analysis for the partner is also part of a standard infertility workup (DynaMedex, 2024). References: DynaMedex. (2024). *Female Infertility.* Retrieved June 6, 2025, https://www-dynamedex-com/condition/female-infertility DynaMedex. (2025). *Endometriosis.* Retrieved June 6, 2025, https://www-dynamedex-com/condition/endometriosis DynaMedex. (2025). *Polycystic ovary syndrome (PCOS).* Retrieved June 6, 2025, https://www-dynamedex-comcondition/polycystic-ovary-syndrome-pcos Feedback: This feels like something you'd actually encounter in an outpatient OB/GYN setting! You included just enough detail to guide the learner toward some	workup! Thank you for your hard work on my question!	

	important differentials without making it too obvious. Overall, it's a thoughtful, well-structured question, great work!		
6	References: Feedback:		/ 10
7	Priority Nursing Assessments: The top priority assessments include a focused abdominal exam to evaluate the location, quality, and progression of pain, and vital signs monitoring to detect signs of systemic involvement such as fever, tachycardia, or hypotension that could indicate infection or acute surgical abdomen. Assessing for nausea, vomiting, and changes in bowel or urinary habits is also essential for forming an early clinical picture (DynaMedex, 2023). Priority Nursing Interventions: Initial interventions would include NPO status in anticipation of possible surgical intervention and IV access placement for fluid resuscitation or administration of medications. Additionally, pain control using prescribed analgesics and ongoing monitoring for signs of clinical deterioration are essential nursing priorities (DynaMedex, 2023). Anticipated Tests/Imaging: To differentiate between appendicitis and ovarian torsion, the first-line imaging would likely be a pelvic and abdominal ultrasound with Doppler flow to assess ovarian blood supply, which is crucial for diagnosing	Assessments: Focused abdominal assessment, detailed pain assessment, menstrual and sexual history 2/2 Interventions: Initiate NPO status, PIV access, provider communication 2/2 Anticipated Tests/Imaging: Blood tests (CBC, CMP, CRP), pregnancy test, urinalysis, pelvic and abdominal ultrasound 2/2	/ 10

	torsion. If findings are inconclusive, especially in older adolescents, abdominal and pelvic CT scan may be considered to visualize the appendix and surrounding structures more clearly (Taylor et al., 2025). Pharmacological Interventions: Two commonly anticipated medications include IV analgesics (such as morphine or ketorolac) for pain relief and antiemetics (such as ondansetron) to manage nausea and vomiting. If infection is suspected or confirmed, broad-spectrum antibiotics may also be administered preoperatively (DynaMedex, 2023). Differences in Management: Pediatrics vs. Adults: In pediatric patients like Stella, there is often a higher threshold for CT imaging due to concerns about radiation exposure, so ultrasound is preferred as the initial diagnostic tool. Additionally, in pediatrics, the presentation can be more atypical, and clinicians may need to rely more on observation and serial exams. Surgical teams experienced in pediatric anatomy and care are typically consulted, and recovery protocols may include more family-centered care and psychosocial support than adult protocols (Taylor et al., 2025). References: DynaMedex. (2023). *Acute abdominal pain in adolescents - Approach to the Patient.* Retrieved June 6, 2025, https://www-dynamedex-com/approach-to/acute-abdominal-pain-in-adolescents-approach-to-the-patient Taylor, G. A., Brandt, M. L., MD, & Lopez, M. E. (2025). Acute appendicitis in children: Diagnostic imaging. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/acute-appendicitis-in-children-diagnostic-imaging Feedback:	Pharmacology: IV Analgesics (morphine, Tylenol), antibiotics, antiemetics, IV fluids 2/2 Pediatrics vs. Adults: transvaginal US is more standard and is the gold standard for diagnosing in adults, pelvic (external) is more appropriate in most pediatric cases – bladder must be full to evaluate the ovaries this way – prompt fluid bolus measures can be used. Communication with patient RE sexual history may be sensitive and should be had separately from parents/caregivers; developmentally appropriate assessments (including pain); weight based dosing of medications 2/2	

