BNURS506 Quiz Answering

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

#:	Your Answer	Feedback from Grader	Score
1	1. This student most likely has testicular torsion based on his symptoms, including severe pain in his scrotum that has worsened overnight after physical activity, walking hunched over, which could be a result of radiating abdominal pain and cupping his genital area to help relieve pain, (Brenner & Ojo, 2024). Testicular torsion requires urgent medical evaluation because, if not treated, testicular torsion can result in loss of the testicle due to the twisting of the spermatic cord that causes venous compression, edema, and ischemia due to arterial occlusion (Brenner & Ojo, 2024). 2. Immediate steps that the school nurse should take to assess this student include attaining a complete detailed history of the events leading up to this incident, evaluating the patient's level of pain, and potentially assessing the amount of swelling in the scrotum, if possible (Brenner & Ojo, 2024). Overall, if the nurse recognizes this as testicular torsion, it is a medical emergency, and they should call 911 and have the child sent to the hospital (Brenner & Ojo, 2024). The nurse should also notify the student's parents as soon as possible regarding the situation and inform them that the student requires immediate medical attention. They should either come to the school or meet the child at the hospital. While awaiting further medical attention, the nurse should encourage the student to assume the most comfortable position, remain calm, and be assured that help is on the way. To treat testicular torsion, manual detorsion is often attempted prior to surgery but should not be done by the school nurse as it could make symptoms worse (Brenner & Ojo, 2024). The student will most likely undergo surgery as soon as possible for a surgical detorsion and fixation; therefore, keeping the student NPO may help speed up this process.	Correct identification of diagnosis based on symptoms. Great nursing assessment, in a school setting if the student is stable, calling home is the first line. If a parent/guardian can't pick up or child is in severe distress then 911. The only other patient education piece I would add that with loss of testicle would result in loss of fertility if not addressed in a timely manner.	10/ 10

	3. Key educational points that should be shared with student and their family to prevent delayed reporting and promote future awareness of testicular health include the following. ● signs and symptoms of testicular torsion, which include sudden onset of pain that can worsen over time, nausea/vomiting, and testicular swelling (Brenner & Ojo, 2024) ● any abnormal findings or pain in the groin is not normal, and they should seek medical attention ● checking the groin area for any signs of abnormality should also start becoming a regular practice and is important for future testicular health and to recognize what is normal vs. abnormal for the student's body ● Delayed reporting of any signs and symptoms can result in the loss of a testicle, especially since detorsion should be performed within 4-6 hours to have the highest chance of viability (Brenner & Ojo, 2024). Therefore, it is important to communicate these concerns sooner rather than later ● having open conversations at home is important, and education about reproductive health should be discussed and trust built if the student is uncomfortable about these topics References: Brenner, J. S., & Ojo, A. (2024). Causes of scrotal pain in children and adolescents. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/causes-of-scrotal-pain-in-children-and-adolescents Feedback: This is a well written question about testicular torsion, and I like how there was an emphasis on real world application for children and their families. It is a reminder that not everyone knows about serious health concerns and its part of our job as providers to help, educate, and encourage them. To		

	bolster this question, you could always put a photo diagraming the anatomy of the testes, but overall great question.		
3	1. This patient most likely had an ectopic pregnancy that ruptured based on her symptoms, including severe lower abdominal pain, vaginal bleeding that has worsened, and now acute distress evidenced by unbearable pain and vomiting (Tulandi, 2024). The patient's history of endometriosis and being a current smoker also increase her risk of having an ectopic pregnancy (Tulandi, 2024). To diagnose an ectopic pregnancy, on a transvaginal ultrasound, there would be no evidence of an intrauterine pregnancy, and either visualization of a inhomogeneous extraovarian adnexal mass, an extraovarian adnexal mass containing an empty gestational sac, or intraperitoneal bleeding (Tulandi, 2024). 2. Beta-human chorionic gonadotropin hormone is secreted into maternal circulation after implantation, which can occur 6-10 days after ovulation and is used to confirm pregnancy and track its progression over time (Barbieri, 2024). During pregnancy, serum hCG concentration doubles every 29-53 hours during the first 30 days after implantation, peaks at 8-10 weeks, and then slowly declines until reaching a plateau in the second or third trimester (Barbieri, 2024). Abnormal levels of b-hCG can indicate an ectopic pregnancy in conjunction with the transvaginal ultrasound findings. During ectopic pregnancies, hCG levels rise abnormally or plateau, which is around <35% over two days; compared to normal pregnancies, the hCG level should double every couple of days (Tulandi, 2024). An ectopic pregnancy diagnosis is confirmed when any of the following are present: visualization of extrauterine gestational sac with a yolk sac or embryo on transvaginal ultrasound, a positive serum hCG with no products of conception on uterine aspiration, and subsequent rising/plateau of hCG levels, or visualization during surgery with histologic confirmation (Tulandi, 2024). 3. After the patient returns from the OR, I would monitor and assess the following. - Vital signs	Thank you for your feedback. I will try to make the question more clear. you answered all the questions accurately and details that i was asking for. Appreciate the in-text citations. I will work on my skills to write more clearly which will make the reader feel good about reading my contents.	10 / 10

	- Pain level and pain control - Any signs or symptoms of vaginal bleeding or internal hemorrhage, which can also include routine labs to monitor CBC (Tulandi, 2024) - Monitor for signs of infection, including fever, incision site inflammation/redness, increased pain - Checking hCG levels to ensure they are going down until the levels are undetected. If hCG levels don't progressively decrease, then the patient may be given methotrexate to ensure all products of conception are removed (Tulandi, 2024). - Losing a pregnancy can also be very emotional therefore I would ensure that the patient is receiving adequate psychological support and has resources on hand References: Barbieri, R. L. (2024). Lab interpretation: Positive hCG in women. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/positive-hcg-in-women Tulandi, T. (2024). Ectopic pregnancy: Clinical manifestations and diagnosis. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/ectopic-pregnancy-clinical-manifestations-and-diagnosis Feedback: I liked that this question covered multiple areas from diagnosis, assessment findings, labs, and finally post operative care. The wording of the question could have been a bit more clear, especially question 1. I can infer that the question is asking to give a diagnosis, but the wording "what led to the emergency procedure" could be confusing. To rephrase, the question could be "What do you think the suspected diagnosis is and how would the vaginal ultrasound findings support this diagnosis?".		

5	1. She technically is not experiencing infertility yet because the consensus among infertility exerts is that infertility evaluation should be done for couples that have not been able to conceive after 12 months of unprotected intercourse (Kuohung & Hornstein, 2023). Since this patient and her partner have been trying to conceive for 9 months, they don't quite meet the threshold yet for infertility classification but it's appropriate to get evaluated earlier based on medical history and physical symptoms, especially since this patient has a history of irregular menstrual cycles, painful periods, and intermittent LLQ bloating (Kuohung & Hornstein, 2023). These symptoms could indicate that she has an underlying gynecologic condition. 2. Two disorders that this patient may be facing are endometriosis and polycystic ovarian syndrome (PCOS). Endometriosis is an inflammatory disease characterized by the presence of endometrial glands and stroma outside the uterine cavity, which can cause painful menstruation (one of the patient's symptoms), chronic pain, and infertility (Schenken, 2025). There is a constellation of symptoms that can indicate endometriosis, which includes abdominal pain (i.e. patient's LLQ pain/bloating) with or without relation to menstruation, pain during urination, pain during defecation, constipation/diarrhea, irregular bleeding, nausea/vomiting, and feeling tired/lacking energy (Schenken, 2025). To assess endometriosis, I would ask if the patient has experienced any of these symptoms along with dyspareunia (pain while having intercourse), do a physical assessment, and potentially inquire about further testing depending on what the patient reports which would include ultrasound and surgical diagnosis through biopsy (Schenken, 2025). PCOS is the most common cause of infertility in women and is characterized by ovulatory dysfunction and hyperandrogenism (Shaw & Rosenfield, 2023). Some of its clinical features include menstrual irregularity (what the patient has), signs of hyperandrogenism such as hirsutism or mod/severe acne, polycystic ovaries, and obesity/insulin resistance. The cause of PCOS is unknown and can be difficult to diagnose, but further assessment of PCOS for this patient would include	I see what you mean with your feedback– I'm sorry I made you unsure! Your answer was very detailed. You included everything I was looking for even before answering number 3 as you stated diagnostics for each syndrome. Thanks for your hard work on this, you did great!	10/ 10