	You did a nice job balancing the urgency of acute abdominal pain with subtle clues that push the learner to think about both gynecologic and surgical causes. Overall, it's a well-constructed, thoughtful question that hits on both assessment and decision-making. Great work!		
8	References: Feedback:		/ 10
9	1. The image depicts the clinical maneuver known as Rovsing's sign, which is used to assess for appendicitis. To perform this test, the examiner applies deep palpation to the left lower quadrant (LLQ) of the abdomen. A positive Rovsing's sign occurs when pain is felt in the right lower quadrant (RLQ) upon palpation of the LLQ. This happens because pressure on the left side stretches the peritoneum and elicits pain at the site of inflammation, typically the inflamed appendix on the right side. The significance of this finding lies in its support of peritoneal irritation, especially associated with acute appendicitis. While not 100% specific or sensitive, a positive Rovsing's sign increases suspicion of appendiceal involvement, especially when correlated with other classic signs such as McBurney's point tenderness, rebound tenderness, and migration of pain from the periumbilical region to the RLQ—all of which Alsil demonstrates (Brandt & Lopez, 2025).	Congrats! You have provided the answers I was looking for. Thanks for the feedback, Since you got the answers right. I'll further share a fun fact about Rovsing signs. Rovsing sign, initially described Niels Thorkild Rovsing (1862-1927), involves deep palpation at the left lower quadrant with a sliding motion directed proximally at the descending colon towards the splenic flexure. As described by Rovsing in 1907: "I wondered whether I could elicit the typical pain in the right iliac fossa by applying pressure at the left iliac fossa.	10/ 10

	2. To further evaluate and confirm a diagnosis of acute appendicitis, several diagnostic adjuncts are typically used. A complete blood count (CBC) may reveal an elevated white blood cell count**,** particularly with a neutrophilic shift**,** which supports the presence of inflammation or infection. An elevated C-reactive protein (CRP) level can also provide additional evidence of systemic inflammation. In adolescents, particularly females, an abdominal ultrasound is often the initial imaging modality of choice due to its safety and lack of radiation. Ultrasound can help identify a non-compressible, dilated appendix and signs of surrounding inflammation, such as free fluid or fat stranding. However, if the ultrasound findings are inconclusive or if the patient's body habitus limits visualization, a CT scan of the abdomen and pelvis with contrast may be ordered. CT imaging offers higher sensitivity and specificity and can more clearly visualize the appendix and rule out other intra-abdominal pathology. In situations where radiation exposure is a concern, such as in pregnancy, an MRI may be used as an alternative (Taylor et al., 2025). References: Brandt, M. L., MD, & Lopez, M. E. (2025). Acute appendicitis in children: Clinical manifestations and diagnosis. *UpToDate.* Retrieved June 6, 2025, https:\www-uptodate-com\contents/acute-appendicitis-in-children-clinical-manifestations-and-diagnosis DynaMedex. (2023). *Acute abdominal pain in adolescents - Approach to the Patient.* Retrieved June 6, 2025, https://www-dynamedex-com/approach-to/acute-abdominal-pain-in-adolescents-approach-to-the-patient Taylor, G. A., Brandt, M. L., MD, & Lopez, M. E. (2025). Acute appendicitis in children: Diagnostic imaging. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/acute-appendicitis-in-children-diagnostic-imaging	This involves compressing the descending colon by pushing the fingers of my right hand onto the fingers of the left hand placed flat against the abdomen in the left iliac fossa. Using this method, the hands slide upward toward the left colonic flexure". Thus, the maneuver involves more than simple palpation of the left iliac fossa as stated by the authors — it causes air within the colon to flow retrograde in response to compression, resulting in distension of the inflamed appendix and activation of a viscerosensory segmental reflex (Yale et al., 2022).	

	Feedback: This is such a well-structured and realistic case—great job! The way the symptoms progressed from vague periumbilical pain to localized right lower quadrant tenderness was textbook for appendicitis, and the inclusion of the image was a nice touch to reinforce physical exam findings like Rovsing's sign.		
10	References: Feedback:		/ 10
11	(C) Ulcerative Colitis Nataly's symptoms and colonoscopy findings are most consistent with ulcerative colitis (UC). UC is a chronic inflammatory bowel disease (IBD) characterized by continuous mucosal inflammation starting at the rectum and extending proximally through the colon. Key symptoms include bloody diarrhea, mucus in stool, rectal urgency, tenesmus, lower abdominal cramping, and systemic signs like fatigue, weight loss, and nausea (DynaMedex, 2025). Pharmacological Treatments: 1. 5-Aminosalicylic Acid (5-ASA) Compounds (e.g., Mesalamine): These are first-line medications for mild to moderate ulcerative colitis. They act topically on the colonic mucosa to reduce inflammation, particularly effective when disease is confined to the colon. They can be delivered orally or rectally depending on disease location. 5-ASAs are often used	*Great job! All questions were answered accurately and completely. I appreciate the feedback!*	10/ 10