	attaining further medical history related to gaining weight, increased hair production, acne, and history of diabetes (Shaw & Rosenfield, 2023). Additionally, anovulation is very common in PCOS, which is when the ovaries fail to release an egg during a menstrual cycle, resulting in a lack of ovulation and could be contributing to this patient's trouble with fertility (Shaw & Rosenfield, 2023). Since her periods are irregular, it may appear that she is ovulating when she is not. Diagnostic testing would include ultrasound imaging, lab work, and full physical assessment. 3. Multiple factors may contribute to infertility. Therefore, it's important to assess both the patient and her partner. In this case, since the OB/GYN is specifically evaluating the patient, the diagnostic evaluations will focus on her. Both the patient and her partner would be asked to provide a complete medical history and undergo a physical examination. To note, the male partner would most likely also get a semen analysis done along with other testing. For the patient, diagnostic evaluation could include the following. - Menstrual history - Pelvic and intrauterine ultrasound - Labs including assessment of luteinizing hormone surge in urine prior to ovulation, FSH/estradiol levels to assess ovarian reserve, luteal phase progesterone level to assess ovulation, TSH, prolactin, b-hCG (Kuohung & Hornstein, 2023). - Future testing can include hysterosalpingogram or sonohysterogram to test tubal patency and uterine cavity along with laparoscopy if endometriosis is suspected (Kuohung & Hornstein, 2023) References: Kuohung, W., & Hornstein, M. D. (2023). Overview of infertility. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/overview-of-infertility		

	Schenken, R. S. (2025). Endometriosis in adults: Clinical features, evaluation, and diagnosis. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/endometriosis-in-adults-clinical-features-evaluation-and-diagnosis Shaw, N., & Rosenfield, R. L. (2023). Definition, clinical features, and differential diagnosis of polycystic ovary syndrome (PCOS) in adolescents. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/definition-clinical-features-and-differential-diagnosis-of-polycystic-ovary-syndrome-pcos-in-adolescents Feedback: I liked how this question touched on infertility and how there are multiple factors that can contribute to infertility. The question was written clearly but, in the future, more detail could be included regarding the amount of information you want in the answer. I found myself writing a very long answer because I didn't know what the exact expectations were for the answers.		
7	1. Priority nursing assessments for this patient would include vital signs to assess for infection/shock, a physical assessment with an abdominal-focused evaluation to check for distension, pain, bowel sounds, palpation, tenderness, and involuntary guarding, along with attaining a full medical history to determine if there could be underlying contributing factors causing the acute abdominal pain (Neuman, 2025). Some	Assessments: Focused abdominal assessment, detailed pain assessment, menstrual and sexual history 2/2	/ 10

	interventions would include managing Stella's pain with analgesics, controlling her nausea and vomiting with antiemetics, attaining IV access and potentially starting hydration, and preemptively making her NPO if surgical intervention is needed. Additionally, helping the patient get comfortable and seeking input from Stella's parents is crucial. 2. The lab tests that would be ordered for this patient include CBC, serum chemistries, and urinalysis (Neuman, 2025). Additionally, imaging is important to help distinguish between appendicitis and ovarian torsion, which can include ultrasound, x-rays, and/or CT scans (Neuman, 2025). To assess for ovarian torsion, an ultrasound with a doppler would be used to assess whether ovarian blood flow is decreased or absent, which could suggest ovarian torsion and the ovary may appear rounded, enlarged, or may appear differently compared to the other ovary due to edema, engorgement, or hemorrhage (Laufer, 2024). To determine if a patient may have appendicitis, the goal of ultrasound is to visualize the appendix. However, if the appendix is not visualized, other signs, such as RLQ free fluid, fat stranding, and adjacent bowel wall thickening, can support a diagnosis of appendicitis (Taylor et al., 2024). 3. Pharmacologic interventions for this patient could include analgesics for pain management, antiemetics to control nausea and vomiting, and IV antibiotics, especially if the patient has appendicitis. IV fluids could also be initiated to prevent dehydration, especially since the patient has been having nausea/vomiting and would be needed during surgery. 4. This case may be managed differently between pediatrics and adults first based on imaging preference. In pediatrics, we want to minimize exposure to higher amounts of radiation; therefore, ultrasound imaging is preferred since it involves no radiation exposure (Neuman, 2025). Conversely, if an adult presents with these symptoms, they may be more likely to undergo CT imaging. Additionally, due to the differences in development between pediatrics and adults, there may be different underlying medical concerns that contribute to the patient's symptoms, which should be identified and ruled out. For example, since this patient has not started menstruating yet, that would mean complications due to	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 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 Wow, great work. If I could assign bonus points I would!	

	pregnancy are not a primary concern compared to an adult patient. Finally, pediatric care is often family-centered and requires input from both the patient and their family compared to an adult who is their own decision maker. Considering and respecting these relationships is crucial, especially in pediatric cases, when parents often possess greater knowledge of their child's medical history. Depending on the age of the child, they may also have a harder time expressing and describing their symptoms compared to an adult, so increased patience and acknowledgement of developmental considerations is important. References: Laufer, M. R. (2024). Ovarian and fallopian tube torsion. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/ /ovarian-and-fallopian-tube-torsion Neuman, M. I. (2025). Emergency evaluation of the child with acute abdominal pain. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/emergency-evaluation-of-the-child-with-acute-abdominal-pain Taylor, G. A., Brandt, M. L., Esperanza Lopez, M. (2024). Acute appendicitis in children: Diagnostic imaging. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/acute-appendicitis-in-children-diagnostic-imaging Feedback:		

	I liked how this question covered multiple areas of knowledge including assessment, interventions, imaging, pharmacology, and the differences in care between pediatrics and adults. Though the foundations of medicine are practiced the same in pediatrics and adults, I liked how this question called out how there are still differences between pediatric and adult care that need to be considered.		
9	1. This patient most likely has appendicitis based on their signs and symptoms, including abdominal pain aggravated by movement, nausea, vomiting, fever, and RLQ tenderness (Brandt & Esperanza Lopez, 2024). Figure 1 illustrates the assessment of the Rovsing sign, which involves deep palpation of the left lower quadrant (LLQ) and the gradual release of pressure (Guo, 2025). A positive Rovsing sign is characterized by right lower abdominal pain upon palpation of the LLQ and can indicate appendicitis (Guo, 2025). When pressure is applied to the LLQ, this can increase tension near the appendix, increase intestinal gas in the colon, and cause resistance at the ileocecal valve, resulting in pain on the right side (Guo, 2025). 2. Appendicitis is caused by nonspecific obstruction of the appendiceal lumen, which can be caused by fecal material, undigested food, or enteric pathogens (Brandt & Esperanza Lopez, 2024). To further evaluate whether this patient has appendicitis, the provider will do a complete physical assessment and attain lab work such as CBC, CRP, and a urinalysis (Brandt & Esperanza Lopez, 2024). Diagnostic imaging would also be conducted and may include ultrasound or CT (Brandt & Esperanza Lopez, 2024). Overall, during the assessment and evaluation of this patient, other potential differential diagnoses should be ruled out based on the patient's medical history, symptoms, and diagnostic testing (Brandt & Esperanza Lopez, 2024). References:	Thank you for providing the right answers, which I was looking for. Your answers were well thought supported by great scholarly articles. Great answers!	10/ 10

	Brandt, M. L., & Esperanza Lopez, M. (2024). Acute appendicitis in children: Clinical manifestations and diagnosis. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/acute-appendicitis-in-children-clinical-manifestations-and-diagnosis Guo, L. (2025). Roving's sign. *Osmosis from Elsevier.* Retrieved May 29, 2025, from https://www.osmosis.org/answers/Rovsing-sign Feedback: Great question! This was clear, concise, and straight forward. I liked how you included a photo to demonstrate the assessment which was helpful when answering this question.		
11	1. C) Ulcerative colitis – Nataly's symptoms are most indicative of ulcerative colitis, including frequent bloody/mucous diarrhea multiple times a day, rectal urgency, tenesmus, abdominal pain, weight loss, and fatigue. Additionally, her colonoscopy results are in line with ulcerative colitis, showing continuous inflammation extending from the rectum proximally (Peppercorn & Kane, 2024). Nataly's symptoms don't align with Crohn's disease because Cronh's often involves unpredictable symptom flares with other systemic manifestations, including arthritis, and results on the colonoscopy would show a cobblestone appearance (Ball et al., 2023). Her symptoms are also much more severe than traditional irritable bowel syndrome and don't involve inflammation (Ball et al., 2023). Finally, she most likely doesn't have microscopic colitis because tissues often appear normal on a colonoscopy, and hers was not.	*Great job! All questions were answered accurately and completely. I apologize that took you that long to answer the questions. I have to say that you went way beyond to answer it. For the first question you just needed to say Option C is correct. The second part is a bit longer and definitely takes a considered amount of time to answer it. Looking at the bright side, you made it!! No more questions to answer or to make it. It is over!!*	10/ 10