	long-term for both induction and maintenance of remission (Hashash & Reguerio, 2025). 2. Biologic Agents (e.g., Infliximab, Adalimumab): For patients with moderate to severe UC who do not respond to 5-ASAs or corticosteroids, biologics such as anti-TNF agents are used. These target and neutralize tumor necrosis factor-alpha, a key inflammatory cytokine, to reduce disease activity and maintain remission. They are considered when there is moderate/severe disease, steroid dependence, or complications (Cohen & Stein, 2025). Surgical Procedures: 1. Subtotal or Total Colectomy with Ileostomy: This may be necessary in cases of toxic megacolon, perforation, or medically refractory disease. In this procedure, the colon is removed and a stoma is created to allow waste to exit the body through the abdominal wall. It is often a life-saving measure in acute settings (Fleshner, 2025). 2. Proctocolectomy with Ileal Pouch-Anal Anastomosis: This surgery removes the colon and rectum but reconstructs the intestinal tract by creating a pouch from the ileum and connecting it to the anus, allowing for more natural bowel movements. It is often performed electively in patients who require surgery but want to avoid a permanent ostomy (Fleshner, 2025). Nataly will require lifelong monitoring due to the chronic and relapsing nature of ulcerative colitis. key aspect of her care will be undergoing regular colonoscopies, typically every one to two years starting eight years after diagnosis, to screen for colorectal cancer, as ulcerative colitis significantly increases this risk. She will also need routine blood tests, including a complete blood count (CBC), C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), liver function tests, and therapeutic drug monitoring if she is on biologic therapies. If she requires long-term corticosteroid treatment, bone density scans will be necessary to monitor for osteoporosis. Additionally, her care plan should include staying up to date on vaccinations and monitoring for infections, particularly if she is receiving immunosuppressive medications (DynaMedex, 2025).		

	References: Cohen, R. D., & Stein, A. C. (2025). Management of moderate to severe ulcerative colitis in adults. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/management-of-moderate-to-severe-ulcerative-colitis-in-adults DynaMedex. (2025). *Ulcerative colitis in adults.* Retrieved June 6, 2025, https://www-dynamedex-com/condition/ulcerative-colitis-in-adults Fleshner, P. R. (2025). Surgical management of ulcerative colitis. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/surgical-management-of-ulcerative-colitis Hashash, J. A., & Regueiro, M. (2025). Medical management of low-risk adult patients with mild to moderate ulcerative colitis. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/medical-management-of-low-risk-adult-patients-with-mild-to-moderate-ulcerative-colitis Feedback: This is a really well-done question. You did a great job capturing the classic presentation of ulcerative colitis with the combination of symptoms and colonoscopy findings. It was comprehensive without being overwhelming, nice job!		
12	References:		/ 10

	Feedback:		
13	1) Esophagitis (EoE) is a chronic, immune-mediated disease characterized by eosinophilic infiltration of the esophageal epithelium, driven primarily by allergic responses to food or environmental antigens. The resulting inflammation leads to esophageal remodeling, fibrosis, and narrowing, which cause progressive dysphagia and food impaction (DynaMedex, 2024). 2) Sam's personal history of atopic conditions, including seasonal allergies and atopic dermatitis, is highly relevant since EoE is strongly associated with atopic disease. In addition, his family history of EoE in both his father and brother suggests a possible genetic predisposition. These patterns, along with his progressive difficulty swallowing solid foods and compensatory behaviors (e.g., chewing excessively and drinking water), are classic indicators of EoE (Bonis & Gupta, 2025). 3) One common approach is the elimination diet, often beginning with the six-food elimination diet (SFED), which removes common allergens such as dairy, wheat, soy, eggs, nuts, and seafood. This helps identify food triggers that may be driving the eosinophilic inflammation (DynaMedex, 2024). Proton pump inhibitors (PPIs) are another effective first-line treatment. Beyond acid suppression, PPIs have anti-inflammatory effects that reduce eosinophil levels in the esophageal tissue in many patients with EoE (Bonis & Gupta, 2025). For more persistent or severe cases, topical corticosteroids such as swallowed fluticasone or budesonide are used. These reduce inflammation locally in the esophagus and help alleviate symptoms and histological findings without the systemic effects of oral steroids (Bonis & Gupta, 2025). References:	Great work with this answer! I appreciate your use of in-text citations, and your answers demonstrated your understanding of this topic. Your explanation of the pathophysiology, medical/family histories, and possible treatment options were great and answered the question completely. I appreciate your feedback as well!	10/ 10