	2. The goal of ulcerative colitis treatment is to achieve remission by demonstrating complete mucosal healing (Cohen & Stein, 2025). For mild to moderate ulcerative colitis (UC), patients typically start 5-aminosalicylic acid medications, such as mesalamine (Al Hashash & Regueiro, 2025). Mesalamine works by reducing inflammation in the intestinal lining and can be administered rectally through a suppository or enema or orally (Al Hashash & Regueiro, 2025). If UC progresses to moderate to severe ulcerative colitis, two pharmacological treatments include biologics such as azathioprine and glucocorticoids such as prednisone (Cohen & Stein, 2025). Azathioprine is a biologic, specifically an anti-tumor necrosis factor agent-based therapy, used to induce remission in moderate to severe UC with an expected clinical response from a few days to 8 weeks. Glucocorticoids are used to induce remission and provide more immediate symptom relief for patients who are started on a biologic for induction therapy (Cohen & Stein, 2025). They shouldn't be used long-term due to their list of side effects and because they are not used to maintain disease remission once achieved (Cohen & Stein, 2025). Patients often respond to glucocorticoids within a week with symptom improvement and should be tapered off the medication (Cohen & Stein, 2025). Two surgical procedures include restorative proctocolectomy with ileal pouch-anal anastomosis and total abdominal colectomy with end ileostomy (Fleshner, 2025)). A proctocolectomy with ileal pouch-anal anastomosis is an elective surgery for patients with chronic UC or who have increased cancer risk and could be considered during severe cases of UC and/or if medication management does not have desired results (Fleshner, 2025). During this surgery, the colon and rectum are removed while preserving the anal sphincter, which allows the patient to have normal bowel movements (Fleshner, 2025). Patients with UC can develop life-threatening complications such as colonic perforation, gastrointestinal hemorrhage, and toxic megacolon, which would all require emergency total abdominal colectomy with end ileostomy surgery where the entire colon is removed (Fleshner, 2025). Since Nataly has UC, she will go through regular monitoring and health procedures throughout her life, which include screening and prevention of		

	other diseases because of UC, such as cancer and osteoporosis (Al Hashash & Regueiro, 2025). She will receive regular colonoscopies to assess UC disease progression and risk for colorectal/anal cancer, along with bone mineral density testing to check for osteoporosis since UC increases the risk for bone loss (Al Hashash & Regueiro, 2025). Lab monitoring would also include assessing for anemia due to frequent bleeding as a result of UC, labs aimed at monitoring medication side effects such as serum creatinine if taking 5-ASA medications, complete CBC and liver function tests if patients are on biologics such as azathioprine, and finally CRP/ESR to monitor inflammation caused by UC (Al Hashash & Regueiro, 2025). References: Al Hashash, J., & Reguero, M. (2025). Medical management of low-risk adult patients with mild to moderate ulcerative colitis. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/ /medical-management-of-low-risk-adult-patients-with-mild-to-moderate-ulcerative-colitis Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart. R. W. (2023). *Seidel's guide to physical examination.* Elsevier Inc. https://www-clinicalkey-com./#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top Cohen, R. D., & Stein, A. C. (2025). Management of moderate to severe ulcerative colitis in adults. *UpToDate.* Retrieved May 29, 2025, from		

	https://www.uptodate.com/contents/ /medical-management-of-moderate-to-severe-ulcerative-colitis-in-adults Fleshner, P. R. (2025). Surgical management of ulcerative colitis. *UpToDate.* Retrieved May 29, 2025, from https://www.uptodate.com/contents/surgical-management-of-ulcerative-colitis Feedback: I liked how this question blended both multiple choice and open-ended answers. Nataly's symptoms clearly indicated ulcerative colitis which was helpful when answering the question. One thing to note is that this question was long and had what felt like 5 different parts including identifying the diagnosis, naming pharmacological treatment, surgical treatments, describing those treatments along with timing, and finally routine monitoring of the disease. Though the question touched on multiple attributes of UC, because there were many parts, I spent a significant amount of time answering this question. This may not have been your intention, and I could have done way too much work here, but it would be helpful in the future to tell the reader how detailed/long of an answer you're expecting.		
13	1. Eosinophilic esophagitis (EoE) is a chronic immune/antigen-mediated esophageal disease where eosinophils, a type of white blood cell, build up in the lining of the esophagus due to a reaction to foods, allergens, or acid reflux (Mayo Clinic, 2024). This buildup of eosinophils can lead to increased inflammation or damage to the esophageal tissue, resulting in	You did a great job with these answers! Your description of the pathophysiology demonstrated your understanding of this condition and your description of his medical and family history did as well. Nice work with identifying the management techniques. I appreciate	10/ 10

	symptoms such as difficulty swallowing or food getting stuck when swallowing (Mayo Clinic, 2024). 2. Sam has a history of seasonal allergies and atopic dermatitis, which are risk factors associated with EoE due to a heightened allergy response (Mayo Clinic, 2024). He also reports having progressive dysphagia and chest discomfort and said he must chew his food excessively while drinking water to help the food go down his throat. Increased chewing and the need for water could indicate that he's experiencing impaction, which occurs when food becomes stuck in the esophagus after swallowing (Mayo Clinic, 2024). Dysphagia, chest discomfort, and impaction are classic symptoms of EoE (Mayo Clinic, 2024). There is also a genetic component to EoE, and studies have shown that EoE can run in families; therefore, since Sam's dad and brother have EoE, he is at a higher risk of having it as well (Mayo Clinic, 2024). 3. Treatment of EoE can include the following techniques: - Dietary therapy – Changing a patient's diet is the first line of treatment for EoE because patients with EoE often have high rates of food allergies that contribute to the development of EoE and its symptoms (Bonis & Gupta, 2025). Dietary therapy would include allergen avoidance with elimination and/or elemental diets, which is primarily a liquid-based diet (Bonis & Gupta, 2025). - Proton pump inhibitors – PPIs are also a first-line pharmacologic option along with dietary changes and topic glucocorticoids (Bonis & Gupta, 2025). PPIs help decrease acid production, therefore limiting acid reflux and inflammation (Bonis & Gupta, 2025). - Esophageal dilation – Esophageal dilation is done when other treatments and therapies have not worked and when patients have high-grade strictures (Bonis & Gupta, 2025). This procedure widens or stretches narrowed areas in the esophagus to treat dysphagia but does not address any underlying inflammation the patient may have (Mayo Clinic, 2024). References:	the use of the in-text citations. Thanks for your feedback!	

	Bonis, P. A. L., & Gupta, S. K. (2025). Treatment of eosinophilic esophagitis (EoE). *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/treatment-of-eosinophilic-esophagitis-eoe Mayo Clinic. (2024). *Eosinophilic esophagitis.* Retrieved May 30, 2025, from https://www.mayoclinic.org/diseases-conditions/eosinophilic-esophagitis/symptoms-causes/syc-20372197 Feedback: This question is clearly written and touched on multiple components of EoE including pathophysiology, symptoms, family history/genetics, and treatment. I also liked how you incorporated an image of EoE to help further demonstrate what it would like when performing an EGD. Great job!		
15	1. Earl likely has liver cirrhosis due to his alcohol consumption, indicated by his various symptoms, including fatigue, weight loss, abdominal pain, confusion, yellow appearing skin/eyes (jaundice), abdominal distension, tea-colored urine, elevated ammonia, and liver enzyme tests (Ball et al., 2023). His use of Tylenol 1000mg Q4 hours can also contribute to his cirrhosis since he is taking much more than the suggested maximum of 4g/day, therefore contributing to his liver injury. 2. Ascites is the accumulation of fluid in the peritoneal cavity, one of the most common complications of cirrhosis (Goldberg & Chopra, 2025). To treat his ascites, Earl will get a paracentesis to drain the fluid from his abdomen. This procedure involves inserting a needle into the peritoneal cavity to drain ascite fluid.	Awesome job in providing a thorough and correct answer to this question! Earl does, in fact, have cirrhosis and is presenting with some significant ascites that would benefit from a paracentesis. Really impressive education pointers you mention that would benefit Earl while he takes his regimented lactulose as well. Thank you so much for your feedback!	10/ 10