	Bonis, P. A. & Gupta, S. K. (2025). Clinical manifestations and diagnosis of eosinophilic esophagitis (EoE). *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/clinical-manifestations-and-diagnosis-of-eosinophilic-esophagitis-eoe Bonis, P. A. & Gupta, S. K. (2025). Treatment of eosinophilic esophagitis (EoE)inical manifestations and diagnosis of eosinophilic esophagitis (EoE). *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/treatment-of-eosinophilic-esophagitis-eoe DynaMedex. (2024). *Eosinophilic esophagitis in adults.* Retrieved June 6, 2025, https://www-dynamedex-com/condition/eosinophilic-esophagitis-in-adults Feedback: You did a nice job tying in both the clinical presentation and family history to build a strong suspicion for EoE before even revealing the endoscopy results. I also like that you included the diagnostic findings and prompted learners to think about individualized treatment approaches, it makes the question feel very applied and practical. Great work!		
14	References: Feedback:		/ 10

15	1. Earl is most likely experiencing decompensated alcoholic cirrhosis, a severe form of chronic liver disease caused by long-term heavy alcohol use. His symptoms (jaundice, ascites, progressive confusion, elevated liver enzymes, and elevated ammonia) are hallmark features of liver failure. The tea-colored urine suggests bilirubin spilling into the urine due to impaired liver processing. Cirrhosis leads to portal hypertension and loss of liver function, both of which contribute to the accumulation of fluid in the abdomen and neurotoxic substances like ammonia (DynaMedex, 2024). 2. To relieve the abdominal fluid buildup, Earl will likely undergo a paracentesis, a procedure in which a needle is inserted into the abdominal cavity to drain the ascitic fluid. This is often done for both diagnostic and therapeutic purposes. In cases of tense or symptomatic ascites, like Earl's, therapeutic paracentesis can significantly relieve discomfort and improve breathing and mobility (Lindor, 2025). 3. When administering lactulose, it's important to explain that this medication works by reducing ammonia levels through promoting frequent bowel movements. One key point to educate Earl on is that the goal is to have two to three soft stools per day, not diarrhea, which can lead to dehydration and electrolyte imbalances. Additionally, Earl should be made aware that lactulose may cause bloating, gas, or cramping, especially at the start, but it is critical to continue taking it regularly to help manage his confusion and prevent worsening encephalopathy (Ridola & Riggio, 2025). References: DynaMedex. (2024). *Alcohol-related liver disease.* Retrieved June 6, 2025, https://www-dynamedex-com/condition/alcohol-related-liver-disease Lindor, K. D. (2025). Ascites in adults with cirrhosis: Initial therapy. *UpToDate.* Retrieved June 6, 2025,	I am very impressed with your answer, awesome job! You have accurately and in detail diagnosed what Earl was presenting with. You have also correctly mentioned what procedure Earl would most benefit from to rid him of the excess fluid collection in his abdomen. The education points you mention are also very important and definitely something I would relay to Earl when administering the lactulose. Thank you so much for your feedback!	10/ 10

	https://www-uptodate-com/contents/ascites-in-adults-with-cirrhosis-initial-therapy Ridola, L., & Riggio, O. (2025). Hepatic encephalopathy in adults: Treatment. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/hepatic-encephalopathy-in-adults-treatment Feedback: This is a strong and realistic clinical scenario—nicely done! The details about Tylenol use, bloating, and tea-colored urine add depth and make the case feel like something you'd genuinely encounter at the bedside. I also like how you tied in both the acute concerns (like ascites and encephalopathy) with chronic history to prompt critical thinking. Great work!		
16	References: Feedback:		/ 10
17	1. Tirzepatide is a dual glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) receptor agonist. This medication mimics both incretin hormones, which enhance insulin secretion, suppress glucagon, slow gastric emptying, and promote satiety (Jastreboff et al., 2022). By slowing gastric emptying, tirzepatide prolongs the time food remains in the stomach. This mechanism contributes to early satiety and reduced caloric intake, aiding weight	You knocked this out of the park! Great work answering this question and you described your answers very well. Thank you for your feedback, and I	10 / 10