	3. Lactulose lowers patients' ammonia levels by creating an acidic pH in the GI tract (colon) due to bacterial degradation of the medication (Mueller et al., 2025). This acidic environment prevents ammonia from diffusing across the GI membrane (decreasing blood ammonia levels), therefore trapping ammonia into the stool and is thus excreted (Mueller et al., 2025). This is the first point of education I would provide to Earl. Lactulose's mechanism of action makes it a laxative, and it will cause him to have multiple bowel movements, so it may be helpful to plan accordingly and be near a bathroom when he's taking the medication. It is also important to educate Earl on the potential side effects of lactulose, which can include abdominal cramps, distension, abdominal pain, bloating, diarrhea, nausea, and vomiting (Mueller et al., 2025). Many of these symptoms can be attributed to the medication's mechanism of action, and although they can be unpleasant, Earl needs to take his doses of lactulose to lower ammonia levels and treat or prevent his hepatic encephalopathy, as indicated by his confusion (Mueller et al., 2025). References: Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., & Stewart. R. W. (2023). *Seidel's guide to physical examination.* Elsevier Inc. https://www-clinicalkey-com./#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top Goldberg, E., & Chopra, S. (2025). 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 Mueller, B., Roberts, J. A,. Heung, M. (2025). Lactulose: Drug information. *UpToDate Lexidrug.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/lactulose-drug-information Feedback: This question is written very clearly and provides a significant amount of background information to help the reader make a diagnosis. You did a great job describing this patient's medical history and each question was straightforward.		
17	1. Tirzepatide is a dual agonist for glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP) receptors (Farzam & Patel, 2024). The medication stimulates insulin release from the pancreas, reduces hyperglycemia, and increases adiponectin levels (Farzam & Patel, 2024). In addition to treating hyperglycemia in diabetic patients, this medication is used for weight loss because it subsequently decreases a patient's appetite, slows gastric emptying, and decreases inappropriate glucagon secretion (Farzam & Patel, 2024). Tirzepatide peaks between 8-72 hours with a half-life of 5 days, which is why it is given once a week (Farzam & Patel, 2024). Consequently, some of the medication's adverse effects are gastrointestinal, causing nausea, vomiting, diarrhea, and delayed gastric emptying, which could explain Ruth's symptoms (Farzam & Patel, 2024). Additionally, studies have shown that tirzepatide can increase a patient's risk for developing gallbladder issues such as cholecystitis in Ruth's case (Zeng et al., 2023). GLP-1 can impair gallbladder motility/contractility, causing delayed emptying and cause bile stasis (Zeng et al., 2023). These medication side effects, especially the risk factors/impact tirzepatide can have on the gallbladder, along with Ruth's	Wow, you did an awesome job! You touched on all of the highlights I was looking for and more. Your explanations were concise but details, and I appreciate all the work you put into this. I hope it is helpful to you in your practice setting. Really nice work and thank you for your feedback!	10 / 10

present gallstones, could have all combined and contributed to her developing acute calculous cholecystitis.