	loss. However, this delayed gastric motility can also cause or exacerbate gastrointestinal side effects such as nausea, vomiting, bloating, and abdominal discomfort, particularly in patients just starting or escalating the dose (Wong, 2023). In Ruth's case, her severe nausea and vomiting may be partially linked to tirzepatide's pharmacologic effect on gastric motility, alongside the more immediate problem of acute cholecystitis, which is a known complication of both obesity and rapid weight loss—another possible side effect of tirzepatide (Jastreboff et al., 2022) 2. The anesthesiologist is likely performing a gastric ultrasound to assess the residual volume in Ruth's stomach before induction of anesthesia. This is especially relevant for patients taking GLP-1 receptor agonists like tirzepatide, which can significantly delay gastric emptying, leading to increased aspiration risk even after standard preoperative fasting periods. Recent ASA guidelines recommend considering individualized fasting assessments or potentially delaying elective surgeries in high-risk patients who've taken a GLP-1 RA within 48 hours (ASA, 2023). Postoperatively, nursing care should include aspiration precautions such as elevating the head of the bed, monitoring for signs of delayed gastric emptying, and cautious reintroduction of oral intake based on return of bowel function and guidance from the care team. Additionally, it's important to monitor glycemic control, as both surgical stress and interruption of antidiabetic therapy can affect blood glucose levels. References: American Society of Anesthesiologists (ASA) (2023). *American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists*. https://www.swa10.com/uploads/6/1/4/3/61438899/glp-1.asa.2023.pdf Jastreboff, A. M., Aronne, L. J., Ahmad, N. N., Wharton, S., Connery, L., Alves, B., Kiyosue, A., Zhang, S., Liu, B., Bunck, M. C., & Stefanski, A. (2022). Tirzepatide	hope this is helpful to you in your practice setting.	

	Once Weekly for the Treatment of Obesity. *The New England Journal of Medicine*, *387*(3), 205–216. https://doi.org/10.1056/NEJMoa2206038 Wong, E. (2023). Tirzepatide: A novel dual GIP and GLP-1 receptor agonist. *Journal for Nurse Practitioners*, *19*(1), 104474-. https://doi.org/10.1016/j.nurpra.2022.10.003 Feedback: Your quiz question is timely, complex, and very clinically relevant. You did a great job connecting tirzepatide's pharmacology with real-world concerns like pre-op risk and GI symptoms. Really thoughtful, nice job!		
18	References: Feedback:		/ 10
19	1. The patient is most likely experiencing an upper gastrointestinal (GI) bleed, likely related to his history of peptic ulcer disease, which is exacerbated by his use of apixaban (Eliquis), a direct oral anticoagulant. His report of dark, tarry stools (melena) is a classic sign of digested blood from the upper GI tract. Weakness, dizziness, and hypotension (BP 95/60) indicate volume depletion, possibly from ongoing blood loss (DynaMedex, 2023).	1. Gastrointestinal (UGI) Bleeding. 2/2 Awesome, you got it. 2. Interventions*3. 6/6 Awesome!! you mention IV fluid, Eliquis, PPI, and blood transfusion.	10/ 10

	2. First, the patient should be placed on cardiac and oxygen monitoring while vital signs are continuously reassessed, given the risk of hemodynamic instability. Second, initiate IV access to begin fluid resuscitation to support blood pressure and perfusion. Third, type and crossmatch for blood products should be ordered, as the patient may require a blood transfusion if hemoglobin is low or bleeding continues. Additionally, the provider may order IV proton pump inhibitors to reduce gastric acid and stabilize any bleeding ulcers, and reversal agents for apixaban may be considered if bleeding is severe. The patient should remain NPO in anticipation of upper endoscopy, which is typically performed within 24 hours to locate and treat the source of the bleed (Saltzman, 2025). 3. The patient should be educated about the importance of reporting any signs of GI bleeding in the future, such as black stools, fatigue, or lightheadedness, especially while on anticoagulation therapy. It is also important to review the risks associated with NSAID use, alcohol, and anticoagulants, which can aggravate peptic ulcer disease. Education should emphasize medication safety and the importance of regular follow-up with his healthcare provider (Saltzman, 2025). References: DynaMedex. (2023). *Occult GI bleeding - Approach to the patient.* Retrieved June 6, 2025, https://www-dynamedex-com./approach-to/occult-gi-bleeding-approach-to-the-patient Saltzman, J. R. (2025). Approach to acute upper gastrointestinal bleeding in adults. *UpToDate.* Retrieved June 6, 2025, https://www-uptodate-com/contents/approach-to-acute-upper-gastrointestinal-bleeding-in-adults Feedback: The case feels realistic and applicable to everyday practice, especially in acute care or emergency settings. I like that you balanced the need for rapid intervention with the opportunity for teaching and patient education. Great work!	3. nursing education*2. 2/2 That's good you mention signs of bleeding, and risk of taking NSAIDs and follow up.	

20	References: Feedback:		/ 10