2. One of tirzepatide's side effects is delayed gastric emptying, a consequence of being a GLP-1 agonist, which poses a concern for regurgitation and aspiration in patients under general anesthesia (Joshi et al., 2023). Ruth's nausea, vomiting, and the potential presence of abdominal distension along with her abdominal pain are all predictors that she may have increased residual gastric contents (Joshi et al., 2023). According to the ASA guidelines, if a patient is taking a GLP-1 agonist, such as tirzepatide, once a week, they should hold the medication for at least a week prior to surgery (Joshi et al., 2023). Since her last dose was 48 hours ago, the provider will do an ultrasound of her stomach to evaluate the volume of gastric contents present and evaluate her risk for aspiration (Joshi et al., 2023). Even if she's been NPO prior to surgery, the delayed gastric emptying caused by the medication can still cause her to have increased gastric residual volume (Joshi et al., 2023).
When Ruth returns from surgery post-op precautions would focus on preventing aspiration. This would include maintaining the head of her bad >30 degrees, monitoring for any nausea/vomiting, and treating it with antiemetics as needed. Additionally, Ruth's diet should only be advanced, as indicated by the provider. Other post-operative care considerations would include general monitoring for pain, infection, wound care, and mobility.

References:

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19	1. This patient likely has an upper GI bleed evidenced by his melena which are dark, tarry stools (Rockey, 2024). This patient has peptic ulcer disease, which is one of the primary causes of an upper GI bleed, and the bleeding could be coming from the ulcers in his stomach or duodenum (Rockey, 2024). Additionally, since this patient has a history of a-fib and takes apixaban this increases his risk for bleeding since apixaban is an	1. Gastrointestinal (UGI) Bleeding. 2/2 Awesome, you got it. 2. Interventions*3. 6/6 Awesome!! you mention IV fluid, hold Eliquis, labs, PPI, endoscopic and blood transfusion.	10/ 10

	anticoagulant. This patient's hypotension, slight tachycardia, and dizziness could also indicate hemodynamic instability because of a bleed (Rockey, 2024). 2. The interventions I would provide to this patient include the following. - Hemodynamic stabilization – This patient is exhibiting signs of hemodynamic instability due to the GI bleed. To address this, a large-bore IV would need to be placed and fluid resuscitation initiated, with the potential for a blood transfusion as needed, depending on the patient's H/H levels (Saltzman, 2025). Routine vital signs should be taken during this time to determine if the patient is responding to fluids as evidenced by improved BP and tachycardia, along with decreased dizziness. - Holding the patient's apixaban is also crucial, as the patient is actively bleeding, and the medication can exacerbate the symptoms or worsen the bleeding (Saltzman, 2025). - General lab work would also be collected, including CBC, coagulation studies (PT/INR, PTT), type and screen in case blood transfusion is needed, BUN/Creatinine, and a stool sample to confirm the presence of occult blood in the stool - A GI consult should also be attained with the anticipation that this patient will get an endoscopy to confirm the presence of an upper GI bleed (Saltzman, 2025). During the endoscopy, once a bleeding lesion is identified, the provider can treat it and achieve hemostasis, stopping the bleeding (Saltzman, 2025). 3. The first point of education I would provide to this patient would regard the use of apixaban and how that increases his risk for bleeding. Given his history of peptic ulcer disease in conjunction with taking apixaban, that overall increases the risk for an upper GI bleed, and it's important to recognize the signs and symptoms of a bleed at home (Saltzman, 2025). This would include dark/tarry stools, vomiting blood, feeling dizzy/lightheaded, and any visible signs of bleeding, which could include bright red blood in the stool in worse cases (Saltzman, 2025). If he starts experiencing any of these symptoms, he should seek medical care immediately. A second piece of education I would provide to this patient	3. nursing education*2. 2/2 That's good you mention signs of bleeding and importance of PPIs.	

	involves the importance of following up with a gastroenterologist and treating or managing his peptic ulcer disease with medications such as proton pump inhibitors to prevent future incidences of bleeding (Saltzman, 2025). Taking a PPI at home, such as omeprazole, can decrease stomach acid and help the ulcers heal, limiting the risk of the ulcers bleeding in the future (Saltzman, 2025). References: Rockey, D. C. (2024). Causes of upper gastrointestinal bleeding in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/causes-of-upper-gastrointestinal-bleeding-in-adults Saltzman, J. R. (2025). Approach to acute upper gastrointestinal bleeding in adults. *UpToDate.* Retrieved May 30, 2025, from https://www.uptodate.com/contents/approach-to-acute-upper-gastrointestinal-bleeding-in-adults Feedback: This question is well written, concise, and provided enough detail to help the reader determine a diagnosis. You covered multiple topics related to upper GI bleeds including symptoms, interventions, and patient education.		